

Banda

District AIDS Action Plan



2009–2012

BANDA DISTRICT AIDS PREVENTION AND CONTROL UNIT

Uttar Pradesh State AIDS Control Society

Lucknow

APRIL 2009

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FOREWORD

The third phase of the National AIDS Control Program (NACP) aims to decentralize program implementation from the state to the district level. This is envisaged to be done through setting up District AIDS Prevention and Control Units (DAPCUs). The DAPCUs are to be institutionalized with the District Health Society and will share the administrative and financial structures of the National Rural Health Mission (NRHM). The DAPCU in each district will be responsible for implementation of district AIDS control and prevention strategies; which includes implementing NACP strategies, facilitating convergence with NRHM activities, and building synergies with other related departments in the district. Convergence with NRHM is a crucial strategy to ensure optimum utilization of resources under NACP and NRHM and the construction of a strong monitoring and evaluation system through public health infrastructure in the district.

Uttar Pradesh State AIDS Control Society (UPSACS) has initiated the process of decentralization and has constituted District AIDS Prevention and Control Committees (DAPCCs) in five category “A”¹ districts—Allahabad, Banda, Deoria, Etawah and Mau. DAPCCs are similar to existing district program committees for all national programs and are responsible for overseeing planning and monitoring of district HIV programs. UPSACS, in consultation with the district stakeholders, has developed District AIDS Action Plans (DAPs), which aim to provide the DAPCUs with a framework for guiding implementation of HIV programs and supporting the achievement of state HIV/AIDS objectives.

I take this opportunity to acknowledge the contributions made by various stakeholders to the development of the DAPs. I acknowledge and appreciate the United States Agency for International Development (USAID) for providing financial and technical support. I also appreciate the contributions of the USAID | Health Policy Initiative, which managed and provided technical assistance in formulation of the DAPs. I would like to acknowledge the work of members of my team and the Technical Support Unit, who facilitated the execution of field work, district consultations, and plan development. I also acknowledge representatives from various departments, NGOs, and CBOs who participated in consultations.

I am confident that the DAPCUs—with support from NRHM and the District Administration, as well as other stakeholders from the government, non-governmental, and private sector—will make good use of the DAPs to implement robust HIV/AIDS programs.

S.P Goyal

Project Director,

Uttar Pradesh State AIDS Control Society

¹ More than 1 percent ANC prevalence reported by any of the sites in the district in the last three years.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
AYUSH	Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy
ANM	auxiliary nurse midwife
ASHA	accredited social health activist
AWC	<i>anganwadi</i> center
AWW	<i>anganwadi</i> worker
BCC	behavior change communication
CBO	community-based organization
CCC	community care center
CHC	community health center
CMHO	Chief Medical and Health Officer
CSR	corporate social responsibility
DACO	District AIDS Control Officer
DAP	District AIDS Action Plan
DAPCC	District AIDS Prevention and Control Committee
DAPCU	District AIDS Prevention and Control Unit
DAPM	District Program Manager for HIV/AIDS
DHAP	District Health Action Plan
DHS	District Health Society
DIC	drop-in center
DLHS	District Level Household Survey
DOHFW	Department of Health and Family Welfare
DOTS	directly observed therapy, short-course
DPMU	District Program Management Unit
DUDA	District Urban Development Agency
ESI	Employee State Insurance
FOGSI	Federation of Obstetrical and Gynecological Associations of India
FP	family planning
FSW	female sex worker
HIV	human immunodeficiency virus
HRG	high-risk group
HSS	Household Sample Survey
ICDS	Integrated Child Development Services
ICT	integrated counseling and testing
ICTC	integrated counseling and testing center
IDU	injection drug user
IEC	information, education, and communication
IMA	Indian Medical Association
IMNCI	integrated management of newborn and childhood illnesses
KVK	<i>Krishi Vignan Kendras</i>
LT	laboratory technician
M&E	monitoring and evaluation
MCHN	maternal and child health and nutrition
MIS	management information system
MPW	multi-purpose health worker
MSM	men who have sex with men
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NACP-III	National AIDS Control Program, Phase III
NBCP	National Blindness Control Program

NFHS	National Family Health Survey
NGO	nongovernmental organization
NLEP	National Leprosy Eradication Program
NRHM	National Rural Health Mission
NSS	National Student Service
NVBDCP	National Vector Borne Disease Control Program
NYK	<i>Nehru Yuva Kendra</i>
OI	opportunistic infection
OVC	orphans and vulnerable children
PEP	post exposure prophylaxis
PHC	primary health center
PLHIV	people living with HIV
PPTCT	prevention of parent-to-child transmission
PRI	Panchayati Raj Institutions
RCH	reproductive and child health
RCH-II	Reproductive and Child Health Program, Phase II
RMP	registered medical practitioner
RNTCP	Revised National TB Control Program
RTI	reproductive tract infection
SC	scheduled caste
SHG	self-help group
SRS	Sample Registration System
ST	scheduled tribe
STI	sexually transmitted infection
TB	tuberculosis
TG	transgender
TI	targeted intervention
TSU	Technical Support Unit
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
UPSACS	Uttar Pradesh State AIDS Control Society
USAID	U.S. Agency for International Development

BACKGROUND AND METHODOLOGY

I.1 Context

The contribution of health to economic and social development, as well as to overall quality of life, has long been recognized. In April 2005, the government of India launched the National Rural Health Mission (NRHM) to revitalize the health system and provide effective health care to rural populations throughout the country. The goal of NRHM is to “improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children².” NRHM focuses on 18 states, including Uttar Pradesh, with weak public health indicators and/or infrastructure. The mission seeks to ensure access to affordable, accountable, and effective primary health care by strengthening local-level health systems.

Under NRHM, states are encouraged to decentralize planning and implementation, making District Health Action Plans (DHAPs) the basis for health sector interventions. DHAPs reflect the unique epidemiological status of each district and are made up of five parts: 1) reproductive and child health (RCH); 2) immunization; 3) NRHM additionalities; 4) National Disease Control Program; and 5) intersectoral convergence, including the Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy (AYUSH).

In November 2006, the government of India approved Phase III of the National AIDS Control Program (NACP-III). The overall goal of NACP-III is to halt and reverse the spread of the HIV epidemic in India over the next five years by integrating programs for prevention, care, support, and treatment. The program’s priority areas include the following:

- Preventing new infections in high-risk groups (HRGs) and in the general population through saturation coverage of HRGs with targeted interventions (TIs) and scaled-up interventions in the general population.
- Increasing the proportion of people living with HIV/AIDS (PLHIV) who receive care, support, and treatment.
- Strengthening infrastructure, systems, and human resources in prevention, care, support, and treatment programs at the district, state, and national levels.
- Strengthening the nationwide strategic information management system.

The specific objective of NACP-III is “to reduce new infections as estimated in the program by 40 percent in the vulnerable states so as to stabilize the epidemic.” NACP-III emphasizes district-level planning and implementation to mitigate the effects of HIV/AIDS. It aims to integrate NACP interventions into the NRHM framework to optimize scarce resources, improve service provision, and ensure the longterm sustainability of interventions. To achieve this, District AIDS Action Plans (DAPs) will become the sixth component of the DHAP framework, drawing strength from convergence with other components of the district plan.

As described in Box 1 below, all districts in the country are classified as category A, B, C, or D, based on HIV prevalence and risk factors.

² Ministry of Health and Family Welfare. National Rural Health Mission (2005–2012): Mission Document. Accessible at <http://mohfw.nic.in/NRHM/Documents/NRHM%20Mission%20Document.pdf>.

Box I. Criteria for Classification of Districts under NACP-III

Category A: More than 1 percent HIV prevalence reported by any antenatal care (ANC) site in the district in the last three years.

Category B: Less than 1 percent HIV prevalence reported by all ANC sites over the last three years and more than 5 percent prevalence reported among any HRG, including individuals with sexually transmitted infections (STIs), female sex workers (FSWs), men having sex with men (MSM), and injection drug users (IDUs).

Category C: Less than 1 percent HIV prevalence reported by all ANC sites over the last three years, less than 5 percent HIV prevalence among HRGs, and the existence of known “hotspots” (the presence of migrant populations, truckers, large numbers of factory workers, tourists, and/or other groups with elevated risk of contracting HIV).

Category D: Less than 1 percent HIV prevalence reported by all ANC sites over the last three years, less than 5 percent HIV prevalence among HRGs, with no known hotspots; or poor/non-existent HIV data.

Source: Prioritization of Districts for Program Implementation, NACO.

Five districts in Uttar Pradesh (UP) have been identified as high prevalence, category A districts; Allahabad, Banda, Deoria, Etawah, and Mau. There are also 63 category C and two category D districts in UP. There are no category B districts in the state. District AIDS Action Plans are being prepared for category A districts based on the framework of services for districts in this category laid out in the National AIDS Control Organization (NACO) guidelines. The district plans integrate a variety of components to effectively implement prevention and treatment services and ensure the achievement of state and national HIV objectives. Table 1 outlines the package of services for category A districts, such as Banda.

Table 1. Package of Services for Category A Districts³

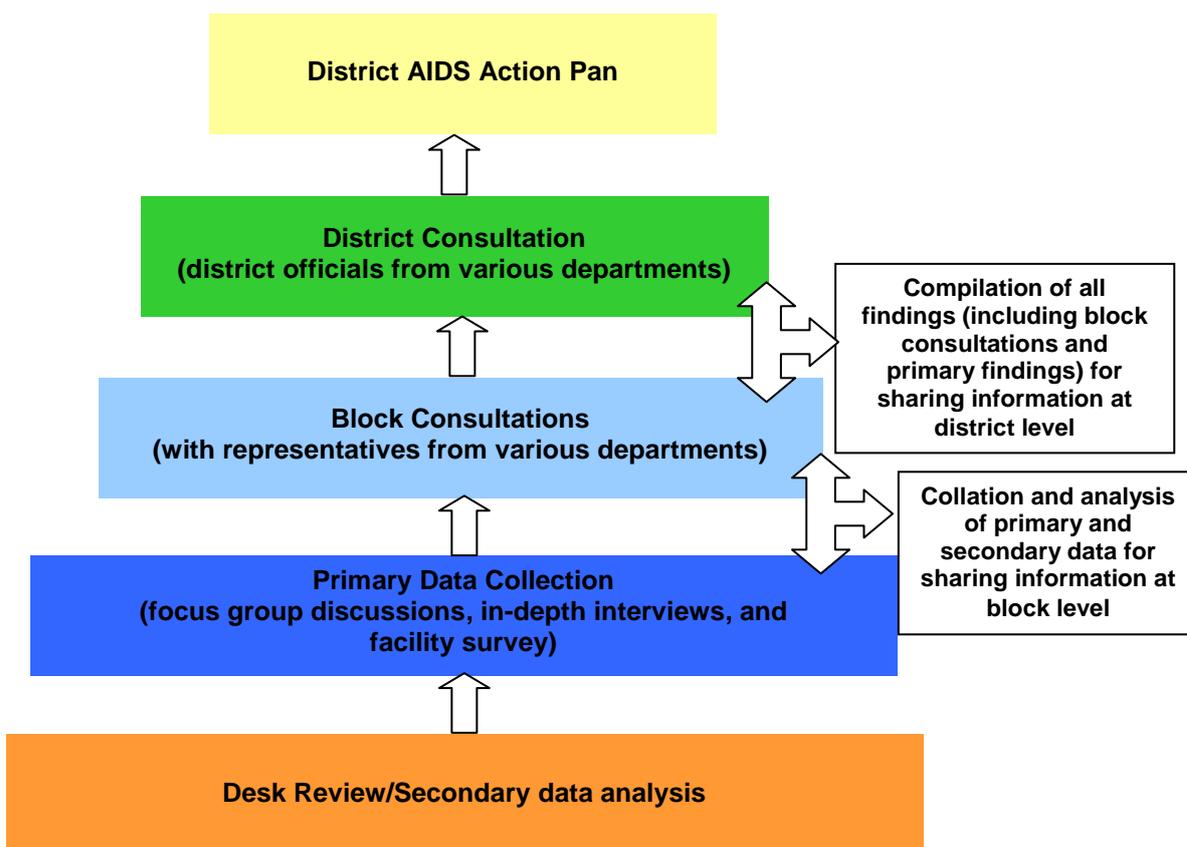
Level	Target Group	Services Provided
<ul style="list-style-type: none"> • Medical colleges • District, block and sub-divisional hospitals • Village/community 	<ul style="list-style-type: none"> • General population • High-risk groups (HRGs) • People living with HIV (PLHIV) 	<ul style="list-style-type: none"> • All HIV-related services will be made available under one roof, with necessary linkages to other services. HIV-related services include the following: <ul style="list-style-type: none"> - integrated counseling and testing (ICT) services - prevention of parent-to-child transmission (PPTCT) services - sexually transmitted infection (STI) services - diagnosis and treatment of opportunistic infections (OIs); and - antiretroviral therapy (ART). • Community health centers (CHCs) and nonprofit private health institutions will provide ICT, PPTCT, STI, and OI services, with necessary linkages to prevention, care, and treatment services. • Primary health centers (PHCs) and designated private providers will be responsible for STI control, diagnosis and treatment of OIs, and condom promotion. • Mobile ICT centers (ICTCs) will be deployed to serve hard-to-reach areas.

³ NACO: NACP-III Project Implementation Plan, Government of India, 2006, p.80

1.2 Overview of Plan Development Process

The DAP was prepared through a series of consultative processes carried out at different levels. Preparations involved exploring the district’s epidemiological situation, undertaking a needs assessment, and identifying opportunities for convergence with the district’s overarching NRHM program. A blend of grassroots-level analysis, block-level findings and secondary data analysis provided input for the district action plan. Each step of the data collection and planning process provided input for the following steps. The diversity of inputs yielded a comprehensive picture of the district’s HIV scenario, enabling planners to effectively tailor the DAP framework, prioritizing activities and resources to meet residents’ needs. Field studies and consultations were carried out in two blocks; Naraini and Mahua.

Figure 1. Preparation Process for District AIDS Action Plan



Secondary Data Review

The first step in creating the DAP was to undertake a needs assessment. The assessment compiled secondary data from a number of sources, including the third National Family Health Survey (NFHS-III), the state program implementation plan, and the state annual action plan. These sources were used to analyze the district’s HIV situation and design the DAP framework.

Primary Data Collection

After completing the needs assessment, the field team began collecting primary data. The team carried out interviews and discussions with both primary stakeholders (community members, including HRGs such as truckers) and secondary stakeholders (community health workers and other service providers, district and block officials, employees of nongovernmental organizations—NGOs—etc.). The interactive data collection process enabled the team to identify social and operational factors that are affecting—or have the potential to affect—program activities. To ensure the use of uniform data collection methods, all field team members attended a two-day orientation prior to beginning their

work. The training introduced them to the purpose of the study and familiarized them with the survey instruments.

Collation and Analysis of Primary and Secondary Data

Upon completion of primary data collection, the team began compiling a situation assessment based on both primary and secondary data. At the same time, core team members and field executives began making arrangements for block-level consultations. Close coordination with district- and block-level functionaries ensured a constant flow of relevant qualitative information, which supplemented the primary data collected by field teams.

Block-level and District-level Consultations

Block- and district-level consultations were conducted to ensure the inclusion of grassroots issues in the DAP. The main objective of these consultations was to validate the findings from primary data collection and to develop a district-specific planning framework based on those findings. Consultations with representatives of stakeholder departments such as Health, Women Empowerment and Child Development, Education, and Panchayati Raj Institutions (PRIs) provided relevant input from block-level bodies and guaranteed that the DAP would be the result of a collective, participatory process. The field executives and resident core team members were entrusted with the task of coordinating the stakeholder consultation exercise.

Preparation of the District Action Plan

Interactive consultations at the block level provided inputs for developing the DAP framework and prioritizing activities and resources. Strategies and specific activities were designed based on the information gathered from primary and secondary sources within the parameters set by NACP-III objectives. The final plan is based on a blend of grassroots-level analysis, block-level findings, and an overall district-level situation analysis. Some of the findings from these consultations and focus group discussions may be useful in designing training programs for stakeholders.

The DAPs were finalized after extensive review and feedback through a state consultative meeting in participation with the Uttar Pradesh State AIDS Control Society (UPSACS), the Technical Support Unit (TSU), state-level partners, and district NGO partners.

2.1 Geography and Overview of Health Scenario

Banda is the easternmost district of Bundelkhand and forms a part of Chitrakoot division. It is bordered on the north by the district of Fatehpur, on the east by the district of Chitrakut, on the west by the districts of Hamirpur and Mahoba, and on the south by the Satna and Panna districts of Madhya Pradesh.

The district is composed of four sub-districts or *tehsils*; Banda, Naraini, Baberu, and Atarra, and eight blocks; Badokhar-khurd, Jaspura, Tindwari, Naraini, Mahua, Baberu, Bisanda, and Kamasin. The Baghein river traverses the district from southwest to northeast.

Table 2: General Indicators

	Banda	Uttar Pradesh
Geographical area (in sq.km.)	4,460	240,928
<i>Tehsils</i> /Sub-districts	4	300
Blocks	8	901
Total number of villages	682	107,452
Number of inhabited villages	682	97,942
Number of inhabited villages <5000	42	2562
Number of towns	12	215

Source: Census of India (2001)

comparison with the state average.

Banda is predominantly rural, with the great majority (nearly five-sixths) of its population living in villages. The district's population density is only half that of the state average and there are large patches of uninhabited land. In some parts of the district, the population is scattered, which poses a challenge for service provision and access to basic facilities. Both female and male literacy rates are low in

Stone crushing/modeling is one of Banda's key economic activities and attracts migrants from nearby areas. Long exposure to stone crushers leads to a number of ailments among workers, particularly respiratory tract infections, tuberculosis (TB), and skin diseases. As part of the *pathaar* (stone) region, access to services, including basic health services, is a major challenge for Banda. *Pathaar* regions not only have difficult terrain, they also have extremely hot summers that last from April to October. The combination of terrain and weather conditions negatively impacts the outreach efforts of programs in the district.

Banda's decadal growth rate is significantly lower than the state average, which itself is among the lowest in the country. Data from the third District Level Household Survey (DLHS-3) paint a grim picture of development in Banda district and the resulting standard of living.

Table 3. Demographic Indicators

Population Index (2001)	Banda	Uttar Pradesh
Total population	1,537,334	166,197,921
Female population	710,790	78,632,552
Male population	826,544	87,565,369
Rural population	1,293,316	131,658,339
Urban population	244,018	34,539,582
Child population (0–6 years)	288,283	30,472,042
Percent of child population (0–6 years)	18.75%	18.33%
Population density	340	689
Decadal growth rate (1991–2001)	18.49%	25.80%
Male/female ratio	860	898
Ratio of male/female children (0–6 years)	916	915
Literacy rate	54.38%	57.36%
Male literacy rate (7+ years)	69.28%	70.23%
Female literacy rate (7+ years)	36.78%	42.98%
Scheduled Caste (SC) population	20.83%	21.1%
Scheduled Tribe (ST) population	0.00%	0.1%

Source: Census of India (2001)

Table 4. Standard of Living Index

	DLHS-3		DLHS-2	
	Total	Rural	Total	Rural
Low (%)	77.1	85.4	66.4	87.3
Medium (%)	12.7	10.0	18.2	10.6
High (%)	10.2	4.7	15.4	2.1

Source: DLHS-3

Figure 2. Health Facilities in Banda

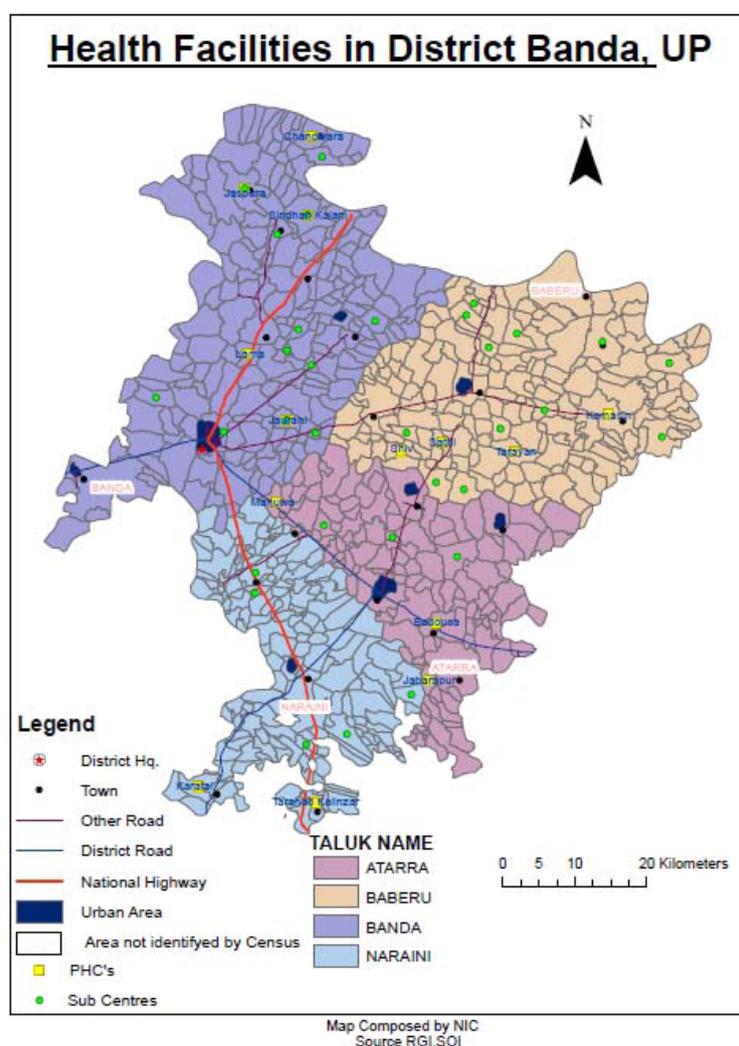


Table 5. Health Facilities At-a-Glance

	Banda	Uttar Pradesh
Medical colleges	-	19
District hospitals (male)	1	70
District hospitals (female)	1	69
Community Health Centers (CHCs)	3	386
PHCs (includes block, sub-block, and additional PHCs)	50	3,660
Sub-centers	201	20,521
Anganwadi centers (AWCs)	1,323	153,223
DOTS ⁴ centers	168	25,733
Microscopy centers	15	1,750
TB units***	4	369

Sources: NRHM PIP 2007; TB India 2009; Central TB Division, Ministry of Health and Family Welfare; District TB Office

⁴ Directly observed therapy, short-course

Table 6. Fertility Indicators

	Banda	Uttar Pradesh
Total fertility rate	4.6	4.4
Crude birth rate	32.4	31.4

Source: Census of India (2001)

Mother and Child Health Indicators

Mother and child health indicators for Banda raise serious concerns. The district ranks far below the state average for mother and child health, and UP's indicators are themselves among the poorest in the country. Female sterilization is the preferred method for limiting family size in the district. Nearly one out of five women opt for sterilization, whereas male sterilization figures are very low (0.3%). While these figures nearly match the state average for UP, they point to potential challenges faced by married women in negotiating safe sex. Every third girl married in Banda is underage, a large majority of pregnant women do not receive full ANC, and fewer than one in women deliver in a health care institution. Women's youth at marriage heightens their vulnerability to a number of health risks, including sexually transmitted infections (STIs) and HIV. Limited access to ANC facilities in the district is an obstacle to the provision of effective prevention of parent-to-child transmission (PPTCT) services.

Table 7. Mother and Child Health Indicators

	Banda	Uttar Pradesh
Total number of pregnant women	56,638 ⁵	6,611,040
Girls married before completing 18 years of age	29.0%	33.1%
Women who had at least three ANC visits (in last pregnancy)	20.3%	21.9%
Women who received full ANC ⁶	-	2.8%
Institutional deliveries	17.6%	24.5%
Institutional deliveries under JSY ⁷	21,146	956,007
Home deliveries attended by skilled personnel	9.3%	7.4%
Children (ages 12–23 months) who received full immunization ⁸	13.7%	30.3%

Table 8. Family Planning Indicators

	Banda (%)	Uttar Pradesh (%)
Women who use any method of family planning	45.1%	38.4%
Women who use any modern method of family planning	25.8%	26.7%
Female sterilization	18.6%	16.5%
Male sterilization	0.3%	0.2%
Couples using condoms	6.1%	7.1%
Unmet need for family planning	26.9%	33.8%

Source: DLHS-3

⁵ 30 birth rate plus 10 percent wastage

⁶ Full ANC: At least three visits for antenatal check-up, one Tetanus Toxoid injection received, and 100 IFA tablets or adequate amount of syrup consumed.

⁷ *Janani Suraksha Yojana*, Health Directorate. Progress report for 2008–2009.

⁸ Full immunization: BCG, three doses each of DPT and polio vaccine, and one dose of measles vaccine.

2.2 Overview of HIV/AIDS Situation

Banda's HIV/AIDS profile is described using two parameters; vulnerability factors and infection patterns over time. Data pertaining to HRGs, migration patterns, HIV and STI awareness, and condom use have been analyzed to gain an insight into factors affecting Banda's vulnerability to HIV. The presentation of infection patterns is based on HIV sentinel surveillance data and data on detected cases of HIV collected from service delivery points (SDPs).

High-risk and Vulnerable Populations

Certain groups, including FSWs, MSM, transgender (TG), and injection drug users (IDUs), have been identified as facing a higher risk of contracting HIV than the general population. Elevated HIV prevalence rates among these groups contribute to the rapid spread of HIV. The table below presents data on seropositivity among HRGs in Banda.

Table 9. Seropositivity among HRGs as Reported by TI Projects (Feb–Dec 2008)

	HRG		
	MSM	IDU	FSW
Number of people counseled	352	469	821
Number of people referred to ICTC	40	307	347
Number of people who visited ICTC	300	150	450
Number of people found HIV-positive	12	12	24

Recognizing the importance of saturating coverage among HRGs to prevent further spread of the epidemic, NACO and UPSACS commissioned studies to map the number of sites and the estimated population of HRGs in Uttar Pradesh. The first such state-level study was conducted in 2001 and a second study was carried out in 2008. The profile of HRGs in Banda is presented in Table 10 below. The information presented in the table is based on the provisional report of the 2008 mapping data, which is currently being revalidated by NACO. Further details on HRGs are provided in the section on targeted interventions (see page 20).

Table 10. HRG Populations in Banda (2008)

FSW	Sites	14
	Total	297
MSM	Sites	9
	Total	118
IDU	Sites	2
	Total	21
Hijra⁹	Sites	11
	Total	163

⁹ *Hijras* are a specialized category of transgender individuals. They constitute a distinct socio-religious and cultural group, a 'third gender'. They dress in feminine attire and are organized under seven main *gharans* (clans). Hijras can be further classified into *niravan* (those who have been castrated) and *akva* (those who have not undergone emasculation). For the purposes of TI projects, Hijras are covered under the term 'transgender' or TGs.

Table 11: HIV-related Facilities and Targets for 2009–2010

	Banda		Uttar Pradesh	
	Existing	Target (2009–2010)	Existing	Target (2009–2010)
ICTCs	7	None	171	16
PPTCT centers	1	None	79	-
District hospitals (male)	1	None	7	5
Dist hospitals (female)	1	None	70	-
ART centers	-	1 (link ART)	69	-
Blood banks	1	None	46	13
Blood storage units	-	-	20	11
STI clinics	1	None	79	2
TI STI clinics	2	None	91	3
Community care centers (CCCs)			9	1
Drop-in centers (DICs)	-	1	5**	-

** There are presently 11 DICs in UP, but as of 2009–2010 there will be only five in category A districts

Targeted Intervention

There two TI projects operating in Banda. The projects are operated by Mangal Jyoti Mahilla evam Bal Uthan Sansthan and Anudhay Seva Sansthan. Both projects are composite¹⁰ interventions and are reaching out to all three HRGs (FSWs, MSM, and IDUs). Coverage targets for the projects' first year of operation (2008–2009) are included in Table 12.

Table 12. NGO TIs in Banda District

Implementing Organization	Type of Intervention	Target Population (2008–2009)			
		FSW	MSM	IDU	Total
Mangal Jyoti Mahilla evam Bal Uthan Sansthan	Composite	300	125	200	625
Anudhay Seva Sansthan	One new TI (Composite)	250	150	0	400

HIV and AIDS Awareness

Lack of knowledge of HIV, especially of prevention methods, is one of the key vulnerability factors for communities. Although overall there was only a marginal change between DLHS-2 and DLHS-3, the survey data show that the percentage of women who had heard about HIV/AIDS in Banda district declined slightly. Over the same period, the number of women in Banda who knew that consistent condom use reduces the chance of HIV transmission increased substantially, from 16.5 to 26.7 percent. Almost 84 percent of those unmarried women who had heard about HIV/AIDS have correct knowledge about it, with only marginal differences between rural and urban populations. It is interesting to note that correct knowledge of HIV/AIDS among unmarried women ages 15–24 in rural areas was exactly the same as in urban areas.

¹⁰ Composite interventions target all three high-risk groups (FSW, MSM, and IDUs) simultaneously. As the mapping exercise revealed small populations for each HRG, using a composite approach is most effective.

Table 13. Knowledge of HIV/AIDS and RTI¹¹/STI among Women

	DLHS-3		DLHS-2	
	Total	Rural	Total	Rural
Ever-married Women Ages 15–49 (in percent)				
Had heard of HIV/AIDS	27.2	21.2	28.4	14.3
Knew that consistent condom use can reduce the chances of contracting HIV	26.7	23.1	16.5	16.4
Had correct knowledge of HIV/AIDS (of those who had heard of HIV/AIDS)	84.8	81.9	-	-
Had been tested for HIV	1.2	1.1	-	-
Had heard of RTI/STI	11.2	8.0	-	-
Unmarried Women Ages 15–24 (in percent)				
Had heard of HIV/AIDS	51.1	42.2	-	-
Knew that consistent condom use can reduce the chances of contracting HIV	31.2	33.9	-	-
Had correct knowledge of HIV/AIDS	88.8	88.3	-	-
Had been tested for HIV	0.5	0.0	-	-
Had heard of RTI/STI	15.3	12.7	-	-

Source: DLHS 3

Condom Use

Condom use is an important factor in HIV prevention. District-level data show a slight decline in condom use for family planning (FP) over the two survey periods from 8 percent to 6 percent.

HIV Prevalence

HIV prevalence can be determined by examining data from a variety of sources, including the annual Household Sample Survey (HSS) conducted by NACO and data from SDPs. ICTCs, ART centers, and district-level PLHIV networks are three main sources of service delivery data that are useful for tracking HIV prevalence. Analyzing these data provides an overview of the district's HIV situation.

Table 14. HIV Sentinel Surveillance Data (in percent)

	2004	2005	2006	2007 ¹²
ANC Clinic	1.75	0.00	0.00	0.00

Source: UPSACS

Seropositivity rates at ANC clinics and PPTCT centers in Banda have declined significantly over the last three years; falling from 1.75 percent in 2004 to zero in 2008. Before assuming that this indicates a receding epidemic situation in the district, it is important to study the underlying causes of this sudden drop in prevalence.

¹¹ Reproductive tract infection

¹² The data for 2008 are currently being compiled.

Table 15. ICTC Data (Jan–Dec 2008)

	Banda	Uttar Pradesh
Number of ICTCs	7	155
Total population (estimated as of January 2008)	1,689,285	196,049,343
Sexually active population	844,642	98,024,671
Population prone to risky sexual behavior	42,232	4,901,234
Number of people tested for HIV at ICTCs (April 2007–January 2008)	2,485	240,438
Seropositivity	0.89%	4.54%
Persons counseled and tested per ICTC per day	39	172
Targets for 2009–2010	12,872	574,790

Source: AAP-UP-09-10

Table 16. PPTCT Center Data

	Banda	Uttar Pradesh
Number of PPTCT centers	1	79
Number of people tested for HIV at PPTCT centers (January–December 2008)	13,469	218,785
Seropositivity	0%	0.16%
Number of people counseled and tested per PPTCT center per month	1,497	308
Targets for 2009–2010	10,620	474,202

Source: AAP-UP-09-10

Table 17: Number of STI Cases Attended and Treated at STI Clinics and NGO STI Clinics (Jan–Dec 2008)

Month	First Clinic Visit (for index STI/RTI complaint)		First Clinic Visit (for no STI/RTI complaint)		Total Number of First Clinic Visits		Repeat STI/RTI visit (for index STI/RTI complaint)		Total Number of Syndromic Diagnosis Cases		
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Total
Jan	86	0	86	0	172	0	0	0	169	0	169
Feb	700	232	0	0	700	232	248	133	675	232	907
March	564	234	0	0	564	234	238	85	522	204	726
April	392	166	0	0	392	166	0	0	381	174	555
May	358	188	0	0	358	188	101	142	353	195	548
June	412	208	0	0	412	208	153	115	411	223	634
July	566	164	0	0	566	164	188	87	566	164	730
Aug	736	172	0	0	736	172	300	149	736	172	908
Sept	99	55	508	119	607	174	159	113	607	174	781
Oct	20	36	609	109	629	145	196	99	20	36	56
Nov	33	23	483	133	516	156	119	78	516	156	672
Dec	18	14	385	167	403	181	41	32	406	181	587
Total	3,984	1,492	2,071	528	6,055	2,020	1,743	1,033	5,362	1,911	7,273

Table 18. HIV-related Facilities At-a-Glance

	Banda		Uttar Pradesh	
	Existing	Target (2009–2010)	Existing	Target (2009–2010)
ICTCs	7	-	155	-
PPTCT centers	1	-	79	-
Blood banks	1	-	67	-
Blood storage units	1	1	-	-
STI clinics	2	-	79	65
TI STI clinics	2	-	91	17
Community Care Centers (CCC)	-	-	9	1
Number of TIs	2	-	52	
Drop-in centers				
Sentinel surveillance sites	-	-	98	-

There has been a significant increase in the number of integrated counseling and testing centers (ICTCs) in Banda, with six new ICTCs becoming operational in 2008 alone. Currently, there are ICTCs at the district hospital, three CHCs (Baberu, Jaspura, Narayani), and three PHCs (Bisanda, Kamasim, Sindwari). In terms of facilities and infrastructure for HIV-related services, the proposed targets for 2009–2010 include only one new item; a female STI clinic. However, there is a need to constantly monitor ICT facilities to ensure that they are providing consistent, high-quality services.

Table 19. Blood Bank Status Report

	2008	Cumulative (2002-2008)
Number of units tested	333	2,591
Number of units found HIV-positive	2	10

Source: UPSACS

Infrastructure and Services

The table below provides an overview of infrastructure and existing services in Banda. This is based on a facility survey and discussions with concerned staff at UPSACS and the Technical Support Unit carried out as part of the DAP preparation process.

Table 20. Infrastructure and Services

Infrastructure	ICTC District hospital (male)	ICTC District hospital (female)
Is water available for drinking?	Yes	No
Is water available for toilet?	Yes	Yes
Is electricity available in the facility?	Yes	Yes
What type of power backup facility is available	Generator	Inverter
Communication Facilities	ICTC District hospital (male)	ICTC District hospital (female)
Is there a telephone in the facility?	No	No
Is there a STD telephone facility?	No	No
Is there a computer in the facility?	Yes	Yes
Does the facility have a computerized health management system in place to store patient records?	Yes	Yes
Services	ICTC District hospital (male)	ICTC District hospital (female)
What services are offered at the center?	HIV counseling and testing	HIV counseling and testing
Days allotted for counseling and testing of pregnant women	All working days	All working days
Does the facility provide group counseling?	Yes	Yes
If yes, how many people (on average) per group?	4–5	4–5
How long (on average) is each group session?	30–35 min	30–35 min
Are condoms available in the center?	Yes	Yes
Where are the condoms kept?	Counseling room	Counseling room
HIV Counseling	ICTC District hospital (male)	ICTC District hospital (female)
Is there a waiting room/area available?	Yes	Yes
Number of chairs in the waiting room	5	5
Is there a counseling room?	Yes	Yes
Number of counseling rooms	1	1
Physical infrastructure in counseling room:		
a. Desk and chair for the counselor	Yes	Yes
b. Lockable filing cabinet for records	Yes	Yes
c. Computer with printer and UPS	Yes	Yes
d. Computer table, with a chair	Yes	Yes
e. Waste basket	Yes	Yes
f. Number of chairs for clients	2	2
Is privacy ensured?	Yes	Yes

HIV Testing	ICTC District hospital (male)	ICTC District hospital (female)
Is separate lab/blood sample collection room?	Yes	Yes
Equipment observed in testing room:		
Refrigerator	Yes	Yes
Centrifuge	Yes	Yes
Needle destroyer	Yes	Yes
Micropipette	No	Yes
Components for infection control and waste management	Yes	Yes
Testing kits	Yes	Yes
Safe delivery kits	No	Yes
Staff	ICTC District hospital (male)	ICTC District hospital (female)
Counselors	-	1
Laboratory technicians	1	-
Patients per day	12–15	15–20
Waiting time for patients	10–15 min	10–15 min
IEC Material	ICTC District hospital (male)	ICTC District hospital (female)
Flipcharts	Yes	No
Condom demonstration models	No	No
Posters	Yes	Yes
Pamphlets/Handouts	Yes	Yes
Is any audiovisual material being played in the waiting room?	No	No

FRAMEWORK FOR PROGRAM ACTIVITIES

NRHM is a comprehensive, broad-based program, which integrates all vertical health programs of the Department of Health and Family Welfare (DOHFW), including the second phase of the Reproductive and Child Health Program (RCH-II), the National Vector Borne Disease Control Program (NVBDCP), the Revised National TB Control Program (RNTCP), the National Blindness Control Program (NBCP), and the National Leprosy Eradication Program (NLEP). Under the NRHM framework, different national programs merge together at the state level into a common State Health Society, while at the district level all program societies merge into the District Health Society (DHS). The governing body of each DHS is chaired by the Chairman of the *Zila Parishad*¹³/District Collector; the executive body is chaired by the District Collector; and the Chief Medical and Health Officer (CMHO) is the Member Secretary.

Different programs in DHS operate through program-specific committees constituted at the district level. These committees ensure convergence across all programs, while at the same time maintaining independence in achieving program goals through specific interventions. To optimize scarce resources and mainstream HIV, NACP is being integrated into the NRHM framework. The new institutional framework for NACP activities at the district level under NACP-III merges the District AIDS Control Society with the DHS and creates linkages with the Block Rural Health Mission and with Village Health and Sanitation Committees.

3.1 District AIDS Prevention and Control Committee (DAPCC)

Analogous to the role of district program committees for national programs under the NRHM framework, the DAPCC is intended to exercise effective ownership, implementation, supervision, and mainstreaming of NACP activities at the district level. The committee is responsible for overseeing the planning and monitoring of the physical and financial activities planned in the District AIDS Action Plan. It will ensure appropriate management of funds coming to the District AIDS Program Control Unit (DAPCU) for project activities.

The DAPCC has not been established in Banda district. The members of the committee will include the following:

1. Chief Medical and Health Officer (CMHO): Chairman
2. Medical Superintendent, District Hospital
3. District HIV/AIDS Control Officer (DACO): Member Secretary
4. District Program Manager for HIV/AIDS (DAPM)
5. District Program Manager for NRHM
6. District-level officers for tuberculosis (TB) and RCH
7. District Information, Education, and Communication (IEC) officer
8. District Monitoring and Evaluation (M&E) officer
9. Medical Officers in rotations: Officer-in-Charge of ART center, community care center (CCC), and ICTC (*three*)
10. One representative each of TI projects, CCCs, and PLHIV networks (*three*)
11. Representatives of related departments identified by DAPCU for convergence— Women Empowerment and Child Development, Panchayati Raj Institutions (PRIs), Labor, Mines, Industry, Tourism, Urban Local Bodies, etc. (*five*)

¹³ District Council

3.2 District AIDS Prevention and Control Unit (DAPCU)

The District AIDS Prevention and Control Unit (DAPCU), also called the District Program Management Unit (DPMU) or the District AIDS Cell, will be the secretariat and the central coordinating unit for day-to-day program operations. An additional District Medical Officer/Deputy CMHO (Health) or the district officer for leprosy will be appointed as the District AIDS Control Officer (DACO). The DACO is the nodal person for all HIV/AIDS activities in the district and will spearhead implementation of district-level strategies for the prevention and control of HIV in Banda.

The DAPCU is headed by the District Program Manager for HIV/AIDS (DAPM), who reports to the DACO. The proposed DAPCU would have the following institutional structure:

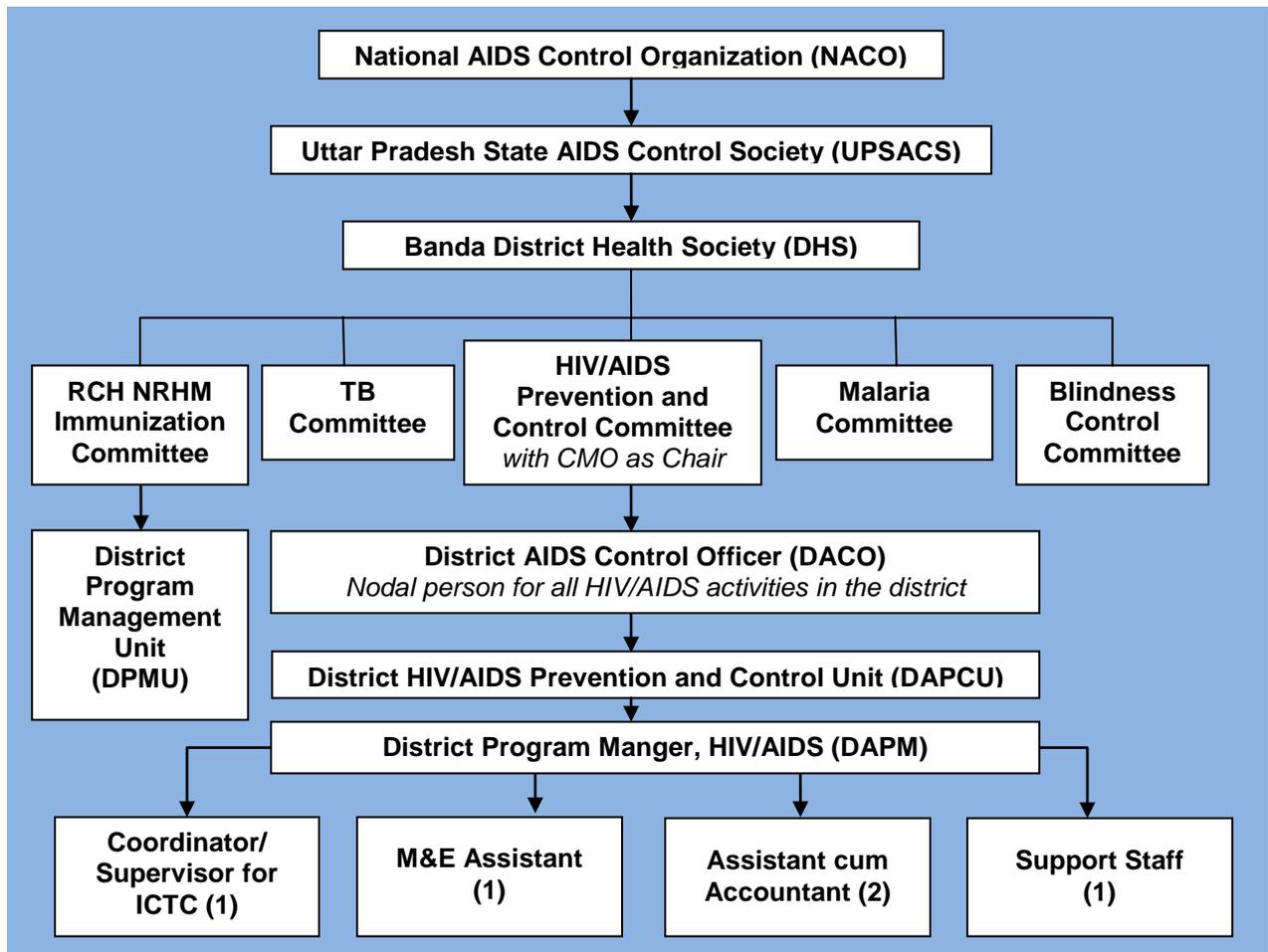


Table 21. DAPCU Roles and Responsibilities

Area	Specific Responsibilities
Implementation of NACP–III Strategies	<ul style="list-style-type: none"> ○ Monitor and implement program activities. ○ Coordinate with partners for program planning, implementation, and review. ○ Supervise and carry out district-level capacity building. ○ Supervise ICTCs (District ICTC Coordinator). ○ Report quarterly to District Coordination Committee and UPSACS on progress and program activities.
Convergence with NRHM activities	<ul style="list-style-type: none"> ○ Coordinate convergence of district HIV/AIDS program activities with NRHM activities.
Convergence with NRHM activities	<ul style="list-style-type: none"> ○ Coordinate convergence of district HIV/AIDS program activities with other related departments.

DAPCU staff are appointed on a deputation/contract basis. The selection of staff will be made by UPSACS and DHS in accordance with state-specific policies. The terms of reference for DAPCU staff are listed in the section on Human Resource Planning (see section 7.2 on page 41).

PURPOSE OF THE PLAN

NACP-III envisions expanding the network of HIV/AIDS services from the NACP-II pattern of selective NGO/CBO¹⁴-led provision of care, support, and treatment, to universal delivery of services through integration with the public health infrastructure. This will ensure an enhanced continuum of care for PLHIV and others affected by HIV. The new approach emphasizes decentralization of services, mainstreaming, intersectoral convergence, and community ownership of and support for HIV/AIDS prevention and control efforts.

The DAP offers a roadmap for effectively decentralizing implementation of the NACP. The objectives and broad strategies outlined in the plan are for the period coinciding with the NACP-III (2009–2012); however, plan activities will need to be reviewed and revised on an annual basis in keeping with the targets set for the district, changing epidemiological trends, and emerging challenges and opportunities.

Vision

To create and implement a multipronged, sustainable strategy that will enable Banda to achieve the NACP-III goal of halting and reversing the HIV/AIDS epidemic by 2012 through effective management of core NACP interventions and by expanding access to services through mainstreaming with NRHM and other relevant departments.

Goal

To implement a comprehensive intersectoral action plan to reduce the incidence of new HIV cases to zero in Banda district by 2012 by deploying effective prevention strategies and providing accessible testing, treatment, care, and support services that are free from stigma; thereby improving the quality of life of PLHIV and others affected by HIV.

Strategy

The main strategy under NACP-III is to expand the network of HIV/AIDS services through integration with the public health infrastructure. The new approach emphasizes decentralization of services, mainstreaming, intersectoral convergence, and community ownership of and support for HIV/AIDS prevention and control efforts.

¹⁴ Community-based organization

INSTITUTIONAL STRENGTHENING FOR CORE ACTIVITIES

5.1 Targeted Intervention (TI)

To saturate coverage of HRGs and prevent new HIV infections, UPSACS has launched targeted intervention projects in collaboration with local-level NGO partners. The TI strategy focuses on raising HRGs' level of HIV knowledge through interpersonal communication, motivating them to adopt safer behaviors, improving their access to condoms and other prevention services—especially STI and ICT services—and creating an enabling environment for HIV prevention. The strategy will achieve its goals by expanding the reach of TI projects through partnerships with NGOs/CBOs and through a link worker scheme.

Objective

To facilitate the mainstreaming of TI projects into the district's existing health care system.

Situation Analysis

A recent mapping study¹⁵ estimates that there are 297 FSWs, 139 MSM (including 21 *hijras*), and 163 IDUs in Banda. No data is available on migrant populations in the district. Currently, there are two TI projects being implemented in Banda. The projects are being implemented by local NGO partners; Mangal Jyoti Mahilla evam Bal Uthan Sansthan and Abhuday Sansthan.

The TI projects are largely concentrated in Banda's urban areas. Through composite interventions, they are reaching out to 550 FSWs, 275 MSMs, and 200 IDUs. The TI projects use a peer-led approach and their key activities include interpersonal communication, STI services, condom promotion, a needle exchange program for IDUs, and community mobilization campaigns to encourage safe behaviors. The projects also operate two STI clinics, with one part-time doctor for each clinic and one full-time nurse for the IDU project. The TI projects work among HRGs through peer educators who are appointed by the HRG community. The projects also promote condoms by making them available in locations that are easily accessible to HRGs. There is a need to design behavior change communication (BCC) material targeted toward specific groups and to focus on generating awareness in their particular context.

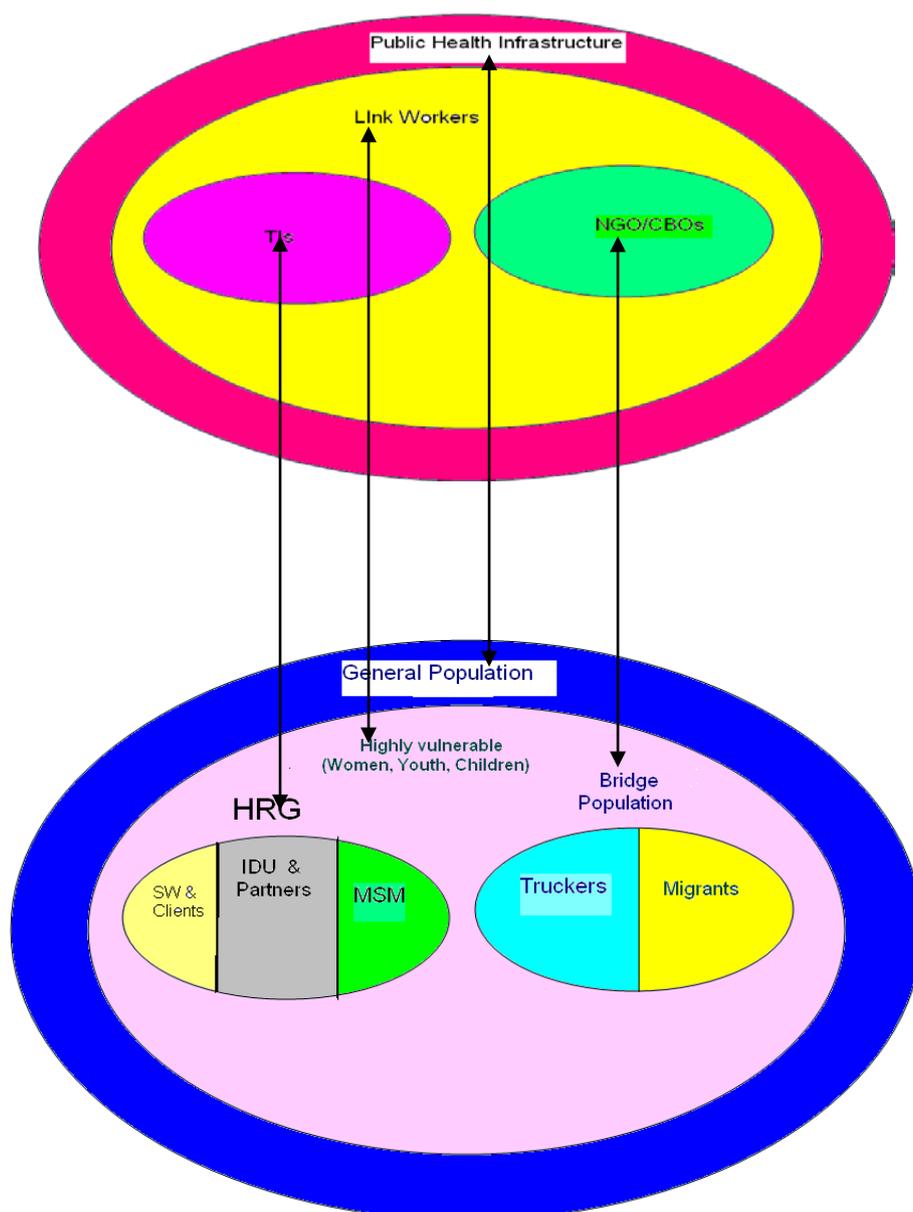
There is considerable scope for strengthening coordination among agencies and departments working on HIV, such as TB clinics, STI clinics, ICTCs, PPTCT centers, and other district-level health units. High levels of HIV-related stigma contribute to widespread reluctance to seek testing services, which in turn affects the number of HIV cases reported in the district.

Table 22: Outreach Coverage by NGO TI Projects (Jan-July '08)

	FSW		IDUs		MSM	
	New	Repeat	New	Repeat	New	Repeat
Contacted by NGO staff/outreach worker	250	2,756	96	1,750	78	997
Contacted by peer educator	252	3,338	96	2,458	83	1,468

¹⁵ The mapping of core and migrant groups (under NACP-III) in Uttar Pradesh was done by Social and Rural Research Institute (IMRB) for Constella Futures and Family Health International. Revalidation of this data is being done by NACO.

Figure 4. Population Mapping for Targeting Service Provision¹⁶



Strategies

- Strengthen systems for effective implementation of TI projects.
- Utilize public health delivery system to provide supplies, service delivery, and follow-up for HRGs.
- Initiate private sector partnerships to expand coverage of HIV interventions for HRGs.

¹⁶ Operational guidelines for Districts AIDS Prevention Control Units

Action Plan

- Involve TI project representatives in district-level meetings conducted by DAPCU and DHS.
- Coordinate monthly interaction between NGOs/TI projects and public health department to share and plan activities targeting HRGs.
- Establish systems for monitoring, feedback, and reporting.
- Ensure that TI projects' monthly reports to UPSACS are copied to DAPCU for their information and any necessary action.
- Carry out spot checks to assess quality of TI project services and send reports to UPSACS as appropriate.
- Intensify link worker scheme to reach out to rural areas.
- Coordinate with UPSACS to facilitate uninterrupted supply of necessary materials (IEC material, condoms, etc.)
- Sensitize health care providers at all levels, including health outreach workers, to enable them to assist in TI project activities to improve grassroots-level service delivery.
- Serve as effective channel of communication among TI projects, other service providers, and UPSACS to resolve any bottlenecks or challenges that arise.

Responsibility

DAPCU, TI implementers

5.2 Antiretroviral Therapy (ART) / Treatment

The antiretroviral therapy (ART) program has adopted a public health approach to the administration and distribution of antiretroviral (ARV) drugs. This approach entails a comprehensive prevention, care, and treatment program with a standardized, simplified combination of ART regimens; a regular, secure supply of high-quality ARVs; and a robust monitoring and evaluation system. The public health approach for scaling up ART aims to provide care and treatment to as many people as possible, while working toward universal access to care and treatment. Access to and availability of ART remains a major cause of concern for PLHIV throughout India. Often PLHIV encounter problems when attempting to access ART, such as long queues, malfunctioning CD4 count machines, ARV stockouts, lack of availability of second line drugs, poor management and administration, and indifferent or uncooperative staff.

Objective

To make ART available to all eligible PLHIV in Banda.

Situation Analysis

Banda has no full ART center, but a link ART center (for drug disbursement) was established in the district hospital in October 2008 and, as of December, 32 PLHIV were accessing ART through the center. As the center opened only recently, it still faces a number of operational challenges. For example, the pharmacist in the district hospital is overworked, which negatively impacts appropriate distribution of ARV drugs. At present, individuals are referred to Lucknow, Allahabad, and Varanasi for comprehensive ART services. However, due to their distant location and the cost of travel, few PLHIV actually travel to these centers for follow-up tests or biannual CD4 counts, leading to inconsistent treatment adherence. There is an informal network of PLHIV in the district that provides ad hoc support to PLHIV for treatment preparedness and adherence, including nutrition advice and facilitating access to ARTs. However, no formal system or budget exists to provide this type of support.

Strategy

- Monitor and follow up with PLHIV to ensure ART adherence.

Action Plan

- Address administrative and logistical issues to ensure effective functioning of link ART center (including furnishing, privacy of space, necessary trainings, etc.).
- Assist in maintaining adequate and regular supply of drugs to link ART/ART center, providing regular updates to UPSACS in case of supply gap.
- Recruit link ART center staff.
- Facilitate linkages between ART center and outreach workers, link workers, and NGO/TI project staff.
- Help strengthen district PLHIV network.
- Organize periodic trainings and refresher courses, especially on counseling PLHIV on ART to facilitate treatment adherence.
- Promote sample collection for CD4 count around hotspots.
- Ensure records of PLHIV in district are regularly updated and lost-to-follow-up cases are tracked.

Responsibility

CMO/Medical Officer-in-Charge for Health (NRHM), UPSACS, DAPCC, DAPCU, NGOs, PLHIV networks

5.3 Integrated Counseling and Testing (ICT)

HIV counseling and testing services are a key entry point to HIV prevention, as well as to the provision of treatment, care, and support to HIV-positive individuals. ICTCs provide the entire range of ICT services; including HIV testing, pre- and post-test counseling, distribution of medicines, and follow-up care, in a supportive and confidential environment.

Objective

To provide HIV testing and counseling services, prevent the transmission of HIV, and promote positive living among PLHIV.

Situation Analysis

The district has one ICTC in the male district hospital and one PPTCT center in the female district hospital. In 2008, six new ICTCs were established at CHCs and 24/7 PHCs and mandatory training for ICTC staff was conducted.

Table 23. ICTC Status

	2008	Cumulative (2002-2008)
Number of people tested	2,485	3,312
Number found HIV-positive	2	98
Percent found HIV-positive	0.89%	-

Source: UPSACS

There is currently a shortage of staff at Banda's district hospital ICTC and PPTCT center. The PPTCT center has one lab technician and no counselor, while the ICTC has no lab technician, one counselor (female) and one visiting, part-time doctor. ICTCs in Banda have no linkages with NGO TI projects, nor has a mechanism been established to facilitate such linkages. Clients visiting the centers are primarily voluntary rather than referred. In 2008, 2,485 people were tested at Banda's ICTCs, of whom 22 were found to be HIV-positive. At the PPTCT center 13,469 people were tested in 2008, none of whom were HIV-positive.

The ICTCs and PPTCT center have adequate supplies of HIV test kits and condoms. In early 2008, however, delays in the supply of test kits from NACO to UPSACS led to a gap in district-level availability. Post exposure prophylaxis (PEP) drugs are not readily available in Banda, nor are there any condom demonstration models at centers providing ICT services.

Strategies

- Strengthen existing ICTCs and PPTCT center and expand coverage through convergence with other departments and organizations.
- Catalyze increased demand for ICT services.
- Promote public-private partnerships for providing ICT services in underserved areas.

Action Plan

- Facilitate expansion of ICT services through CHCs and 24/7 PHCs and through engagement of private providers.
- Fill vacant counselor and lab technician positions at ICTCs and PPTCT center.
- Carry out periodic inventory control and quality checks at ICTCs and PPTCT center (responsibility of District ICTC Coordinator and/or Medical Officer-in-Charge)
- Build capacity of counselors and lab technicians to improve service delivery.

- Organize monthly, district-level meeting to ensure integrated functioning of different departments and program elements (ICTCs, TI projects, STI clinics, and TB department).
- Request periodic need-based service delivery training for ICTCs/PPTCT center staff from UPSACS.
- Promote outreach and follow-up services through link workers and outreach workers.
- Facilitate establishment of referral protocol between DOTS center and ICTCs/PPTCT center.
- Ensure availability of test kits and other necessary equipment at ICTCs/PPTCT center and inform UPSACS of any gaps in supply delivery.
- Establish formal linkages with TI projects to promote positive living among PLHIV.
- Work with NGOs and other service providers to enhance demand for ICT services through innovative use of IEC.

Responsibility

DAPCU, DAPCC, UPSACS, NGOs/TI implementers

5.4 Blood Safety

Blood banks are guided by the National Blood Policy and the Drugs and Cosmetics Act, which mandate the ready, timely availability of safe (tested/screened), high-quality blood. Blood is primarily tested for HIV, hepatitis, syphilis, and malarial infection before transfusion. To phase out reliance on professional, remunerated blood donors and build a base of voluntary donors, blood banks, under the aegis of state blood transfusion councils, hold regular awareness and donation campaigns.

Objective

To reduce HIV transmission in Banda through improved blood safety, and to ensure the timely availability of safe blood and blood products.

Situation Analysis

Banda has one blood bank and there are no blood storage or blood component separation facilities in the district. The blood bank is located in the district hospital and is supported by NACO and UPSACS. Blood units are collected from a variety of donors. From April–December 2008, replacement collection at the government blood bank was 343 units; voluntary blood collection was 409 units; and 88 units were collected 21 voluntary blood donation camps. Donated blood units are tested for infections, including HIV, hepatitis B, hepatitis C, syphilis and malaria. There are two blood bank technicians, one medical officer, one lab attendant, and one nurse employed at Banda's blood bank.

Table 24. Available Equipment and Functional Status

Name of Equipment	Number	Functional
Blood bank refrigerator	3	Yes
Donor couch	0	-
Bio-mixer	0	-
Tube sealer, striper with cutter	0	-
Di-electric sealer	1	Yes
Domestic refrigerator	1	Yes
Bench top centrifuge	1	Yes
Dry incubator	1	Yes
Serological water bath	1	Yes
Autoclave	1	Yes
Binocular microscope	1	Yes
Micropipettes	3	Yes

Strategies

- Improve blood bank operations.
- Promote voluntary blood donation to maintain optimal blood supply levels in correspondence with district's needs.

Action Plan

- Appoint DACO as nodal officer for blood safety and provide him/her with support necessary to manage blood safety program.
- Ensure adequate supply and functionality of equipment and consumables through NRHM and NACP and regularly inform UPSACS about supply status to guarantee uninterrupted supply.
- Enforce compliance with blood collection, supply, and storage protocols; and with blood transfusion safety standards.

- Train blood bank medical officer and staff to ensure compliance with NRHM and NACP blood safety protocols.
- Organize blood donation camps in partnership with youth programs, NGOs, and government departments; and educate community on importance of voluntary blood donation and use of safe/screened blood in transfusion.

Responsibility

Nodal officer (DACO), district hospital

5.5 Supplies and Logistics

Ensuring the availability and quality of medicines and other consumables at treatment centers is of the utmost importance. Therefore, adherence to proper stock-keeping practices, such as proper and safe storage of materials; use of first-in, first-out mechanisms; estimation of supply requirements; proper indenting and follow-up, is critical.

Objective

Ensure the regular, uninterrupted supply of goods and consumables under NACP and NRHM to support HIV prevention, treatment, care, and support activities.

Situation Analysis

ICTCs, the PPTCT center, link ART centers, TI projects, and blood banks are the main SDPs in Banda. The primary supply requirements for these SDPs are refrigerators, centrifuges, needle destroyers, micropipettes, components for infection control and waste management, adult and pediatric ARV drugs, and testing kits. There is also a need for a regular supply of condoms and IEC material to NGOs implementing TI projects to facilitate smooth implementation of their interventions.

Table 25. Supply Needs by Service Delivery Point

Service Delivery Points	Estimated Supply Requirements (2009–2010)
7 ICTCs 1 PPTCT	<ul style="list-style-type: none"> • 2,342 rapid test kits (1st, 2nd, 3rd) • 2,342 disposable syringes and gloves • 5 condoms each for 12,872 people accessing ICT services (64,360 total) • Nevirapine tablets • Nevirapine syrups • Safe delivery kits
2 TI projects	<ul style="list-style-type: none"> • Disposable needles (to be procured directly by TI NGOs) • Condoms and lubricants • HRG-specific IEC material, especially take-away materials and BCC kits for peer educators
1 Blood bank	<ul style="list-style-type: none"> • Test kits for HIV, HBSAG (hepatitis B), HCV (Hepatitis C), MP, and syphilis (VDRL) • Blood bags, disposable syringes, and other consumables • IEC material
1 Link ART center	<ul style="list-style-type: none"> • ART drugs for new cases every month • ART drugs for the cumulative number of people on ART (32) • PEP drugs

Strategies

- Achieve optimal resource utilization through convergence with NRHM/public health department.
- Provide adequate and timely funding to guarantee uninterrupted supply and avoid stockouts.

Action Plan

- Verify stocks, estimate need, and collect materials on a monthly basis.
- Collect supply requirements quarterly from district hospital, ICTCs, PPTCT center, blood banks, TI projects, ART center, and nodal link workers and send request to UPSACS.
- In case of stockout, arrange restocking from parallel health interventions under NRHM.
- Appoint district program supervisor as person-in-charge for supplies.
- Use NRHM logistics system to procure and deliver HIV-related supplies.
- Ensure appropriate storage mechanisms for goods and supplies.
- Ensure that proper inventory is maintained and updated regularly.

Responsibility

District ICTC Coordinator, ART Coordinator (Medical Officers-in-Charge)

CONVERGENCE WITH NRHM

As HIV spreads beyond isolated groups and begins to affect the general population, preventing and reversing the epidemic's spread requires coordinated collective action on the part of all stakeholders. NACP-III aims to integrate its interventions into existing NRHM institutional frameworks at the district level. This will enable NACP to reach individuals all the way down to the village level, while making optimal use of limited human and financial resources. NACP-III envisions achieving its goals by expanding the scope and effectiveness of actions through the creation of a wider support system. This would involve integrating HIV interventions, such as voluntary counseling and testing services and IEC with other NRHM service delivery channels, as well as training grassroots workers such as auxiliary nurse midwives (ANMs), accredited social health activists (ASHAs), and *anganwadi* workers (AWWs) in HIV service delivery. To facilitate this integration, actions for convergence and mainstreaming of HIV/AIDS interventions have been proposed in the DAP.

Convergence of the AIDS control program and NRHM will be carried out by placing the NACP under the overall umbrella of the NRHM framework through the DHS. The district planning process under the NRHM and the initiatives under the RCH-II program offer an opportunity to merge HIV/AIDS-related services into general health services.

Objective

To create a district structure for planning, implementation, and supervision of NACP activities.

Situation Analysis

Under NACP-II, the implementation of HIV/AIDS activities was mostly conducted through TI projects and NGOs. The nodal officer for district-level activities was the District TB Officer. The Uttar Pradesh Health Department is developing a system for achieving convergence of NACP activities with the NRHM institutional framework at the district level.

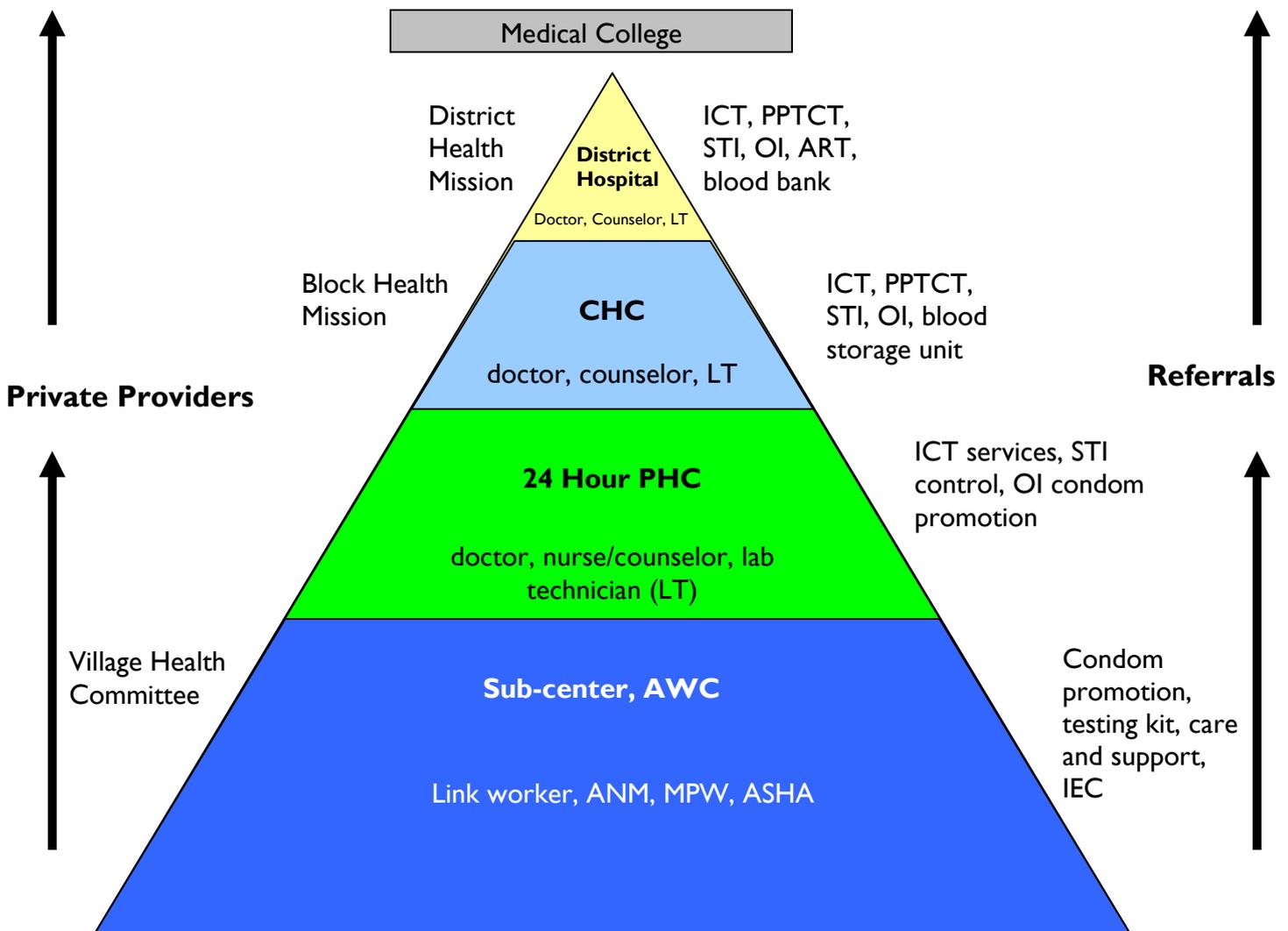
While DAPCC has been established in principle, so far only one of the six members of the DAPCU—the ICTC Coordinator—has been appointed in Banda. The DAPCU has not yet become fully operational.

Strategies

- Operationalize DAPCC.
- Develop detailed plan for convergence with key stakeholder organizations/departments, including the following elements:
 - Strengthen service delivery by expanding availability of HIV services at CHCs and PHCs.
 - Mainstream district-level NACP structure with public health infrastructure.
 - Upgrade district-level technical capacity by using contract mechanisms to engage qualified professionals.
 - Integrate NACP functions with RCH program, TB control program (referral protocol between DOTS and ICTCs), and other health and family welfare programs.
 - Collaborate with NGOs, CBOs, professionals, and other civil society organizations to deliver sensitization, care and support services, and referrals.
 - Address HIV issues at the village level through *anganwadis* for women and adolescents.
 - Engage AWWs to provide nutritional support for HIV-positive pregnant women.
 - Involve private doctors in providing HIV-related services.
 - Intensify counseling, advocacy, and referrals at village level through Maternal and Child Health and Nutrition (MCHN) day.

- Furnish honoraria to ASHAs, ANMs, and multi-purpose health workers (MPWs) for providing HIV-related services.
- Address HIV prevention, control, care, treatment, and support in Village, Block, and District Health Plans—implemented by Village Health and Sanitation Committee, Block Rural Health Mission, and District Health Mission, respectively.
- Engage PLHIV network in efforts to reduce stigma and discrimination, improve quality of HIV-related services, promote treatment adherence, and reduce number of PLHIV lost to follow-up

Figure 3. Institutional Framework: Public Health Sector Services



6.1 Condom Promotion

In addition to being a safe method of population control, condoms have assumed special significance in the era of HIV/AIDS, as they are the only effective method—apart from total abstinence—of preventing the sexual transmission of HIV. Departments of health and family welfare and NGOs are working to overcome moral, ethical, and/or religious barriers to promoting the use of condoms among sexually active people—particularly those who engage in high-risk behaviors. In order to increase access to condoms, especially among marginalized and hard-to-reach groups, the UPSACS program implementation plan calls for intensified rural marketing programs and non-conventional distribution approaches.

Objective

Condom promotion for dual safety.

Situation Analysis

Condoms are freely available to both the general population and HRGs at ICTCs and STI clinics. Most of the demand for condoms among HRGs is fulfilled by TI projects through peer educators and STI clinics. However, free condoms available at STI clinics and testing centers reach only those who visit them. There are no condom vending machines at hotspots. Community health workers' capacity to promote condoms also needs to be built, as they currently promote condoms predominantly to "eligible couples" for family planning purposes. There is also a need to address the prevalent attitudes, perceptions, and myths regarding condoms among health care providers, including outreach workers. Whereas TI projects usually have an uninterrupted supply of condoms, condom stockouts occur in ICTCs and STI clinics, largely because of a lack of timely reporting of supply needs.

Strategies

- Pursue collaborative condom promotion and supply strategy under NRHM and NACP.
- Use effective inventory management to ensure uninterrupted supply of condoms at all levels.

Action Plan

- Promote correct and consistent use of condoms among PLHIV and general population through intensified IEC/BCC activities.
- Build capacity of health staff and link workers in condom promotion, including ability to demonstrate correct condom use for HRGs and PLHIV.
- Develop and roll out plan for installing and monitoring condom vending machines at hotspots, STI clinics, and other strategic locations.
- Ensure free and regular supply of condoms to HRGs.
- Use social marketing to promote condom use in rural areas through health workers and link workers.
- Identify needs and gaps in condom availability each month and ensure timely supply from UPSACS.

Responsibility

Health department, DAPCU, UPSACS, NGOs/TI implementers, ICTCs

6.2 Maternal Health

The district PPTCT center aims to prevent the spread of HIV among women, especially expectant mothers. Parent-to-child transmission of HIV can occur during pregnancy, at the time of delivery, and through breast-feeding. The PPTCT center works to prevent this through a combination of low-cost, short-term, preventive drug treatments; safe delivery practices; counseling and support; and safe infant feeding methods. Institutional deliveries bring pregnant women into the formal health system, after which they can be motivated to undergo counseling and testing and health care providers can conduct post-delivery follow-up with HIV-positive mother/baby pairs.

Objective

To promote the early identification of HIV-positive pregnant women to enable timely care and support to prevent parent-to-child transmission of HIV in Banda.

Situation analysis

The number of institutional deliveries in Banda is quite low in comparison with the state average. Only 17.6 percent of women deliver in institutions, many of whom are underage. This assumes tremendous significance given that the estimated number of pregnancies for the year 2009–2010 is 56,638. With such a low percentage of institutional deliveries, a large number of pregnant women may not be able to access appropriate services for preventing parent-to-child transmission of HIV.

The post of counselor at the PPTCT center has been vacant for a long time. Women accessing the center therefore do not receive any counseling. In 2008, 13,469 persons were tested at the PPTCT, none of whom were found to be HIV-positive.

Strategies

- Scale up PPTCT services by involving private providers.
- Promote institutional deliveries and develop support mechanisms for HIV-positive pregnant women.

Action Plan

- Maintain supply chain of safe delivery kits and drugs from UPSACS to PPTCT center.
- Generate demand for PPTCT services through IEC.
- Communicate and provide PPTCT counseling services at ANC day.
- Provide specialist doctor (obstetrician/gynecologist) through convergence with RCH-NRHM.
- Train practitioners to handle PLHIV cases and administer nevirapine.
- Motivate pregnant women to go for institutional delivery through community-level workers, link workers, and appropriate use of IEC.
- Track and support HIV-positive women through service providers (ASHAs, ANMs, link workers, outreach workers, and other local societies/social workers).
- Collaborate with private practitioners and encourage them to share their ANC data with DAPCU.

Responsibility

Health (NRHM), UPSACS, DAPCU, private providers

6.3 Infant and Pediatric Care

NACP-III provides pediatric ART services through ART centers. The DAP proposes to link PPTCT centers with ART centers for diagnosis and follow-up. At present there is no fully functional ART center in Banda district, thus the district does not provide data on the number of children on ART. An adequate support mechanism for HIV-positive children and children born to HIV-positive parents in Banda needs to be developed.

Objective

To identify HIV-positive newborns in a timely fashion and provide them with the care, support, and treatment they require

Situation Analysis

Currently there is no data regarding infant and pediatric HIV care in the district.

Strategies

- Intensify tracking of HIV-positive mothers and outreach by health workers and link workers.
- Ensure institutional deliveries for HIV-positive mothers and keep records of children who test positive for HIV.
- Expand outreach through convergence with NRHM-RCH under Integrated Management of Newborn and Childhood Illnesses (IMNCI) initiative.

Action Plan

- Follow up with HIV-positive mothers to ensure that their newborns are tested six weeks after delivery.
- Facilitate timely and adequate provision of ART drugs to HIV-positive mothers and children.
- Orient health workers and link workers on follow-up for HIV-positive mothers and provision of counseling for care and support of both mother and child.
- Advocate with Integrated Child Development Services (ICDS) staff for convergence with ICDS to provide nutritional support to HIV-positive mothers and children.
- Liaise with and train private practitioners to increase availability of PPTCT services.

Responsibility

Health (NRHM), UPSACS, DAPCU, private providers

6.4 Sexually Transmitted Infection (STI)

The prevalence of STIs significantly increases the risk of HIV transmission, as the presence of ulcers or discharge facilitates HIV transmission. As STIs and HIV are spread by the same set of risk behaviors, the government places top priority on the prevention and control of STIs as a strategy for controlling the spread of HIV/AIDS in the district.

Situation Analysis

Two STI clinics (one NGO STI clinic and one at the male district hospital) are currently operating in Banda. Between April and December 2008, 4,866 STI cases were treated at the male hospital STI clinic. However, only 21 cases were treated at the gynecological OPD. There is one counselor at the hospital STI clinic who is attached to the ICTC. The Medical Officer in-Charge of the ICTC also acts as the Officer-in-Charge of the STI clinic.

Table 26. Distribution of STIs by HRG (Jan–Dec 2008)

	FSW	MSM	IDU	Truckers	Migrants	Clients of SW
Number who attended STI clinic	14	11	10	0	0	0
Number treated at STI clinic	8	3	4	0	0	0
Number who attended NGO STI clinic	6	5	4	0	0	0
Number treated at NGO STI clinic	3	2	2	0	0	0

Objective

Reduce Banda's STI burden.

Strategies

- Expand access to quality STI treatment.
- Promote health seeking behavior among STI cases and their partners.
- Coordinate convergence with RCH/NRHM for STI clinics and treatment program.

Action Plan

- Ensure adequate logistical arrangements and supplies and regularly monitor service delivery quality.
- Appoint qualified and dedicated staff on contractual basis to strengthen STI team.
- Strengthen mechanisms for referring STI cases to ICTCs.
- Organize orientation of government and private health providers on STI treatment services.
- Build capacity of outreach workers to strengthen STI service delivery.
- Periodically review inventory to ensure availability of STI drugs at sub-centers, PHCs, and CHCs.
- Prepare IEC material on STIs for use by ASHAs/ANMs in counseling sessions.
- Develop flipcharts and booklets for STI counseling emphasizing link between STIs and HIV/AIDS.
- Lead convergence process with RCH camps for outreach and mainstreaming of STI treatment in villages.

Responsibility

Health (NRHM), UPSACS, DAPCU

6.5 IEC and Advocacy for Behavior Change

As one of the most vulnerable districts in Uttar Pradesh, Banda has been prioritized by UPSACS for IEC action. The purpose of developing an IEC strategy is to generate awareness of HIV in the community through mass, folk, and other forms of media; to motivate behavior change in identified at-risk population groups; and to generate demand for health services. This will help create an enabling environment for HIV prevention, as well as for the provision of institutional and community-based care and support.

Situation analysis

As the local dialect is spoken throughout the district, existing IEC material is not effective in communicating messages to the community. In the past, there has been a tendency to use hoardings and wall writings, posters, and pamphlets as a “straightjacket” approach. Adequate attention has not been paid to client-friendly education and services, interpersonal communication, or tailoring messages to reach specific target groups.

Objective

To raise awareness of HIV, promote health seeking behavior, encourage safe practices for HIV prevention, and increase social acceptance of and support for PLHIV.

Strategies

- Design focused strategies for specific target groups such as HRGs, adolescents, women, and general community
- Integrate relevant HIV-related information and advice in IEC strategy for doctors, paramedics, and other health workers.
- Develop integrated communication strategies for local governing bodies, such as PRIs and municipal corporations.

Action Plan

- Develop materials with prevention messages for specific HRG members (such as IDUs, sex workers, truckers, migrants), vulnerable populations (such as women and youth), and for the general community.
- Mainstream HIV/AIDS messages into other departments’ IEC material.
- Build peer educators’ ability to track behavior change patterns.
- Work with NGOs/TI implementers to generate effective IEC material by involving target groups.

For the general population

- Use print media, TV, radio, hoardings, wall paintings, street plays, puppet shows, meetings, etc. to disseminate HIV prevention messages.
- Display IEC material, such as hoardings and wall paintings, in public places and use folk media generate awareness and encourage behavior change.
- Promote acceptance of PLHIV by addressing HIV-related stigma and discrimination.
- Focus on specific messages such as safe sex practices and voluntary testing.

For adolescents

- Carry out youth education by adding HIV subject for adolescents to school curricula.
- Involve teachers and influential community members in spreading HIV messages.
- Use Red Ribbon clubs in schools and colleges to sensitize youth on HIV issues.
- Sensitize children in school on importance of voluntary testing and counseling.
- Target youth population in villages, especially girls reached through ICDS, by forming adolescent groups at village level.

- Organize voluntary blood donation camps.

For women

- Discuss HIV prevention and safe sex practices during self-help group (SHG) and *Mahila Mandal* meetings or during ANC day.
- Promote PPTCT services and safeguards for newborns.

For HRGs and PLHIV

- Disseminate prevention messages promoting safe sex in locations frequented by HRGs.
- Promote voluntary counseling and testing through referral from TI projects.
- Involve PLHIV in creation of IEC material targeting PLHIV.
- Mobilize peers among HRGs by networking and involving hotels, taxi stands, and truck operator agencies.
- Improve access to and increase usage of contraceptives (for both males and females) and distribute condoms in high-risk areas.

For service providers

- Build capacity of health workers, outreach workers, and link workers to use IEC effectively.

Responsibility

DAPCU, SACS, NGOs/TI implementers, other relevant departments

INTERSECTORAL CONVERGENCE

NACP-III acknowledges the importance of engaging with a wide range of stakeholders to expand outreach and coverage of services to different population groups, right down to the village level. While response to the epidemic is the responsibility of the Health Department, wider intersectoral convergence with different departments functioning at the district level is necessary to successfully expand coverage of services.

Table 27 presents an indicative list of relevant departments/organizations and sample activities that can be undertaken by these organizations. Operationalization of intersectoral convergence will involve the following steps:

- DAPCU will advocate with different departments for their active involvement in HIV prevention and care initiatives.
- As a first step toward their commitment to intersectoral convergence, each department will appoint a nodal officer who will be in charge of the department's HIV-related work.
- Each department will prepare a departmental mainstreaming plan based on its comparative strength. Mainstreaming plans will include identified welfare schemes/programs that can be used for prevention and impact mitigation. The plan will include block- and village-level activities, list of beneficiaries, and targets.
- Department nodal officers will be inducted as DHS members and participate in all monthly meetings. During these meetings they will share detailed plans, provide activity updates, and seek technical guidance.
- Key departments could meet more frequently to plan and implement activities as outlined in the DAP.

7.1 Role of Key Functionaries/Committees

DAPCC

The DAPCC, which oversees the planning and implementation of district health plans and is the overall guiding and supervisory body for the district HIV program, will monitor intersectoral convergence. It will coordinate all HIV programs being implemented by various departments to ensure interdepartmental and intersectoral coordination at the district level.

District Collector/Magistrate

As the chair of the DHS, the District Collector/Magistrate will actively advise pertinent departments to mainstream HIV/AIDS and will monitor their engagement in HIV/AIDS programs. S/he will nominate an officer (such as the District Revenue Officer) to serve as his/her link officer in the DAPCU. The link officer will coordinate with all departments involved to facilitate implementation, reporting, and monitoring of intersectoral convergence activities on behalf of the District Collector/Magistrate.

DAPCU

The DAPCU will provide technical support to district-level departments/organizations to integrate HIV into their functions. It will also facilitate linkages between district HIV services and relevant departments and organizations.

Nodal Officers (of departments)

Each of department identified for mainstreaming will designate a nodal officer for HIV. This officer will be given in-depth training on major aspects of HIV programs so that s/he is able to design and implement departmental HIV plans and suggest any necessary modifications/adaptations of

departmental welfare schemes/programs to benefit PLHIV and vulnerable populations. The nodal officer will carry out his/her responsibilities in coordination with the DAPCU.

At block-level the Block Development Officer will coordinate with concerned departments' block-level representatives. The PRI representative will be the nodal officer for coordination and monitoring of all HIV-related welfare activities at the village level.

Table 27. Sample Government Programs and Activities for Convergence

Department	Convergence Issues	Nodal Officer
Women Empowerment and Child Department	<ul style="list-style-type: none"> ➤ Integrate HIV into all department training programs. ➤ Train <i>anganwadi</i> workers (AWWs) to counsel pregnant women on PPTCT. ➤ Scale up shelter and rehabilitation homes and essential services for HIV-positive and HIV-affected women and children. ➤ Step up nutritional support for PLHIV with focus on orphans and vulnerable children (OVC). ➤ Involve PLHIV as members of self-help groups (SHGs). ➤ Establish Red Ribbon clubs among adolescent girls. ➤ Train AWWs to detect and report HIV-related discrimination in villages. 	CDPO, ICDS
Panchayati Raj	<ul style="list-style-type: none"> ➤ Train department personnel and elected representatives on sensitization and community ownership, participatory planning, and care and support. ➤ Issue instructions to <i>panchayats</i>¹⁷ to protect PLHIV and HIV-affected households from discrimination and protect inheritance rights of widows and orphans. ➤ Advocate with <i>panchayat</i> leaders to ensure that no HIV-positive child is discriminated against in school. ➤ Issue guidelines to <i>panchayats</i> to discuss HIV-related issues relevant to village in <i>gram sabhas</i> and other meetings ➤ Request <i>panchayats</i> with independent budgets to allocate resources to supplement HIV prevention and control program activities. 	CEO, Zila Parishad
Rural Development	<ul style="list-style-type: none"> ➤ Incorporate HIV/AIDS in all department training programs. ➤ Ensure that vulnerable populations, HRGs, and PLHIV benefit from Employment Guarantee Programs and other economic opportunities. ➤ Issue direction to ensure HIV-affected widows have access to pension schemes without discrimination. ➤ Strengthen poverty alleviation programs to benefit vulnerable populations. ➤ Establish SHGs to work with Red Ribbon clubs to support prevention, treatment, and support efforts for women. 	Project Director, District Rural Development Agency (DRDA)
Youth Affairs and Sports	<ul style="list-style-type: none"> ➤ Train all NSS program officers and NYK coordinators ➤ Mobilize youth groups and programs (including NSS, National Cadet Corps, and NYK) to spread awareness about HIV/AIDS and fight stigma and discrimination. ➤ Initiate youth-focused public information campaigns at cultural and sporting events. ➤ Engage youth to promote voluntary blood donation ➤ Train youth to act as peer leaders on HIV/AIDS within their communities. ➤ Undertake social marketing of condoms through youth clubs and youth development centers. ➤ Promote youth-friendly services. 	District Sports Officer
SC/ST Welfare	<ul style="list-style-type: none"> ➤ Analyze special vulnerabilities of SC/ST populations, with focus on women and children and prepare a plan to address identified risks. ➤ Train traditional healers and registered medical practitioners (RMPs) with influence in the community on STI management and provision of referrals to ICTCs. 	District Social Welfare Officer

¹⁷ Village-level administrative bodies.

Department	Convergence Issues	Nodal Officer
Agriculture	<ul style="list-style-type: none"> ➤ Mainstream HIV into KVK (<i>Krishi Vignan Kendras</i>) and agriculture colleges. ➤ Sensitize agriculture extension workers to alleviate potential impacts of HIV by carrying out HIV-related activities in affected and vulnerable communities. ➤ Integrate HIV into key rural livelihood programs. 	District Agriculture Officer
Labor /Industry	<ul style="list-style-type: none"> ➤ Provide package of services, including prevention and treatment services, in all major Employee State Insurance (ESI) hospitals. ➤ Advocate with and facilitate trade unions to manage provision of HIV services to migrant laborers and informal sector workers and to take lead on reducing stigmatization of HIV-positive workers and their families. ➤ Integrate HIV prevention into all department training programs. ➤ Promote HIV prevention with industry as part of corporate social responsibility (CSR) efforts. 	District Industry Officer, CII/FICCI District Coordinator
Police and Jail	<ul style="list-style-type: none"> ➤ Design and implement awareness and sensitization programs for police personnel dealing with HRGs and NGO workers. ➤ Train in-house doctors on pre-post counseling and set up voluntary counseling and testing centers within command hospitals. ➤ Place condom dispensing machines in strategic locations and improve STI treatment services for police and prison inmates. 	Superintendent of Police
Education	<ul style="list-style-type: none"> ➤ Incorporate adolescent education program/life skills programs in all schools and colleges. ➤ Incorporate HIV prevention programs into all non-formal and out-of-school education programs. ➤ Introduce a module on HIV/AIDS into teacher training curriculum. ➤ Incorporate HIV orientation into curricula of all technical and vocational training institutes. ➤ Ensure that HIV-positive and HIV-affected children are not discriminated against in schools. 	District Education Officer
Transport (including bus stands and railway stations)	<ul style="list-style-type: none"> ➤ Implement HIV prevention programs at major transport hubs. ➤ Facilitate campaigns disseminating prevention messages through public and private sector transport systems. ➤ Ensure availability of condoms at highway-based congregation points (such as <i>dhabas</i>¹⁸ and motels). ➤ Promote IEC at bus stands and railway stations. ➤ Install condom vending machines at strategic locations. ➤ Scale up IEC efforts on buses and trains along known migration routes. ➤ Train all personnel on HIV. 	District Transport Officer
Municipal Corporation and Urban Local Body	<ul style="list-style-type: none"> ➤ Integrate HIV into programs of District Urban Development Agency (DUDA), the urban basic services program, and other relevant social welfare programs. ➤ Strengthen urban HIV prevention programs with special emphasis on migrant and slum populations. ➤ Set up shelter homes for orphans, the destitute, and street children. ➤ Accord benefits to PLHIV in Municipal Corporations' economic support programs. ➤ Strengthen urban infrastructure to provide better living conditions for in-flowing migrant communities, thereby reducing their vulnerabilities. 	Municipal Commissioner
Civil Supplies	<ul style="list-style-type: none"> ➤ Ensure HRGs and PLHIV receive ration cards. ➤ Disseminate HIV awareness messages through public distribution outlets. ➤ Mainstream HIV into department training programs. 	District Supply Officer

¹⁸ Small eateries

7.2 Human Resource Planning

Operationalization of DAPCU

As mentioned earlier, the DAPCC will have an advisory function and be chaired by the Chief Medical Officer. The DACO, a person appointed as available from among the Assistant District Medical Officer, Deputy CMHO (Health), and the district leprosy officer, will be the nodal officer in charge of the DAPCU. The DACO will work with a team of six full-time staff, including the DAPM, a supervisor for ICTCs, two assistants/accountants, an M&E assistant, and selected support staff. The UP state government will issue a notification to this effect.

Table 28. Terms of Reference (TOR) for DAPCU staff

District Program Manager for HIV/AIDS (DAPM)	
Planning and Implementation of DAPs	<ul style="list-style-type: none"> ○ Send regular reports to UPSACS. ○ Operationalize ICTCs, PPTCT centers, blood banks, and blood storage units. ○ Ensure engagement of contractual manpower, including link workers, lab technicians, and consultants. ○ Maintain systems for timely payments, training, and monitoring of staff. ○ Manage supply chain at district and sub-district levels. ○ Facilitate supply of testing and delivery kits, condoms, drugs, and other consumables from district government to public health institutions—ICTCs, PPTCT centers, ART centers, blood banks, and TI projects. ○ Coordinate with partners for program planning, implementation, and review.
Capacity Building	<ul style="list-style-type: none"> ○ Implement training plans. ○ Provide district-level support for TI projects, with emphasis on ensuring access to services, including referrals to public health infrastructure (both facilities and manpower).
Advocacy	<ul style="list-style-type: none"> ○ Organize stakeholder consultations with government departments, NGOs, and PLHIV through NGO forum. ○ Undertake effective IEC campaigns for NACP activities.
Program Management	<ul style="list-style-type: none"> ○ Institutionalize system of interaction with DPMU for NRHM to work out effective convergence with activities under NRHM, RCH, TB, and IEC. ○ Ensure need-based institutionalization of systems for disbursing funds to <i>Rogi Kalyan Samitis</i>¹⁹ and collecting utilization certificates. ○ Maintain a bank account for DAPCU and submit use of funds reports and annual audits to UPSACS. ○ Oversee operational status of blood banks and their adherence to NACP protocols. ○ Collect information monthly about each institution's operational status, compile data, and send to UPSACS. ○ Supervise functioning of HIV service outlets by visiting outlets frequently and attending quarterly meetings of medical officers and monthly meetings of other project staff. ○ Provide feedback and support to field staff to enhance performance.

¹⁹ Committees formed at district level that are given resources to address specific issues related to health/infrastructure in the area.

Monitoring and Evaluation (M&E) Assistant
<ul style="list-style-type: none"> ○ Enter data and send reports to UPSACS/NACO and partner NGOs on time. ○ Ensure that reports submitted by field staff are complete and submitted on time. ○ Undertake field visits to verify registers, PHC maps, and overall content and quality of information in centers. ○ Maintain and regularly update district dashboard. ○ Update team members about district situation in monthly team meetings.
Coordinator/Supervisor for ICTC
The role of the Coordinator/Supervisor for ICTC is to assist the DAPM in implementation of ICT programs, including PPTCT and HIV/TB testing.
Assistant cum Accountant
<ul style="list-style-type: none"> ○ Accurately maintain DAPCC accounts. ○ Prepare budgets for activities in accordance with UPSACS guidelines. ○ Ensure funding disbursements for DAP activities. ○ Monitor and report on utilization of funds. ○ Facilitate annual audits of DAPCC accounts for submission to UPSACS.
Other Contractual Manpower at Sub-district Level
<ul style="list-style-type: none"> ○ NACP-III envisions creation of a new cadre of link workers for providing HIV/AIDS prevention, control, care, and support services in villages with populations greater than 5,000. ○ Approximately 40 link workers may be engaged in each district. ○ In villages where link workers and volunteers are not engaged, services will be provided by mainstream health workers (ANMs, MPWs, and ASHAs). ○ Provision of induction and in-service training to link workers and support for advocacy/IEC materials and monthly meetings will be an important task of DAPCU. ○ Link workers will be monitored by two superiors in accordance with operational guidelines. ○ Broadly, it is proposed to implement this program component through NGOs. ○ Methods of engaging contractual manpower through DAPCU, NGOs, or Hospital Management Society will be decided by UPSACS.
ICTC Staff
<ul style="list-style-type: none"> ○ NACP-III envisions provision of contractual lab technicians and counselors at every ICTC and PPTCT center. ○ DAPCU will operationalize systems for assessing manpower requirements, recruitment, managing funding flows and payments of honoraria, and monitoring progress toward program goals.

The staff of the DAPCU may be selected on a deputation/contract basis as per the guidelines issued by NACO/UPSACS. UPSACS/DHS will select DAPCU staff in accordance with the state's specific policy. The suggested terms of reference for DAPCU staff are included in the table above.

TRAINING PLAN

A scaled-up multisectoral response in Banda will require equipping service providers with necessary skills and orienting health workers, policymakers, private providers, employees of cognate departments, NGOs, SHG members, and PRI members on various facets of HIV and AIDS. The training plan for capacity building at the district level will be prepared to enable time-bound coverage of the entire training load. Some trainings will be funded by UPSACS and other NACP partners, such as USAID and UNICEF. Others could be incorporated into training modules already planned by various departments for their personnel. The corporate/private sector and professional bodies, such as the Indian Medical Association (IMA) and the Federation of Obstetrical and Gynecological Associations of India (FOGSI), will also be motivated to self-finance orientations for their members.

Table 29. Stakeholders in Banda Training Plan

Public Representatives, NGOs, and Private Sector Stakeholders	Service Delivery Personnel	Other Functionaries
1. District heads of self-help organizations	1. Counselors	1. District-, block- and village-level officers/ functionaries of key departments identified for convergence
2. Heads of local urban bodies	2. Lab technicians	2. ANMs, MPWs, and ASHAs
3. <i>Zila panchayat</i> presidents	3. Medical Officers-in-Charge of ICTCs	3. <i>Anganwadi</i> workers
4. <i>Block panchayat</i> presidents	4. Obstetric and gynecological, and pediatric medical officers	4. Police personnel and jail staff
5. <i>Gram panchayat</i> presidents	5. RNTCP medical officers	5. Teachers in colleges and schools
6. Officeholders of civil society partners forum at state, district, and national levels	6. Medical officers in ART clinics	
7. Officeholders of PLHIV networks at district, state, and national levels	7. Nurses	
8. <i>Nehru Yuvak Kendra</i> regional and district coordinators	8. Pharmacists	
9. Trade and industry associations	9. Record keepers	
10. Professional medical associations	10. PHC and CHC medical officers	
	11. Medical officers in government hospitals	
	12. Private practitioners	
	13. Paramedical staff	
	14. Medical Officer-in-Charge of blood bank	
	15. Blood bank technicians	
	16. Technical assistants in component separation units	
	17. Outreach volunteers for treatment adherence	
	18. Labor welfare officers (workplace interventions)	
	19. NGO program managers (support for migrants)	
	20. STI specialists	
	21. Lab technicians in district and medical college hospitals	
	22. Program managers of social management organizations	

A training needs assessment will be organized in the district involving all the potential stakeholders involved in the HIV response. Based on the needs assessment, an annual action plan for capacity

building will be developed for the district and a special allocation of funds will be sought from UPSACS. The training plan for Banda will include the stakeholders listed in Table 29 above.

The draft training plan will be finalized after approval of the district plan and discussion with relevant stakeholders.

Table 30. Key Participants, Implementers, and Tentative Time Line

Category of Participating Personnel	Implementing Agency	Time Line (Q1 Q2 Q3 Q4)
Public representatives, NGOs, and private/corporate stakeholders	DAPCU, development partners	Q3 and Q4
Service delivery personnel	UPSACS, TSU, and development partners	Q2 and Q4
Other functionaries	NRHM and development partners	Q4

Table 31. Proposed Training Content

Target group	Agenda for training
Medical officers (including private practitioners)	<ul style="list-style-type: none"> • HIV diagnostics and quality assurance • HIV-TB coinfection • STI treatment • ART and treatment adherence • Treatment of opportunistic infections, STIs • ICT and PPTCT protocols • Safe delivery practices (in case of HIV-positive mothers)
Counselors	<ul style="list-style-type: none"> • Basic training on HIV and STI counseling • HIV diagnostics and quality assurance • Post exposure prophylaxis (PEP) • AIDS ethics and confidentiality protocols • Partner notification • Reduction of social stigma and discrimination through PLHIV experience sharing • Counseling skills (special focus on PPTCT counseling) • Drugs and their administration protocols (such as nevirapine)
Outreach workers, link workers, peer educators	<ul style="list-style-type: none"> • Strengthening service delivery for STI cases • Correct condom use and demonstrating correct condom use • IEC for reducing HIV-related social stigma and discrimination • Care and support for HIV-positive mothers
Lab technicians	<ul style="list-style-type: none"> • HIV diagnostics and quality assurance • Testing and confidentiality protocols • PEP • Infection control and bio-medical waste management
ANMs, AWWs, ASHAs	<ul style="list-style-type: none"> • Basic training on HIV • Effective IEC mechanisms for reducing social stigma and discrimination • Referral of pregnant mothers for PPTCT
PLHIV	<ul style="list-style-type: none"> • Adoption of safe practices and correct condom use • Orientation for positive living

Once the State Training and Resource Center (STRC) is established as set forth in the NACO guidelines, STRC services will be utilized to plan and implement the capacity building program. The UNDP-supported, mainstreaming, TSU will also be involved in planning capacity building programs in the district.

MONITORING AND EVALUATION

Effective implementation of the activities outlined in this plan will depend on the availability of sufficient human, financial, and institutional resources. Furthermore, the sustainability of the district's HIV response will depend on an efficient monitoring process in the areas of policy development, institutional strengthening, and service delivery.

One of the objectives of a decentralized HIV response is to ensure quality through regular monitoring and periodic evaluation. Monitoring will ensure that activities are being implemented in accordance with the DAP and that all partners and implementing agencies are contributing to the accomplishment of policy objectives. Monitoring and evaluation should be seen as mutually beneficial, as it will enable implementing agencies to assess their performance and seek corrective measures, while helping the government formulate appropriate policies.

The district will have a full-time Assistant Program Coordinator for M&E and a Data Entry Operator as part of the DAPCU. The DAPCU will also work as the coordinating agency for surveillance activities and special surveys conducted by UPSACS and other partners at the district level. The district-level dashboard of indicators (See Annex I) will provide the framework for monitoring and evaluating the district HIV/AIDS program.

9.1 M&E Functions of DAPCU

- Document reporting processes and enforce data quality standards.
- Distribute reporting formats to all relevant units.
- Provide software training to district-level units.
- Ensure that all partners report routine program monitoring data to district.
- Conduct regular field visits to provide supportive supervision to reporting units and monitor progress (responsibility of district-level program officers).
- Review data and provide specific feedback.
- Conduct program evaluations.

Effective monitoring and evaluation tools will be developed and customized for each intervention. These tools will reveal strengths and weaknesses in programs and activities and identify areas in need of resources. The cost-effectiveness of selected interventions will be determined through special operational research.

The DAP is a working document and will be subjected to regular critical review. This will be undertaken at the district level with inputs from all concerned stakeholders. It is proposed that the DAP be revised on an annual basis and that yearly operational plans with specific annual targets be developed. If there are any changes to the NRHM, the DAP will be revised to align with those changes.

Table 32. Budget for Banda DAPCU (Year 1)

A. Staff Salary				
	Staff Position	Number	Salary (Rs.)	Annual Expenditure (Rs.)
1.	District Program Manager (regular)	1	8,000–13500	20,000×12 = 240,000 With periodical increment and other benefits applicable for government employees
2.	M&E Assistant	1	8,000 consolidated	8,000×12 = 96,000
3.	Assistant cum Accountant	1	8,000 consolidated	8,000×12 = 96,000
4.	Supervisor	1	8,000 consolidated	8,000×12 = 96,000
	Total			528,000
B. Fixed Costs (One-time Costs)				
	Particular			Annual Expenditure
1.	Computer, printer, and accessories			90,000
C. Recurring Costs				
	Particular	Monthly Expenditure		Annual Expenditure (Rs.)
1.	Operating expenses	5,000		5,000×12 = 60,000
2.	Local travel	1,500		1,500×12 = 18,000
	Total			78,000
Grand Total (A+B+C)				696,000

In addition, the district-level program budget (for TI projects; care, support, and treatment; blood safety; IEC; and other components) will be incorporated into the UPSACS annual action plan (AAP) in accordance with NACO guidelines.

Annex I: District Dashboard

The NACP has put into place a rigorous monitoring system, composed of 140 indicators, which are to compiled and reported at the district, state, and national levels on a monthly, quarterly, and annual basis. To facilitate implementation of this system, UNICEF will support operationalization of *HIV Info*. Building on the *Dev Info database*, *HIV Info* will be able to depict data in tables, graphs, and maps down to the block level, and will also be able to cross-reference data from other sources, including NFHS–III, the census, and the Sample Registration System (SRS). It is recommended that the DAPCU maintain a district dashboard to monitor the progress of the AIDS Action Plan.

Composition of the dashboard should be as follows:

1. District AIDS Society merged into DHS (Y/N)
2. DAPCC constituted (Y/N)
3. DAPCU operationalized (Y/N)

	Total Number	DACO	DAPM	ICTC Supervisor/Coordinator	M&E Asst.	Assistant cum Accountant	Support Staff (include #)
Posts sanctioned							
Posts filled							
Induction training completed							

4. District mapping undertaken (Y/N)
5. Link worker strategy finalized

Number of link workers sanctioned	
Number of link workers in place	
Number of link workers trained (induction/in-service)	

6. Lab technicians

Number of lab technicians sanctioned	
In place	

7. Counselors

Number of counselors sanctioned	
Number of counselors in place	

8. Delegation of administrative and financial powers complete (Y/N)
9. Funding flow system in place (Y/N)

10. Funds

Amount of funds sanctioned	
Amount of funds received	
Amount of funds expended	

11. Supplies

a) Two Months' Stock Available for:	
ART drugs	
condoms	
delivery kits	
testing kits	
IC and WM ²⁰ consumables	
Auto-disable syringes	
b) Stockout Summary	
Total number of stockouts reported	
Number of facilities reporting stockouts	
Commodities for which stockouts occurred	

Detailed Stockout Chart:

Facility Name	Commodity Type

12. Institutions functional

	ICTC	PPTCT	STD	RNTCP	Blood Bank
Sanctioned					
Functional					
Tests/Referral					

²⁰ Infection control and waste management

13. Blood Banks

	Public	Private
Number functioning		
Number licensed		
Type of infection control and waste management measures being implemented		
Blood donation camp held		
Number of PLHIV identified		

14. Coverage

	Target	Achievement
FSW		
MSM		
IDU		
Transgender		
Short-stay migrants		
Adolescents		
Pregnant women		
HIV-positive delivery		
PLHIV (for ART)		
Condom promotion		

15. Cases of discrimination reported

	Place where Discrimination Occurred	Type of Discrimination	Description of Discrimination Target (i.e., FSW, MSM, HIV-positive woman, child of HIV-affected family)
1.			
2.			
3.			
4.			
SUMMARY			
Number of Locations in which Discrimination Occurred			
Total Number of Discrimination Incidents Reported			

16. Trainings

Category	Target Number of Individuals to be Trained	Actual Number of Individuals Trained	Type of Training Received
ASHA			
ANM			
Doctors			
Other departments			

17. IEC²¹

Planned	Achievement

18. Tribal strategy

Planned	Progress

19. Monthly/Quarterly DAPCU meetings

Meeting Date	Number of TI Project Attendees	Number of Other NGO/CBO Attendees	Number of Attendees with Other Affiliations (please list affiliation)	Total Number of Attendees
Total Meetings Held				
Total Attendees				
Groups Represented				

20. PLHIV Trends

PLHIV	ICTC	HRG Category	On ART	Death
Existing				
New				

²¹ Detailed tables for Questions 18 and 19 to be developed in accordance with yearly action plan.

Annex II: Proposed Meeting / Reporting Schedule

Meeting/Report Description	Frequency
DAPCC meetings	Monthly
NGO forum meetings	Quarterly
Review by UPSACS	Quarterly
Stakeholder consultations	Half-yearly
Thematic reviews	Monthly for each component (TI, Package of services, safe blood and blood products, condom promotion, convergence, improved access to continuum of care, provision of services to HIV-positive and HIV-affected children, and management of treatment adherence)
Supervision by UPSACS, development partners, NACO	Quarterly
District plan preparation meetings	Yearly
District plan review meetings	Quarterly
Submission of dashboard	Quarterly
Submission of audit reports	Quarterly, half-yearly, and yearly

Annex III: DAPCU Program Activities

Sl. No	Thematic Component	Roles and Functions of DAPCU
I. Service Delivery		
1	Targeted interventions	<ul style="list-style-type: none"> Facilitate access to HIV/AIDS prevention and treatment services, general health services, and other entitlements, including package of services for HRGs. Create a supportive environment in which TIs can function.
2	Package of services	<ul style="list-style-type: none"> Monitor service delivery. Manage integration of HIV services with general health system and relevant non-health interventions.
3	Safe blood and blood products	<ul style="list-style-type: none"> Develop district-wide information and transportation schedule to provide blood and blood components to blood storage centers. Systematize voluntary blood donation. Schedule and monitor activities of voluntary blood donation camps. Address infrastructure issues pertaining to new blood banks.
4	Condom promotion	<ul style="list-style-type: none"> Monitor availability of condoms at service delivery points.
5	Convergence with RCH, TB, and other Ministry of Health and Family Welfare (MOHFW) programs	<ul style="list-style-type: none"> Work with pertinent program officers to effectively integrate their functions.
6	Improved access to continuum of care, including ART and OI treatment	<ul style="list-style-type: none"> Monitor management of OIs and ART.
7	Provision of care, support, and treatment services to HIV-positive and HIV-affected children	<ul style="list-style-type: none"> Monitor children born to HIV-positive mothers for early signs of need for ART. Monitor rights of HIV-positive and HIV-affected children and investigate rights violations. Advocate for protection of children's rights with district authorities and organizations.
8	Management of treatment adherence	<ul style="list-style-type: none"> Follow up with patients through home-based counseling to ensure treatment adherence.
II. Monitoring and Stimulating HIV Awareness and Impact Mitigation		
9	Women, children, and young adults	<ul style="list-style-type: none"> Work with district-level departments for prevention, treatment, and impact mitigation focused on women, children, and adolescents.
10	Migrants, trafficked persons, and populations in cross-border areas	<ul style="list-style-type: none"> Provide pre-departure guidance to migrants and provide linkages to organizations in destination areas. Link migrants and populations in cross-border areas with existing health services for STI management and condom promotion.
11	HIV/AIDS response in the world of work	<ul style="list-style-type: none"> Facilitate access to treatment and prevention services for individuals referred through workplace interventions.
12	Communication and social mobilization	<ul style="list-style-type: none"> Conduct district-level IEC campaigns. Use local channels for demand generation. Work with PRIs and local civil society organizations to carry out social mobilization activities for HIV prevention and management.

13	Mainstreaming with public and private sector	<ul style="list-style-type: none"> • Provide technical support to district-level organizations to integrate HIV into programs/activities. • Link DAPCU with various departments providing HIV services within district.
14	Civil society partnership forum at district level	<ul style="list-style-type: none"> • Support formation and functioning of new district civil society partners forum.
15	Strengthening community care and support programs	<ul style="list-style-type: none"> • Establish referral linkages between service providers and community and monitor functioning of approved centers.
III. Management		
16	Linking care, support, and treatment with prevention	<ul style="list-style-type: none"> • Monitor integration of care, support, and treatment services with prevention efforts.
17	Impact mitigation	<ul style="list-style-type: none"> • Establish linkages among DAPCU, district-level organizations, and departments providing support to PLHIV and their families. • Facilitate access to social support services for PLHIV.
18	Surveillance	<ul style="list-style-type: none"> • Oversee collection and forwarding of samples.
19	Capacity building	<ul style="list-style-type: none"> • Conduct district-level trainings (See Section 8: Training Plan).
20	Program management	<ul style="list-style-type: none"> • Engage contractual manpower at DAPCU (laboratory technicians, consultants, and link workers).
21	Financial management	<ul style="list-style-type: none"> • Maintain flow of funds for NACP activities. • Submit utilization certificates and ensure financial propriety.
22	Management Information System (MIS)	<ul style="list-style-type: none"> • Maintain district dashboard and report regularly to UPSACS on physical, financial, and epidemiological progress.

Annex IV: Personnel Responsible for Service Delivery at Different Levels

	Levels of service	Personnel delivering services	Type of services
1.	Community	i. ASHA (NRHM states) ii. RMP	<ul style="list-style-type: none"> Referring pregnant women for tests and follow-up of PPTCT prophylaxis treatment Treatment of STIs, minor ailments, and OIs (such as diarrhea) Condom supply
2.	PHC/ private provider/ 30,000 population	i. PHC doctor/private practitioner ii. Nurse iii. Lab technician (LT) iv. Pharmacist/dispenser v. Record keeper	<ul style="list-style-type: none"> STI control and condom promotion HIV testing and counseling OI prophylaxis and treatment Antenatal care and counseling for prophylaxis
3.	CHC/ Trust Hospitals/ 100,000 population	i. CHC doctor/Trust hospital doctor ii. Counselor iii. Nurse iv. Lab technician v. Pharmacist/dispenser vi. Outreach worker	<ul style="list-style-type: none"> STI control and condom promotion Integrated health counseling/testing PPTCT, delivery, abortion, and sterilization services for women (including those who are HIV-positive) Diagnosis and treatment of common OIs ART follow-up and referral Maintenance of computerized patient records
4.	District-level/ Teaching hospitals	i. Specialist ii. Doctor iii. Nurse iv. Counselor v. Lab technician vi. Manager of drugs supply chain vii. Treatment supporter (NGO/PLHA/CBO, etc.) viii. Outreach worker	<ul style="list-style-type: none"> Management of complications ART Care and support Integrated counseling and testing Management of STIs and OIs PPTCT services Ensuring drug supply at district level Facilitating access to care and support for PLHIV
5.	NGO/CBO/FBO ²²	i. NGO/CBO administering CCC and family support centers ii. NGO/FBO/other managing TI project iii. Outreach worker	<ul style="list-style-type: none"> Palliative care and treatment of minor OIs STI treatment Counseling, social services Adherence monitoring

²² Faith-based organization

BANDA DISTRICT AIDS PREVENTION AND CONTROL UNIT
Uttar Pradesh State AIDS Control Society
Lucknow