

# *Deoria*

## **District AIDS Action Plan**



**2009–2012**

**DEORIA 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”<sup>1</sup> 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.

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<sup>1</sup> More than 1% prevalence reported by any ANC site in the district in the last three years.

## ABBREVIATIONS

AAP	annual action plan
AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ANM	auxiliary nurse midwife
ART	antiretroviral therapy
ARV	antiretroviral
ASHA	accredited social health activist
AYUSH	Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
AWC	<i>anganwadi</i> center
AWW	<i>anganwadi</i> worker
CBO	community-based organization
CCC	community care center
CHC	community health center
CMHO	Chief Medical and Health Officer
CPR	contraceptive prevalence rate
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
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
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
IMA	Indian Medical Association
IEC	information, education, and communication
JSY	<i>Janani Suraksha Yojana</i>
KVK	<i>Krishi Vignan Kendras</i>
LT	laboratory technician
M&E	monitoring and evaluation
MCH	maternal and child health
MCHN	maternal and child health and nutrition
MOHFW	Ministry of Health and Family Welfare
MOIC	medical officer-in-charge
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
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
SDP	service delivery point
SHG	self-help group
SRS	Sample Registration System
ST	scheduled tribe
STI	sexually transmitted infection
STRC	State Training and Resource Center
TB	tuberculosis
TI	targeted intervention
TSU	Technical Support Unit
UNDP	United Nations Development Program
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

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### 1.1 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 children.”<sup>2</sup> 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 three 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.” Uttar Pradesh (UP) is categorized as a vulnerable state. 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 long term 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.

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<sup>2</sup> 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 (FSWd), 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 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. DAPs 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 (see Table 1 for details on the category A package of services). 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 I. Package of Services for Category A Districts<sup>3</sup>**

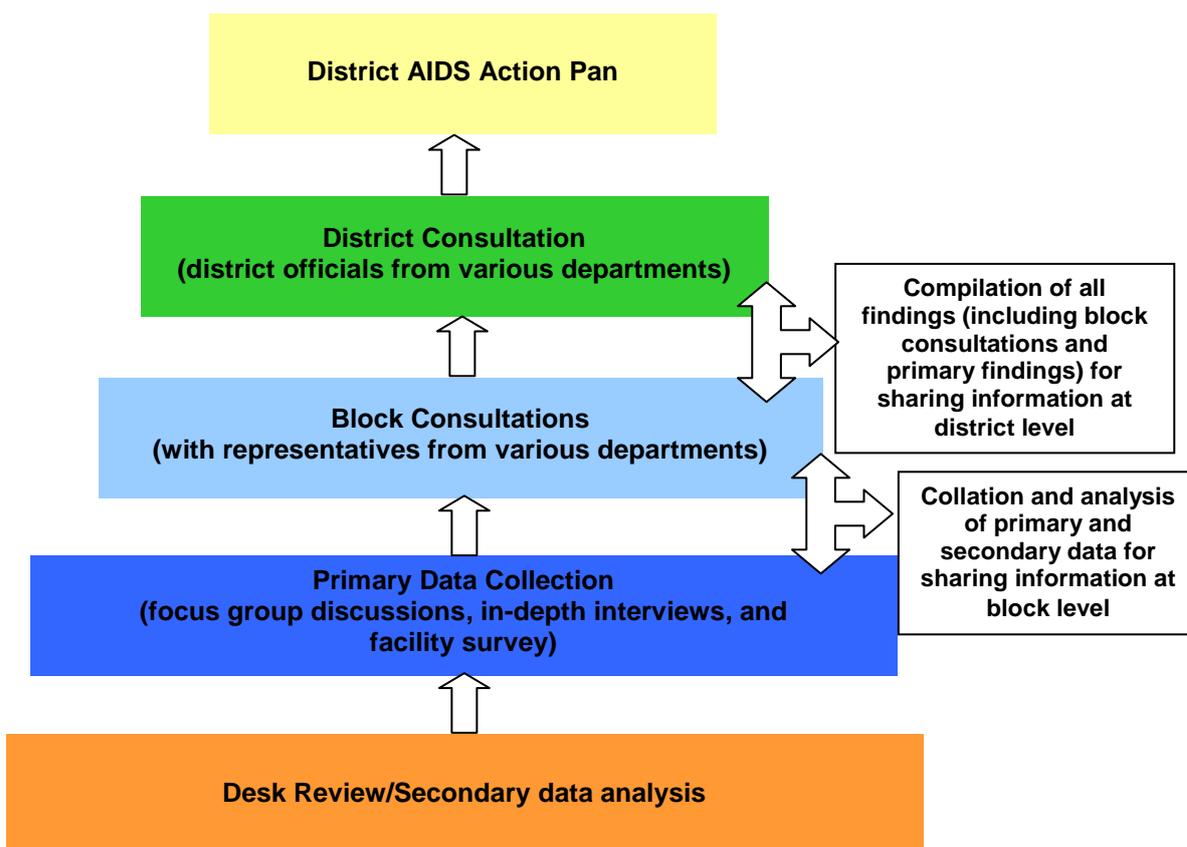
Level	Target Group	Services Provided
<ul style="list-style-type: none"> <li>• Medical colleges</li> <li>• District, block and sub-divisional hospitals</li> <li>• Village/community</li> </ul>	<ul style="list-style-type: none"> <li>• General population</li> <li>• High-risk groups (HRGs)</li> <li>• People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

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

## 1.2 Overview of Plan Development Process

The process of preparing the Deoria DAP entailed consultative processes at different levels. These processes shaped the design and execution of the study. 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 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 four blocks, Barhaj, Gauribazar, Pathardeva, and Rudrapur.

**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

Deoria is situated in the southeastern part of Uttar Pradesh. It is an administrative district of UP, with its headquarters located at Deoria town. The district is bordered by Kushinagar district in the north, by the districts of Gopalganj and Siwan (Bihar state) in the east, by the districts of Mau and Ballia in the south, and by Gorakhpur district in the west. Deoria district forms a part of Gorakhpur division.

Deoria has a total population of 2,712,650, which is almost evenly split between male and female. The great majority of the district's population (90%) live in rural areas, while the remaining 10 percent reside in urban locales. Deoria's population density (1,007 people per square kilometer) is higher than the state average of 689 persons per square kilometer, and ranks ninth among all UP districts. While there is negligible (0.02%) representation of scheduled tribes (STs) in the district, 18 percent of the population belongs to the scheduled castes (SC) category.

**Table 2. General Indicators**

	Deoria	Uttar Pradesh
Geographical area (in sq.km.)	2,538	240,928
<i>Tehsils</i>	5	300
Blocks	16	901
Total number of villages	2,008	107,452
Number of inhabited villages	2,008	97,942
Number of inhabited villages <5000	36	2,562
Number of towns <sup>4</sup>	10	215

Source: Census of India (2001)

The literacy rate in Deoria (58.64%) is marginally higher than that of the state overall (57.36%). However, there are marked gender differences in the district's literacy rates. While three-quarters of males in Deoria are literate, the female literacy rate is only 42.51 percent. Deoria's sex ratio (number of females per males) is 1,002, the third most balanced in the country. The percentage of girls marrying below legal age in the

district (51%) is relatively higher than in the state as a whole (41%).

Administratively, the district is composed of five *tehsils*—Barhaj, Bhatpar Rani, Deoria, Rudrapur, and Salempur. These *tehsils* are further divided into 16 blocks and 2,008 villages. Deoria district covers 1.1 percent of UP's geographical area and accounts for 1.6 percent of its population.

**Table 3. Standard of Living Index**

	DLHS-3		DLHS-2	
	Total	Rural	Total	Rural
Low (%)	72.5	75.4	60.5	69.5
Medium (%)	16.4	16.8	23.6	24.0
High (%)	11.1	7.8	15.9	6.4

Source: DLHS-3

<sup>4</sup> <http://www.india9.com/i9show/-Uttar-Pradesh/Banda/Banda-District-16644.htm>

**Table 4. Demographic Indicators**

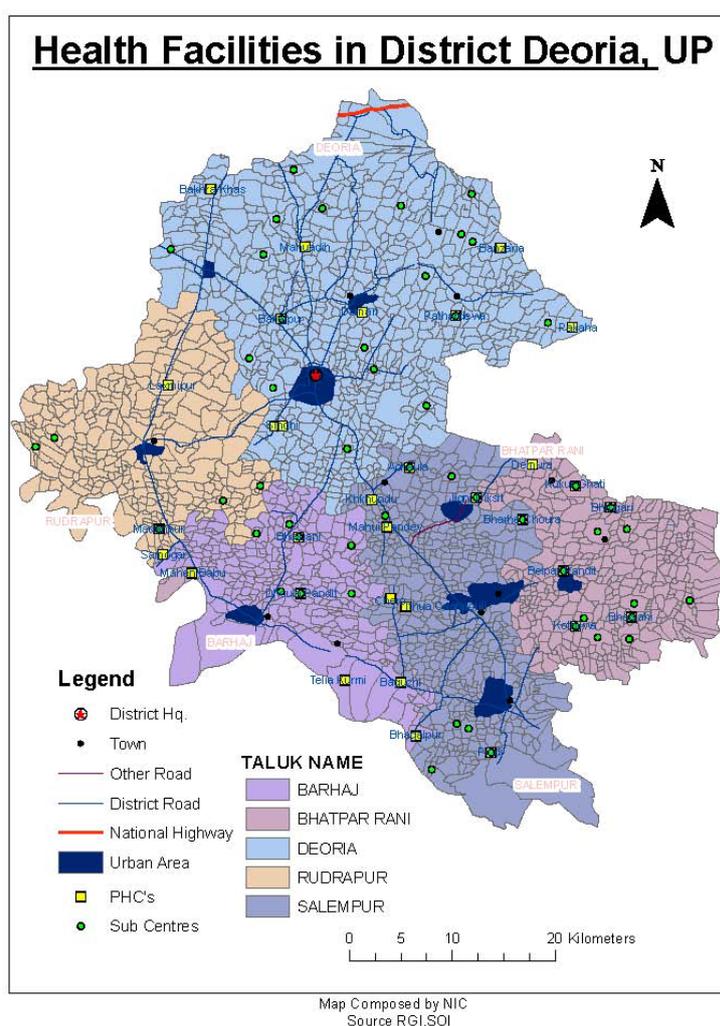
<b>Population Index (2001)</b>	<b>Deoria</b>	<b>Uttar Pradesh</b>
Total population	2,712,650	166,197,921
Female population	1,355,023	78,632,552
Male population	1,357,627	87,565,369
Rural population	2,444,345	131,658,339
Urban population	268,305	34,539,582
Child population (0–6 years)	497,606	30,472,042
Percent of child population (0–6 years)	18.34%	18.33%
Population density	1,077	689
Decadal growth rate (1991–2001)	25.03%	25.80%
Male/female ratio	1,002	898
Ratio of male/female children (0–6 years)	947	915
Literacy rate	58.64%	57.36%
Male literacy rate (7+ years)	75.01%	70.23%
Female literacy rate (7+ years)	42.51%	42.98%
Scheduled caste (SC) population	18%	21.1%
Scheduled tribe (ST) population	0.02%	0.1%

Source: Census of India (2001)

**Health Facilities in the District**

There are two district hospitals, 18 CHCs, 28 PHCs, and 43 sub-centers in the district. Some of the district's health facilities function 24/7 to expand access to services in emergency situations.

**Figure 2. Health Facilities in Deoria**



**Table 5. Health Facilities At-a-Glance**

	Deoria	Uttar Pradesh
Medical colleges	-	19
District hospitals (male)	1	70
District hospitals (female)	1	69
Community health centers (CHCs)	7	372
Primary health centers (includes block, sub-block, and additional PHCs)	15	3,660
Sub-centers	317	20,521
Anganwadi centers (AWCs)	2,513	153,223
DOTS <sup>5</sup> centers	375	24,549
Microscopy centers	31	1,750
Tuberculosis TB units	6	369

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

<sup>5</sup> Directly observed therapy, short-course

**Table 6. Fertility Indicators**

	Deoria	Uttar Pradesh
Total fertility rate	4.4	4.4
Crude birth rate	31.1	31.4

Source: Census of India (2001)

According to the 2001 census, the total fertility rate (average number of children born to a woman during her reproductive years) in Deoria is 4.4 and the crude birth rate is 31.1.

On the whole, Deoria's maternal and child health indicators are better than the state average, as illustrated by the data in Table 7 below. According to the third District Level Household Survey (DLHS-3) conducted in 2007–2008, 46.9 percent of women in the district received at least three antenatal check-ups during their last pregnancy compared to only 21.9 percent for the state as a whole. Deoria also has a higher proportion of institutional deliveries (41.1%) than UP overall (24.5%). The percentage of home deliveries attended by skilled personnel in the district (9.8%) was also higher than the state average (7.4%). The district's performance in the area of childhood immunization is also much better than average for UP state. The percentage of children ages 12–23 months receiving full immunization in Deoria (71.6%) is more than double the percentage for UP as a whole (30.3%).

**Table 7. Mother and Child Health Indicators**

	Deoria	Uttar Pradesh
Total number of pregnant women	-	6,611,040
Girls married before completing 18 years of age	35.3%	33.1%
Women who had at least three ANC visits (in last pregnancy)	46.9%	21.9%
Women who received full ANC <sup>6</sup>	-	2.8%
Women who received postnatal care	61%	33.8%
Institutional deliveries	41.1%	24.5%
Institutional deliveries under JSY <sup>7</sup>	22,722	956,007
Home deliveries attended by skilled personnel	9.8%	7.4%
Children (ages 12–23 months) who received full immunization <sup>8</sup>	71.6%	30.3%

Source: DLHS-3 (2007–2008)

**Table 8. Family Planning Indicators**

Among Currently Married Women (Ages 15–49)	Deoria (%)	Uttar Pradesh (%)
Women who use any method of family planning	32.5	38.4
Women who use any modern method of family planning	24.5	26.7
Female sterilization	15.9	16.5
Male sterilization	0.1	0.2
Couples using condoms	6.5	7.1
Unmet need for family planning	33.8	33.8

Source: DLHS-3 (2007–2008)

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

<sup>7</sup> Janani Suraksha Yojana, Health Directorate. Progress report for 2008–2009.

<sup>8</sup> Full immunization: BCG, three doses each of DPT and polio vaccine, and one dose of measles vaccine

Deoria's overall contraceptive prevalence rate (CPR) is 32.5 percent, which is appreciably lower than the average CPR for the state (38.4%). Use of female sterilization in the district (15.9%) is also slightly lower than in the state overall (16.5%). Condom usage, which is already low for the state overall (7.1%) is even lower in Deoria (6.5%). The district's unmet need for family planning matches the overall state need exactly (33.8%).

## 2.2 Overview of HIV/AIDS Situation

The spread of HIV in India has been diverse, with much of India having a low rate of HIV prevalence. The epidemic has been most extreme in the southern and far northeastern regions of the country. According to national HIV statistics, Uttar Pradesh is categorized as a low prevalence state. HIV is present in all parts of the state, although at varying rates. It appears to be highest in eastern UP.

Deoria's HIV/AIDS profile is described here using two parameters; vulnerability factors and infection patterns over time. Vulnerability factors can be understood by analyzing the presence of people practicing high-risk behavior, the level of awareness of HIV, and condom use. The presentation of infection patterns is based on HIV sentinel surveillance data and data on the number of detected HIV cases from various service delivery points (SDPs).

### High-risk and Vulnerable Populations

Since the routes for transmission of HIV are known—sexual, blood and blood products, and perinatal—certain HRGs have been identified. The elevated prevalence rates among these groups—such as female sex workers (FSWs), men who have sex with men (MSM), transgenders (including *hijras*,<sup>9</sup> and injection drug users (IDUs)—contribute to the rapid spread of HIV. NACO and UPSACS have commissioned studies to map the number of sites and the estimated population of various HRGs in the state. The first such state-level study was conducted in 2001 and a second study was carried out in 2008. The profile of HRGs in Deoria presented in Table 9 below reflects the district's vulnerability to HIV infection. The study identified 345 FSWs out of which 15 are highway-based and 330 are street-based workers. The exercise also identified 465 MSM in 13 sites, 190 IDUs in nine sites, and 122 *hijras* in five sites.

**Table 9. High-risk Groups in Deoria (2008)**

<b>FSW</b>	Sites	16
	Total	345
<b>MSM</b>	Sites	13
	Total	465
<b>IDU</b>	Sites	9
	Total	190
<b>Hijras</b>	Sites	5
	Total	122

Source: UPSACS 2008

### Targeted Intervention

In Deoria one composite<sup>10</sup> targeted intervention project is currently being implemented by UPSACS through a local NGO partner to reduce the rate of HIV transmission among FSWs, IDUs, and MSM.

**Table 10. NGO-implemented Targeted Intervention Project in Deoria**

Implementing Organization	Type of Intervention	Size of Target Population (2008–2009)			
		FSW	MSM	IDU	Total
Purvanchal Sewa Sansthan	Composite	330	150	250	730
Target for 2009–2010	3 new TI projects	TBD	TBD	TBD	TBD

Source: TSU

<sup>9</sup> *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.

<sup>10</sup> 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 11. Seropositivity among HRGs as Reported by NGO TI Projects (Jan–Dec 2008)**

	Number of HRG Individuals
Number who attended NGO STI clinic	281
Number treated at NGO STI clinic	226
Number referred to ICTC from NGO clinic	625
Number referred from NGO clinic who were tested at ICTC	531
Number found HIV-positive (of those referred from NGO clinic)	10

Source: UPSACS

### HIV and AIDS Awareness

Lack of knowledge of HIV, especially of prevention methods, is one of the key vulnerability factors for communities. The results of the DLHS-3 in Deoria,<sup>11</sup> show that less than half of ever-married women and less than two-thirds (63.4%) of unmarried women have heard of HIV/AIDS. Interestingly, the awareness level in rural areas is comparable to levels of awareness in the district as a whole. Deoria's awareness indicators are superior to overall indicators for the state, with only 29 percent of women in UP having heard of STI/RTI (reproductive tract infection) compared to 34.8 percent of women in Deoria. Similarly, the percentage of women who know that consistent condom use can reduce the chances of contracting HIV was higher (37.7%) than the state average (30%) recorded through NFHS-III.

**Table 12. Knowledge of HIV/AIDS and STI/RTI among Women**

	DLHS-3		DLHS-2	
	Total	Rural	Total	Rural
<b>Ever-married Women Ages 15–49 (in percent)</b>				
Had heard of HIV/AIDS	42.4	40.6	52.6	48.9
Knew that consistent condom use can reduce the chances of contracting HIV	33.1	31.3	17.7	15.8
Had correct knowledge of HIV/AIDS (of those who had heard of HIV/AIDS)	89.2	89.6	- <sup>12</sup>	-
Had been tested for HIV	1.2	1.2	-	-
Had heard of RTI/STI	34.8	34.8	-	-
<b>Unmarried Women Ages 15–24 (in percent)</b>				
Had heard of HIV/AIDS	63.4	63.2	-	-
Knew that consistent condom use can reduce the chances of contracting HIV	37.7	37	-	-
Had correct knowledge of HIV/AIDS	90.1	89.3	-	-
Had been tested for HIV	0	0	-	-
Had heard of RTI/STI	25.6	25.5	-	-

Source: DLHS-3

### Condom Use

In places where HIV prevention efforts have successfully reduced prevalence and infection rates, condoms have invariably played a key role. Prevention efforts through condom promotion are highly cost-effective. In DLHS-2 and DLHS-3, condom use in Deoria was reported to be 6.9 and 6.5

<sup>11</sup> IIPS: DLHS-3, Reproductive and Child Health Project, District Fact Sheet 2007-09, MAU, Mumbai, 2008

<sup>12</sup> These questions were not included DLHS-II.

respectively showing a reduction in the use. Through TI and social marketing, UPSACS distributed over 390,359 condoms in 2008.

### HIV Prevalence

HIV prevalence can be determined by examining data from a variety of sources, including from the annual Household Sample Survey (HSS) conducted by NACO and 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. An analysis of these data from Deoria provides an overview of the HIV situation in the district.

Analyzing trends in sentinel surveillance data show the state's low overall HIV prevalence. District prevalence rates do not show any specific trend. ANC sentinel surveillance data for UP from 1998 through 2006 show that only five districts registered prevalence rates of higher than 1 percent during this period—Allahabad (1.50% in 2006), Banda (1.75% in 2004), Deoria (1.25% in 2006), Etawah (3.00% in 2002), and Mau (1.46% in 2006).

**Table 13. HIV Sentinel Surveillance Data (in percent)**

Site	2001	2002	2003	2004	2005	2006	2007 (Jan–July)
Uttar Pradesh	0.05	0.37	0.19		1.73	0.25	0.02
Deoria	-	-	-	0.00	0.00	1.25	0.00*

Source: Behavioral Surveillance Survey (BSS) 2007

\*The data for July 2007 onwards is not available from district authorities.

The prevalence rate recorded through sentinel surveillance at ANC sites in Deoria in 2006 was 1.25 percent, which (as described earlier) caused it to be classified as a category A district under NACP-III. The seropositivity rate among pregnant women reported in the district's PPTCT center was 0.40 percent in 2007 (one reactive individual out of 251 individuals tested). Seropositivity at voluntary counseling and testing centers is over 20 percent (average approximately 24%).

**Table 14. ICTC Data (Jan–Dec 2008)**

	Deoria	Uttar Pradesh
Number of ICTCs	8	155
Projected population for 2009	3,276,451	196,049,343
Sexually active population	1,638,226	98,024,671
Population prone to risky sexual behavior	81,911	4,901,234
Number of people tested for HIV at ICTCs	5,474	240,438*
Seropositivity	4.17%	4.54%
Persons counseled and tested per ICTC per day	76	172
Targets for 2009–2010	24,573	574,790

Source: AAP-UP-09-10

\*April 2007–January 2008

The second set of data that can be used to present the district's HIV situation is data from ICTCs. An analysis of ICTC data from 2004–2008 shows that Deoria's seropositivity rate (number of people testing seropositive/total number tested x 100) of 4.17 percent is close to the rate for the state (4.54%).

**Table 15. PPTCT Center Data (Jan–Dec 2008)**

	Deoria	Uttar Pradesh
Number of PPTCT centers	1	79
Number of people tested for HIV at PPTCT center	3,651	218,785
Seropositivity	0.03%	0.16%
Number of people counseled and tested per PPTCT center per month	406	308
Targets for 2009–2010	20,273	474,202

Source: AAP-UP-09-10

Deoria has a single PPTCT center. In 2008, 8,755 women registered at the center, of whom only one tested positive for HIV. It is evident from the PPTCT center data that women who register at the PPTCT do not complete the entire process, from pre-counseling to post-counseling and collecting test results. This highlights the need for better follow-up and improved counseling services at the center.

**Table 16. PPTCT Center Status (2008)**

Month	Number of Clients Registered	Received Pre-test Counseling	Tested for HIV	Received Post-test Counseling	Received Test Results	Seropositivity	Received Nevirapine (mother/baby pairs)
Jan	736	614	586	325	325	0	0
Feb	870	383	347	315	315	0	0
Mar	1,220	423	423	392	392	0	0
Apr	170	170	10	10	10	0	0
May	702	228	0	0	0	0	0
June	0	283	0	0	0	0	0
July	570	460	360	336	336	0	0
Aug	888	441	365	338	338	0	0
Sept	1,074	454	444	403	403	0	0
Oct	1,061	409	396	298	379	0	1
Nov	490	472	291	243	279	0	0
Dec	974	482	429	396	396	1	0
<b>Total</b>	<b>8,755</b>	<b>4,819</b>	<b>3,651</b>	<b>3,056</b>	<b>3,173</b>	<b>1</b>	<b>1</b>

**Table 17: Trends in Referrals and Identification of PLHIV**

Referred From	Referred To					
	TI Project		PPTCT center/PHC		Private Clinic	
	Tested	HIV-positive	Tested	HIV-positive	Tested	HIV-positive
ICTC	285		-	-	-	-
PPTCT center	100	3	-	-	20	-

**Table 18: Counseling, Testing, and Treatment Targets for 2009-10**

Description of Service	Target (2009–2010)
Counseling and testing of HRGs in ICTCs	350
Counseling and testing of pregnant women in PPTCT centers	20,273
Administration of Nevirapine	0
Referrals from ICTCs to Revised National TB Control Program (RNTCP)	2,457
Referrals from RNTCP to ICTCs	1,153

**Table 19: Number of STI Cases Attended and Treated at STI Clinics and NGO STI Clinics (Jan–Dec 2008)**

2008	First Clinic Visit (for Index STI/RTI Complaint)		First Clinic Visit (for No STI/RTI Complaint)		Total Number of First Clinic Visits		Repeat Clinic Visit (for Index STI/RTI Complaint)		Total Number of Syndromic Diagnosis Cases		
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Total
Jan	20	9	0	0	20	9	0	0	0	426	428
Feb	24	12	0	397	24	409	0	0	0	409	409
Mar	21	17	0	0	21	17	0	0	5	475	480
Apr	18	428	0	0	18	428	0	0	3	426	429
May	13	5	0	0	13	5	0	0	2	486	488
June	21	445	0	0	21	445	0	0	4	438	442
July	17	12	0	0	17	12	0	0	10	571	581
Aug	15	16	0	0	15	16	0	0	15	16	31
Sep	37	37	0	0	37	37	0	0	42	32	74
Oct	48	57	0	0	48	57	0	0	52	50	102
Nov	49	490	0	75	49	565	2	110	51	492	543
Dec	52	519	0	69	52	588	1	110	53	519	572
<b>Total</b>	<b>335</b>	<b>2,047</b>	<b>0</b>	<b>541</b>	<b>335</b>	<b>2,588</b>	<b>2</b>	<b>220</b>	<b>237</b>	<b>4,340</b>	<b>4,579</b>

Source: UPSACS

**Distribution of Patients on ART**

Deoria currently has 488 PLHIV, of whom 285 are on ART. In addition, there are reportedly 10 children who were on ART who have now been lost to follow-up. A link ART center was established in Deoria in February 2009. The link ART center will provide services for drug administration and management and counseling for drug adherence. However, the center has not yet begun distribution of antiretroviral (ARV) drugs. Nor will it provide CD4 testing..

**Table 20: Identification and Registration of PLHIV**

PLHIV detected in Deoria (cumulative 2002–November 2008)	488
PLHIV registered at ART center (cumulative as of December 31, 2008)	285

**Infrastructure and Services**

There are two counseling and testing centers currently operating in Deoria's district hospitals (one in the male facility and one in the female facility). Table 21 provides a snapshot of HIV-related facilities currently available in the district and targets for establishing new facilities in 2009–2010.

**Table 21: HIV-related Facilities and Targets for 2009–2010\***

	Deoria		Uttar Pradesh	
	Existing	Target (2009–2010)	Existing	Target (2009–2010)
<b>ICTCs</b>	8	1	171	16
<b>PPTCT centers</b>	1	None	79	-
<b>District hospitals (male)</b>	1	None	7	5
<b>Dist hospitals (female)</b>	1	None	70	-
<b>ART centers</b>	-	1 (link ART)	69	-
<b>Blood banks</b>	1	None	46	13
<b>Blood storage units</b>	-	-	20	11
<b>STI clinics</b>	1	-	79	2
<b>TI STI clinics</b>	1	None	91	3
<b>Community care centers (CCCs)</b>	-	1	9	1
<b>Drop-in centers (DICs)**</b>	-	1	5**	-

\*Targets in the table are as of December 2008. The link ART center in Deoria was established in February 2009.

\*\* In the future, DICs will be established only in category A districts. There are presently 11 DICs in UP, but as of 2009–2010, there will be only five.

Table 22 provides an overview of infrastructure and services in Deoria's ICTCs and PPTCT center. This is based on a facility survey and discussions with concerned staff at UPSACS and the Technical Support Unit (TSU).

**Table 22: Infrastructure and Services**

	<b>ICTC District Hospital (Male)</b>	<b>PPTCT center District Hospital (Female)</b>	<b>ICTC CHC, Barhaj</b>
<b>Infrastructure</b>			
Is water available for drinking?	Yes	No	Yes
Is water available for toilet?	Yes	Yes	No
Is electricity available in the facility?	Yes	Yes	Yes
What type of power backup facility is available?	Generator	Inverter	Generator
<b>Communication Facilities</b>			
Is there a telephone in the facility?	No	No	No
Is there a STD telephone in the facility?	No	No	No
Is there a computer in the facility?	Yes	Yes	Yes
Does the facility have a computerized health management system in place to store patient records?	Yes	Yes	Yes
<b>Services</b>			
What services are offered at the center?	Pre-test counseling, post-test counseling, ongoing counseling, and HIV testing	Pre-test counseling, post-test counseling, ongoing counseling, and HIV testing for PPTCT	Pre-test counseling, pre-test counseling, and HIV testing
	<b>ICTC District Hospital (Male)</b>	<b>PPTCT center District Hospital (Female)</b>	<b>ICTC CHC, Barhaj</b>
Day(s) allotted for counseling and testing of pregnant women	N/A	All working days	N/A
Does the facility provide group counseling?	Yes	Yes	No
If yes, how many people (on average) per group?	4–5	4–5	-
How long (on average) is each group session?	20–30 min	15–20 min	-
Are condoms available in the center?	Yes	Yes	Yes
Where are the condoms kept?	Counseling room	Counseling room	Counseling room
<b>HIV Counseling</b>			
Is there a waiting room/area available?	Yes	No	Yes
Number of chairs in the waiting room	4	-	0
Is there a counseling room?	Yes	Yes	Yes
Number of counseling rooms	1	1	1

	ICTC District Hospital (Male)	PPTCT center District Hospital (Female)	ICTC CHC, Barhaj
Physical infrastructure in counseling room:			
a. Desk and chair for the counselor	Yes	Yes	Yes
b. Lockable filing cabinet for records	Yes	Yes	Yes
c. Computer with printer and UPS	Yes	Yes	Yes
d. Computer table, with a chair	Yes	Yes	Yes
e. Waste basket.	Yes	Yes	Yes
f. Number of chairs for clients	4	2	2
Is privacy ensured?	Yes	Yes	Yes
<b>HIV Testing</b>			
Is there a separate lab/blood sample collection room?	Yes	No	No
Equipment observed in testing room:			
Refrigerator	Yes	Yes	No
Centrifuge	Yes	Yes	No
Needle destroyer	Yes	Yes	No
Micropipette	Yes	Yes	No
Components for infection control and waste management	Yes	Yes	No
Testing kits	Yes	Yes	No
Safe delivery kits	-	Yes	No
<b>Staff</b>			
Counselors	2	1	1
Laboratory technicians	1	0	1
Patients per day	25–30	15–20	2
Waiting time for patients	20 min	20 min	-
<b>IEC<sup>13</sup> Material</b>			
Flipcharts	3	1	2
Condom demonstration models	2	0	0
Posters	2	5	2
Pamphlets/handouts	Yes	Yes	No
Is any audiovisual material being played in the waiting room?	No	No	No

<sup>13</sup> Information, education, and communication

## FRAMEWORK FOR PROGRAM ACTIVITIES

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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*<sup>14</sup>/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 District Health Society and creates linkages with the Block Rural Health Mission and 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 outlined 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 yet been established in Deoria 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 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 NGO TI projects and PLHIV networks (*three*)
- (11) Representatives of related departments identified by DAPCU for convergence— Women Empowerment and Child Development, Panchayati Raj Institutions (PRI), Labor, Mines, Industry, Tourism, Urban Local Bodies, etc. (*five*)

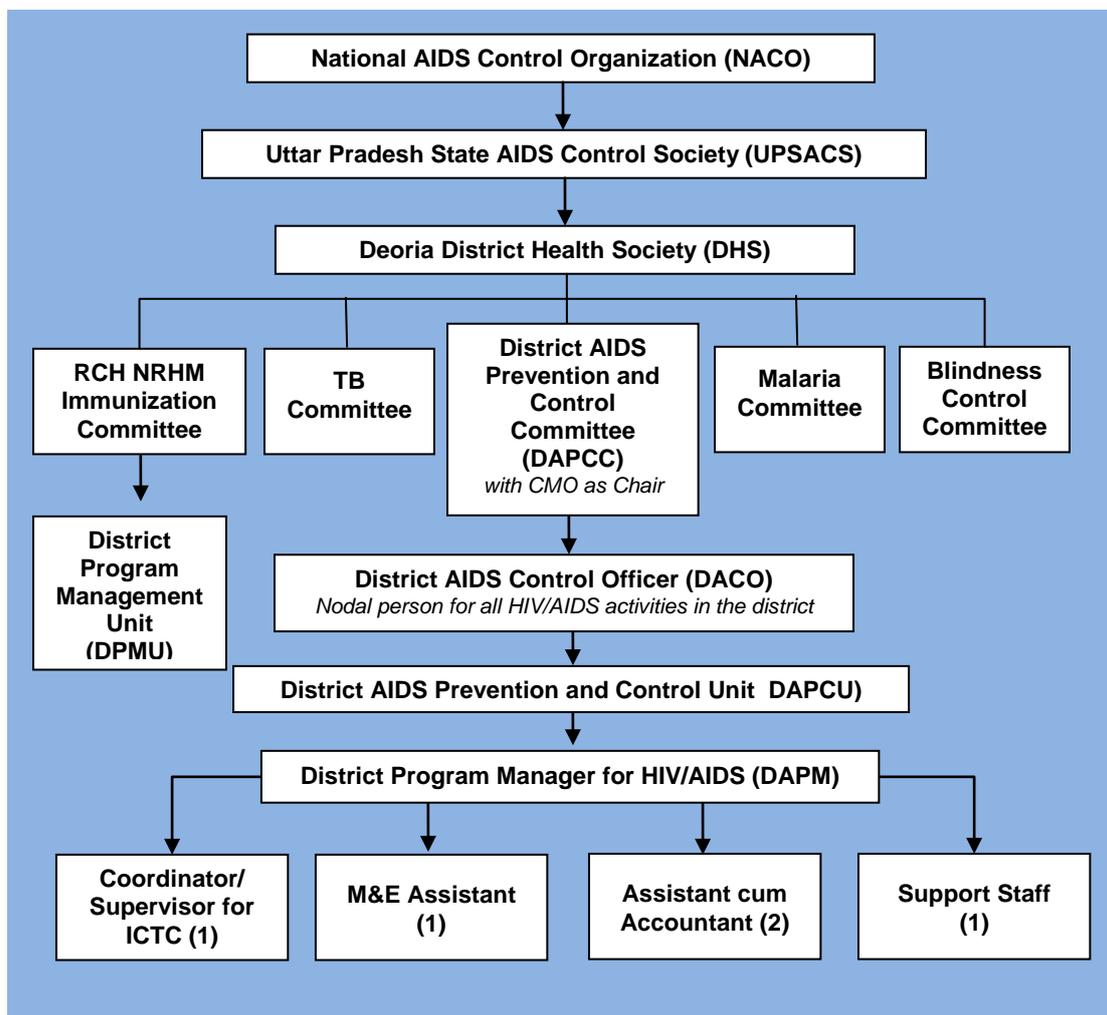
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<sup>14</sup> District Council

### 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 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 Deoria.

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 23. DAPCU Roles and Responsibilities**

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

The terms of reference for DAPCU staff are listed in the section on Human Resource Planning (see section 7.2 on page 49).

## PURPOSE OF THE PLAN

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The DAP offers a roadmap for effectively decentralizing implementation of the National AIDS Control Program. The objectives and broad strategies outlined in the plan are for the period coinciding with 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 Deoria 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 activities and other relevant departments.

### Goal

To implement a comprehensive intersectoral action plan to reduce the incidence of new HIV cases to zero by 2012 in Deoria district 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 HIV-positive individuals and others affected by HIV.

### Strategy

The main strategy under NACP-III is to expand the network of HIV/AIDS services from the NACP-II pattern of selective NGO/CBO-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.

This action plan seeks to define and implement a unified strategy under the leadership of the District Collector to combine efforts to maximize impact and optimize the use of limited resources. From the district level, the HIV program will filter down to the village and *anganwadi* level through a cadre of customized service providers called “link workers.”<sup>15</sup> The DAPCU will ensure professional management of the program through regular monitoring and supervision.

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<sup>15</sup> Link workers are community workers who have been identified to reach out to rural populations on HIV-related issues.

## INSTITUTIONAL STRENGTHENING FOR CORE ACTIVITIES

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### 5.1 Targeted Intervention (TI)

Like all category A districts, the epidemic in Deoria, while primarily confined to HRGs, is gradually moving into the general population. For this reason, the principle strategy for targeted HIV intervention is to saturate coverage of HRGs in the state to prevent new HIV infections. To achieve this goal, UPSACS is implementing a number of targeted intervention projects in collaboration with local-level NGO partners. These projects consist of a multifaceted program of direct interventions. The five key elements of the TI strategy are behavior change; access to STI services through an NGO or public/private health facility; monitoring availability and utilization of condoms; building ownership; and building an enabling environment for HIV prevention, treatment, and support.

NACP-III in UP<sup>16</sup> aims to reduce new infections by 60 percent in high prevalence districts and by 40 percent in vulnerable districts in the program's first year to reverse the epidemic's overall spread in the state. This will be achieved in part through expanding the reach of targeted interventions through NGO and CBO-implemented TI projects and the introduction of link worker schemes.

#### Objective

To support TI projects and facilitate their mainstreaming into the district's existing health care system to improve their effectiveness and sustainability.

#### Situation Analysis

A mapping study carried out in 2008<sup>17</sup> mapped various sites in the district to identify and locate HRGs. The study mapped 16 sites to identify and locate FSWs operating in the district. It estimated that there are 15 highway/*dhaba*-<sup>18</sup>based and 330 street-based FSWs active in the district. Mapping in 13 sites projected 465 MSM living in Deoria, of whom 400 are *kothis*.<sup>19</sup> Mapping of nine sites identified 190 IDUs, of whom approximately 70 percent were found to be sharing needles. Out of the 1,600 circular migrants that were identified through the mapping exercise, 4.8 percent were found to engage in high-risk behaviors.

Currently there is one TI project being implemented in Deoria district. The project is being implemented by UPSACS through a local NGO, Purvanchal Sewa Sansthan. Its area of operation is largely urban. Project workers target HRGs in selected hotspots, such as hotels, guest-houses, lodges, cinema halls, taxi and bus stands, railway stations, parks, and *mohalla* (neighborhoods) inhabited by transgender individuals. The project reaches out to 330 FSWs, 150 MSM, and 250 IDUs through a composite intervention. The TI project carries out its work through peer educators who are members of the target groups.

In addition to the TI project being implemented by Purvanchal Sewa Sansthan, a private, Ghaziabad-based agency called Gram Niyojan Sansthan began operating in the district in October 2008. The organization is deploying a team of 40 link workers and four supervisors to cover 100 villages in Deoria. The link workers will identify additional volunteers from villages and train them on disseminating information on HIV/AIDS, HIV prevention, linkages and referrals to services, as well as how to conduct behavior change activities.

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<sup>16</sup> Uttar Pradesh Program Implementation Plan for NACP-III, UPSACS, Lucknow, May 2008

<sup>17</sup> The mapping of core and migrant groups (under NACP-III) in Uttar Pradesh was carried out in 2008 by Social and Rural Institute (IMRB) on behalf of Futures Group International and Family Health International.

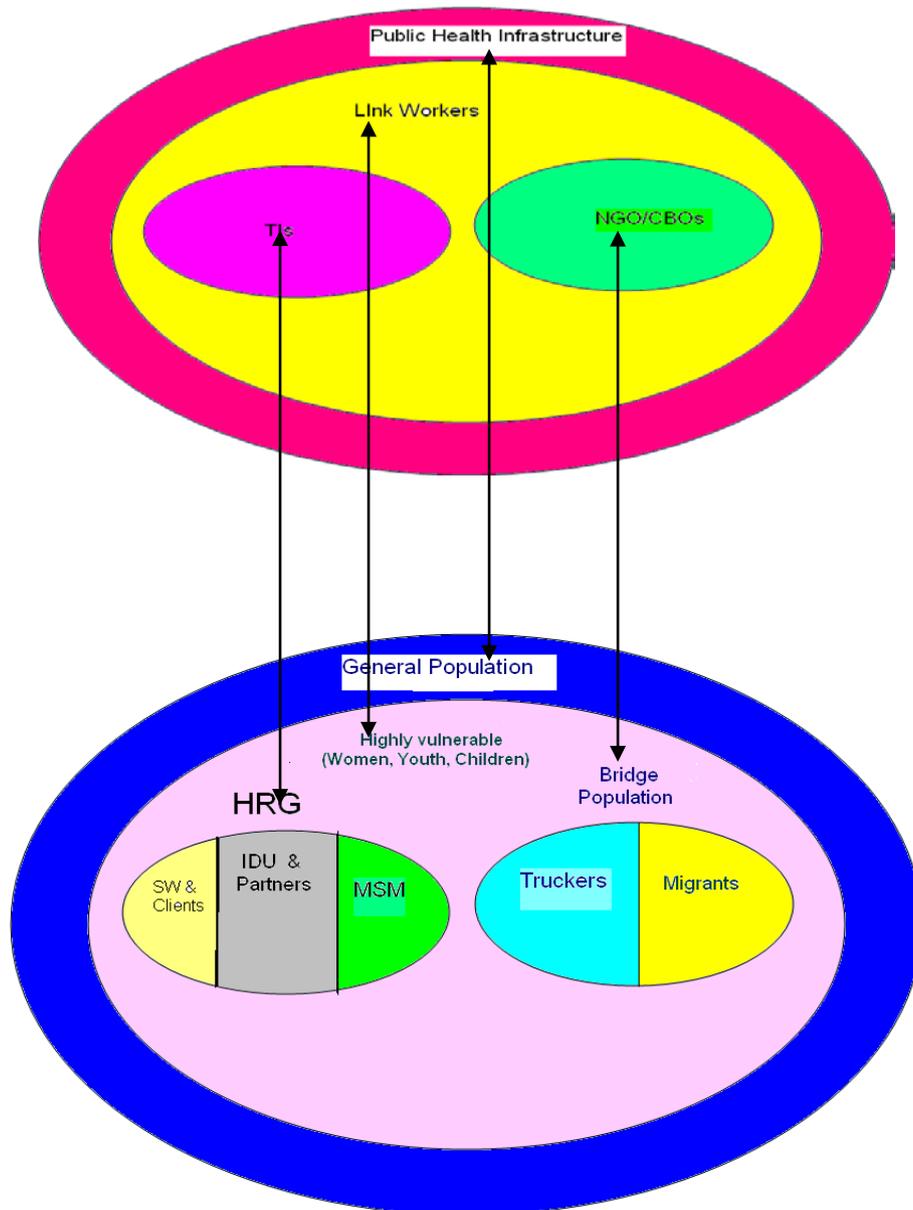
<sup>18</sup> Small eatery

<sup>19</sup> the individual who takes the female sexual role in a MSM relationship

**Table 24: Outreach Coverage by NGO TI Project (Jan-July '08)**

	FSW		FSW Clients		IDU		MSM		Other	
	New	Repeat	New	Repeat	New	Repeat	New	Repeat	New	Repeat
Contacted by NGO staff/outreach worker	7	227	22	15	3	89	2	145	26	50
Contacted by peer educator	6	345	23	14	4	215	6	328	23	10

**Figure 3. Population Mapping for Targeting Service Provision<sup>20</sup>**



<sup>20</sup> Operational guidelines for Districts AIDS Prevention Control Units

Interviews and discussions during preparation of the DAP revealed a lack of functional coordination and linkages between Deoria's ICTCs and the TI projects. The field work also highlighted the inaccessibility of testing services for the rural population, low demand for services, and poor quality of services as additional challenges facing the district.

### **Strategies**

- Strengthen coordination and leadership at district level.
- Integrate functioning of TI projects with public health delivery system to provide supplies, service delivery, and follow-up to HRGs.
- Ensure convergence with PRI and municipal bodies to reach out to HRGs on awareness and service delivery issues.

### **Action Plan**

- Improve coordination by establishing a coordination committee to meet once every six months under DAPCU.
- Conduct quarterly review of program activities undertaken by TI projects (responsibility of DAPCU).
- Involve TI project representatives in district-level meetings, consultations, and decisionmaking.
- Facilitate interactions between TI projects and ICTC/PPTCT center counselors and medical officers-in-charge on monthly basis.
- Establish coordination between TI project and outreach workers from counseling and testing centers for grassroots service delivery.
- Foster effective coordination and collaboration among various partners, including ICTCs, PPTCT center, district-level line departments, and health departments, for improved service delivery.
- Involve PRI/local governance officials as part of outreach strategy.
- Provide regular support to TI projects in terms of materials such as IEC material and condoms (responsibility of DAPCU).
- Involve private medical facilities to strengthen service delivery and follow-up mechanisms.

### **Responsibility**

DAPCU, TI implementers, ICTCs

## **5.2 Antiretroviral Therapy / Treatment**

Under NACP-III, first line ARV drugs are being made available through public health facilities to all PLHIV who need ART. The primary aim of the ART strategy is to suppress viral replication and restore the immune systems of PLHIV to slow disease progression and enhance overall quality of life. To ensure achievement of these objectives, NACP-III seeks to achieve drug adherence rates of 95 percent. In accordance with NACP-III, the objective of the UPSACS ART program is to provide free ART to all eligible PLHIV. There are currently nine ART centers in UP state and PLHIV have begun receiving ART.

### **Objective**

To make ART available to all eligible PLHIV in Deoria district.

### **Situation Analysis**

Deoria district has one link ART center, which is located in the district hospital. The center was established in February 2009. It shares space with the ICTC at the district hospital and consists of one room, which is used for registration of patients and record keeping. Currently, there is no separate examination and counseling room. The center has one computer system, which is used for keeping records for both the ICTC and the ART center. There is one pharmacist and a medical officer who acts as the Officer-in-Charge of both the ICTC and the ART center. The center has not yet begun distribution of ARV drugs. However, IEC material such as posters and audiovisual aids are already available. Unfortunately, there is a noticeable lack of IEC specific to ART and treatment adherence.

As a CD4 count testing facility is not available in the district, patients are referred to Gorakhpur B.R.D. Medical College. Stakeholder consultations revealed that accessing services at these ART centers is difficult sometimes because of a lack of availability of ARV drugs, overcrowding, and large numbers of holidays. To access these services, PLHIV face loss of working days and incur travel, boarding, and lodging expenses. The district also does not have a community care center or drop-in center to provide care and support services to PLHIV.

There are currently 136 PLHIV in the district, of whom 107 are on ART, 29 are recently-identified cases, and 151 are lost to follow-up cases. In addition, 10 children who were on ART are also lost to follow-up. The cumulative number of PLHIV in Deoria ever registered for ART (as of December 31, 2008) is 285.

### **Strategies**

- Strengthen existing link ART center.
- Strengthen referral mechanisms.
- Promote counseling for treatment adherence and follow-up.

### **Action Plan**

- Build infrastructure and make optimal use of space available for ART.
- Provide need-based training to ART center staff and medical doctor.
- Orient and train community health worker and link worker to increase demand and ensure drug adherence.
- Conduct outreach to PLHIV and enroll them in pre-ART.
- Ensure constant availability of ARV drugs and other critical materials at link ART center.
- Follow up with ART clients and update PLHIV records on monthly basis.

- Establish care and support services.
- Network and coordinate with state PLHIV network to facilitate formation of district-level PLHIV network.
- Ensure integrated functioning of district-level PLHIV network (once formed) with ART center.

**Responsibility**

CMO/Medical Officer-in-Charge, Health (NRHM); UPSACS; DAPCU; NGOs; link ART center, State Network of Positive People

### **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. Under NACP-III, existing voluntary counseling and testing centers and PPTCT centers have been remodeled to integrate all HIV-related services and are now called “integrated counseling and testing centers (ICTCs).” ICTCs are located within district and sub-district hospitals, CHCs, PHCs, and TB microscopy centers. 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. As the integration process is still underway, ICTCs still refer all pregnant women to PPTCT centers for PPTCT services, while those with STI or TB symptoms are referred to STI clinics, and RNTCP centers.

#### **Objective**

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

#### **Situation Analysis**

The district has nine ICTCs (including one PPTCT center) at present. One ICTC is housed in the district hospital (male) and the PPTCT center operates at the district hospital (female). There are also six ICTCs operating at CHCs in the blocks of Barhaj, Salempur, Rudrapur, Bhatparani, Gauri-bazar, Patherdewa, and Lar. The counseling and testing centers at the district hospital have been operating for more than three years, while the ICTCs at CHC-level are recently established. With the opening of these new ICTCs, the district has achieved its target of opening seven new centers in 2008–2009.

As of January 2009, there are nine trained counselors serving Deoria district (one at each ICTC). In addition to the counselors, there are eight laboratory technicians, four of whom have already been trained. In the last year, two 12-day trainings were organized for ICTC counselors in Lucknow. In addition, the counselors attended a five-day training to improve their computer skills.

Outreach workers have not yet been appointed in the Deoria link ART center. However, a counselor has been charged with carrying out outreach work. As described in the section on targeted intervention, a link worker scheme with 40 link workers (20 male and 20 female) is being operated in the district by Gram Navyojna Sansthan. The project also has four supervisors and a project manager. Its target is to cover 100 villages. Various awareness camps have already been organized to promote voluntary testing at ICTCs.

The ICTCs at the district hospital have linkages with the TI project being implemented by Purvanchal Sewa Sansthan, as well as with other NGOs working on HIV/AIDS in the district (namely Sukhi Seva Sansthan, Shishu Seva Shansthan, Deoria Paschim Network, and Rotary Club), however there is no formal mechanism to ensure regular interaction between NGOs and ICTCs. Referral mechanisms do exist between the DOTS center and ICTCs. A few private doctors also refer patients to ICTCs for HIV testing. However, clients visiting the ICTCs are primarily referred rather than voluntary. Most are referred by TI project outreach workers, link workers, the TB clinic, or the STI clinic. The number of individuals seeking post-test counseling is relatively low.

**Table 25. ICTC Status 2005–2008**

Year		Number of Clients who Received Pre-test Counseling/Information			Number of Clients Tested for HIV			Number of Clients Who Received Post-test Counseling			Number of Clients Found HIV-positive (after three tests)		
		M	F	T	M	F	T	M	F	T	M	F	T
2005	Total	22	13	35	26	17	43	22	13	35	7	5	12
2006	Total	353	282	635	144	87	231	133	79	212	35	24	59
2007	Total	1,611	1,324	2,935	1,308	957	2,265	1,248	913	2,161	125	70	195
2008	Total	3,458	3,525	6,983	3,005	2,467	5,472	2,945	2,411	5,356	133	93	226
	Jan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Feb	181	169	350	181	169	350	170	160	330	4	5	10
	Mar	258	160	418	248	150	398	237	144	381	11	5	16
	Apr	151	128	279	143	116	259	134	107	241	12	5	17
	May	174	170	344	53	30	83	53	30	83	5	6	11
	June	185	170	355	179	170	349	170	160	330	15	8	23
	July	226	189	415	226	189	415	223	185	408	7	7	14
	Aug	200	178	378	200	178	378	193	171	364	11	4	15
	Sep	216	193	409	209	183	392	207	181	388	18	15	33
	Oct	280	249	529	270	228	498	265	223	488	14	11	25
	Nov	860	529	1,389	714	502	1,216	714	500	1,214	18	9	27
	Dec	727	1,390	2,117	582	552	1,134	579	550	1,129	18	17	35

**Table 26. District Hospital Testing and Counseling Report 2008\***

Month	Number of Clients who Received Counseling	Number of Clients Tested for HIV			Number of Clients Found HIV-positive		
		Male	Female	Total	Male	Female	Total
Jan	493	211	175	386	9	8	17
Feb	380	182	164	346	5	5	10
Mar	407	243	144	387	10	5	15
Apr	278	142	116	258	12	5	17
May	344	53	80	133	5	6	11
Jun	352	180	170	350	15	8	23
Jul	412	225	187	412	7	7	14
Aug	385	200	176	376	11	4	15
Sep	401	208	181	389	17	14	31
Oct	350	182	183	365	12	9	21
Nov	410	214	130	344	10	8	18
Dec	445	237	208	445	13	11	24
<b>Total</b>	<b>4,657</b>	<b>2,277</b>	<b>1,910</b>	<b>4,191</b>	<b>126</b>	<b>90</b>	<b>216</b>

\*Includes both PPTCT center and ICTC at district male and female hospitals.

In terms of infrastructure, each ICTC housed at the district hospital is composed of two rooms, one for counseling and the other for laboratory tests. All necessary pieces of equipment, such as a refrigerator,

a centrifuge, a needle destroyer, and a micropipette, are available in the centers. Other counseling aids, such as flip charts, condom demonstration models, a TV and DVD player, and IEC material (pamphlets, posters, and booklets) are also available. Supplies requiring monthly replenishment include HIV testing kits, syringes, gloves, condoms (12,000 per month), nevirapine tablets, nevirapine syrup, and safe delivery kits. During the last month, 5,430 condoms were distributed by ICTCs in Deoria. According to interviews and discussions during preparation of the DAP, ICTCs do not face problems related to stockout.

### **Strategies**

- Implement convergence with NRHM and public health department for strengthening ICTC services at CHC level.
- Ensure availability of adequately qualified staff (specifically counselors) at all levels.

### **Action Plan**

- Link ICT centers with other government health departments, specifically PHCs.
- Recruit professional counselors and other critical staff for newly formed ICTCs.
- Ensure consistent availability of testing kits and other necessary equipment at ICTCs.
- Carry out regular resource and training needs assessments for service delivery.
- Identify private providers with high STI client load, and franchise and train private practitioners in RTI/STI treatment and provision of referrals to ICT services.
- Increase service outreach, particularly in rural areas, by introducing mobile ICTC vans.
- Generate demand for services through IEC campaigns (both interpersonal and mass media).
- Increase outreach work by mandating field visits by ICTC counselors at least once each week.
- Conduct regular facilitative technical supervision of program activities (responsibility of district ICTC coordinator)
- Hold at least three district-level public meetings or workshops each year involving TI project representatives, PLHIV, ICTC staff, ART center staff, TB department staff, and staff providing STI services.
- Orient accredited social health activists (ASHAs), link workers, *anganwadi* workers (AWWs), and auxiliary nurse midwives (ANMs) to advocate for positive living and treatment adherence among PLHIV.
- Develop yearly action plan based on findings of resource and training needs assessment.
- Tailor communication activities to context, particularly IEC material targeting HRGs.

### **Responsibility**

Link ART center, DAPCU, UPSACS, TI projects

## 5.4 Blood Safety

NACP-III aims to ensure the timely (within one hour of need arising) provision of safe, high-quality blood through a well-coordinated national blood transfusion service. During NACP-III, UPSACS aims to reduce transmission of HIV infection through blood and blood products to less than 0.3 percent and to increase the availability of safe blood and blood products by enhancing the collection and storage of blood.

### Objective

To reduce transmission of HIV in Deoria through increased access to safe blood and to ensure timely availability of safe blood and blood products

### Situation Analysis

Deoria district has one government blood bank, established in the year 2000. During December 2008, 72 units of blood were collected, out of which 26 units are available at present. With a population of 2.7 *lakh*, an estimated 60 units of blood is required per month in the district. There is currently no blood storage unit or private blood bank in Deoria. Rotary Club, by the name of Nirankari Sansthan, is associated with a blood bank and provides necessary support in times of need. About 10 blood donation camps were organized during the last year. Blood donation camps are usually organized at the blood bank, at PHCs, at community sites with help from NGOs, or in colleges. Donor records are kept in accordance with the national drug and cosmetic guidelines.

Access to safe blood is mandated by law. The blood units obtained at the blood bank are tested for contamination (the presence of transmitted infections). Tests performed include tests for HIV, hepatitis B and C, syphilis, and malaria. As of now, no cases of HIV have been identified among blood donors. During the preparation process for the DAP, stakeholders reported that there are sufficient supplies of test kits, blood bags, syringes, IEC material, and other consumables on hand. They reported that the facility does not face stockouts. However, there is need for other equipment, such as donor beds (2), laminar air flow, a blood collection monitor, and a blood shake mixer. With respect to staff, while there are four lab technician posts sanctioned, there is only one lab technician (appointed on a contract basis) currently serving. Positions for medical officer, pharmacist, staff nurse, and clerk are all vacant. There is also a felt need for specific training for blood bank staff on blood safety protocols and procedures.

### Strategies

- Strengthen and upgrade blood bank to meet district requirements.
- Promote voluntary blood donation to maintain optimal blood supply levels in accordance with district's needs.
- Link with NGOs and Rotary/Lions Club to organize blood donation camps under technical supervision.

### Action Plan

- Fill vacant posts at blood bank through contractual placements.
- Streamline collection, supply, and storage of blood in district.
- Assess demand for and manage supply of blood products and related equipment through NRHM and NACP.
- Conduct training for blood bank medical officer and staff in accordance with NRHM and NACP protocols.
- Promote voluntary blood donation by organizing frequent blood donation camps.

**Table 27. Blood Bank Targets for 2009–2010**

Description of Activity or Service	Target (2009–2010)
Voluntary collection (blood bank)	88 units (30% increase from 2008–2009)
Voluntary collection (donation camps)	64 units (three times 2008–2009 level)
Number of voluntary blood donation camps (20 units / camp)	3 camps
Total voluntary collection	152
Total private collection	0
Replacement collection	632 (10% increase from 2008–2009)
Estimated total collection for the state 2009-10	784

- Strengthen safety protocols for blood transfusion.
- Link private medical college and private institutions through coordination meeting each six months.
- Coordinate and link with private medical college and other private institutions to strengthen blood safety norms.
- Organize integrated sensitization and communication camp with respect to blood donation and blood safety norms.

**Responsibility**

UPSACS, DACO (nodal officer for blood safety)

## 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 at the district hospital and at CHCs have a separate waiting area, while the PPTCT center does not. An exclusive counseling room is available in all counseling and testing centers in the district and privacy is ensured during client counseling sessions. Counseling rooms have basic physical infrastructure (i.e. desks, chairs, cabinets, computers, printers, and waste baskets). There is a separate lab/room for blood sample collection only in the district hospital ICT center. Other basic equipment available in testing rooms at the district hospital ICTC and PPTCT center include refrigerators, centrifuges, needle destroyers, micropipettes, components for infection control and waste management, and testing kits. Safe delivery kits and drugs are also available at the PPTCT center. IEC material, such as flipcharts, posters, and pamphlets, are available at all centers. The centers, as well as TI projects and community health workers, have adequate condom supplies. Two condom demonstration models are also present at the district hospital ICTC.

**Table 28. HIV Test Kit Stock Situation at ICTCs in Deoria**

Year	Month	HIV Test Kit 1		HIV Test Kit 2		HIV Test Kit 3		HIV Test Kit 4	
		Received	Consumed	Received	Consumed	received	Consumed	Received	Consumed
2008	Jan	0	0	0	0	0	0	0	0
2008	Feb	200	289	240	217	350	208	0	0
2008	Mar	210	235	201	398	0	220	0	0
2008	Apr	0	114	0	283	0	199	3	197
2008	May	0	14	0	0	0	18	0	66
2008	June	336	208	0	0	0	0	0	182
2008	July	532	443	150	100	340	278	0	0
2008	Aug	0	393	150	87	0	43	864	260
2008	Sept	1,680	430	150	351	150	0	0	0
2008	Oct	780	801	105	44	0	2	0	0
2008	Nov	886	1,156	148	235	0	0	0	0
2008	Dec	1,820	1,480	200	67	0	0	0	0
2009	Jan	1,180	1,171	340	261	192	94	0	0

The number of HIV tests being conducted in Deoria increased from 233 in 2006 to 4,191 in 2008. To achieve maximum impact from the scale-up of ICTCs in 2008 (from two to nine), each center must receive optimal quantities of necessary supplies. ICTCs, the PPTCT center, TI projects, the blood bank, and the link ART center are the main SDPs for HIV testing in the district.

**Table 29: Stock Record for Disposable Gloves and Condoms at ICTCs in Deoria**

Year	Month	Disposable Gloves					Condoms				
		Opening Stock	Received	Consumed	Closing Stock	Requested	Opening Stock	Received	Consumed	Closing Stock	Requested
2008	Jan	0	0	0	0	0	0	0	0	0	0
2008	Feb	125	25	45	105	50	56,330	0	9,600	46,730	0
2008	Mar	805	0	770	35	75	30,730	0	5,300	25,430	0
2008	Apr	735	700	55	1,380	150	39,290	0	8,520	30,770	0
2008	May	680	0	30	650	150	18,330	0	3,750	14,580	0
2008	June	650	0	65	585	150	23,280	0	5,775	17,505	0
2008	July	595	0	95	500	100	17,505	0	11,820	5,685	6,000
2008	Aug	500	50	90	460	50	5,675	42,000	6,620	41,055	0
2008	Sept	12,010	12,050	3,198	20,862	50	41,055	0	2,391	38,664	0
2008	Oct	617	375	157	835	300	47,504	54,000	4,074	97,430	0
2008	Nov	722	60	177	605	500	109,350	24,000	19,840	113,510	3,000
2008	Dec	597	100	223	474	803	101,510	48,000	9,780	139,730	3,505
2009	Jan	549	100	193	456	450	151,740	12,000	8,345	155,395	2,000

**Table 30. Supply Needs by Service Delivery Point**

Service Delivery Points	Supplies Needed
8 ICTCs 1 PPTCT	<ul style="list-style-type: none"> <li>• Rapid test kits</li> <li>• Disposable syringes and disposable gloves (450 requested in January)</li> <li>• 2,000 condoms</li> <li>• 150 Nevirapine tablets</li> <li>• 50 Nevirapine syrups</li> <li>• 50 safe delivery kits</li> <li>• 50 doses of post exposure prophylaxis (PEP)</li> </ul>
1 TI project	<ul style="list-style-type: none"> <li>• Disposable needles for 80 percent coverage of IDUs in TI project target population</li> <li>• Condoms and lubricants</li> <li>• HRG-specific IEC material, especially take-away materials and behavior change communication kits for peer educators</li> </ul>
Blood banks	<ul style="list-style-type: none"> <li>• Test kits for HIV, HBSAG (hepatitis B), HCV (Hepatitis C), MP, and syphilis (VDRL)</li> <li>• Blood bags, disposable syringes, and other consumables</li> <li>• IEC material</li> </ul>
Link ART center	<ul style="list-style-type: none"> <li>• ARV drugs for new cases each month</li> <li>• ARV drugs for cumulative number of people on ART</li> <li>• Disposables and reagents for CD4 count</li> <li>• PEP drugs</li> </ul>

In the area of targeted interventions, there is a need to create and distribute HRG-specific IEC material, especially take-away materials and kits for peer educators.

The logistics supply chain from UPSACS to the district level needs to be streamlined through the DAPCU. Currently, SDPs make requests directly to UPSACS and in most cases supplies have to be collected from the UPSACS office in Lucknow. Delay in obtaining supplies affects ICTC service

delivery. With the introduction of the DAPCU, SDPs can assess their needs on a quarterly basis and the DAPCU can obtain the necessary supplies from UPSACS and distribute them directly to SDPs.

### **Strategies**

- Put in place an integrated supply and logistics framework and mechanisms.
- Pursue convergence with NRHM and public health department to optimize use of available resources.
- Ensure adherence to system of inventory control and quality checks.
- Provide adequate and on time funding to ensure uninterrupted supply and avoid stockouts.

### **Action Plan**

- Hold stakeholder consultation to come up with integrated supply and logistics framework.
- Appoint District ICTC Coordinator to act as person-in-charge of supplies.
- Put in place mechanism to provide regular feedback on stockouts.
- Carry out monthly stock verification, estimation, and collection of materials in accordance with requirements.
- Introduce systematic inventory control and supply utilization mechanisms.
- Adopt appropriate storage mechanisms for goods and supplies.
- Arrange with NRHM for restocking through parallel health interventions in urgent cases.
- Manage flow of goods and supplies through UPSACS.

### **Responsibility**

DAPM, District ICTC Coordinator, ART Coordinator

## CONVERGENCE WITH NRHM

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HIV/AIDS is no longer restricted to any specific group or location. The epidemic is driven by many factors, which relate to various aspects of the health sector and also impact other sectors. Thus, efforts to reverse the epidemic call for synergized, collective action from all stakeholders. One of the key lessons of NACP-II was that centralized program implementation limits opportunities for the optimal utilization of HIV/AIDS-related services (ICT, PPTCT, STI, ART, etc.) and offers inadequate outreach to clients accessing the public health infrastructure for family welfare, TB, and OI services. Since HIV/AIDS programs under NACP-II were being administered directly by State AIDS Control Societies, ownership among doctors, lab technicians, and nurses remained low despite receiving orientation on the AIDS program.

NACP-III envisions expanding outreach and effectiveness of concerted actions through the creation of a wider support system. The mainstreaming of HIV/AIDS issues with the general health system down to the village level in category A and B districts will be carried out through grassroots workers, such as ANMs, ASHAs, and multi-purpose workers (MPWs). Hence, convergence and actions for mainstreaming HIV/AIDS are proposed in the DAP.

### **Institutional Arrangements at District Level**

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

### **Objective**

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

### **Situation Analysis**

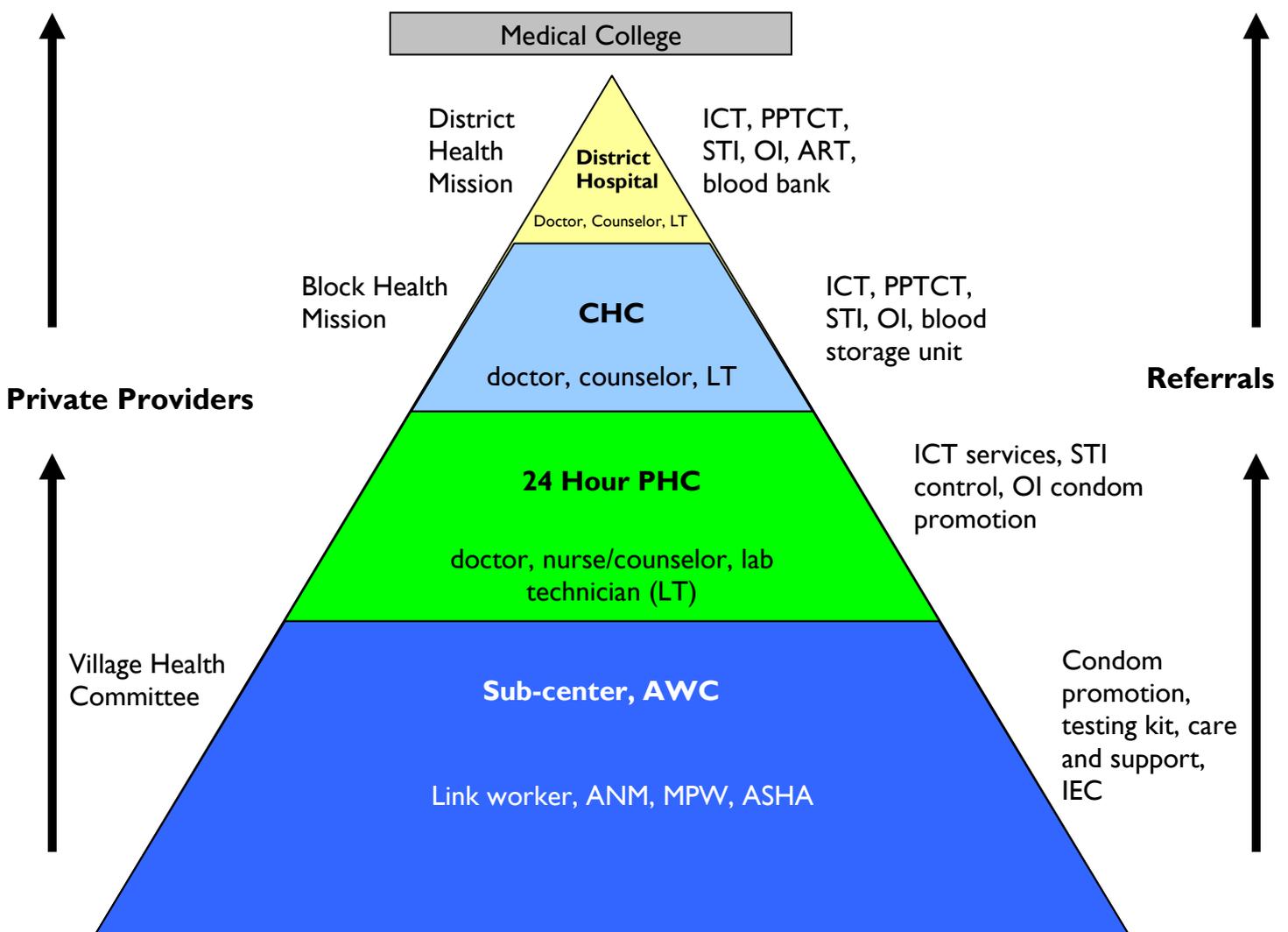
The DAPCC is not yet in place. Apart from the concerned departments within the health department (i.e. ICTCs, STI clinic, TB clinic, PLHIV network, link workers, community health workers, and concerned NGOs), other agencies and departments are not actively participating in the program. The lack of stakeholders like Integrated Child Development Services (ICDS) workers is negatively influencing the program's momentum.

### **Strategies**

- Form and operationalize DAPCC.
- Sensitize district health and link department functionaries on role of DAPCC.
- Provide “innovation fund” for DAPCU (to be approved by UPSACS) to use to promote innovative activities to mitigate effects of HIV in Deoria.
- Mainstream DAP and strategies as part of NRHM action plan.
- Develop microplan for convergence with key stakeholder organizations/department, including the following elements:
  - Formation of coordination committee in congruence with NRHM coordination committee.
  - Strengthening of service delivery through expansion of HIV services at CHC and PHC level.
  - Deployment of professionals/doctors on deputation or contract basis to upgrade HIV technical capacity at district level.
  - Overall building of HIV/AIDS technical capacity at district level.
  - Mainstreaming of district-level HIV structure with public health infrastructure.

- Integration of functions with RCH program, TB control program (referral protocol between DOTS and ICTCs), and other relevant health and family welfare programs.
- Convergence of NACP activities with District Health Administration for optimization of resources and efforts.
- Escalation of link worker scheme to focus on identified HRGs.
- Coordination and collaboration with local bodies (CBOs, professional associations, and other civic organizations) for sensitization, care and support services, and treatment referrals.
- Mainstreaming of HIV program activities through existing cadre of community health workers (i.e. ANMs, MPWs, and ASHAs).
- Strengthening of HIV service delivery through integration of ICTCs, ART center, CHCs, PHCs, and sub-centers.
- Inclusion of HIV prevention and control, care, treatment, and support in Village Health Plan, Block Health Plan, and District Health Plan (implemented by Village Health and Sanitation Committee, Block Rural Health mission, and District Health Mission, respectively).
- Expansion of counseling, advocacy, and testing services at village level through Maternal and Child Health and Nutrition (MCHN) Days

**Figure 4. 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.

### Objective

To achieve dual protection against unwanted pregnancy and STIs and to reduce sexual transmission of HIV.

### Situation Analysis

To increase access to condoms, especially among marginalized groups and in challenging areas, UPSAC's program implementation plan includes intensified rural marketing programs and non-conventional distribution approaches. The plan will minimize wastage of free condoms provided through the public health network by carrying out rational forecasting of needs and improving procurement processes.

There are two condom demonstration models available at the ICTC in the district male hospital and both are in functional condition. A total of 8,345 condoms were distributed through ICTCs in Deoria in January 2009. The primary sources of condoms for people (particularly for FSWs and their clients) include *paan* (betel) shops and chemists, ASHAs, ANMs, NGO field workers, and health centers (including ICTCs). Free condoms available at STI clinics and testing centers reach only those who visit them, limiting their distribution impact. Community health workers promote condoms predominantly for family planning purposes and lack skills for disseminating knowledge and IEC material on HIV/AIDS, which could help them raise awareness of HIV. The TI project receives a supply of condoms from UPSACS, which it distributes among HRGs through peer educators. There are currently no condom vending machines in the district.

### Strategies

- Implement collaborative condom promotion and supply strategy under NRHM and NACP.
- Make strategic connections with condom social marketing organizations, such as Hindustan Latex, Ltd. and DKT.
- Improve inventory management to ensure uninterrupted supply of condoms.

### Action Plan

- Assess needs and gaps in condom availability on a monthly basis.
- Ensure free and regular condom supply to HRGs through TI projects.
- Conduct outreach to chemists and other retailers through social marketing agencies.
- Promote correct and consistent use of condoms among general population through intensified IEC/behavioral change communication activities.
- Coordinate with social marketing agencies, which are coordinated by DAPCU, to undertake promotional activities.
- Establish condom distribution depots at block level.
- Install condom vending machines at hotpots and STI clinics in collaboration with TI project, ensuring better access to condoms.
- Reach out to colleges as part of outreach for condom promotion and introduce concept of condom use as part of colleges' sex education curricula.

- Orient district-level PLHIV network on adoption of safe sex practices.
- Build capacity of health staff, outreach workers, and link workers to demonstrate correct and consistent condom use.
- Sensitize ANMs, MPWs, ASHAs, and link workers to enhance condom promotion and IEC efforts.

**Responsibility**

Health department, DAPCU, UPSACS, TI implementers, ICTCs, district-level PLHIV network

## 6.2 Maternal Health

The district PPTCT program aims to prevent the spread of HIV among women, especially expectant mothers, as well as to prevent parent-to-child transmission of HIV. 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 mothers into the ambit of the formal health department, where they can be motivated to undergo counseling and testing and subsequent follow-up of HIV-positive mothers and babies can be carried out.

### 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 the district.

### Situation Analysis

There is only one ICTC with PPTCT facilities available in the district. It is located at the district female hospital. Trends over the last few months show fluctuations in the number of women being tested for HIV at the center. PPTCT center records for 2008 show that 586 women were tested for HIV in January. The number of women tested fell drastically in April, to only 10. In July the number increased to 360, and continued to increase in December, when 429 women were tested. A total of 8,755 women were registered at the PPTCT center in 2008, out of whom 4,819 received pre-test counseling. Following pre-test counseling, only 3,651 women were tested for HIV.

### Strategies

- Ensure high-quality services at PPTCT center.
- Promote institutional and safe deliveries.
- Strengthen advocacy and counseling services to motivate pregnant women to seek PPTCT services in a timely fashion.

### Action Plan

- Promote and provide PPTCT counseling services at ANC day.
- Use ANC day to motivate pregnant women to go for institutional delivery.
- Track and support HIV-positive pregnant women through ANMs, ASHAs, link workers, and HIV/AIDS outreach workers.
- Train community health workers in PPTCT counseling.
- Train service providers and ANMs in administration and composition of drugs like nevirapine to deal with PPTCT cases.
- Liaise with private sector to handle PPTCT cases (responsibility of DAPCU).
- Train government staff and private practitioners on PPTCT protocols.
- Expand PPTCT services at CHCs and PHCs, particularly those that are near hotspots.
- Train doctors to manage deliveries of HIV-positive women.
- Collaborate with private health care providers to improve access to services.
- Forge strong linkages with existing maternal and child health (MCH) program in district.
- Promote institutional deliveries through *Janani Suraksha Yojana*.
- Undertake IEC campaigns to increase HIV awareness and demand for PPTCT services through cinema, newspapers, posters, and group discussions.

- Train service providers, such as ANMs and medical officers, to administer Nevirapine to mother/baby pairs.
- Provide support to HIV-positive women through service providers (ASHAs, ANMs, link workers, outreach workers) and other local social workers.
- Disburse safe delivery kits through NRHM from UPSACS to PPTCT.
- Increase demand for PPTCT services through integrated communication campaign with NRHM.
- Emphasize strong interpersonal communication at PPTCT center.

**Responsibility**

Health (NRHM), UPSACS, DAPCU, private providers

## **6.3 Infant and Pediatric Care**

### **Objective**

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

### **Situation Analysis**

The district does not have extensive data on the number of HIV-positive children. The concerned centers had data only on those children who are currently on ART. However, those children currently on ART had not received follow-up. In Deoria, 41 percent of births take place in institutional settings, 9.8 percent take place at home in the presence of a trained provider, and the remaining 49.2 percent are unassisted. The low level of institutional deliveries puts a significant female population out of the purview of counseling and testing services. Despite the growing outreach of ASHA workers, their effectiveness is abysmally low. Less than 2 percent of women are seeking ANC or institutional delivery as a result of their facilitation and motivation. Presently, there is no support mechanism in the district for HIV-positive children born to HIV-positive mothers.

### **Strategies**

- Ensure institutional deliveries for HIV-positive mothers.
- Strengthen PPTCT services in government and private hospitals.
- Foster strong linkages with voluntary organizations and pediatricians to improve outreach.
- Mainstream care and support services as part of government MCH program.
- Provide adequate treatment, care, and support to newborns, including nutritional support and ART.

### **Action Plan**

- Establish database of HIV-positive children and help link ART center and district PLHIV network.
- Put in place system for tracking number of children seeking ART and streamlining drug supply.
- Follow up with PLHIV mothers to ensure that their newborns are tested six weeks after delivery.
- Arrange for nutritional support for HIV-positive mother/baby pairs through convergence with ICDS (AWWs).
- Ensure that HIV-positive newborns receive nutritional support and ART, as needed, in a timely fashion.
- Build the capacity of link workers, ANMs, and ASHAs to track and follow up with HIV-positive mothers.
- Improve tracking and follow-up of HIV-positive mothers and their newborns by strengthening PPTCT services in private hospitals.

### **Responsibility**

Health (NRHM), UPSACS, DAPCU

## 6.4 Sexually Transmitted Infection (STI)

The presence of a sexually transmitted infection (STI) significantly increases an individual's risk of contracting or transmitting HIV, especially when there is an ulcer or discharge. 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.

### Objective

Reduce the STI burden in Deoria district and enhance HIV prevention efforts and early identification of PLHIV through cross-referrals.

### Situation Analysis

The district has one STI clinic, which is located in the district hospital. There is also an STI clinic operated as part of the NGO-implemented TI project. The district hospital center provides services related to counseling, testing, and treatment of STIs. The clinic has one counselor, one lab technician, and a nurse. The lab technician works for both the ICTC and the STI clinic. Between February and December 2008, 281 members of HRGs registered at the NGO STI clinic, almost 80 percent of whom were tested for STIs. Similarly, the total number of people tested for STIs at the government STI clinic during the same period was 443. The NGO STI clinic has linkages and referral mechanisms with the district hospital ICT center and the PPTCT center. Through outreach workers, the clinic referred 625 people to ICTCs in 2008. Link workers also work in close coordination with the clinic.

The distribution of HRG individuals attending the TI project STI clinic between January and July 2008 shows that more FSWs attended the clinic than MSM or IDUs. The clinic's records show that almost 50 cases were referred to the ICTC for HIV testing. At the TI project STI clinic, a total of 33 individuals who were counseled were motivated to seek HIV testing, and 348 condoms were provided.

**Table 31. Number of HRGs Treated at NGO-STI clinic (Feb–Dec 2008)**

Number of HRG members treated at NGO STI Clinic	281
Number of HRG members treated at NGO STI clinic	226
Number of HRG members and community members referred to ICTC*	625
Number of HRG members referred who tested HIV positive	10

\* This figure includes HRG members directly referred from the field in addition to those who attended the NGO STI clinic

**Table 32. Patients Accessing STI Services at Government STI Clinic (Jan–Dec 2008)**

	Male	Female	Total
Number of patients counseled	338	333	671
Number of condom provided	6,622	633	7,255
Number of RPR <sup>21</sup> tests conducted	241	202	443
Number of RPR tests found reactive	18	13	31
Number of partner notifications undertaken	0	0	0
Number of patients referred to ICTC	204	201	405
Number found HIV-positive (of above)	1	2	3

<sup>21</sup> rapid plasma reagin (blood test for syphilis)

## **Strategies**

- Mainstream STI treatment in all government programs and schemes.
- Promote health seeking behavior among STI cases and their partners.
- Ensure logistics and supplies for uninterrupted service delivery.

## **Action Plan**

- Strengthen existing STI clinics in government facilities and set up clinics in private facilities.
- Implement convergence with RCH/NRHM for STI clinics and treatment program.
- Increase resources and service provision for RTI/STI treatment through public-private partnerships.
- Train government and private health providers on STI treatment.
- Build capacity of outreach workers to strengthen service delivery for STI cases.
- Ensure availability of STI drugs at PHCs, CHCs, and sub-centers.
- Develop drug supply mechanism to facilitate flow of STI drugs from UPSACS to TI project STI clinic.
- Train TI project staff on STI management.
- Increase manpower by appointing qualified and dedicated staff on contractual basis.
- Use IEC material to disseminate knowledge about STIs and their link to HIV/AIDS through ASHAs and ANMs.
- Develop flipcharts and booklets for STI counseling.
- Converge with RCH camps for outreach and mainstreaming of STI treatment in villages.
- Strengthen referral mechanisms for STI cases to ICTCs.

## **Responsibility**

Health (NRHM), UPSACS, DAPCU

## 6.5 IEC and Advocacy for Behavior Change

As one of the most vulnerable districts in UP, Deoria has been prioritized for IEC action. The purpose of developing an IEC strategy is to motivate behavior change among at-risk population groups and generate demand for health services. The strategy will also help create an enabling environment for HIV prevention, as well as for the provision of institutional and community-based care and support.

### 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.

### Situation Analysis

Results from the DLHS-RCH (2002–2004) related to knowledge of HIV/AIDS among ever-married adults show that 52.6 percent of women in Deoria had heard of HIV/AIDS in comparison with 81.6 percent of men. Discussions and interviews carried out during the DAP preparation process reveal that TV, radio, and newspaper are the major sources through which the general community receives HIV/AIDS information. In addition to these sources, community health workers (ANMs/ASHAs) also talk to people about HIV/AIDS, but this is not a focused dissemination of information.

The community at large does not have much more than surface knowledge of HIV. This is true of health workers as well. They lack information on available services, referrals, and linkages. Barring a few exceptions, the community workers lacked knowledge of PLHIV, which led to discriminatory attitudes and an inability to provide high-quality services to PLHIV free from discrimination. Red Ribbon clubs, which target youth, have been established at schools and colleges in the district and are currently operational. During stakeholder consultations, PLHIV talked about the discrimination they encounter once their HIV status is made public. There is a dearth of IEC material that explicitly illustrates the kind of discrimination and alienation faced by PLHIV and possible ways to mitigate stigma and discrimination through attitudinal and behavioral change.

### Strategies

- Create “enabling environment” through advocacy, training, and experience sharing of various stakeholders.
- Implement integrated communication program to generate demand for counseling and testing and PPTCT services.
- Dissaggregate audiences and address each group through focused interpersonal IEC programs.
- Develop IEC strategy for doctors, paramedics, and other service providers.
- Upgrade skills of peer educators for tracking behavior change patterns.
- Implement integrated interpersonal communication strategy targeting HRGs.

### Action Plan

- Liaise with TI projects to generate and disseminate IEC material.
- Mainstream HIV/AIDS messages in other departments’ IEC material.
- Develop material on prevention messages for specific HRGs (IDUs, FSWs, truckers, and migrants), vulnerable populations (women and youth), and for general community.
- Train members of organized community groups to empower them with effective communication skills.
- Involve religious/faith-based institutions in HIV prevention efforts.
- Recognize traditional healers as equal partners with medical personnel and bring them on board in fight against HIV.

#### *For general population*

- Disseminate messages through print, TV, radio, hoardings, wall paintings, street plays, puppet shows, meetings, and other activities.
- Display IEC material in public places, including major government offices, health institutions (both government and private), and hotels.
- Promote improved health seeking behavior and adoption of safe sex practices through dissemination of IEC material.
- Generate awareness on free voluntary testing.
- Advocate for public acceptance of PLHIV by addressing HIV-related stigma and discrimination.

#### *For adolescents*

- Educate youth on HIV through adolescent groups and sessions in schools.
- Involve teachers and influential community members in youth education efforts.
- Promote formation of Red Ribbon clubs in schools and colleges to sensitize youth on HIV issues.
- Endorse life skills education at primary and secondary schools.
- Sensitize children at schools on 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.
- Provide separate clinics for adolescents.

#### *For women*

- Discuss HIV prevention and safe sex practices during self-help group (SHG) and *Mahila Mandal* meetings or on ANC day.
- Sensitize women on their vulnerability to HIV infection and build negotiation skills to enhance their ability to negotiate safe sex practices with partners.
- Promote PPTCT services and safeguards for newborns.

#### *For HRGs and PLHIV*

- Disseminate prevention messages for safe sex in locations frequented by HRGs.
- Involve PLHIV in IEC development to design appropriate messages.
- Enhance capacity of health workers/link workers to promote IEC material.
- Network with drivers, hotels, private doctors, and nursing homes to reach out to HRGs.
- Improve access to and increase usage of contraceptives (for both males and females).
- Increase access to condoms through distribution in high transmission areas.

#### *For service providers*

- Build capacity of health workers, outreach workers, and link works on effective use of IEC.

### **Responsibility**

DAPCU, UPSACS, TI NGOs, other relevant departments

## INTERSECTORAL CONVERGENCE

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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 33 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 33. Sample Government Programs and Activities for Convergence**

Department	Convergence Issues	Nodal Officer
Women Empowerment and Child Department	<ul style="list-style-type: none"> <li>➤ Integrate HIV into all department training programs.</li> <li>➤ Train <i>anganwadi</i> workers (AWWs) to counsel pregnant women on PPTCT.</li> <li>➤ Scale up shelter and rehabilitation homes and essential services for HIV-positive and HIV-affected women and children.</li> <li>➤ Step up nutritional support for PLHIV with focus on orphans and vulnerable children (OVC).</li> <li>➤ Involve PLHIV as members of self-help groups (SHGs).</li> <li>➤ Establish Red Ribbon clubs among adolescent girls.</li> <li>➤ Train AWWs to detect and report HIV-related discrimination in villages.</li> </ul>	CDPO, ICDS
Panchayati Raj	<ul style="list-style-type: none"> <li>➤ Train department personnel and elected representatives on sensitization and community ownership, participatory planning, and care and support.</li> <li>➤ Issue instructions to <i>panchayats</i><sup>22</sup> to protect PLHIV and HIV-affected households from discrimination and protect inheritance rights of widows and orphans.</li> <li>➤ Advocate with <i>panchayat</i> leaders to ensure that no HIV-positive child is discriminated against in school.</li> <li>➤ Issue guidelines to <i>panchayats</i> to discuss HIV-related issues relevant to village in <i>gram sabhas</i> and other meetings</li> <li>➤ Request <i>panchayats</i> with independent budgets to allocate resources to supplement HIV prevention and control program activities.</li> </ul>	CEO, Zila Parishad
Rural Development	<ul style="list-style-type: none"> <li>➤ Incorporate HIV/AIDS in all department training programs.</li> <li>➤ Ensure that vulnerable populations, HRGs, and PLHIV benefit from Employment Guarantee Programs and other economic opportunities.</li> <li>➤ Issue direction to ensure HIV-affected widows have access to pension schemes without discrimination.</li> <li>➤ Strengthen poverty alleviation programs to benefit vulnerable populations.</li> <li>➤ Establish SHGs to work with Red Ribbon clubs to support prevention, treatment, and support efforts for women.</li> </ul>	Project Director, District Rural Development Agency (DRDA)
Youth Affairs and Sports	<ul style="list-style-type: none"> <li>➤ Train all NSS program officers and NYK coordinators</li> <li>➤ Mobilize youth groups and programs (including NSS, National Cadet Corps, and NYK) to spread awareness about HIV/AIDS and fight stigma and discrimination.</li> <li>➤ Initiate youth-focused public information campaigns at cultural and sporting events.</li> <li>➤ Engage youth to promote voluntary blood donation</li> <li>➤ Train youth to act as peer leaders on HIV/AIDS within their communities.</li> <li>➤ Undertake social marketing of condoms through youth clubs and youth development centers.</li> <li>➤ Promote youth-friendly services.</li> </ul>	District Sports Officer
SC/ST Welfare	<ul style="list-style-type: none"> <li>➤ Analyze special vulnerabilities of SC/ST populations, with focus on women and children and prepare a plan to address identified risks.</li> <li>➤ Train traditional healers and registered medical practitioners (RMPs) with influence in the community on STI management and provision of referrals to ICTCs.</li> </ul>	District Social Welfare Officer

<sup>22</sup> Village-level administrative bodies.

Department	Convergence Issues	Nodal Officer
Agriculture	<ul style="list-style-type: none"> <li>➤ Mainstream HIV into KVK (<i>Krishi Vignan Kendras</i>) and agriculture colleges.</li> <li>➤ Sensitize agriculture extension workers to alleviate potential impacts of HIV by carrying out HIV-related activities in affected and vulnerable communities.</li> <li>➤ Integrate HIV into key rural livelihood programs.</li> </ul>	District Agriculture Officer
Labor /Industry	<ul style="list-style-type: none"> <li>➤ Provide package of services, including prevention and treatment services, in all major Employee State Insurance (ESI) hospitals.</li> <li>➤ 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.</li> <li>➤ Integrate HIV prevention into all department training programs.</li> <li>➤ Promote HIV prevention with industry as part of corporate social responsibility (CSR) efforts.</li> </ul>	District Industry Officer, CII/FICCI District Coordinator
Police and Jail	<ul style="list-style-type: none"> <li>➤ Design and implement awareness and sensitization programs for police personnel dealing with HRGs and NGO workers.</li> <li>➤ Train in-house doctors on pre-post counseling and set up voluntary counseling and testing centers within command hospitals.</li> <li>➤ Place condom dispensing machines in strategic locations and improve STI treatment services for police and prison inmates.</li> </ul>	Superintendent of Police
Education	<ul style="list-style-type: none"> <li>➤ Incorporate adolescent education program/life skills programs in all schools and colleges.</li> <li>➤ Incorporate HIV prevention programs into all non-formal and out-of-school education programs.</li> <li>➤ Introduce a module on HIV/AIDS into teacher training curriculum.</li> <li>➤ Incorporate HIV orientation into curricula of all technical and vocational training institutes.</li> <li>➤ Ensure that HIV-positive and HIV-affected children are not discriminated against in schools.</li> </ul>	District Education Officer
Transport (including bus stands and railway stations)	<ul style="list-style-type: none"> <li>➤ Implement HIV prevention programs at major transport hubs.</li> <li>➤ Facilitate campaigns disseminating prevention messages through public and private sector transport systems.</li> <li>➤ Ensure availability of condoms at highway-based congregation points (such as <i>dhabas</i><sup>23</sup> and motels).</li> <li>➤ Promote IEC at bus stands and railway stations.</li> <li>➤ Install condom vending machines at strategic locations.</li> <li>➤ Scale up IEC efforts on buses and trains along known migration routes.</li> <li>➤ Train all personnel on HIV.</li> </ul>	District Transport Officer
Municipal Corporation and Urban Local Body	<ul style="list-style-type: none"> <li>➤ Integrate HIV into programs of District Urban Development Agency (DUDA), the urban basic services program, and other relevant social welfare programs.</li> <li>➤ Strengthen urban HIV prevention programs with special emphasis on migrant and slum populations.</li> <li>➤ Set up shelter homes for orphans, the destitute, and street children.</li> <li>➤ Accord benefits to PLHIV in Municipal Corporations' economic support programs.</li> <li>➤ Strengthen urban infrastructure to provide better living conditions for in-flowing migrant communities, thereby reducing their vulnerabilities.</li> </ul>	Municipal Commissioner
Civil Supplies	<ul style="list-style-type: none"> <li>➤ Ensure HRGs and PLHIV receive ration cards.</li> <li>➤ Disseminate HIV awareness messages through public distribution outlets.</li> <li>➤ Mainstream HIV into department training programs.</li> </ul>	District Supply Officer

<sup>23</sup> 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 34. 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"> <li>○ Send regular reports to UPSACS.</li> <li>○ Operationalize ICTCs, PPTCT centers, blood banks, and blood storage units.</li> <li>○ Ensure engagement of contractual manpower, including link workers, lab technicians, and consultants.</li> <li>○ Maintain systems for timely payments, training, and monitoring of staff.</li> <li>○ Manage supply chain at district and sub-district levels.</li> <li>○ 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.</li> <li>○ Coordinate with partners for program planning, implementation, and review.</li> </ul>
Capacity Building	<ul style="list-style-type: none"> <li>○ Implement training plans.</li> <li>○ Provide district-level support for TI projects, with emphasis on ensuring access to services, including referrals to public health infrastructure (both facilities and manpower).</li> </ul>
Advocacy	<ul style="list-style-type: none"> <li>○ Organize stakeholder consultations with government departments, NGOs, and PLHIV through NGO forum.</li> <li>○ Undertake effective IEC campaigns for NACP activities.</li> </ul>
Program Management	<ul style="list-style-type: none"> <li>○ Institutionalize system of interaction with DPMU for NRHM to work out effective convergence with activities under NRHM, RCH, TB, and IEC.</li> <li>○ Ensure need-based institutionalization of systems for disbursing funds to <i>Rogi Kalyan Samitis</i><sup>24</sup> and collecting utilization certificates.</li> <li>○ Maintain a bank account for DAPCU and submit use of funds reports and annual audits to UPSACS.</li> <li>○ Oversee operational status of blood banks and their adherence to NACP protocols.</li> <li>○ Collect information monthly about each institution's operational status, compile data, and send to UPSACS.</li> <li>○ Supervise functioning of HIV service outlets by visiting outlets frequently and attending quarterly meetings of medical officers and monthly meetings of other project staff.</li> <li>○ Provide feedback and support to field staff to enhance performance.</li> </ul>

<sup>24</sup> Committees formed at district level that are given resources to address specific issues related to health/infrastructure in the area.

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

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 Deoria will require equipping service providers with necessary skills and orienting health workers, policymakers, private providers, employees of cognate departments, NGOs, self-help group (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 35. Stakeholders in Deoria Training Plan**

Public Representatives, NGOs, and Private Sector Stakeholders	Service Delivery Personnel	Other Functionaries
<ol style="list-style-type: none"> <li>1. District heads of self-help organizations</li> <li>2. Heads of local urban bodies</li> <li>3. <i>Zila panchayat</i> presidents</li> <li>4. <i>Block panchayat</i> presidents</li> <li>5. <i>Gram panchayat</i> presidents</li> <li>6. Officeholders of civil society partners forum at state, district, and national levels</li> <li>7. Officeholders of PLHIV networks at district, state, and national levels</li> <li>8. <i>Nehru Yuvak Kendra</i> regional and district coordinators</li> <li>9. Trade and industry associations</li> <li>10. Professional medical associations</li> </ol>	<ol style="list-style-type: none"> <li>1. Counselors</li> <li>2. Lab technicians</li> <li>3. Medical Officers-in-Charge of ICTCs</li> <li>4. Obstetric and gynecological, and pediatric medical officers</li> <li>5. RNTCP medical officers</li> <li>6. Medical officers in ART clinics</li> <li>7. Nurses</li> <li>8. Pharmacists</li> <li>9. Record keepers</li> <li>10. PHC and CHC medical officers</li> <li>11. Medical officers in government hospitals</li> <li>12. Private practitioners</li> <li>13. Paramedical staff</li> <li>14. Medical Officer-in-Charge of blood bank</li> <li>15. Blood bank technicians</li> <li>16. Technical assistants in component separation units</li> <li>17. Outreach volunteers for treatment adherence</li> <li>18. Labor welfare officers (workplace interventions)</li> <li>19. NGO program managers (support for migrants)</li> <li>20. STI specialists</li> <li>21. Lab technicians in district and medical college hospitals</li> <li>22. Program managers of social management organizations</li> </ol>	<ol style="list-style-type: none"> <li>1. District-, block- and village-level officers/ functionaries of key departments identified for convergence</li> <li>2. ANMs, MPWs, and ASHAs</li> <li>3. <i>Anganwadi</i> workers</li> <li>4. Police personnel and jail staff</li> <li>5. Teachers in colleges and schools</li> </ol>

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 Deoria will include the stakeholders listed in Table 35 above.

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

**Table 36. 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 37. Proposed Training Content**

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

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

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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 38. Budget for Deoria DAPCU (Year I)**

<b>A. Staff Salary</b>				
	Position	Number	Salary (Rs.)	Annual Expenditure (Rs.)
1.	District Program Manager (regular)	1	8,000–13,500	20,000×12 = 240,000  With periodic increment and other applicable government employee benefits
2	Supervisor	1	13,000 Consolidated (including 2,500 PoL and 500 communication)	13,000×12 = 156,000
3	M&E Assistant	1	8,000 consolidated	8,000×12 = 96,000
4.	Accountant	1	8,000 consolidated	8,000×12 = 96,000
5.	Assistant	1	8,000 consolidated	8,000×12 = 96,000
	<b>Total</b>			<b>684,000</b>
<b>B. Fixed Costs (One-time costs)</b>				
6	Computer, printer and accessories	1		90,000
	<b>Total</b>			<b>90,000</b>
<b>C. Recurring Costs</b>				
	Particular	Monthly Expenditure		Annual Expenditure (Rs.)
7	Operating expenses	5,000		5,000×12 = 60,000
8	Local travel	1,500		1,500×12 = 18,000
	<b>Total</b>			<b>78,000</b>
<b>Grand Total (A+B+C)</b>				<b>852,000</b>

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

<b>a) Two Months' Stock Available for:</b>	
ART drugs	
condoms	
delivery kits	
testing kits	
IC and WM <sup>25</sup> consumables	
Auto-disable syringes	
<b>b) Stockout Summary</b>	
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					

<sup>25</sup> 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.			
<b>SUMMARY</b>			
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. IEC<sup>26</sup>

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
<b>Total Meetings Held</b>				
<b>Total Attendees</b>				
<b>Groups Represented</b>				

20. PLHIV Trends

PLHIV	ICTC	HRG Category	On ART	Death
Existing				
New				

<sup>26</sup> 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
<b>I. Service Delivery</b>		
1	Targeted interventions	<ul style="list-style-type: none"> <li>Facilitate access to HIV/AIDS prevention and treatment services, general health services, and other entitlements, including package of services for HRGs.</li> <li>Create a supportive environment in which TIs can function.</li> </ul>
2	Package of services	<ul style="list-style-type: none"> <li>Monitor service delivery.</li> <li>Manage integration of HIV services with general health system and relevant non-health interventions.</li> </ul>
3	Safe blood and blood products	<ul style="list-style-type: none"> <li>Develop district-wide information and transportation schedule to provide blood and blood components to blood storage centers.</li> <li>Systematize voluntary blood donation.</li> <li>Schedule and monitor activities of voluntary blood donation camps.</li> <li>Address infrastructure issues pertaining to new blood banks.</li> </ul>
4	Condom promotion	<ul style="list-style-type: none"> <li>Monitor availability of condoms at service delivery points.</li> </ul>
5	Convergence with RCH, TB, and other Ministry of Health and Family Welfare (MOHFW) programs	<ul style="list-style-type: none"> <li>Work with pertinent program officers to effectively integrate their functions.</li> </ul>
6	Improved access to continuum of care, including ART and OI treatment	<ul style="list-style-type: none"> <li>Monitor management of OIs and ART.</li> </ul>
7	Provision of care, support, and treatment services to HIV-positive and HIV-affected children	<ul style="list-style-type: none"> <li>Monitor children born to HIV-positive mothers for early signs of need for ART.</li> <li>Monitor rights of HIV-positive and HIV-affected children and investigate rights violations.</li> <li>Advocate for protection of children's rights with district authorities and organizations.</li> </ul>
8	Management of treatment adherence	<ul style="list-style-type: none"> <li>Follow up with patients through home-based counseling to ensure treatment adherence.</li> </ul>
<b>II. Monitoring and Stimulating HIV Awareness and Impact Mitigation</b>		
9	Women, children, and young adults	<ul style="list-style-type: none"> <li>Work with district-level departments for prevention, treatment, and impact mitigation focused on women, children, and adolescents.</li> </ul>
10	Migrants, trafficked persons, and populations in cross-border areas	<ul style="list-style-type: none"> <li>Provide pre-departure guidance to migrants and provide linkages to organizations in destination areas.</li> <li>Link migrants and populations in cross-border areas with existing health services for STI management and condom promotion.</li> </ul>
11	HIV/AIDS response in the world of work	<ul style="list-style-type: none"> <li>Facilitate access to treatment and prevention services for individuals referred through workplace interventions.</li> </ul>
12	Communication and social mobilization	<ul style="list-style-type: none"> <li>Conduct district-level IEC campaigns.</li> <li>Use local channels for demand generation.</li> <li>Work with PRIs and local civil society organizations to carry out social mobilization activities for HIV prevention and management.</li> </ul>

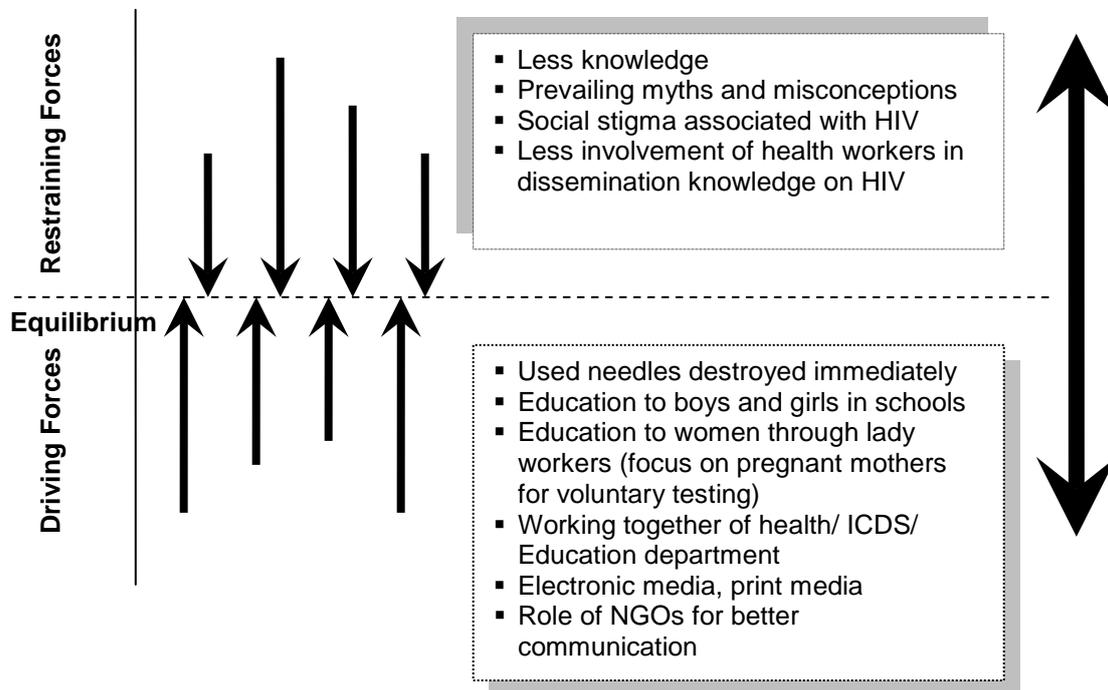
13	Mainstreaming with public and private sector	<ul style="list-style-type: none"> <li>• Provide technical support to district-level organizations to integrate HIV into programs/activities.</li> <li>• Link DAPCU with various departments providing HIV services within district.</li> </ul>
14	Civil society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

## Annex IV: Personnel Responsible for Service Delivery at Different Levels

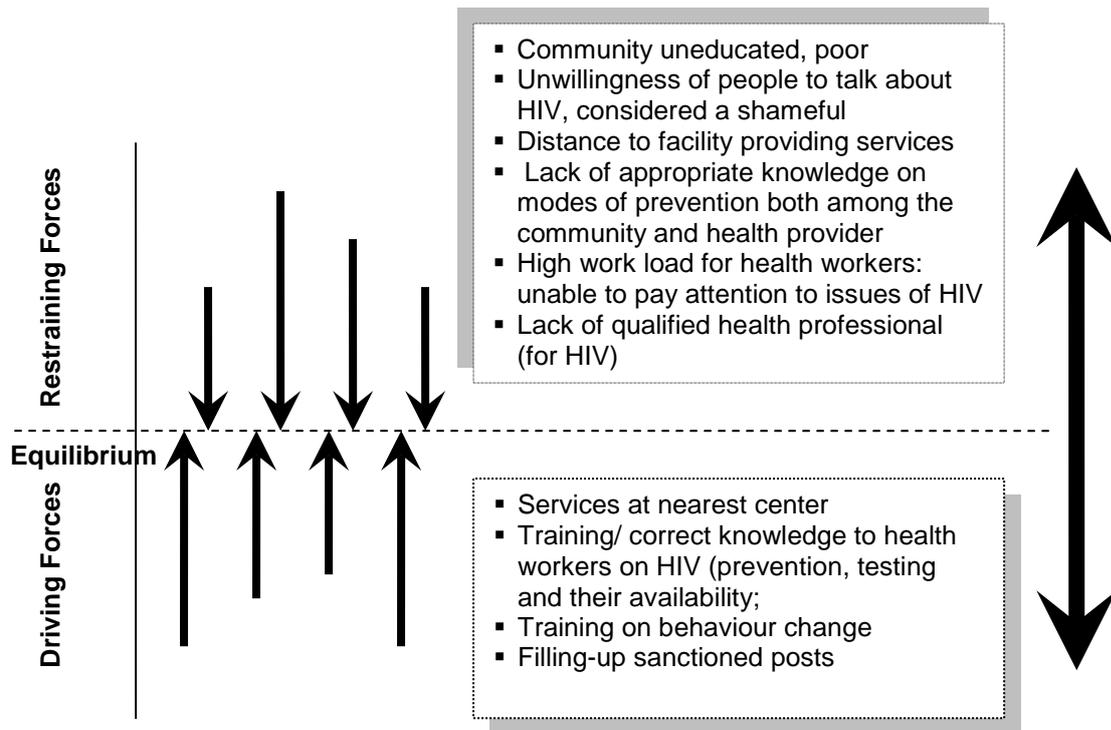
	Levels of service	Personnel delivering services	Type of services
1.	Community	i. ASHA (NRHM states) ii. RMP	<ul style="list-style-type: none"> <li>Referring pregnant women for tests and follow-up of PPTCT prophylaxis treatment</li> <li>Treatment of STIs, minor ailments, and OIs (such as diarrhea)</li> <li>Condom supply</li> </ul>
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"> <li>STI control and condom promotion</li> <li>HIV testing and counseling</li> <li>OI prophylaxis and treatment</li> <li>Antenatal care and counseling for prophylaxis</li> </ul>
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"> <li>STI control and condom promotion</li> <li>Integrated health counseling/testing</li> <li>PPTCT, delivery, abortion, and sterilization services for women (including those who are HIV-positive)</li> <li>Diagnosis and treatment of common OIs</li> <li>ART follow-up and referral</li> <li>Maintenance of computerized patient records</li> </ul>
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"> <li>Management of complications</li> <li>ART</li> <li>Care and support</li> <li>Integrated counseling and testing</li> <li>Management of STIs and OIs</li> <li>PPTCT services</li> <li>Ensuring drug supply at district level</li> <li>Facilitating access to care and support for PLHIV</li> </ul>
5.	NGO/CBO/FBO <sup>27</sup>	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"> <li>Palliative care and treatment of minor OIs</li> <li>STI treatment</li> <li>Counseling, social services</li> <li>Adherence monitoring</li> </ul>

<sup>27</sup> Faith-based organization

## Annex V. Field Force Analysis (Community- and Service Provider-Levels)



**Field Force Analysis at Community Level**



**Field Force Analysis at Service Provider Level**

## Annex VI: List of District Workshop Participants

S.No.	Name of Participant	Designation	Department
1	Dr. Kuldeep Kumar	CMO	Health
2	Dr. R S Mishra	CMS District Hospital	Health
3	Dr. O P Tripathi	DTBO	Health
4	Dr. M P Singh	Medical Officer II	Health
5	Dr. Hari Shankar	Medical Officer	Health
6	Dr. S N Tripathi	Medical Officer	Health
7	Dr. D V Shahi	MOIC	Health
8	Dr. V K Sinha	MOIC	Health
9	Dr. A K Mishra	MOIC	Health
10	Dr. P N Singh	Suptt. CHC Salempur	Health
11	Dr. A K Choudhry	MOIC	Health
12	Dr. S K Rao	MOIC	Health
13	Sandhya Tripathi	Supervisor	GNK Link Worker Scheme
14	Sudhakar Mishra	Supervisor	GNK Link Worker Scheme
15	A K Yadav	Lab Technician	ICTC District Hospital
16	Vidya Prakash	Counselor	ICTC District Hospital
17	Upendra Tiwari	Supervisor ICTC	ICTC District Hospital
18	Dhananjay Panday	Manager (NGO)	T. I. Project Deoria
19	Arun Kumar	Member (NGO)	T. I. Project Deoria
20	Mritunjay Panday	Counselor (NGO)	T. I. Project Deoria
21	Deendayal Divadi	ORW (NGO)	T. I. Project Deoria
22	Anonymous	In-charge DNP+	PLHIV
23	Anonymous	DNP+ Member	PLHIV
24	Anonymous	DNP+ Member	PLHIV
25	Akhilendra Shahi	Secretary	Red Cross Deoria
26	Rajendra Prasad	Secretary	Rotary Club
27	Smt. Kusumlata Mishra	CDPO	ICDS
28	Smt. Phoolmati	CDPO	ICDS
29	Shreesh Prakash	CDPO	ICDS
30	Mohd Sajid Ansari	DPO	ICDS
31	Shanti Yadav	CDPO	ICDS
32	Mithlesh Maurya	CDPO	ICDS
33	Geeta Singh	CDPO	ICDS
34	Padmawati	CDPO	ICDS
35	Asha Panday	CDPO	ICDS
36	Kalawati Ray	CDPO	ICDS
37	Jigyasu Pragyana	CDPO	ICDS
38	Pankaj Kumar	CDPO	ICDS
39	Rinku Singh	CDPO	ICDS
40	Rampa Tiwari	CDPO	ICDS
41	K Mishra	Social Worker	Social Worker
42	Anil Kumar Ray	Correspondent	Amar Ujala

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