

Mau

District AIDS Action Plan



2009–2012

MAU DISTRICT AIDS PREVENTION AND CONTROL UNIT

Uttar Pradesh State AIDS Control Society

Lucknow

APRIL 2009

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FOREWORD

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

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

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

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

S.P Goyal

Project Director,

Uttar Pradesh State AIDS Control Society

¹ More than 1% 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
AWC	<i>anganwadi</i> center
AWW	<i>anganwadi</i> worker
AYUSH	Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy
CBO	community-based organization
CCC	community care center
CHC	community health center
CMHO	Chief Medical and Health Officer
CPR	contraceptive prevalence rate
DACO	District AIDS Prevention and Control Officer
DAP	District AIDS Action Plan
DAPCC	District AIDS Prevention 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
DLHS	District-Level Household Survey
DLN	district-level PLHIV network
DOHFW	Department of Health and Family Welfare
DOTS	directly observed treatment, short-course
DPMU	District Program Management Unit
FP	family planning
FRU	first referral unit
FSW	female sex worker
HIV	human immunodeficiency virus
HRG	high-risk group
HSS	Household Sample Survey
ICDS	Integrated Child Development Services
ICT	integrated counseling and testing
ICTC	integrated counseling and testing center
IDU	injection drug user
IEC	information, education, and communication
IMNCI	integrated management of newborn and child illnesses
JSY	<i>Janani Surakhsha Yojana</i>
KVK	<i>Krishi Vignan Kendras</i>
LT	laboratory technician
M&E	monitoring and evaluation
MCHN	maternal and child health and nutrition
MIS	management information system
MPW	multi-purpose health worker
MSM	men who have sex with men
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NACP-III	National AIDS Control Program, Phase III
NBCP	National Blindness Control Program
NFHS	National Family and Household 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
ST	scheduled tribe
STI	sexually transmitted infection
TB	tuberculosis
TI	targeted intervention
TSU	Technical Support Unit
UNDP	United National Development Program
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
UPSACS	Uttar Pradesh State AIDS Control Society

BACKGROUND AND METHODOLOGY

I.1 Context

The contribution of health to economic and social development, as well as to overall quality of life, has long been recognized. In April 2005, the government of India launched the National Rural Health Mission (NRHM) to revitalize the health system and provide effective health care to rural populations throughout the country. The goal of NRHM is to “improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.”² 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 (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.

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

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

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

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

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

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

Source: Prioritization of Districts for Program Implementation, NACO.

Five districts in 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 Districts³

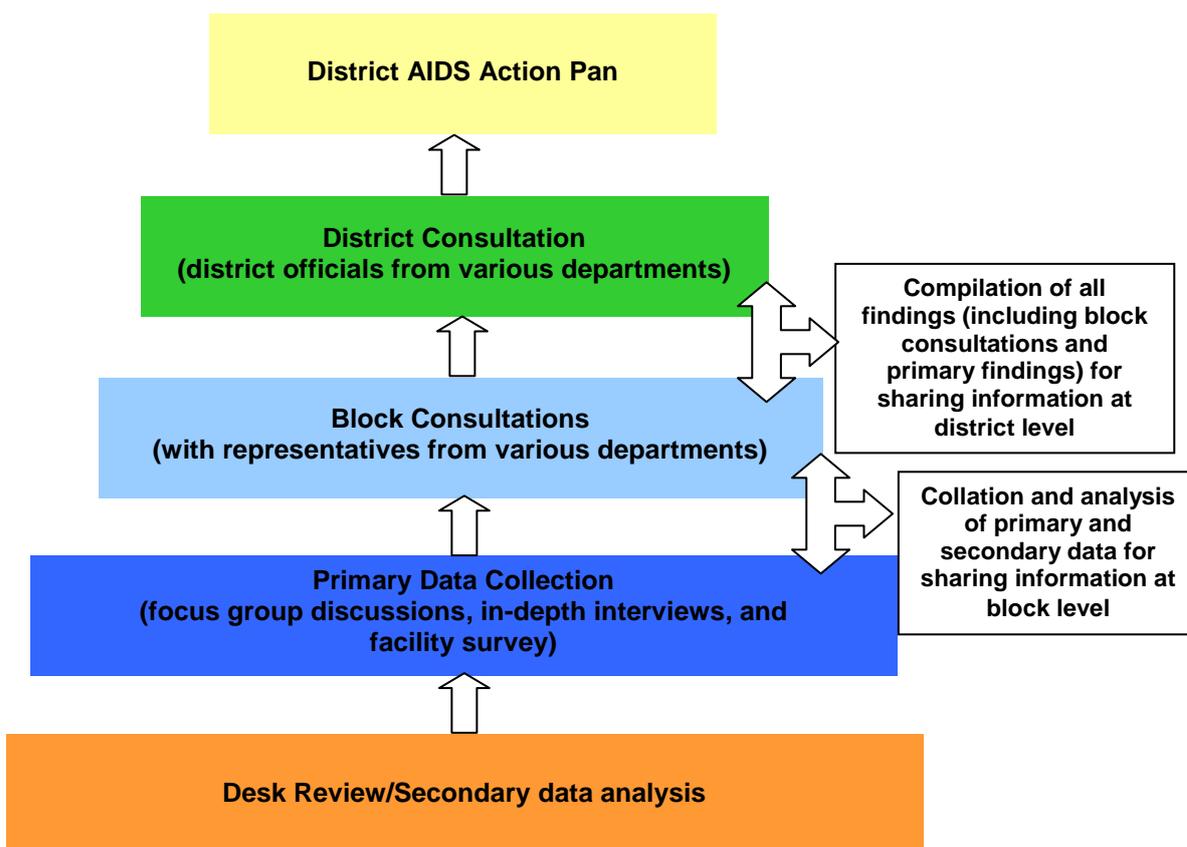
Level	Target Group	Services Provided
<ul style="list-style-type: none"> • Medical colleges • District, block and sub-divisional hospitals • Village/community 	<ul style="list-style-type: none"> • General population • High-risk groups (HRGs) • People living with HIV (PLHIV) 	<ul style="list-style-type: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

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

1.2 Overview of Plan Development Process

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

Figure 1. Preparation Process for District AIDS Action Plan



Secondary Data Review

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

Primary Data Collection

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

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

Collation and Analysis of Primary and Secondary Data

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

Block-level and District-level Consultations

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

Preparation of the District Action Plan

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

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

2.1 Geography and Overview of Health Scenario

Mau district, which is situated in the southeastern part of Uttar Pradesh, was formed in November 1988. District headquarters are located in the town of Mau. The district, which is part of Azamgarh division, lies between the latitudes of 83° 17' and 84° 52' east and between the longitudes of 24° 47' and 26° 17' north. Mau is bordered by the district of Ghazipur in the south, the district of Ballia in the east, and the district of Azamgarh in the west. The river Ghagra forms the district's northern boundary.

The district is composed of four *tehsils*—Ghosi, Madhuban, Maunath Bhanjan, and Muhammadabad Gohna. The *tehsils* are further divided into nine blocks and 1,499 villages. The average population per village in Mau is 996 people.

According to the 2001 census, the district has a population of around two million people (approximately 1% of the state's total population) and the sex ratio in the district is 986 females per 1,000 males. One-fifth of Mau's population is under the age of seven. The district's population density is 1,080 people per square kilometer, which is much higher than UP's average population density (689). Mau's rural-urban population distribution resembles that of the state overall, with one-fifth of the district's residents residing in urban areas. The district's religious composition is 80 percent Hindu and 19 percent Muslim. Nearly a quarter (23%) of the district's population belong to a scheduled caste (SC) or tribe (ST), which are socially disadvantage groups. More than one-third of Mau's residents live below the poverty line, and only a quarter of households in the district have a television.

Table 2. General Indicators

	Mau	Uttar Pradesh
Geographical area (in sq.km.)	1,715	240,928
<i>Tehsils</i>	4	300
Blocks	9	901
Total number of villages	1,499	107,452
Number of inhabited villages	1,499	97,942
Number of inhabited villages <5,000	18	2,562
Number of towns	6	215

Source: Census of India (2001)

The literacy rate in Mau district is 62 percent, slightly higher than the state average, and three-quarters of males and nearly half of females in the district are literate. The district's annual growth rate is 2.79 percent, which is higher than the state's 2.58 percent annual growth rate.

Table 3. Demographic Indicators

	Mau	Uttar Pradesh
Total population	1,853,997	166,197,921
Female population	920,474	78,632,552
Male population	933,523	87,565,369
Rural population	1,493,628	131,658,339
Urban population	360,369	34,539,582
Child population (0–6 years)	372,524	30,472,042
Percent of child population (0–6 years)	20.09%	18.33%
Population density	1,080	689
Decadal growth rate (1991–2001)	27.91%	25.80%
Male/female ratio	986	898
Ratio of male/female children (0–6 years)	945	915
Literacy rate	62.16%	57.36%
Male literacy rate (7+ years)	75.60%	70.23%
Female literacy rate (7+ years)	48.66%	42.98%
Scheduled caste (SC) population	22.74%	21.1%
Scheduled tribe (ST) population	0.02%	0.1%

Source: Census of India (2001)

Table 4. Standard of Living Index

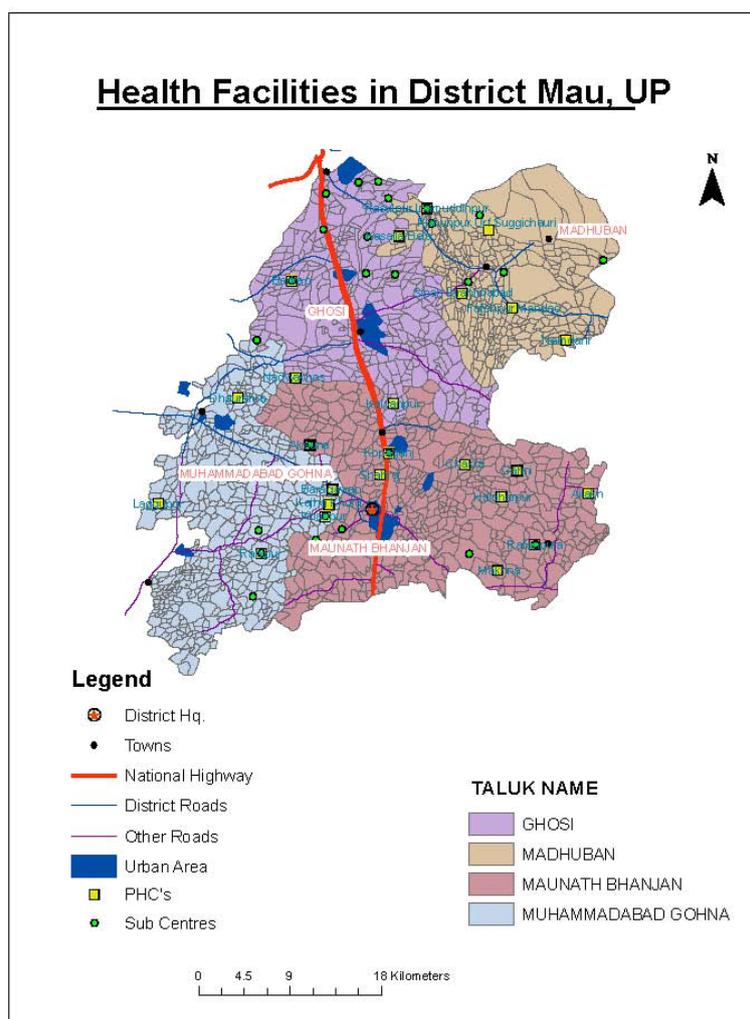
	DLHS-3		DLHS-2	
	Total	Rural	Total	Rural
Low (%)	66.0	73.9	49.8	61.4
Medium (%)	21.0	18.7	35.2	30.8
High (%)	13.0	7.5	14.9	7.9

Source: Third District-level Household Survey (DLHS-3)

Health Facilities in the District

There are two district hospitals, nine CHCs, 14 PHCs, and 34 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 Mau



Map composed by NIC
Source - RGI, SOI



Table 5. Health Facilities At-a-Glance

	Mau	Uttar Pradesh
Medical colleges	-	19
District hospitals (male)	1	70
District hospitals (female)	1	69
Community health centers (CHCs)	3	372
Primary health centers (includes block, sub-block, and additional PHCs)	42	3,660
Sub-centers	226	20,521
Anganwadi centers (AWCs)	1,732	153,223
DOTS ⁴ centers	224	24,549
Microscopy centers	14	1,750
Tuberculosis (TB) units	4	369

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

⁴ Directly observed therapy, short-course

Table 6. Fertility Indicators

	Mau	Uttar Pradesh
Total fertility rate	4.6	4.4
Crude birth rate	33.8	31.4

Source: Census of India (2001)

According to the 2001 census, Mau's total fertility rate (average number of children born to a woman during her reproductive years) is 4.6. According to the third District Level Household Survey (DLHS-3), conducted in 2007–2008, 27 percent of girls in Mau marry before completing 18 years of life and one-third of currently married women in the district have three or more children.

Mau's maternal and child health indicators are better than the state average. According to DLHS-3, 35 percent of women in the district received at least three antenatal check-ups during their last pregnancy and four out of 10 pregnant women have given birth in health facilities. Furthermore, the proportion of safe deliveries (deliveries conducted by health professionals whether in the home or in health institutions) in Mau is double the overall proportion for the state.

Table 7. Mother and Child Health Indicators

	Mau	Uttar Pradesh
Total number of pregnant women	-	6,611,040
Girls married before completing 18 years of age	26.7%	33.1%
Women who had at least three ANC visits (in last pregnancy)	35.3%	21.9%
Women who received full ANC ⁵	-	2.8%
Women who received postnatal care within 48 hours (in last delivery)	26.2%	33.8%
Institutional deliveries	39.7%	24.5%
Institutional deliveries under JSY ⁶	9,809	956,007
Home deliveries attended by skilled personnel	14%	7.4%
Children (ages 12–23 months) who received full immunization ⁷	44.7%	30.3%

Source: DLHS-3 (2007–2008)

The percentage of mothers in Mau who received postnatal care within 42 days of delivery (26.2%) is lower than the state average (33.8%). The district's performance in the area of childhood immunization is higher than the state average, with 45 percent of the district's children fully immunized compared to only 30 percent of children in the state as a whole. The relative superiority of Mau's health indicators compared to state health indicators points to a higher level of awareness regarding availability of services.

DLHS-3 data also show the percentage of women in the district motivated by Accredited Social Health Activists (ASHAs) to seek health services such as ANC (0.8%), institutional delivery (0.6%), and family planning (0.4%). Even though these percentages are not high, they illustrate the presence of an important opportunity. By building the capacities of ASHAs to reach out with HIV information and referrals to HIV prevention and care services in the district, access to and utilization of these services could be increased significantly.

⁵ Full ANC: At least three visits for antenatal check-up, one Tetanus Toxoid injection received, and 100 IFA tablets or adequate amount of syrup consumed.

⁶ *Janani Suraksha Yojana*, Health Directorate. Progress report for 2008–2009.

⁷ Full immunization: BCG, three doses each of DPT and polio vaccine, and one dose of measles vaccine

Table 8. Family Planning Indicators

Among Currently Married Women (Ages 15–49)	Mau (%)	Uttar Pradesh (%)
Women who use any method of family planning	40.8	38.4
Women who use any modern method of family planning	21.5	26.7
Female sterilization	16.2	16.5
Male sterilization	0	0.2
Couples using condoms	4.0	7.1
Unmet need for family planning	37.2	33.8

Source: DLHS-3 (2007–2008)

Mau's overall contraceptive prevalence rate (CPR) is 41 percent, which is slightly higher than the state average (38.4%). However, the percentage of Mau's rural population (40%) that uses any family planning (FP) method is slightly higher than the average for the state's overall rural population (36.7%). Use of permanent family planning (sterilization) is 16 percent in the district, which is only slightly lower than the average use of such methods in the state as a whole (16.5%). The use of spacing methods is negligible in the district (only 5% of couples) and is half the average use of such methods in the entire state. Among current FP users, a majority of couples in Mau district rely on traditional FP methods, which indicates enormous potential for transitioning traditional FP users to modern FP methods. The total unmet need for FP reported by couples in the district is 37 percent. Of unmet need reported in the district, 26 percent is demand for limiting.

2.2 Overview of HIV/AIDS Situation

Mau'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.

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*,⁸ 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 Mau presented in Table 9 below reflects the district's vulnerability to HIV infection. The revised methodology of the second study has enabled the identification of self identified HRGs in the district. The provisional report of the 2008 mapping study identified 183 FSWs in 11 sites, the majority of whom are street-based. The study also identified 580 MSM in 16 sites, 180 IDUs in 18 sites, and 31 *hijras* in three sites.

Table 9. High-risk Groups in Mau (2008)

FSW	Sites	11
	Total	183
MSM	Sites	16
	Total	580
IDU	Sites	18
	Total	180
Hijras	Sites	3
	Total	31

Source: UPSACS 2008

Targeted Intervention

In Mau two composite⁹ TI projects are being implemented by NGOs to reduce the rate of HIV transmission among FSWs, IDUs, and MSM.

Table 10: NGO-implemented Targeted Intervention Projects in Mau

Implementing Organization	Type of Intervention	Size of Target Population (2008–2009)			
		FSW	MSM	IDU	Total
Navchetna Gramin Vikas Avam Kalyan Sanstha	Composite	300	125	200	625
Balwadi Evam Nirbal Sewa Nari Kala Kendra Samiti	One new TI project (composite)	250	150	0	400

Source: TSU

⁸ *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

⁹ 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	576
Number treated at NGO STI clinic	288
Number referred to ICTC from NGO clinic	819
Number referred from NGO clinic who were tested at ICTC	589
Number found HIV-positive (of those referred from NGO clinic)	6

Source: UPSACS

HIV and AIDS Awareness

The results of the DLHS-3 in Mau,¹⁰ show that only half of ever-married women and 69 percent of unmarried women have heard about HIV/AIDS. Interestingly, the awareness level in rural areas is comparable to levels of awareness in the district as a whole. Mau's awareness indicators are superior to overall indicators for the state, with only 29 percent of women in the state having heard of STI/RTI (reproductive tract infection) compared to 46 percent in Mau (NFHS-III). Similarly, the percentage of women who knew that consistent condom use can reduce the chances of contracting HIV was higher (34.8%) 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
Ever-married Women Ages 15–49 (in percent)				
Had heard of HIV/AIDS	47.6	46.9	40.5	41.1
Knew that consistent condom use can reduce the chances of contracting HIV	34.8	26.2	23.2	20.0
Had correct knowledge of HIV/AIDS (of those who had heard of HIV/AIDS)	78.4	76.4	- ¹¹	-
Had been tested for HIV	0.9	0.9	-	-
Had heard of RTI/STI	46.1	43.4	39.2	38.5
Unmarried Women Ages 15–24 (in percent)				
Had heard of HIV/AIDS	69.1	70.5	-	-
Knew that consistent condom use can reduce the chances of contracting HIV	40.0	27.0	-	-
Had correct knowledge of HIV/AIDS	86.9	84.8	-	-
Had been tested for HIV	0.4	0.5	-	-
Had heard of RTI/STI	43.2	40.4	-	-

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 Mau was reported to be only 3.9 and 4.0 percent, respectively.¹² Through TI and social marketing, UPSACS distributed over 390,359 condoms in 2008. UPSACS distributed 28,119 condoms to HRGs in Mau through its TI project between January and December 2008 and 4,600 condoms were sold through social marketing during the same period.

¹⁰ IIPS: DLHS-3, Reproductive and Child Health Project, District Fact Sheet 2007-09, MAU, Mumbai, 2008.

¹¹ These questions were not included DLHS-II.

¹² IIPS: DLHS-3, Reproductive and Child Health Project, District Fact Sheet 2007-8, Mau, Mumbai, 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 (DLNs) are three main sources of service delivery data that are useful for tracking HIV prevalence. An analysis of these data from Mau provides an overview of the HIV situation in the district.

Table 13. HIV Sentinel Surveillance Data (in percent)

Site	2001	2002	2003	2004	2005	2006	2007
Uttar Pradesh	0.05	0.37	0.19	-	1.73	0.25	0.02
Mau	-	-	-	-	-	1.46	0.86

Source: Behavioral Surveillance Survey (BSS) 2007

Mau has 1 ANC sentinel surveillance site and was categorized as category A district in 2006, when a 1.46 percent prevalence rate was reported. The 2007 data show that the prevalence rate has fallen significantly to 0.86 percent. It will be important to observe prevalence trends over the next couple of years. If rates continue to decline, it will be vital to study the factors that have contributed to this decline and apply the lessons in other districts.

The second set of data that can be used to present the district's HIV situation are data from ICTCs. An analysis of ICTC data from 2004–2008 shows that while the cumulative HIV positivity rate (number of people testing seropositive/total number tested x 100) in the state is 7.13 percent, Mau has a seropositivity rate of only 3.36 percent. Between 2004 and 2008, 6,062 people were tested for HIV in Mau, of whom 300 tested positive. Among those who tested positive during this period, 43 percent (129) were women and 57 percent (171) were men.

Table 14. ICTC Data (Jan–Dec 2008)

	Mau	Uttar Pradesh
Number of ICTCs	2 ¹³	155
Total population (estimated as of January 2008)	2,211,756	196,049,343
Sexually active population	1,105,878	98,024,671
Population prone to risky sexual behavior	55,294	4,901,234
Number of people tested for HIV at ICTCs	3,063	240,438*
Seropositivity	3.36%	4.54%
Persons counseled and tested per ICTC per day	43	172
Targets for 2009–2010	16,977	574,790

Source: AAP-UP-09-10

*April 2007–January 2008

¹³ The number of ICTCs is now eight, as six new centers began operating in 2009. However, the data presented here is for 2008.

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

	Mau	Uttar Pradesh
Number of PPTCT centers	1	79
Number of people tested for HIV at PPTCT centers	1,253	218,785
Seropositivity	0.08%	0.16%
Number of people counseled and tested per PPTCT center per month	139	308
Targets for 2009–2010	14,006	474,202

Source: AAP-UP-09-10

Mau has a single PPTCT center. The number of women registering at the PPTCT center in Mau rose from 1,359 in 2007 to 1,691 in 2008. Despite the rise in the number of women registering, over the same time period the seropositivity rate recorded at the center declined from 0.4 percent in 2007 to 0.08 percent in 2008.

Table 16: 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	15	45	0	0	15	45	14	3	15	45	60
Feb	4	63	0	639	4	702	0	60	2	58	60
March	3	74	0	358	3	432	1	15	3	74	77
April	5	81	0	468	5	549	0	4	7	80	87
May	6	80	0	640	6	720	0	0	6	80	86
June	6	36	0	629	6	665	1	2	5	57	62
July	2	48	0	582	2	630	0	2	2	48	50
Aug	6	41	0	370	6	411	0	3	5	41	46
Sept	8	47	0	629	8	676	0	2	8	96	104
Oct	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Nov	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Dec	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Total	55	515	0	4,315	55	4,830	16	91	53	579	632

Source: UPSACS

Distribution of Patients on ART

At the end of December 2008, Mau had 113 PLHIV on antiretroviral (ARV) drugs. The nearest ART centers are located in Banaras and Gorakhpur districts. A link ART center was established in Mau in 2008 and is linked to the Banaras/Varanasi ART center. The link ART center provides services for drug administration and management and counseling for drug adherence. However, it does not

provide CD4 testing. The table below presents the distribution of PLHIV from Mau receiving ART from different ART centers in UP state

Table 17. Distribution of Patients on ART (as of December 2008)

Allahabad	Gorakhpur	Lucknow	Varanasi/Banaras	Total
1	5	4	103	113

Infrastructure and Services

As shown in Table 18 below, there are currently two counseling and testing centers operating in the district hospital, one each at the male and female district hospitals.

Table 18: HIV-related Facilities and Targets for 2009–2010

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

*Six additional ICTCs were established in 2009, which makes it a total of 8.

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

Table 19 provides an overview of infrastructure and services in Mau's ICTCs and PPTCT center. This is based on facility survey and discussions with concerned staff at UPSACS and the TSU.

Table 19: Infrastructure and Services

	ICTC District Hospital (Male)	PPTCT center District Hospital (Female)
Infrastructure		
Is water available for drinking?	Yes	No
Is water available for toilet?	Yes	Yes
Is electricity available in the facility?	Yes	Yes
What type of power backup facility is available?	Generator	Generator
Communication Facilities		
Is there a telephone in the facility?	No	No
Is there a STD telephone in the facility?	No	No
Is there a computer in the facility?	Yes	Yes
Does the facility have a computerized health management system in place to store patient records?	Yes	Yes

	ICTC District Hospital (Male)	PPTCT center District Hospital (Female)
Services		
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
Day(s) allotted for counseling and testing of pregnant women	N/A	All working days
Does the facility provide group counseling?	Yes	Yes
If yes, how many people (on average) per group?	4–5	4–5
How long (on average) is each group session?	30–45 min	20–25 min
Are condoms available in the center?	Yes	Yes
Where are the condoms kept?	Lab	Counseling room
HIV Counseling		
Is there a waiting room/area available?	Yes	No
Number of chairs in the waiting room	4	-
Is there a counseling room?	Yes	Yes
Number of counseling rooms	1	1
Physical infrastructure in counseling room:		
a. Desk and chair for the counselor	Yes	Yes
b. Lockable filing cabinet for records	Yes	Yes
c. Computer with printer and UPS	Yes	Yes
d. Computer table, with a chair	Yes	Yes
e. Waste basket.	Yes	Yes
f. Number of chairs for clients	2	3
Is privacy ensured?	Yes	Yes
HIV Testing		
Is there a separate lab/blood sample collection room?	Yes	Yes
Equipment observed in testing room:		
Refrigerator	Yes	Yes
Centrifuge	Yes	Yes
Needle destroyer	Yes	Yes
Micropipette	Yes	Yes
Components for infection control and waste management	Yes	Yes
Testing kits	Yes	Yes
Safe delivery kits	-	Yes
Staff		
Counselors	1	1
Laboratory technicians	-	1
Patients per day	8–9	15–20
Waiting time for patients	30 min	25–30 min
IEC¹⁴ Material		
Flipcharts	No	No
Condom demonstration models	No	No
Posters	4	No
Pamphlets/handouts	No	No
Is any audiovisual material being played in the waiting room?	No	No

¹⁴ Information, education, and communication

FRAMEWORK FOR PROGRAM ACTIVITIES

NRHM is a comprehensive, broad-based program, which integrates all vertical health programs of the Department of Health and Family Welfare (DOHFW), including the second phase of the Reproductive and Child Health Program (RCH-II), the National Vector Borne Disease Control Program (NVBDCP), the Revised National TB Control Program (RNTCP), the National Blindness Control Program (NBCP), and the National Leprosy Eradication Program (NLEP). Under the NRHM framework, different national programs merge together at the state level into a common State Health Society, while at the district level all program societies merge into the District Health Society (DHS). The governing body of each DHS is chaired by the Chairman of the *Zila Parishad*¹⁵/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 District AIDS Prevention and Control Committee (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 Mau 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 (PRIs), Labor, Mines, Industry, Tourism, Urban Local Bodies, etc. (*five*)

¹⁵ 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 Mau.

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:

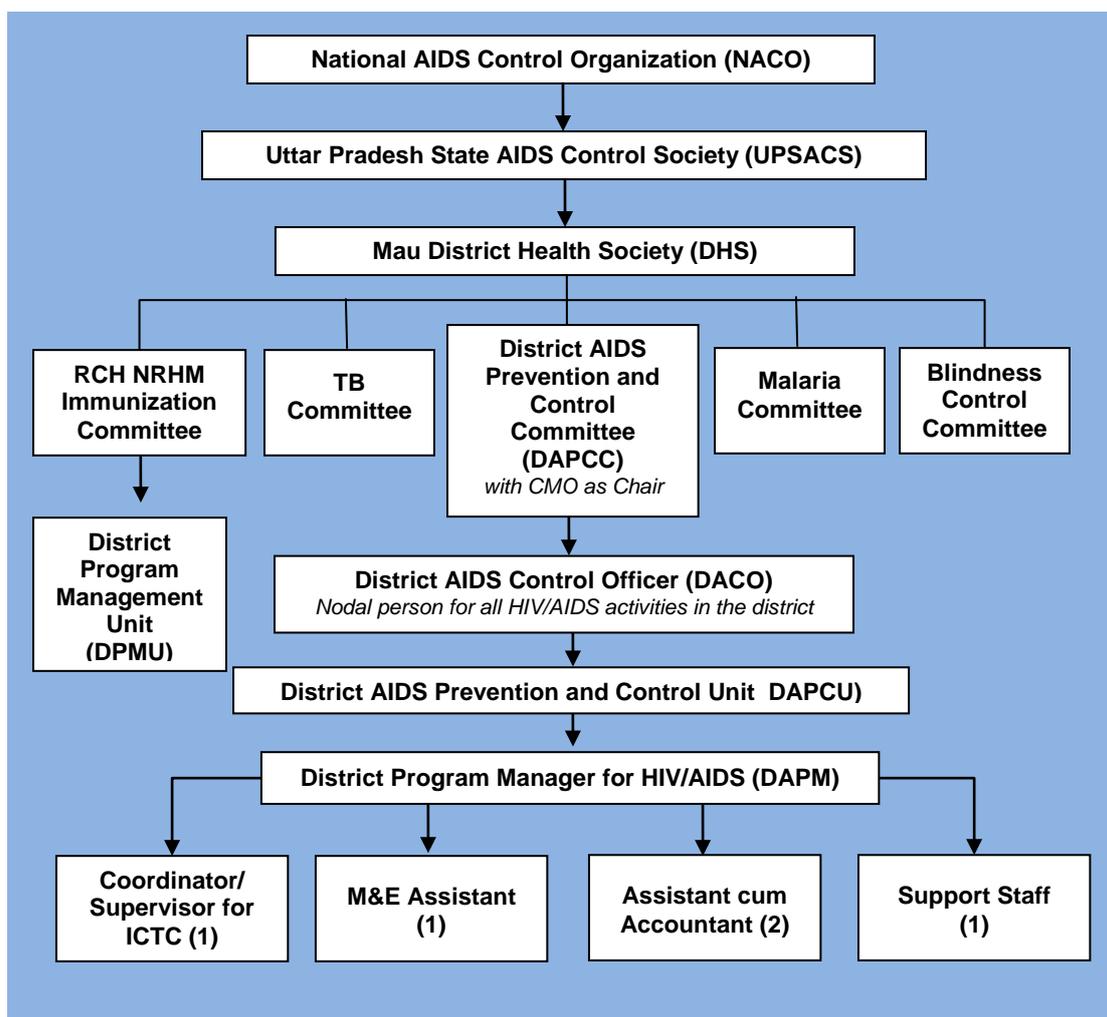


Table 20. DAPCU Roles and Responsibilities

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

The terms of reference for DAPCU staff are listed in the section on Human Resources Planning (see Section 7.2 on page 41).

PURPOSE OF THE PLAN

The DAP offers a roadmap for effectively decentralizing implementation of the National AIDS Control Program (NACP). 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 Mau 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 Mau 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.”¹⁶ The DAPCU will ensure professional management of the program through regular monitoring and supervision.

¹⁶ Link workers are community workers who have been identified to reach out to rural populations on HIV-related issues.

INSTITUTIONAL STRENGTHENING FOR CORE ACTIVITIES

5.1 Targeted Intervention (TI)

The HIV epidemic in Uttar Pradesh, as in India as a whole, is concentrated in sub-populations with relatively higher HIV risk due to their occupation (FSWs), sexual preferences (MSM), or recreational activities (IDUs). UP is classified as a low prevalence, but highly vulnerable, state, and epidemiological trends indicate that the epidemic is moving toward the general population. NACP-III in UP¹⁷ 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.

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

Objective

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

Situation Analysis

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.

A mapping study carried out in 2008 estimates that there are currently 183 FSWs operating in Mau. These include brothel-based, home-based, and street-based sex workers. Data from the study show that the majority (approximately 82%) of FSWs are street-based, highlighting the challenge of reaching this highly scattered population. According to the study, there are 580 MSM in the district, of whom 337 are transgender. Approximately 180 IDUs in 18 sites were also identified, of whom around 38 percent share needles while injecting drugs.

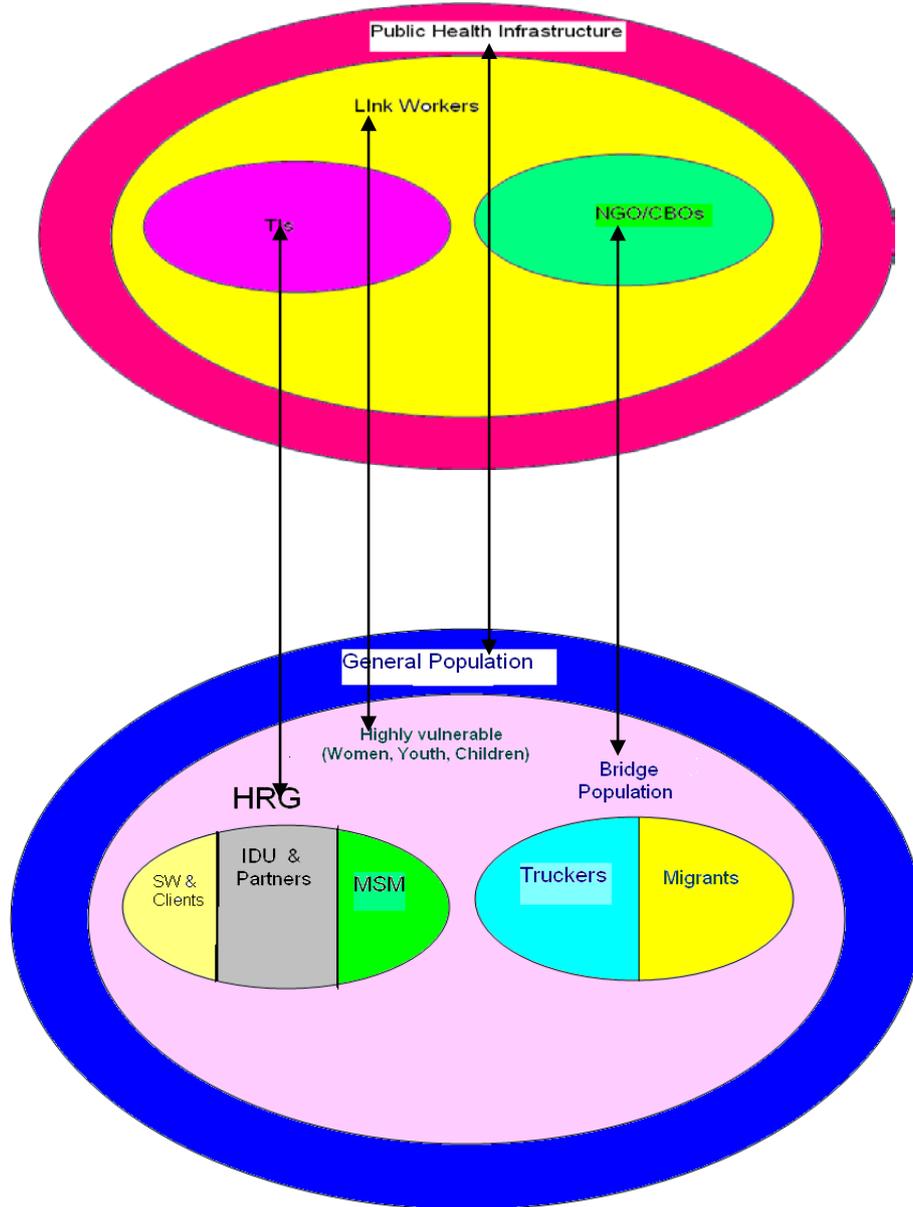
Currently, there are two TI projects operating in Mau, targeting a combined population of 425 FSWs, 500 MSM, and 100 IDUs.¹⁸ The interventions are being implemented by UPSACS through local NGO partners. The project implemented by Navchetna Gramin Vikas Evam Kalyan Sansthan targets a core group that includes MSM, FSWs, and IDUs. The second, implemented by Balwadi Evam Nirbal Seva Nari Kala Kendra Samiti, serves a core group of FSWs and MSM. The collective annual budget for the two interventions is Rs. 1,553,944. Both projects operate through composite interventions in urban areas and extend services through community-based peer educators who are either members of the relevant HRG or related to HRG members. The main activities being implemented through TI projects are 1) outreach to HRGs; 2) STI management; 3) referral and networking services for STI management; 4) interpersonal communication and promotion of safe

¹⁷ Uttar Pradesh Program Implementation Plan for NACP-III, UPSACS, Lucknow, May 2008

¹⁸ The NGO targets are higher than the mapping data. The mapping data is currently being validated by NACO and targets may be revised accordingly.

behavior; 5) condom promotion and distribution; and 6) needle and syringe exchange program. Another key activity includes encouraging HRGs to access existing prevention and treatment facilities, including by accompanying them to testing and ART centers.

Figure 4. Population Mapping for Targeting Service Provision¹⁹



¹⁹ Operational guidelines for Districts AIDS Prevention Control Units

Strategies

- Strengthen systems for effective implementation of TI projects.
- Integrate functioning of TI projects with public health delivery system to provide supplies, service delivery, and follow-up to HRGs.
- Collaborate with private partners (institutions, doctors, and NGOs) to improve service delivery and expand coverage of HIV interventions for HRGs.

Action Plan

- Supervise TI projects to improve project execution and achieve 100 percent condom use, testing at ICTCs, and access to STI services for target populations.
- Establish systems for getting feedback and interacting with officer-in-charge of ICTC/PPTCT center in TI projects' areas of operation to share information and plan follow-up activities.
- Verify the monthly Computerized Management Information System reports and submit to UPSACS for reference and follow-up.
- Ensure regular supply of materials (IEC material, condoms, etc.) from UPSACS/DAPCU to TI projects.
- Conduct advocacy and sensitize district-level stakeholders, such as district administration, police, and PRIs, to create enabling environment for smooth implementation of TI projects.
- Coordinate and implement trainings for TI project personnel.
- Build peer educators' capacity to enhance demand generation and improve accessibility of services.
- Coordinate district events and activities (such as World AIDS Day, Red Ribbon Express, etc.)
- Establish systems for soliciting feedback from HRGs and use resulting input to revise program activities.

Responsibility

DAPCU, TI implementers

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 Mau district.

Situation Analysis

There are currently 113 PLHIV on ART in Mau district. However, Mau does not currently have a full service ART center, nor is there a community care center to provide care and support services to PLHIV. A link ART center was established in the district in 2008. The center administers drugs, and provides management and counseling for treatment adherence. However, it is not equipped to provide CD4 testing. As a result, PLHIV in Mau currently rely on ART centers in Varanasi, Gorakhpur, Allahabad, and Lucknow for this service. In addition, the link ART center's infrastructure and management systems are still being developed, which sometimes leads to irregular supplies of ARVs.

Strategies

- Strengthen existing link ART center.
- Ensure constant availability of ART drugs.
- Promote counseling and monitoring for treatment adherence.
- Build public-private partnerships for laboratory services (such as OI and CD4 testing).

Action Plan

- Strengthen systems for monitoring PLHIV and children on ART.
- Introduce CD4 testing at link ART center.
- Improve referral services for CD4 testing,²⁰ OI services, and care and support.
- Coordinate with the State Network of Positive People to establish a DLN to provide care and support services.
- Follow up with UPSACS to obtain second line ARV drugs in accordance with district requirements.
- Facilitate coordination among Chief Medical Officer, Chief Medical Superintendent and Officer-in-Charge of link ART center.
- Train link ART center staff to improve treatment adherence counseling services.
- Connect link ART center with ICTCs for care and support services.
- Ensure adequate and regular supply of ARV drugs to link ART center.
- Monitor and track client records to foster improved treatment adherence.
- Orient health workers on tracking PLHIV and ensuring treatment adherence.

Responsibility

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

²⁰ Until CD4 services are available at link ART center.

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 number of ICTCs in Mau has more than tripled recently, with the introduction of six new centers in 2009. Out of the eight ICTCs now operating in the district, one is located at the district male hospital, three are located at CHCs, and four are housed in PHCs. Each ICTC has one counselor. There is also a PPTCT center at the district female hospital, which is staffed by one female counselor and a lab technician.

Table 21. ICTC Status (2004–2008)

	Number of Clients who Received Pre-test Counseling/Information			Number of Clients Tested for HIV			Total Number of Clients Found HIV-positive (after three tests)		
	M	F	T	M	F	T	M	F	T
2004	92	185	277	60	65	125	10	7	17
2005	106	87	193	102	85	187	8	7	15
2006	388	393	781	379	383	762	24	23	47
2007	1,365	419	1,784	1,128	392	1,680	61	43	104
2008	2,766	925	3,691	2,496	812	3,308	68	49	117

The table above shows that the number of people counseled and tested for HIV in Mau has increased significantly over the past five years, which is an important step toward controlling the epidemic’s spread. With six new ICTCs added in 2009, the number of people being tested should continue to increase.

The space allotted for district-level ICTCs and PPTCT centers is not adequate to maintain patient privacy and confidentiality or to provide group counseling, nor is there a specific waiting area for clients. General materials, such as tables, chairs, fans, and filing cabinets, are already in place. The centers also have a regular supply of condoms. However, non-latex condoms are not available for those who are allergic to latex or water-based lubricants.

Counselors have been trained by UPSACS and provide preventive care, counseling, health education, and psychosocial support. During interviews conducted as part of the DAP preparation process, ICTC staff suggested that documented guidelines on safeguarding patient confidentiality and maintaining patient records could improve the quality of services. Lab technicians and counselors are responsible for ensuring the availability of supplies, such as testing kits and IEC materials. However, centers

continue to experience stockouts of critical supplies. In the case of a stockout, it takes an average of one week to replenish supplies. Center staff maintain records of supply needs and submit requests to UPSACS on a monthly basis. The center currently lacks effective linkages and two-way referrals with TI projects or the DOTS center.

Table 22. PPTCT Status (2007–2008)

Year	Number Registered	Number Tested	Number HIV-positive
2007	1,359	987	4
2008	1,691	1,253	1

The situation is similar for PPTCT centers. Data for 2007–2008 show an increase in the number of pregnant women registering and being tested for HIV and a concurrent decline in seropositivity from 0.4 percent to 0.08 percent. These are encouraging trends; however, it is equally important to ensure that women who are tested receive ARV treatment, are counseled to seek institutional/caesarean delivery, and receive follow-up treatment and counseling after delivery.

Strategies

- Strengthen ICTCs and PPTCT center to improve access to and quality of services.
- Increase budget for HIV testing kits and equipment to ensure availability.
- Establish linkages between TI projects and ICTCs/PPTCT center to promote positive living among PLHIV.

Action Plan

- Develop/translate guidelines on patient confidentiality and storage of patient records.
- Orient and train ICTC/PPTCT center staff on roles and responsibilities and relevant guidelines and procedures.
- Involve ICTC counselors in community outreach to generate demand for services and increase referrals.
- Supervise ICTCs and PPTCT center to improve quality of testing and counseling services, including executing regular monitoring visits for quality assurance (responsibility of DACO and UPSACS officials).
- Encourage collaboration among ICTCs, PPTCT center, and TI projects to increase awareness of testing services and generate demand for testing.
- Follow up with UPSACS to ensure uninterrupted supply of testing kits and other equipment.
- Generate demand for ICT services through mass campaigns.
- Orient ASHAs, *anganwadi* workers (AWWs), and link workers on provision of referrals to PPTCT center and ICTCs and on follow-up with HIV-positive pregnant women.
- Organize mobile camps for testing, especially in rural areas.
- Develop annual plan with targets for each ICTC and the PPTCT center.

Responsibility

DAPCU, UPSACS, NGOs

5.4 Blood Safety

NACP-III aims to ensure the timely (within one hour after a need arises) 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 Mau District through increased access to safe blood and to ensure timely availability of safe blood and blood products

Situation Analysis

There is currently no blood bank or blood storage unit, either public or private, in Mau. The nearest blood bank is located in Gorakhpur, which has a negative impact on the timely availability of safe, high-quality blood and blood products, especially during emergencies. UPSACS plans to establish a blood bank in the district in 2008–2009.

Strategies

- Map district demand for blood and blood products.
- Promote voluntary blood donation to maintain optimal blood supply levels in accordance with district's needs.
- Ensure quality compliance.
- Build capacity of doctors and paramedics to ensure blood safety.

Action Plan

- Establish blood bank facility.
- License blood bank and strengthen blood bank safety protocols.
- Establish blood storage facility at first referral unit (FRU)-level based on NACO guidelines.
- Train blood bank medical officer and staff in accordance with NRHM and NACP protocols.
- Ensure supply of equipment and consumables through NRHM and NACP.
- Appoint DACO as district nodal officer for blood safety. She/he will ensure convergence among blood supply-related interventions of public health, UPSACS, and DHS at district level and visit blood banks monthly to monitor quality.
- Mobilize stakeholders such *Nehru Yuva Kendra* (NYK), PRIs, and *Mahila Samakhya* to promote voluntary blood donation.
- Conduct study on people's perceptions toward voluntary blood donation and safe blood transmission in both rural and urban areas.

Responsibility

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

In 2009 Mau has already set up six additional ICTCs, which will increase the number of HIV tests performed in future years. Even before the addition of these new centers, data from the two operational ICTCs show a rising trend in testing. The number of people tested at the ICTCs rose from 1,680 people in 2007 to 3,308 in 2008; almost a 50 percent increase in the number of people accessing ICT services at the centers.

Table 23. Supply Needs by Service Delivery Point

Service Delivery Points	Supplies	Estimated Requirements for 2009–2010
8 ICTCs 1 PPTCT center	<ul style="list-style-type: none"> • 3 rapid test kits for 15,000 tests • 15,000 disposable syringes and gloves • 5 condoms each for 15,000 people accessing ICT services • Nevirapine tablets • Nevirapine syrups • Safe delivery kits 	<ul style="list-style-type: none"> • Need Data
TI projects	<ul style="list-style-type: none"> • Disposable needles for 80 percent coverage of IDUs in TI project target population • Condoms and lubricants • HRG-specific IEC material, especially take-away materials and behavior change communication kits for peer educators 	<ul style="list-style-type: none"> •
Blood banks	<ul style="list-style-type: none"> • Test kits for HIV, hepatitis B, hepatitis C, MP, and syphilis • Blood bags, disposable syringes, and other consumables • IEC material 	<ul style="list-style-type: none"> •
Link ART center	<ul style="list-style-type: none"> • ARV drugs for 60 new cases each month • ARV drugs for cumulative number of people on ART • Disposables and reagents for CD4 count • Post exposure prophylaxis (PEP) drugs 	<ul style="list-style-type: none"> •

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

The logistics supply chain from UPSACS to the district level needs to be streamlined through DAPCU. Currently, service delivery points (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 and many people have been denied quality services as a result of the delays. 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.

Another logistical issue facing PHCs and ICTCs is that the computers supplied to these centers are inaccessible to counselors and lab technicians, which affects report preparation and management information system (MIS) maintenance.

Strategies

- Carry out monthly inventory control and quality checks.
- Streamline funding flows for supplies and logistics.
- Pursue convergence with NRHM and public health department to optimize use of available resources.

Action Plan

- Develop systems for methodical inventory control and train responsible personnel.
- Collect supply requirements from SDPs (district hospitals, ICTCs, PPTCT center, blood banks, blood storage units, TI projects, link ART centers, drop-in centers, and nodal link workers) on a quarterly basis and submit to UPSACS.
- Carry out monthly stock verification and follow up with UPSACS to ensure regular supply of high-quality drugs and equipment to SDPs.
- Coordinate with SDPs and parallel interventions to replenish supplies in case of stockout.

Responsibility

DAPM, District ICTC Coordinator, ART Coordinator

CONVERGENCE WITH NRHM

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 in Uttar Pradesh envisions the mainstreaming of HIV/AIDS issues with the general health system down to the village level in category A and B districts through grassroots workers, such as ANMs, ASHAs, and multi-purpose health workers (MPWs). HIV-related issues will be included in IEC material, training curricula, monitoring and evaluation indicators, and reporting formats in the health system. Issues of family planning, nutrition, the triple protective role of condoms, referrals, and other important HIV-related issues will be integrated into NACP activities at all levels.

Objective

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

This will help achieve greater ownership at district level and effective outreach of strategies and ensure sustainability by mainstreaming NACP activities with the public health infrastructure. Convergence of NACP and District Health Administration activities will optimize impact and the efficient use of resources.

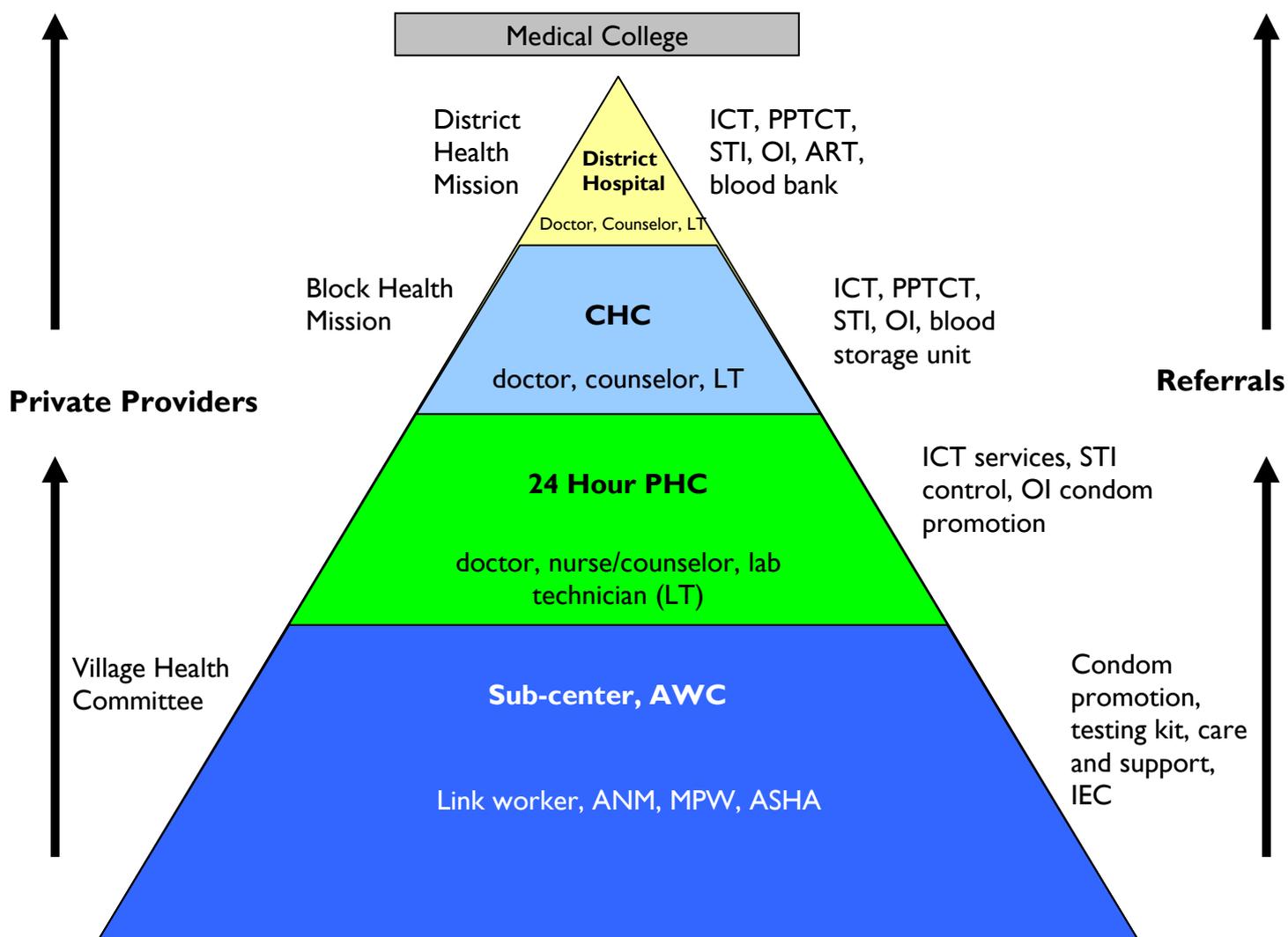
Situation Analysis

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

Strategies

- Place AIDS control program under broad umbrella of Mau DHS within NRHM framework, while retaining operational autonomy through DAPCC structure.
- Operationalize DAPCC.
- Upgrade technical capacity at district level through creation of a DAPCU manned by professionals either on deputation or engaged through contracts.
- Develop frontline workers' (such as ASHAs and AWWs) capacity to reach out to HRGs and increase their awareness of and access to HIV-related services.
- Mainstream program activities through existing cadre of community health workers, including ANMs, MPWs, and ASHAs.
- Strengthen service delivery by integrating HIV interventions with CHCs, block PHCs, PHCs, and sub-centers.
- Advocate for inclusion of HIV/AIDS prevention, control, care, support, and treatment agenda in Village, Block, and District Health Plans—implemented by Village Health and Sanitation Committee, Block Rural Health Mission and District Health Mission, respectively.
- Expand scope of work of Maternal and Child Health and Nutrition (MCHN) days.
- Provide counseling services and referrals for testing services at village level.

Figure 3. Institutional Framework: Public Health Sector Services



6.1 Condom Promotion

Objective

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

Situation Analysis

Under NACP-I and NACP-II, condom promotion was carried out through linkages with the National Family Planning Program. NACP-III aims to more than double condom use from its present level (about 1.6 billion pieces per annum) to 3.5 billion pieces per annum by 2009 through intensive demand generation and supply efforts with support from an outsourced agency (the Hindustan Latex Family Planning Promotion Trust). It also aims to improve access and implement social marketing initiatives.

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.

The TI projects have mapped hotspots of HRGs and the outlets they use to access condoms. Free condoms are available at ICTCs. In addition, commercial brands are available at pharmacies and other shops. Non-conventional condom outlets have been established in TI project areas and in urban locales. Since rural-specific interventions are infrequent or inadequate, condom availability and accessibility remain very low in rural areas.

Information from NGO staff confirms a large demand for condoms among HRGs. The existing gap between supply and demand is a result, not of the overall availability of condoms, but their lack of availability at convenient times and locations for HRGs, such as during late-night hours and in places where they congregate or serve clients. The limited outreach of NGOs restrains condom promotion significantly, particularly with bridge populations. Furthermore, there is crucial need of high-quality, population specific IEC material for outreach workers to improve their communication with HRGs.

Strategies

- Synergize NRHM and NACP condom promotion strategies to improve availability and accessibility of condoms.
- Use innovative mechanisms, such as vending machines and social marketing campaigns, to increase availability of condoms.
- Build capacity of district-level health workers (outreach workers, link workers, ANMs, and ASHAs) to promote consistent and correct condom use.
- Increase IEC efforts to promote dual protection message.

Action Plan

- Implement visibility drives and communication campaigns (both generic and brand-specific) to reach various audiences (HRGs, migrants, and general population) with condom promotion message.
- Use innovative strategies, such as collaboration with village-level networks, self-help groups (SHGs), and other department schemes (such as NYK) to promote condom use and increase access to condoms in underserved rural areas.
- Carry out quarterly condom needs assessment for HRGs and manage inventory to ensure regular supply of condoms to HRGs.
- Establish village-level condom distribution depots.
- Install condom vending machines at hotspots and STI clinics to improve access to condoms.
- Encourage PLHIV to adopt safer sexual practices.

Responsibility

Health department, DAPCU, UPSACS, TI implementers, ICTCs, and peer educators

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.

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

The district has one PPTCT center, which is located in the female district hospital. Between 2007 and 2008, the number of women registering and taking HIV tests during ANC increased from 987 to 1,253 and over 90 percent of women who were tested received post-test counseling.

Mau faces substantial challenges in scaling up its PPTCT services, including ensuring that patients receive high-quality counseling and the complete package of PPTCT services. There is currently little follow-up with HIV-positive mothers to provide them with the information and care and support they require.

Strategies

- Intensify awareness generation activities to motivate pregnant women to access PPTCT services in a timely fashion.
- Strengthen PPTCT center.
- Build health care practitioners' capacity to handle deliveries of HIV-positive women.
- Establish support mechanisms for HIV-positive pregnant women.
- Ensure uninterrupted supply chain of safe delivery kits and Nevirapine to PPTCT center.

Action Plan

- Train and orient ASHAs, ANMs, link workers, and AWWs to counsel pregnant women on HIV, increase awareness of PPTCT services, and provide referrals.
- Promote institutional deliveries through *Janani Surksha Yojana* (JSY).
- 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.
- Orient private practitioners on HIV and PPTCT to increase referrals to testing centers.
- Track and support HIV-positive pregnant women through ASHAs, link workers, ANMs, and the district-level PLHIV network.
- Educate and sensitize pregnant women, their husbands, and their families on HIV-related issues.
- Ensure timely and uninterrupted supply of safe delivery kits from UPSACS to ICTCs, outreach workers,
- Oversee operation of PPTCT services (responsibility of DAPM).

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

Under NACP-III, pediatric ART services—which were not included in NACP-II—will be provided through ART services through ART centers. The DAP proposes to link PPTCT centers with ART centers for diagnosis and follow-up. At present there is no ART center in Mau district, thus the district does not provide data on the number of children on ART. An adequate support mechanism for HIV-positive children and children born to HIV-positive parents needs to be developed.

Strategies

- Intensify tracking of and outreach to HIV-positive mothers by health workers and link workers.
- Ensure institutional deliveries for HIV-positive mothers and keep records of children who test positive for HIV.
- Expand outreach through convergence with NRHM-RCH under IMNCI (integrated management of newborn and child illnesses) program.

Action Plan

- Ensure follow-up and testing of babies born to HIV-positive mothers six weeks after delivery.
- Facilitate timely and adequate provision of ART to HIV-positive mothers and children.
- Coordinate orientation of health workers and link workers on sensitization of HIV-positive mothers on issues such as registering, pre-ART, treatment adherence, nutrition, and feeding practices.
- Advocate with Integrated Child Development Services (ICDS) staff for convergence with ICDS to provide nutritional support to HIV-positive mothers and children.
- Liaise with and train private practitioners to increase availability of PPTCT services.
- Include HIV-positive newborn care in IMNCI (Integrated Management of Neonatal and Childhood Illness) trainings.

Responsibility

Health (NRHM), UPSACS, DAPCU, private providers

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 Mau district and enhance HIV prevention efforts and early identification of PLHIV through cross-referrals.

Situation Analysis

Two health facilities in Mau report on the treatment of STIs—the male district hospital and the female district hospital. The total combined number of STI cases reported by these two facilities between January and December 2008 was 632, of which 53 (8%) were in males and 579 (92%) were in females. The higher number of STI cases reported by the female hospital could be a result of FSWs accessing services.

Strategies

- Strengthen STI clinics' capacity to provide quality services.
- Ensure uninterrupted supply of necessary equipment and consumables.
- Promote health seeking behavior among STI cases and their partners.
- Build capacity of outreach workers and health workers to strengthen STI service delivery.

Action Plan

- Begin providing STI services at CHCs and PHCs.
- Increase availability of STI drugs at sub-centers, CHCs, and PHCs.
- Employ staff on contractual basis to increase provision of STI services.
- Provide IEC material on STIs to community-level health workers.
- Conduct demand generation campaigns in rural areas to increase availability of STI information and services.
- Ensure availability of condoms at village level to control STIs.
- Establish STI clinics at HIV hotspots near highway/*dhaba*.²¹
- Equip highway clinics with well-trained manpower and adequate supplies of testing kits and other necessary equipment.
- Identify HIV-positive FSWs and sensitize them on condom use.
- Strengthen mechanisms for referring STI cases to ICTCs.
- Disseminate STI information at village level through community health workers (ASHAs, ANMs, MPWs, and AWWs).

Responsibility

Health (NRHM), UPSACS, DAPCU

²¹ Small eatery

6.5 IEC and Advocacy for Behavior Change

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

Although there is increasing awareness of HIV in the district, data show that the majority of clients access HIV-related services as a result of referrals and few clients independently seek HIV prevention and care services. This indicates an ongoing need to raise awareness about HIV-related services and strengthen health workers' motivation to encourage people to utilize ICT and ART services. In Mau, where only 26 percent of the population has television, there is a strong need to develop interpersonal strategies for information generation rather than relying on electronic media. Group discussions with primary and secondary stakeholders revealed that, while levels of denial, stigma, and discrimination have declined over the last five years, they are still present at various service delivery points. This is due to low levels of knowledge about HIV and AIDS and negative attitudes toward PLHIV.

Strategies

- Implement IEC campaign to increase information on availability of HIV-related services for HRGs, bridge populations, adolescents, women, and the general community.
- Implement IEC campaign to address stigma and discrimination among health care providers.
- Develop IEC strategy to encourage local self-governing bodies, such as PRIs and municipal corporations, to place HIV/AIDS response on annual plan agendas.
- Develop advocacy programs targeting PRI and faith leaders to increase their ownership of district HIV/AIDS program.

Action Plan

- Display IEC material prepared by NACO, UPSACS, and NGOs in public places, including major government offices, health institutions, transport hubs, tourist spots, etc.
- Mainstream HIV/AIDS messages in IEC materials used by other departments.
- Encourage NGOs, TI projects, Federation of Obstetrical and Gynecological Associations of India (FOGSI), and other organizations and associations to generate IEC material on HIV/AIDS.
- Implement IEC campaigns using variety of outlets including print, TV, radio, *melas* (health camps), and meetings.
- Organize programs, such as bus caravans, which evoke public awareness of need for effective HIV response and reduce HIV-related stigma.
- Organize periodic programs for local self-government representatives and local leaders using the United Nations Development Program (UNDP) Panchayati Raj Institutions 365 module.

For general population

- Promote public acceptance of PLHIV.
- Promote voluntary testing.

For adolescents

- Use print media, TV, radio, hoardings, wall paintings, street plays, puppet shows, meetings, etc. to disseminate HIV prevention messages.
- Incorporate AIDS awareness into school health program.
- Promote Red Ribbon clubs in schools, colleges, National Student Service (NSS), and NYK.
- Organize blood donation campaigns.
- Promote sexual health/HIV education in formal and non-formal education programs.

For women

- Discuss HIV/AIDS issues such as safe sex, and community, nutritional, and economic support for PLHIV in SHG meetings and during MCHN Days.
- Promote PPTCT services and safeguards for newborns.

For HRGs and PLHIV

- Develop safe sex prevention messages and disseminate them in locations frequented by HRGs.

For service providers

- Implement IEC campaign to address stigma and discrimination among service providers.

Responsibility

DAPCU, UPSACS, TI NGOs, other relevant departments

INTERSECTORAL CONVERGENCE

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

Table 24 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 24. Sample Government Programs and Activities for Convergence

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

²² Village-level administrative bodies.

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

²³ 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 25. Terms of Reference (TOR) for DAPCU staff

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

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

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

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

TRAINING PLAN

A scaled-up multisectoral response in Mau will require equipping service providers with necessary skills and orienting health workers, policymakers, private providers, employees of cognate departments, NGOs, SHG members, and PRI members on various facets of HIV and AIDS. The training plan for capacity building at the district level will be prepared to enable time-bound coverage of the entire training load. Some trainings will be funded by UPSACS and other NACP partners, such as USAID and UNICEF.²⁵ 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 FOGSI, will also be motivated to self-finance orientations for their members.

Table 26. Stakeholders in Mau Training Plan

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

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

²⁵ The United Nations Children's Fund

be developed for the district and a special allocation of funds will be sought from UPSACS. The training plan for Mau will include the stakeholders listed in Table 26 above.

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

Table 27. 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 28. Proposed Training Content

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

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

MONITORING AND EVALUATION

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

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

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

9.1 M&E Functions of DAPCU

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

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

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

Table 29. Budget for Mau DAPCU (Year I)

A. Staff Salary				
	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
	Total			684,000
B. Fixed Costs (One-time costs)				
6	Computer, printer and accessories	1		90,000
	Total			90,000
C. Recurring Costs				
	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
	Total			78,000
Grand Total (A+B+C)				852,000

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

Annex I: District Dashboard

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

Composition of the dashboard should be as follows:

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

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

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

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

6. Lab technicians

Number of lab technicians sanctioned	
In place	

7. Counselors

Number of counselors sanctioned	
Number of counselors in place	

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

10. Funds

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

11. Supplies

a) Two Months' Stock Available for:	
ART drugs	
condoms	
delivery kits	
testing kits	
IC and WM ²⁶ consumables	
Auto-disable syringes	
b) Stockout Summary	
Total number of stockouts reported	
Number of facilities reporting stockouts	
Commodities for which stockouts occurred	

Detailed Stockout Chart:

Facility Name	Commodity Type

12. Institutions functional

	ICTC	PPTCT	STD	RNTCP	Blood Bank
Sanctioned					
Functional					
Tests/Referral					

²⁶ Infection control and waste management

13. Blood Banks

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

14. Coverage

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

15. Cases of discrimination reported

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

16. Trainings

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

17. IEC²⁷

Planned	Achievement

18. Tribal strategy

Planned	Progress

19. Monthly/Quarterly DAPCU meetings

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

20. PLHIV Trends

PLHIV	ICTC	HRG Category	On ART	Death
Existing				
New				

²⁷ Detailed tables for Questions 18 and 19 to be developed in accordance with yearly action plan.

Annex II: Proposed Meeting / Reporting Schedule

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

Annex III: DAPCU Program Activities

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

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

Annex IV: Personnel Responsible for Service Delivery at Different Levels

	Levels of service	Personnel delivering services	Type of services
1.	Community	i. ASHA (NRHM states) ii. RMP	<ul style="list-style-type: none"> Referring pregnant women for tests and follow-up of PPTCT prophylaxis treatment Treatment of STIs, minor ailments, and OIs (such as diarrhea) Condom supply
2.	PHC/ private provider/ 30,000 population	i. PHC doctor/private practitioner ii. Nurse iii. Lab technician (LT) iv. Pharmacist/dispenser v. Record keeper	<ul style="list-style-type: none"> STI control and condom promotion HIV testing and counseling OI prophylaxis and treatment Antenatal care and counseling for prophylaxis
3.	CHC/ Trust Hospitals/ 100,000 population	i. CHC doctor/Trust hospital doctor ii. Counselor iii. Nurse iv. Lab technician v. Pharmacist/dispenser vi. Outreach worker	<ul style="list-style-type: none"> STI control and condom promotion Integrated health counseling/testing PPTCT, delivery, abortion, and sterilization services for women (including those who are HIV-positive) Diagnosis and treatment of common OIs ART follow-up and referral Maintenance of computerized patient records
4.	District-level/ Teaching hospitals	i. Specialist ii. Doctor iii. Nurse iv. Counselor v. Lab technician vi. Manager of drugs supply chain vii. Treatment supporter (NGO/PLHA/CBO, etc.) viii. Outreach worker	<ul style="list-style-type: none"> Management of complications ART Care and support Integrated counseling and testing Management of STIs and OIs PPTCT services Ensuring drug supply at district level Facilitating access to care and support for PLHIV
5.	NGO/CBO/FBO ²⁸	i. NGO/CBO administering CCC and family support centers ii. NGO/FBO/other managing TI project iii. Outreach worker	<ul style="list-style-type: none"> Palliative care and treatment of minor OIs STI treatment Counseling, social services Adherence monitoring

²⁸ Faith-based organization

Annex V: List of District Workshop Participants

1	A.L .Verma	CDO	
2	Dr. B.Kumar	Add. C.M.O.	Health
3	Dr. Mohd. Asif Khan	MOIC	Health
4	Dr. A.K. Azizi	MOIC	Health
5	Dr. P. Panday	Superintendent CHC, Ghosi	Health
6	Dr. R.N. Singh	Deputy CMO	Health
7	Dr. V.K. Srivastav	Superintendent CHC	Health
8	Dr. V.P. Singh	DTO	Health
9	Sanjay Kumar	H.E.O PHC, Ratan pura	Health
10	Sharwan Kumar	H.E.O PHC, Dohrighat	Health
11	V.P. Chourasiya	H.E.O PHC, Fatehpur	Health
12	Vandana Srivastava	Counselor PPTCT center	Health
13	Dr. A.K.Ranjan		Health
14	Satya Prakash Pandey	Counselor ICTC	Health
15	Virender Kmar	General Secretary	Red Cross
16	Dr. R.K. Agarwal	Secretary	I.M.A. Mau
17	Dr. Ramesh Kumar	Teacher	Education
18	Dr. R.L. Srivastava	Principal	Education
19	Mobani Shastri	C.D.P.O. Ghosi	ICDS.
20	S.P. Shahi	C.D.P.O. Rani pur	ICDS
21	Kunti Devi	C.D.P.O. Mohamdabadi	ICDS
22	Droupadi	C.D.P.O.	ICDS
23	Archana Singh	Mukhya Sevika	ICDS
24	Urmila Rai	Mukhya Sevika	ICDS
25	Chandra Mani Devi	Mukhya Sevika	ICDS
26	Phool Kumari Devi	Mukhya Sevika	ICDS
27	Saraswati Verma	Mukhya Sevika	ICDS
28	Jyoti Rai	D.C.	SARD
29	Aparna Tripathi		R.R.c.
30	Sri Ram Singh	B.D.O Pradhan	Rural Development
31	Bali Ram	A.D.O.	Rural Development
32	Akhilesh Srivastava	Project Manager	T.I.Balvani Mau NGO
33	Manoj kumar Pandey	O.R.W	T.I.Balvani Mau NGO
34	Ajay Bernwal	Project Manager	TI project (NGO)
35	Prem Lata Mourya	O.R.W	TI project (NGO)
36	Manoj Kumar Tiwari	D.R.P.Link Worker	TI Grameen Vikas Sansthan Mau
37	Ravi Prakash Srivastav	M.E.O.	TI Grameen Vikas Sansthan Mau
38	Anonymous	President	Mau Network of Positive People
39	Anonymous	Member	Mau Network of Positive People
40	Anonymous	Member	Mau Network of Positive People
41	Anonymous	Member	Mau Network of Positive People

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