

Allahabad

District AIDS Action Plan



2009–2012

ALLAHABAD DISTRICT AIDS PREVENTION AND CONTROL UNIT

Uttar Pradesh State AIDS Control Society

Lucknow

APRIL 2009

TABLE OF CONTENTS

Foreword.....	iii
Abbreviations	iv
I. Background and Methodology	1
1.1 Context	1
1.2 Overview of Plan Development Process	3
II. District Profile	4
2.1 Geography and Overview of Health Scenario.....	4
2.2 Overview of HIV/AIDS Situation.....	8
III. Framework for Program Activities	16
3.1 District AIDS Prevention and Control Committee (DAPCC)	16
3.2 District AIDS Prevention and Control Unit (DAPCU).....	17
IV. Purpose of the Plan	19
4.1 Vision.....	19
4.2 Goal.....	19
4.3 Strategy	19
V. Institutional Strengthening for Core Activities	
5.1 Targeted Intervention (TI).....	20
5.2 Antiretroviral Therapy (ART) / Treatment	23
5.3 Integrated Counseling and Testing (ICT).....	25
5.4 Blood Safety.....	28
5.5 Care and Support.....	31
5.6 Supplies and Logistics.....	33
VI. Convergence with NRHM	35
6.1 Condom Promotion	36
6.2 Maternal Health.....	38
6.3 Infant and Pediatric Care.....	40
6.4 Sexually Transmitted Infection (STI)	42
6.5 IEC and Advocacy for Behavior Change.....	44
VII. Intersectoral Convergence	46
7.1 Role of Key Functionaries/Committees	46
7.2 Link Worker Program	49
7.3 Public Private Partnerships	50
7.4 Human Resource Planning.....	51
VIII. Training Plan	53
IX. Monitoring and Evaluation	56
9.1 M&E Functions of DAPCU	56
X. Budget	57
XI. Annexes	58
Annex I: District Dashboard	58
Annex II: Positive Antenatal Case Line-list Register	62
Annex III: Proposed Meeting / Reporting Schedule	63
Annex IV: DAPCU Program Activities	64
Annex V: Personnel Responsible for Service Delivery at Different Levels	66

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 HIV/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). DAPCUs 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 DAPCUs with a framework for guiding implementation of HIV programs and supporting the achievement of state HIV/AIDS objectives.

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

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

S.P Goyal

Project Director,

Uttar Pradesh State AIDS Control Society

¹ More than 1 percent ANC prevalence reported by any of the sites in the district in the last 3 years.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ANM	auxiliary nurse midwife
ANP+	Allahabad Network of Positive People
ART	antiretroviral therapy
ASHA	accredited social health activist
AWC	<i>anganwadi</i> center
BCC	behavior change communication
BPHCs	block primary health center
CBO	community-based organization
CCC	community care center
CHC	community health center
CMHO	Chief Medical and Health Officer
DACO	District AIDS Control Officer
DAP	District AIDS Action Plan
DAPM	District Program Manager for HIV/AIDS
DAPCC	District AIDS Prevention and Control Committee
DAPCU	District AIDS Prevention and Control Unit
DHS	District Health Society
DIC	drop-in center
DLHS	District Level Household Survey
DOTS	directly observed therapy, short-course
DPMU	District Program Management Unit
EFICOR	Evangelical Fellowship of India Commission on Relief
FOGSI	Federation of Obstetrical and Gynecological Associations of India
FRU	first referral unit
FSW	female sex worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
HRG	high-risk group
ICDS	Integrated Child Development Services
ICT	integrated counseling and testing
ICTC	integrated counseling and testing center
IDU	injection drug user
IEC	information, education, and communication
IMA	Indian Medical Association
IMNCI	integrated management of neonatal and childhood illnesses
JSY	<i>Janani Suraksha Yojana</i>
LW	link worker
M&E	monitoring and evaluation
MCHN	maternal and child health and nutrition
MIS	management information system
MLN	Motilal Nehru
MOHFW	Ministry of Health and Family Welfare
MOIC	Medical Officer-in-Charge
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
NGO	nongovernmental organization
NRHM	National Rural Health Mission
NSS	National Student Service

NYK	<i>Nehru Yuva Kendra</i>
OI	opportunistic infection
OVC	orphans and vulnerable children
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
RTI	reproductive tract infection
SDP	service delivery point
SHG	self-help group
STI	sexually transmitted infection
STRC	State Training and Resource Center
TB	tuberculosis
TFR	total fertility rate
TG	transgender
TI	targeted intervention
TSU	Technical Support Unit
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
UPSACS	Uttar Pradesh State AIDS Control Society
USAID	U.S. Agency for International Development
UT	Union Territory

BACKGROUND AND METHODOLOGY

I.1 Context

The Government of India approved Phase III of the National AIDS Control Program (NACP-III) in November 2006. In its latest phase, the program, which began in 1992, has begun categorizing districts according to their current HIV prevalence rates and the presence of risk factors that could fuel future expansion of the epidemic. The package of services for each state and district has been designed in accordance with this categorization.

Based on HIV prevalence, six states in India have been identified as high prevalence states, three as moderate prevalence states, and the rest as low prevalence states. On the basis of risk factors such as migration, population size, and weak health infrastructure, the low prevalence states/Union Territories (UTs) have been further classified as ‘highly vulnerable’ or ‘vulnerable’ states. Uttar Pradesh (UP) has been classified as a low prevalence, highly vulnerable state.

Within individual regions, there is a high degree of variation in the HIV epidemic, which is spreading more rapidly in rural areas. To address this lack of uniformity, NACP-III plans to extend its organizational structure from the state to the district level. Based on epidemiological and vulnerability criteria similar to those used to classify states, all 611 districts in the country have been classified into four categories: category A, high prevalence (163 districts); category B, concentrated epidemic (59 districts); category C, increased presence of vulnerable populations (278 districts); and category D, low/unknown vulnerability (111 districts). NACP-III has used these categories to design differential packages of services tailored to each district’s epidemiological profile.

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 high-risk group (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. A district is classified as category A if any antenatal care (ANC) or prevention of parent-to-child transmission (PPTCT) site in the district has reported more than one percent HIV prevalence during the last three years.

District AIDS Action Plans (DAPs) are the key to effectively decentralizing implementation of the HIV/AIDS control program. The Uttar Pradesh State AIDS Control Society (UPSACS) has decided to develop a DAP for each Category A district in the state. The plans are based on the framework of services for category A districts described in the National AIDS Control Organization (NACO) guidelines (see Table 1). The Allahabad DAP will be a component of the District Health Plan prepared under the National Rural Health Mission (NRHM). The Allahabad District HIV/AIDS Program will include the interventions outlined in this plan, which are evidence-based and have been developed through a consultative process with a wide array of stakeholders in accordance with available data.

Table 1. Package of Services for Category A Districts²

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.

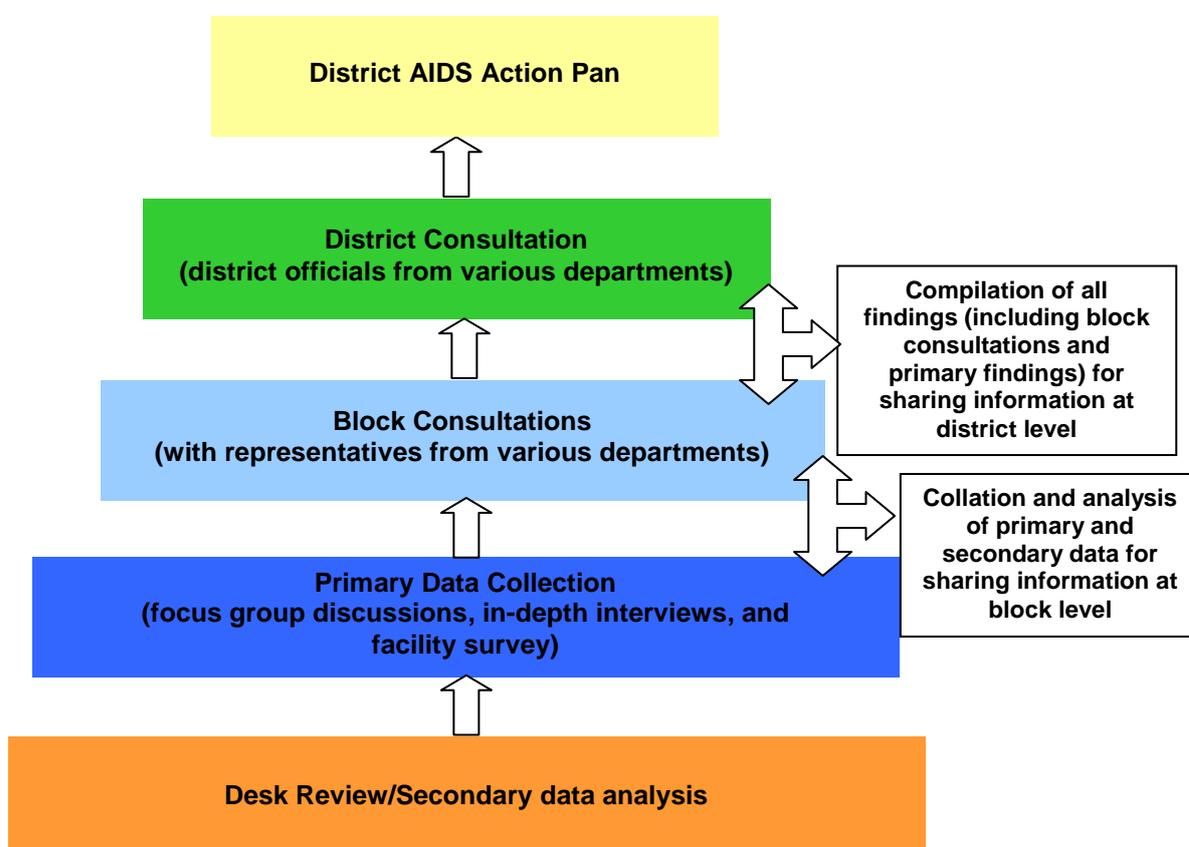
² NACO: NACP-III Project Implementation Plan, Government of India, 2006, p.80

I.2 Overview of Plan Development Process

The process of developing the Allahabad AIDS Action Plan was initiated in 2006, in conjunction with preparation for the third phase of NACP. Consultants collected district-specific data on HIV prevalence and services in Allahabad. A two-day workshop, presided over by the District Collector, was also held to discuss HIV issues in the district and appropriate strategies for responding to the epidemic. A variety of stakeholders from NGOs, relevant departments of Motilal Nehru Medical College, Kamla Nehru Memorial Hospital Trust, CARE UP, and UPSACS participated in the workshop. Following the workshop, a strategic plan for Allahabad was developed.

After the approval of NACP-III, NACO drafted a template for DAPs that could be adapted based on the district's HIV classification category. On behalf of UPSACS, the USAID | Health Policy Initiative updated the data in the strategic plan based on the NACO template. The process of developing the DAP included stakeholder meetings in the district and collection and compilation of the latest data. Most of the data on service delivery were retrieved from UPSACS' Computerized Management Information System through the Technical Support Unit (TSU). The draft report was then shared for review with personnel in the district and their suggestions were incorporated.

Figure I. Preparation Process for District AIDS Action Plan



2.1 Geography and Overview of Health Scenario

One among the 70 districts of Uttar Pradesh, Allahabad is surrounded by Varanasi in the east, Jaunpur in the northeast, Kaushambi in the west, Banda in the southwest, Pratapgarh in the north, Mirzapur in the southeast, and the Rewa district (located in Madhya Pradesh state) in the south. Allahabad spreads up to 63 kilometers from east to west and 109 kilometers from north to south. It is situated in the eastern region of the state and is known for the *Sangam*; a holy place for Hindus where three great rivers, the Ganges, the Yamuna, and the mythological river Saraswati, meet.

Allahabad figured prominently in the freedom movement and many of the movement's famous programs and policies were planned and initiated there. Allahabad has produced eminent saints, sages, politicians, scholars, historians, artists, musicians, journalists, educators, and lawyers.

Table 2: General Indicators

	Allahabad	Uttar Pradesh
Geographical area (in sq.km.)	5,437	240,928
Tehsils	8	303
Developmental Blocks	20	823
Municipal Corporations	1	11
Gram panchayats	1,425	58,624
Number of inhabited villages	3,074	97,134
Number of inhabited villages <5000	2773	2562
Number of towns	9	215

Source: Census of India (2001)

Although Allahabad is only the fifth largest district in Uttar Pradesh, it is the most populous. It is often called the second capital of Uttar Pradesh, as the headquarters of several important judicial and administrative offices are located there. Administratively, the district is divided into 20 development blocks, 12 towns, 1,425 village *panchayats*, and 3,064 villages. Allahabad city is one of the largest commercial centers in the state. It is also one of

the most prominent industrial towns, with 18 medium and large industrial units, and more than 3,000 small scale industries operating there. The Third All India Census for Small Scale Industries shows that there are more than 10,000 unregistered small scale industry units in the district, employing thousands of people. The major industries that have units in Allahabad are ITI Naini, Raymonds Synthetics-Karchana, Hindustan Cables-Naini, Triveni Sheet Glass Ltd-Naini, IFFCO-Phulpur, and GEEP industries.

According to the 2001 census, Allahabad's total population is 49.41 *lakhs*, of which 26.26 are male and 23.15 are female. The district accounts for 2.97 percent of the state's total population and has a higher population density (911) than the state average (689). While one in four people living in Allahabad reside in an urban area, the state average is one in five. More than four-fifths of the district's population is Hindu and about one-eighth are Muslim. Scheduled Castes (SCs) and Scheduled Tribes (STs) constitute 21.66 percent of the population. Between 1991 and 2001 the district's growth rate (26.72%) was slightly higher than the state average (25.80%). The district's sex ratio of 882 females per 1,000 males is lower than the state level (898 per 1,000). Allahabad's child sex ratio in the zero to six age group is higher (936 females per 1,000 males) than the state average (914). The district's literacy rate is also slightly higher than the state average.

Table 3. Demographic Indicators

Population Index (2001)	District	State
Total population	4,936,000	166,197,921
Female population	2,310,000	78,632,552
Male population	2,626,000	87,565,369
Rural population	3,729,000	131,658,339
Urban population	1,207,000	34,539,582
Child population (0–6 years)	223,000	30,472,042
Percent of child population (0–6 years)	4.52%	18.33%
Population density	911	689
Decadal growth rate (1991–2001)	26.72%	25.80%
Male/female ratio	879	898
Ratio of male/female children (0–6 years)	936	915
Literacy rate	62.89%	57.36%
Male literacy rate (7+ years)	75.80%	70.23%
Female literacy rate (7+ years)	46.37%	42.98%
Scheduled Caste (SC) population	21.57%	21.1%
Scheduled Tribe (ST) population	0.08%	0.1%

Table 4. Standard of Living Index

	DLHS-3		DLHS-2	
	Total	Rural	Total	Rural
Low (%)	64.3	81.6	57.3	77.1
Medium (%)	13.3	13.5	21.0	19.2
High (%)	22.4	4.8	21.8	3.7

Source: DLHS-3

Figure 2. Health Facilities in Allahabad

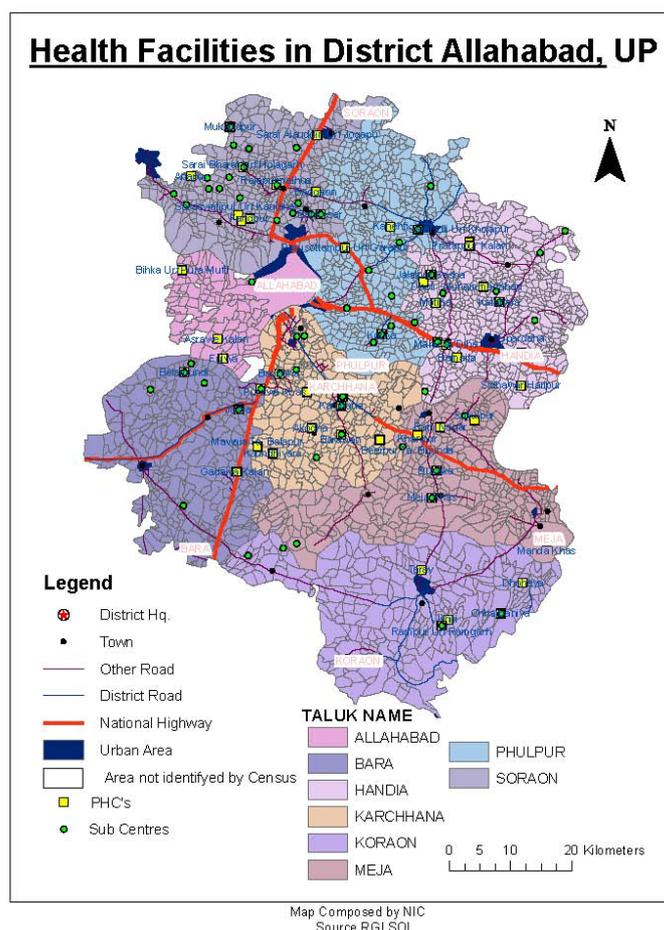


Table 5. Health Facilities At-a-Glance

	Allahabad	Uttar Pradesh
Medical colleges	1	19
District hospitals (male)	1	70
District hospitals (female)	1	69
Community Health Centers (CHC)	13	386
Primary Health Centers (includes block, sub-block, and additional PHCs)	8	3,660
Sub-centers	539	20,521
Anganwadi centers (AWCs)	4,190	153,223
DOTS ³ centers	572	25,733
Microscopy centers	55	1,750
Tuberculosis (TB) clinics	11	369

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

³ Directly observed therapy, short-course

Table 6. Fertility Indicators

	Allahabad**	Uttar Pradesh
Total fertility rate	4.2	3.99*
Crude birth rate	30.2	31.4

*Source: NFHS-3; ** DLHS-2; ***SRS 2007

The total fertility rate (TFR), i.e. average number of children born to a woman in her reproductive age for Allahabad is 4.2 which is higher than the state average.

Table 7. Mother and Child Health Indicators

	Allahabad	Uttar Pradesh
Total number of pregnant women	196,988	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)	29.3%	21.9%
Women who received full ANC ⁴	N/A	2.8%
Institutional deliveries (January–September 2008)	8,839	24.5% (956,007)
Number of institutional deliveries under JSY ⁵	8,839	956,007
Home deliveries attended by skilled personnel	17.6%	7.4%

Source: DLHS-3

Table 8. Family Planning Indicators

	Allahabad (%)	Uttar Pradesh (%)
Women who use any method of family planning	42.3	38.4
Women who use any modern method of family planning	36.5	26.7
Female sterilization	28.5	16.5
Male sterilization	0.3	0.2
Couples using condoms	4.8	7.1
Unmet need for family planning	27.8	33.8

Source: DLHS-3

⁴ 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.

⁵ *Janani Suraksha Yojana*, Health Directorate. Progress report for 2008–2009.

2.2 Overview of HIV/AIDS Situation

Allahabad’s HIV/AIDS profile is described here using two parameters; vulnerability factors and infection patterns over time. Vulnerability factors can be understood by analyzing migration patterns, the presence of people engaging in high-risk behaviors, the level of HIV awareness, and condom use. The presentation of infection patterns is based on HIV Sentinel Surveillance (HSS) data and data on detected cases of HIV from various service delivery points (SDPs).

High-risk and Vulnerable Populations

Since HIV is spread through known routes—sexual, blood and blood products, and perinatal—certain HRGs have been identified. These groups, such as FSWs, MSM, transgender (TG), and injection drug users (IDUs), have high HIV prevalence rates, which contributes to the rapid spread of the virus.

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 Allahabad presented in Table 9 below reflects the district’s vulnerability to HIV infection. Comparing the mapping reports of 2001 and 2008, it can be seen that the revised methodology of the study has enabled the identification of more HRGs. According to the provisional report of the 2008 mapping study, there are about 635 FSWs in 16 sites, 825 MSM in 21 sites, 725 IDUw in 37 sites, and 100 *hijras*⁶ in four sites in Allahabad.

Brothels were found operating in the Meerganj area and floating sex work was found near Rambagh Railway station, Mundera Mandi, and Gausnagar. IDU sites were found at Rasulabad Ghat, Shivkuti riverbank, Kalyani Devi Mandir, Salori, TB colony, Allahpur and PD Tandon Park.

Table 9. HRG Populations in Allahabad

		UPSACS 2001	UPSACS 2008	UNICEF 2008
FSW	Sites	6	16	93
	Total	354	635	569–813
MSM	Sites	7	21	43
	Total	28	825	325–482
IDU	Sites	7	37	20
	Total	39	725	80–114
Hijras	Sites	1	4	NA
	Total	10	100	NA

While the UPSACS-supported studies were more urban focused, the United Nations Children’s Fund (UNICEF) commissioned a study to map HRGs in the rural areas of Allahabad in 2008. This study is quite valuable in understanding rural areas’ vulnerability to the HIV epidemic and developing appropriate interventions. The study, which was conducted by SWARG with technical support from Swasti, covered 132 villages in 20 blocks of Allahabad. The study estimated the presence of 569–813 FSWs in 93 villages, 315–481 MSM in 43 villages, and 80–114 IDUs in 20 villages. Nearly 70 percent of the HRGs were identified within eight blocks of the national/state highways. Soraon and Chaka blocks have the most exposure to these highways.

⁶ *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.

Female sex workers in rural areas, who do not want to risk exposure as sex workers in their villages, also operate outside the village, especially during the *kumbh fair* at Allahabad. Some also operate in Allahabad's red light areas. The FSWs identified at Shankargarh reported visiting truck stop points in mining areas. Four blocks, Chaka, Soroan, Shankargarh, and Kaudihar, accounted for 43 percent of the FSWs identified in the study. Out of 398 MSM, 58 percent operate in their villages, while 42 percent operate outside their village of residence. IDUs were mainly found in blocks in close proximity to urban areas, as well as in some parts of Chaka and Kaudihar that fall in urban corporation areas.

Migration Patterns and HIV

Migration patterns in UP and Allahabad contribute to the district's vulnerability to HIV. Of all the states in India, Uttar Pradesh has the highest rate of out-migration. Upon their return, these migrants risk spreading the epidemic from high prevalence states and cities to their home district. According to a mapping exercise carried out in Uttar Pradesh, the state has 456 in-migrant sites with a population of 58,909, and 319 out migrant sites with a population of 47,406. In Allahabad, according to a mapping study by TNS Mode for Care India and NGO partner Lok Smriti Seva Sansthan, there are 14 migrant sites with a total population of 7,150.

According to a separate report by the Registrar General of India, the total number of in-migrants in Allahabad district is 696,243.⁷ Among them, 48,259 are males and 647,984 are females. Rural areas contain 643,902 migrant, while 52,341 reside in urban areas. The major destinations of out-migrants from the district are Jharkhand, West Bengal, Gujarat, Maharashtra, Punjab, Delhi, Assam, and Rajasthan. There is also a large amount of movement between Allahabad and other districts of UP state, as well as between Allahabad and Nepal. Allahabad's mobile population is largely composed of groups such as seasonal migrants, truck drivers, and traveling workers, as well as cross-border migrant laborers, professionals, and itinerant traders.

The UNICEF study showed that the highest level of male permanent migration in Allahabad is from Bahadurpur and Uruwa blocks. The Shankargarh block has the highest number of truck drivers, as there are a large number of stone and silica sand quarries in the area. These truck drivers travel both short and long distances and some are reported to engage in high-risk behaviors.

HIV and AIDS Awareness

The third District Level Household and Facility Survey (DLHS-3) of Allahabad,⁸ based on data collected from 1500 women ages 15–49, shows that only half of ever-married women and 76 percent of unmarried women have heard about HIV/AIDS. The results of the DLHS-3 study also show a significantly increase in the level of HIV awareness in comparison with the DLHS -2⁹ study conducted in 2004. At that time, only 35.6 and 39.7 percent of ever married women in Allahabad were aware of STI/RTI¹⁰ and HIV/AIDS, respectively, and 45.6 and 76 percent of ever married men in were aware of STI/RTI and HIV/AIDS, respectively.

⁷ Report of the situation analysis for HIV/AIDS in Allahabad district of Uttar Pradesh, (draft), SWARG/UNICEF, 2008.

⁸ IIPS: DLHS-3, Reproductive and Child Health Project, District Fact Sheet 2007-8, Allahabad, Mumbai, 2008

⁹ IIPS, GoI, TNS: DLHS-2 Uttar Pradesh, Reproductive and Child Health Project, IIPS, Mumbai 2004.

¹⁰ Reproductive tract infection

Table 10. Knowledge of HIV/AIDS and RTI/STI among Women

	DLHS-3		DLHS-2	
	Total	Rural	Total	Rural
Ever-married Women Ages 15–49 (in percent)				
Had heard of HIV/AIDS	48.8	39.3	39.7	24.2
Knew that consistent condom use can reduce the chances of contracting HIV	45.0	42.1	28.0	12.5
Had correct knowledge of HIV/AIDS (of those who had heard of HIV/AIDS)	92.1	91.0	-	-
Had been tested for HIV	2.6	2.2	-	-
Had heard of RTI/STI	22.1	17.6	35.6	24.9
Unmarried Women Ages 15–24 (in percent)				
Had heard of HIV/AIDS	76.6	68.1	-	-
Knew that consistent condom use can reduce the chances of contracting HIV	48.0	44.9	-	-
Had correct knowledge of HIV/AIDS	96.6	94.7	-	-
Had been tested for HIV	0	0	-	-
Had heard of RTI/STI	34.6	31.3	-	-

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 Allahabad was reported to be only 4.8 and 6.5 percent, respectively.¹¹ With condoms available in a wide variety of brands and prices, lack of condom use is principally attributed to shyness, embarrassment, and lack of cooperation from sex partners. Increased demand for condoms will protect against HIV and other STIs and reduce unwanted pregnancies.

The key findings of the Allahabad situation assessment¹² are listed below:

- Allahabad is an important urban hub for educational, religious, industrial, and trading activities in eastern UP, and therefore attracts a large population of visitors and in-migrants from rural Allahabad. There are also a large number of out-migrants to other states.
- Allahabad has a large number of professional colleges, universities, and coaching centers. HIV awareness programs for youth attending these institutions are not adequate.
- Villages involved in trade and commerce and/or situated near state and national highways are vulnerable to HIV infection as a result of their large mobile populations and a higher incidence of sex work.
- A significant proportion of sexually active individuals have multiple partners.
- The district has large clusters of vulnerable populations, including FSWs, *hijra*, MSM, IDUs, and truckers.
- The level of awareness of STI/RTI in general, and of HIV/AIDS in particular, is low, as is the level of condom use.

HIV Prevalence in Allahabad

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

¹¹ IIPS: DLHS-3, Reproductive and Child Health Project, District Fact Sheet 2007-8, Allahabad, Mumbai, 2008

¹² Report of the situation analysis for HIV/AIDS in Allahabad district of Uttar Pradesh, (draft), SWARG/UNICEF, 2008.

The first sentinel site in Allahabad became active in 2001, five years after HIV sentinel surveillance was initiated in India. Unlinked, anonymous samples from people attending the STI clinic at Allahabad District Hospital were used to test for the presence of HIV. HIV prevalence in 2001 was 0.8 percent. In 2004, prevalence rose to 2 percent before dipping to zero in each of the following three years. In 2003, samples were collected from the targeted intervention (TI) project for FSWs implemented by Sarvajan Kalyan Samiti. They showed 12 percent prevalence, which grew to 20 percent in the following year. For technical reasons, the data from the FSW site was not factored into the state average. In 2006 and 2007 the prevalence among FSWs in Allahabad, although still higher than the state average of 0.78 percent, was found to have fallen to 1.6 percent.

Table 11. HIV Sentinel Surveillance Data (in percent)

Sites		2001	2002	2003	2004	2005	2006	2007
STI clinic	Uttar Pradesh	1.34	1.37	1.28	NA	2.66	0.95	0.81
	Allahabad	0.8	0.4	0.4	2	0	0	0
ANC clinic	Uttar Pradesh	0.05	0.37	0.19	NA	1.73	0.25	0.02
	Allahabad	NA	NA	NA	NA	NA	1.5	0.5
TI project for FSWs	Uttar Pradesh	NA	NA	NA	NA	NA	1.52	0.78
	Allahabad	NA	NA	11.96	20	10.8	1.6	1.6

While attendees of the STI clinic and FSWs are expected to show higher rates of HIV prevalence, women attending ANC clinics are representative of the general population. Blood samples from pregnant women attending ANC clinics at the CHC in Handia were collected in 2006 and 2007 and HIV prevalence rates were found to be 1.5 and 0.5 percent, respectively—much higher than the average prevalence in UP state. The high prevalence of HIV among pregnant women indicates that the virus is not contained among HRGs and that it has already been transmitted to Allahabad's general population.

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 2002–2008 shows that, while the cumulative HIV positivity rate (number of people testing sero-positive/total number tested x 100) in the state is only 7.13 percent, 19 districts have reported positivity rates higher than the state average. Table 13 shows the yearly positivity rates of the 11 districts in UP that have reported more than 10 percent positivity rates since 2002. Of these, Allahabad has the sixth highest positivity rate, with a cumulative positivity rate of approximately 12 percent and yearly rates ranging from 7.13 percent in 2008 to 21.43 percent in 2004.

Table 12. Trends in Referrals to ICTCs and HIV Test Results (Jan–Oct 2008)

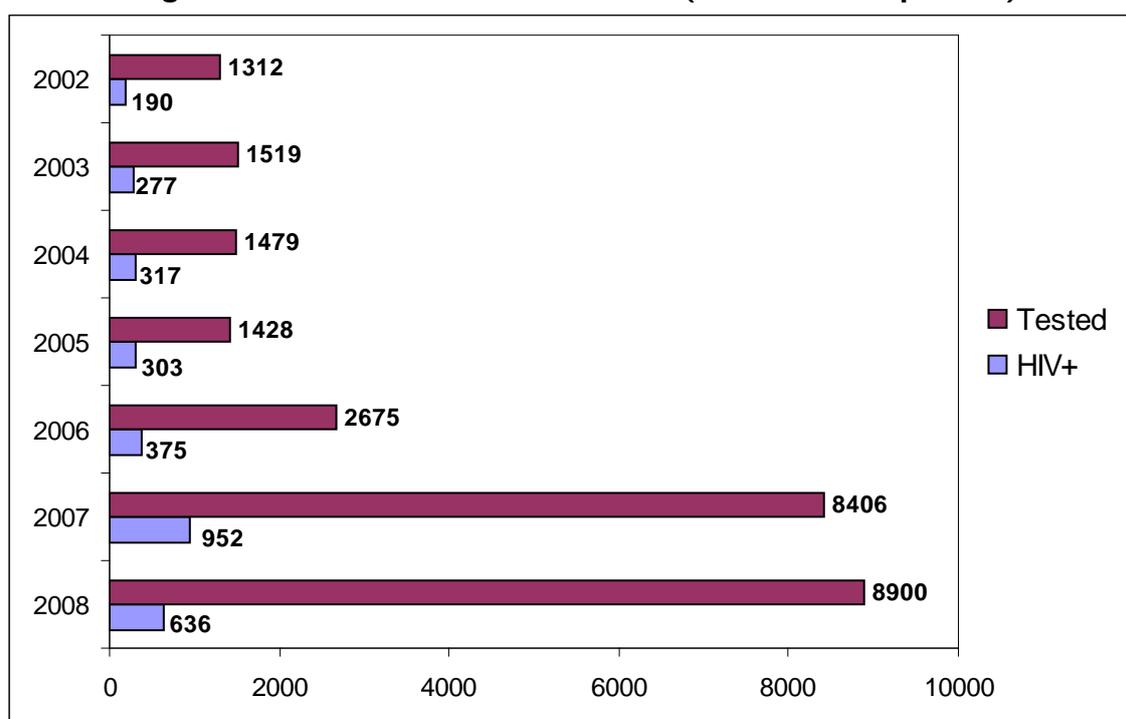
Source of Referral	TI		PPTCT/PHC		Private Clinic	
	Tested	Positive	Tested	Positive	Tested	Positive
Uttar Pradesh	2,067	135	5,613	66	475	4
Allahabad	280	3	255	1	0	0

**Table 13. Proportion of HIV-positive Cases in ICTCs
(in districts reporting positivity rates over 10 percent)**

No.	District	2002 (%)	2003 (%)	2004 (%)	2005 (%)	2006 (%)	2007 (%)	2008* (%)	Cumulative (%)
	Uttar Pradesh	12.19	9.86	8.23	9.5	11.01	7.21	4.9	7.13
1	Gorakhpur	45.21	55.56	25.85	25.71	18.35	17.38	21.48	20.26
2	Basti	28.10	31.25	26.44	21.00	17.05	16.02	5.63	15.29
3	Varanasi	12.63	7.48	7.72	13.61	20.79	18.69	15.81	14.74
4	Agra	27.96	25.64	18.20	15.76	16.72	14.67	10.50	14.37
5	Meerut	16.83	20.30	11.02	8.45	13.86	18.78	12.97	14.19
6	Allahabad	14.48	18.24	21.43	21.22	14.02	11.33	7.15	11.86
7	Siddharth Nagar	38.46	38.84	32.79	19.63	14.10	6.61	7.83	11.04
8	Faizabad	31.36	29.08	28.52	14.85	10.95	9.86	3.39	10.97
9	Lucknow	8.54	7.77	8.40	8.63	15.26	13.21	9.63	10.83
10	Maharajganj	NA	28.13	11.11	14.04	12.26	12.45	7.47	10.56
11	Azamgarh	23.36	16.36	14.67	10.87	14.98	12.77	5.34	10.00

*up to October 2008

Figure 3. Number of Individuals Tested (Total and HIV-positive)



Between 2002 and 2008, a total of 25,719 people were tested for HIV in Allahabad, of whom 3,050 tested positive. Figure 3 illustrates the number of people tested and the number of people found HIV-positive during this period.

Table 14. PPTCT Center Data (Jan–Dec 2008)

	Allahabad	Uttar Pradesh
Number of PPTCT centers	2	79
Number of people tested for HIV at PPTCT centers	7,718	218,785
Seropositivity	0.30	0.16%
Number of people counseled and tested per PPTCT center per month	57	308
Targets for testing in 2009–2010	44,770	474,202

Norms for licensed blood banks require that every unit of blood be tested for HIV before it is approved for transfusion. Consolidated data from Allahabad's seven blood banks (Table 15) show that between 2002 and 2008, 307 units of blood tested positive for HIV, 1,391 for Hepatitis B, 405 for Hepatitis C, and 494 for VDRL (syphilis) reactivity. Yearly data reveals that the number of HIV-positive units has increased progressively, from only three units in 2002 to 96 units in 2008. The number of blood units testing positive for Hepatitis B, Hepatitis C, and VDRL also increased.

Table 15. Test Results from Allahabad Blood Banks (2002–2008)

Year	Total Units	HIV-positive	Hep B	Hep C	VDRL
2002	18,599	3 (0.02%)	36 (0.19%)	16 (0.09%)	12 (0.06%)
2003	24,220	26 (0.11%)	150 (0.62%)	37 (0.15%)	38 (0.16%)
2004	21,092	18 (0.09%)	177 (0.84%)	22 (0.10%)	38 (0.18%)
2005	13,047	15 (0.11%)	113 (0.87%)	22 (0.17%)	25 (0.19%)
2006	24,619	81 (0.33%)	287 (1.17%)	91 (0.37%)	79 (0.32%)
2007	31,560	68 (0.22%)	348 (1.10%)	89 (0.28%)	220 (0.70%)
2008*	28,132	96 (0.34%)	280 (1.00%)	128 (0.45%)	82 (0.29%)

* up to November

The ART center is a third source of data on HIV prevalence in Allahabad. The center collects data on the number of people registered for HIV care and receiving ART, which is an excellent indicator of the district's HIV case load. The Allahabad ART center opened in October 2007. Government norms and regulations mandate that all people who test positive for HIV in the district be referred to the ART center to be registered as pre-ART cases. Comparison of ICTC data with data from the ART center reveals that only half of those who tested positive at ICTCs have been registered at the ART center. The ART center's records show a total of 1,264 HIV-positive individuals registered, 791 of whom have begun ART.

Table 16. ART Center Statistics

Name of ART center	Number of PLHIV			
	On ART	New	Died	Lost to follow-up
MLN, Allahabad	751	791	24	2
BHU, Varanasi	2,310	4,162	421	626
CSMMU, Lucknow	2,002	2,912	93	433
LLRM, Meerut	680	962	130	76
BRD, Gorakhpur	972	1,163	27	108
JLN, Aligarh	176	231	17	7

While the two data sets above illustrate the extent of the HIV epidemic in the district as a whole, membership statistics from the Allahabad Network of Positive People (ANP+) provide a detailed picture of the epidemic's presence in the district's various blocks.

Table 17. ANP+ and ART Statistics

ANP+ Clients Served, By Residence			ART Center data		
Location	No.	Percent	Month	Registered for HIV care	Receiving ART
Allahabad urban	76	22.0	Oct 07	36	0
Bahadurpur	35	10.1	Nov 07	60	0
Soraon	28	8.1	Dec 07	73	47
Phoolpur	25	7.2	Jan 08	92	67
Pratappur	25	7.2	Feb 08	88	87
Baharia	24	7.0	Mar 08	119	57
Hologarh	16	4.6	Apr 08	82	73
Dhanupur	15	4.3	May 08	125	102
Handia	14	4.1	Jun 08	106	85
Saidabad	12	3.5	July 08	100	57
Kaudihar	11	3.2	Aug 08	96	55
Chaka	10	2.9	Sept 08	102	47
Karchana	10	2.9	Oct 08	77	54
Kaundhiara	9	2.6	Nov 08	108	60
Manda	8	2.3	Total	1,264	791
Meja	8	2.3			
Mauaima	6	1.7			
Jasra	4	1.2			
Shankargarh	4	1.2			
Koraon	3	0.9			
Uruwa	2	0.6			
Total	345	100			

ANP+ has 424 PLHIV members (216 male, 165 female, and 43 children). Nearly one quarter of its members (22 percent) reside in urban Allahabad, 10 percent in Bahadurpur, 8 percent in Soraon, and 7 percent each in Phoolur, Pratappur, and Baharia. Since its founding, ANP+ has provided services to 532 people, of whom 187 are from outside the district.

Table 18. HIV/TB Activities (Jan–Oct 2008)

Index	Uttar Pradesh	Allahabad
Referred from ICTC to TB microscopy center	3,586	172
Referred from TB microscopy center to ICTC	6,016	178
Tested and found positive (percent)	15.5% (930)	23.0% (41)

Table 19. HIV-related Facilities At-a-Glance

	Allahabad		Uttar Pradesh	
	Existing	Target (2009–2010)	Existing	Target (2009–2010)
ICTCs	26	1	171	16
PPTCT centers	2	None	79	-
District hospitals (male)	1	None	7	5
Dist hospitals (female)	1	None	70	-
ART centers	1	None	69	-
Blood banks	7*	None	46	13
Blood storage units	-	None	20	11
STI clinics	2	None	79	2
TI STI clinics	4	None	91	3
Community care centers (CCCs)	1	None	9	1
Drop-in centers (DICs)	1	None	5**	-

* This includes private blood banks which have been provided license by UPSACS

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

FRAMEWORK FOR PROGRAM ACTIVITIES

District Health Society (DHS)

Under the NRHM framework, different national programs, such as the reproductive and child health program (RCH), malaria, TB, leprosy, and the national blindness control program, have been merged into a common State Health Society chaired by the Chief Minister of the state. Similarly, at the district level all program societies have been merged into the District Health Society (DHS). Government funds are allocated to the State Health Society and passed on to District Health Societies. The governing body of the DHS is chaired by the chairman of the *Zila Parishad*¹³//District Collector. The executive body is chaired by the District Collector. The Chief Medical and Health Officer (CMHO) is the member secretary of the DHS. Different programs operate through program-specific committees constituted at the state and district levels and maintain separate bank accounts at each level. After the requisite approvals, funds coming to the DHS are transferred to the bank accounts of individual program committees. This system ensures convergence, while maintaining the independence necessary to achieve program goals through specific interventions.

District officials from related departments supporting health, family welfare, and sanitation activities in the district are represented in the DHS. Issues of program implementation and convergence are discussed at a monthly meeting under the guidance of the District Collector.

The District AIDS Prevention and Control Unit (DAPCU) will be merged with the DHS. To sustain the program's current momentum and ensure continued focus on HIV/AIDS priorities, the state may direct that the DHS convene separate meetings dedicated to monitoring implementation of NACP activities.

3.1 District AIDS Prevention and Control Committee (DAPCC)

Analogous to the district program committees for all national programs under the NRHM framework, the DAPCC will be constituted for effective ownership, implementation, supervision, and mainstreaming of NACP activities at the district level. The DAPCC will oversee the planning and monitoring of activities outlined in the DAP. It will ensure appropriate management of DAPCU funds. Ideally, the DAPCC should not have more than 20 members. A recommended DAPCC membership list is given below. Within the parameters of this broad structure, states may add further persons as special invitees.

- (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 (NRHM)
- (6) District-level officers for TB and reproductive and child health (RCH)
- (7) District Information, Education, and Communication (IEC) officer
- (8) Monitoring and Evaluation (M&E) officer
- (9) Medical Officers in rotation, with one each responsible for ICT, ART, and CCC (*three*)
- (10) One representative each of TIs, CCCs, and PLHIV networks (*three*)
- (11) Representatives of related departments identified by DAPCU for convergence (Women Empowerment and Child Development, Panchayati Raj Institutions (PRIs), Labor, Mines, Tribal, Industry, Tourism, Urban Local Bodies, etc.) (*five*)

¹³ District Council

3.2 District AIDS Prevention and Control Unit (DAPCU)

The District AIDS Prevention and Control Unit (DAPCU), also called the District Program Management Unit (DPMU) or the District AIDS Cell, will be the secretariat and the central coordinating unit for day-to-day program operations. In keeping with state government regulations, a nodal officer for the AIDS prevention and control program at the district level may be appointed from among the following: the Additional District Medical Officer, the Deputy CMHO (Health), and the District Leprosy Officer. 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 Allahabad. He or she will be central to framing and implementing the district-level strategy for prevention and control of HIV. The DACO will help the district administration carry out a unified action plan for stabilizing and reversing the HIV/AIDS epidemic in Allahabad by building convergence within the health and family welfare sector, as well as with various other stakeholders in the district. The DACO will ensure the continuity of the supply chain, service delivery, and implementation of UPSACS directives.

The DAPCU is headed by the District Program Manager for HIV/AIDS (DAPM), who reports to the DACO. The role of the District Program Manager will be similar to the role of the District Program Management Unit for NRHM activities. The proposed DAPCU would have the following institutional structure:

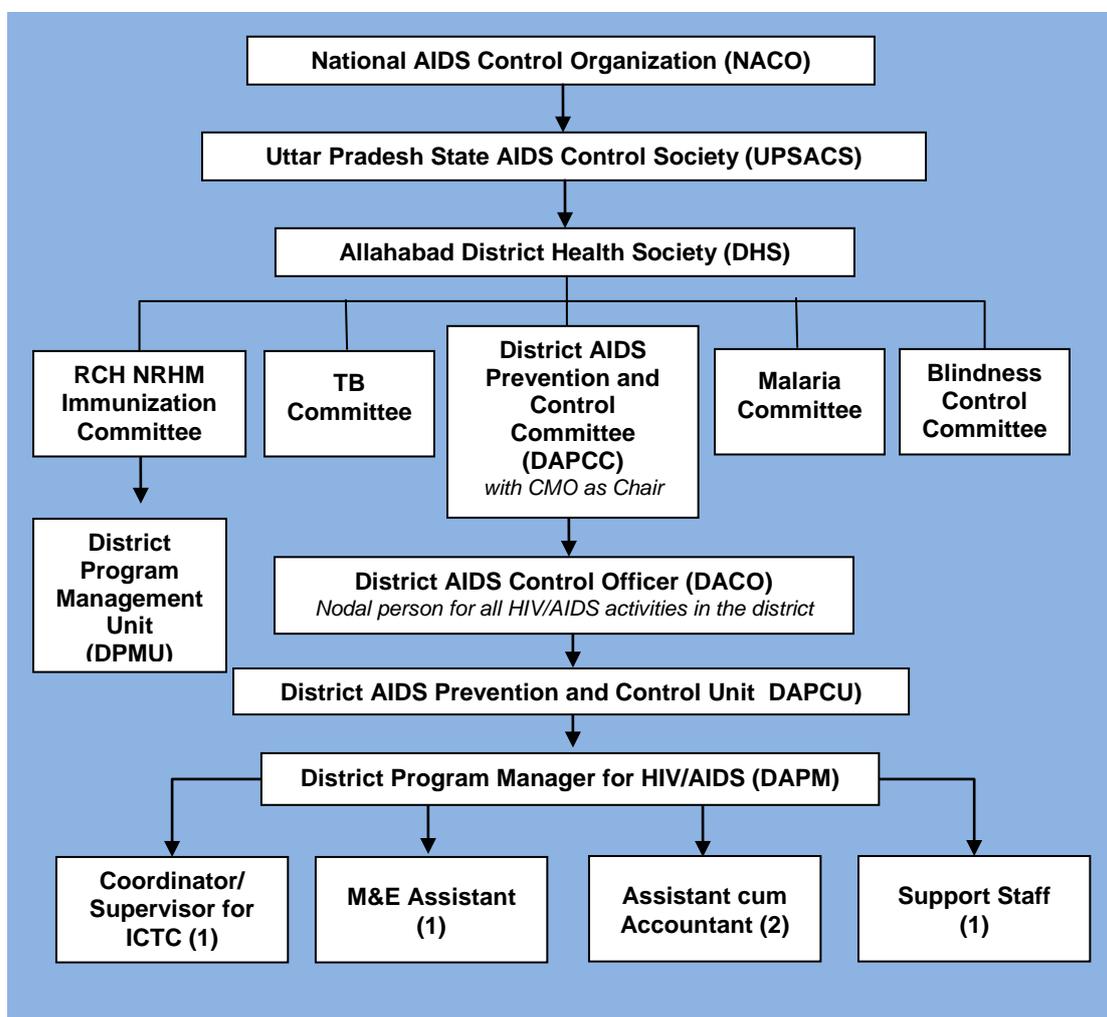


Table 20. DAPCU Roles and Responsibilities

Area	Specific Responsibilities
Implementation of NACP-III Strategies	<ul style="list-style-type: none"> ○ Monitor and implement core components of program activities covering prevention, treatment, care, and mitigation. ○ 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 the District Coordination Committee and UPSACS on progress and program activities.
Convergence with NRHM activities	<ul style="list-style-type: none"> ○ Coordinate convergence of district HIV/AIDS program activities with NRHM activities.
Convergence with NRHM activities	<ul style="list-style-type: none"> ○ Coordinate convergence of district HIV/AIDS program activities with other related departments.

DAPCU staff are appointed on a deputation/contract basis. The selection of staff will be made by the SACS/DHS in accordance with state-specific policies. Terms of reference for DAPCU staff are listed in section 7.4 of this document, on page 48.

PURPOSE OF THE PLAN

The DAP is the key to effectively decentralizing implementation of the HIV/AIDS control program. NACP-III envisions expanding 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.

Vision

The vision of the Allahabad District AIDS Action Plan is to create and implement a multifaceted, sustainable strategy that will enable the district to achieve the NACP-III goal of halting and reversing the AIDS epidemic by 2012. The DAP will achieve this goal by effectively managing core NACP interventions and expanding outreach services through mainstreaming activities with NRHM and its associated departments.

Goal

The goal of the Allahabad DAP is to outline and implement a comprehensive multisectoral program to reduce the incidence of new HIV cases to zero. This goal will be achieved by carrying out effective prevention strategies, providing accessible testing, and ensuring that PLHIV have access to treatment, care, and support services free from stigma and discrimination.

Strategy

The main strategy of this plan is the expansion of HIV services through convergence with the public health infrastructure. The new approach will emphasize decentralization of services, mainstreaming, multisectoral collaboration, and community ownership and support for HIV/AIDS prevention and control efforts. It envisions a unified strategy under the leadership of the District Collector, harmonizing efforts to achieve maximum impact and use available resources effectively. From the district, the program will filter down to every village and *anganwadi* through a cadre of customized service providers called “link workers” (LWs). The DAPCU will ensure professional management of the program through regular monitoring and supervision.

INSTITUTIONAL STRENGTHENING FOR CORE ACTIVITIES

5.1 Targeted Intervention (TI)

Objective

To support and mainstream targeted intervention projects to achieve greater effectiveness and sustainability.

Situation Analysis

The specific objectives of NACP-III in Uttar Pradesh¹⁴ are to reduce the estimated number of new HIV infections in the state by 60 percent in the first year in high prevalence districts and by 40 percent in vulnerable districts. Achieving these objectives would mark a significant reversal of the HIV epidemic in the state. NACP-III recognizes the need for a comprehensive package of graded services covering the entire population of the district, rather than the focused approach adopted in the earlier phases of NACP. Four broad service areas have been identified as follows:

- Saturating coverage of three high-risk groups: FSWs and their clients, IDU, and MSM;
- Expanding coverage of two bridge populations (truckers and migrant workers);
- Preventing HIV among highly vulnerable populations: women, youth, and children; and
- Preventing HIV among the general population through a multisectoral response and mainstreaming.

TI projects for truckers and FSWs were initiated in Allahabad in 2001. As of 2008, there are four TI projects operating in the district. The project implemented by SWARG focuses specifically on MSM, that of Sarvajan Kalyan Samiti on FSWs, and Lok Smriti Seva Sansthan on IDUs. All four projects work in urban areas. If we compare the percentage of HRGs covered through these projects, we see that coverage of HRGs in Allahabad's urban areas has yet to reach the saturation point. Jila Yuva Kalyan Samiti operates in the outskirts of Allahabad municipality and in rural areas. The project covers a target population of 500 through a composite¹⁵ intervention. The National Highways Authority is also in the process of launching a truckers' intervention.

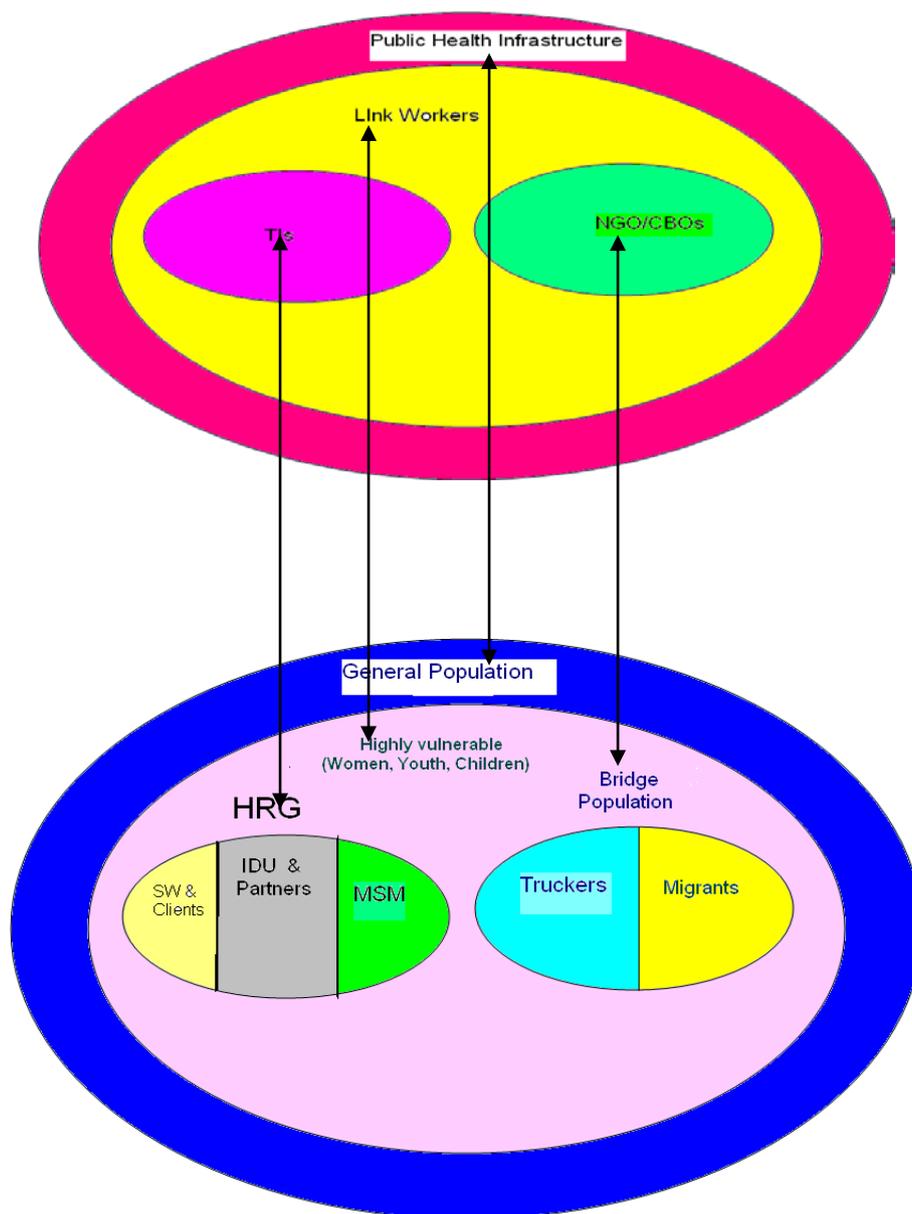
Table 21. Trends in Coverage of HRGs

HRG		2001 Mapping	2008 Mapping	Number Covered	Percent Covered	2008 Rural Mapping
FSW	Sites	6	16	NA	NA	93
	Total	354	635	500	78.74	569–813
MSM	Sites	7	21	NA	NA	43
	Total	28	825	750	90.91	325–482
IDU	Sites	7	37	NA	NA	20
	Total	39	725	500	68.97	80–114
Hijra	Sites	1	4	NA	NA	NA
	Total	10	100	NA	NA	NA
Truckers	Sites	12	NA	NA	NA	NA
	Total	2,700	NA	NA	NA	NA

¹⁴ Uttar Pradesh PIP for National AIDS Control Program Phase 3, UPSACS, Lucknow, May 2008 version

¹⁵ 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.

Figure 4. Population Mapping for Targeting Service Provision¹⁶



TI implementers noted that HRG-specific IEC material is not currently available. According to the UPSACS program implementation plan, safe needles and syringes will be provided for an effective harm reduction strategy involving the IDU population. In addition, substitution therapy, including Methadone and Buprenorphine, will be adopted as appropriate. However, substitution therapy has not yet been initiated in Allahabad. As of now, the needle exchange program is able to meet only 60 percent of the actual need, which is not sufficient for effective execution of the program.

There are no coordination mechanisms or capacity building systems to support TI implementing agencies in the district. The partners themselves organize some informal meetings and discuss issues related to TI project implementation. On average, four one-day training programs are organized during the year for TI implementers.

¹⁶ Operational guidelines for Districts AIDS Prevention Control Units

Strategies

- Mainstream TI projects with public health delivery system for supplies, service delivery, and follow-up.
- Establish effective linkages between TIs and local self-governing bodies to increase accessibility of services.

Action Plan

- Increase coverage of three existing TI projects or initiate new projects in Allahabad's urban areas to achieve 100 percent saturation of HRGs.
- Reduce time period between contracting and transferring funds to TI partners.
- Reach out to HRGs in rural areas through link workers scheme.
- Initiate substitution therapy in IDU interventions.
- Increase coverage of needle exchange programs from 60 percent to 80 percent and make appropriate budgetary allocations to TI implementing partners.
- Prepare and distribute HRG-specific IEC material to TI projects.
- Route supply of condoms and IEC material to TI implementers from UPSACS through DAPCU.
- Create enabling environment for TI projects to function by sensitizing all gatekeepers in Allahabad, including police personnel, health care workers, and administrators.
- Include TI representatives in DAPCU and DHS.
- Institute formal system of monthly interactions with the Officer-in-Charge of ICT/PPTCT in TI projects' areas of operation.
- Ensure that TI projects' management information system (MIS) reports to UPSACS are shared with DAPCU.
- Initiate community collectivization activities of HRGs in all TI projects and increase participation of community members in project implementation.
- Mentor and monitor TIs to achieve 100 percent condom use, testing at ICTCs, and access to STI services.

Responsibility

DAPCU and TIs

5.2 Antiretroviral Therapy (ART) / Treatment

Objective

To make ART services available to all eligible PLHIV in Allahabad.

Situation Analysis

The ART center at Motilal Nehru Medical College Hospital became operational in October 2007. By the end of November 2008, a total of 1,264 PLHIV had been registered at the center. About 213 cases were transferred to the hospital from the Varanasi ART center, in addition to 56 cases from Lucknow, and 41 cases from private providers. The number of people registered at the Allahabad ART center is only 42 percent of the cumulative number of people who havetested HIV-positive in the district through November 2008. Analyzing data on the places of residence of 729 PLHIV on ART, reveals that 404 PLHIV in treatment reside in Allahabad, 149 in Pratapgar, 45 in Kaushambi, and 21 each in Fatehpur and Jaunpur. The remaining PLHIV come from the other 19 districts in UP and from the Amaliya and Rewa Districts of Madhya Pradesh. On average, about 90 new patients begin ART each month at the Allahabad center. If this trend continues, there will be a need to establish link ART centers in Allahabad, Pratapgar, and Kaushambi in the near future.

Figure 5. Number of PLHIV Registered and Receiving ART (Motilal Nehru Medical College)

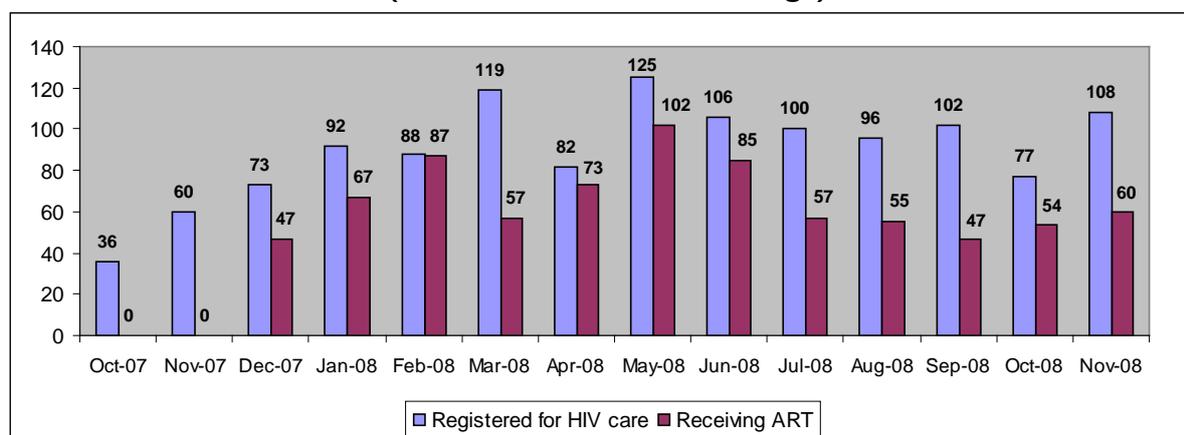


Figure 5 shows that about 63 percent of registered cases (791 people) have been initiated on ART. Analysis of the gender distribution of patients registered at the ART center shows that, while there is no significant disparity in the number of male and female adults registered for ART, significantly more males than females have actually initiated treatment. Among children, more than twice as many male as female children have registered for ART and more than twice as many male children have initiated ART (Table 22).

Table 22. ART Registration and Treatment with Gender Differentiation

Indicator	Adults			Children (<15 years)		Total
	Male	Female	TS/TG	Male	Female	
Cumulative number of people registered for HIV care (as of November 30, 2008)	596	556	1	80	31	1,264
Cumulative number of patients ever started on ART (as of November 30, 2008)	455	297	0	27	12	791
Percentage of registered individuals who have initiated ART	76.3%	53.4%	0.00%	33.8%	38.7%	62.6%

Even though the medical college hospital has provided sufficient space (three rooms) for the ART center, renovations have not been undertaken to make optimal use of the space. The telephone and internet connections are located in the nodal officer's chamber, rather than in the center itself. All center staff share a single room, which compromises patient privacy and confidentiality. There are currently three vacant staff positions at the center; second counselor, care coordinator, and pharmacist. The outreach workers of ANP+ and the CCC are assisting the ART center, as well as helping PLHIV access other services.

The center offers CD4 tests twice a week. The center has reported only two cases lost to follow-up. There have been 24 deaths reported to date among PLHIV registered at the ART center. The pre-ART counseling process should include preparing clients for the need to be admitted to the CCC, as many clients are unaware of the need to be admitted and are therefore unprepared.

Strategies

- Strengthen the district's ART center.
- Promote counseling for ART compliance.
- Map all eligible adult and child PLHIV in Allahabad and register them at ART center.
- Systematically monitor ART adherence.
- Ensure timely supply of ART drugs to avoid drug shortages at ART center.

Action Plan

- Complete renovation and furnishing of ART center as soon as possible.
- Provide adequate semi-enclosed space that offers privacy and confidentiality during counseling sessions.
- Segregate blood collection space for CD4 testing in ART center.
- Explore possibility of expanding ART services to district hospital to handle increasing number need for ART.
- Establish link ART centers in Allahabad, as well as in Pratapgar and Kaushambi.
- Assume responsibility for administration of ART center (nodal officer for ART).
- Establish linkages between ART center and ICTCs and CCC for care and support services.
- Update registration and tracking of PLHIV on ART.
- Map eligible PLHIV through LWs, NGOs, outreach workers, and ANP+.
- Provide orientation on tracking PLHIV to monitor treatment adherence to health staff, outreach workers, and PLHIV networks in districts that send patients to Allahabad for ART.
- Provide need-based training for ART center team members periodically.
- Establish Allahabad ART center as a model of high-quality service delivery so that it serves as a learning site in UP.

Responsibility

CMO/Medical Officer-in-Charge (MOIC), Health (NRHM); UPSACS; DAPCU; NGOs

5.3 Integrated Counseling and Testing (ICT)

Objective

The objective of setting up Integrated Counseling and Testing Centers (ICTCs) is to provide HIV counseling and testing services, to prevent HIV transmission, and to promote positive living among PLHIV.

Situation Analysis

In NACP-III, three types of ICTC are visualized by UPSACS; general ICTC, general ICTC plus PPTCT, and HIV-TB ICTC. In 2008, the number of ICTCs was increased from five to 19, of which two (at the district women's hospital and at SRN Medical College) are general plus PPTCT. ICTC facilities are also now available at 13 CHCs (Handia, Phulpur, Soraon, Chaka, Kaundhiyara, Jasra, Shankergarh, Kerchana, Meja, Ramnagar, Manda, Koraon, and Harakpur). Counselors and lab technicians have been appointed at the newly-established ICTCs in these CHCs, but they have not yet been trained.

Table 23. 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)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
2004	833	401	1,234	994	485	1,479	210	107	317
2005	1,057	425	1,482	1,028	412	1,440	199	104	303
2006	1,983	974	2,957	1,887	788	2,675	231	149	380
2007	4,769	3,018	7,787	4,245	2,788	7,033	543	366	909
2008	9,397	7,234	16,631	7,165	5,758	12,923	435	346	781

Source: UPSACS

Table 24. Number of People Tested for HIV in Allahabad

Year	Number tested
2002	1,312
2003	1,519
2004	1,479
2005	1,428
2006	2,675
2007	8,406
2008	8,900

The number of people being tested for HIV in Allahabad has increased fourfold in the last two years. This is an important achievement, as increasing testing rates is a critical element of strengthening the district's HIV response.

Allahabad has experienced a shortage of tri-dots test kits in since July 2008. As a result, the reactive samples for bi-dots and comp aid tests are being sent to SRN Medical College for confirmation or clients are being referred directly to the ICTC at SRN Medical College. There is a major problem in the supply chain management of test kits in the district. For the past year, lab technicians have had to go to UPSACS to procure the necessary test kits for each of the ICTCs.

The infrastructure of the five ICTCs located in municipal areas (two at medical colleges and one each at Kamal Nehru, Colvin, and Duffrin hospitals) offers confidentiality. The centers themselves are strategically located within their respective facilities hospital. However, infrastructure at the new CHC-level ICTCs urgently requires upgrading.

Table 25. PPTCT Status (January–December 2008)

	Number of Clients who Received Counseling	Number of Clients Tested for HIV	Number of Clients Found HIV-positive
Jan	655	627	2
Feb	702	571	4
Mar	700	679	4
Apr	316	257	0
May	266	194	1
June	575	507	3
July	983	428	1
Aug	782	778	2
Sept	841	745	3
Oct	840	665	0
Nov	1,339	1,042	0
Dec	1,253	1,223	3
Total	9,252	7,716	23

Source: UPSACS

ICTCs in rural areas report that, on average, 10 people come to the ICTC each day, of whom 60 percent are female and 40 percent are male. Each month, four or five HIV cases are typically detected per ICTC. Among individuals who come for testing, 80 percent return to collect their test results and access follow-up services. Only one quarter of those who sought ICT services did so on their own initiative, without being referred by another provider or facility. Monitoring of service quality and standards in rural ICTCs is generally poor. Administrative procedures regularly delay the supply of testing kits and payment of ICTC staff salaries. The lack of internet facilities in ICTCs negatively affects reporting and MIS management.

Strategies

- Pursue convergence with NRHM and public health department to achieve optimal use of resources as ICTCs are established at CHC level.
- Overcome bottlenecks to eliminate delays and stockouts.
- Carry out inventory control and quality checks at district level.
- Strengthen monitoring of ICTCs .

Action Plan

- Improve ICTC infrastructure and publicize availability of ICTC services at CHC level to expand access, ensure prevention, and encourage positive living.
- Establish ICTC services at district's two major private sector hospitals (Jeevan Jyoti and Nazareth hospitals).
- Organize training program for all counselors and laboratory technicians in Allahabad.
- Organize refresher training program for staff of pre-2008 ICTCs.
- Generate demand for ICTC through targeted IEC program.

- Strengthen linkage between ICTCs and TB, PPTCT, STI, ART, care, and support services, and with mainstreaming departments.
- Establish system for regular technical supportive supervision by District ICT Supervisor.
- Develop and strengthen referral protocol between DOTS and ICTCs.
- Eliminate delays in salary payment and ensure timely transfer of advance funds from UPSACS to DAPCU.
- Increase number of counselors to two (one male and one female) in centers with high case loads.
- Assign link worker to ICTCs in rural areas to provide follow-up services and other community outreach work.
- Conduct regular monitoring visits for quality assurance (DACO and UPSACS).
- Prepare annual plans with targets for each ICTC in a participatory manner.
- Translate consent forms into Hindi to increase transparency.

Responsibility

DAPCC, DAPCU, ICTCS, UPSACS, NGOs

5.4 Blood Safety

Objective

The objective of the blood safety program is to reduce the transmission of HIV through blood and blood products and to ensure the timely availability of safe blood and blood products to patients and health institutions, especially first referral units (FRUs) and facilities in remote and rural areas, by enhancing safe blood collection and storage in the district.

Situation Analysis

During NACP-III, UPSACS aims to reduce the transmission of HIV infection through blood and blood products to less than 0.3 percent and increase the availability of safe blood and blood products by enhancing blood collection and storage. To this end, four blood storage centers will be established at CHC-level in each district. These centers will be established in a phased manner and will be linked with districts' blood banks. UPSACS also aims to establish 17 blood component separation centers at the divisional level. Literature on the appropriate use of blood and blood products will be distributed to health care providers in the government and private sectors, especially surgeons, obstetricians, orthopedic surgeons, and specialists working at trauma centers. More replacement donors will be counseled and encouraged to become voluntary donors. Voluntary blood donation camps and coordinated behavior change communication (BCC) campaigns will be regularly conducted to gradually increase voluntary blood donation. UPSACS also aims to develop built-in systems to ensure the quality of blood-related services, promote injection safety, and reduce the number of hospital-acquired infections.

Access to safe blood is mandated by law and is the primary responsibility of NACO. An area's blood requirement is generally estimated to equal one percent of its population. Therefore, Allahabad, with a population of 4.9 *lakhs*, will require approximately 49,000 units of blood every year. However, the total supply of blood collected in the district in 2006, 2007, and 2008 was only 24,619; 31,560; and 28,132, respectively—little more than half the amount needed (Table 26).

Table 26. Blood Collection in Allahabad (Voluntary and Replacement)

Year	District Hospital		MLN MC		Military		Private		Total				Grand Total
	Vol.	Rep.	Vol.	Rep.	Vol.	Rep.	Vol.	Rep.	Vol.	Percent	Rep.	Percent	
2002	28	106	22	6,638	128	66	8,523	3,088	8,701	46.8	9,898	53.2	18,599
2003	13	236	20	2,058	208	135	10,613	10,937	10,854	44.8	13,366	55.2	24,220
2004	165	623	48	2,685	199	102	7,665	9,605	8,077	38.3	13,015	61.7	21,092
2005	6	148	5	1,918	80	48	4,211	6,631	4,302	33.0	8,745	67.0	13,047
2006	66	338	84	1,246	156	52	6,088	16,589	6,394	26.0	18,225	74.0	24,619
2007	58	343	46	1,876	118	36	4,954	24,129	5,176	16.4	26,384	83.6	31,560
2008	35	344	21	5,789	247	52	5,484	16,160	5,787	20.6	22,345	79.4	28,132

There are currently seven blood banks (three public and four private) in Allahabad, all of which are located in urban areas. As a result, the shortage of blood is particularly acute in Allahabad's rural areas. There is also no facility for blood storage at FRU level. The public sector blood banks are located in the district hospital (Colvin), MLN Medical College, and the military hospital. The private

sector blood banks are managed by the Allahabad Medical Association, Sanjeevani Hospital, S. M. Medicare Pvt., and Ltd. Indira Diagnostic Center.

The majority (92 percent in 2007) of Allahabad's blood supply is currently being provided by the four private blood banks. The contribution of government blood banks is miniscule in comparison. Among sources of blood collection, the quantity of voluntary blood donations is far less than replacement donor contributions in both government and private blood banks. In 2007, voluntary donors accounted for only 16.4 percent of total blood donations in the district. In 2008, the share of voluntary blood donations rose slightly, to 20.6 percent of total donations. UPSACS aims to achieve an 80 percent increase in voluntary blood donation under NACP-III. In Allahabad, UPSACS will strengthen two blood banks and establish a new blood component separation unit.

Blood supplies can be used more effectively if donated units are divided into components (such as red cell and plasma concentrates). In this way, a single unit of donated blood can meet the needs of multiple patients. NACP-III aims to have 60 percent of all blood units collected undergo blood component processing. Currently, blood component separation facilities are only available in one government and one private blood bank in Allahabad.

Strategies

- Strengthen district's blood bank and blood storage unit infrastructure through inputs from UPSACS and NRHM.
- Promote blood donation to maintain blood supply levels in correspondence with district needs.
- Augment voluntary blood donation by establishing structured blood donation program.
- License all blood banks and strengthen safety protocols in both public and private blood banks.
- Ensure compliance with quality assurance standards.
- Build capacity of doctors and paramedics to ensure blood safety.
- Institute supervisory system for public and private blood banks and blood storage units at district level through DACO, including blood supply, data sharing, and compliance with quality standards.
- Promote good blood safety practices.
- Increase availability of safe blood in rural areas.
- Establish fixed schedule for supplying blood to blood storage centers.

Action Plan

- Geographically map blood banks and blood storage units to streamline collection, supply, and storage of blood.
- Establish four blood storage units at CHC level and link them with blood banks. Expand blood component separation facilities at government blood banks and encourage use of component transfusion.
- Establish blood storage facility at FRU level based on NACO guidelines.
- Appoint DACO as nodal officer for blood safety. DACO will ensure convergence of public health, UPSACS, and DHS blood-related interventions at district level and will conduct monthly review visits to district blood banks.
- Train blood bank medical officers and staff in accordance with NRHM and NACP protocols.
- Ensure constant supply of equipment and consumables through NRHM and NACP.
- Emphasize quality assurance by creating external assurance team based at medical college.
- Carry out a study of people's perceptions toward voluntary blood donation and safe blood transmission in both rural and urban areas.

- Collaborate with various stakeholders, such as Red Cross, National Student Service (NSS), and Nehru Yuva Kendra (NYK), to raise awareness of lifesaving role of safe blood and organize voluntary blood donation camps to double blood donations.
- Institute yearly award for organization that mobilizes the most blood donations and for donor who donates the most blood.

Responsibility

Nodal officer (DACO)

5.5 Care and Support

Together with prevention, expanding care, support, and treatment has been shown to reduce AIDS-related mortality, as well as stigma, discrimination, and poverty.

Objective

The objective of the care and support program is to increase adherence to ART and to provide home- and community-based care and support services to PLHIV.

Situation Analysis

In July 2008, a 10 bed CCC was established in Allahabad with technical and financial support from the Hindustan Latex Family Planning Promotion Trust, through the PACT project. The Umang CCC is managed by an NGO, SWARG. With the introduction of ART into their menu of services, CCCs now have a critical role to play in helping PLHIV gain access to ART and counseling on primary prevention, nutrition, drug adherence, and other related topics. The Allahabad CCC will be linked to ART center and will act as a bridge between the ART center and PLHIV. The CCC will ensure that all patients receive counseling before initiating ART and/or follow-up counseling through a community-level outreach worker. In the last five months, 877 people (437 males and 440 females) have accessed CCC services in Allahabad. The district's CCC currently has excess capacity that is not being used.

Apart from the CCC, another organization, the Society of Under-privileged People (SOUP), is also providing care and support services to PLHIV with support from the Evangelical Fellowship of the India Commission on Relief (EFICOR). Services provided by SOUP include psychosocial support, home-based care, support for testing and treatment, and a residential facility for women and children in need. Overall, SOUP has supported approximately 100 PLHIV from Allahabad and neighboring districts and the organization is currently supporting 40 PLHIV.

Table 27. Services Provided by ANP+

Referral Services							
Month	ART	VCT ¹⁷	PPTCT	Private Providers	Others	Total	Counseling
April 2007	10	16	2	5	7	40	59
May 2007	9	15	1	6	13	44	62
Jun 2007	26	7	1	6	4	44	85
Jul 2007	15	5	0	8	9	37	73
Aug 2007	8	4	0	8	8	28	76
Sep 2007	6	7	0	7	7	27	70
Oct 2007	6	6	1	0	5	18	40
Nov 2007	16	10	0	1	9	36	49
Dec 2007	16	8	1	1	11	37	25
Jan 2008	22	4	0	0	0	26	51
Feb 2008	12	10	0	0	3	25	42
Mar 2008	13	6	1	0	6	26	35

ANP+, which was formally established in October 2007, is managing a drop-in center (DIC) with support from UPSACS and is one of the implementing partners under the GFATM¹⁸-supported PACT

¹⁷ Voluntary counseling and testing

project. Services provided by ANP+ include PLHIV networking in Allahabad and beyond, peer counseling, linkages with other health and development facilities, advocacy, and awareness raising programs.

ANP+ has provided around 32 PLHIV with referral services and 56 PLHIV with peer counseling services. The network also organizes regular support group meetings. In addition, the outreach workers of ANP+ and the CCC are providing supportive assistance at ART centers. While PLHIV from all 20 blocks of Allahabad have accessed ANP+ services, most of the network's activities are based at their center. There is a need to expand services to the block level.

During the consultative meetings held as part of the DAP preparation process, representatives of ANP+ reported difficulties in accessing medical services at the government hospital. In most instances, PLHIV have been referred to the medical ward of the SRN Medical College, a tertiary hospital that sometimes cannot cater to minor illnesses. Current referral linkages to the district hospital and other public health systems are not effective.

Strategies

- Develop CCC as a link between PLHIV and ART center.
- Increase access to ART and OI treatment and other psychosocial services.
- Establish links with TI projects and use them to supplement CCC programs.

Action Plan

- Refer all people initiated on ART to CCCs for drug adherence counseling and monitoring for side effects.
- Advertise CCC's OI services to increase utilization of OI services by PLHIV.
- Scale up ANP+ services at block level beginning with five blocks (Bahadurpur, Soraon, Phoolpur, Pratappur, and Baharia) where highest number of PLHIV have received services.
- Organize monthly coordination meetings between ART center, CCC, ANP+, and TI implementers to track patients lost to follow-up and conduct outreach to all patients on ART to ensure 100 percent treatment adherence.
- Divide outreach areas between CCC and ANP+ so lost to follow-up cases can be successfully tracked.
- Establish systems to enhance effective coordination between link workers scheme and CCC.
- Organize capacity building programs for ANP+ members to keep them up-to-date about changes in service delivery.

Responsibility

DAPCU, CCC, ANP+ ART Center

¹⁸ Global Fund to Fight AIDS, Tuberculosis and Malaria

5.6 Supplies and Logistics

Objective

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

Situation Analysis

With the scale-up from five to 17 ICTCs in Allahabad in 2008, the number of HIV tests being performed annually should rise from the 2007 level of 8,900 to about 15,000 in 2009. Hence, there is a need for more test kits and consumables at ICTCs. The district is already experiencing a shortage of rapid test kits, which is seriously affecting ICTCs' ability to provide services.

In the area of targeted intervention, there is a need to increase TI projects' coverage of IDUs from its current level (60 percent) to achieve 80 percent coverage. Effective implementation of TI projects also requires the design and distribution of HRG-specific IEC material, especially take-away material and kits for peer educators.

The logistics supply chain from UPSACS to the district level needs to be streamlined through the DAPCU. Currently, SDPs make requests directly to UPSACS and in most cases supplies have to be collected from the UPSACS office in Lucknow, which means being absent from the center and often means paying travel expenses out of their own pockets. During discussions with ICTC personnel, they reported delays of two to three months in procuring supplies, including syringes and test kits. This affects ICTC service delivery and many people have been denied high-quality services as a result of such delays. With the introduction of the DAPCU, SDPs will assess their supply needs on a quarterly basis and the DAPCU will obtain the 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 negatively affects report preparation and MIS maintenance.

Table 28. Supply Needs by Service Delivery Point

Service Delivery Points	Estimated Supply Requirements (2009–2010)
17 ICTCs	<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
TI projects	<ul style="list-style-type: none"> • Disposable needles for 80 percent coverage of IDUs in TI projects • Condoms and lubricants • HRG-specific IEC material, especially take-away material and BCC kits for peer educators
Blood banks	<ul style="list-style-type: none"> • Test kits for HIV, HBSAG (hepatitis B), HCV (Hepatitis C), MP, and syphilis (VDRL) • Blood bags, disposable syringes, and other consumables • IEC materials
ART center	<ul style="list-style-type: none"> • ART drugs for 60 new cases each month • ART drugs for cumulative number of people on ART • Disposables and reagents for CD4 count • PEP drugs

Strategies

- Pursue convergence with NRHM and public health department to achieve optimal utilization of resources.
- Eliminate bottlenecks to avoid delays and stockouts.
- Institute inventory control and quality assurance procedures.

Action Plan

- Designate DAPCU Supervisor as supply officer for NACP activities.
- Collect supply requirements quarterly from district hospital, ICTCs, PPTCT centers, blood banks, blood storage units, TI projects, ART centers, DICs, CCCs, and nodal link workers.
- Compile supply requirements and develop systematic inventory controls in consultation with CMO.
- Use NRHM logistics system for supply procurement and delivery.
- Liaise with UPSACS to ensure timely receipt of goods/supplies.
- In case of stockout, arrange replenishment of supplies from parallel health interventions wherever possible.

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 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 auxiliary nurse midwives (ANMs), accredited social health activists (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 throughout 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 that will achieve greater ownership among communities 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.

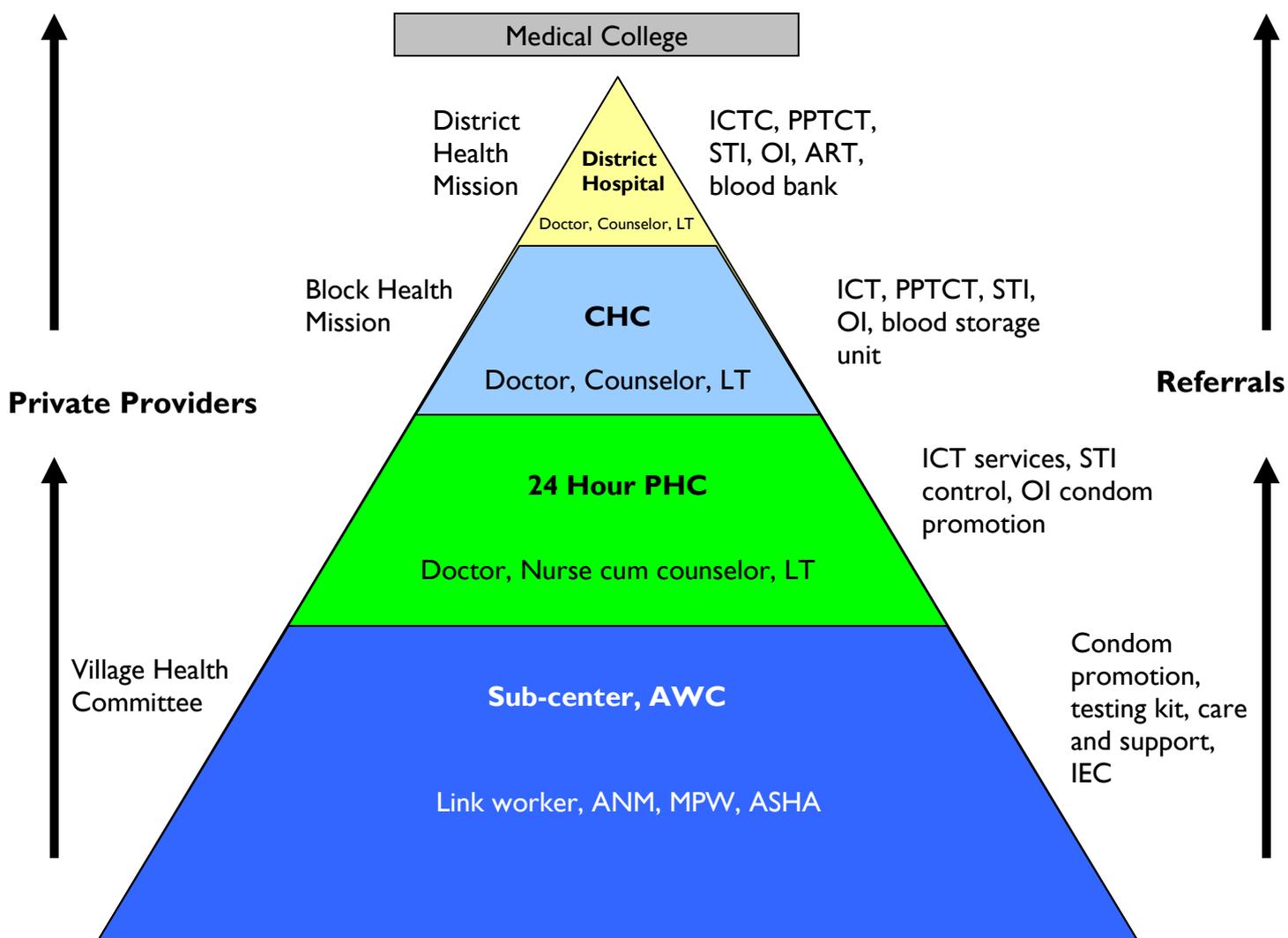
Situation Analysis

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 currently 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 Allahabad DHS within the NRHM framework, while retaining autonomy of operations through DAPCC structure.
- Upgrade district-level technical capacity through creation of DAPCU manned by professionals either on deputation or engaged through contracts.
- Create cadre of link workers to focus on HRGs.
- Mainstream program activities through existing cadre of health workers, including ANMs, MPWs, and ASHAs.
- Strengthen service delivery by integrating with CHCs, BPHCs, PHCs, and sub-centers.
- Include HIV/AIDS prevention, control, care, treatment, and support agenda in Village Health Plan, Block Health Plan, and District Health Plan; which are implemented by Village Health and Sanitation Committee, Block Rural Health Mission, and District Health Mission, respectively.
- Expand counseling, advocacy, and testing services at village level through Maternal and Child Health and Nutrition (MCHN) days.

Figure 6. Institutional Framework: Public Health Sector Services



6.1 Condom Promotion

Objective

The objective of the condom promotion program in Allahabad is to reduce sexual transmission of HIV through condom promotion.

Situation Analysis

NACP-III proposes to increase the supply of condoms, while simultaneously improving access and implementing social marketing initiatives. In order to increase access to condoms, especially among marginalized groups and in challenging areas, the UPSACS 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 rationally forecasting needs and improving procurement processes.

The TI projects have mapped existing HRG hotspots, and condoms are available in various outlets in these places. Needs assessments of FSWs and MSM in Allahabad estimate that consistent condom use among FSWs is only 40 percent and 9 percent, respectively, despite the fact that condoms are freely available at ICTCs, ART centers, ANP+, and CCCs. Commercial brand condoms are also available at

pharmacies and 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 are quite low in rural areas. There are no condom vending machines in the Allahabad.

Strategies

- Promote safer sexual practices among PLHIV.
- Carry out IEC campaigns to promote dual protection message.
- Institute collaborative condom promotion and supply strategy under NRHM and NACP.
- Promote condom usage among PLHIV.
- Ensure free and regular supply of condoms to HRGs.
- Promote condoms through social marketing and link workers in rural areas.
- Build capacity of link workers, outreach workers, and other health staff to demonstrate correct and consistent condom use.

Action Plan

- Ensure availability of condoms at hotspots, STI clinics, and DICs.
- Introduce condom vending machines.
- Enhance IEC on condoms and set up non-conventional condom outlets in rural areas.
- Incorporate condom promotion in training and orientation modules for ANMs, MPWs, ASHAs, and link workers.
- Organize special orientation for PLHIV on positive prevention.
- Establish appropriate logistics planning mechanisms to ensure uninterrupted condom supply at all levels.

Responsibility

Health department, DAPCU, UPSACS, NGOs/TI implementers, ICTCs, ANP+, peer educators

6.2 Maternal Health

Objective

To promote the identification of HIV-positive pregnant women to enable timely provision of PPTCT to HIV-positive mothers in the district.

Situation Analysis

Until last year, there were only two ICTCs with PPTCT facilities available in the district; one at the female district hospital (Dufrin), and one at SRN Medical College. The design of Allahabad's new PPTCT scheme is based on data from these two facilities over the last four years.

Data from 2005–2008 show a drastic increase in the number of women accepting HIV tests during ANC (from 54 in 2005 to 3,525 in 2007). The percentage of women tested who received post-test counseling also rose, from 55 percent in 2007 to 86 percent in 2008. In addition to women who attended ANC clinics, 1,768 women in 2007 and 1,283 in 2008 registered directly for labor. Testing rates among women who registered directly were noticeably lower than those for women attending ANC, and their testing rate actually declined slightly between 2007 and 2008. In 2007 only 1,026 (58 percent) of directly registered women accepted testing and only 644 (50 percent) were tested in 2008.

Out of the 18 women accessing ANC who were identified as HIV-positive in 2007, two did not return to collect their test results. In 2008, only one of the 24 HIV-positive ANC attendees did not collect her results. Of the 20 HIV-positive women reported to have delivered children in Allahabad since 2005, only 17 mother/child pairs received Nevirapine. While the reason the other three pairs did not receive Nevirapine is unknown, it is possible that either the mother or the child died during delivery.

While PHCs have adequate infrastructure, they do not effectively meet the needs of local residents. This is due to service providers' stigma and negative attitudes toward HRGs, and to an inadequate supply of materials from district headquarters. Information on the availability of services in the area is also limited.

Strategies

- Scale up advocacy and counseling to motivate pregnant women to access PPTCT services.
- Promote coordination among ART center, CCC, and NRHM to enable tracking of HIV-positive pregnant women to ensure they receive timely services.
- Ensure presence of trained practitioners to handle deliveries of HIV-positive women.
- Establish support mechanisms for HIV-positive pregnant women.
- Maintain supply chain of safe delivery kits and Nevirapine for PPTCT cases.

Action Plan

- Counsel all pregnant women on PPTCT services at MCHN Day.
- Promote institutional deliveries through *Janani Surksha Yojana*.
- Train doctors, ANMs, and other service providers to administer Nevirapine to mother/baby pairs.
- Track and support HIV-positive pregnant women through ASHAs, link workers, ANMs, and outreach worker in CCCs and ANP+.
- Use referral protocol for PPTCT and HIV/AIDS (See Annex II for line list register used for monitoring).
- Identify doctors and hospitals prepared to handle PPTCT cases and offer information to HIV-positive pregnant women through Red Ribbon clubs or Helpline.
- Ensure consistent and adequate supply of safe delivery kits from UPSACS to ICTCs, and outreach workers.
- Deploy mobile ICTCs in hard-to-reach areas to provide ICT services at MCHN Day.

- Liaise with private nursing homes and hospitals to ensure provision and monitoring of PPTCT services and sharing of data with DAPCU.
- Introduce PPTCT cards for inter-district referral system to enhance Nevirapine coverage for mother/baby pairs.
- Oversee functioning of PPTCT services (responsibility of District ICT Supervisor).
- Recommend addition of PPTCT services at selected PHCs (responsibility of DAPCU). PHCs recommended for upgrade will include those close to national highways; those that conduct at least 10 deliveries per month; those with outpatient attendance great than 700 per month; those in hard-to-reach areas, such as tribal areas; and those in hotspots and tourist centers.
- Ensure availability of obstetric/gynecological doctors at ICTCs and PPTCT centers through convergence with NRHM.

Table 29. PPTCT Trends in Allahabad (2005–2008)

	2005	2006	2007	2008*
Women Attending Antenatal OPDs				
Number of new ANC registrations	189	1,338	5,527	2,622
Number of new ANC attendees who received pre-test counseling	76	76	3,960	2,465
Number of new ANC attendees tested for HIV	54	600	3,525	2,402
Number of ANC attendees found to be HIV-positive	2	6	18	24
Number of ANC attendees who received post-test counseling	44	418	3,010	2,265
Number of HIV-positive women who collected HIV test results	2	6	16	23
Number of HIV-positive ANC attendees who received post-test counseling	0	0	16	23
Spouses/Partners of HIV-positive Women				
Number of spouses/partners of HIV-positive women counseled	1	2	13	NA
Number of spouses/partners of HIV-negative women counseled	54	425	1,126	NA
Number of spouses/partners of HIV-positive women tested for HIV	2	2	12	16
Number of spouses/partners found to be HIV-positive	2	2	11	0
Women Registering Directly for Labor (No ANC)				
Number of women registered directly for delivery without ANC registration	121	431	1,768	1,283
Number of women registered directly for delivery who received counseling	0	178	1,297	1,098
Number of women tested for HIV (out of those counseled)	0	51	1,026	644
Number of women found to be HIV-positive	0	2	3	0
Deliveries and Live births				
Total number of deliveries	0	58	2,505	1,803
Total number of deliveries of HIV-positive women	0	4	7	9
Total number of live births to HIV-positive mothers	0	0	6	9
Total number of mother/baby pairs who received Nevirapine	0	2	6	9

* up to Nov 2008

Responsibility

Health (NRHM), UPSACS, DAPCU, PPCTC, private health care providers

6.3 Infant and Pediatric Care

Objective

Identify HIV-positive newborns and provide them with quality care, support, and treatment services.

Situation Analysis

Under NACP-III, a pediatric ART program will be implemented through all ART centers in the country. This will consolidate services for both parents and children in a single SDP. State Pediatric Referral Centers and regional Pediatric “Centers of Excellence” will offer effective referral linkages from the point of entry into the health system up to the tertiary level. PPTCT centers will be linked with pediatric and adult ART centers for follow-up and early diagnosis of children and mothers.

In Allahabad, the pediatric ART program is implemented through the ART center at Motilal Nehru Medical College. As of November 2008, 111 children under age 15 had been registered at the center, of whom 39 had begun ART. There have been no deaths reported among children in the program.

**Table 30. Pediatric ART Program Statistics
(ART Center, Motilal Nehru Medical College, November 2008)**

Indicator	Children <15 Years		Total
	Male	Female	
Cumulative number of children registered for HIV care	80	31	111
Cumulative number of children ever started on ART	27	12	39
Cumulative number of child deaths since the program's beginning	0	0	0

Pregnant HIV-positive women deliver and receive nevirapine at the PPTCT center. However, the PPTCT center and the ART center currently lack effective linkages to ensure that mother/baby pairs receive follow-up services and are enrolled in the ART program. Out of six live births in Allahabad in 2007, only one baby received follow-up through the eighteenth month for HIV testing. The other five infants were not tracked at all. Since there are relatively few deliveries of HIV-positive women in the district, the staff of the PPTCT center should make a serious effort to ensure that these infants are tested and, if necessary, linked with pediatric ART services. Pediatric HIV cases can also be linked with the *anganwadi* center (AWC) and NGOs, such as PLUS, that provide HIV care.

Allahabad's rural areas currently lack an adequate support mechanism for HIV-positive children or children born to HIV-positive parents. Clients use existing local facilities and are sometimes referred to the medical college and district hospitals for follow-up and care and support. No survey of resource agencies working on children's issues has been carried out in the district. Coordination mechanisms to link government facilities to each other and to link government facilities to private providers are absent.

Strategies

- Train and monitor link workers, ANMs, and ASHAs to improve tracking of HIV-positive mothers.
- Strengthen PPTCT services in public and private hospitals to ensure timely tracking and follow-up of HIV-positive mothers.
- Pursue convergence with NRHM (RCH) under IMNCI (integrated management of neonatal and childhood illnesses) program.
- Pursue convergence with Integrated Child Development Services (ICDS) for nutritional support for HIV-positive mothers and their newborns.

Action Plan

- Follow up with mother/baby pairs from the PPTCT center and make sure every infant born to an HIV-positive mother is tested for HIV six weeks after delivery.
- Ensure ART support for HIV-positive newborns.
- Create linkages with ICDS program and NGOs to provide children born to HIV-positive mothers with nutritional support.
- Include HIV-positive newborn care in IMNCI trainings.

Responsibility

Health (NRHM), UPSACS, DAPCU, PPTCT, private providers

6.4 Sexually Transmitted Infection (STI)

Objective

Reduce the STI burden in the district and enhance HIV prevention efforts and early identification of PLHIV.

Situation Analysis

Four facilities in Allahabad report on STI treatment, including the district hospitals (both male and female, the gynecology and STI departments of the medical college, and Phulpur CHC. In 2004, the total number STI cases reported in Allahabad was 3,058, of which 1,985 (65 percent) were in males and 1,073 (35 percent) were in females. In 2007, the total number of cases decreased to 2,249, with a significant decrease in the percentage of cases appearing in women (23 percent). In spite of awareness drives and condom promotion activities, the incidence of new STI cases has not changed noticeably, which poses a challenge to the district HIV/AIDS program. This challenge must be successfully addressed to accomplish DAP objectives.

In rural areas, most of the STI cases reported in women involve symptoms of vaginal discharge and abdominal pain. The cases are detected in ANC clinics and either treated there or referred to relevant specialists. Providers report cases of relapse cases due to incomplete treatment or patients' inability to obtain appropriate medicines. Members of HRGs are sometimes reluctant to agree to treatment because of health care providers' negative attitude toward them.

Table 31. Patients Attending STI Clinics/OPD in Allahabad

Year	New		Old		Total		Grand Total
	Male	Female	Male	Female	Male	Female	
2004	1,820	999	165	74	1,985	1,073	3,058
2005	1,617	669	41	16	1,658	685	2,343
2006	1,416	645	16	44	1,432	689	2,121
2007	1,710	516	22	1	1,732	517	2,249

Strategies

- Promote health seeking behavior among STI cases and their partners.
- Expand access to quality STI treatment.
- Pursue convergence with NRHM (RCH) for STI clinics and treatment programs.
- Build capacity of outreach workers to strengthen STI service delivery.

Action Plan

- Increase awareness and condom use to reduce number of new STI cases.
- Emphasize availability of STI services and link between STIs and HIV/AIDS in ASHA, MPW, and ANM trainings.
- Promote discussion of STIs on MCHN day and in self-help group (SHG) meetings.
- Prepare targeted IEC material on STIs for ASHAs and ANMs to use during counseling.
- Train ANMs, MPWs, and ASHAs to improve their ability to identify STIs and make referrals.
- Ensure availability of STI drugs at sub-centers, PHCs, and CHCs.
- Use manpower rationalization and/or contractual engagement under NRHM to ensure availability of trained personnel public health institutions.
- Introduce mechanism for referring STI cases to ICTCs.

- Build capacity of all obstetrical/gynecological doctors to diagnose and treat STIs in partnership with Federation of Obstetrical and Gynecological Associations of India (FOGSI) and Indian Medical Association (IMA).

Responsibility

Health (NRHM), UPSACS, STI clinics, DAPCU

6.5 IEC and Advocacy for Behavior Change

Objective

To raise awareness of HIV/AIDS, to promote health seeking behavior and HIV prevention, and to increase social acceptance and support for PLHIV.

Situation Analysis

Data from ICTCs show that fewer clients are ‘walk-ins’ than are referred by other SDPs. This indicates a need to raise awareness about ICT services and to strengthen health workers’ motivation to encourage people to utilize ICT and ART services. Denial, stigma, and discrimination have declined over the last five years, but are still present at various SDPs. This is due to low levels of knowledge about HIV and AIDS and negative attitudes toward PLHIV. Now that the ART center is operational, most PLHIV are indiscriminately referred to the center or to the medical college for services even though other SDPs can easily provide OI treatment.

Strategies

- Implement IEC campaigns for HRGs, bridge populations, adolescents, women, and general community to increase information on availability of services.
- Implement IEC campaign for doctors, paramedics, and other health workers.
- Use dual protection messages to promote condom use.
- Develop IEC strategy for local self-governing bodies, such as PRIs and municipal corporations, to encourage them to include HIV response in annual plans.
- Develop advocacy programs for PRI leaders and faith leaders to increase ownership of and participation in district’s HIV/AIDS program.

Action Plan

- Display IEC material prepared by NACO, UPSACS, and NGOs in public places, including major government offices, health institutions, transport nodes, tourist spots, etc.
- Mainstream HIV messages in IEC material used by other departments.
- Encourage NGOs, TI implementers, FOGSI, and other organizations and associations to generate IEC material on HIV/AIDS.

For the general population

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

For adolescents

- Incorporate AIDS awareness into school health program.
- Promote Red Ribbon clubs in schools, colleges, and NSS/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 day.
- Promote PPTCT services and safeguards for newborns.

For HRGs and PLHIV

- Develop safe sex prevention messages and disseminate them in locations frequented by HRGs (FSWs, MSM, IDUs, truckers, transgenders, migrants, slum populations, etc.).

For providers

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

Activities

- Implement IEC using various 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 United Nations Development Program (UNDP) Panchayati Raj Institutions 365 module.

Responsibility

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

INTERSECTORAL CONVERGENCE

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 32. 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 	

Department	Convergence Issues	Nodal Officer
	<p>community ownership, participatory planning, and care and support.</p> <ul style="list-style-type: none"> ➤ Issue instructions to <i>panchayats</i>¹⁹ 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
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 	

¹⁹ Village-level administrative bodies.

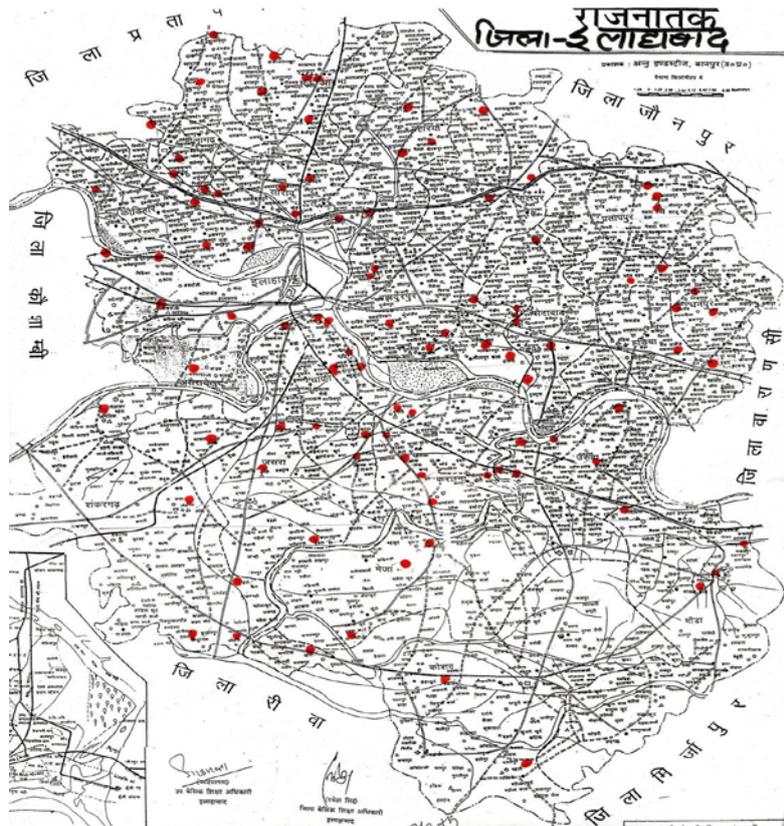
Department	Convergence Issues	Nodal Officer
	<p>and colleges.</p> <ul style="list-style-type: none"> ➤ Incorporate HIV prevention programs into all non-formal and out-of-school education programs. ➤ Introduce a module on HIV/AIDS into teacher training curriculum. ➤ Incorporate HIV orientation into curricula 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>²⁰ 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

²⁰ Small eateries

7.2 Link Worker Program

Under NACP-III, a new cadre of link workers will be created to provide HIV services in villages with populations over 5,000. As a partner to NACP-III, UNICEF has committed to designing and implementing the link worker scheme in Allahabad. HRG populations in rural Allahabad have been mapped²¹ for this purpose, and 100 villages from 20 blocks have been identified for implementation of the link worker program. Two link workers (one female and one male) will serve a population of 1,000, and a total of 40 link workers will be placed. Villages where link workers will be placed are represented on the map in Figure 7 below.

Figure 7. Map of Link Worker Scheme in Allahabad



²¹ Report of the mapping of high-risk groups for HIV/AIDS in rural areas of the Allahabad district of Uttar Pradesh, UNICEF-LWP-Mapping findings, SWARG/SWASTI/UNICEF, Allahabad, 2008.

7.3 Public Private Partnerships

Objective

To foster the support and involvement of multisectoral partners, including NGOs, the corporate sector, professional associations, CBOs, and PLHIV networks in Allahabad's AIDS prevention and control program.

Situation Analysis

There are currently four NGOs receiving grants from UPSACS to implement TI projects. Through the GFATM-supported "PACT project," one NGO is also running a CCC, and one other CBO is contracted to run a Allahabad's DIC. Apart from this, there are nine other organizations working on NRHM-RCH issues and more working on youth development, livelihood, and other development issues in the district. Under the IEC and advocacy element of this plan, Red Ribbon clubs will be established in educational institutions in Allahabad.

Strategies

- Promote public-private partnerships in HIV/AIDS program by liaising with leaders of industry, trade, and medical associations.
- Increase public support for HIV/AIDS program.
- Encourage and support PLHIV networks.
- Use NGOs to meet home-based care and nutrition needs and provide OI referrals.

Action Plan

- Develop HIV/AIDS NGO forum in Allahabad and implement mentoring plan to provide supportive supervision to NGOs.
- Give new NGO forum representation in DHS/DAPCC.
- Develop capacity of ANP+ to provide home-based care, nutrition, and peer counseling services.
- Organize positive speakers' bureau and special events for PLHIV.
- Provide publicity for public-private partnership models operating in Allahabad.
- Initiate and promote corporate/industry-led HIV interventions.
- Set up district-level coordination mechanism to bring together UPSACS implementing partners and corporate and service sector leaders/officials, and organize periodic meetings to assess integrated efforts to address HIV.

Responsibility

DAPCU, ANP+, Population Foundation of India

7.4 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 33. 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>²² 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.

²² 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. ○ Allahabad link workers program is supported by UNICEF. ○ 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 Allahabad will require equipping service providers with necessary skills and orienting health workers, policymakers, private providers, employees of cognate departments, NGOs, self-help group (SHG) members, and PRI members on various facets of HIV and AIDS. The training plan for capacity building at the district level will be prepared to enable time-bound coverage of the entire training load. Some trainings will be funded by UPSACS and other NACP partners, such as USAID and UNICEF. Others could be incorporated into training modules already planned by various departments for their personnel. The corporate/private sector and professional bodies, such as the Indian Medical Association (IMA) and the Federation of Obstetrical and Gynecological Associations of India (FOGSI), will also be motivated to self-finance orientations for their members.

Table 34. Stakeholders in Allahabad 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/ functionaries 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 involving all the potential stakeholders involved in the HIV response. Based on the needs assessment, an annual action plan for capacity

building will be developed for the district and a special allocation of funds will be sought from UPSACS. The training plan for Allahabad will include the stakeholders listed in Table 34 above.

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

Table 35. 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 36. 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 37. Budget for Allahabad 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 ²³ 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					

²³ 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. IEC²⁴

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				

²⁴ Detailed tables for Questions 18 and 19 to be developed in accordance with yearly action plan.

Annex II: Positive Antenatal Case Line-list Register

Name of the Center:

District:

Reporting Month:

Expected Month of Delivery:

S.No.	Details	Sl. No.	Sl. No.	Sl. No.
1	Date of registration in this center			
2	HIV tested earlier? (Give PID No. if Yes)			
3	Name of center where HIV was diagnosed earlier			
4	PID No.			
5	EDD			
6	Husband's HIV status (1. Positive 2. Negative 3. Indeterminate 4. Not known)			
7	Expected place of delivery (with address and other detail including phone/mobile number)			
8	Link with '7' (if 7 is different from this center, send details to the place of delivery) (Yes/No)			
9	Link to ambulance service			
10	Outcome of pregnancy (1. Live birth 2. Still birth 3. Aborted/MTP/Miscarriage 4. Others (specify) 5. Not known)			
11	Date of delivery			
12	Actual place of delivery (give details)			
13	Type of delivery (1. Vaginal 2. Caesarian)			
14	Name of the doctor/staff who attended to delivery			
15	Administration of NVP to mother (Yes/No). If No, give reason.			
16	Administration of NVP to child (Yes/No). If No, give reason.			
17	Child has been breast fed since birth (Yes/No)			
18	Status of the child at six weeks/six months/18 months (1. Positive 2. Negative 3. Indeterminate 4. Not known)			
19	Family planning operation/permanent sterilization performed during delivery (Yes/No)			
20	Remarks			

Annex III: 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 IV: 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 V: 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 ²⁵	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

²⁵ Faith-based organization

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Lucknow