

# *Etawah*

## **District AIDS Action Plan**



**2009–2012**

**ETAWAH DISTRICT AIDS PREVENTION AND CONTROL UNIT**

**Uttar Pradesh State AIDS Control Society**

**Lucknow**

**APRIL 2009**

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## FOREWORD

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

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

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

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

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

## ABBREVIATIONS

AAP	annual action plan
AIDS	acquired immune deficiency virus
ANC	antenatal care
ANM	auxiliary nurse midwife
ART	antiretroviral therapy
ARV	antiretroviral
ASHA	accredited social health activist
AWC	<i>anganwadi</i> center
AWW	<i>anganwadi</i> worker
AYUSH	Department of Ayurveda, Naturopathy and Yoga, Unani, Siddha, and Homeopathy
CBO	community-based organization
CCC	community care center
CHC	community health center
CMHO	Chief Medical and Health Officer
CSR	corporate social responsibility
DACO	District AIDS Control Officer
DAP	District AIDS Action Plan
DAPCC	District AIDS Prevention and Control Committee
DAPCU	District AIDS Prevention and Control Unit
DAPM	District Program Manager for HIV/AIDS
DHAP	District Health Action Plan
DHS	District Health Society
DIC	drop-in center
DLHS	District Level Household Survey
DOHFW	Department of Health and Family Welfare
DPMU	District Program Management Unit
DUDA	District Urban Development Agency
ESI	Employee State Insurance
FOGSI	Federation of Obstetrical and Gynecological Associations of India
FSW	female sex worker
HIV	human immunodeficiency virus
HRG	high-risk group
HSS	Household Sample Survey
ICDS	Integrated Child Development Services
ICT	integrated counseling and testing
ICTCs	integrated counseling and testing centers
IDU	injection drug user
IEC	information, education, and communication
IMA	Indian Medical Association
IMNCI	integrated management of neonatal and childhood illness
INP+	National Network of Positive People
JSY	<i>Janani Suaksha Yojana</i>
KVK	<i>Krishi Vignan Kendras</i>
LT	laboratory technician
M&E	monitoring and evaluation
MCHN	maternal and child health and nutrition
MIS	management information system
MOHFW	Ministry of Health and Family Welfare
MOIC	Medical Officer-in-Charge
MPW	multi-purpose health worker
MSM	men having sex with men
NACO	National AIDS Control Organization
NACP	National AIDS Control Program

NACP-III	National AIDS Control Program, Phase III
NBCP	National Blindness Control Program
NFHS	National Family Health Survey
NGO	nongovernmental organization
NLEP	National Leprosy Eradication Program
NRHM	National Rural Health Mission
NVBDCP	National Vector Borne Disease Control Program
NYK	<i>Nehru Yevak Kendra</i>
NSS	National Student Service
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
RCH-II	Reproductive and Child Health Program, Phase II
RIMS	Rural Institute of Medical Sciences and Research
RMP	registered medical practitioner
RNTCP	Revised National TB Control Program
RPR	rapid plasma reagin
RTI	reproductive tract infection
SC	scheduled caste
SDP	service delivery point
SHG	self-help group
SRS	Sample Registration System
ST	scheduled tribe
STI	sexually transmitted infection
STRC	State Training and Resource Center
TB	tuberculosis
TFR	total fertility rate
TI	targeted intervention
TSU	Technical Support Unit
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
UPSACS	Uttar Pradesh State AIDS Control Society
USAID	U.S. Agency for International Development

## BACKGROUND AND METHODOLOGY

### I.1 Context

The contribution of health to economic and social development, as well as to overall quality of life, has long been recognized. In April 2005, the government of India launched the National Rural Health Mission (NRHM) to revitalize the health system and provide effective health care to rural populations throughout the country. The goal of NRHM is to “improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.”<sup>2</sup> NRHM focuses on 18 states—including Uttar Pradesh—with weak public health indicators and/or infrastructure. The mission seeks to ensure access to affordable, accountable, and effective primary health care by strengthening local-level health systems.

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

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

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

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

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

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

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

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

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

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

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

Source: Prioritization of Districts for Program Implementation, NACO.

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

**Table 1. Package of Services for Category A Districts<sup>3</sup>**

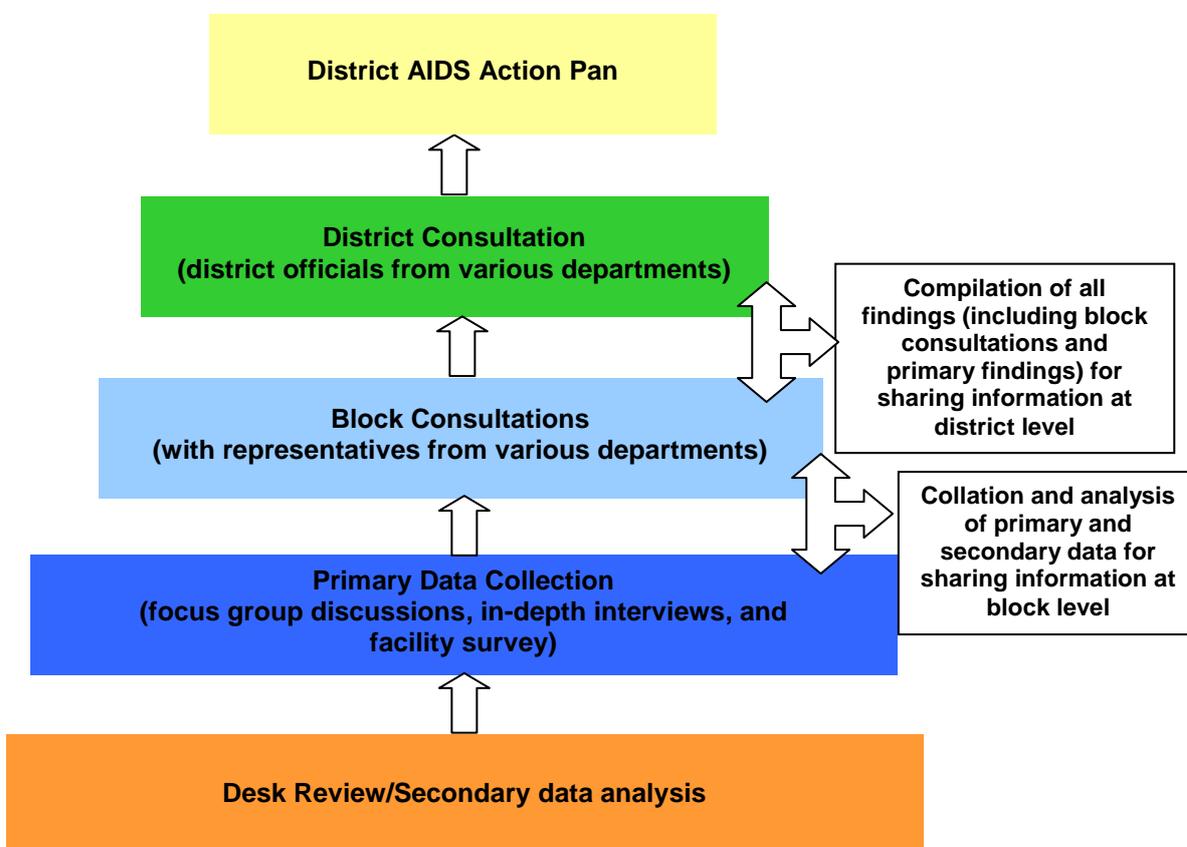
Level	Target Group	Services Provided
<ul style="list-style-type: none"> <li>• Medical colleges</li> <li>• District, block and sub-divisional hospitals</li> <li>• Village/community</li> </ul>	<ul style="list-style-type: none"> <li>• General population</li> <li>• High-risk groups (HRGs)</li> <li>• People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

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

## 1.2 Overview of Plan Development Process

The Etawah DAP was created by compiling inputs from a wide variety of sources, including a literature review, firsthand data collection from stakeholders, collation and analysis of primary and secondary data, and interactive consultations at the block level. Each step of the data collection and planning process provided input for the following steps. The diversity of inputs provided a comprehensive picture of the district's HIV scenario, enabling planners to more effectively tailor the plan to residents' needs. Field studies and consultations were carried out in two blocks, Jaswant Nagar and Mahewa.

**Figure I. Preparation Process for District AIDS Action Plan**



### Secondary Data Review

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

### Primary Data Collection

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

### **Collation and Analysis of Primary and Secondary Data**

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

### **Block-level and District-level Consultations**

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

### **Preparation of the District Action Plan**

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

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

## 2.1 Geography and Overview of Health Scenario

Etawah district is located in the southwestern part of Uttar Pradesh, with headquarters at Etawah town. The district is part of Kanpur division. Etawah's northern end borders Farrukhabad and Mainpuri, while its small western border adjoins *tehsil* Bah of Agra district. On its east is Auraiya district, and Jalaun and Gwalior (in Madhya Pradesh state) lie to the south.

The district is composed of eight blocks: Basrehar, Barhpura, Bharthana, Chakarnagar, Jaswantnagar, Mahewa, Takha, and Sefai. There are 10 towns in the district. Etawah has a significant place in the political map of UP.

**Table 2. General Indicators**

	Etawah	Uttar Pradesh
Geographical area (in sq.km.)	2,538	240,928
<i>Tehsils</i>	5	300
Blocks	8	901
Total number of villages	686	107,452
Number of inhabited villages	686	97,942
Number of inhabited villages <5,000	17	2,562
Number of towns <sup>4</sup>	10	215

Source: Census of India (2001)

The district's literacy rate among both girls and boys is significantly higher than the state average. This is a considerable achievement given that nearly three-quarters of the district's population live in rural areas. There is, however, a noticeable difference between male and female literacy rates within the district, where nearly 80 percent of males and only 57 percent of females are literate. The male to female ratio in Etawah is also much

lower (858) than the state average (898). The percentage of children in the district's population (17.22%) is slightly lower than the state average (18.33%). Etawah's decadal growth rate for the previous decade (1991–2001) is only 21.59 percent, which is substantially lower than the state average (25.8%) Most of the other indicators for Etawah more or less match the overall state indicators.

**Table 3. Standard of Living Index**

	DLHS-3		DLHS-2	
	Total	Rural	Total	Rural
Low (%)	77.1	82.8	63.2	69.6
Medium (%)	15.5	13.4	25.8	25.5
High (%)	15.5	3.8	10.9	4.9

Source: DLHS-3

<sup>4</sup> <http://www.india9.com/i9show/Etawah-District-17596/Cities%20and%20Towns.htm>

**Table 4. Demographic Indicators**

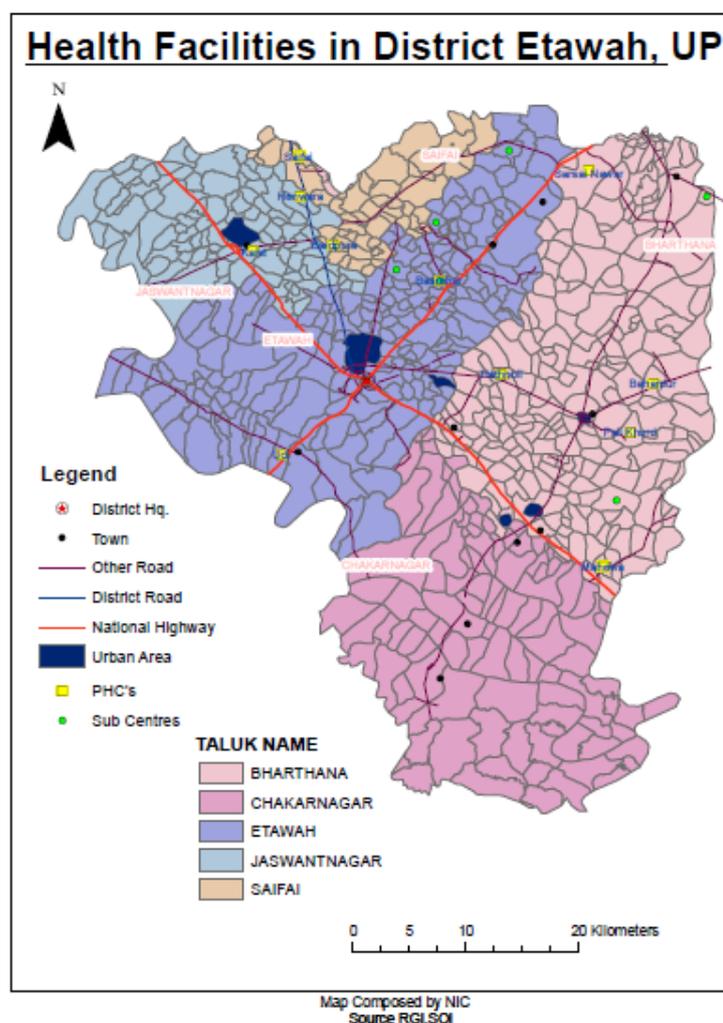
	<b>Etawah</b>	<b>Uttar Pradesh</b>
Total population	1,338,871	166,197,921
Female population	618,122	78,632,552
Male population	720,749	87,565,369
Rural population	1,030,789	131,658,339
Urban population	308,082	34,539,582
Child population (0–6 years)	230,617	30,472,042
Percent of child population (0–6 years)	17.22%	18.33%
Population density	586	689
Decadal growth rate (1991–2001)	21.59%	25.80%
Male/female ratio	858	898
Ratio of male/female children (0-6 years)	894	915
Literacy rate	69.57%	57.36%
Male literacy rate (7+ years)	79.92%	70.23%
Female literacy rate (7+ years)	57.38%	42.98%
Scheduled caste (SC) population	23.41%	21.1%
Scheduled tribe (ST) population	0.00%	0.1%

Source: Census of India (2001)

### **Health Facilities**

There are two district hospitals (one male, one female), four CHCs, eight PHCs, and 30 sub-centers in Etawah district. Three of the CHCs have 24 hour normal delivery facilities and one CHC has a newborn care unit. According to DLHS-3 data, 37 villages in the district have *anganwadi* centers (AWCs).

**Figure 2. Health Facilities in Etawah**



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

	Etawah	Uttar Pradesh
Medical colleges	1	19
District hospitals (male)	1	70
District hospitals (female)	1	69
Community Health Centers (CHCs)	4	372
Primary Health Centers (includes block, sub-block, and additional PHCs)	31	3,660
Sub-centers	161	20,521
Anganwadi centers (AWCs)	1,238	153,223
DOTS <sup>5</sup> centers	204	24,549
Microscopy centers	14	1,750
Tuberculosis (TB) units	3	369

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

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

**Table 6. Fertility Indicators**

	Etawah	Uttar Pradesh
Total fertility rate	4.0	4.4
Crude birth rate	29.5	31.4

Source: Census of India (2001)

According to the 2001 census, the total fertility rate (TFR), (i.e., the average number of children born to a woman in her reproductive age), for Etawah is 4.0, which is lower than the state average of 4.4.

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

	Etawah	Uttar Pradesh
Total number of pregnant women	51,650	6,611,040
Girls married before completing 18 years of age	25.6%	33.1%
Women who had at least three ANC visits (in last pregnancy)	18.2%	21.9%
Women who received full ANC <sup>6</sup>	3.6%	2.8%
Women who received postnatal care within 48 hours (in last delivery)	33%	33.8%
Institutional deliveries	26.5%	24.5%
Institutional deliveries under JSY <sup>7</sup>	15305	956,007
Home deliveries attended by skilled personnel	3.5%	7.4%
Safe deliveries (deliveries conducted by health professionals)	3.5%	28.7%
Children (ages 12–23 months) who received full immunization <sup>8</sup>	24.3%	30.3%
Children (ages 12–23 months) who received no immunization	31.9%	24.0%

Source: DLHS-3

According to DLHS-3 (2007–2008), more than a quarter of currently married women were married before completing 18 years of age. Less than one out of five pregnant women had at least three ANC visits during their last pregnancy and nearly three out of four women did not deliver in an institution. While this is more or less comparable with overall state averages for these indicators, it points to poor health seeking behavior among women in the district.

**Table 8. Family Planning Indicators**

Among Currently Married Women (Ages 15–49)	Etawah (%)	Uttar Pradesh (%)
Women who use any method of family planning	31.2	38.4
Women who use any modern method of family planning	25.4	26.7
Female sterilization	15.5	16.5
Male sterilization	0.1	0.2
Using condoms	6.4	7.1
Unmet need for family planning	44.1	33.8

Source: DLHS-3

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

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

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

Family planning indicators for Etawah, especially overall use of FP, use of modern FP methods, and use of sterilization are marginally lower than the state average. However, the district's unmet need for FP district is very high (44.1%). Of that unmet need, the greatest proportion (32.1%) is for limiting, compared with spacing (12%). It should be noted that DLHS-3 also recorded a decline in condom use among currently married women to 6.4 percent, down from 10.4 percent recorded in DLHS-2.

## 2.2 Overview of HIV/AIDS Situation

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

### High-risk and Vulnerable Populations

Several groups, including FSWs, MSM, transgenders (including *hijras*),<sup>9</sup> and IDUs, have been identified as high-risk groups (HRGs). Members of these groups have elevated HIV prevalence rates and are central to the spread of the epidemic. Recognizing the importance to saturating coverage among HRGs to prevent further spread of HIV, NACO and UPSACS commissioned studies to map the number of sites and the estimated population of various HRGs in UP.

The first such state-level study was conducted in 2001 and a second study was carried out in 2008. The profile of HRGs in Etawah is presented in Table 9 below. The profile is based on the provisional report of the 2008 mapping data, which is currently being revalidated by NACO. Further detail on the situation of HRGs in Etawah is provided in the section on targeted intervention.

**Table 9. HRG Populations in Etawah (2008)**

<b>FSW</b>	Sites	5
	Total	150
<b>MSM</b>	Sites	2
	Total	16
<b>IDU</b>	Sites	13
	Total	102
<b>Hijras</b>	Sites	4
	Total	35

### Targeted Intervention

There is only one targeted intervention project being carried out in Etawah currently. The project, which is being implemented by Warsi Seva Sadan, is a composite<sup>10</sup> intervention, which began in October 2008. Warsi Seva Sadan is reaching out to three HRGs (FSWs, MSM, and IDUs). The organization aims to reach 450 men and women from these groups during the first year of project implementation.

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

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

**Table 10. NGO-implemented Targeted Intervention Projects in Etawah**

Implementing Organization	Type of Intervention	Size of Target Population (2008–2009)			
		FSW	MSM	IDU	Total
Warsi Seva Sadan	Composite	250	150	100	450

### HIV and AIDS Awareness

Lack of knowledge of HIV, especially of prevention methods, is one of the key vulnerability factors for communities. Although there was only a marginal change between DLHS-2 and DLHS-3 in terms of the percentage of women in Etawah who had heard about HIV/AIDS, the number of women who knew that consistent condom usage reduces the chance of transmission almost doubled over the same period. Almost 95 percent of unmarried women and 93.8 percent of married women who had heard about HIV/AIDS had correct knowledge about it, with only marginal differences in knowledge between rural and urban populations. Comparatively, only one out of four unmarried women and one out of three married women in the district know that consistent condom use can reduce the risk of transmission.

**Table 11. Knowledge of HIV/AIDS and RTI<sup>11</sup>/STI among Women**

	DLHS-3		DLHS-2	
	Total	Rural	Total	Rural
<b>Ever-married Women Ages 15–49 (in percent)</b>				
Had heard of HIV/AIDS	38.6	31.0	34.3	26.7
Knew that consistent condom use can reduce the chances of contracting HIV	32.3	29.2	16.9	15.3
Had correct knowledge of HIV/AIDS (of those who had heard of HIV/AIDS)	93.8	92.1	- <sup>12</sup>	-
Had been tested for HIV	1.9	1.5	-	-
Had heard of RTI/STI	24.1	22.0	-	-
<b>Unmarried Women Ages 15–24 (in percent)</b>				
Had heard of HIV/AIDS	60.0	53.1	-	-
Knew that consistent condom use can reduce the chances of contracting HIV	26.8	14.5	-	-
Had correct knowledge of HIV/AIDS (of those who had heard of HIV/AIDS)	94.9	93.5	-	-
Had been tested for HIV	0.0	0.0	-	-
Had heard of RTI/STI	27.5	25.1	-	-

Source: DLHS-3

### Condom Use

In places where HIV prevention efforts have successfully reduced prevalence and infection rates, condoms have invariably played a key role. Prevention efforts through condom promotion are highly cost-effective. DLHS-3 reported only 6.4 percent condom use in Etawah.<sup>13</sup> When UPSACS launched the targeted intervention project in October 2008, one of the project's activities was the distribution of condoms to HRGs. Between November and December 2008, approximately 6,700 condoms were distributed to HRGs through the NGO-implemented TI project. Social marketing of condoms is expected to start in 2009.

### HIV Prevalence

HIV prevalence can be determined by examining data from a variety of sources, including the annual Household Sample Survey (HSS) conducted by NACO and data from SDPs. ICTC, ART, and district-

<sup>11</sup> Reproductive tract infection

<sup>12</sup> These questions were not included DLHS-2.

<sup>13</sup> IIPS: DLHS-3, Reproductive and Child Health Project, District Fact Sheet 2007-8, Etawah, Mumbai, 2008

level PLHIV networks are three main sources of service delivery data that are useful for tracking HIV prevalence. An analysis of these data provides an overview of the HIV situation in Etawah.

**Table 12. HIV Sentinel Surveillance Data (in percent)**

Site	2001 (Aug–Oct)	2002 (Aug–Oct)	2003 (Aug–Oct)	2004 (Jul–Sep)	2005 (Aug–Oct)	2006 (Sep–Dec)	2007 (Sep–Dec)
Uttar Pradesh	0.05	0.37	0.19	0	1.73	0.25	0.02
Etawah	0.25	3.00	0.00	0.00	0.25	0.25	0.02

Source: Behavioral Surveillance Survey (BSS) 2007

As mentioned earlier, a district is classified as a category A district under NACP-III if any of its ANC sites have reported greater than 1 percent HIV prevalence in any of the three years prior to 2006. In Etawah's case, the very high prevalence in 2002 (3%) is the reason for its category A status.

**Table 13. ICTC Data (Jan–Dec 2008)**

	Etawah	Uttar Pradesh
Number of ICTCs	7	155
Total population (estimated as of January 2008)	1,537,016	196,049,343
Sexually active population	768,508	98,024,671
Population prone to risky sexual behavior	38,425	4,901,234
Number of people tested for HIV at ICTCs	3,117	240,438*
Seropositivity	0.71%	4.54%
Persons counseled and tested per ICTC per day	49	172
Targets for testing in 2009–2010	11,739	574,790

Source: AAP-UP-09-10

\*April 2007–January 2008

ICTCs are another source of data that can help understand the district's HIV situation. Between January 2004 and December 2008, 6,948 men and women were tested at ICTCs in Etawah. Of these, 3,117 people were tested in 2008, with a seropositivity rate of 0.71 percent, which is significantly lower than the state average (4.54%). Five new ICTCs were established in Etawah in 2008–2009. The new testing centers were established at CHCs and 24/7 PHCs. The average number of people counseled and tested per ICTC per day in Etawah is lower than the state average because testing rates at the new ICTCs are still low, as they are still in their start-up phase.

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

	Etawah	Uttar Pradesh
Number of PPTCT centers	2	79
Number of people tested for HIV at PPTCT centers	3,834	218,785
Seropositivity	0.08%	0.16%
Number of people counseled and tested per PPTCT center per month	213	308
Targets for testing in 2009–2010	14,006	474,202

There are two PPTCT centers currently operating in Etawah. PPTCT data for the district is available only for the year 2008. In that year, seropositivity among PPTCT clients in Etawah (0.08%) was only half the state average (0.16%). The number of people tested at each PPTCT center per month in Etawah (213) is much lower than the state average (308).

## Sexually Transmitted Infection (STI) and HIV

Sexually transmitted infection (STI) is an important indicator of the risk of HIV transmission in any setting. There are two sources of information about STIs at the district level; government STI clinics and STI data from NGO-implemented TI projects. As the sole TI project in Etawah only began operating in October 2008, its data is not yet of significant value.

**Table 15. Persons Visiting and Treated for STIs in Government Clinics (Jan–Dec 2008)**

2008	First Clinic Visit (for index STI/RTI complaint)		First Clinic Visit (for no STI/RTI complaint)		Total Number of First Clinic Visits		Repeat Clinic Visit (for index STI/RTI complaint)		Total Number of Syndromic Diagnosis Cases		
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Total
Jan	25	30	240	250	265	280	35	0	60	0	60
Feb	0	122	0	0	0	122	0	0	0	122	122
March	27	78	250	140	277	218	14	11	26	71	97
April	35	308	280	190	315	498	13	12	29	239	268
May	41	262	260	150	301	412	18	13	34	178	212
June	40	307	300	150	340	457	12	12	34	222	256
July	131	264	1,475	1,173	1,606	1,437	38	11	87	189	276
Aug	154	261	0	0	154	261	18	5	141	190	331
Sept	121	202	0	0	121	202	13	14	112	123	235
Oct	121	159	0	0	121	159	13	69	117	123	240
Nov	136	155	0	0	136	155	19	4	134	126	260
Dec	153	220	0	0	153	220	19	8	149	169	318
<b>Total</b>	<b>984</b>	<b>2,368</b>	<b>2,805</b>	<b>2,053</b>	<b>3,789</b>	<b>4,421</b>	<b>212</b>	<b>159</b>	<b>923</b>	<b>1,752</b>	<b>2,675</b>

### Distribution of Patients on ART

By the end of December 2008, there were 17 PLHIV on ART in Etawah, all of whom were being treated at the ART Center in Lucknow. A link ART center was established in Etawah in 2008. A full ART center for the district is planned to open in Saifai in 2009–2010. In January 2009, a new ART center was also established in Agra, which is relatively accessible to PLHIV in Etawah.

### Infrastructure and Services

There are seven ICTCs and two PPTCT centers in Etawah. In addition to the two testing and counseling centers at the male and female district hospitals, four new ICTCs were set up at CHCs (in Jasvantnagar, Bharthana, Safai, and Rajpur) and two ICTCs were established in 24/7 PHCs (in Maheba and Basrehar). There are currently no community care centers (CCCs) in the district, but one is being proposed for 2009–2010. As mentioned above, a full-fledged ART center is also proposed for 2009–2010.

**Table 16. HIV-related Facilities and Targets for 2009–2010**

	Etawah		Uttar Pradesh	
	Existing	Target (2009–2010)	Existing	Target (2009–2010)
<b>ICTCs</b>	7*	None	171	16
<b>PPTCT centers</b>	2	None	79	-
<b>ART centers</b>	1 (link ART)	Upgrade to full ART center	7	5
<b>District hospitals (male)</b>	1	None	70	-
<b>Dist hospitals (female)</b>	1	None	69	-
<b>Blood banks</b>	2	Upgrade Saifai blood bank to add blood component separation unit	46	13
<b>Blood storage units</b>	None	None	20	11
<b>STI clinics</b>	1	1 (Female)	79	2
<b>TI STI clinics</b>	1	None	91	3
<b>Community Care Centers (CCC)</b>	-	1	9	1
<b>Drop-in centers (DICs)</b>	-	1	5**	-

\* Three of these ICTCs were established in November 2008 (at CHCs in Jaswant Nagar, Basrehar, and Chakarnagar).

Table 17 below provides an overview of infrastructure and existing services in Etawah. The data is based on a facility survey and discussions with concerned staff at UPSACS and the TSU. Computers, computer tables, and management information systems (MIS) are not yet in place at the newly-established centers. While the infrastructure is, by and large, in place, the District AIDS Prevention and Control Unit (DAPCU) will need to ensure that the services and infrastructure are well maintained.

**Table 17. Infrastructure and Services**

	ICTC District Hosp.	PPTCT District Hosp.	ICTC CHC Bharthana	ICTC CHC Jaswant Nagar	ICTC CHC Saifai	ICTC CHC Rajpur	PPTCT MC Saifai
<b>Infrastructure</b>							
Is water available for drinking?	Yes	Yes	No	No	No	No	Yes
Is water available for toilet?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Is electricity available in the facility?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
What type of power backup facility is available	Generator	Generator	Generator (inverter)	Generator	Generator	Generator	Generator
	ICTC District Hosp.	PPTCT District Hosp.	ICTC CHC Bharthana	ICTC CHC Jaswant Nagar	ICTC CHC Saifai	ICTC CHC Rajpur	PPTCT MC Saifai
<b>Communication Facilities</b>							
Is there a telephone in the facility?	Mobile of Counselors/LT <sup>14</sup>	Mobile of Counselors/LT	Mobile of Counselors/LT	Mobile of Counselors/LT	Mobile of Counselors/LT	Mobile of Counselors/ LT	No
Is there a STD telephone facility?	No	No	No	Mobile of Counselors/LT	Mobile of Counselors/LT	Mobile of Counselors/LT	No
Is there a computer in the facility?	Yes	Yes	No	DAPCU will procure computer. Budget released	DAPCU will procure computer. Budget released	DAPCU will procure computer. Budget released	Yes
Does the facility have a computerized health management system in place to store patient records?	Yes	No	No	No	No	No	Yes
	ICTC District Hosp.	PPTCT District Hosp.	ICTC CHC Bharthana	ICTC CHC Jaswant Nagar	ICTC CHC Saifai	ICTC CHC Rajpur	PPTCT MC Saifai
<b>Services</b>							
What services are offered at the center?	Pre-test counseling,	Pre-test counseling,	Pre-test counseling,	Pre-test counseling,	Pre-test counseling,	Pre-test counseling,	Pre-test counseling,
	Post-test counseling,	Post-test counseling,	Post-test counseling,	Post-test counseling,	Post-test counseling,	Post-test counseling,	Post-test counseling,
	Ongoing counseling,	Ongoing counseling,	Ongoing counseling,	Ongoing counseling,	Ongoing counseling,	Ongoing counseling,	Ongoing counseling,
	HIV testing	HIV testing for PPTCT	HIV testing	HIV testing	HIV testing	HIV testing	HIV testing for PPTCT
Days allotted for counseling and testing of pregnant women	All working days	All working days	All working days	All working days	All working days	All working days	All working days
Does the facility provide group counseling?	Yes	Yes	No	Yes	Yes	Yes	Yes
If yes, how many people (on average) per group?	10–15	20–25	6–7	8–10	4–5	6–8	15–20

<sup>14</sup> Laboratory technician

How long (on average) is each group session?	30–45 min	30–45 min	25–30 min	25–30 min	10–15 min	20–25 min	25–30 min
Are condoms available in the center?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Where are the condoms kept?	Counseling room/Lab	Counseling room	Counseling room	Counseling room	Counseling room	Counseling room	Counseling room
	ICTC District Hosp.	PPTCT District Hosp.	ICTC CHC Bharthana	ICTC CHC Jaswant Nagar	ICTC CHC Saifai	ICTC CHC Rajpur	PPTCT MC Saifai
<b>HIV Counseling</b>							
Is there a waiting room/area available?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Number of chairs in the waiting room	6	7	5	8	6	5	10
Is there a counseling room?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Number of counseling rooms	1	1	1	1	1	1	1
Physical infrastructure in counseling room:							
a. Desk and chair for the counselor	Yes	Yes	Yes	Yes	Yes	Yes	Yes
b. Lockable filing cabinet for records	Yes	Yes	Yes	Yes	Yes	Yes	Yes
c. Computer with printer and UPS	Yes (UPS not working)	Yes	No	No	No	No	Yes
d. Computer table, with a chair	Yes	Yes	No	No	No	No	Yes
e. Waste basket	Yes	Yes	Yes	Yes	Yes	Yes	Yes
f. Number of chairs for clients	3	6	4	6	6	10	10
Is privacy ensured?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	ICTC District Hosp.	PPTCT District Hosp.	ICTC CHC Bharthana	ICTC CHC Jaswant Nagar	ICTC CHC Saifai	ICTC CHC Rajpur	PPTCT MC Saifai
<b>HIV Testing</b>							
Is there a separate lab/blood sample collection room?	No	No	No	No	No	No	No
Equipment observed in testing room:							
a. Refrigerator	Yes	Yes	Yes	Yes	Yes	Yes	Yes
b. Centrifuge	No	No	Yes	Yes	Yes	Yes	No
c. Needle destroyer	Yes	Yes	Yes	Yes	Yes	Yes	Yes
d. Micropipette	No	No	Yes	Yes	Yes	Yes	Yes
e. Components for infection control and	Yes	No	Yes	Yes	Yes	Yes	Yes

waste management							
f. Testing kits	Yes	Yes	Yes	Yes	Yes	Yes	Yes
g. Safe delivery kits	No	Yes	No	No	No	No	No
	ICTC District Hosp.	PPTCT District Hosp.	ICTC CHC Bharthana	ICTC CHC Jaswant Nagar	ICTC CHC Saifai	ICTC CHC Rajpur	PPTCT MC Saifai
<b>Staff</b>							
Counselors	1	1	1	1	1	1	1
Laboratory technicians	1	1	1	1	1	1	1
Patients per day	10–15	10–15	10	15	10	8	15–20
Waiting time for patients	30–45 min	40–45 min	30–40 min	25–30 min	5–10 min	15–20 min	40 min
	ICTC District Hosp.	PPTCT District Hosp.	ICTC CHC Bharthana	ICTC CHC Jaswant Nagar	ICTC CHC Saifai	ICTC CHC Rajpur	PPTCT MC Saifai
<b>IEC Material</b>							
Flipcharts	1	No	2	1	1	No	2
Condom demonstration models	No	No	No	No	No	No	No
Posters	25	10	20	10	70	10	50
Pamphlets/handouts	100	50	No	50	100	No	No
Is any audiovisual material being played in the waiting room?	Yes	Yes	No	No	No	No	Yes

## FRAMEWORK FOR PROGRAM ACTIVITIES

NRHM is a comprehensive, broad-based program, which integrates all vertical health programs of the Department of Health and Family Welfare (DOHFW), including the second phase of the Reproductive and Child Health Program (RCH-II), the National Vector Borne Disease Control Program (NVBDCP), the Revised National TB Control Program (RNTCP), the National Blindness Control Program (NBCP), and the National Leprosy Eradication Program (NLEP). Under the NRHM framework, different national programs merge together at the state level into a common State Health Society, while at the district level all program societies merge into the District Health Society (DHS). The governing body of each DHS is chaired by the Chairman of the *Zila Parishad*<sup>15</sup>/District Collector; the executive body is chaired by the District Collector; and the Chief Medical & Health Officer (CMHO) is the Member Secretary.

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

### 3.1 District AIDS Prevention and Control Committee (DAPCC)

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

The DAPCC has been formed in Etawah district. The members of the committee are as follows:

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

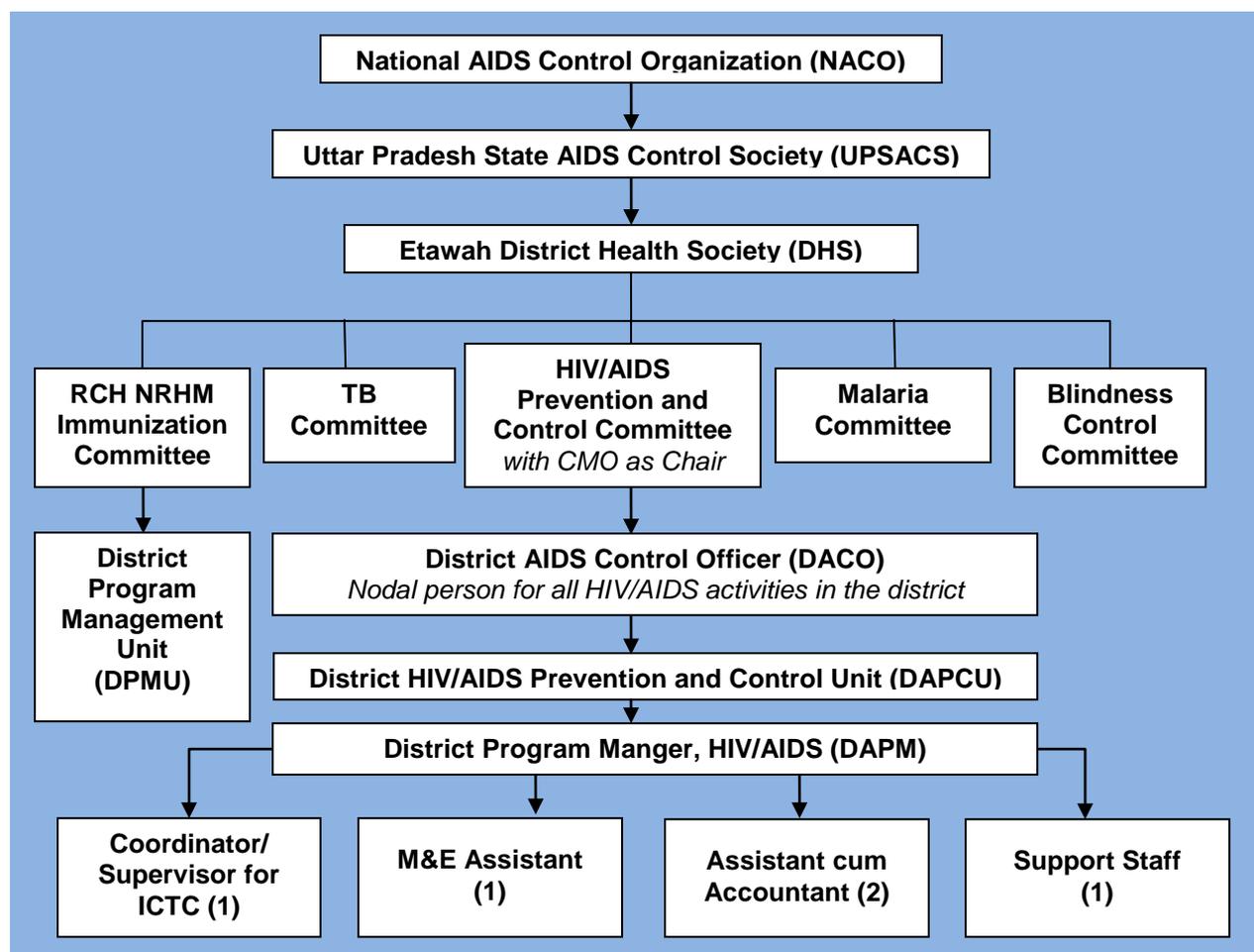
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<sup>15</sup> District council

### 3.2 District AIDS Prevention and Control Unit (DAPCU)

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

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



**Table 18. DAPCU Roles and Responsibilities**

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

The terms of reference for DAPCU staff are listed in the section on Human Resource Planning (see Section 7.2 on page 43).

## PURPOSE OF THE PLAN

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

NACP-III envisions expanding the network of HIV/AIDS services from the NACP-II pattern of selective NGO/CBO<sup>16</sup>-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

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

### Goal

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

### Strategy

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

This action plan seeks to define and implement a unified strategy under the leadership of the District Collector to combine efforts to maximize impact and optimize the use of limited resources. From the district level, the HIV program will filter down to the village and *anganwadi* levels through a cadre of customized service providers called “link workers.”<sup>17</sup> The DAPCU will ensure professional management of the program through regular monitoring and supervision.

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<sup>16</sup> Community-based organization

<sup>17</sup> Link workers are community workers who have been identified to reach out to rural populations on HIV-related issues.

## INSTITUTIONAL STRENGTHENING FOR CORE ACTIVITIES

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### 5.1 Targeted Intervention (TI)

Like all category A districts, the epidemic in Etawah, while primarily confined to HRGs, is gradually moving into the general population. To saturate coverage of HRGs and prevent new HIV infections, UPSACS is implementing targeted intervention projects in collaboration with local-level NGO partners. The TI strategy focuses on raising the level of HIV knowledge among HRGs through interpersonal communication, motivating them to adopt safer behaviors, improving their access to condoms and other prevention services—especially STI and ICT services—and creating an enabling environment for HIV prevention. The link workers scheme also plays an important role in covering pockets of HRGs especially in the rural areas.

NACP-III in UP<sup>18</sup> aims to reduce new infections by 60 percent in high prevalence districts and by 40 percent in vulnerable districts in the program's first year to reverse the epidemic's overall spread in the state.

#### Objective

To support and mainstream TI projects to improve their effectiveness and sustainability.

#### Situation Analysis

In a statewide mapping<sup>19</sup> exercise commissioned by NACO in select sites of each district in Uttar Pradesh in 2008, an estimated 150 FSWs were found in Etawah, most of them between 18 and 34 years of age. Among these FSWs, 55 were found to be home-based (concentrated in Ram Gunj and Mewati Mohalla), while 95 were street-based, mostly around the Takiya transport, in front of Ghantaghar, near the taxi stand and the railway station, and near Yadav Nagar and Ganesh rice mills. No FSWs were found to be operating from line-hotels, *dhabas*,<sup>20</sup> lodges, or brothels. At the time of the mapping exercise, HIV interventions for FSWs were present in select locations—Mewati Mohalla, Namo bus stand, Tiraha, *tehsil* Chauraha, and Takiya transport.

Of all the category A districts<sup>21</sup> in UP, Etawah was found to have the smallest number of MSM—only 16 compared to the 825 MSM identified in Allahabad, or the 580 found in Mau. All 16 MSM in Etawah were “double-deckers”<sup>22</sup> identified at two sites; there were no *kothis*.<sup>23</sup> Mapping of *hijras* at four sites showed that there were 35 *hijras*, of whom nearly one-third were commercial and the rest non-commercial. Servicemen and rickshaw pullers are the largest clients of *hijras*. The mapping exercise identified 102 IDUs at 13 sites. Among those identified, 65 were found to be sharing needles. The mapping also indicated that about eight percent of the 287 single circular migrants engaged in high-risk behaviors.

There is currently only one targeted intervention being implemented in Etawah. Warsi Seva Sadan, a Kannauj-based NGO, began implementing the TI project in Etawah in October 2008. The program is a composite intervention that reaches FSW (250), MSM (150), and IDU (100) populations in urban and peri-urban areas of the district. It offers a package of services, which contain common program components but can be customized to meet the needs of different HRGs. Common elements include peer-led outreach and behavior change communication (BCC); distribution and promotion of free

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<sup>18</sup> Uttar Pradesh Program Implementation Plan for NACP-III, UPSACS, Lucknow, May 2008

<sup>19</sup> The mapping of core and migrant groups (under NACP-III) in Uttar Pradesh was done by Social and Rural Research Institute (IMRB) for Constella Futures and Family Health International. Revalidation of this data is being done by NACO.

<sup>20</sup> Small eateries

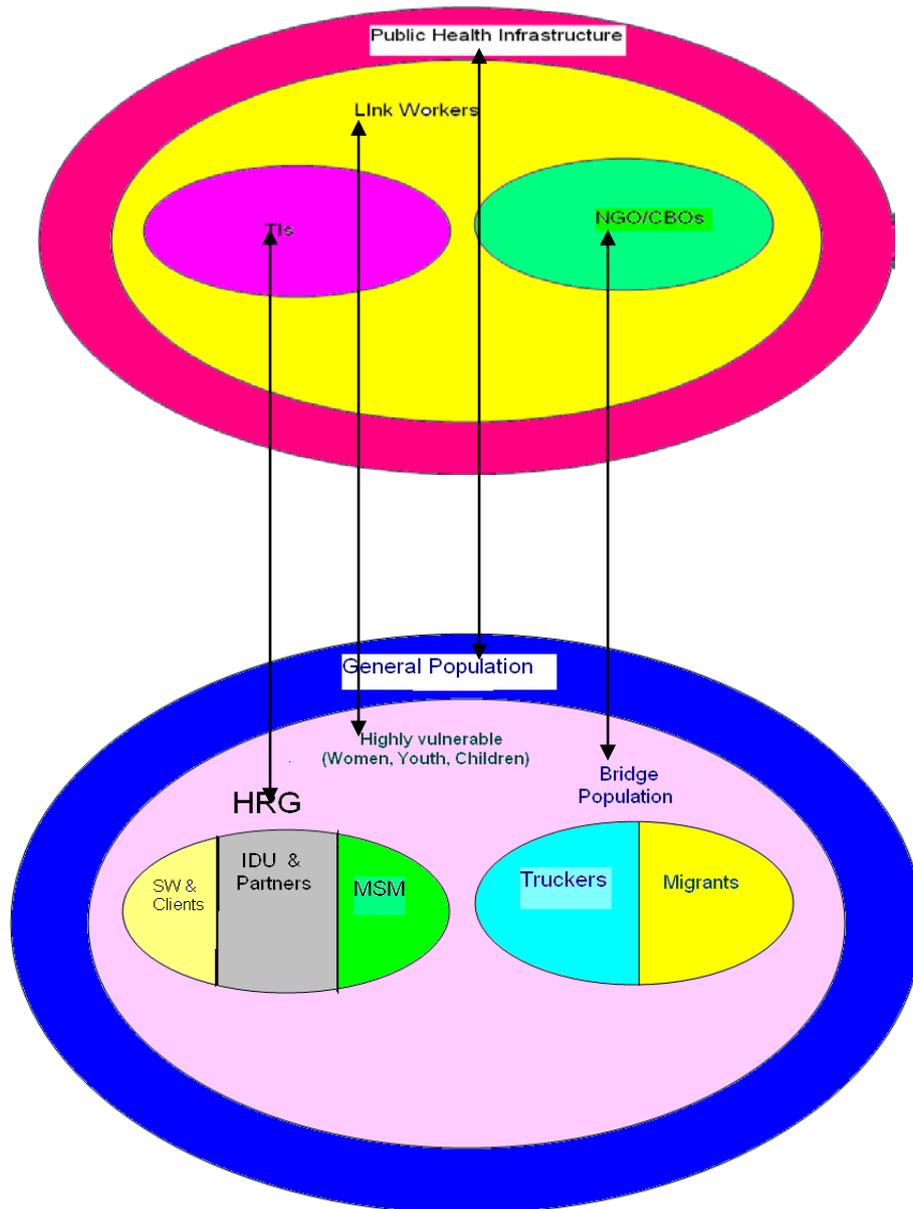
<sup>21</sup> Allahabad, Banda, Deoria, Etawah, and Mau

<sup>22</sup> those who act both as receptive and penetrative partners in a MSM relationship

<sup>23</sup> the individual who takes the female sexual role in a MSM relationship

condoms, needles/syringes, and other HIV prevention commodities; STI services; promotion of testing and referrals to ICTCs; establishment of linkages with TB department and ICTCs; and capacity building to enable HRGs to assume ownership of the program. The program reinforces its capacity building efforts by educating and mobilizing the community on HIV issues.

**Figure 3. Population Mapping for Targeting Service Provision<sup>24</sup>**



<sup>24</sup> Operational guidelines for Districts AIDS Prevention Control Units

## **Strategies**

- Evolve systems for unhindered implementation of TI project.
- Mainstream functioning of TI project with public health delivery system for supplies, service delivery, and follow-up.
- Collaborate with private providers for improved delivery and outreach of services.

## **Action Plan**

- Facilitate overall implementation of TI project in Etawah.
- Provide supportive supervision to TI project and build capacity of TI personnel.
- Include representative of TI implementing organization in DAPCU as a member of DAPCC and ensure that monthly management information system report from TI project to UPSACS is copied to DAPCU for necessary information and follow-up.
- Operationalize monthly interactions at district level to share and plan TI project activities.
- Undertake advocacy with police personnel, district administration officials, and other stakeholders to create a supportive environment for TI project activities (especially for outreach workers and peer educators).
- Sensitize health care providers at all levels (including health outreach workers) to enable them to assist in TI project activities, thereby improving grassroots-level service delivery.
- Establish systems for obtaining periodic feedback from clients of health care services.
- Keep DAPCU informed about supply of condoms and IEC materials to TI project from UPSACS.
- Engage DAPCU staff in spot-checks and monitoring of TI project implementation.
- Provide necessary support for formation of CBOs by catalyzing technical assistance and creating enabling environment.

## **Responsibility**

DAPCU and TI implementers

## 5.2 Antiretroviral Therapy / Treatment

The antiretroviral therapy (ART) program has adopted a public health approach to the administration and distribution of antiretroviral (ARV) drugs. This approach entails a comprehensive prevention, care, and treatment program with a standardized, simplified combination of ART regimens; a regular, secure supply of high-quality ARV drugs; and a robust monitoring and evaluation system. The public health approach for scaling up ART aims to provide care and treatment to as many people as possible, while working toward universal access to care and treatment. Access to and availability of ART remains a major cause of concern for PLHIV throughout India.

### Objective

To make ART available to all eligible PLHIV in Etawah.

### Situation Analysis

There is one link ART center in Etawah district. The center provides services for drug administration and management and counseling for drug adherence. The link ART center was only recently established and infrastructure and systems for managing the center are still being set up. One round of training of key center staff has already been carried out.

Of the 114 individuals who have tested HIV-positive<sup>25</sup> in the district, 17 are currently on treatment at the ART center in Lucknow. Since the Lucknow ART center is quite far from Etawah, it is being considered that individuals should receive services from the more easily accessible Aligarh-based Jawaharlal Medical College or the newly opened ART Center at Agra Medical College. The lack of accessible ART services is affecting treatment adherence, as PLHIV have to lose at least a day's work and wages to access treatment. These barriers to access are compounded for HIV-positive women and poor PLHIV. Currently, Etawah does not have an initiative to help PLHIV overcome logistical and administrative barriers to treatment. However, there is a plan to establish a full-fledged ART Center at the UP Rural Institute of Medical Sciences and Research, in Saifai in Etawah district by 2009–2010, which will help address some of the concerns related to access.

### Strategies

- Operationalize, strengthen, and upgrade existing link ART services in the district.
- Facilitate public-private partnership for testing, CD4 monitoring, and OI management.
- Establish systems to improve treatment adherence.

### Action Plan

- Address all administrative and logistical issues related to effective functioning of link ART center (including furnishing, privacy of space, necessary trainings, etc.).
- Facilitate registration of patients to Agra or Aligarh ART centers until ART center is established in Etawah.
- Assist in maintaining adequate and regular supply of drugs to link ART/ART center, providing regular updates to UPSACS in case of gaps in supply. Also follow up with UPSACS for supply of second line drugs in accordance with district requirements.
- Follow up to ensure timely execution of proposed plan to establish full ART center in Saifai.
- Ensure consistent registration and tracking of PLHIV on ART.
- Coordinate between ART centers and outreach workers/link workers for care and support services/counseling.
- Periodically organize trainings and refresher courses, especially for counseling PLHIV on treatment adherence.
- Coordinate with India Network of Positive people (INP+) to initiate district-level PLHIV network.

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<sup>25</sup> Cumulative number of cases tested HIV positive at the ICTCs up to December 2008. Source: SACS

- Promote sample collection for CD4 count around hotspots.
- Engage ICTC coordinator and *anganwadi* workers (AWWs) to track lost to follow-up cases.
- Ensure that Medical Officer-in-Charge (MOIC) is accountable for ART program and provides regular updates to DAPCC.

**Responsibility**

CMO/MOIC, Health (NRHM); UPSACS; DAPCU; NGOs

### 5.3 Integrated Counseling and Testing (ICT)

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

#### Objective

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

#### Situation Analysis

There are nine ICTCs/PPTCT centers in Etawah district. This includes one PPTCT center (ANC-ICTC) at the UP Rural Institute of Medical Sciences and Research (RIMS), Saifai; one PPTCT center at the district female hospital; and a general ICTC at the male district hospital. There are also four new ICTCs at four CHCs in Jasvantnagar, Bharthana, Safai, and Rajpur; and two ICTCs in 24/7 PHCs in Maheba and Basrehar. Between January and December 2008, 3,316 people were tested at ICTCs and 6,220 were tested at the PPTCT center. Of those tested at the ICTCs, 46 were found to be HIV-positive. Of those tested at the PPTCT center, four people tested positive, yielding seropositivity rates of 0.71 percent and 0.08 percent, respectively.

**Table 19. ICTC Status (2003–2008)**

	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
<b>2003</b> (Jun–Dec)	144	86	230	144	86	230	8	6	14
<b>2004</b>	663	357	1020	251	205	456	11	7	18
<b>2005</b>	1530	800	2330	281	196	477	4	2	6
<b>2006</b>	516	387	903	280	231	511	16	8	24
<b>2007</b>	1152	1851	3003	812	1411	2223	15	16	31
<b>2008</b> (Jan–Dec)	1909	2505	4414	1422	1894	3316	36	10	46

Source: UPSACS

At present, there are several critical barriers limiting the impact of ICTCs in Etawah. First, there are no linkages between the counseling centers and NGOs, nor do the centers make any special provisions for people referred by NGOs. Second, the centers are not carrying out any outreach work. As a result, the community at large remains unaware that ICT services are available in the district hospital, limiting the number of clients accessing ICT services. The centers do not have data on the geographic distribution of individuals testing positive for HIV. They face problems with irregular supplies of consumable items, as well as a lack of space in which to organize group counseling. Current ICT facilities also do not provide ideal conditions for patient privacy and confidentiality.

**Table 20. PPTCT Status (January–November 2008)**

Month	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
January	38	318	356	31	303	334	2	3	5
February	68	387	455	65	363	428	0	1	1
March	78	483	561	73	452	525	0	0	0
April	15	175	190	5	64	69	0	0	0
May	37	328	365	-	-	-	-	-	-
June	28	382	410	14	209	223	0	0	0
July	15	261	276	15	246	261	0	0	0
August	15	418	433	10	383	393	1	0	1
September	10	399	409	9	386	395	1	1	2
October	0	288	288	-	275	275	-	-	-
November	6	529	535	5	506	511	-	1	1
<b>TOTAL</b>	<b>310</b>	<b>3,968</b>	<b>4,278</b>	<b>227</b>	<b>3,187</b>	<b>3,414</b>	<b>4</b>	<b>6</b>	<b>10</b>

Source: UPSACS

### Strategies

- Strengthen services at existing ICTCs and expand coverage through convergence with NRHM.
- Increase demand for testing and counseling.
- Promote public-private partnership for expanding ICT services.
- Institutionalize formal linkages with TIs to promote positive living among PLHIV.

### Action Plan

- Increase the number of ICTCs at CHCs and 24/7 PHCs to maximize utilization and improve access.
- Build the capacity of existing ICTC staff to improve service delivery, especially in the area of counseling.
- Organize refresher training for staff (counselors and technicians) once every six months to reinforce service delivery skills.
- Train counselors and lab technicians and position them at new ICTCs.
- Involve ICTC counselors in community outreach for demand generation.
- Undertake regular facilitative supervision (ICTC coordinator).
- Design and roll out IEC campaigns to increase demand for ICT services (independently and in convergence with government health system/NRHM).
- Establish linkages with outreach workers and link workers to provide HIV-positive individuals with orientation on ART and healthy living.
- Streamline supply system for testing kits and other materials.
- Foster coordination among ICTCs, TIs, and DAPCU.

### Responsibility

DAPCC, DAPCU, UPSACS, NGOs

## 5.4 Blood Safety

### Objective

To reduce the transmission of HIV through infected blood products in Etawah district through blood safety and to ensure the timely availability of safe blood and blood products.

### Situation Analysis

Etawah district aims to reduce the transmission of HIV through blood and blood products to less than 0.3 percent and to make sufficient quantities of safe, high-quality blood and blood products available to all those who need them at the right time and in the right place—especially at emergency obstetric centers, trauma centers, and surgical units, and in remote and rural areas. There are currently two blood banks in Etawah—one at Dr. B.R. Ambedkar district hospital and the other at RIMS, Saifai. The blood banks are operated by UPSACS according to NACO norms. In 2008–2009, UPSACS aims to raise voluntary blood donation levels to 60 percent of total government sector blood collection. Between April and December 2008, 2,223 units of blood were collected in Etawah as replacement and 264 units were collected through voluntary donation. In 2009–2010, the aim is to collect 3,260 units as replacement and 920 units through voluntary donation. To achieve this target, the district will organize more voluntary blood donation camps in 2009–2010 than it has in previous years.

### Strategies

- Strengthen blood bank infrastructure in accordance with UPSACS and NRHM guidelines.
- Promote voluntary blood donation through donation camps to maintain optimal blood supply levels.
- Promote blood safety practices and verify the quality of blood products.

### Action Plan

- Provide necessary support to DACO (as nodal officer for blood safety) to enable him/her to effectively manage district blood safety program.
- Streamline Etawah's blood collection, supply, and storage procedures and systems.
- Facilitate capacity building of blood bank medical officers and staff for blood safety in accordance with NRHM and NACP protocols.
- Ensure uninterrupted supply of equipment and consumables through NRHM and NACP and keep UPSACS informed about blood bank inventory status.
- Undertake IEC and advocacy for blood safety during blood donation camps and educate community on voluntary blood donation, as well as use of safe/screened blood in transfusion.
- Involve other departments and organizations—such as *Nehru Yuvak Kendra* (NYK), National Student Service (NSS), and NGOs—in promoting voluntary blood donation.

### Responsibility

DACO (nodal officer for blood safety)

## 5.5 Supplies and Logistics

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

### Objective

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

### Situation Analysis

The older ICT and PPTCT centers in Etawah possess the minimum requirements for physical infrastructure, such as a desk for the counselor; chairs; a lockable filing cabinet for keeping records; a waste basket; and a computer with table, printer, and UPS. Among the new ICTCs, some elements of the physical infrastructure, such as drinking water, generators, computers, printers, and UPS, are still being set up.

**Table 21. Supply Needs by Service Delivery Point**

Service Delivery Points	Supplies	Estimated Requirements for 2009–2010
7 ICTCs	<ul style="list-style-type: none"> <li>3 rapid test kits for 15,000 tests</li> <li>15,000 disposable syringes and gloves</li> <li>5 condoms for each client accessing ICT services</li> </ul>	<ul style="list-style-type: none"> <li>11,739 rapid test kits (1st, 2nd, 3rd)</li> <li>11,739 disposable syringes and gloves</li> <li>58,693 condoms</li> </ul>
2 PPTCT centers	<ul style="list-style-type: none"> <li>Rapid test kits</li> <li>Nevirapine tablets</li> <li>Nevirapine syrup</li> <li>Safe delivery kits</li> </ul>	<ul style="list-style-type: none"> <li>9,684 rapid test kits</li> <li>26 Nevirapine tablets</li> <li>26 Nevirapine syrups</li> <li>90 safe delivery kits</li> </ul> <p>Estimates based on 51,650 estimated annual pregnancies with a 0.2% ANC prevalence (HSS 2007), yielding an anticipated 103 HIV-positive women requiring services.</p>
1 TI project	<ul style="list-style-type: none"> <li>Disposable needles for 80 percent coverage of IDUs in TI projects</li> <li>Condoms and lubricants</li> <li>HRG-specific IEC material, especially take-away materials and behavior change communication kits for peer educators</li> </ul>	Provision in TI project budget managed by NGOs.
2 blood banks	<ul style="list-style-type: none"> <li>Test kits for HIV, HBSAG (Hepatitis B), HCV (Hepatitis C), MP, and VDRL (syphilis)</li> <li>Blood bags, disposable syringes, and other consumables</li> <li>IEC material</li> </ul>	<ul style="list-style-type: none"> <li><b>TO BE INSERTED</b></li> </ul>
1 link ART center (plus 1 full ART center proposed for 2009)	<ul style="list-style-type: none"> <li>ARV drugs for new cases every month</li> <li>ARV drugs for the cumulative number of people on ART</li> <li>Disposables and reagents for CD4 count</li> <li>Post exposure prophylaxis (PEP) drugs</li> </ul>	<ul style="list-style-type: none"> <li>ARVs for new cases</li> <li>ARVs for 17 existing cumulative cases</li> <li>Disposables and reagents for CD4 will be needed when full ART center is established.</li> </ul>

There are communication aids such as TV and DVD players, posters and information on the walls, flip charts, and take-home leaflets/pamphlets for clients and visitors. The required testing equipment—such

as refrigerators, centrifuges, micropipettes, and waste-bins—as well as consumables like condoms, sterile needles and syringes, vials and tubes for collection and storage of blood, cotton swabs, and spirits are adequate and in place.

The logistics supply chain from UPSACS to the district level needs to be streamlined through the DAPCU. Currently, SDPs make requests directly to UPSACS and in most cases supplies have to be collected from the UPSACS office in Lucknow. Delay in getting supplies affects ICT service delivery, as a result of which many people are denied quality services. With the introduction of the DAPCU, SDPs can assess their supply needs on a quarterly basis and the DAPCU can obtain the necessary supplies from UPSACS and distribute them directly to SDPs.

### **Strategies**

- Achieve optimum utilization of resources through convergence with NRHM and other public health departments.
- Employ inventory control and quality checks to overcome delays and stockouts.
- Streamline fund flows for supplies and logistics.

### **Action Plan**

- Manage supplies and logistics at district level (responsibility of ICTC coordinator).
- Ensure regular supply of drugs and upkeep of equipment by carrying out monthly stock verifications and monitoring quality of storage facilities.
- Compile monthly list of supply requirements from ICTCs, PPTCT centers, blood banks, TI project, and link ART center and follow up with UPSACS (and NRHM if needed) to ensure timely delivery of supplies.
- Use NRHM logistics system to procure and deliver HIV supplies in district and create new supply chain mechanism between UPSACS and DAPCU that maintains clear lines of communication with both SDPs and UPSACS.
- Develop and roll out plan for convergence with other programs in consultation with CMHO.

### **Responsibility**

District ICTC coordinator, ART coordinator (Medical Officer-in-Charge)

## CONVERGENCE WITH NRHM

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

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

### Objective

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

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

### Situation Analysis

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

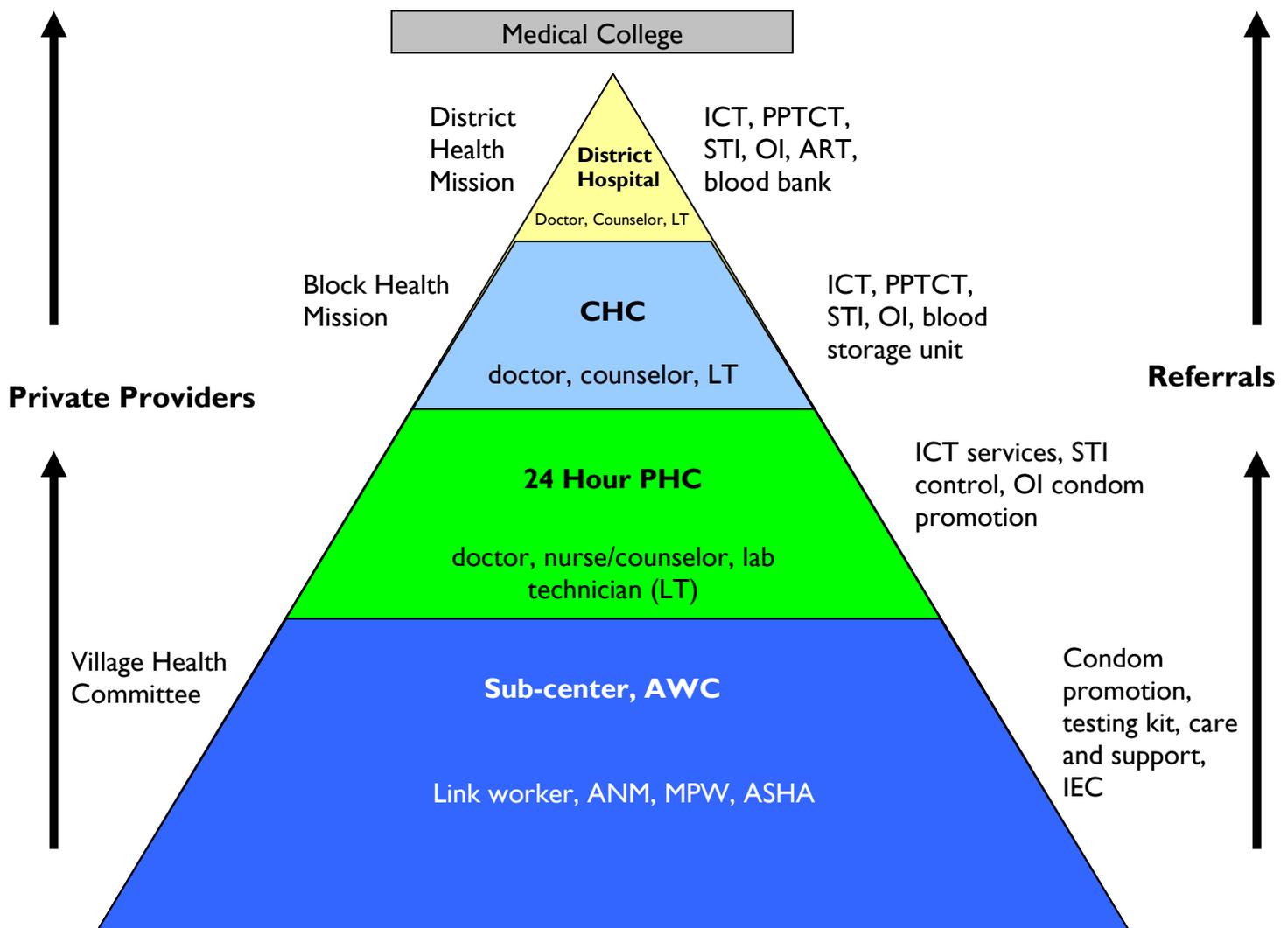
While the DAPCC has been established in principle, so far only one of the six members of the DAPCU—the ICTC Coordinator—has been appointed in Etawah. Therefore, the DAPCU has not yet become fully operational.

### Strategies

- Operationalize the DAPCC.
- Develop a detailed plan for convergence with key stakeholder organizations/departments, including the following elements:
  - Strengthen service delivery by expanding availability of HIV services at CHC and PHC level.
  - Mainstream district-level NACP structure with public health infrastructure.
  - Upgrade district-level technical capacity by engaging qualified professionals using contract mechanisms.
  - Integrate NACP functions with RCH program, TB control program (referral protocol between DOTS and ICTCs), and other health and family welfare programs.
  - Collaborate with NGOs, CBOs, professional associations, and other civil society organizations to deliver sensitization, care and support services, and referrals.

- Address HIV issues at village level through *anganwadis* for women and adolescents.
- Engage AWWs to provide nutritional support for HIV-positive pregnant women.
- Involve private doctors in providing HIV-related services.
- Intensify counseling, advocacy, and referrals at village level through Maternal and Child Health and Nutrition (MCHN) Day.
- Furnish honoraria to ASHAs, ANMs, and multi-purpose health workers (MPWs) for providing HIV-related services.
- Address HIV prevention, control, care, treatment, and support in Village, Block, and District Health Plans—implemented by Village Health and Sanitation Committee, Block Rural Health Mission, and District Health Mission, respectively.
- Engage PLHIV network in ensuring reduction in stigma and discrimination, provision of quality services, treatment adherence, and reduction of cases lost to follow-up.

**Figure 4. Institutional Framework: Public Health Sector Services**



## 6.1 Condom Promotion

In addition to being a safe method of population control, condoms have assumed special significance in the era of HIV/AIDS, as they are the only effective method—apart from total abstinence—of preventing the sexual transmission of HIV. Departments of health and family welfare and NGOs are working to overcome moral, ethical, and/or religious barriers to promoting the use of condoms among sexually active people—particularly those who engage in high-risk behaviors.

### Objective

To promote condom usage for dual protection from unwanted pregnancy and STIs.

### Situation Analysis

NGOs and government health departments have adopted a policy of promoting condom use through community-based distribution and social marketing. In general, the social marketing strategy has helped increase the use of condoms. However, there is still an urgent need to ensure the availability of condoms in all the places they are needed.

Hospitals, STI clinics, counseling centers, TI implementers, and community drug stores have adequate supplies of condoms. The TI projects have mapped hotspots of HRGs and which outlets they access to get condoms, and non-conventional condom outlets have been established in TI project areas and in urban areas. At the same time, there is still a need to increase the general availability of condoms in public places, such as important road and railway junctions, parks, hotels, motels, and lodges. While two condom vending machines are available at the district hospital ICTC and another is available at the ICTC in the Bharthana CHC, these machines are not always working. The quality and reliability of condoms is also an issue.

Demand for different varieties of condoms, such as condoms with non-latex/water-based lubricants and gels for users with allergies, or thick condoms for MSM, is not currently being met. Culturally acceptable information packages about the efficacy of condoms are largely missing from media campaigns. The inclusion of information on condoms in such campaigns could have a positive impact on the use of condoms for both birth control and HIV prevention. When designing convergence plans it must be noted that family planning programs largely focus on “eligible couples,” whereas HIV programs cover HRGs who may or may not fall within the category of eligible couples.

### Strategies

- Implement a collaborative condom promotion and supply strategy under NRHM and NACP and a combined communication strategy promoting dual protection messages.
- Promote safe sex practices for PLHIV.

### Action Plan

- Develop and roll out an integrated communication strategy for RCH and HIV/AIDS.
- Ensure promotion and distribution of condoms among FSWs through outreach workers, peer educators, and non-traditional outlets.
- Facilitate installation of condom vending machines at hotspots and STI clinics and ensure their functionality through monthly checks.
- Promote safe sex practices among PLHIV.
- Organize appropriate logistics planning to ensure uninterrupted supply of condoms at all levels.
- Build capacity of staff (community-level workers, outreach workers, and link workers) to demonstrate correct condom use and present enhanced IEC.
- Undertake monthly assessment of supply needs to streamline supply system.
- Strengthen link worker program component to intensify condom promotion.

### Responsibility

Health department, DAPCU, UPSACS, TI implementers, ICTCs, district PLHIV network, peer educators

## **6.2 Maternal Health**

The district PPTCT program aims to prevent the spread of HIV among women, especially expectant mothers, as well as to prevent parent-to-child transmission of HIV. Parent-to-child transmission of HIV can occur during pregnancy, at the time of delivery, and through breast-feeding. The PPTCT center works to prevent this through a combination of low-cost, short-term, preventive drug treatments; safe delivery practices; counseling and support; and safe infant feeding methods.

### **Objective**

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

### **Situation Analysis**

There are two PPTCT centers in the district, one at the district female hospital and one at RIMS, Saifai. Each center has one counselor and one lab technician. On average, 213 persons are counseled/tested per PPTCT center each month. Among the women who visited the center in 2008, six were found HIV-positive. A large number of susceptible women remain untested for HIV because the center primarily receives clients who are referred from ANC. Sociological factors such as stigma, discrimination, and ignorance play a critical part in clients' decision to access services. The fear of a positive result and lack of support from male partners deter women from undergoing HIV testing. Operational factors such as counselors' lack of interpersonal skills and the lack of outreach staff also have a negative influence on the provision of PPTCT services.

### **Strategies**

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

### **Action Plan**

- Provide for an obstetric/gynecological doctor at PPTCT centers.
- Maintain supply chain of safe delivery kits and Nevirapine.
- Promote voluntary testing among pregnant women.
- Establish referrals for services through NGO workers and community health workers.
- Ensure systems for follow-up with each woman identified as HIV-positive to ensure treatment adherence.
- Organize orientation of health workers on HIV and counseling for PPTCT as well as on life skills education for encouraging positive living among PLHIV.
- Provide training to doctors on safe delivery techniques for HIV-positive mothers.
- Collaborate with private practitioners and build their capacity to identify and refer HIV-positive pregnant women during ANC.
- Monitor operation of PPTCT services (responsibility of District ICTC Coordinator).

### **Responsibility**

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

## **6.3 Infant and Pediatric Care**

### **Objective**

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

### **Situation Analysis**

The PPTCT center does not have data on the number of children seeking ART. Currently, there is no mechanism or system to provide referral from health centers and sub-centers for testing, institutional support to HIV-positive children or their parents, or targeted tracking of children.

### **Strategies**

- Promote institutional deliveries and follow up with all HIV-positive mothers and their newborns to ensure that infants are tested and provided with ART if needed.
- Expand outreach of coverage through convergence with NRHM, especially Integrated Management of Neonatal and Childhood Illness (IMNCI).
- Collaborate with private practitioners to strengthen PPTCT services.

### **Action Plan**

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

### **Responsibility**

Health (NRHM), UPSACS, DAPCU, private providers

## 6.4 Sexually Transmitted Infection (STI)

The presence of a sexually transmitted infection (STI) significantly increases an individual's risk of contracting or transmitting HIV, especially when there is an ulcer or discharge. As STIs and HIV are spread by the same set of risk behaviors, the government places top priority on the prevention and control of STIs as a strategy for controlling the spread of HIV/AIDS in the district.

### Objective

To reduce the STI burden in Etawah.

### Situation Analysis

There is currently only one STI clinic operating in Etawah and it is based in the Etawah district hospital. The records show that in 2008 RPR<sup>26</sup> tests were performed on a total of 415 men and 500 women and none were found positive for syphilis (RPR reactive).

### Strategies

- Provide STI treatment and counseling services at RCH-NRHM camps.
- Promote health seeking behavior among STI cases and their partners.
- Expand access to quality STI treatment.

### Action Plan

- Establish STI management services at CHCs and PHCs.
- Ensure availability of STI drugs at sub-centers, PHCs, and CHCs.
- Ensure logistics and supplies for uninterrupted service delivery.
- Increase availability of trained human resources for STI service delivery under NRHM.
- Strengthen capacity of outreach workers and health workers to identify STIs and improve service delivery for STI cases.
- Strengthen mechanisms for referring STI cases to ICTCs.
- Disseminate knowledge about STI and its possible link with HIV/AIDS at village level through community health workers (ASHAs, ANMs, MPWs, and AWWs).
- Prepare IEC material (flipcharts) for ASHAs/ANMs to use during village-level counseling.
- Involve and train private providers in treatment of STIs.

### Responsibility

Health (NRHM), UPSACS, DAPCU

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<sup>26</sup> rapid plasma reagin (blood test for syphilis)

## 6.5 IEC and Advocacy for Behavior Change

The purpose of developing an IEC strategy is to motivate behavior change among at-risk population groups and generate demand for health services. The strategy will also help create an enabling environment for HIV prevention, as well as for the provision of institutional and community-based care and support.

### Objective

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

### Situation Analysis

According to the National Family Health Survey-3 (2005–2006), 40 percent of ever-married women have heard of HIV/AIDS compared to 74 percent of men. Electronic and print media have achieved almost universal coverage for dissemination of HIV/AIDS information. The increase in levels of HIV/AIDS awareness in the general community can be partly attributed to electronic media, which have conveyed HIV messages all the way to the village level. While there is general awareness about the disease, specific aspects such as modes of transmission and prevention methods remain unfamiliar to a large portion of the population. There is a dearth of appropriate programs that stress interpersonal communication for targeted groups, such as HRGs, migrant laborers, truckers, and the rural community in general.

The role of local media in generating an enabling environment for HIV prevention and care of PLHIV has been limited. Local newspapers, magazines, and other print media have been used to conduct social mobilization campaigns to generate awareness about HIV prevention and share information and expertise. Media campaigns in rural areas are largely centered on posters, pamphlets, pictorial charts, or wall writings. Local media outlets have not incorporated local language, culture, or traditions to reinforce positive cultural and social values that could be used to support HIV prevention messages. Nor have the local campaigns used creative media, such as folk dances, puppet shows, and street plays to convey HIV messages. There is a particular lack of customized IEC material and orientation programs for migrant laborers, truck drivers, and their helpers.

### Strategies

- Develop IEC material for specific HRGs (such as IDUs, FSWs, truckers, and migrants) and vulnerable populations (women and youth), as well as for general community.
- Develop an IEC strategy for doctors, paramedics, and other service providers.
- Involve NGOs, self-help groups (SHGs), community workers from various departments (such as health, education, and *panchayats*),<sup>27</sup> as well as link workers, to promote HIV awareness and behavior change.

### Action Plan

- Liaise with NGOs and TI projects to generate and disseminate IEC material.
- Upgrade peer educators' IEC, advocacy, and behavior change skills.
- Mainstream HIV/AIDS messages in other departments' IEC material.

#### *For general population*

- Display IEC material in public places, including major government offices, health institutions (both government and private), and hotels.
- Scale up IEC activities at village level and catalyze IEC material relevant in rural context.
- Involve more male workers, *panchayat* members, and *pradhans* in IEC campaigns to sensitize male community members.

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<sup>27</sup> Village-level administrative bodies.

*For adolescents*

- Sensitize youth on HIV issues through Red Ribbon clubs in schools and colleges.
- Organize blood donation camps in schools.
- Promote adolescent education program in high school.
- Include sessions and question box on HIV/AIDS in schools..
- Sensitize young populations—especially girls—in villages by forming adolescent groups through ICDS.

*For women*

- Address HIV issues during SHG and *Mahila Mandal* meetings and ANC day.
- Sensitize women whose spouses are circular migrants on their vulnerability to HIV infection.
- Strengthen women’s negotiation skills for safe sex.
- Promote voluntary testing through IEC using TV, radio, and interpersonal communication.
- Promote PPTCT services and safeguards for newborns.

*For HRGs and PLHIV*

- Develop focused advertising at petrol-pumps and highway hotels.
- Promote HIV testing for truckers and migrant laborers through peer educators.
- Promote voluntary counseling and testing through referral from TI project.
- Display safe sex prevention messages in locations frequented by HRGs.
- Sensitize core group members on their legal rights.
- Involve PLHIV in development of IEC activities/material to ensure use of appropriate messages.
- Improve access to and increase usage of condoms in and around high transmission areas.

*For service providers*

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

**Responsibility**

DAPCU, UPSACS, TI NGOs, other relevant departments

## INTERSECTORAL CONVERGENCE

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

Table 22 presents an indicative list of relevant departments/organizations and sample activities that can be undertaken by these organizations. Operationalization of intersectoral convergence will involve the following steps:

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

### 7.1 Role of Key Functionaries/Committees

#### **DAPCC**

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

#### **District Collector/Magistrate**

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

#### **DAPCU**

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

#### **Nodal Officers (of departments)**

Each of department identified for mainstreaming will designate a nodal officer for HIV. This officer will be given in-depth training on major aspects of HIV programs so that s/he is able to design and implement departmental HIV plans and suggest any necessary modifications/adaptations of departmental welfare schemes/programs to benefit PLHIV and vulnerable populations. The nodal officer will carry out his/her responsibilities in coordination with the DAPCU.

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

**Table 22. Sample Government Programs and Activities for Convergence**

Department	Convergence Issues	Nodal Officer
Women Empowerment and Child Department	<ul style="list-style-type: none"> <li>➤ Integrate HIV into all department training programs.</li> <li>➤ Train <i>anganwadi</i> workers (AWWs) to counsel pregnant women on PPTCT.</li> <li>➤ Scale up shelter and rehabilitation homes and essential services for HIV-positive and HIV-affected women and children.</li> <li>➤ Step up nutritional support for PLHIV with focus on orphans and vulnerable children (OVC).</li> <li>➤ Involve PLHIV as members of self-help groups (SHGs).</li> <li>➤ Establish Red Ribbon clubs among adolescent girls.</li> <li>➤ Train AWWs to detect and report HIV-related discrimination in villages.</li> </ul>	CDPO, ICDS
Panchayati Raj	<ul style="list-style-type: none"> <li>➤ Train department personnel and elected representatives on sensitization and community ownership, participatory planning, and care and support.</li> <li>➤ Issue instructions to <i>panchayats</i><sup>28</sup> to protect PLHIV and HIV-affected households from discrimination and protect inheritance rights of widows and orphans.</li> <li>➤ Advocate with <i>panchayat</i> leaders to ensure that no HIV-positive child is discriminated against in school.</li> <li>➤ Issue guidelines to <i>panchayats</i> to discuss HIV-related issues relevant to village in <i>gram sabhas</i> and other meetings</li> <li>➤ Request <i>panchayats</i> with independent budgets to allocate resources to supplement HIV prevention and control program activities.</li> </ul>	CEO, Zila Parishad
Rural Development	<ul style="list-style-type: none"> <li>➤ Incorporate HIV/AIDS in all department training programs.</li> <li>➤ Ensure that vulnerable populations, HRGs, and PLHIV benefit from Employment Guarantee Programs and other economic opportunities.</li> <li>➤ Issue direction to ensure HIV-affected widows have access to pension schemes without discrimination.</li> <li>➤ Strengthen poverty alleviation programs to benefit vulnerable populations.</li> <li>➤ Establish SHGs to work with Red Ribbon clubs to support prevention, treatment, and support efforts for women.</li> </ul>	Project Director, District Rural Development Agency (DRDA)
Youth Affairs and Sports	<ul style="list-style-type: none"> <li>➤ Train all NSS program officers and NYK coordinators</li> <li>➤ Mobilize youth groups and programs (including NSS, National Cadet Corps, and NYK) to spread awareness about HIV/AIDS and fight stigma and discrimination.</li> <li>➤ Initiate youth-focused public information campaigns at cultural and sporting events.</li> <li>➤ Engage youth to promote voluntary blood donation</li> <li>➤ Train youth to act as peer leaders on HIV/AIDS within their communities.</li> <li>➤ Undertake social marketing of condoms through youth clubs and youth development centers.</li> <li>➤ Promote youth-friendly services.</li> </ul>	District Sports Officer
SC/ST Welfare	<ul style="list-style-type: none"> <li>➤ Analyze special vulnerabilities of SC/ST populations, with focus on women and children and prepare a plan to address identified risks.</li> <li>➤ Train traditional healers and registered medical practitioners (RMPs) with influence in the community on STI management and provision of referrals to ICTCs.</li> </ul>	District Social Welfare Officer
Agriculture	<ul style="list-style-type: none"> <li>➤ Mainstream HIV into KVK (<i>Krishi Vignan Kendras</i>) and agriculture colleges.</li> <li>➤ Sensitize agriculture extension workers to alleviate potential impacts of HIV by carrying out HIV-related activities in affected and vulnerable communities.</li> </ul>	District Agriculture

<sup>28</sup> Village-level administrative bodies.

Department	Convergence Issues	Nodal Officer
	<ul style="list-style-type: none"> <li>➤ Integrate HIV into key rural livelihood programs.</li> </ul>	Officer
Labor /Industry	<ul style="list-style-type: none"> <li>➤ Provide package of services, including prevention and treatment services, in all major Employee State Insurance (ESI) hospitals.</li> <li>➤ Advocate with and facilitate trade unions to manage provision of HIV services to migrant laborers and informal sector workers and to take lead on reducing stigmatization of HIV-positive workers and their families.</li> <li>➤ Integrate HIV prevention into all department training programs.</li> <li>➤ Promote HIV prevention with industry as part of corporate social responsibility (CSR) efforts.</li> </ul>	District Industry Officer, CII/FICCI District Coordinator
Police and Jail	<ul style="list-style-type: none"> <li>➤ Design and implement awareness and sensitization programs for police personnel dealing with HRGs and NGO workers.</li> <li>➤ Train in-house doctors on pre-post counseling and set up voluntary counseling and testing centers within command hospitals.</li> <li>➤ Place condom dispensing machines in strategic locations and improve STI treatment services for police and prison inmates.</li> </ul>	Superintendent of Police
Education	<ul style="list-style-type: none"> <li>➤ Incorporate adolescent education program/life skills programs in all schools and colleges.</li> <li>➤ Incorporate HIV prevention programs into all non-formal and out-of-school education programs.</li> <li>➤ Introduce a module on HIV/AIDS into teacher training curriculum.</li> <li>➤ Incorporate HIV orientation into curricula of all technical and vocational training institutes.</li> <li>➤ Ensure that HIV-positive and HIV-affected children are not discriminated against in schools.</li> </ul>	District Education Officer
Transport (including bus stands and railway stations)	<ul style="list-style-type: none"> <li>➤ Implement HIV prevention programs at major transport hubs.</li> <li>➤ Facilitate campaigns disseminating prevention messages through public and private sector transport systems.</li> <li>➤ Ensure availability of condoms at highway-based congregation points (such as <i>dhabas</i><sup>29</sup> and motels).</li> <li>➤ Promote IEC at bus stands and railway stations.</li> <li>➤ Install condom vending machines at strategic locations.</li> <li>➤ Scale up IEC efforts on buses and trains along known migration routes.</li> <li>➤ Train all personnel on HIV.</li> </ul>	District Transport Officer
Municipal Corporation and Urban Local Body	<ul style="list-style-type: none"> <li>➤ Integrate HIV into programs of District Urban Development Agency (DUDA), the urban basic services program, and other relevant social welfare programs.</li> <li>➤ Strengthen urban HIV prevention programs with special emphasis on migrant and slum populations.</li> <li>➤ Set up shelter homes for orphans, the destitute, and street children.</li> <li>➤ Accord benefits to PLHIV in Municipal Corporations' economic support programs.</li> <li>➤ Strengthen urban infrastructure to provide better living conditions for in-flowing migrant communities, thereby reducing their vulnerabilities.</li> </ul>	Municipal Commissioner
Civil Supplies	<ul style="list-style-type: none"> <li>➤ Ensure HRGs and PLHIV receive ration cards.</li> <li>➤ Disseminate HIV awareness messages through public distribution outlets.</li> <li>➤ Mainstream HIV into department training programs.</li> </ul>	District Supply Officer

<sup>29</sup> Small eateries

## 7.2 Human Resource Planning

### Operationalization of DAPCU

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

**Table 23. Terms of Reference (TOR) for DAPCU staff**

District Program Manager for HIV/AIDS (DAPM)	
Planning and Implementation of DAPs	<ul style="list-style-type: none"> <li>○ Send regular reports to UPSACS.</li> <li>○ Operationalize ICTCs, PPTCT centers, blood banks, and blood storage units.</li> <li>○ Ensure engagement of contractual manpower, including link workers, lab technicians, and consultants.</li> <li>○ Maintain systems for timely payments, training, and monitoring of staff.</li> <li>○ Manage supply chain at district and sub-district levels.</li> <li>○ Facilitate supply of testing and delivery kits, condoms, drugs, and other consumables from district government to public health institutions—ICTCs, PPTCT centers, ART centers, blood banks, and TI projects.</li> <li>○ Coordinate with partners for program planning, implementation, and review.</li> </ul>
Capacity Building	<ul style="list-style-type: none"> <li>○ Implement training plans.</li> <li>○ Provide district-level support for TI projects, with emphasis on ensuring access to services, including referrals to public health infrastructure (both facilities and manpower).</li> </ul>
Advocacy	<ul style="list-style-type: none"> <li>○ Organize stakeholder consultations with government departments, NGOs, and PLHIV through NGO forum.</li> <li>○ Undertake effective IEC campaigns for NACP activities.</li> </ul>
Program Management	<ul style="list-style-type: none"> <li>○ Institutionalize system of interaction with DPMU for NRHM to work out effective convergence with activities under NRHM, RCH, TB, and IEC.</li> <li>○ Ensure need-based institutionalization of systems for disbursing funds to <i>Rogi Kalyan Samitis</i><sup>30</sup> and collecting utilization certificates.</li> <li>○ Maintain a bank account for DAPCU and submit use of funds reports and annual audits to UPSACS.</li> <li>○ Oversee operational status of blood banks and their adherence to NACP protocols.</li> <li>○ Collect information monthly about each institution's operational status, compile data, and send to UPSACS.</li> <li>○ Supervise functioning of HIV service outlets by visiting outlets frequently and attending quarterly meetings of medical officers and monthly meetings of other project staff.</li> <li>○ Provide feedback and support to field staff to enhance performance.</li> </ul>

<sup>30</sup> Committees formed at district level that are given resources to address specific issues related to health/infrastructure in the area.

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

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

## TRAINING PLAN

A scaled-up multisectoral response in Etawah 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 24. Stakeholders in Deoria Training Plan**

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

A training needs assessment will be organized in the district involving all the potential stakeholders involved in the HIV response. Based on the needs assessment, an annual action plan for capacity building will be developed for the district and a special allocation of funds will be sought from UPSACS. The training plan for Etawah will include the stakeholders listed in Table 24 above.

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

**Table 25. 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 26. Proposed Training Content**

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

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

## MONITORING AND EVALUATION

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

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

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

### 9.1 M&E Functions of DAPCU

- Document reporting processes and enforce data quality standards.
- Distribute reporting formats to all relevant units.
- Provide training on relevant software to district-level units.
- Ensure that all partners report routine program monitoring data.
- 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 27. Budget for Etawah DAPCU (Year I)**

<b>A. Staff Salary</b>				
	Staff Position	Number	Salary (Rs.)	Annual Expenditure (Rs.)
1.	District Program Manager (regular)	1	8,000–13,500	20,000×12 = 240,000  With periodical increment and other benefits applicable for government employees
2.	M&E Assistant	1	8,000 consolidated	8,000×12 = 96,000
3.	Assistant cum Accountant	1	8,000 consolidated	8,000×12 = 96,000
4.	Supervisor	1	8,000 consolidated	8,000×12 = 96,000
	<b>Total</b>			<b>528,000</b>
<b>B. Fixed Costs (One-time Costs)</b>				
	Particular			Annual Expenditure (Rs.)
1.	Computer, printer, and accessories			<b>90,000</b>
<b>C. Recurring Costs</b>				
	Particular	Monthly Expenditure		Annual Expenditure (Rs.)
1.	Operating expenses	5,000		5,000×12 = 60,000
2.	Local travel	1,500		1,500×12 = 18,000
	<b>Total</b>			<b>78,000</b>
<b>Grand Total (A+B+C)</b>				<b>696,000</b>

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

## Annex I: District Dashboard

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

Composition of the dashboard should be as follows:

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

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

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

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

6. Lab technicians

Number of lab technicians sanctioned	
In place	

7. Counselors

Number of counselors sanctioned	
Number of counselors in place	

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

10. Funds

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

11. Supplies

<b>a) Two Months' Stock Available for:</b>	
ART drugs	
condoms	
delivery kits	
testing kits	
IC and WM <sup>31</sup> consumables	
Auto-disable syringes	
<b>b) Stockout Summary</b>	
Total number of stockouts reported	
Number of facilities reporting stockouts	
Commodities for which stockouts occurred	

**Detailed Stockout Chart:**

Facility Name	Commodity Type

12. Institutions functional

	ICTC	PPTCT	STD	RNTCP	Blood Bank
Sanctioned					
Functional					
Tests/Referral					

<sup>31</sup> Infection control and waste management

13. Blood Banks

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

14. Coverage

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

15. Cases of discrimination reported

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

16. Trainings

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

17. IEC<sup>32</sup>

Planned	Achievement

18. Tribal strategy

Planned	Progress

19. Monthly/Quarterly DAPCU meetings

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

20. PLHIV Trends

PLHIV	ICTC	HRG Category	On ART	Death
Existing				
New				

<sup>32</sup> Detailed tables for Questions 18 and 19 to be developed in accordance with yearly action plan.

## Annex II: Proposed Meeting / Reporting Schedule

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

## Annex III: DAPCU Program Activities

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

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

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

	Levels of service	Personnel delivering services	Type of services
1.	Community	i. ASHA (NRHM states) ii. RMP	<ul style="list-style-type: none"> <li>Referring pregnant women for tests and follow-up of PPTCT prophylaxis treatment</li> <li>Treatment of STIs, minor ailments, and OIs (such as diarrhea)</li> <li>Condom supply</li> </ul>
2.	PHC/ private provider/ 30,000 population	i. PHC doctor/private practitioner ii. Nurse iii. Lab technician (LT) iv. Pharmacist/dispenser v. Record keeper	<ul style="list-style-type: none"> <li>STI control and condom promotion</li> <li>HIV testing and counseling</li> <li>OI prophylaxis and treatment</li> <li>Antenatal care and counseling for prophylaxis</li> </ul>
3.	CHC/ Trust Hospitals/ 100,000 population	i. CHC doctor/Trust hospital doctor ii. Counselor iii. Nurse iv. Lab technician v. Pharmacist/dispenser vi. Outreach worker	<ul style="list-style-type: none"> <li>STI control and condom promotion</li> <li>Integrated health counseling/testing</li> <li>PPTCT, delivery, abortion, and sterilization services for women (including those who are HIV-positive)</li> <li>Diagnosis and treatment of common OIs</li> <li>ART follow-up and referral</li> <li>Maintenance of computerized patient records</li> </ul>
4.	District-level/ Teaching hospitals	i. Specialist ii. Doctor iii. Nurse iv. Counselor v. Lab technician vi. Manager of drugs supply chain vii. Treatment supporter (NGO/PLHA/CBO, etc.) viii. Outreach worker	<ul style="list-style-type: none"> <li>Management of complications</li> <li>ART</li> <li>Care and support</li> <li>Integrated counseling and testing</li> <li>Management of STIs and OIs</li> <li>PPTCT services</li> <li>Ensuring drug supply at district level</li> <li>Facilitating access to care and support for PLHIV</li> </ul>
5.	NGO/CBO/FBO <sup>33</sup>	i. NGO/CBO administering CCC and family support centers ii. NGO/FBO/other managing TI project iii. Outreach worker	<ul style="list-style-type: none"> <li>Palliative care and treatment of minor OIs</li> <li>STI treatment</li> <li>Counseling, social services</li> <li>Adherence monitoring</li> </ul>

<sup>33</sup> Faith-based organization

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