

**Country Consultation  
on Health Sector Response to HIV  
WHO HIV/AIDS Global Strategy 2011-2015**

**14-15 September 2010**

**WHO Country Office for India**

## Introduction

WHO, India conducted a consultation on 14-15<sup>th</sup> September 2010 at Delhi with a purpose to solicit the contributions of in-country experts to the WHO HIV/AIDS strategy development process. The consultation brought various experts from government, Academic Institutions, UN and Civil Society on one platform.

The objectives of the consultation were:

- To update key stakeholders on the WHO HIV/AIDS draft strategy framework and its development process.
- To receive inputs on the key areas of the strategy and identify priority issues for the country.
- To get views on WHO's role in supporting the national response and relevance of the proposed focus areas for WHO under the proposed strategy.
- To discuss the opportunities and modalities for collaboration and joint work.

The consultation was participatory in nature and gave opportunities to experts to share their experiences and learning related to health and HIV policies and programmes. An effort was made to weave in these learning and experiences in the draft Global strategy so as to make it more responsive to the Indian context.

## Proceedings

Dr Po-Lin Chan, Medical Officer HIV/AIDS welcomed the participants and gave an overview of the consultation. This was followed by addresses by Dr Iyanthi Abeyewickreme, Regional Adviser HIV/AIDS/STI, WHO SEARO and, Dr. Sangay Thinley Ag. WHO Representative to India.



Dr Iyanthi Abeyewickreme provided the rationale for launching a new Global Health Sector Strategy on HIV/AIDS and highlighted how the global strategy should provide a framework for partnerships, convergence and action at global, regional and country levels. She shared the four strategic directions that are outlined in the draft strategy which are: *Expanding coverage and impact of HIV interventions; Linking and integrating programmes and services; Building sustainable health systems; and Creating supportive environments for*

*HIV responses.* She also highlighted that WHO strategy complements the strategies of key partners like UNAIDS, other development partners and civil society and builds on the achievements and experiences of the "3 by 5" initiative and the WHO HIV/AIDS Universal Access Plan 2006-2010.

In his address, Dr. Sangay Thinley reiterated that the proposed strategy aims to align with broader strategic frameworks, including the Millennium Development Goals, primary health care renewal, Universal Access commitments and the UNAIDS Strategy for 2011-2015. He further said that WHO has a key role to play in promoting high quality evidence-based policies and interventions and providing support to countries for their adaptation and implementation. This can be done effectively by forging partnerships covering a range of areas as advocacy and leadership, research and development, policy and programmatic guidance, implementation, community development and inclusion. He thanked the experts for attending the consultation and hoped their inputs would help further strengthen the strategy and align it with the country specific needs and learning.

Dr. DCS Reddy NPO, Strategic Information, HIV/AIDS, WHO India proposed the vote of thanks.

The inauguration was followed by the key note addresses on the four Strategic Directions

- I.: Health system strengthening: Key for better HIV related outcome by Prof.C.A.K.Yesudian
- II: Linking and integrating health and HIV programme & services by Dr Subhash Salunke
- III: Expanding coverage and impact of HIV interventions by Dr S.M.Mehendale
- IV: Creating supportive environments for effective HIV responses by Dr Charles Gilks

The session was chaired by Dr. IC Sharma and Co-Chaired by Dr. Iyanthi Abeyewickreme

### Highlights of the presentations and discussions during the plenary

- ◆ There is a need to identify strength in the existing health system to effectively address the issue of HIV at the policy and implementation level.
- ◆ The existing health care services at the delivery level ushered under NRHM can be utilized for effectively integrating health and HIV programme. There is a need for more decentralised delivery systems at the district level with proper infrastructure, workforce strengthening etc.
- ◆ Health systems strengthening should go beyond National AIDS Control Program (NACP)-National Rural Health Mission (NRHM) or National AIDS Control Program –Revised National Tuberculosis Control Program (RNTCP) integration. With increasing feminization of the epidemic, linkages with ministry of Women & Child Development is very important.
- ◆ Private sector should be involved in the strategy to address the integration of health and HIV programmes.
- ◆ A strategy for Integration and convergence should be worked at all levels - centre, state and also at the district level too.
- ◆ For expanding coverage one needs to look at not only the sites but also focus on the quality of services, staff training, infrastructure, facilities etc.
- ◆ There is a steep growth of Targeted interventions (TIs) from 17 to 1516 during the period 1995 -2008; this has been useful as epidemic in India is concentrated.
- ◆ Currently, TIs focused mainly on the male and not so much on the women/female partners and women migrants.



- ◆ Supportive environment is critical for HIV prevention. While framing policies and programmes for creating supporting environment one must take into account the district, state and local specific context.

- ◆ The first line ART treatment is being accessed by the PLHIV fairly well (though there are challenges in certain parts of inaccessible rural India). However, the second line ART treatment is still inaccessible by and large by the PLHIV due to cost factor and certain other reasons.
- ◆ Stigma and discrimination is still wide spread and it is not only that the health providers discriminate, but also the PLHIV self stigmatize themselves. There is a need to identify and address the factors for stigma and self stigma. For this it is imperative to understand the environment in which the PLHIV are living.
- ◆ Along with a sound legal framework, there should be conducive HIV programmes/policies for the overall creation of positive environment.
- ◆ Rights and needs of women, adolescent girls needs to be emphasized and they should be empowered.
- ◆ Health system strengthening alone is not sufficient to address HIV related issues; community level systems should be created and strengthened for a comprehensive and sustainable response.
- ◆ There is a need for more efficient utilization of funds along with strong monitoring and accountability.
- ◆ MARPs can play a significant role in designing the integration of HIV into health system and in monitoring. Their participation should be encouraged and institutionalized.



The key note addresses were followed by group work on the four strategic directions. The participants were divided in to four groups. A chair was identified for each group:



The key discussion points for the groups were as follows:

- ◆ What are the issues and challenges?
- ◆ Identify and rank the priority areas?
- ◆ How do we operationalise within the priority areas at the various levels of health systems?
- ◆ How to measure goals, indicators, and targets?
- ◆ What should WHO focus on?

The groups reported back in the plenary and made presentations. The panel for the presentations was Dr. Suresh Mohammed, Dr. PL Joshi, Dr. S. Salunke and Prof.C.A.K. Yesudian. This was followed by discussions.

## Summary of Participant's Input on the Strategy

### Global Vision and Goals

The participants expressed that the **four goals are crucial and comprehensive** and all countries should address these. It is imperative to align the goals to national guidelines and targets and should be achieved within human rights framework. Health system strengthening was crucial participants also emphasized the importance of strengthening community structures and systems. The community structures should be sustainable and support building of conducive environment for HIV affected people and MARPs. Political commitment and policy coherence should be strengthened/reinforced and should reflect in the Global strategy.

## **Priority areas**

Groups identified the priority areas that need to be addressed under each strategic direction in the Global strategy.

### **Strategic Direction 1: Expanding coverage and impact of HIV interventions**

- Universal Availability of Condom Promotion; STI Diagnosis & Rx; Blood Safety Services across the health System. Female condoms and lubricants too should be included under services.
- Universal Access to Counseling, Testing and other Services in high prevalence districts for:
  - ANC (PPTCT)
  - TB patients
  - AIDS patients (ART)
- Integrated strategies for demand generation & delivery of services by private sector where needed (especially urban areas)

### **Strategic Direction 2: Linking and integrating programmes and services**

Linkages and integration should be clearly defined. This can be viewed at various levels of services and programmes.

Some health services/programmes that have clear linkages with HIV are

- Sexual, Reproductive and Child Health including maternal care, neonatal health, family planning, RTI/STI, Cancer Cervix, Nutrition
- Tuberculosis prevention, diagnosis and treatment
- Drug dependence and Hepatitis B
- Palliative care

Intersectoral coordination will facilitate the above linkages. At the centre and state level it is important to see how different ministries and departments can facilitate linkages/integration between their programmes. For e.g.: Ministry of Health and Ministry of Women and Child Development have programmes for adolescents but both ministries' run their programmes vertically.

There are times when two ministries may have programmes for the same target group but with different approaches like the National AIDS Control Organization's approach for drug users is harm reduction and Ministry of Social Justice and Empowerment follows

the de-addiction and reform approach. Policy coherence becomes a priority area to be addressed.

**Strategic Direction 3: Building health systems for better HIV and health outcomes**

It was strongly felt that this was an important strategic direction which will impact HIV and general health outcomes. The priority areas identified under this were

- Comprehensive HIV prevention, treatment and care for most at risk populations (FSW, MSM, TG, prisoners, including harm reduction and OST for IDU)
- HIV counseling and testing and PPTCT
- Prevention of sexual transmission of HIV (condoms, STI control, behavior change, male circumcision)
- Community involvement with due consideration to equity issues [gender, MARPs]
- How to minimize stigma at the level of
  - Community
  - Health service outlets
  - TI intervention sites
  - National level IEC campaigns focusing on stigma and discrimination against MARP

One area which came out during discussions was the role of private sector in service provision for MARPs. It was agreed by all that at present MARPs are largely accessing private practitioners and the linkages between private practitioners and public health systems need to be strengthened.

**Strategic Direction 4: Creating supportive environments for HIV responses**

The group proposed that there should be an anti-discrimination law or HIV/AIDS Law which should be overarching and should address various issues around stigma, discrimination, services, rights etc.

The other priority issues were:

- Stigma and discrimination
  - Redressal mechanisms to be instituted
  - Health Ombudsman (in every district)
- *Rogi Kalan Samiti* with expanded membership of PLHAs, MARPs (in every hospital)

- Law and Police Practices to be strengthened and operationalised
  - Revive “task force” between NACO and Ministry of Home to review legislation affecting MARPs
  - Expand membership to cover MARP representatives
- Policy Coherence
  - Inter-ministerial consultation
  - Joint policy statements
- Political Commitment
  - Dialogue with legislative forums/parliamentary bodies

## Indicators

The groups discussed the indicators proposed in the global strategy and broadly agreed with the indicators. There were suggestions on the targets and its time frame for each indicator wherein it was said that these should be fixed locally taking into cognizance where the country (specific region within country) at present stands on each indicator. It was emphasized here that the targets and timelines should align with the existing ones under the government programmes.

In context of India there were suggestions for downsizing the targets and revisiting the time limits.

It was also brought out during discussions that there is a need to look beyond the existing HRGs and identify new risk groups if any.

### ***The specific suggestions on the indicators under Goal 1:***

- ◆ Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse
  - Target by 2015: 80% (***group suggests downward revision of this target, since, the epidemic is concentrated and the indicator captures the risk in the general population***)
- ◆ Percentage of men and women aged 15-49 who received an HIV test in the last 12 months and who know their results

- Target by 2015: 80% (*since the present rate is around 3% (NFHS-3); the group suggests realistic downward revision of this target*)
- ◆ Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results
  - Target by 2015: 80%
- ◆ Number of adults and children with advanced HIV infection receiving antiretroviral therapy
  - Target by 2015: To be determined (*number or percentage of eligible individuals as per national guidelines*)
- ◆ Number of syringes distributed per injecting drug user (*who are accessing HIV prevention services*) per year
  - Target by 2015: >100 syringes in at least 100 countries (*group suggested at least 365 syringes and needles per IDU per year; timeframe should be two years*)

There were two additional indicators proposed, one on Oral Substitution Treatment and another on Stigma and Discrimination under the first Goal.

These were:

- ◆ **Number of OST sites per 1000 IDU: target 3 (each site catering to 200-300 IDUs)**
- ◆ **MARP reporting stigma and discrimination at the testing facility: target less than 5%)**

It was strongly expressed that the human rights framework must be followed and the targets specially likes of HIV testing should be achieved without coercion.

There was a suggestion to remove indicator 5.3 which is to *improve efficiency and effectiveness of health related service delivery*. The participants felt it was important to measure the convergence between health and HIV services and measure the outcomes for the same for HIV prevention and care rather than just measuring health systems performance.

### **Additional Indicators proposed by the group**

The general feeling was that the indicators under the draft global strategy have a very heterosexual mainstreamed approach. Indicators on women and HRGs should be included. Single women and married monogamous women are excluded from the programmes. So there should be a coverage indicator for them. With regards to HRGs

the denominators (their exact numbers) for most indicators are not available, so the indicators should be framed accordingly.

Some other areas were identified for which indicators should be developed and included in the Global strategy. These were

- ◆ Convergence and its impact usually remains unmeasured , so there is need to identify both process & output / outcome indicators for:
  - Measuring progress on Health Systems & NACP convergence/ integration
  - Impact of integration on HIV related outcomes
- ◆ Counselling and Testing: Conventionally the indicator is the number of people counseled & tested and number of positive cases. The counseling and follow up of people with negative results is equally crucial for prevention but never measured. An indicator on the same should be included.
- ◆ Indicators also should be identified for
  - Each of the 6 building blocks of health systems
  - Quality antenatal care as it impacts PPTCT
  - MDG indicator on condom use as a proportion of contraceptive use
  - Proportion of MARPs seeking healthcare
  - Proportion of sites reporting service provision to MARPs

## **Monitoring and Evaluation**

The groups discussed and shared the areas that should be monitored. It was discussed that the key areas for monitoring should be clearly defined. The discussions brought out the following areas:

- ◆ Coverage
  - Number of TIs
  - Interface between different TIs e.g. partners of IDU, MSM)
  - Coverage of women
- ◆ Access

- HRGs access to health and HIV services is limited. The Transgenders are also not typically covered under health systems. So their access to services should be a specific area to be monitored.
- At times the HRGs themselves impose stigma on self and do not partake into programmes and avail services. This needs to be addressed to enhance access to services
- Community level systems that can help promote HRGs' access to services should be identified and strengthened. Their strengthening and support to HRGs has to be monitored
- ◆ Stigma and discrimination
  - Number of reports on Stigma and Discrimination
  - Decrease in number of reports on Stigma and Discrimination
  - Change in attitude of service providers
- ◆ Convergence
  - Progress on convergence
  - Impact of convergence on HIV services
  - Utilization of services by HIV affected people and MARPs
  - Upper caste, economically backward and tribals not partaking services. Their involvement should be promoted and monitored
- ◆ Impact
  - There should be an inbuilt prospective program evaluation plan
  - 5-7% of program resources should be allocated for M&E

The discussion also highlighted that addressing gender is more than just collecting gender disaggregated data. Issues like spousal violence, migration, influence access to testing and treatment and these should be addressed. A high registration and an equally high drop-out of services are observed among women. This needs to be monitored.

The quality of the program (for implementing the global strategy) should be maintained and monitored. Some suggestions on enhancing quality of services were as follows:

- Positioning of program and its indicators (e.g. HIV testing) in the context of the local epidemic and local vulnerability (contextual) factors

- Range of services should be decided depending on epidemiology
- Generate data where it is lacking
- Flexibility in program design (location, typology etc.)
- Including private providers in the ambit of programmes

It was suggested that tools like community audits should also be used to understand/measure the quality of services including attitude of providers.

### **WHO Action: Supporting National Responses**

WHO's role was largely seen in capacity building; developing guidelines; advocacy and research. A big gap was felt in operational research (OR) at the country level. It was said that most ORs have focussed on the high prevalence states of South and North-east and the learning may not be applicable to other parts of India.

For each strategic direction the following suggestions were made:

#### **Strategic Direction 1: Expanding coverage and impact of HIV interventions**

- Facilitate cross-learning on addressing Health Systems/Health Programme related challenges
- Documentation and dissemination of best practices in systems strengthening and service delivery options in the NRHM & Health/Disease Control programmes at national, state and district level
- Technical capacity building for integrated strategic planning and implementation at various levels including assistance for enhancing quality assurance , performance monitoring and outcome evaluation
- Support for strengthening technical capacity of service delivery personnel – integrated & innovative training strategies
- Support to decentralize the service delivery and promote access of those who are under treatment/would be needing treatment.

#### **Strategic Direction 2: Linking and integrating programmes and services**

There is scope of integration beyond HIV-TB, HIV-STI. WHO should facilitate the following:

- Advocacy and technical assistance to government for linking between programmes like NRHM, NACP III and Integrated Child Development Scheme (ICDS)
- Skill building of health care providers on gender and sexuality and its linkages with HIV
- Technically support inclusion of HIV in district level health plans under NRHM will be a good effort towards convergence in services and programmes.

**Strategic Direction 3: Building health systems for better HIV and health outcomes**

- Assist countries to develop guidelines to help address legal and policy barriers resulting in increased access to HIV prevention, treatment and care support by MARPs
- Technical assistance to countries to generate quality strategic information (including program data management) through effective monitoring for evidence based programming
- Facilitate resource mobilization and provide technical assistance for operations research including impact evaluation
- Operation research for developing alternative service models

**Strategic Direction 4: Creating supportive environments for HIV responses**

- Advocacy for political and programmatic attention to MARPs
- Support operational research and generation of evidence
- Technical assistance for policy coherence