Integration of PMTCT and MNCH Services in Telangana State: Current Scenario and Futuristic Blueprint
Integration of PMTCT and MNCH Services in Telangana State
Current Scenario and Futuristic Blueprint

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Preface

This document is based on a combination of recommendations through review of published literature on the models of integration that have been implemented globally and in the Country and lessons learned from field observations in Telangana State. The published literature contains strategic directions, reports of consultation meetings, systematic reviews conducted by various national and international experts etc. It offers a range of models of integration including contributing and inhibiting factors for integration. This document intends to inform the program planners, policy makers and managers in making appropriate choice on the models of integration and test their feasibility.

The recommendations provided in the document are to increase HIV screening of all pregnant women, early detection and early treatment of the pregnant women living with HIV and enhance linkages of the HIV infected mothers and their exposed children to MCH/HIV services. While there are already steps taken by the state government to enhance integration between HIV and Health departments to achieve these objectives, the document highlights certain integration models tested across and the suitability of some of them to the state to not only improve follow-up rates of mothers and children in accessing the necessary HIV care but also to improve maternal and child survival rates.
Acknowledgements

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We sincerely thank the respective DPMUs, DAPCU's and other key HIV/AIDS and MNCH service providers in the districts visited for sharing with us their rich experience in implementing the program and coordinating the meetings with the staff of ICTC/PPTCT/ART centres, district hospitals and CHCs/PHCs. The support extended by frontline health workers and HIV positive pregnant women and mothers are greatly appreciated.

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# Table of Contents

Preface ...................................................................................................................... 3  
Acknowledgment ....................................................................................................... 4  
Acronyms/Abbreviations .......................................................................................... 6  

I. Background and Introduction ............................................................................... 8  

II. Current status of PPTCT/MNCH Integration in the Country/State .................... 10  

III. Country’s Elimination Plan .............................................................................. 12  

IV. Current Status of HIV Services in Telangana State ........................................ 12  
   a. MNCH Services in the Erstwhile Andhra Pradesh ............................................. 12  
   b. HIV Services in Telangana State ................................................................... 12  
   c. MCH and HIV Scenario ............................................................................... 12  
   d. Field Observations on Integration in Telangana State .................................. 13  

V. Implementation of Integrated MCH and PPTCT Programs ............................... 14  
   Global, National and State experiences  
   a. Global Experiences/Policies/Reports and Guidelines on Integration ............. 14  
   b. Countries Experiences/Policies/Reports and Guidance on Integration .......... 14  

VI. Recommendations: ......................................................................................... 19  
   a. Models for Integration ................................................................................ 20  
   b. Requirements for Successful Integration ...................................................... 22  

VII. Conclusion ....................................................................................................... 23  

VIII. Annexures ...................................................................................................... 24  

IX. References ....................................................................................................... 40
### Acronyms/Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Ante Natal Care</td>
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<tr>
<td>ANM</td>
<td>Auxillary Nurse Midwives</td>
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<td>APVVP</td>
<td>Andhra Pradesh Vaidhya Vidhana Parishad</td>
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<tr>
<td>ART</td>
<td>Anti Retroviral Treatment</td>
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<td>ASHA</td>
<td>Accredited Social Health Activist</td>
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<tr>
<td>DAPCU</td>
<td>District AIDS Prevention and Control Unit</td>
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<tr>
<td>DME</td>
<td>Directorate of Medical Education</td>
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<tr>
<td>DoHFW</td>
<td>Department of Health and Family Welfare</td>
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<tr>
<td>EID</td>
<td>Early Infant Diagnosis</td>
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<td>EMTCT</td>
<td>Elimination of Mother To Child Transmission of HIV</td>
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<tr>
<td>FI-ICTC</td>
<td>Facility Integrated - Integrated Counseling and Testing Centres</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<td>GO</td>
<td>Government Order</td>
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<td>GOI</td>
<td>Government of India</td>
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<td>HBsAg</td>
<td>Hepatitis B Surface Antigen</td>
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<td>HEI</td>
<td>HIV Exposed Infant</td>
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<tr>
<td>HFW</td>
<td>Health and Family Welfare</td>
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<tr>
<td>HIV</td>
<td>Human Immuno-Deficiency Virus</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>IATT</td>
<td>Inter Agency Task Team</td>
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<td>ICTC</td>
<td>Integrated Counseling and Testing Centre</td>
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<tr>
<td>L&amp;D</td>
<td>Labour &amp; Delivery</td>
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<td>LMIC</td>
<td>Low and Middle-Income Countries</td>
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<td>MCTS</td>
<td>Mother and Child Tracking System</td>
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<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
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<td>MNCHN-</td>
<td>Maternal, Newborn and Child Health, Nutrition and Family Planning</td>
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<tr>
<td>FP</td>
<td>Planning</td>
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<td>MTCT</td>
<td>Mother To Child Transmission of HIV</td>
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<td>NACP</td>
<td>National AIDS Control Program</td>
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<td>NBCC</td>
<td>Newborn Baby Corner</td>
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<td>NBSU</td>
<td>Newborn Stabilization Unit</td>
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<td>NHSRC</td>
<td>National Health System Resource Centre</td>
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<td>NRC</td>
<td>Nutrition Rehabilitation Centre</td>
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<td>NRHM</td>
<td>National Rural Health Mission</td>
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<td>NVP</td>
<td>Nevirapine</td>
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<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother To Child Transmission of HIV</td>
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<td>PPP</td>
<td>Public Private Partnership</td>
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<td>PPTCT</td>
<td>Prevention of Parent To Child Transmission of HIV</td>
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<td>RMNCH</td>
<td>Reproductive, Maternal, Newborn and Child Health</td>
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<tr>
<td>SNCU</td>
<td>Special Newborn Care Unit</td>
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<tr>
<td>SPHO</td>
<td>Senior Public Health Officer</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>SRS</td>
<td>Sample Registration Survey</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>VDRL</td>
<td>Venereal Disease Research Laboratory Test</td>
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<td>WHO</td>
<td>World Health Organization</td>
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I. Background & Introduction

In 2013, an estimated 35 million people were living with HIV globally. Currently, HIV is the leading cause of death among women of reproductive age and it is noted that only 44% of pregnant women in low and middle-income countries (LMIC) received HIV testing and counseling. Alarmingly, 3 out of 10 pregnant women living with HIV did not receive effective antiretroviral medicines to prevent mother to child transmission of HIV. It is implied that children living with HIV are one-third less likely to receive antiretroviral therapy compared to adults. Data shows that only 42% of the infants born to mothers living with HIV in LMIC received virological test within 2 months as recommended by World Health Organization (WHO). Beginning antiretroviral therapy before the twelfth week of life reduces HIV-related mortality in children living with HIV by 75%. (UNAIDS Gap Report, 2014)

India being one of the 22 global priority countries is also lagging behind in reaching its goal of elimination of Pediatric HIV. Thirteen states (Andhra Pradesh, Maharashtra, Karnataka, Tamil Nadu Bihar, Maharashtra, Uttar Pradesh, Gujarat, Odisha, West Bengal, Rajasthan, Jharkhand, Madhya Pradesh and Chhattisgarh) account for 90% of the estimated HIV+ pregnant women in the country (National Strategic Plan, 2013) and it is estimated that 51% of AIDS-related deaths in Asia happen in India (UNAIDS Gap Report, 2014). However, the HIV treatment coverage is at 36% and only about 70% of estimated pregnant
women in India are enrolled into ante-natal care (ANC) at national level and less than 60% of all deliveries are institutional deliveries. Out of these, only 31% of the pregnant women receiving counseling and testing services and 33% of pregnant women were tested HIV+ve and 37% of the estimated HIV+ve pregnant women received PPTCT services (National Strategic Plan, 2013). A major contributor to the coverage gap is the limited availability of PPTCT services for 26% of women delivering at private health facilities or 13% at home and of 25% unreported deliveries (NHSRC 2013). Moreover, only 63% percentage of the HIV exposed infants have received confirmed HIV diagnosis leaving an opportunity for 37% of them to initiate early treatment (National Strategic Plan, 2013). Limited number of EID testing centres, long travel to the EID centres, low health seeking behavior among parents, fear of knowing the HIV status of their child and shortage of test kits are some of the factors hindering the uptake of early infant diagnosis.
II. Current status of PPTCT/MNCH Integration in the Country/ State

The Country envisions that the set targets can be achieved through scaling-up of revised PPTCT regimens, increasing access to ART for all positive pregnant women and integrating PPTCT services with National Health Mission. The integration is possible through provision of HIV screening at all facilities conducting deliveries (>5 deliveries/ month), establishment of facilities for HIV screening at the time of ANC registration at sub-centre level, availability of common ANC and ICTC registration at medical colleges, district and sub-district hospitals, mechanisms for safe institutional deliveries for all HIV infected women, synchronization of follow-up visits integrated with other visits of the mother and child namely immunization, growth monitoring etc.

Maternal, newborn and child health (MNCH) services are an entry point to reach women and children with timely and effective interventions for HIV prevention, treatment and care continuum. Integrating PPTCT interventions into MNCH services for routine delivery of services is critical to achieving universal access and coverage of HIV interventions. Towards this, a joint directive (Annexure -5) was issued by Department of AIDS Control, NACO and Department of Health and Family Welfare in July 2010 to harness optimal utilization of resources under NRHM and NACP and avoid duplication of services. The joint directive has suggested the respective state officials from both the departments to plan accordingly such that their annual work plans reflect the convergence decisions made by the Department of AIDS Control, NACO and Department of Health and Family Welfare. The key points in the directive includes emphasis on universal testing to be part of routine antenatal testing check-up, the expansion of roles of health and HIV staff to HIV services and health services respectively and increased linkages and coordination mechanisms among health, HIV/AIDS, NGOs and other key stakeholders for overall improvement of maternal and child well-being irrespective of whether they are dealing with HIV/non-HIV populations.

The then united Andhra Pradesh was proactive in owning up this directive and accordingly the state government has released a special G.O. Rt.No. 1858 on 31 December 2012 (Attached as annexure - 6) to bring NACP-NRHM functional synergy and effective linkages of all health services provided through institutions under the administrative control of Commissioner of Public Health Medical and Family Welfare, DME, APVVP and Director of Public Health. The G.O has assigned the PPTCT related roles to the health functionaries under NHM for creating effective linkages between the MCH and PPTCT programs. The strategy allowed the use of ANM services for follow-up of positive pregnant based on clause of ‘Shared Confidentiality’. The Senior Public Health officers (SPHO) who is given charge of each CHNC (Community Health and Nutrition Cluster) that covers 4-6 PHCs oversees the involvement of ANMs in PPTCT program. Each CHNC was assigned with one stand-alone ICTC and works closely with the ICTC.

Prior to that, GoAP also issued another important G.O. 249 on 24 September 2012 to operationalize MAARPU (Change) for improved convergence efforts by the Health, Women's Development & Child
Welfare, Panchayat Raj and Rural Development Departments, working along with the Self Help Groups (SHGs) and their federations, to bring about a quick decline in the Infant Mortality Rate (IMR), Maternal Mortality Ratio (MMR) and Malnutrition in the State of Andhra Pradesh. Further, the National Strategic Plan for PPTCT by Government of India summarized the flow of pregnant women presenting for Ante-natal Care and PPTCT services and the service integration at the sub-centre level. (Annexure 1)

**PPTCT Four Prong Strategy**: Without intervention, the risk of MTCT ranges from 20% to 45%. However, with specific interventions in non-breastfeeding populations, the risk of MTCT can be reduced to less than 2%, and to 5% or less in breastfeeding populations.

To prevent the transmission of HIV from mother to baby, the World Health Organization (WHO) promotes a comprehensive approach, which includes the following four components (Fig 1):

1. Primary prevention of HIV infection among women of childbearing age
2. Preventing unintended pregnancies among women living with HIV;
3. Preventing HIV transmission from a women living with HIV to her infant; and
4. Providing appropriate treatment, care and support to mothers living with HIV and their children and families
III. Country’s Elimination Plan

The Country being one of the signatory of the 22 Global Priority Countries (http://www.emtct-iatt.org/priority-countries/) will have met the 2 overall Global Plan targets for elimination of new HIV infections among children and keeping their mothers alive.

The two overall Global Plan targets are:

1. Reduce the number of new childhood HIV infections by 90% and
2. Reduce the number of HIV-related maternal deaths by 50%

In line with the Global plan for elimination of pediatric HIV among children and keeping their mothers alive, the Country has set the following objectives (National Strategic Plan, 2013):

1. Detect more than 80% HIV infected pregnant women
2. Provide access to comprehensive PPTCT services to more than 90% of the detected pregnant women
3. Provide access to early infant diagnosis to more than 90% HIV exposed infants
4. Ensure access to antiretroviral drug prophylaxis or treatment to 100% HIV exposed infants (HEI)
5. Ensure more than 95% compliance with ART in HIV+ pregnant women and ARV / ART in exposed children.

IV. Current Status of HIV Services in Telangana State

a. MNCH Services in the Erstwhile Andhra Pradesh: The distribution of overall health facilities such as District hospitals, Sub-district hospitals, Community Health centres, Primary Health Centres, and Sub-Centres are adequate as per the IPHS norms. Complete range of maternal and child health services including quality facility based new born care and Nutritional Rehabilitation Centres (NRCs) are available. In addition, Special New Born Care Units (SNCUs), New Born Stabilization Units (NBSUs) and New Born Baby Corners (NBCCs) are available as per the norms and are providing good quality services. The total Fertility Rate of the State is 1.8. The Infant Mortality Rate is 39 and Maternal Mortality Ratio is 110 (SRS 2010-12) which are lower than the National average. The Sex Ratio in the State is 992 (as compared to 940 for the country).

b. HIV Services in the Telangana State: The State of Telangana has 681 Integrated Counseling and Testing Centres (ICTCs)/ PPTCT centres including stand alone, facility integrated and public private partnership (PPP) sites. The stand-alone ICTC/PPTCT centres are co-located in the government health facilities with dedicated counselors and lab technicians appointed by State AIDS Control Society. The State has taken steps to scale-up FI-ICTCs / PPTCT centres to the sub-district level and also to few private facilities. The characteristic of these FI-ICTCs
(PHCs and PPP) is that the staff nurses and lab technicians of those facilities are trained in HIV counseling and testing and are expected to provide these services as part of their routine work. Through these 681 centres, around 292000 pregnant women of an estimated 640,000 women received counseling and testing services leaving a service gap of 54% (CMIS data, 2013).

c. **MCH and HIV Scenario:** Telangana state reports 74% of institutional deliveries with 49% in public sector and 51% in the private sector. However, the state noted 21% of unreported deliveries (NHSRC 2013). Of the total estimated pregnant women in the state, around 46% of the women received HIV counseling and testing. This low uptake of counseling and testing services despite registration in the hospitals for ante-natal care is due to lack of appropriate and timely linkages to the PPTCT centres and limited or very few private sites reporting to the government. This further results in late enrollment in treatment, low uptake of family planning services, lost to follow-up of the HIV positive mothers.

d. **Field Observations on Integration in Telangana State:** The DCS-CESS team conducted field visits to Medak and Mahbubnagar districts on the current status of PPTCT and MCH integration and following are the observations:

- The state has taken steps to integrate HIV positive pregnancies as part of the priority pregnancies and special care for high risk pregnancies. However, follow-up of HIV positive pregnant women by the ANMs and ASHA workers is limited.
- HIV counseling and testing facilities are currently available as standalone and facility integrated services in both public and private sector. Currently, the staff nurses and lab technicians appointed by the National Health Mission conduct counseling and testing as part of their routine ante-natal care in the facility integrated ICTCs established in the PHCs. However, integration at full length is not visible as directed in the GO RT 1858.
- HIV testing is offered as part of antenatal screening package in all the hospitals. So far, only FICTCs and PPP facilities are conducting HIV testing with a single prick and single sample. Routine referral for HIV testing is yet to accelerate.
- Significant difference between the reported deliveries (505383) in the facilities and the women tested for HIV (292000) at the ICTCs is noted.
- A special cadre, Senior Public Health Officers (SPHO) has been created to oversee HIV activities at the sub-district level.
- The medical officers, staff nurses, ANM, and ASHAs were trained on basics of HIV, revised PPTCT guidelines, and roles and responsibilities as laid out in the GO RT 1858 in the year 2012. However, the ICTC staff have not been trained on RMNCH components.
V. Implementation of Integrated MCH and PPTCT Programmes: Global, National and State experiences

With limited availability of distinctive set of integrated best practices, this section makes an effort to present below the experiences, strategic directions and reports from global, national and state level. The summaries presented below have examined the integration models in the reviewed documents so as to help the planners and the program managers to formulate common themes that emerge out of these reviews to necessitate implementation.

a. Global Experiences/ Policies/Reports and Strategic Guidance/ Guidelines on Integration:

1. Systematic Review of Integration of Maternal, Neonatal And Child Health And Nutrition, Family Planning And HIV, May 2011 (Systematic Review)
   This systematic review presented broadly six models of integration such as ANC services adding ART delivery for eligible pregnant women, PMTCT integrated into ANC services, HIV treatment/secondary prevention adding Family Planning (FP) services, HIV counseling and testing adding FP services, Child malnutrition services adding HIV testing and Post-abortion care adding HIV testing. This review indicated that the promoting factors for integration included stakeholder support and interest in integration, including country-level support, staff personality, experience, and buy-in, substantial training, supervision, and investment, transferability of training to different domains, relatively simple and inexpensive interventions added to existing services, integrated electronic patient record systems and notes across services, male partner involvement, avoid inconvenience of crowded ART clinics and high visit burden and community involvement. However, factors such as limited financial resources, clients fear of breach of confidentiality, high staff turnover, extra responsibility by supervisors was seen as uncompensated additional work, and late presentation for care leading to difficulty in offering linked services inhibited integration.

   A systematic review of research published between January 2000 and March 2011 was conducted with an objective to identify studies examining the impact of PMTCT on primary maternal and child health care outcomes. This paper synthesizes evidence evaluating the impact of these programs. By following a pre-specified protocol based on the Cochrane Handbook for Systematic Reviews of Interventions, 5,855 papers were assessed, 154 reviewed, and included 21 articles. These articles offer evidence of beneficial synergies between PMTCT programs and both STI prevention and early childhood immunization. Other data, including information about antenatal and delivery care, family planning and nutrition supplementation varied considerably across studies demonstrating both positive and negative effects of PMTCT.

This document suggests that there are key cross cutting issues to consider when developing PMTCT programs. Improving Safe Motherhood and Child Survival activities are imperative to the establishment of successful PMTCT programs. Better identification and treatment of sexually transmitted infections (STIs), malaria, and nutritional and micronutrient deficiencies during pregnancy can benefit all pregnant women. At the same time, these interventions may reduce the risk of HIV infection in the mother and the risk of transmission of HIV to the child. Interventions that identify risk factors in pregnancy and prevent premature birth will both increase infant survival in the general population, and decrease the risk of MTCT, which is multiplied with pre-term birth. Another key issue is the widespread association of breastfeeding with HIV, which threatens one of the most effective child survival strategies the world over. When developing MTCT strategies, globally and locally, extreme care must be taken to prevent the “spillover effect” of generally undermining of breastfeeding.

Towards this, interventions that minimize risk during each possible period of HIV transmission in the maternity cycle, from before pregnancy, through pregnancy and birth, and during infant feeding must be developed. Strong and comprehensive MCH services, within which all possible opportunities to reduce transmission are supported. Community and facility services that complement and reinforce each other for maximum impact on MTCT, on the health of the mother, and on the preventive, mobilizing effect of the program on the community at large are linked and integrated.

4. **PMTCT Strategic Vision, 2010–2015: Preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals, Moving towards the elimination of paediatric HIV** (Strategic Guidance)

One of the strategic directions of World Health Organization (WHO) is to promote and support integration of HIV prevention, care and treatment services within maternal, newborn and child health and reproductive health programmes. This document mentions that PMTCT services have sometimes been established as standalone vertical programmes, lacking sufficient integration with MNCH programmes. However, integration will provide the basic platform and infrastructure for effective and sustainable delivery of HIV services as both MNCH and PPTCT services share the same goals of reduction of maternal and child mortality and morbidity.

High priority will be given to strengthening linkages between PMTCT and HIV care and treatment services for women, their children and other family members in order to support an effective continuum of care. Finally, WHO will promote increased community participation (including male partners and community health workers) for support and delivery of PMTCT services.

5. **Integrated EMTCT Commodities Package, The Inter-Agency Task Team (IATT) for Prevention & Treatment of HIV Infection in Pregnant Women, Mothers and Children**
A user-friendly framework has been developed to enable programme and supply chain managers to know at a glance the full scope of commodities required for integrated service delivery of a comprehensive Elimination of Mother To Child Transmission (EMTCT) programme (Fig 1). It brings together a number of existing commodities packages which make up a comprehensive EMTCT programme including the areas of Family planning (FP), sexually transmitted infection (STI), gender based violence (GBV) and maternal, newborn and child health (MNCH).


This document provides direction to optimize effectiveness, efficiency and better alignment and integration of HIV services where appropriate. Towards this, UNICEF will work at the national and sub-national levels to impact service integration and improve referral linkages across the Maternal, Neonatal, and Child Health (MNCH) platform and other service delivery points, such as nutrition, community child health services, family planning, HIV, and drug dependency programmes. Concurrently, synergies between HIV, Health, Nutrition, Child Protection, Social Policy and Education sectors will be identified and strengthened to leverage better and more equitable results for children and adolescents within the context of HIV and AIDS.

This report documents that integrating HIV interventions into MNCH services is expected to maximize the benefits from visits to health facilities for both mothers and children, and enable health systems to be more responsive to the needs of women, children and their families. The key issues associated with the integration of HIV/MNCH services are training, human resources and roles, commodities, family-focused approach, HMIS and monitoring. Experiences from integration efforts in various programmes demonstrated that integration of HIV/MNCH services is achievable. However, the integrated approach cannot progress successfully without consensus on the basic package of health interventions/services and consideration for ownership of integration. The additional factors critical for successful integration of services include supportive resource base, maternal and paediatric patient-tracking, ensuring a continuum of care and adequate and flexible funding. The conceptual framework for integration that is shown in figure 2 (Annexure 2) follows service-based rationale whereby addressing PMTCT is seen as an opportunity to improve the quality and extend the coverage of ANC, delivery and postpartum care.


Research assessing various integration models has shown that integration has great potential to improve service utilization even though there exist gaps on the actual magnitude of benefits of integration. The PMTCT program remains the major integration effort with reasonably high levels of coverage in Malawi, Zambia, and Tanzania, but quite low in Democratic Republic of Congo. Other integration programs in the four countries range from integration of FP into HIV testing and
counselling, FP into HIV care and treatment, HIV into FP, FP into PMTCT, PMTCT into MNCH, and FP and HIV/AIDS into MNCH.

9. Integration of HIV/AIDS services with maternal, neonatal and child health, nutrition, and family planning (MNCHN-FP) services, Lindegren ML, Kennedy CE, Bain-Brickley D, Azman H, Creanga AA, Butler LM, Spaulding, AB, Horvath T, Kennedy GE – The Cochrane Collaboration (Review) This review identified 20 articles representing 19 strategies for integrating the MNCHN-FP and HIV services. Broadly, the review classified into six models of integration namely; ANC services adding ART for eligible pregnant women; ANC services integrating PMTCT services; child malnutrition services adding HIV testing; post-abortion care adding HIV testing, HIV treatment/secondary prevention adding FP services and HIV counselling and testing adding FP services. These interventions denoted substantial onsite training, intense supervision, improvement in work conditions, provision of sufficient equipment or instruments for routine activities, and involvement of the staff in decision making regarding their needs as promoting factors for successful integration.

b. Countries Experiences/ Policies/Reports and Guidelines on Integration

1. Integration of HIV & Maternal Health Programs: Evidence and The Way Forward For India, CEDPA, June 2011 (Systematic Review) In 2008 (published in 2009), CEDPA India conducted a systematic review of evidence to get a clearer understanding of the effectiveness, optimal circumstances, and best practices for strengthening SRH
and HIV linkages. Through the review, it was evident that there is widespread agreement that strengthening linkages at the policy level and integration between sexual and reproductive health (SRH) and HIV services can potentially maximize opportunities to reach populations in need, and help in achieving MDGs 4, 5 and 6. Four priority areas for linkages between sexual and reproductive health and HIV have been identified. These include learning HIV status, promoting safer sex, optimizing links between HIV and STI services, and integrating HIV with maternal and infant health.

2. Integration of services for HIV/AIDS and sexual and reproductive health: Pilot projects in India have paved the way for wider use of effective models, strategies, and tools, PATH (Implementation Experience)

PATH’s convergence projects in Andhra Pradesh and Bihar showed that a district-level approach to convergence of HIV and SRH services can increase access to SRH services for people living with HIV/AIDS or at high risk of HIV if both demand-side and supply-side interventions are implemented simultaneously. Based on this pilot, PATH has identified six key steps to develop and scale up a model for convergence of HIV and SRH services namely, start-up activities, developing training and capacity building material, advocacy, implementation activities, monitoring & evaluation and reporting & information dissemination.


In March 2008, an inter-departmental government directive was issued on PPTCT-NHM integration. The key strategies of integration included effective collaboration and coordination between health department and KSAPS; expanded coverage of hospital deliveries for all HIV positive women through involving the private sector as well as the Yashaswini scheme to facilitate cashless transactions; and robust systems for programme monitoring to ensure timely provision of high quality service. Auxiliary Nurse Midwives (ANMs; grass-root level workers under NHM) were given responsibilities to implement the PPTCT Program. Government District AIDS Prevention and Control Unit Officers, and Reproductive and Child Health Officers jointly monitored the implementation of PPTCT activities at district level. Reporting was built into the regular health department management information system. Line-listings of HIV positive pregnant women were made available to all health care providers on a “shared confidentiality” basis after obtaining client’s consent.

VI. Recommendations

Integrating Maternal, Neonatal, Child Health, Family Planning and HIV services was shown to be feasible across a variety of integration models, settings, and target populations. Complete integration can be achieved only through a high level political commitment, dedicated oversight mechanisms and to start with, simple and tested models of PPTCT and MCH integration. With the implementation of revised PPTCT guidelines, integration between these services is warranted as early identification, initiation of
ART and follow-up of 100% of positive pregnant women is the requirement for Elimination of Mother To Child Transmission of HIV (EMTCT).

Through the review of global and national level experiences in implementing integrated PMTCT and MCH services, the following models and steps for integration are recommended and not limited to:

a. **Models for Integration**

1. **ANC Services including PMTCT services:**
   There must be no missed opportunities during ANC, delivery, post-natal care to provide appropriate PPTCT services. Considering ante-natal care is the first point of contact with the hospital for the pregnant women, inclusion of PPTCT into the ANC services provides an opportunity to identify positive pregnant women at the earliest and refer them for initiation of ART to prevent parent to child transmission of HIV. Three simple steps that can be taken to integrate PPTCT into ANC services are:
   i) Early registration of the pregnant women for ANC services and providing HIV testing i.e. offering HIV testing as part of routine ANC testing profile that includes Hb%, complete urine examination, HIV, HBSAg, VDRL and Widal test for Malaria ii). Train the staff providing ANC services on HIV counseling and testing, so that no pregnant women misses an opportunity in finding out her HIV status.

2. **ANC services including ART delivery for eligible pregnant women:**
   Currently, women identified as HIV positive have multiple encounters with various service providers sometimes even within the same facility. A HIV positive pregnant woman is provided AN care initially at the facility, referred to the HIV counseling and testing centre, once found positive is referred to the ART centre which is at the district hospital and later referred back for ANC services. During the process of referrals from one point of care to the other, many clients are lost to follow-up. Towards minimizing lost to follow-up due to multiple service delivery points the following steps can be followed: i) introduce single window system for ANC and ART service provision to improve provider-patient relationships and adherence to treatment ii) train the staff on task sharing. However, while making efforts to integrate these services, the client load of the centre, confidentiality issues and quality of care must be considered.

3. **PPTCT services integrating counseling on Family Planning:**
   Preventing unintended pregnancy (Prong 2 of PPTCT), HIV and sexually transmitted infections (STIs) among sexually active people are common components to PPTCT and family planning (FP) programs. These two services promote safer sex practices and distribute condoms which provide dual protection against HIV/STIs and unintended pregnancy. Through such integration, the unmet need for contraception particularly among the young women can be addressed. Simple steps that can facilitate integration are: i) include information on contraceptives, distribution of condoms and screening of STIs including syphilis in PPTCT counseling ii) appropriate referrals for specialized FP services
4. **Providing HIV testing and ART during labor and delivery care:**

Women may come for labour and delivery (L&D) services with unknown HIV status. Therefore, offering HIV testing during L&D can optimize access to cascade of PMTCT services and uptake of ARV prophylaxis for both mothers diagnosed HIV positive and postpartum care to exposed infants. Knowing the sero-status also helps in taking precautions for infection control and minimizing occupational exposure. The following steps can be taken to integrate HIV testing into L&D services: i) train the L&D staff in providing counseling and HIV testing, ii) provide whole blood test kits for HIV to facilitate simple testing by the staff iii) appropriate referrals for specialized post-partum care services.

5. **Postpartum care including infant feeding support, growth monitoring and immunization of the HIV exposed infants and children:**

Currently, PPTCT counseling is provided in a separate unit but within the same hospital providing ante-natal, delivery and post-partum care. As a routine, support for infant feeding, growth monitoring and immunization is provided in post-partum care including for those who may be HIV exposed Infants (HEI). Yet, lack of co-ordination and linkages between the post-partum and PPTCT services is leading to lost to follow-up of mother-baby pairs. With the implementation of PPTCT revised guidelines, exclusive breastfeeding is recommended from zero up to six months together with ARVs for mother (life-long) and infant (up to 6 weeks of age) and continue breastfeeding for at least one year (National technical guidelines for PPTCT, 2013) and in case, the child is diagnosed positive, breastfeeding can continue ideally up to two years. At this juncture, passing mixed messages to positive mothers on exclusive breastfeeding should be avoided. Therefore, four steps that would help synchronization of these services are i) training of the staff providing post-partum services on follow-up care of HEIs i.e. exclusive feeding practices, Early Infant Diagnosis at 6 weeks, periodical testing for HIV at 6, 12 and 18 months ii) inclusion of follow-up care of HEIs in the baby’s immunization schedule, provision of cotrimoxazole prophylaxis and NVP syrup to the exposed babies at specified intervals iii) focused counseling to HEI on regular follow-up, exclusive feeding practices, testing for HIV at specified intervals, iv) proper tracking of the HEIs accessing follow-up services in the post-partum units and v) cross sharing of the recorded data between post-partum units and PPTCT centres.

6. **Post-abortion care adding HIV testing:**

Counseling on family planning, prevention of STIs/HIV, promotion of condoms and HIV testing can help women during their post-abortion care to plan adequately about their future pregnancies. It can also facilitate timely linkages to HIV treatment services if diagnosed HIV positive. Specific interventions for such integration may include i) training of the staff providing post-abortion care on HIV counseling and testing, ii) provision of whole blood test kits in the post-abortion care wards, iii) appropriate referrals to care, support and treatment centres.
7. Child malnutrition services adding HIV testing and care:

NFHS-3 (2005-06) data show that overall, 57 per cent of women of childbearing age in India (urban and rural) have anaemia and 30 per cent of infants being born underweight. It is a known fact that there are significant benefits of breastfeeding on children’s health. It is essential to identify HIV-exposed newborns and infected children as they are at increased risk of life-threatening infections such as PCP, tuberculosis, and nutritional deficiencies. Nutritional Rehabilitation Centres (NRCs), Special Newborn Care Units and Anganwadi centres are certain avenues to identify HIV exposed/ positive children.

The NRCs have been set up in the health facilities for inpatient management of severely malnourished children, with counselling of mothers for proper infant and young child feeding, 24 hours care & monitoring of the child, treatment of medical complications, therapeutic feeding and follow up of children discharged from the facility. More focus on the NRCs can be given as they offer an opportunity to identify HIV exposed/infected children among those admitted. Therefore, the following steps can help integration of child malnutrition services and HIV testing and care: i) train the staff of NRCs on identification of the common childhood illnesses and HIV, ii) counsel parents and caregivers of the HIV exposed and infected children on exclusive infant feeding practices and their follow-up care, iii) link them for specialized HIV services if the child is identified positive.

b. Requirements for Successful Integration

Political will and commitment from the government, simple and feasible models of integration, stakeholder support for implementation of integrated models, buy-in from the hospital staff are some promoting factors that help effective integration. The other requirements for successful integration include:

- Additional resources and training for existing personnel to implement the integrated program
- Provision of stigma-free services for HIV positive mother and babies at the integrated facilities
- Joint and rigorous monitoring of the integrated program by the NHM and DAPCU staff
- Integration of key HIV indicators in the Mother and Child Tracking Card (MCTS) and thorough tracking of HIV positive women and their exposed babies
- Reiteration of the roles and responsibilities of the NHM staff through refresher trainings and supportive supervision.
- Improvement of data quality of both MCH and HIV indicators
- Conduct regular maternal and child death audits including those of women and children who were HIV positive
VII. Conclusion:

Integration of PPTCT and MNCH services has many advantages including improving the coverage and quality when compared to offering these services vertically. Additionally, such integration will minimize the number of visits to the facility to receive MNCH and PPTCT services separately. Moreover, integration can increase the uptake of HIV services and promote early diagnosis and treatment of HIV positive pregnant women. Hence, integration of PPTCT and MNCH services are defensible.
VIII. Annexures:

**Annexure 1:** Flowchart showing the flow of pregnant women presenting for Ante-natal Care and PPTCT services at Sub- centre prescribed by National Strategic Plan for PPTCT by Government of India

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- **Screening Test for HIV:**
  - Provide Group/individual counselling session
  - Offer HIV test

- **Screening Test for Syphilis:**
  - Does Finger prick Whole blood test for Syphilis screening. Ask pregnant women for more than one syndrome or condition, check for Vaginal/Cervical Discharge, Genital or ano-rectal ulcer/blisters, Lower Abdominal Pain or tenderness, Ano-rectal Discharge, Ingual Bubo, Genital or anal warts, Individuals with anal or genitalwarts, Genital scabies, Genital Pediculosis, Genital lesions over genitalia

- **Screening Test for Tuberculosis:**
  - Refer pregnant women to designated microscopic center at PHC if there is persistent cough of any duration, usually with expectoration. It may be accompanied by one or more of the following symptoms such as weight loss, chest pain, tiredness, shortness of breath, fever, particularly with rise of temperature in the evening, in some cases there will be blood in the sputum, loss of appetite and night sweats

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- **HIV Negative**
  - Post-test Counseling, information and support
  - Refer to ICTC for confirmation of HIV

- **HIV Reactive**
  - Opt out/ Refuse test
  - Repeat Counseling
  - Offer HIV test at each subsequent visit

- **If HIV reactive refer to PHC/STI Clinic for symptomatic treatment and RPR testing for confirmation**
  - Continue treatment, advice condom use and partner treatment

- **If HIV negative provide post-test counseling**

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- **RPR Positive**
  - ICTC collects 5 ml blood for HIV rapid test and RPR test (if RPR is not done earlier)

- **If HIV Positive**
  - Start treatment immediately, advice condom use and partner treatment

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- **Refer HIV infected pregnant mother to ART centre for CD4 test, TB screening and clinical staging**
- **Ensure all referred pregnant women actually reach the ART centre and are started on ART without delay or waiting for CD4 and other laboratory reports**

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*Page 24*
Annexure 2: Framework for integrated service delivery of a comprehensive Elimination of Mother To Child Transmission (EMTCT) programme by The Inter-Agency Task Team (IATT) for Prevention & Treatment of HIV Infection in Pregnant Women, Mothers and Children
Annexure 3: G.O. number 1858

GOVERNMENT OF ANDHRA PRADESH

ABSTRACT

Health Medical & Family Welfare Department — Prevention of parent to child transmission of HIV / AIDS (PPTCT) - A.P. State AIDS Control Society - Introduction of new efficacious drug regimen - Roles and responsibilities of the various cadres of the staff in the implementation of the PPTCT program. In volume of various department under the control of the HM & FW Department – Guidelines framed – Orders issued.

HEALTH MEDICAL & FAMILY WELFARE (L1) DEPARTMENT

G.O.Rt.No. 1858  

Dated: 31-12-2012

Read the following:-

5. G.O.Ms.No. 102, Health Medical & Family Welfare Department, Dated: 15.05.2012.

ORDER:

HIV/AIDS has become a global, National and state challenge with serious implications for the future economic and social development of our society. While there have been great strides in the Prevention of HIV transmission and care of HIV infection and AIDS, as per the recent reports indicate that, 5.2 lakh people are living with HIV/AIDS in Andhra Pradesh with a prevalence of 1.06%. It is disturbing to note that, in spite of best efforts, half of the new HIV infections are among the young people aged between 15-24 years. Of these 39% are women and 44% are children. Parent to child transmission is one of the major routes of new infections.

2. Treatment care & support services are provided by NACO & APSACS in Andhra Pradesh to bring down the prevalence of HIV infection and improve the quality of life of People Living with HIV (PLHIV).

3. Prevention of the parent to child transmission of HIV program (PPTCT) is one of the major interventions in prevention of occurrence of new HIV infection in children. Government of India and NACO has decided to implement administration of a new efficacious multi drug regimen for all the eligible pregnant women as per WHO recommended guidelines to prevent HIV transmission to the child during pregnancy, delivery & lactation.

4. Andhra Pradesh is selected for the implementation of the program in first phase i.e. (a) Magnitude of HIV/ AIDS, robust health service delivery systems, infrastructure, trained human resources under APVVP , Director of Public Health, Director of Medical Education (b) Effective health service delivery through District & Area hospitals, Community Health Centres, Community Health & Nutrition Clusters, stand alone ICTCs, FICCTCs and ART Centres.

Contd... 2
5. The Government after careful examination hereby direct all the functionaries of Health department to work within the scope of their job responsibilities and achieve the following:

1. 100% HIV testing of all the pregnant women who receive antenatal services from Sub centres, PHCs, CHCs, Area hospitals, District hospitals and Teaching hospitals following all the existing guidelines.

2. Providing new efficacious multi drug regimen to all the identified positive pregnant women free of cost.

3. Ensuring the 100% adherence of pregnant women and lactating mothers to the new drug regimen by collective effort of the staff of Subcenter, PHC, ICTC, ART, CHC, CHNC, obstetric service wing of Teaching, District, Area hospitals by following the protocols.

4. Providing advice on effective infant feeding practices.

5. Providing services and motivate the mother to utilize services offered for early infant diagnosis and treatment.

6. Government also hereby permit:

1. To establish functional synergy and effective linkages of all the health services provided through institutions under the administrative control of Commissioner of Public Health Medical and Family Welfare, Director of Public Health, Commissioner of A.P Vaidya Vidyana Parishath and Director of Medical Education (in coordination with Commissioner Women Development and Child Welfare Department, Mission Director of NRHM and the District Collectors).

2. Assigning PPTCT related roles and responsibilities to health functionaries working under the administrative control of DME, APVVP, Public health and family welfare.

7. The Commissioner of Public Health and Family Welfare, Mission Director – NRHM, Director of Public Health and Family Welfare, Director of Medical Education shall issue necessary orders to all the functionaries under their administrative control.

8. DMHOs, DCHS and District collectors shall implement and review the PPTCT program progress in the district on monthly basis and shall take necessary action to cover all the pregnant women in the district to bring down HIV related IMR and MMR.

9. Necessary guidelines are appended to this order as Annexure I & II.

(BY ORDER AND IN THE NAME OF THE GOVERNOR OF ANDHRA PRADESH)

AJAY SAWHNEY
PRINCIPAL SECRETARY TO GOVERNMENT

To
The Commissioner of Public Health and Family Welfare,
A.P. Hyderabad.
The Managing Director, APSACS, Hyderabad.
The Director of Public Health and Family Welfare, A.P. Hyderabad.
The Commissioner of APVVP, A.P. Hyderabad.
The Director of Medical Education, A.P. Hyderabad.
The Managing Director of APMSIDC, A.P. Hyderabad.
The Director of Institute of Preventive Medicine, A.P. Hyderabad.
The Director of IIH & FW, A.P. Hyderabad.
The Director of SPMU / SPIU, A.P. Hyderabad.
All the District Collector of the Districts concerned through HOD.
All the Project Officer of ITDAs in the State.
All the DM&HO and DCHS of the Districts concerned
All the Regional Directors of Health Services

Copy to:
P.S. to Prl. Secy. to C.M.
OSD to Minister (H&FW)
OSD to Minister (ME)
OSD to Minister (108,104, Arogyasri)
OSD to Minister (PR)
OSD to Minister, Tribal Welfare.
OSD to Minister for Municipal Admn.
PS to Prl. Secretary, HM&FW Dept.
SF/SC.

//FORWARDED :: BY ORDER//

SECTION OFFICER
Annexure 4: D.O. No. 4(1)/2009/NRHM-I

K. Sujatha Rao
Secretary (H&FW)
Department of Health and Family Welfare

K. Chandramouli
Secretary & Director General (NACO)
Department of AIDS Control, NACO
Ministry of Health and Family Welfare

D.O. No. 4(1)/2009/NRHM-I
New Delhi, Dated 27th July, 2010

Dear ,

Sub: NRHM & National AIDS Control Programme (NACP) convergence.

A joint meeting to take intra sectoral convergence further was held between the Department of Health & FW and Department of AIDS Control.

Based on deliberations, following decisions as actionable points for States have been firmed up to harness optimal utilization of resources under NRHM and NACP and also to avoid duplication, for your consideration:

- Universal HIV screening to be included as an integrated component of ANC check up. VHNDs may be utilized for rapid blood test and positive cases to be referred to ICTCs for confirmation. Positive status to be only disclosed to client at ICTCs along with pre and post test counseling.

- The counselors at ICTCs to also counsel the non HIV pregnant women on nutrition, STI and birth spacing.

- The link workers & outreach worker of NGOs under NACP to undertake line listing of all pregnant women and prepare birth plan for non HIV women as well.

- ASHAs to be trained also on the module “Shaping Our Lives” developed by NACO for all field level workers as part of package VI for training ANM and supervisors.

- ASHAs to also provide ANC and STI counseling, referral, pre and post natal care for mother & newborn and mobilize VHSC and other panchayat level resources for nutritional, transport and other support required by HIV positive persons.

- All 24x7 health facilities to be strengthened to provide ICTC services through training of existing staff (Nurses, ANM and lab. Technician). SACS to train the staff and provide rapid HIV kits.

- All 24x7 facilities to also provide PPTCT services through existing trained staff along with labor room testing. SACS to provide prophylactic drugs.

- To improve access to maternal health services to HIV positive women, states may consider appropriate incentive to service providers conducting deliveries in 24x7 facilities. States may also consider additional transport support for HIV positive pregnant women visiting health facilities under untied funds for VHSC.
• FP Counselors may also be trained on STI, PPTCT, ANC and nutrition for improved range of counseling and access to services. SACS may be involved in insemiating training on STI and PPTC.

• For national STI programme, NACO/SACS to continue to monitor and supervise the programme through technical support in training, quality supervision and monitoring access of STI services at facility level and procurement of colour coded drug kits.

• Infrastructure upgradation including augmentation of human resources for the identified 29 districts in the country not having blood banks to be taken up by States on priority under NRHM. SACS to provide Kits, Equipment/ and may take up Refurbishment/ Retro-fitting works, if feasible.

• States to provide support of infrastructure development works under NRHM for Blood storage Centers at FRUs under NRHM and also to ensure that existing Medical Officers and Laboratory Technicians work for blood transfusion services in addition to their duties. SACS to be approached for procurement of equipments, training and recurring expenditure.

• SACS to identify public facilities to be strengthened for OST (Opiate Substitution Therapy) and frame norms for the same. States may support setting up of facility under NRHM.

• All HIV patients to be screened for TB and vice versa

• SACS to take care of Condom Promotion in high prevalence states & in the remaining areas support to be provided by States under NRHM.

• As a follow up to above points PD SACS and MD, NRHM may nominate nodal officers to develop implement and monitor the aforesaid plan.

• At state level PD SACS & Mission Director NRHM may meet each quarter along with their nominated officials, to review planning, progress and identify bottlenecks in relation to implementation.

• State may reflect above convergence plan in their respective Annual NRHM- PIPs and AWP of SACS in the chapter on Convergence.

We would be grateful for action taken and an early intimation to the Ministry on the aforesaid strategies.

With Regards, Yours sincerely,

(K. Chandramouli)  (K. Sujatha Rao)

Secretary/Principal Secretary
Department of Health and & FW
All states/UTS (as per list enclosed)

Copy to
Mission Director (NRHM)
All States/ UTs (as per list enclosed)
Annexure 5: G.O.Ms. No. 249

GOVERNMENT OF ANDHRA PRADESH

ABSTRACT

Convergence to improve Health and Nutrition Status of Women and Children - Interdepartmental Coordination for Effective Convergence – Launch of Maarpu Programme – Orders – Issued

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HEALTH, MEDICAL & FAMILY WELFARE (D2) DEPARTMENT


Read the following:

2) G.O.Rt.No.983, Planning (XVIII) Department, dated 23.08.2012. 3) SBCC Workshop held at IIHFW, Hyderabad on 6.09.2012.

***************

1. The efforts made by the Government of Andhra Pradesh over the past few years have resulted in improvement in the health and nutrition status of women and children. The Maternal Mortality Ratio (MMR – per 1,00,000 live births) has declined from 220 in 1997 (SRS 1997) to 134 in 2009 (SRS 2010) but remains much higher than the MMR of 81 in Kerala (SRS 2010). Similarly, the Infant Mortality Rate (IMR – per 1000 live births) has declined from 63 in 1997 (SRS 1997) to 46 in 2010 (SRS 2010) while Kerala has achieved a significantly lower IMR of 13 (SRS 2010). Further the percentage is still very high for (i) Low Birth Weight children at 19.4%, (ii) children (< 3yrs) who are underweight at 37% and (iii) Pregnant Women (15-49 yrs) who are anaemic at 56%(NFHS -3)

2. The current rate of decline in MMR & IMR is not up to the level expected and needs to improve significantly to achieve the MMR and IMR goals set as part of the Millennium Development Goals (MDGs). On the other hand Malnutrition is not only at unacceptable levels but is also a major underlying cause of maternal & infant deaths. Hence, there is a sense of urgency to adopt strategies that can significantly improve the pace of decline of MMR, IMR and Malnutrition in Andhra Pradesh.

3. In the GO first read above, operational guidelines were issued for institutionalization of Nutrition and Health Days and certain other areas of convergence. Vide reference 2nd read above, a Group of Secretaries (GoS) was constituted for convergence of Social Sector flagship programmes for improvement in Human Development Index (HDI) and achievement of
Millennium Development Goals (MDG). The first meeting of the GoS, chaired by Chief Secretary was held on 16th August 2012. **It emerged that strengthening of health care services and nutritional services is very essential and equally necessary is behavioral change in the community** to tackle critical issues like age at marriage, early initiation of breast feeding, complementary feeding, high anemia levels, early registration of pregnancy, institutional deliveries, new born care etc. It was decided, inter-alia, that all the allied departments need to converge in order to have a synergistic effect and accelerate the improvement in the Maternal and Child Health and Nutrition indicators, and that a workshop would be held to work on the priorities and operational modalities.

4. The workshop was held on 6th September 2012 with various stakeholders to examine the existing convergence efforts and to identify areas in which cohesive and converged action could improve delivery and access to services and bring about behavioral change in the community. In the workshop and follow-up meetings, twenty interventions were identified, which have the highest potential of reducing MMR, IMR and Malnutrition. It was felt that the desired shift from programme-driven service delivery to demand driven mode would get an impetus through convergence efforts. The community would be involved not just in efforts to effect behavioral change but also in making the Health and Nutrition Plan for each village and monitoring the results using appropriate tools such as Quantified Participatory Assessment (QPA) to be sued by user group. The workshop recognized the strength of Self Help Groups (SHGs) that are universally present across the State and are federated at the village, mandal and district level. It was felt that the District Collector must drive the convergence effort in the district with a suitable administrative structure to guide and support this initiative.

5. In view of the above circumstances Government has decided that the **convergence efforts would be taken forward through a programme named “Maarpu”**. Various components of Maarpu are as follows:
   i. Focus on 20 key interventions to reduce MMR, IMR & Malnutrition.
   ii. Convergence in Service Delivery at the habitation level.
   iii. Convergent Behavioural Change Communication (BCC).
   iv. Monitoring of the 20 key interventions.
   v. Participation of SHGs & Village Organisations (VOs)
   vii. Synchronization
   viii. Administrative Structures for convergence.

Each component is detailed below.

6. **Focus on 20 key interventions to reduce MMR, IMR & Malnutrition.** The key interventions are as follows:

1. **Early Registration of Pregnancy.** Registration to be done immediately on confirmation but definitely before 12 weeks of pregnancy and has the following components:
a. A confirmatory pregnancy test
b. Registration
c. Issuance of Mother and Child Protection (MCP) card both in public & private sector.

1. **Ante Natal Checkups (ANCs).** Every pregnant women to have minimum four ANCs of which, one between 16-20 weeks and the other between 32-34 weeks to be attended by the Medical Officer at the Primary Health Centers (PHCs) or as part of Fixed Day Health Services (FDHS). The components of the ANC are:
   i. Haemoglobin estimation (Sahli’s method)
   ii. B.P. measurement
   iii. Urine testing
   iv. Weight monitoring
   v. Tetanus Toxoid
   vi. Distribution and ensuring consumption of Iron Folic Acid (IFA) tablets
   vii. Updating the MCP card after each service delivery
   viii. Health counseling, which includes awareness generation regarding general hygiene, exercise, diet, rest, breast care and danger signs during pregnancy.

2. **Maternal Nutrition.**
   i. Nutrition counseling be anchored by AWW with support of members of Village Health, Sanitation and Nutrition Committee (VHSNC) and particularly with help of ANM/ASHA/SHGs/VOs. Focus will be on diet intake in terms of quantity and quality food with proteins and iron rich foods, and on consumption of IFA tablets.
   ii. Diet supplementation at Anganwadi Center (AWC).

2. **Identification of high-risk pregnancies** & ensuring appropriate referral.

3. **Birth Planning.** Advanced birth planning for the pregnant woman is to be done with four components:
   a. Identification of the Institution where delivery is planned and to promote institutional deliveries at Public Health facilities (even if the delivery is planned in another village/town).
   b. Transport arrangements with 108 or any other alternative method.
   c. Identifying the person(s) accompanying the pregnant woman for delivery.
   d. Arrangements required for 48 hours stay at the hospital after delivery.

4. **Institutional delivery.** Basic Services to be delivered for Intranatal care In Public & Private sector are
   1. Quality of Intra natal care (Partograph to be plotted for every delivery to know the course of parturition).
   2. APGAR score of newborn and birth weight to be recorded in MCP card.
   3. “Zero” doses of BCG, OPV and Hepatitis B and recorded in MCP card.
4. Issue of Birth certificate from MCP card.
   In addition to the above services, Public Health facilities to
5. Make JSY payments before discharge.
6. Ensure safe drop back after 48-hour stay at the hospital.

5. Early initiation of breastfeeding (within an hour of birth). Counseling by Medical Officer or Health staff in case of institutional delivery and by AWW/ASHA/ANM during Home visits.

6. Exclusive breastfeeding for six months. Counseling of mothers at AWCs and during Home visits of AWW/ASHA/ANM.

7. Post Natal Care and Newborn Care. The Medical Officer to do the first postnatal visit at the hospital. The remaining six postnatal visits for the care of the mother & the newborn will to be done primarily by ASHA with support of AWW. ANM/Lady health supervisor/Medical officer shall be doing prioritized postnatal visits to high-risk cases, those that require special care, verify a sample of postnatal visits done by ASHA and provide on job training on post natal visits to ASHA. Apart from the examination the ASHA/AWW are required to:
   1. Identify signs of sickness in both mother and the newborn.
   2. Ensure appropriate, timely referral and inform the Medical Officer of the PHC to ensure that the Specialist/First Referral Unit (FRU) is ready to receive the patient.

8. Immunization. The infant gets zero dose of BCG, OPV and Hepatitis B at time of delivery; three doses each of DPT, OPV, Hepatitis B vaccines in sixth, tenth and fourteenth weeks after birth; Measles vaccine and Vit A after completion of nine months of age; DPT booster doses at 18 months and 60 months with biannual doses of Vit. A solution upto 60 months.

   1. Regular growth monitoring by weighing all children below 5 years and plotting in MCP cards and growth registers of AWC through AWW/ANM.
   2. Immediate counseling of mothers & family members in case of faltering or decrease in weight of children using ready reckoner by AWW/ANM.
   3. Identify moderate & severe malnutrition and ensure nutritional counseling, supplementation and referral.
   4. Identification of Severe Acute Malnutrition (SAM), referral to Nutritional Rehabilitation Centers (NRCs) and follow-up.

    1. Counseling and Home visits for introducing complementary feeding at 7th month and continued breast-feeding up to 2 years.
    2. Counseling on age specific quantity, quality and frequency of dietary intake for children (from 7th month to 5 years) during NHDs, Home visits and Awareness Programmes.
    3. Supplementary nutrition at AWC.

    1. Early identification of ARI & Diarrhoea
2. Use of ORS & Zn for Diarrhoea
3. Continued feeding during episodes of illness.
4. Appropriate referral & follow up.

12. **Strengthening of referral system.** Establishing a referral linkage between community to health facilities and among health facilities. This will particularly include referrals for ARI, Diarrhoea and other severe illnesses among infants and referrals for high-risk pregnancies.

13. **Family Planning.**
   1. Delay in first pregnancy.
   2. Spacing methods after first delivery.
   3. Permanent methods with focus on Male sterilizations.

14. **Maternal & Infant Death Reviews.**
   - Improve reporting of Maternal deaths, Stillbirths & Infant deaths.
   - Do Community Based Maternal Death Review & Facility Based Maternal Death Review.
   - Review at district level with appropriate interventions to prevent such deaths in future.

15. **Sanitation & Hygiene.**
   a. Counseling on Sanitation & Hygiene (Environmental & Personal)
   b. Hand washing practices
   c. Ensuring Cleaning of village water tanks & Chlorination of Water (Wells/Bore wells/Potable water)
   d. Use of Indian Sanitary Latrines (ISL) by households.

16. **Age at Marriage.**
   b. Awareness creation regarding the ill-effects of child marriage and legal provisions

17. **Adolescent Girls.**
   a. Weekly Iron Folic Acid Tablet supplementation at schools and AWC.
   b. Nutrition and health education on lifecycle approach.
   c. Focus on school dropout’s and vocational training

18. **Gender Sensitization.** Focus on
   a. Implementation of PC & PNDT act
   b. Sex Ratio
   c. Girl child education, trafficking and domestic violence

19. **Convergence in Service Delivery at the habitation level.**
Service delivery at the habitation level is to be converged and strengthened by having two Nutrition and Health Days (NHDs) at the Anganwadi Centre each month, instead of the one at present. In addition, Fixed Day Health Services (FDHS) shall be provided once a month at the sub-centre level. Home visits will be made separately and jointly. Details of services are as follows:
1. Out of the two NHDs, NHD-1 will focus on ANC services, immunization and counseling by the AWW with support of ANM, ASHA, members of VHSNC and particularly SHGs & VO.

2. The second NHD i.e. NHD-2 will focus on growth monitoring and counseling, wherein the ANM may not be present but the ASHA, members of VHSNC and particularly SHGs and VO will support the AWW. The ASHA/SHGs/VO will be responsible for mobilizing the user group and will actively contribute to the successful conduct of NHDs and FDHS.

3. The FDHS will be provided by the Medical Officer (MO) using a 104 vehicle. Pharmacist and Lab Technician will also be present for FDHS. The MO will provide the 2nd and 4th ANC to all pregnant women and identify the high-risk pregnancies. The MO shall also examine the malnourished and sick children during FDHS. He will refer the high-risk pregnancy and SAM children for specialized care.

4. Home visits as prioritized will be made by AWW/ASHA/ANM. During these visits the functionaries will involve members of VHNSC and particularly the SHGs/VOs.

20. **Convergent Behavioral Change Communication (BCC).**

Critical aspects for achieving results are community mobilization; counseling on health, nutrition and sanitation. IEC campaigns and demand creation all of which leads to Behavioral Change. This behavioral change will be achieved by:

1. Weeklong IEC campaigns called “Mahila Sishu Chaitanyams” to be held once in three months with focus on messages and themes based on 20 key interventions.

2. Coordinated counseling during NHDs anchored by AWW and supported by the ANM, ASHA, SHGs and VO.

3. Counseling during Home visits by the AWW/ASHA/ANM/SHGs/VOs.

4. SERP conducting annual awareness & training programmes for SHGs and VOs on Health & Nutrition.

**Monitoring of the 20 key interventions.**

1. This will be done by the Convergence Committees at all levels and the district level report will be sent to the Commissioner, Health & Family Welfare for review by the State Level Convergence Committee. Formats will be prescribed for monitoring and these will include those indicators, which are relevant in the present context and have the maximum impact for reducing MMR, IMR and Malnutrition.

2. Monitoring will also be done by involving the community particularly the SHGs and VOs using appropriate tools.

**Participation of SHGs & VOs:** The SHGs/VOs will play a key role in

1. Bringing about behavioral change in the community in the following areas.

   1. Age at marriage.
   2. Early registration of pregnancy.
   3. Promoting the use of MCP card.
   4. To avail two ANCs by Medical Officer.
5. Recommended dietary habits for pregnant & lactating women.
6. Institutional deliveries and 48 hours stay in hospital.
7. Newborn care including prevention of hypothermia.
9. Immunization
10. Growth monitoring
12. Community actions on anemia
13. Personal Hygiene & Sanitation
15. Active participation of community in NHDs, FDHS and Referrals.

2. Preparing Village Health and Nutrition Plans along with the functionaries from health dept. (ANM), WD&CW (AWW), PRI, RWS dept functionaries and members of the VHSNC. The necessary appropriate participatory tools will be prepared jointly by SERP, Health dept. and other concerned departments.
3. Adopting social audit and appropriate monitoring tools to assess the responsiveness of the public health & nutrition systems and to monitor the behavioral outcomes of community.
4. Being in the forefront for mobilizing the user group in successful conduct of NHDs FDHS, referrals and also participate in home visits.
5. Facilitating the efforts for BCC towards maternal and child health care.
6. Helping in service delivery to ensure quality and access of services.

Use of Maternal and Child Protection (MCP) card
The MCP card is a very powerful convergent tool. The MCP card covers all components required for delivering quality MCH care like antenatal services, delivery details, postnatal care, new born care, immunization, growth monitoring, recognizing danger signs during natal care, monetary entitlements, birth certificate and IEC material on nutrition. There is an urgent need to internalize the use of MCP card by all concerned departments. Extensive training, discussion and review under the guidance of District Collector will help to internalize the use of the MCP card.

Synchronization
There will be both Geographical and Functional synchronization. Geographical synchronization will be achieved through alignment of jurisdiction and service areas of functionaries of the allied departments at all levels, using GIS data. Functional synchronization will be achieved through service synchronization, training, data capture & utilization and joint monitoring.
The allied departments (Health & Family Welfare, Women Children, Disabled & Senior Citizens and Rural Development) are currently adopting different mechanisms and means for collection of data on the Mother and Child beneficiaries, with some common variables and a few specific variables for each department. It is decided to have a common database of beneficiaries as a part
of a harmonized MIS from which each of the departments can access the information of the beneficiary.

Administrative Structures for convergence

The following Committees will be set up at various levels for monitoring and implementing the convergence efforts.

1. **State Level Convergence Committee:**
This will have Chief Secretary as Chairperson; Principal Secretaries / Secretaries of Health, Medical and Family Welfare, Women Children, Disabled & Senior Citizens, Rural Development, Panchayati Raj, Rural Water Supply and Sanitation, School Education and Planning as Members; Commissioner (Health & Family Welfare) as Member-Convener; Commissioner (Women Development & Child Welfare), CEO (SERP) and Mission Director (NRHM) as Members & Coconveners.

2. **District Level Convergence Committee:**
This will have District Collector as Chairperson; Joint Collector, Cluster Convergence Officers (they will be District Officers identified by District Collectors), DCHS, Medical superintendent of teaching hospitals, PO (RVM), CEO (ZP), SE (PR), SE (RWS) and representatives of Zilla Mahila Samakhyas (ZMS) as Members; DM&HO as Member-Convener; PD (ICDS) and PD (DRDA) as Members & Coconveners.

3. **Cluster Level Convergence Committee:** This will be constituted at the level of the Community Health & Nutrition Cluster level and will have Cluster Convergence Officer (CCO) as Chairperson; Medical Officers (PHCs), Supervisors (ICDS), Cluster Co-coordinators (SERP) and representatives of Mandal Mahila Samakhyas (MSS) as Members; SPHO as Member-Convener; CDPO and Area Coordinators (SERP) as Members & Coconveners.

4. **Village Level Convergence Committee:** This will be the Village Health, Sanitation & Nutrition Committee (VHSNC) as prescribed by GOI. This will have Sarpanch as Chairperson; all SC/ST/women ward members, any women MPTC member/ZPTC member/MPP President living in the village, president of village education committee, ANM, AWW, ASHA as Members and VOs as Member Conveners.

5. In order to operationalize the process of convergence through “MAARPU” and actively engage all the stakeholders in the process, the District Collectors are requested to convene district level workshops and disseminate the objectives and the key interventions of the Programme. Thereafter the above Committees will meet once in a month and review the implementation of “Maarpu” and progress of key interventions and the behavioral change. The committee can invite NGOs and experts to their meetings.

6. The concerned departments will also supplement the efforts of “Maarpu” by ensuring universal availability of quality services and improving their Programme designs. To support “Maarpu” guidelines on ICT, training etc. will be issued separately.

7. This order is issued in consultation with Department for WCD&SC, Planning Department, and Rural Development Department.
(BY ORDER AND IN THE NAME OF THE GOVERNOR OF ANDHRA PRADESH)

MINNIE MATHEW
CHIEF SECRETARY TO GOVERNMENT

To
The Commissioner, Health & Family Welfare, A.P. Hyderabad
The Mission Director, NRHM, A.P. Hyderabad
The WD&CW Dept., A.P. Secretariat
The PR & RD Dept., A.P. Secretariat
The RWS Dept., A.P. Secretariat
The Rural Development Dept., A.P. Secretariat
The Tribal welfare Dept., A.P. Secretariat
All HODs under the control of HM&FW Dept.,
All the District Collectors & Magistrates
The CEO – SERP, Hyderabad
The Commr, PR, Hyderabad
The Director, Women Development and Child Welfare, Hyderabad
The Commissioner, Rural Development, Hyderabad
The Commissioner, Tribal welfare, Hyderabad
The Chief Engineer, RWS, Hyderabad
All DM&HOs in the state
All Regional Directors of Medical and Health Services in the State
All Regional Directors, WD&CW Agency
All Project Directors, WD&CW Agency
All RDO’s / Sub Collectors

Copy to:-
P.S. to Prl. Secretary to C.M.
P.S. to Chief Secretary to Govt.
P.S. to Minister for IKP, Pensions & SHGs & WCD&SC
P.S. to P.S. to Minister for Medical Education, APVVP & Hospital Services, Health, Family Welfare, Arogyasree, Health Insurance, 104, 108 and Medical Infrastructure
P.S. to Minister for Rural Development, NREGS
P.S. to Minister for Panchayat Raj & Rural Water Supply

/Forwarded::By order/Section Officer
IX. References:

3. Integrated EMTCT Commodities Package, The Inter-Agency Task Team (IATT) for Prevention & Treatment of HIV Infection in Pregnant Women, Mothers and Children
5. Integration of HIV & Maternal Health Programs: Evidence and The Way Forward For India, CEDPA, June 2011
6. Integrating Prevention of Mother-to-Child HIV Transmission into Existing Maternal, Child, and Reproductive Health Programs, Ellen Israel, CNM, MPH and Mary Kroeger, CNM, MPH
7. Integration of Services for HIV/AIDS and Sexual and Reproductive Health: Pilot projects in India have paved the way for wider use of effective models, strategies, and tools, PATH
12. PMTCT Strategic Vision, 2010–2015: Preventing mother-to-child transmission of HIV to reach the UNGASS and Millennium Development Goals, Moving towards the elimination of paediatric HIV
CESS-UNICEF Division for Child Studies
UNICEF is committed to ensure child rights and child centric policies. Centre for Economic and Social Studies (CESS) with its strong presence in policy level and decades of research experience brought UNICEF and CESS together to work jointly on child rights. Subsequently the collaboration between CESS and UNICEF Hyderabad Field Office occasioned launching the Division for Child Studies (DCS) on 20th November 2013 in CESS.

Division for Child Studies (DCS) is one of the dedicated resource of its kind for National and International research academic institutions and policy makers as well as civil society organizations including non-government organizations who are mainly working to bring better policy environment for children.

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