**HIV-NHRM integration — Evolution and strengthening of the PPTCT programme in Karnataka**

*Milestone achieved by integrating HIV indicators into RCH services*

In 2008, Karnataka was the first state to issue a series of orders aimed at implementing the Mother Child Tracking System (MCTS) to enable timely delivery of health services to pregnant women, mothers and newborns. A part of Reproductive and Child Health (RCH) services undertaken by the *National Rural Health Mission (NRHM)*, it took off in 2010 and its success has spurred other states to implement the same. The key objective is boost universal health coverage by monitoring the service delivery, so as to reduce maternal and infant mortality.

In 2013, HIV indicators were integrated into MCTS in Karnataka, which is currently being scaled up. Using existing resources, PPTCT services were combined into RCH services with the objective of ensuring universal coverage of HIV counselling and testing among all the pregnant women, strengthening systems for institutional deliveries for all HIV positive pregnant women; and tracking and addressing HIV infection in children up to 18 months.

**Supporting factors for adding HIV indicators**

- Clear definition of roles and responsibilities of all the stakeholders which included key staff from KSAPS, NRHM, RCH and the TSU.
- Data entered by ICTC and ART counselors themselves, removing the need for hiring additional personnel. Confidentiality of information also maintained.
- Programme run jointly by Department of Health and Family Welfare and KSAPS, without any outside intervention.
- Effective monitoring comprising daily reporting from DRCHO to KSAPS to MD (NRHM) in the beginning, monthly review meetings of Deputy Commissioners, Commissioner of Health and the Director, Health and Family Welfare Services, month and quarterly review as well as field supervision.
- Supplies like condoms, drugs, blood bags and delivery kits common to both RCH and HIV programme.
- District to grassroots level personnel common to both the programmes.
- Special camps conducted at Primary Health Centres to test for HIV to clear backlog.
- Cashless delivery services like Yeshashwini applicable to both NRHM and HIV programmes.
- Initial steps taken to overcome some of the challenges included regular meetings between RCH, HIV and TB unit organized by District AIDS Prevention Control units to build rapport.

*NRHM is now National Health Mission which include Rural and Urban area*
Funds from NRHM pay for all deliveries and reimburse charges for deliveries under Yeshwaswini scheme. An amount of Rs 5,500 is paid per delivery of HIV positive woman. An amount of Rs 10,000 is paid for HIV positive delivery under Caesarean section procedure.

The role of ANMs and ASHAs is crucial in the implementation of this programme. ANMs and ASHA workers are mobilizing pregnant women who are HIV positive for institutional deliveries and follow ups for baby for 18 months. Their responsibilities begin with accompanying the HIV positive women for registration, followed by ANC check ups, institutional delivery, and administration of ART for mother and Nevirapine syrup upto 6 weeks for the newborn and post natal check ups for the newborn at the requisite times. For this, they get an incentive of Rs 1,000 per HIV positive mother.

While nurses have been trained to conduct rapid test for walk in deliveries at PHCs, it is the responsibility of the ANMs/ASHAs to ensure the presence of pregnant women for check ups which are conducted on Thursdays at PHCs.

At the sub centres of Belgaum, Bijapur and Bagalkot, ANMs have been trained to conduct the Rapid test (finger prick test) on pregnant women. If they are found positive then they are referred to the nearest ICTC centres for counseling.

Information is also exchanged during monthly review meetings and if CD4 test reports have not reached the ARTs, then they are handed over during these meetings.

All PHCs have been equipped with refrigerators, centrifuges for HIV counseling and testing and drugs for treatment.

**Challenges:**

1. Interlinking of data between RCH and HIV services for a comprehensive approach to reducing maternal and infant mortality. Since there is no linkage of the data, there is also no question of validating the existing databases on both sides.

2. Bringing more women under universal coverage of ANC, specialized prevention intervention for young people and youth friendly health services. The collation of data from RCH and HIV can aid data analysis which can lead to better understanding of the disease in children.

3. Expand the base of healthcare providers through public-private partnerships to increase institutional deliveries.

4. The NRHM programme can also be strengthened with coordination not just between NRHM and KSAPS, but also with the Department of Women and Child Development to bring in holistic services.

**Outcome of Synthesis:**

The state has seen a clear improvement in women seeking institutional deliveries and HIV positive pregnant women being provided HIV care. There also has been a steep rise in the number of pregnant women who registered at Antenatal Clinics and underwent pre-test counseling, HIV testing; post-test counseling and spouse testing. Subsequently, there has been a corresponding increase in the number of HIV positive women receiving treatment and mother-child receiving Nevirapine. The close tracking of positive women and exposed children ANMs and ASHAs have facilitated integrated care. The augmentation of HIV indicators to RCH services has demystified the disease and removing the stigma attached to those who are infected.

By developing a patient friendly model and implementing it on wide scale through systemic integration, the goal of universal coverage is being achieved through inclusive and equitable programming.