



AIDS Community



Health

Maternal and Child Health Community



Solution Exchange for the AIDS Community Maternal and Child Health Community

Consolidated Reply

Query: Converging HIV and Sexual & Reproductive Health Services - Experiences

Compiled by E. Mohamed Rafique and Meghendra Banerjee, Resource Persons and Rituu B Nanda and Deeksha Sharma, Research Associates

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From [Dr. Amitrajit Saha](#), PATH, New Delhi

Posted 14 December 2007

Global evidence shows that populations at risk of HIV and unintended pregnancies, such as young men and women, people who sell sex, and people with HIV, are not able to access the HIV and SRH services they need. Young unmarried women and sex workers, for example, have difficulty accessing Family Planning services, which gear towards the needs of married women. Services for Family Planning, Maternal and Child Health (MCH), Sexually Transmitted Infection (STI), HIV, and abortion are separate and often target different populations. Consequently, there are several missed opportunities for providing a better response to HIV and SRH. 'Convergence' of HIV and SRH services refers to a very wide range of activities or processes, which are undertaken with the broad objective of capturing these 'missed opportunities' by adding on services or paying attention to the overlap areas in HIV and SRH.

The Government of India has recognized the need for converging or linking HIV and SRH services in the Reproductive and Child Health Programme (RCH II), the National AIDS Control Programme launched in 2007 (NACP-III), and in the NRHM. In recognition of this need, PATH worked with state governments, NGOs, and local communities in Bihar, Andhra Pradesh, Maharashtra, and Uttar Pradesh to identify the options for and challenges of HIV-SRH convergence. Please find at http://www.path.org/files/CP_India_cnvg_rpt.pdf our report from the PATH Convergence project.

One of the benefits of such convergence is improved access to and uptake of key HIV and SRH services with reduced HIV-related stigma and discrimination for the client. In addition, the service

providers gain increased capacity as well as increased ability to meet client needs. Consequently, there are savings on costs and time through reduced duplication of service and delivery functions. We at PATH are considering ways in which to support the development of a National Action Plan on HIV and SRH service convergence focusing on the “most at-risk populations”. We would therefore like your experiences and comments as members of the AIDS and MCH Communities of Solution Exchange, especially in the areas of:

- Overcoming the challenges for converging HIV and SRH services in India, particularly for the most at-risk populations
- Other lessons learnt and experiences of members in converging HIV and SRH services in India

Responses were received, with thanks, from

1. [Ashok Row Kavi](#), , UNAIDS India office, Delhi
2. [Gurpreet Singh](#), Municipal Corporation of Delhi, Delhi
3. [K. S. Sebastian](#), IPPF South Asia Regional Office, New Delhi
4. [Kalpana Apte](#), Family Planning Association of India, Mumbai
5. [Kusum Gopal](#), UNESCO, United Republic of Tanzania
6. [V. Bhava Narayana](#), Pharmed Trade News, Hyderabad
7. [H. S. Sharma](#), Consultant, Gurgaon
8. [Paul Ponniah](#), Jeevan Sagar Trust, Bangalore.

Further contributions are welcome!

[Summary of Responses](#)
[Comparative Experiences](#)
[Related Resources](#)
[Responses in Full](#)

Summary of Responses

Integration of SRH services with HIV services is an essential step in effectively maximizing impact and resources to address HIV, maternal and infant mortality rates, and the need for contraception. Members shared experiences and identified constraints in integration of SRH and HIV programmes, and discussed priority areas for synergies.

Members stated that populations at risk of HIV and unintended pregnancies, such as youth, sex workers, and PLHIV, lack access to SRH services, which are not a part of VCT, or offered during ART. With the feminisation of HIV and women accounting for half of HIV infections, HIV is one of many SRH risks to the health of both women and their children. Limited access to information, counselling and services, poor quality or insufficient care, stigma and discrimination, gender inequalities, and faltering family support are among the barriers that confront HIV positive women. For many of them antenatal care and PMTCT are the primary entry points to SRH services. Often, services ignore the right to informed fertility choices with evidence of discouragement meted out to HIV positive women headed for conception.

Sex workers too face difficulties in pregnancy and childbirth, respondents noted. Stigma in government SRH services is the main barrier to access for sex workers, PLHIV, and men. Often

most people go for HIV testing when they fall sick. Men rarely use government services for management of STIs. This leads to under-utilized government services, overworked doctors and unhappy patients, with waste of time and money in referrals.

Linking the two services opens up SRH services to marginalized groups, utilizes the limited staff and Service Delivery Points, reduces mother to child transmission of HIV and prevents unplanned pregnancies. For example, the [Engender Health project](#) in Tanzania found that integrated services attracted more women than a stand-alone VCT centre, increased the testing of partners of family planning users, and saved costs. Similarly, integration of Reproductive Health Services for Men in [Bangladesh](#) saw an enhanced traffic of male clients.

Despite commitments, efforts to scale up have been limited due to policy, institutional and financing barriers. Different agencies administer, fund and support SRH and HIV programmes. Hence, [Kenya](#) set up a joint HIV and RH taskforce to develop a national integration strategy. Members mentioned negative staff attitude as a major challenge to convergence as SRH staff often raise concerns of stigma by association with HIV services. Staff burnout and trained staff turnover may be problematic and affect the service quality. Clients may abandon clinics because of the stigma of HIV. A wide gap between the demand and availability of facilities for services prevents women from accessing services, especially women living with HIV.

Members mentioned other concerns like donor financing which undermines linkages, lack of understanding of SRH rights approach, and bureaucratic bottlenecks and organizational or legal barriers. There is reluctance to provide SRH services due to religious dogmas on sex work, contraception and on sexual orientation. Some convergence options need additional funds. Private-sector service providers feared whether populations at risk could afford converged services and want government support.

Respondents did not suggest integration across all levels but linkages in context and client needs. [Pathfinder's](#) integrated projects divided into various categories with focus on women, youth, and vulnerable groups. [Family Planning Association of India](#) has worked on integration with SRH and HIV services. At this stage of the Indian epidemic, it may be counter-productive to consider complete integration of HIV and SRH services, as this may dilute the quality of HIV services.

Members cited the [IPPF](#) framework for priority linkages on convergence and provided suggestions:

- Training and sensitization of service providers and capacity building of community-based organisations and faith-based organisations; involve partner organizations to help in capacity building and programme guidance
- Technical support for frontline staff
- Overcoming service providers' fear of contracting HIV through their work by providing equipment for universal precautions
- Assess SRH organizations to determine ways to integrate HIV with their SRH services, while ensuring a referral network to meet needs that fall outside their realm
- Involve various ministries and various stakeholders
- Promote men's involvement in integrated SRH and HIV services.
- Involve the community members in programme planning
- Avoid specific labels, particularly for services
- Create holistic services to meet the needs of vulnerable groups
- Comprehensive promotion and information may encourage people to access services
- Best practices documentation and scientific evaluation on effective methods of integration

There is a continuum of possibilities for integrating HIV in SRH settings, members stated. They emphasised on the integration of services such as family planning, maternal and child health, antenatal care and prevention and management of STIs and HIV to provide clients with a more holistic approach to their reproductive health needs.

Respondents recognised that we could achieve universal access to prevention, treatment, care, and support through linking HIV and SRH services. Convergence needs a systemic approach and involves measures for convergence at the policy level, at the program level, at the service delivery level, as well as at the client and community level. Members underlined that there are many ways to integrate services; integration may require different ways of working rather than large amounts of financial resources. Healthcare is a service industry and such a convergence looks at coordinating the system from the patient's service delivery point of view.

Comparative Experiences

From [Dr. Kalpana Apte](#), Family Planning Association of India, Mumbai

Mumbai

Joint Project of Family Planning Association of India and Humsafar Trust

They implemented a project to involve MSM in SRH issues. Humsafar Trust supported capacity building of providers and gave continued technical support through the project implementation phase. This resulted in creating safe spaces for MSM and helped their wives in accessing SRH services and counseling. The SRH clinic provides RH services to women, children, and men. Hence, lack of any specific labeling helps in reducing stigma associated with the centre. Trained and sensitive service providers have been instrumental in this becoming a very popular clinic.

Kohima

FPAI project with IDUs

FPAI established a critical partnership with Injecting Drug Users and their sex partners as it was a completely neglected aspect of the larger intervention by other organizations. The project provided information on high-risk sexual behaviors to IDUs as other programmes concentrated on risks of needle sharing. The IDUs and their sex partners now are aware of high-risk behaviors and are comfortable in seeking SRH services from FPAI Clinic in Kohima.

From [Rituu B. Nanda](#), Research Associate

Lucknow

Change in attitude of the staff at FPAI clinic

At first, staff was reluctant to integrate VCT services. Staff expressed concern that HIV services might 'take over' the clinic, increase workload and exposure to HIV. With review of procedures for universal precautions, the staff felt more at ease about their risk of occupational exposure. Nurses did risk assessment to refer clients to VCT services. Counsellors started using IEC materials. Staff was involved in dramas to promote the benefits of knowing HIV status through VCT. Several months after the start of the new service, staff saw their role in maintaining the low rates of HIV. The clinic has expanded STI services with greater understanding of HIV.

Bangladesh

Integration of Reproductive Health Services for Men in 2000–2003

FRONTIERS with the Ministry of Health and Family Welfare introduced reproductive health care for men by Family Welfare Centers in Dhaka, Khulna, Rajshahi, and Sylhet districts. The project trained 102 providers who in turn led 436 group discussions with community leaders and male adolescents. Service statistics indicate number of male clients were 345 clients per clinic each month. Of these consultations, 91 percent were for general health problems, and 9 percent were for STIs. Offering reproductive health services for men improved utilization of services by both men and women.

Kenya

Progress in scaling up linkages between SRH and HIV

STI counselling and treatment is a part of ANC, FP and general curative services. FP services are in VCT guidelines though independent developing of VCT centre hinders integration. PMTCT strategy represents a degree of integration with existing RH services, with a joint technical working group and shared supervision with other RH services. Frontiers consortium is implementing multisectoral programmes that address the SRH and HIV needs of adolescents. Institutional and financing constraints and religious conservatism hampers the convergence of SRH and HIV programmes.

Related Resources

Recommended Documentation

From [Dr. K. S. Sebastian](#), IPPF South Asia Regional Office, New Delhi

Sexual and Reproductive Health & HIV/AIDS: A Framework for Priority Linkages

Document by IPPF in collaboration with UNFPA, WHO and UNAIDS; October 2005

http://www.who.int/reproductive-health/stis/docs/framework_priority_linkages.pdf (Size 188 KB)

Calls for intensified linkages between sexual and reproductive health (SRH) and HIV at the policy and programme level

Integrating HIV Voluntary Counselling and Testing Services into Reproductive Health Settings

Joint publication of IPPF South Asia Regional Office and UNFPA

<http://219.83.83.126/gsd/collect/pdf/index/assoc/HASH26cc/625133d1.dir/doc.pdf> (Size: 534 KB)

Describes possibilities for integrating VCT services in SRH settings to determine the appropriate VCT components to integrate, plan, implement, monitor and evaluate them

From [Rituu B. Nanda](#), Research Associate

Integrating SRH and HIV/AIDS Services: Pathfinder International's Experience Synergizing Health Initiatives

By Margot M. Kane and Tayla C; Pathfinder International; March 2005

http://www.cominit.com/healthcomm/uploads/fp_hiv_integration_web_copy_150.pdf (Size 520 KB)

Integration of SRH with HIV services is essential in effectively maximizing impact and resources to confront HIV, maternal and infant mortality rates, and contraception need

Integration of HIV/STI prevention into sexual and reproductive health services: best practices and minimum standards

By Tabac L et al; International Conference on AIDS; July 7-12 2002; Abstract no. WePeF6699;
<http://gateway.nlm.nih.gov/MeetingAbstracts/102250233.html>

The integration of HIV and STI prevention is critical for the holistic SRH services and programming and must incorporate a rights-based approach and a gender perspective

Strengthening linkages for sexual and reproductive health, HIV and AIDS: progress, barriers and opportunities for scaling up

By Nel Druce *et al*; DFID Health Resource Centre; August 2006

http://www.dfidhealthrc.org/publications/srh/HIV_SRH_strengthening_responses_06.pdf ((Size: 292 KB)

Summarizes the main barriers to developing linkages and discusses possible strategies and opportunities for engagement and strengthening linkages

Recommended Organizations and Programmes

Family Planning Association of India, Mumbai (from [Ashok Row Kavi](#), UNAIDS India office, Delhi and [Kalpana Apte](#), Family Planning Association of India, Mumbai)

Bajaj Bhavan, Nariman Point, Mumbai; Tel: +91-22-40863101; Fax: +91-22-4086 3201;
fpai@fpaindia.org; <http://www.fpaindia.org/sections/activities.html>

Supports individuals rights to reproductive choices, works towards reducing the spread and the impact of STIs and HIV and increase access to gender sensitive SRH information

The International Planned Parenthood Federation South Asia, Delhi (from [Dr. K. S. Sebastian](#), New Delhi)

IPPF House, 66 Sundar Nagar, New Delhi; Tel: +91 (11) 2435 9221; +91 (11) 2435 9220
<http://www.ippfsar.org/en/What-we-do/>

Advocates sexual and reproductive health and rights for all and aims to strengthen programme and policy linkages between SRH and HIV in the region

From [Rituu B. Nanda](#), Research Associate

MAMTA- Health Institute for Mother and Child, New Delhi

B-5, Greater Kailash Enclave-II, New Delhi 110048; Tel: 91 11 29220210; mamta@ndf.vsnl.net.in
mamtahealth@vsnl.net; <http://www.mamta-himc.org/ahc.htm>

Has a project on strengthening field level institutions, to build organizational capacity towards Integrated Safe Motherhood and PPTCT

Pathfinder International, New Delhi

Plot No. 10 (third floor), FC-33 Institutional Area, Jasola, New Delhi; Tel: 91-11-4054-1604 /02/03/04; Fax: +91-114054-1605;

http://www.pathfind.org/site/PageServer?pagename=WhatWeDo_RHFP

Pathfinder has integrated HIV prevention and care into all family planning and reproductive programs with focus on HIV targeting vulnerable populations

Recommended Communities and Networks

Family Planning and HIV/AIDS Integration Community, IBP Knowledge Gateway

(from [Rituu B. Nanda](#), Research Associate)

fphivintegration@ibp.wa-research.ch

Family Planning and HIV Integration Community consists of members interested to exchange ideas and field experiences on integrated programmes of HIV and SRH

Recommended Portals and Information Bases

From [Rituu B. Nanda](#), Research Associate

Access My Library.com

http://www.accessmylibrary.com/coms2/summary_0286-9915950_IT%20M

The website offers large amount of technical content and documents on various issues including HIV, sexual and reproductive health as well as on gender

Engender Health

<http://www.engenderhealth.org/ia/swh/plinkingsrhiv.html>

Offers large number of documents with emphasis on integration of SRH and HIV services in relation to PLHIV, women, training and other related issues

Resources for HIV/AIDS and Sexual and Reproductive Health Services

<http://www.hivandsrh.org/>

Provides information on web sites, documents, newsletters, communities, events and funding opportunities for convergence of HIV and SRH services

Pop Council

<http://www.popcouncil.org/frontiers/orsummaries/ors47.html>

This website is a source of information, documents, websites, organisations, and national experiences on integration of SRH and HIV services

Responses in Full

[Ashok Row Kavi](#), UNAIDS India office, Delhi

Family Planning Association of India (FPAI), one of the oldest NGOs in India has done a major project on the convergence of HIV and SRH services. FPAI tried it in Mumbai with Humsafar Trust. Humsafar Trust works with MSM including male sex workers and transgenders. You may contact Kalpana Apte from FPAI for more details.

[Dr. Gurpreet Singh](#), Municipal Corporation of Delhi, Delhi

I fully agree that there is a case for convergence of HIV related and SRH services. In fact, in my opinion, all health programmes including HIV control and pulse polio programme should merge, at least below district level, if not at state level. This will not only avoid duplication but also lead to synergy as already mentioned. This will not only remove stigma as mentioned in this specific case but also lead to a more efficient use of manpower and resources.

[Dr. K. S. Sebastian](#), IPPF South Asia Regional Office, New Delhi

Broadly, convergence between SRH and HIV services requires making a strong connection between sexuality, contraceptive choice, and STI/HIV prevention. It also needs to harness the inherent synergy between preventing unwanted pregnancy and preventing STI/HIV. Thus, convergence needs a “systemic” approach and involves measures for convergence at the policy level, at the program level, at the service delivery level, and at the client and community level. As early as in 2005, IPPF in collaboration with UNFPA, WHO and UNAIDS has produced a framework for priority linkages (and is available at http://www.who.int/reproductive-health/stis/docs/framework_priority_linkages.pdf). Even after 3 years, convergence remained as an unfinished agenda despite a number of attempts towards convergence in many countries. This is due to a number of challenges. Some of the challenges applicable to India are listed below:

- Multiple vertical programs that are administered through different government departments and ministries
- Recent trends in donor financing which has undermined linkages
- Lack of understanding of the sexual and reproductive health rights approach
- Limited training opportunities for health service providers
- Inadequate skill set of SRH providers to deal with issues of sexuality, HIV care, and marginalized populations.
- Resistance from some SRH service providers – a concern that their services would be stigmatized
- A wide gap between the demand and availability of facilities for services (like safe abortion) prevents women from accessing services, especially women living with HIV.
- The social distance between service providers and users
- bureaucratic bottlenecks
- Some organizations are not ready for convergence due to various organizational/ legal barriers
- Rise in religious conservatism – reluctance to provide SRH services due to deep rooted religious dogmas on sex work, contraception and on sexual orientation

IPPF members including Family Planning Association of India are engaged not only in policy advocacy for integration but also in demonstrating integration at service delivery level and the experiences are being documented. A joint publication by IPPF South Asia regional office and UNFPA titled integrating HIV voluntary counseling and testing services into reproductive health settings offers stepwise guidelines for programme managers and service providers (and is available at <http://219.83.83.126/gsdll/collect/pdf/index/assoc/HASH26cc/625133d1.dir/doc.pdf>)

[Dr. Kalpana Apte](#), Family Planning Association of India, Mumbai

Family Planning Association of India (FPAI) considers integration is when every possible opportunity is utilized to extend services and programmes to include HIV. Components of HIV are incorporated while working with partner communities in existing operational areas. In addition, new projects working with newer FPAI communities like MSMs, IDUs and so on are planned and implemented.

FPAI implemented a small yet innovative project in Mumbai where strategies were implemented to involve MSM in SRH issues. Humsafar Trust provided very critical support by way of capacity building of providers; gave continued technical support through the project implementation phase. This has resulted in creating safe spaces for MSM and helped their wives in accessing SRH services and counseling. As the services are provided in an ongoing SRH clinic where a lot of women and children access MCH, Abortion, contraceptive and other RH related services, MSM did not feel pressurized or threatened. Similarly, the clinic also provides Male Reproductive Health Services once a week and hence, lack of any specific labeling helps in reducing stigma to

approach the centre. Trained and sensitive service providers have been instrumental in this becoming a very popular clinic.

In a similar intervention at Kohima, Nagaland, FPAI established a very critical partnership with Injecting Drug users and their sex partners as it was a completely neglected aspect of the larger intervention by other organizations. The high-risk sexual behaviors were not well known to IDUs as the larger programmes only concentrated on risks related to sharing of syringe–needles. Today the IDUs and their sex partners are well aware of all high-risk behaviors and are comfortable in seeking SRH services from FPAI Clinic in Kohima.

Apart from these two specific examples, we have worked on similar integration with SRH or HIV services and community mobilization programmes involving sex workers and other vulnerable groups in Panchkula, Haryana; Kolkata, West Bengal; Bellary, Karnataka and Madurai, Tamil Nadu.

Good Practices

- Involve partner organizations like Humsafar Trust, Kripa, Nagaland Users Network to help in capacity building and programme guidance
- Involve the community members in programme planning as far as possible
- Avoid specific labels, particularly for services
- Invest in training & sensitization of service provide
- Must have technical, namely clinical and programmatic support for frontline staff

Dr. Kusum Gopal, UNESCO, United Republic of Tanzania

We write extensively about the need for resources, tools, administration as indeed, legalities when searching for options on the convergence of HIV and SRH. Yet despite all of this our best efforts in MCH care, it has met with little success. Maternal mortality is on the rise as also neonatal and infant deaths. Culture and religion are not problematic but it is our approach, which needs to be re-evaluated. The Euro-American models are another kind of folk models. We view the rural and urban audiences as amorphous wholes overlooking both humanity and the need for understanding and accepting that human beings worldwide are always in their culture milieu.

On lessons learnt and experiences of members in converging HIV and SRH services, it is time to understand how people, namely the men, women relate to each other; how they view their bodies and what sexual behaviour is being expressed, how and why. Those way men are likely to respect women and girls bodies and there is no better start to contraception than when respectful behaviour and understanding of a woman or girl's sexuality and sexual needs is protected by the men and boys. India like other countries is in need of such an education to both men and boys as indeed, girls and women. This will be faster with convergence of HIV and SRH services.

V. Bhava Narayana, Pharmed Trade News, Hyderabad

Why the convergence should be limited to a section of the Health Care Workers? Must not convergence be across the sector involving everyone in it for it to take real effect? This then calls for a media to talk about all the interlinked issues of convergence to doctors, nurses, pharmacists, Lab technicians, as well as those hospital staff who attend on patients, and the patient at the same time. Please note that publications like Pharmed Trade News offer one such media.

Due to lack of convergence, most of us would agree that though Indian doctors are amongst the best in the world, the Indian healthcare system is not. However, in our own country, the private health care can be excellent; but this is expensive and unaffordable for the vast majority. Therefore, while the government does provide free healthcare, a lot of it is under-utilized due to the lack of convergence. The numerous Mother and Child Hospitals that stand close to HIV or STI service delivery points bear testimony today of not even having any communication, let alone synergizing their acts. Often this leaves doctors overworked and patients unhappy, even after, all the unnecessary waste of time and money in excess referrals. One reason for this sad state of affairs is that the entire medical system is presently built around the doctor. Healthcare is a service industry, and should be designed around the patient. The best way of doing this would be empowering patients with information, so they know how to get the best medical care, in partnership with their doctors in different medical sections. Such a convergence looks at coordinating the system from the client's or patient's service delivery point of view.

Pharmed trade news is starting a detachable, patient education section and requesting pharmacists and doctors to share with their patients. This section will also be available free of cost on request through E-mail. We request members to discuss, especially how the government can also benefit. Members can submit any material developed by them on patient education for publishing in this section.

H. S. Sharma, Consultant, Gurgaon

We still do not know in India, whether to treat the patient or the disease. We are treating the disease alone and not seeing the patient in whom the disease is. In addition, this patient in India lives in a highly conservative society. The person is prepared to die from HIV but is not prepared to disclose his HIV status to the society. If we are talking of convergence and patient education, then let's do so from a micro level. We have to analyze whether at the patient level we have converged our services, providing holistic care and support to the multitude problems brought in the wake of an HIV infection. Only then, it means sense to the patient.

I can illustrate this aspect of convergence and its up take by the patients or society. I went to Ochhi village in Rohtak district of Haryana where a truck driver died of HIV and till date not a single girl of that village could get married as other villagers boycott it, telling everyone that there is HIV in the air of the village! Similarly, a taxi driver died of HIV and his infected wife is confined and isolated socially. However, it is here that convergence of HIV and SRH services can strike at the very root of Stigma and Discrimination. Convergence can change the social consequences that are presently so horrible. In fact, without convergence the present situation is that it is not surprising that people do not want to go to Government facility where there is no confidentiality.

Hence, convergence of HIV and SRH services will provide the additional bonus of providing a cloak of anonymity to the beleaguered person with HIV. As we have not put in practice the recommended confidential system for PLHIV, we have to strengthen our stigma and discrimination reduction measures by convergence of HIV with SRH services. So, for the sake of PLHIV at least, let there be convergence.

Dr. Paul Ponniah, Jeevan Sagar Trust, Bangalore.

The message is informative and encouraging to improve the status of NGO and associated individuals working in the field of HIV and SRH for converging to a greater improvement, with consultation and networking as pointed out classically by PATH. What the worker need is

recognition, encouragement and support in all events to defeat the stigma and infection control system on par with global standards. Extension of knowledge and disease control will encourage many to join hands. Moreover, this will also bring in better disease control when knowledge becomes powerful by sharing and is therefore consequently used by many. So, with such examples of sharing, I am hoping that AIDS Community of Solution Exchange will probe more into the matters of disease control.

Many thanks to all who contributed to this query!

If you have further information to share on this topic, please send it to Solution Exchange for the Aids Community in India at aids-se@solutionexchange-un.net.in or MCH Community at se-mch@solutionexchange-un.net.in with the subject heading "Re:[aids-se] Query: Converging HIV and Sexual & Reproductive Health Services- Experiences. Additional Reply."

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