REPORT Of CST WORKING GROUP FOR NACP-IV, 22nd – 23rd JULY 2011

A working Group was constituted to prepare a vision document on Care, Support & Treatment services under NACP IV. Working Group had two rounds of consultations and a vision document has been prepared as follows:

The report is presented in four sections:

1. ART
2. Pediatric Care
3. HIV/ TB
4. Care & Support

Section no. 1: Antiretroviral Treatment

Introduction

Care, Support & Treatment is an integral component of the National AIDS control programme. During NACP II, the emphasis was on low cost AIDS care that included treatment for Opportunistic infections and Community care Centres for PLHIV. However, the component of ART was added in the later part of NACP II. Subsequently, CST was included as major component in NACP III. The evidence from roll out of ART, global & Indian, has provided further impetus to expansion of treatment services. Recently, ART has been shown to be an important tool for HIV prevention also.

Current status of NACP III

The following **targets** were set to be achieved at the end of NACP III (by March 2012):

1. To provide free ART to 300,000 adult & 40,000 children through 250 ART Centres;
2. To achieve and maintain a high level of drug adherence and minimize the number of patients lost to follow up, so that drugs are effective for longer period of time; and
3. To provide comprehensive care, support and treatment by establishing 350 CCCs.

The delivery of care and treatment services for people living with HIV/AIDS is provided through a three-tier structure. The various levels where HIV care and treatment is provided include:

1. Centre of Excellence (CoE) & ART Plus Centres
2. ART Centres
3. Link ART Centres & Link ART Centre Plus

ART Centres are also linked with Community Care Centres run by NGOs for a comprehensive package of services.

Currently (March' 2011) there are 306 fully functional ART Centres against the target of 250 by March 2012 wherein nearly 12.5 lakh PLHIV are registered and 420000 patients are currently on ART. In addition, 612 Link ART centre (LAC) have been established wherein, 26023 PLHIV are taking services at Link ART centers. Presently there are 10 Center of Excellence, 7 Regional Pediatrics centres are also functional. In addition there are 259 Community Care Centres across the Country

Key challenges observed under NACP-III

- **Linkages between ICTC & ART Services**: At present, nearly 70% of PLHIV detected positive at ICTC are accessing treatment and care services.
- **Geographical barrier**s: Long distances, travelling time and costs to access ART.
- **Late entry into ART services**: The median CD4 count at entry is 119 cells/µL only and it is seen there are number of missed opportunities before actual diagnosis of HIV is made.
- **Pediatric Facilities** for early infant diagnosis and enrollment of young children in ART need to be addressed on priority.
- **Supply chain management** of ARV and OI drugs needs strengthening and decentralization.
- **Shortage of Skilled staff:** Due to low remunerations.
- **Poor ownership of ART Centres** by the institutions and LAC by Health Systems remains a challenge.
- **Irrational** prescriptions particularly that of antiretrovirals, is a matter of concern.
- **Long term sustainability** of the free ART programme.

Goal- CST component:

Universal access to comprehensive, equitable, stigma-free, quality care, support and treatment services to all PLHIV using an integrated approach.

Objectives- CST component NACP-IV

Objective 1: To scale up access to Antiretrovirals and Opportunistic Infections Prophylaxis & Treatment for children, adolescents and adults, free of stigma and discrimination.

Objective 2: To strengthen linkages between ART, ICTC, PPTCT, RNTCP, STI, CCC, DIC and TI.

Objective 3: To strengthen capacity of existing health system for effective delivery of care, support and treatment related services.

Objective 4: To integrate and mainstream care, support and treatment related services within the health system, other department/ministries and private sector.

Objective 5: To strengthen systems for quality assurance, monitoring and evaluation of CST services.

Strategies to achieve above objectives:

Objective 1: To scale up access to Antiretrovirals and Opportunistic Infections Prophylaxis & Treatment for children, adolescents and adults, free of stigma and discrimination.

This objective focuses on:

1. Ensuring universal access to ART as per national guidelines eligibility and Provide/Facilitate Diagnosis, Treatment and Prophylaxis of OIs, malignancies and co-infections
2. Strengthening Paediatric ART services
3. Increased coverage for HRG by developing effective referral mechanisms to access care services
4. Regular follow up and monitoring
5. Improved quality of life
6. Reduction of stigma and discrimination at the health care facilities and in the communities

The objective of up-scaling ART services would be achieved through the following activities:

Activity 1- Treatment services for adults

Activity 1.1: Continuation, Expansion & Strengthening of ART Centers
Based on trends of detection of positive persons, it is estimated that nearly 2.2 million PLHIV (cumulative) are likely to be registered for ART by 2017 out of whom around 8.5 lakh including 46,000 children would require ART. This includes a buffer for those patients eligible with CD4 $\leq$ 350 cells/cmm, TB and HBV co-infections. However, this is only an estimate and "Universal Access" will be the direction to accommodate changing scenarios.

Under ideal conditions, numbers of patients that can be adequately managed per ART center are nearly **3000-4000 PLHIV per ART Centre (Pre-ART as well as on ART)**. In order to decongest ART centres, stable patients shall be provided **2-3 months' supply of drugs** at each visit which will reduce the number of visits. Therefore, it is envisaged to have nearly **600 ART Centers** across the country to ensure accessibility to ART and treatment of opportunistic infections.

It is proposed to have at least one ART Centre or LAC Plus as per requirement in each district irrespective of categorizations. Link ART Centers are planned to be 1500 in number. The number of LAC to be upgraded to LAC Plus will depend on patient loads and degree of difficulty in accessing the ART centres.

Activity 1.2: Provision of Alternative First Line & Second Line ARV drugs
Provision of Alternative First Line & Second Line ARV drugs shall be made through Centers of Excellence and ART Plus Centers . Available data suggests a 2.8% to 4%

failure rate after 3 years, which translate to nearly 50,000-60,000 PLHIV requiring second line ART by end of NACP IV.

There was lot of discussion on usefulness of SACEP mechanism,. While the civil society members felt that this should be removed as it causes delay in access to second line ART, the programme data presented showed that if SACEP was not there, a significant number of patients would been initiated on second line prematurely as their immunological failure was not due to resistance but due to other reasons . Hence it was decided that the mechanism needs to be retained but made more efficient in terms of time taken for review etc and a period of 4 weeks should be the upper limit for any patient to be evaluated by the SACEP.

It was also recommended that each high prevalence state should have one CoE and minimum 4 ART Plus Centres. All other states shall have at least one ART Plus Centre (more if required). The number of COEs including pediatric one need to be raised to 25
It was also proposed that PLHIV failing on 2nd line ART will require appropriate 3rd / salvage therapy during NACP IV.

Activity 1.3 Lab component:

Early Infant Diagnosis:

- Scaling up of EID by Dried Blood Spot for PCR HIV DNA.

OI diagnosis related testing

- Health system strengthening by advocacy at the highest administrative level to facilitate the integration into existing health systems to provide OI diagnostics as a part of basic standards of Infection care.
- The HIV-2 testing algorithms to be developed and disseminated

CD4 testing

- CD4 cell counts availability needs to be scaled up and we may require 375-400 CD4 Machines. The basis for the calculation is the need for an estimated 24 lakhs CD4 testing with estimated 800,000 Pre ART and 850,000 ART patients requiring periodic testing. The existing CD machines need to be utilized optimally and a focus on the management skills needs to be addressed.

Viral load (HIV-1) tests:

- The total number of tests needed over the NACP-IV period will be about 150,000 tests (nearly 50000-60,000 PLHIVs may require 2nd line ART by 2015, Increasing access to 2nd line may increase the need for more number of viral load tests, improvement in screening for 1st line ART treatment failure also may increase the need for more number of viral load tests,). Patients failing 2ndline ART will also require additional viral load estimations.

- The availability of lab facility or link is essential. The exact numbers should be decided based on needs. The need for DBS DNA PCR and Drug resistance may overlap and needs consideration when deciding numbers.
- The utility value of accredited Private labs should also be looked into NACP IV.

Drug Resistance testing

- At present, there are two WHO accredited HIVDR national reference laboratories. As HIVDR surveillance activities expand over the next 5 years, a key laboratory priority is obtaining WHO accreditation for additional national reference laboratories This will require capacity building of human resources as well as upgrades to laboratory facilities. Another HIVDR related laboratory priority for the next five years is the development of capacity and accreditation for reference laboratories in India to conduct HIVDR genotypic testing using in-house assays, rather than commercial assays and using DBS. However this is a cross cutting issue and needs to be addressed in report of working group for Lab services.

Activity 1.4 Supply Chain management: (ARV and OI drugs)

- **ART drugs** should be centrally procurement by NACO who will supply it to SACS. The capacity of SACS to manage the supply chain will be strengthened (Pharmacist and Store manager, Space for storage, and Computers with manpower etc. will be provided). SACS should forecast and include a 3 months' buffer stock.

- **OI drugs** should also be bulk procured and purchased allowing local rate contract by NACO. Forecasting will be a challenge and requires capture of data. An integrated formulary at the hospital that includes medications for OIs into existing hospital procurement list is a way forward. NACO's OI drug purchase lists columns 1 and 2 are the identified drugs that need to be integrated into the existing routine procurement list. Drugs for OI prophylaxis could be purchased using State budget.

Activity 2 : To strengthen Pediatric ART Services

- Pediatric Cousneling
- Early Infant Diagnosis
- Nutrition aspects
- Early identification of CLHIV in the Community
- Provision of ART for all indicated
- CABA

These are described in detail in section 2

Activity 3: Regular Follow Up

Pre ART Care/Support

- Initial minimum 3 months post diagnosis/registration follow up is required q1month at ART/CCC/DIC which may be extended to q1month extended as per need (based on provider, patient, counselor assessments/needs)

- Subsequent visits at the ART center needs to be a minimum of 6 months (including CD4 counts assessment) but remains at the discretion of provider/patient/counselor's assessment. Populations of untested or Negative partner or Discordant couple or initial CD4 in the range of CD4 350-500 or those with untested children requires increased frequency of follow up in Pre-ART Care.

The proposed programme targets are as below:

Table: Programme targets

Activity	**Indicator Name**	**Year 2012-13**	**Year 2016-17**
Activity1.1: Continuation, Expansion & strengthening of ART Centers	No of ART Centers established (cumulative)	400	600
	No. of health care facilities with CD4 count machines. *	260	375
	No of CD4 Tests done each year	19,00,000	24,00,000
	No of PLHIV Registered in HIV Care (cumulative)	14,00,000	22,00,000
	No of PLHIV (adults) registered for HIV care	13,00,000	21,00,000
	No of PLHIV (adults) alive and on ART (cumulative)	5,00,000	8,00,000
Activity 2 : To strengthen Pediatric Services	No of CLHA registered in HIV care	90,000	1,20,000
	No of CLHA Currently on ART	26,000	46,000

Objective 2: To strengthen linkages between ART, ICTC, PPTCT, RNTCP, STI, CCC, DIC and TI.

It is essential that there are adequate linkages between service delivery points on NACP for efficient utilization of the services. The following activities are proposed under this objective.

Activity 2.1: Strengthening coordination and flow of information between various services

To address the gap between those detected positive & enrolled at ART Centers, feedback mechanism need to be strengthened between ART and LAC, ICTC, RNTCP and CCC.

It is envisaged to enroll at-least 85 % of the cumulative patients' detected positive at ICTC. Linkages are to be scaled up by paper referrals (Triplicate form), software development, mobile/SMS, monthly meetings, shared lists, exchange lists, report back within a week, to enable tracking, improved quality , high probability for adherence etc.

Out reach activity need to be done in a holistic manner by mapping the district under various outreach workers available under NACP or health systems.
There is need to strengthen linkages with HRGs. Referral of positive HRGS may be made accompanied/mandatory referral for TI NGOs.

Activity 2.2 : To improve linkages between HIV /TB treatment

This is discussed in section 3.

Objective 3: To strengthen capacity of existing health system for effective delivery of care, support and treatment related services.

Activity 3.1- Training of health care personnel

It recommended that NACO specialist and MO training modules be merged with General health system training. The Health and Family welfare training centers should be roped in for various NACO trainings for mainstreaming. This will ensure owning up by the health department. The IGNOU/NACO Diploma in HIV Medicine programme will also help increasing the awareness among health care providers.

Activity 3.2: Care & support services

The recommendations from care and support sub group in section 4.

Objective 4: To integrate and mainstream care, support and treatment related services within the health system, other department/ministries and private sector.

This objective focuses on strengthening of Health system to improve quality of Care, support and treatment services. It also envisages sustainability of the program by integration in general health System in long run.

Activity 4.1. : Establishment of Link ART Centers for decentralization & reaching closer to clients

As the programme scales up, more LAC need to established and intergrated into existing health infrastructure by following mechanism

i. Integrating HIV trainings into routine trainings of different categories of State Health care providers.
ii. This training to be done by a pool of resource persons through SIHFW etc
iii. Functioning of LAC to be added as a indicator for district level periodic review of health programmes conducted by DM/CMO in each district

Activity 4.3 Laboratory strengthening for care support and treatment

The various laboratory requirement like CD4 testing, viral load, drug resistance, HIV-2 diagnosis are discussed in the objective 1 but integration with other laboratory components within NACP/ Health system needs to be brought in.

Activity 4.4 Strengthening of Supply Chain management: (ARV and OI drugs)

This has already been discussed under objective 1

Activity 4.5: Staffing of facilities for care, support & treatment services

To provide high quality care continuum, the staffing pattern at ART centres has been designed as per the program need for various facilities. It is felt that as we shall be dispensing medicines for longer duration, the staffing pattern needs to be rationalized for better utilization of manpower. Presently all staff at ART centre is contractual except one staff nurse which is provided by the institution. In order to ensure ownership by institution, in addition to staff nurse, one senior resident in case of Medical college /one Medical Officer in case of District hospital and below should be provided by the institution for ART centre in addition to contractual staff provided by NACO.

Activity 4.6: Augmenting Capacity of personnel involved in care, support & treatment program at District, State And National Level

This has been discussed in activity 3.1.

Objective 5: To strengthen systems for quality assurance, monitoring and evaluation of CST services.

Activity 5.1 Strengthening of M & E system for Care & Support Services
Strengthening of M & E system for Care & Support Services to maximize the effectiveness of available information and implement evidence based planning needs to be done.

Also Dissemination of information collected by CIMS should provide feedback to system including care providers to improve delivery and quality of services. (COE, ART Plus initially down to ART level).

Activity 5.2: Expansion of Smart Card System

The smart card needs to be expanded to all ART centers as well as ICTCs to be of maximal benefit.

Activity 5.3 : Drug Resistance monitoring

It was proposed to have comprehensive strategy and work-plan to minimize the emergence and transmission of HIVDR as part of the national AIDS control program. The Components of the HIV DR Country Work plan to be prepared in collaboration with Lab services division in NACO and should include:

1. HIV DR Early Warning Indicators (EWI)
2. Sentinel surveillance for the emergence of HIVDR during treatment
3. HIV DR threshold survey for detection of transmitted drug resistance
4. Development of HIVDR laboratory capacity
5. HIV DR database
6. PPTCT data on resistance needs to be included

Activity 5.4 : Operational Research

National AIDS Control Phase-IV envisages activities to enhance knowledge and skills required for evidence base on various aspects of the epidemic, up-scaled HIV research cross-cutting, multi-disciplinary themes, improved research quality, better research capabilities and expanded partnerships, utilization and management of research based knowledge on HIV/AIDS, relevant measurable and context specific indicators for tracking the epidemic and assessing impact.

Activity 5.5: Pharmacovigilance

The pharmacovigilance of ARV drugs shall be an important component in NACP IV in line with the National pharmacovigilance programme of India (PvPI). The data shall be collected from ART centers/LAC/LAC plus in order to document various ADRs as per standardized definitions and grading of toxicity. This shall feed into the National ART regimen guidance and change if required in the guidelines.

Activity 5.6: Programme implementation and monitoring

Care Support & Treatment Division at NACO will be responsible for planning, financing, implementation; supply chain management, training, Coordination, monitoring & evaluation of care support & treatment services in the country.

Increase in staff at NACO.

(1) The need for 4 PO's to monitor four regions,

The implementation of the at State level shall be the responsibility of all concerned State AIDS Control Societies (SACS) who will be SR for NACO. Each SACS will have CST division consisting of following officers.

- Joint Director I/C (CST)
- Deputy Director / Asst. Director (C&S)
- Assistant Director (Nursing) for high volume states

Appropriate restructuring of SACS with JD (CST), DD (CST) and AD (CST) based on number of facilities for CST.

As per the need of the programme, Regional Coordinators will be amalgamated in TSU.

Planning, implementation; supply chain management, training, coordination, reporting, monitoring & evaluation of care support & treatment services in the concerned state shall be carried out By CST division at SACS.

Accreditation of ART will also be carried on the basis of various parameters including commitment of the institution, availability of staff, quality of services, patient follow up and patient satisfaction.

What are the NACP IV focal areas

The focal areas remain on expansion of services to achieve universal access while planning a phased integration with the existing health systems.

What are the activities that can be integrated with NRHM

The areas related to integration have been discussed under objective 4

Section No. 2: Pediatric Care

Background:

The major route of HIV transmission in children is through parent-to-child transmission. Thus, new HIV infection in children is preventable by strengthening the continuum of care for HIV-infected pregnant women, ensuring delivery of PPTCT interventions and care of HIV-exposed and infected infants to ensure HIV-free survival of these children. Besides the health aspects, children living with HIV and those affected by the disease should be provided with the necessary care and support structures as well as access to all routine health, nutrition and education services. The needs of infants and children including adolescents infected and affected with HIV should take a life-cycle and family-centric approach, thus requiring integration of care and services with the larger health system (e.g. NRHM, state health initiatives).

1. **Health care system & delivery:**

1.1 Current Status:

- The acceleration of ART access for children was initiated in 2006 with pediatric fixed-dose combinations (FDCs) initially introduced at 36 ART Centers. 7 Regional Pediatric Centers (RPCs) were established which now offer alternative first and second line ART (currently 100 patients are on 2nd Line ART). All ART centers provide care and first line ART treatment for children. There are 6 community care centers (CCC) exclusively for children;

- Early infant diagnosis (EID), introduced in February 2010, was rapidly expanded to cover 27 states at 1150 ICTC (all A&B districts). 2,000 infants had DNA PCR on dried-blood spot (DBS) samples detected positive, with 560 confirmed with whole-blood PCR. However of those confirmed PCR positive, the majority of infants have not received ART as per new National Guidelines. In September 2010, following the recommendation for early treatment in HIV infected infants, LPV/r syrups was made available at 17 sites (10 CoEs/ 7 RPCs) to treat infants. Also in 2010, cotrimoxazole prophylactic therapy (CPT) was scaled-up at ICTCs for all HIV-exposed infants. In addition, the Children Affected by AIDS (CABA) scheme was rolled out in 10 pilot districts with focus on linkages, and Strengthening Provider-Initiated Testing (SPRIT) and Counseling such that children with signs & symptoms of HIV are accompanied by staff from the OPD to the ICTC and if infection is confirmed, onwards to ART Centers at 201 sites.

- The most recent pediatric TRG recommended a comprehensive update of the national paediatric guidelines which included updating of the ART eligibility criteria, approach to OI, TB and nutrition care and counseling. Updates on infant feeding recommendations in the context of HIV were recommended which were included in both the PPTCT programme as well as paediatric care.

  The child-focused Balasahyoga & CHAHA programs in 4 states (all of Andhra Pradesh and parts of Maharashtra, Tamil Nadu and Manipur) for last 5 years (Balasahyoga which covers 68,000 children) and in the case of CHAHA for 3.5 years. Other state-based initiatives include the Samastha program (Karnataka Health Promotion Trust) and Jatan project (Gujarat).

1.2 Gaps in the health care system & delivery: About 24,000 children are alive and on ART which constitutes 30% of those registered with the programme. Overall, it is estimated that 115,000 children are living with HIV in the country derived from modeling (Spectrum). Some of the gaps include inadequate HIV testing of family (partners and children) of HIV positive patients, which has been a policy since 2004 but is not rigorously implemented. The abilities of healthcare providers to suspect for HIV infection in a general medical setting and other entry points needs strengthening in order for provider initiated testing and counseling (PITC) to occur. Convergence and integration with general health and other ancillary services, particularly at district, for infants, children including adolescents such as AFHS, MCH, EPI, Nutrition, WCD as well as non-health sector eg. Education, is lacking.

1.3 Lessons from NACP-III: Testing and counseling priorities need to be more targeted to include (a) testing all family members (spouse and children) of any positive patients, as well as (b) PITC for sick children in healthcare settings, in addition to (c) testing all HIV exposed infants as a continuum of the PPTCT programme. Demand generation for testing and treatment literacy are important aspects. Review of HIV service availability (ART/testing/labs etc) needs to be done to determine expansion and coverage of services under NACP-4.

1.4 Specific recommendations:

Testing: to ensure optimal coverage of settings which will yield the highest probability of HIV positive infants and children

- All family members (spouse and children) of HIV positive patients should be tested.
- Strengthen HIV testing for pregnant women in antenatal settings through convergence with NRHM services, to minimise lost opportunities in the contact with pregnant women.
- EID convergence with NRHM to be operationalized
- Provider Initiated Testing and Counseling (PITC) integration into NRHM (RCH especially F-IMNCI, RNTCP integration),

Linkages: needs to be optimized both within the programme as well as to other programmes of health and non-health eg social welfare, WCD, education etc. As HIV-infected children grow into adolescence and adulthood, the spectrum of needs for these

children will change. Thus a long term vision to establish systems of linkages and referrals is required as children live with ART and grow into productive adults.

- Reducing the loss (or improving retention within) from the HIV programme is of priority, especially if there has been contact with healthcare settings:
    - In order to prevent loss of HIV-exposed infants and children living HIV from point of testing to linking into care, line-listing may need innovative solutions and technologies as screening test has to be confirmed (EID with DBS, then WB at ARTC under the current testing algorithm).
    - Strengthen systems of followup for children and their families who are already registered under the ART centers for pre-ART followup, if not on ART.

- In order to prevent loss to follow-up for mother-baby pairs, integration with health and other programs, e.g.Janani Suraksha Yojana (JSY), Indira Gandhi Matritva Sahyog Yojana (IGMSY) as well as better training of general healthcare staff and ownership by district healthcare system including RCH/MCH is required.

- Linkages with other national and state-based programmes for benefits and social welfare is required eg ICDS, nutrition, WCD schemes, social protection etc.

2. **Treatment:** This covers pre-ART, ART, opportunistic infections (OI), adherence counseling, and focus on sub-populations based on age-group: infants, young children, adolescents, and transition to adulthood keeping in mind developmental issues.

2.1 Opportunistic infections (OI):

- Cotrimoxazole preventive therapy (CPT) for HIV-exposed infants (HEI) to be given by counselors at ICTC, and further decentralized to PHC-level and subcenter level. For improved linkages and service delivery at ART Center system and Link ART Center.
- Capacity building around essential care, 'how to suspect' and symptomatic care and clear guidelines for when to refer with a possible approach being IMNCI-HIV at Link ART Centers and other levels of care.
- HIV/TB questions to be referred to sub-group including IPT.

2.2 Pre-ART care:

- In order for an effective continuum of care and high quality of care regular follow up of children living with HIV including 6 monthly CD4 testing.
- Cotrimoxazole to be given every or every other month, diaries kept to track patients not showing up for the scheduled appointments, and ensuring that center is child-friendly.
- Nutritional support including correction of micronutrient deficiencies of all age groups including adolescents and linkage to state-health initiative, e.g. provision of double rations at AWC versus provision at the facility need to be studied further.
- Implement the new nutrition guidelines and anthropometric assessments, as malnutrition in children living with HIV is a concern.

- Define an essential package of pre-ART care taking a multidisciplinary approach including monthly or 2-monthly visits, CPT, counseling and clinical staging, growth monitoring and anthropometric measurement and linkage for nutritional support to ICDS (for children under 6 years) or midday meal for older children.
- Nurse's role & responsibility in pre-ART care to be clearly defined with special focus on mother and child.
- Counseling on paediatric HIV and ART including children and their caregivers needs strengthening for counselors, nurses and doctors (general and paediatricians).

2.3 ART:

- Laboratory tests for baseline and routine investigations includes regular CD4 testing using appropriate machines at high-load centers as well as new technologies ("point-of-care") for rural sites, and hemoglobin and liver function tests, and virological testing in young children as recommended by TRG.
- Regimen requires monitoring of toxicities as well pharmacovigilance, while sequencing of ARVs/new formulations to be decided by TRG.
- In view of the geographical limitations of access to ART especially for infants, travel support to be considered especially in the case of infants, who have to travel frequently with caregivers from far-away places.Transport subsidies rely on state schemes, while decentralization of services will likely results in improved access.
- Counseling on adherence with special focus on disclosure and adolescence has to be considered. The nurses' role need to be clearly defined and could serve as 'back-up' when counselors face high patient load.

Care & Support

2.4 Provision of other health-related care & support:

- Full immunization, access to micronutrients and de-worming. as per national guidelines
- For older children, there is a clear need to address the needs of adolescents. There is need to agree on a standard working definition for health services.

2.5 Provision of nutrition-related care & support:

- Nutrition guidelines have been developed by NACO for children and adults separately and will be rolled-out. However for nutritional supplementation, we need to be clear that we need to align this with other scheme like ICDS, AAY etc.

2.6 Provision of education-related care & support:

- The new Right To Education will be ensured by NCPCR/SCPCR and makes education compulsory for all;
- Midday meal is an essential component of the education program.

2.7 Social protection:

- In addition to the Ministry of Women & Child Development's ICDS program, the Integrated Child Protection Scheme (ICPS) is being rolled out under the Ministry

of Women & Child Development and must be taken into account in the planning process.

- Provides for various form of care including family-based and alternative care including community-based or institutional care and permanent planning including formal foster care and adoption
- Social protection may replace the term care & support in the case of vulnerable groups including children.
- The role of the private sector including CRS initiatives and public-private partnerships (PPP), voluntary and community organization in sustaining care and support for children and their families needs to be defined.

2.8 Collaboration with other Government Ministries and state departments to provide social sector schemes, including MWCD, MSJ, MHRD for accessing social support shall be an important way of ensuring "Care & Support".

3. Treatments numbers, targets and indicators

- 95% of HIV-exposed infants are tested
- 90% of eligible infants and children accessing cotrimoxazole
- 80% of children of adult female patients have been tested
- 95% of children living with HIV identified registering in care at ART Centers (linkages)
- Survival targets: 5-year survival (quality of treatment program) to be x% (to be discussed)
- The current estimates of 115,000 children living with HIV in India based on extrapolating spectrum projections were questioned and the need for a size estimation exercise of HIV-affected children and children living with HIV was discussed

No of CLHA registered in HIV care	100,000	104,000	107,500	110,000	113,000
No of CLHA Currently on ART	36,900	40,082	43,194	45,100	46,330

Section no. 3:HIV/TB

Background

HIV epidemic is closely associated with TB epidemic. It is known that HIV-infection is strongest known risk factor for progression of latent TB infection to active TB disease. HIV infection in individuals already infected with M.TB is associated with massive increase in risk of TB disease from about 10% lifetime risk to more than 10% annual risk. HIV-infected TB patients are more likely to die compared to HIV-negative TB patients. Conversely people living with HIV/AIDS are highly susceptible to acquire TB infection and such TB infection expedite progression of HIV infection to full blown AIDS. Therefore

TB is common opportunistic infection among PLHIV and the most common cause of death

Achievements and Ongoing initiatives:

1. HIV and TB programme co-ordination mechanisms are established at National, State and District level include mechanisms for both policy and technical review
2. Intensified TB case finding (ICF) activities are established at all ICTC and ART centres in the country-
    a. Performance of ICF at ICTC performance has improved over last 4 years with referral of 3.5% in 2007 to 7.4% in 2010. ICF has contributed about 6% to TB cases notification of RNTCP
    b. ICF at ART centres was started in 2010 and is also showing good results with diagnosis of about 11000 TB patients in 2010
3. Prevention of TB:
    a. NACO has accepted WHO ART guidelines (July 2010) to initiate ART in all PLHIV at CD4 count less than 350/mm^3. This has known TB preventive effect.
    b. NACP has implemented basic Air borne Infection Control (AIC) guidelines like cough etiquettes, fast-tracking of TB suspects, use of personal protection etc. in ART centres
4. Provider initiated HIV testing and counseling to all TB patients is implemented as **Intensified TB/HIV package**. TB programme record and report document HIV status etc. under shared confidentiality. It is implemented in phased manner in all states except Bihar, Jammu & Kashmir and 4 union territories. Proportion of TB patients with known HIV status is improving with about 40% TB patient with known HIV status in 2010 nationally. It is about 80% in HP states where the infrastructure is better
5. Decentralized provision of co-trimoxazole prophylaxis therapy (CPT) to HIV-infected TB patients is improving over past few years with >90% patients receiving CPT during TB treatment
6. Provision of ART to HIV-infected TB patients, currently only about 50% patients are receiving ART

Gaps and challenges

1. **TB/HIV programme level coordination**: lack of full time nodal officer for HIV/AIDS in C and D category districts
2. TB/HIV activitie**s** not implemented in HIV care settings like LACs, CCCs and the NACO Targeted Intervention projects for HRG
3. Limitations of TB diagnostic tool for TB and MDR-TB among PLHIV
4. **Limited access of HIV test for TB patients** due to great deficit in number of HIV testing facilities compared to TB testing facilities under RNTCP. Non-collocation of these facilities too is also a factor
5. **Linkage of HIV infected TB patients to ART:** Only about 50% of diagnosed HIV infected TB patients are linked to ART centres and care and support. Reason being that TB treatment (DOTS) is available in all health centres across the country whereas ART is initiated only at 300 odd ART centres, which calls for long distance travel and out of pocket expenses for the patient.

Vision and Strategy for NACP IV

The overall goal of TB/HIV collaboration is to reduce mortality and morbidity in HIV-infected TB patients. This can be achieved by early and universal access to diagnosis and treatment of co-infected individuals. Hence joint vision of the two national programmes for TB/HIV activities is Universal access to TB/HIV care meaning:

1. **Early detection of HIV/TB** by

a. All TB patients to have their HIV status known

b. Expansion of intensified TB case finding to all High Risk Groups through TI projects

2. **Early institution of care** for HIV-infected TB patients

   a. Enable linkage of all HIV infected TB patient to ART care and support and co-trimoxazole prophylaxis therapy
   b. Initiation of ART in HIV infected TB patients irrespective of CD4 count as per WHO guideline

3. **Prevention** of TB among PLHIV

   a. Early initiation of ART in "all PLHIV" (CD4 count less than 350), to minimize incident TB
   b. Adoption of Isoniazid Preventive Therapy policy based on evidence generated in the country
   c. Implementation of Airborne Infection Control measures like administrative, environmental and personal protection at ART centres /LAC etc.

Emerging issues:

1. WHO guideline for adoption of strategies with potential for early HIV detection like HIV testing of TB suspects and contacts of HIV infected TB patients. NACP to consider evidence generated in the country.
2. Consideration of WHO policy guideline for adoption of Expert MTB/Rif for early diagnosis of TB (especially smear negative TB) and MDR TB in PLHIV
3. TB preventive therapy (IPT) for all eligible PLHIV
4. Airborne Infection Control (AIC) measures at all HIV care settings including measures for prevention of TB among health care staff

Changes suggested for institutional setup:

1. Establishment of facility integrated ICTC (F-ICTC) preferentially at RNTCP DMC's
   a. Until all DMC are upgraded as "HIV screening centre" with training of existing manpower
2. Expansion of ICF activities to cover PLHIV also at LAC, CCC etc. along with high risk groups catered to by NACO TI projects
3. Systematic measures to link HIV infected TB patient to ART centres by optimizing efforts of existing outreach workers in NACP under different schemes like ILFS/LWS/CCC ORW/ DLN etc.

Important programme Targets:

Existing

1. All states to conduct quarterly TB/HIV working group meetings and >90% DCC meetings
2. Increasing trend in number of clients referred for TB diagnosis at ICTC and ART centres
3. More than 80% TB patients registered in RNTCP to have their HIV status known
4. More than 80% HIV-infected TB patients to be linked to CPT and ART

New:

1. More than 80% TB "suspects" to have HIV status Known in high HIV prevalence settings
2. 100% ART centres to implement air borne infection control guidelines
3. More than 80% of eligible PLHIV to be initiated on IPT

Monitoring Indicators:

State and district-level coordination

1. Proportion of SCC/SWG meetings held at state level over 4 quarters
2. Proportion of Districts with at least 2 DCC Meetings over past 4 Quarters

Intensified Case Finding (reported separately for ICTC and for ART centres) -

1. Number (%) of ICTC and ART centre submitting monthly ICF report to SACS and NACO
2. Number (%) of ICTC clients and ART patients referred to DMC as TB suspect
3. Number (%) of (2) diagnosed with TB
4. Among (3), number/percentage of diagnosed TB patients put on DOTS

Detection of HIV in TB patients, & HIV treatment

1. Number (%) of TB "suspects" with known HIV status
2. Percentage of RNTCP registered TB patients with known HIV status
3. Number/ percentage of HIV-positive TB patients receiving CPT during TB Treatment
4. Number/ percentage of HIV-positive TB patients receiving ART during TB Treatment

TB prevention

1. Number (%) of ART centres following AIC guidelines
2. Number (%) of eligible PLHIV initiated on IPT

Section no 4: Care & Support

Vision

Enhance quality of life for People living with and affected by HIV including children, adopting a rights-based approach ensuring universal access to comprehensive services

Objective
To establish services and promote utilization to enhance the quality of life for People living with and affected by HIV with a special focus on women and children

What is Comprehensive Care?
The working group identified the key elements of comprehensive care that include clinical services, psychosocial, nutritional, social, economic, legal, and educational support

Challenges

NACP-III service delivery was concentrated in urban areas and covered mostly general population, xxxxx of adult were accessing ART services (4 lakh on ART, xx on pre-ART), xx of children were accessing ART services (4 lakh on ART, xx on pre-ART), while TG, HRG (FSW, MSM, IDU) and rural population may not have been covered.

i. ***Unmet care and support needs***
Though the access to clinical services has improved significantly in NACP 3, not all infected individuals receive comprehensive and holistic care and support especially that addressing psychosocial needs. There are limited strategies that are operational to mitigate impact for PLHIVs, children and their families. Additionally, the coverage of MARPS, PLHAs living in rural area and hard to reach areas with care and support services is inadequate. Though there are many service delivery points for different issues, the linkages and referrals between various service components such as DIC/DLN, ART, ICTC, TI are inadequate

ii. ***Inadequate utilization of existing schemes and structures***
Though the utilization of services has been improving year-on-year, the proportion of HIV infected women accessing services continues to be a challenge due to stigma. The health care workers sensitivity is low. There is a lack of clarity of the roles of link - and outreach workers. It is also not clear as to who they are accountable to. Their out-reach services are offered in a vertical manner requiring strengthening of co-ordination. Mechanisms for referral are weak and inadequate.

iii. ***Lack of M&E systems to measure care & support***
The current M&E system captures information on clinical services. However, it does not capture indicators by HRG or residential status (urban vs rural). Additionally, there are no indicators that capture type - and quality of services.
:
Proposed Strategy
To scale up to deliver comprehensive quality care and support services.

Currently not all services are offered to PLHIV and their families. In order to deliver these services certain changes in the existing strategies will be required.

1. Provide and scale up need-based services according to populations FSW, Female Injecting Drug Users (FIDUS), TG, Women, children (male and female) especially SRH services, nutrition and all social protection schemes including insurance
2. Strengthen outreach services in the community leveraging and modifying existing resources. ASHA, ANM, AWW on the NRHM/ICDS side and link and other

outreach workers supported by NACP to be utilized for provision of comprehensive care & support services. LWS and other outreach workers will continue to play a mentoring role to NRHM/ICDS outreach workers.

3. Strengthen linkages and referrals between various service components such as TI, DIC, ICTC, ART and CCC
4. Formulate comprehensive care & support guidelines (SRH) and review all existing policies/ guidelines including DIC, CCC, pediatric counselling especially disclosure
5. Strengthen linkage with private sectors (corporate and private healthcare providers) to provide care and support comprehensively. CCCs, DICs and DLNs should be encouraged to partner with private sector.
6. The mandate of CCCs should be expanded to provide services in managing other chronic illness such as diabetes, hypertension in rural areas with its usual focus on HIV. This will add to complement the efforts to integrate with NRHM.

To enhance the quality and accountability of service provision

1. Adoption of Community Audit as done in People's Health Movement will greatly help enhance quality of service. Additionally, it is recommended that the District AIDS Committee and Rogi Kalyan Samiti should have representatives from PLHIVs and HRGs.
2. DAPCU to take ownership on care and support services. DAPCU should be given flexibility in strategizing and implementing at the district level based on evidence, context and people at the centre.
3. Client-oriented services and tools should be made available.
4. Monitoring
    a. Review M and E indicators(qualitative and quantitative) related to care and support services
    b. Evaluate impact and cost of existing schemes (district dashboard)
    c. Increasing scope of existing state and district level coordination committees, including PRI to address issues related to care and support as part of community monitoring system
    d. Rational use of technology to provide real time information, mobile phone use

Changes suggested for Institutional set up

Comprehensive Care and Support Centre (Renamed)

- CCSC role to be broadened towards chronic disease management both prevention and treatment including palliative care for all
- CCC should be included as a structure providing health services by RSBY – as this will enhance the sustainability of CCCs in future
- Psychosocial support to be provided at all levels including in the rural set ups – DICs and CCCs
- CCC should not be dependent on ART registration and monitoring

DICs

- Jeevan Deep model from Gujarat can be untilised for scaling up/modifying
- Resource centres for women and children – Women commission has committed to support this centre and mandate NACO to support capacity building of positive women

NRHM Supported institution

- Mahila mandals, District Health Societies , Village health and sanitation committee to be used for sensitising the communities on HIV
- Strengthen linkages and provide training to NRHM Personnel through NHRC, NIHFW, SIHFW and NIPCCD – NACO to provide faculty , tool and manuals and involve community reps in training as resource people

- Establishment of safe homes for women and children- NACO to advocate with WCD for providing support to positive women and children and HRGs .
- Provision of care and support services for CABA in all districts either through direct services or linkages (NGO-run or CABA scheme)

Monitoring indicators

- No of adults living with HIV who are provided comprehensive care and support servic clinical plus two additional care services which are need based es
- No of children infected and affected by HIV who are provided comprehensive care and support services –clinical plus two additional care services which are need based
- Proportion of MARPs linked to care and support services provide under various departments/CS and communities
- Proportion of PLHIVs who have been enrolled in RSBY/state health schemes