

Report of Working Group on ICTC/PPTCT services for NACP IV

A strategy document

Background

NACP Phase III (2007-2012) launched in 2007 aimed to halt and reverse the epidemic in India over a period of five years. Given that over 99 percent of the population in the country is free from HIV infection, NACP III placed the highest priority on preventive efforts while seeking to integrate prevention with care, support and treatment.

A four-pronged plan of action was developed based on the experiences and lessons drawn from NACP I & II are as follows:

- Prevent infections through saturation of coverage of high-risk groups with targeted interventions and scaled up interventions in the general population.
- Provide greater care, support and treatment to larger numbers of PLHIV.
- Strengthen the infrastructure, systems and human resources in prevention, care, support and treatment program at district, state and national levels.
- Strengthen the nationwide strategic information management system.

The NACP III saw the integration of the different testing and counseling facilities that were established under NACP II. As a consequence within the same health facility (under one roof) services became available for all those who came for testing (voluntary, referrals from targeted intervention programme for most at risk populations, by health providers, TB centers, STI clinics and pregnant women). Thus, the integrated counseling and testing centers (ICTC) focused on testing and counseling for HIV, offering the complete package of PPTCT and linking people attending these centers to care and treatment. The ICTCs are located at government health care facilities in tertiary and secondary healthcare institutions and in some primary healthcare centers in the Category A, B and a few vulnerable C districts.

A. Current Status

NACP III made a strong beginning with rapid scale up, swift staff recruitment and capacity building. Operational guidelines were formulated and minimum standards set up under all components to ensure quality service delivery.

PART A : ICTC

I. Establishment of Integrated Counselling and Testing Services and provision of ICTC services

- a) **Achievements:** During NACP III, the number of stand alone ICTCs have increased from 2185 ICTCs to 5246 ICTCs (up to March 2011). In addition, 1632 facility integrated ICTCs (F ICTCs) in public health settings as well as 670 ICTCs under PPP model were also established. This scale up expanded programme coverage to rural areas. At present integrated counseling and Testing facilities are available at 24x7 PHCs in high prevalence states and up to CHC/ sub district level facilities in other vulnerable states. This includes 135 mobile ICTCs which have been established for hard to reach population and for regions with difficult terrain.
- b) **Ongoing initiatives:** Counselling and testing of general clients includes testing of HRGs, STI patients, bridge populations (truckers / migrants), TB patients and walk in clients other than pregnant women. The programme has shown a remarkable achievement in counseling and testing of general clients from 4 million tested in the year 2007 to more than 9.5 million in the year 2010-11 and a significant improvement in coverage of HRGs, STI patients and TB patients.

Typology	2007-08	2008-09	2009-10	2010-11	2011-12*
HRGs	96140	368108	747981	929852	185545
STI Patients	48004	291164	323631	417671	85923
TB Patients	132146	173116	315960	516285	77013
Total General Clients	3077531	8427395	8263420	8979345	1623830

(*April to May)

Some significant initiatives in NACP III which strengthened the overall quality of the ICTC component, improved access to services and boosted the uptake of services are as under

- Developing a standard National policy for Counseling & Testing for all testing facilities and setting up of strong quality assurance systems.
- Free counseling and testing services, linkages with TI NGOs,
- Provider initiated counseling through health care providers.

- Outreach activity by ICTC Counselors for motivating HRGs to access services, follow-up and linkages to care, support and treatment.
- Rolling out of EID through ICTCs has made a significant contribution to the PPTCT programme.
- Intensified TB – HIV package rolled out in the country for improving HIV-TB collaborative activities and putting an increased number of persons -HIV-TB co-infection under care, support and treatment.
- Beginning convergence with NRHM and health systems with establishment of F-ICTCs, whole blood testing by RNTCP LTs and labour room testing.
- Establishment of Saksham - GFATM R7 training institutes across the country for capacity building (training and counselling supervision) of counsellors working in various settings.

However, notwithstanding the impressive gains made during NACP III, there continued to be gaps in implementation such as suboptimal linkages between various components of the program, inadequate supply chain management, etc

II. HIV-TB Coordination activities

In NACP III, the HIV-TB coordination activities were successfully implemented through an intensified HIV-TB package implemented across the country. The core activities in HIV-TB collaboration aim at early detection of HIV infected TB patients and linking to HIV care and support and TB treatment. These include

- Intensified TB case finding at HIV care settings
- Offer HIV test to all TB patients

Achievement in brief:

	Testing of TB patients	Detection of HIV among TB patients
2007	132146	20925
2008	173116	23530
2009	315960	37196
2010	516285	42510

III. Laboratory Services

Counseling and Testing for HIV is provided through the ICTCs across the country. High standards of testing are maintained by using 3 test principles for diagnosing HIV in these centres. There are established quality assurance measures for ICTCs through 118 SRLs across the country. Quality Managers at SACS and Technical Officers at the State Reference

Laboratories (SRLs) are in place to monitor the quality of Laboratory services. There is a functional robust External Quality assessment scheme upto ICTC level.

IV. Capacity Building

A network of 38 institutions of higher learning has been established across the country for training of counsellors through the Saksham, GFATM R7, HIV/AIDS Counselling Programme and 118 training institutes for lab services (SRLs). In addition, existing training infrastructure like the National Institute for Health and Family Welfare (NIHFW) and the State Institutes for Health and Family Welfare (SIHFW) are also utilized for certain training like ICTC team training, ANMs training, HIV-TB trainings, etc.

B. Major ongoing weaknesses and gaps:

- Limited coverage of pregnant women
- Access of services by high risk groups:
- Limited reach of ICTC services to the vast geography of the country
- Inadequate linkages between TB clinics and ICTC
- Follow up of HIV+ individuals including pregnant women for continuum of care
- Linkages with care, support and treatment services:
- Quality of testing and counseling:
- Quality of trainings:
- Procurement and Supply chain management:
- Inadequacies in public health infrastructure, including training facilities:
- Weak Public Private Partnerships

C. NACP IV

Goal: Universal access for people at risk of HIV to access quality counseling and testing services and link all HIV infected persons to receive a continuum of care, support and treatment services.

I. Objectives:

1. To continue, expand and accelerate the coverage of counseling and testing services to at risk population.
2. To increase uptake of HIV testing among identified key populations (Female sex workers, men who have sex with men and injecting drug users)

3. To increase uptake of HIV testing among highly vulnerable groups (STI clients, migrants and other bridge populations)
4. To increase testing and counselling among TB clients through integration of HIV screening as part of TB services and intensifying TB screening and diagnosis at all HIV care facilities
5. To link all HIV positive individuals with a variety of care, support and treatment services available through the national health programs by the end of NACP IV.

Strategies

1. To continue and accelerate the coverage of counseling and testing services to at risk population:

NACP IV will leverage wide scale expansion in the National Rural Health Mission (NRHM) both in terms of geographical coverage and human resource capacity for counseling and testing.

Strategies for reaching this ambitious testing target are as follows:

- Strengthen the existing stand alone ICTCs supported by NACO: All existing **5246** stand alone ICTC will be continued and strengthened during NACP IV. During the phase, the stand alone ICTCs will be relocated to ensure their presence in all health facilities up to community health centers (CHCs) resulting in **5069** stand alone ICTCs across the country.
- Integrate testing and counseling with the general health services of NRHM (facility integrated ICTC): To expand the coverage of testing and counseling services among the rural population and to integrate ICTC services in the general health system, **6368** new facility integrated ICTC will be added to the existing **1632** centers at the primary health center level.
- Expanding testing and counseling in the private health sector through public private partnership (PPP) program: To increase the coverage of pregnant women and key populations accessing private sector, **730** new centers (facility integrated) will be added to the existing **670** centers in the private sector. Different schemes for private sectors will be developed and strengthened to ensure maximum participation
- Initiate community based HIV screening: Community based screening by front line health workers such as Auxiliary Nurse Midwives will be initiated after pilot testing in high burden districts (with low rates of institutional delivery) for augmenting PPTCT coverage
- Integrate HIV screening at TB clinics: HIV screening will be integrated as part of routine care at all the RNTCP Designated Microscopy Centers (DMCs – 12, 500) through training and multi tasking role of the existing personnel under RNTCP.

2. Increasing access to testing and counseling among identified key populations:

Increasing the uptake of testing and counseling among identified key population, TB clients, pregnant women, rural populations, STI clients, and the sexually active and vulnerable general population is critical to maximization of case identification in India.

Towards this, NACP IV aims to reach the population testing targets as detailed below:

- Decentralized services, use of mobile clinics to reach hard to access populations and mobilization through ASHAs and link workers
- Linkages between ICTCs and prevention interventions (TI) will be strengthened through capacity building, facilitation of cross visits, monitoring of referrals, and increasing the visibility of ICTCs and their personnel.
- Advocacy for creating an enabling environment and reducing stigma and discrimination both at the health facility and the community level will be undertaken to further increase testing uptake among these populations.
- Communication tools that are targeted to improve risk perception, health seeking behavior, and knowledge about services among clients
- Strengthen the communication and counselling skills of ICTC counsellors and health care providers at FICTCs to sensitively respond to the counselling and testing needs of vulnerable and marginalized groups and to provide client friendly services

3. Sexually active and vulnerable population including STI Clients, migrants and other bridge populations:

Under NACP IV rigorous efforts will be made to increase testing uptake in high prevalence districts among highly vulnerable groups.

- Towards this, innovative information and communication campaigns using a combination of mass, out-door and mid media contextualized for different parts of the country and target populations will be used to improve risk perception, health seeking behavior, and knowledge of service availability.
- These media campaigns will be augmented by strengthening linkages and referrals between ICTCs, STI clinics and the ongoing prevention intervention programs targeted at migrant workers, truckers etc.
- Strengthening provider initiated counseling and testing
- In addition, link workers and mobile ICTCs will be utilized to increase the uptake among underserved sexually active and vulnerable populations.

4. To increase testing and counselling among TB clients:

NACP IV also aims at increasing testing and counseling among TB clients through integration of HIV screening as part of TB services and intensifying TB screening and diagnosis at all the HIV care facilities.

- Improved technical and administrative coordination, monitoring, and shared ownership
- Scale up ICF at all HIV care settings, including ICTCs, ART and Community Care Centers (CCC), and at Targeted Intervention (TI) NGOs.
- Efforts will be made for Airborne Infection Control (IC), and to introduce Isoniazide Prophylactic Treatment (IPT).
- Routine offering of provider-initiated HIV counseling and testing for all TB clients, will be scaled up across the country

5. Linking positive individuals with prevention, care and support services

Recognizing that testing and counseling services serve as entry points for involving all those tested positive with a continuum of care, NACP IV aims to link all HIV positive individuals with a variety of care, support and treatment services available through the national health programs. Referral and linkages with a full range care, support, and treatment services will be improved through mapping of services in each district, strengthening referral, coordination and information sharing mechanisms among services providers, and adding referrals and linkages to the performance indicators of ICTC personnel and respective service providers.

D. Emerging Issues:

In light of the above strategies to be scaled up and implemented, the following issues emerge which can impact the outcome of the programme performance

- Capacity building of public and private health care institutions in PITC.
- Addressing stigma & discrimination at health care settings by sensitization of the health care providers and advocacy with stakeholders.
- Recording and reporting of information by F ICTCs.
- Supply Chain Management issues regarding testing kits and drugs with the expansion of service outlets below district level.
- Competency based training for health providers at different levels

E. Program Targets

Targets for facilities (2012 – 2017)

Category of ICTCs	Base line March 2011	2016-17	Remarks
Stand alone (including mobile)	5246	5069 + 150 mobile vans	Upto CHC level.
Facility Integrated (Government)	1632	8000	Upto PHC level.
Facility Integrated (Private)	670	1400	Pvt. Sector
Total	7548	14469 + 150	

Indicator	Baseline March 2011 (in millions)	2016-17 (End line) (in millions)
A. General Clients tested	9.5 (59%)	13.2 (44%)
No of TB clients tested for HIV	1.0 (6.2%)	1.2 (9.1%)
HRG core group	0.8 (5%)	2.0 (15.1%)
No of STI patients tested for HIV	0.4 (2.5%)	2.5 (19%)
B. Pregnant women tested	6.6 (41%)	16.8 (56%)
Total tested (A+B)	16.1(100%)	30.0 (100%)

F. Monitoring Indicators: Same as NACP III

To ensure that the NACP IV programme performs upto the expected standards and scale, the following monitoring indicators are proposed

- 1) Establishment of ICTCs (Stand alone, Mobile ICTCs, Facility Integrated ICTCs and PPP ICTCs)
 - a) No of Stand Alone ICTCs established and reporting
 - b) No of Mobile ICTCs established and reporting
 - c) No of Facility Integrated ICTCs established and reporting
 - d) No of PPP ICTCs established and reporting
- 2) General clients tested for HIV
 - a) No of general clients tested for HIV & positivity
 - b) No of TB patients tested for HIV & positivity
 - c) No of STI patients tested for HIV & positivity
 - d) No of HRG clients tested for HIV & positivity
 - e) No & % of HIV +ve individuals detected at ICTC, linked to ART Centre (Registered)
- 3) Pregnant women tested for HIV
 - a) No of pregnant women tested for HIV
 - b) No & % of pregnant women detected HIV +ve
 - c) No & % of Mothers and Babies provided ARV prophylaxis
 - d) No & % of HIV +ve pregnant women undergone CD4 testing
 - e) No & % of HIV +ve pregnant women eligible for ART
 - f) No & % of HIV +ve pregnant women initiated on ART
 - g) No & % of HIV +ve pregnant women LFU (lost for follow-up)
- 4) HIV-TB Co-infection
 - a) No of ICTC clients referred to RNTCP
 - b) No of TB patients referred to ICTCs
 - c) No of HIV-TB co-infection cases detected
 - d) No of HIV-TB co-infected cases initiated on CPT
 - e) No of HIV-TB co-infected cases initiated on ART
- 5) EQAS
 - a) No & % of ICTCs participated in EQAS
 - b) No & % of ICTCs receiving EQAS reports from SRLs
 - c) No & % of ICTCs reporting discordance
- 6) Monitoring & Supervision
 - a) No of review meetings of ICTC held
 - b) No of coordination meetings for ICTC / ART / TI / STI / RNTCP
 - c) No of supervisory visits by SACS officials
 - d) No of joint programmatic reviews with RCH / NRHM

- e) No of joint programmatic reviews with RNTCP

G. NACP IV Focal Areas

Quality

- Competency based capacity building and supervision
- sustaining high standards of lab services

Innovation

- community based screening for pregnant women after pilot testing
- couple counselling and contact tracing

Integration

- Designated Microscopic Centres for screening tests as per state need.
- Utilizing mobile health clinics under NRHM for counselling and testing including HRGs
- Expanding the role of the counselor and laboratory technician and re-designating the post of ICTC Counselor/STI counselor as health counselor.
- Provision of HR support up to CHC level for counselors and lab technicians
- ICTC laboratory technician to conduct other tests like CBC and sputum tests.
- Use of ASHA, ANM and Anganwadi workers for referrals and linkages and addressing stigma and discrimination.

Sustainability

- Promote “ownership” and accountability of existing general health system in management and monitoring of HIV services

Leveraging of partnership

- Partnership with IMA, FOGSI, MCI, State Medical Council, State Doctors Association, Academic institutions, positive persons networks, INC, Association of Physicians of India, NABH and NABL, etc

H. Integration with NRHM

1) Method

Establishment issues

- a) Testing services at all 24 x 7 facilities
 - Human resource for counseling and testing

- Infrastructure and equipment for testing
 - RNTCP DMCs to be mandated for HIV testing
- b) Logistic Management
- Infrastructure for cold chain maintenance
 - Storage
 - Transport
 - Bio medical waste management

Financial issues

- HIV test kits for screening at all 24x7 facilities
- Accommodating ICTC staff below sub district level into NRHM structure (into ARSH program)
- Training cost for capacity building of NRHM staff in HIV

Technical issues

- a) Support supervision and monitoring of NACP activities at state and district level.
- b) Integrate the HIV component (including stocks) in the NRHM MIS.
- c) Capacity building to address stigma and discrimination towards PLHIV by the staff of health facilities.
- d) Involvement of NRHM staff like ANM and ASHA can improve the utilization of counseling & testing services for HIV by community mobilization
- e) All NRHM training programmes can include HIV into the curriculum so that all health staff is sensitized and utilization of NACP services can be increased.

2) Time frame

Issues	2012-13	2013-14	2014-15	2015-16	2016-17
Establishment issues	Tamilnadu, Karnataka, Andhra Pradesh, Uttarakhand, Chandigarh, Manipur, Daman & Diu, Dadra & Nagar Haveli	Maharashtra, Gujarat, Delhi, Himachal Pradesh, Punjab, Kerala, Nagaland, Goa, Pondicherry,	Madhya Pradesh, Rajasthan, Chhattisgarh, Haryana, Orissa, Mizoram, Meghalaya	Uttar Pradesh, Bihar, Assam, Arunachal Pradesh	Jharkhand, West Bengal, Tripura, Sikkim, Jammu & Kashmir
Financial issues					
Technical issues					

I. Important cross cutting issues

- Procurement:
 - ✓ Uninterrupted supply of testing kits
 - ✓ Rate Contract system for procurement of testing kits
 - ✓ Decentralized procurement (Regional / State level)
 - ✓ Monitoring of Supply chain management
- Finance:
 - ✓ Optimal utilization of existing human resources under NACP at SACS / District level
 - ✓ Rationalized pay structure (parity) at National / State / District /Unit level
- Program Management
 - ✓ Regional level program monitoring structure
- Programmatic cross cutting issues with
 - ✓ Lab services division: EQAS, Supply of testing kits in flexi packs, use of ELISA for high load ICTCs at all medical college level
 - ✓ TI Division: Tracking of referrals from HRGs to ICTC,
 - ✓ LWS division: Tracking of referrals from TI / LWS NGOs, follow up of clients for linkages with CST,
 - ✓ STI division: Tracking of referrals from STI clinics (designated, TI, NRHM) to ICTC
 - ✓ M&E division: Robust system for data management and analysis, simplifying reporting formats for F ICTCs, operational research, capacity building

J. Overall suggestions and recommendations for NACP IV

- Strengthen ICTC- ART linkages to prevent drop outs, LFU and ensure continuum of care
- Integration of NACP –ICTC component within NRHM: integrate with commitment and ownership by NRHM. Expand services with state specific strategies in collaboration with NRHM
- Simplify M& E system avoiding duplicate recording processes which add to the workload
- Address supply Chain management issues
- Increase access/utilization by HRGs and other vulnerable community (expand services with TIs)
- Use of ELISA in high load ICTCs as a testing strategy in place of testing using rapid kits

- PITC with opt out policy should be expanded to priority OPDs in priority states and districts following an operational cum feasibility study
- Counselling component in NACP- IV needs a fundamental shift in approaches used in terms of programme planning (updates, supportive supervision), capacity building (pre service and in-service trainings of counselors, nurses, doctors etc).
- Multi-tasking of ICTC Counselors and Lab technicians for mainstreaming them into the health system
- Improve the infrastructure of existing facilities
- Assessment studies on:
 - Piloting HIV testing of all Out Patients and Indoor Patients in priority OPDs in select districts (Operational cum Feasibility study)
 - Assessment of Facility Integrated ICTC model and PPP model ICTC including assessment of recording and reporting strategy
 - HIV testing of TB suspects
 - Assessment of community based screening for HIV

PART B: PPTCT

The transmission of HIV from infected mother to child is one of the mode of transmission that can be minimized with adequate and appropriate medical intervention as a health sector response. In the absence of any intervention, a substantial proportion of children born to women living with HIV will acquire the virus from their mother during pregnancy, labour, delivery and through breastfeeding. *Without any intervention*, the risk of transmission from parent-to-child is estimated to be 15-45%. The program aims towards reduction of new HIV infections in pediatric age group through this route.

Current status of NACP III

In March 2000, NACO initiated a 2-year PPTCT feasibility study aimed at designing an implementation model of PPTCT for the public health sector. The study involved 11 major hospitals of the 5 most affected states in India. Besides demonstrating that it was possible to implement PPTCT in the public sector, these studies also found that the programme provided opportunities for HIV prevention counselling, STI diagnosis and treatment of 98-99% of the women who were uninfected.

PPTCT programme was scaled up in the country in NACP III, with SD Nevirapine as the regimen of choice. This regimen has now been revised in view of higher efficacy of combination anti retroviral and utility of extended NVP prophylaxis amongst children who are breast fed. Exclusive breast feeding is recommended for 6 months in India.

Under NACP III, the specific targets that were set for PPTCT are depicted in the table below:

Year	Year 1	Year 2	Year 3	Year 4	Year 5
Number of pregnant women to be covered	2,025,000	3,782,000	4,900,000	6,500,000	7,500,600
Number of HIV positive women to be covered	20,000	36,700	55,000	71,000	75,600

As of May 2011, 6.6 million out of total 27 million pregnant women were counseled and tested during 2010-11 financial year at 7538 facilities (5246 stand alone ICTC, 2302 facility integrated ICTC and 670 in the private sector). During the year 2010-11, 16954 out of 43000 estimated HIV+ pregnant women were identified and 11962 mother-baby pairs received NVP. In 2010, 9917 pregnant women were offered CD4 testing , out of which 3969 (40%) were eligible for ART as their CD4 count was less then 350 cells/cmm. Out of the eligible women, 2265 (57%) were started on ART.

PPTCT related Achievements under NACP III

Program Component	Year 1 (07-08)		Year 2 (08-09)		Year 3 (09-10)		Year 4 (10-11)		Year 5 (11-12)
	Target	Ach	Target	Ach	Target	Ach	Target	Ach	Target
No of pregnant women to be covered (in lakhs)	20.25	23.27	37.82	46.35	49.00	61.19	65.00	66.38	75.00
No of HIV +ve pregnant women detected		14991		21809		20071		16954	

No of HIV +ve pregnant women to be covered with ARV Prophylaxis	20000	7447	36700	10948	55000	12282	71000	11962	75600
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However, during the NACP III, with the evolution of new and better estimates, the numbers of pregnant women infected with HIV were revised. According to NACO estimates (2009), there are approximately 43000 (Range ; 22599-69876) HIV positive pregnant women in the country.

Strengths under the current PPTCT program under NACP III:

During the third phase of program, the PPTCT component achieved 90% of NACP III goals for testing and counseling. It was able to saturate public health sector with testing and counseling facilities in high prevalence states. A dedicated workforce including counselors, out reach workers and others have been created and existing in varying strengths across the country. The program was able to design, disseminate and use effective IEC as well as the program was Ability to partner with civil society and positive networks for service delivery, including the private sector to some extent.

Strengths of NRHM: NRHM , as an umbrella to various national programs has a well established presence in most geographic areas. It has large work force, and existing institutional framework and infrastructure at all levels of the health system. There are existing success stories in improvement of ANC coverage and increase in institutional deliveries over the last few years under NRHM that could be leveraged.

Way forward

Though India remains a low prevalence country for HIV, there is significant HIV burden when the prevalence is quantified in numbers. Under the NACP IV, it is envisaged to consolidate on the gains made during the third phase of the program. At the same time, it is also important to realize that the success of PPTCT component will heavily rely on the extent of the ANC coverage and institutional deliveries (both in public and especially the private sector), adherence to ARV intervention – prophylaxis or ART and follow up by the field level work force . Hence,

integration of services with the NRHM will be the most critical and essential activity under NACP IV. With an effective integration, we should be able to minimize the verticality of the NACP over time, and therefore deliver the services through optimal utilization of the infrastructure, human resources and task sharing within the general health system and NRHM. A strong focus is required on enabling the negative women to maintain their sero-status and enabling them to access the family planning services (Prong 1 and 2 under the PPTCT – Primary prevention and meeting the unmet need of family planning).

Integration with NRHM in a planned and phased manner (to improve coverage with ANC, identify HIV status as high risk pregnancy, follow up of mother baby pair, integrate trainings , joint monitoring and supervision, availability of family planning services to HIV positive mothers, involvement of private sector, nutrition, etc) have to be undertaken in a coordinated way with NRHM.

There is a need to have counselor trained in a way to provide holistic counseling that addresses a range of needs from , ANC, HIV, infant feeding, STI, TB etc. Similarly, the integration needs to happen for the different laboratory services / components.

The NACP IV should view PPTCT interventions as a part of the cascade / continuum of care rather than an isolated intervention that addresses only HIV. This should include not only positive women but also HIV negative women and discordant couples (Prong 1 and 2 strengthening). This intervention should be taken as an opportunity to offer appropriate health care services including HIV for the whole family (family centric approach)

Vision:

Universal access to comprehensive PPTCT services to pregnant women and appropriate HIV services to their families as an integrated health care package.

Goal : The goal of the NACP IV regarding the PPTCT component is to intensify efforts to work towards elimination of new HIV infections from mother to child and improve maternal and child survival (in the context of HIV) *{Definition of elimination: Reduce new pediatric infection by 90% and to reduce PTCT to <5%}*

Objectives (By end of NACP IV):

- To offer HIV test to all pregnant women accessing services
- To reduce parent-to-child transmission to less than 5%

- To link all HIV-positive pregnant women and exposed babies to care, support and treatment services at the earliest. (PPTCT cascade)
- To provide access to family planning services to HIV-positive pregnant women
- To Link HIV-negative women to sexual and reproductive health services offered by NRHM

Challenges expected in NACP IV:

PPTCT was accorded primacy in the NACP III for implementation. However, following challenges exist in implementation:

Coverage of services:. Currently, of 27 million estimated annual pregnancies, approximately 10 million deliveries occur in institutes under the public sector. According to NFHS data, 35.1% are home deliveries and rest occur in private sector. The overall coverage of HIV screening for pregnant women is around 24% currently, predominantly in public sector.

It will be of utmost importance to collaborate and integrate with NRHM, to improve ANC coverage and to ensure that the women who access ANC care are tested for HIV as a part of other counseling and laboratory work up as standard ANC care.

Amongst the 43000 estimated HIV positive pregnancies, the program has been able to identify only around 40%. NACP has successfully managed to cover pregnant women in urban public health infrastructure. Low coverage of pregnant women living in rural areas is an important challenge.

Follow up of Mother – Baby pair: Only 27.8% of the estimated HIV+ received NVP (CMIS 2010-11). The follow up of mother baby pair has been poor. Combined strengths of NACP and NRHM for effective outreach would be critical in ensuring comprehensive care and optimum utilization of human resources.

Integration with Care, support and treatment services , MCH/RCH (NRHM) services , WCD and other services . Though NACP-PPTCT has established itself well in departments of Obstetrics and Gynaecology and Medicine in tertiary care centres, its linkages with other National programmes are inadequate and it continues to operate as a separate programme. There are many complementary National programmes run by other ministries where functional linkages can be mutually beneficial.

Supply-chain management A robust supply chain management system is essential for rolling out PPTCT regimen. Since the PPTCT programme is now going to be scaled up in rural areas, supply chain management for medicines, HIV testing kits and maintenance of equipment can pose challenges

Human resources: Dedicated, trained counselors and lab technicians have been provided under NACP. Most of the staff working in antenatal services have been trained in urban and semi-urban PPTCT centres in providing PPTCT services. However, the current National regimen based on single dose nevirapine has been revised with a new multi-drug regimen recently for which training is yet to be undertaken. Additionally, the rural outreach of the programme is being scaled up based on NRHM infrastructure. The staff at the existing health facilities need to be trained and their capacity built up on HIV related services and issues. This is likely to pose challenge in terms training load, appropriateness of training curriculum and training institutions and budgetary allocation.

Meaningful Involvement of private sector: Approximately 40% pregnant women having institutional deliveries tend to deliver in private nursing homes. Unless there is effective involvement of private sector, elimination of new pediatric HIV infection as well as new infection among women is likely to be difficult. Through involvement of professional bodies / associations like FOGSI and IAP, we need to further scale up and strengthen PPTCT interventions. Adequate sensitization and training of health care provider in private sector as well as demand generation through intensified IEC activities will go a long way in achieving this goal.

Low utilization of related services by spouse / partner / children

Unless the partner and children of HIV infected woman are tested, the efforts to provide quality care are likely to remain incomplete. Despite efforts in NACP III, the utilization of HIV testing related services by spouse /partner/children remains low and needs to be focused upon.

Priorities –

1. Strengthening integration of PPTCT services into the health systems

- a. Including PPTCT curriculum in the training package of the PHC staff and frontline health workers including skilled birth attendants (SBAs)
- b. Task sharing among all the staff (PHC) for counseling and testing and continuum of care services
- c. Tracking of the identified positive pregnant women and follow-up by the link workers/ASHAs/ ANMs /positive networks/AWW
- d. Counseling, testing and continuum of care to the spouse / children of the positive pregnant women
- e. Referral and linkages between with the STI, TB and other CST services
- f. Strengthening linkages between ICTC and CST services
- g. Enabling negative women to remain negative through ongoing counseling of couple, testing and increasing access to prevention tools (male condoms, female condoms)
- h. Offering breast feeding counseling, nutrition counseling and family planning services
- i. Community based counseling and testing through mobile medical units of NRHM, mobile ICTCs and ANMs using whole blood finger prick test (WB FPT)
- j. Strengthen PICT for admitted patients also.

2. Implementation priorities

- a. **Phased scale up** of revised PPTCT guidelines at all levels of health care, including private sector
- b. **Trainings:** Training of trainers and cascade trainings on revised PPTCT guidelines, including private health sector.
- c. **Build capacity** of state institutes in a phased manner for training and also integration of HIV as a part of routine NRHM trainings. Also work with NIHF, NIPCCD and NHSRC for integrating PPTCT/HIV into curriculum of different cadres of health force.
- d. Design and develop tools for effective monitoring and evaluation of the implementation of the revised PPTCT guidelines
- e. Provision for Implementation/ Operational research (IR/OR)

3. Strengthening of health systems including capacity building, reporting, monitoring and supply chain management

Capacity building

- a. Pre induction training of doctors and nurses in HIV service delivery
- b. Refreshers and CME for the professional bodies such as FOGSI, IMA, IAP, Nursing etc)
- c. Development of comprehensive manual for the above categories in English and local languages

Reporting and monitoring

- a. Harmonizing the M&E framework of NRHM with the NACP CMIS
- b. Joint monitoring of HIV and RCH integrated programs by the NRHM POs and DAPCUs
- c. Safeguards for confidentiality of data

Supply chain management

- a. Ensuring uninterrupted supply of test kits, drugs and consumables throughout the year at all facilities
- b. Training of staff in maintenance of records of supplies

4. Promote private-sector participation in PPTCT programme / services

- a. Leveraging existing public private sector partnership to scale up PPTCT services in the private sector
- b. Encouraging implementation of revised PPTCT guidelines in the eligible (infrastructure, monitoring system) private health sector
- c. Couple counseling and STI counseling of negative and discordant couples
- d. Maintaining and reporting of PPTCT service delivery data in line with the NACP and NRHM M&E framework
- e. Linking private health facilities to referral units via service directory, e-forum, telephonic messages, helpline/ toll free numbers for information on HIV / PPTCT related services

5. Comprehensive communication strategy

- a. Developing tailor-made IEC for general public including awareness campaigns for effective utilization of services

- b. Enhancing the inter personal communication skills among the health care providers
- c. Improving provider initiated counseling and testing (PICT) / opt out testing through awareness campaigns conducted by the ASHAs/ ANMs/ Outreach workers

Specify important program targets and indicators – Targets to be set by ICTC group

Targets

- 1. All health facilities offer HIV testing & Counselling (refer to ICTC group targets)
- 2. 80 % of pregnant women are counseled and tested for HIV (To be confirmed depending on NRHM planned coverage)

Indicators (in line with program description and M & E group)

- 1. % of HIV positive pregnant women undergo CD4 testing
- 2. % of eligible positive pregnant women to be initiated ART
- 3. % of positive pregnant women not needing ART, provided ARV prophylaxis.
- 4. % of positive pregnant women undergo institutional delivery
- 5. % of HIV exposed infants undergo testing (EID)
- 6. % of HIV exposed babies are given Exclusive breast feeding for 6 months / exclusive replacement feed for 6 months

Overall suggestions and recommendations for NACP IV

1. Policy Recommendations:

a. ***Technical Guidelines :***

- i. Implementation of Revised PPTCT guidelines both in public and private health facilities

- ii. Implementation of guidelines for care of HIV exposed child including EID in public and private health facilities
 - iii. Revision of training modules in-accordance with revised guidelines and IEC materials for all health care provider
 - b. **Provider initiated HIV testing (PITC):** PITC should be expanded to the public and private health sector.
 - c. **NRHM Integration:** As the success of the PPTCT program banks to a large extent on the MCH program under NRHM, integration should be done as per the details spelt out.
2. **Implement approaches for reducing new HIV infections in women of child bearing age.**
 3. **Implement approaches for ensuring access to family planning services to all HIV+ pregnant women**
 4. **Implement approaches for Improving Private Sector involvement:**
 - a. Evolve different models of implementation for engaging private providers: Not all private providers may have equal skills and infrastructure to provide the services under the PPTCT program. Hence, to encourage their participation, programme may provide specific sets of services tailored to the capacity of the private sector player under consideration.

These could be

- i. Screening and referral of HIV+ pregnant women to PPTCT services (leverage current screening practices)
 - ii. Testing and counseling and referral
 - iii. Full cascade of PPTCT services
- b. Evaluate use of incentives: The following incentives for the involvement of private sectors may be considered
 - i. Certification/accreditation
 - ii. Financial incentives (leverage schemes provided by NRHM, no additional financial incentives from NACP)

- iii. Official partnership with the government (current PPP model)
 - iv. Provide test kits, capacity building support, ARV prophylaxis, PEP drugs and EID (current PPP model)
 - v. Help them to protect their staff through training on universal precautions, and provision of PEP regimens
- c. Evolve policy on reporting and quality control for private health providers similar to public health providers.
 - d. Sensitize and train private providers in collaboration with professional organizations (FOGSI, IAP, IMA and others)
