NACP IV
Working Group Meeting :
Care, Support and Treatment

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New Delhi

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Goal

- Universal access to comprehensive, quality, equitable and stigma free care, support and treatment services all PLHIVs

Objectives (Proposed):

- Objective 1: To upscale access to Anti Retroviral Treatment, prophylaxis and treatment of Opportunistic Infections inc. Paediatric ART services
- Objective 2 : To strengthen linkages between ART, ICTC , PPTCT, RNTCP, STI, CCC , Key populations and other services
- Objective 3 : To strengthen and mainstream care & support services to improve drug adherence
- Objective 4 : To build capacities and strengthen Health System for mainstreaming and long term sustainability of services
- Objective 5 : To develop and strengthen systems for quality assurance, monitoring and evaluation of services.

Expected Outcomes

- 95% of diagnosed HIV positive HIV clients at ICTCs to be linked to CST services
- Provide/Facilitate Diagnosis, Treatment and Prophylaxis of OIs and other co infections (with special reference to HIV-TB Co infection and HIV-Hep B/C co infections).
- Maintain high level of adherence (>95%) through treatment literacy
- ART to all those who are eligible as per the national guidelines
- Regular follow up of HIV care
- Improved quality of life of all PLHIVs
- Strengthening the linkages with HRG-TIs to ensure coverage to CST services

Expected Outcomes ..contd

- Nutritional counseling and linkages to other Govt. and social schemes.
- Operational Research and clinical research relevant to the national program
- Stigma and Discrimination reduction in both at communities and health care facilities
- Integration (and Mainstreaming) with Govt. Health system-NRHM, Govt. Health system, Public Private Partnerships and Other agencies.
- Strengthening and the decentralization of the supply chain management of drugs and consumable
- Early warning indicators and Drug resistance surveillance

Scale up plan

- Target for ART in public sector including children : 800,000 including 50,000 children
- Total number of ARTCs : 600
- Every district need to have one ART Centre or LAC Plus center
- LAC and LAC PLUS centers: 1500 LAC and 200 LAC plus centers and the phased up gradation of 50% of LACs into LAC Plus centers

Discussion Points on specific issues

ART Centres

- Optimal number of patients per ART Centre : appoximately 1500 on ART
- Monthly visit for the patients to ARTC during the first year of ART and then once in 3 months for stable patients (asymptomatic and immunological response to ART)

LAC

Existing challenges:

- Lack of ownership of LACs by the institutions
- Frequent transfer of LAC MOs by the state health officials in spite of the existing guidelines; the training of LAC MOs; ICTC need to be more involved in LAC functioning

Suggested Steps:

- LACs need to mainstreamed with health system in terms of functioning as well as monitoring.
- Mainstreaming to be initiated at LAC level; two views – this can be initiated at (option-1) at Low prevalence States; (option-2) high prevalence States

CCC's

- Currently there were 259 CCCs
- The role of CCCs has shifted from social aspects to medical aspects
- Emphasis on adherence

Points discussed :

- Relevance of CCC model in present context.
- Is CCC's a cost effective model?
- The group was of the opinion that CCC model in the current format is neither very relevant nor cost effective.
- It could create an environment for stigma and discrimination
- It could be a center for "chronic care" ; include palliative care for all chronic diseases , Including the non-communicable diseases

  ? ? How feasible is this model

  The group discussed the feasibility of the this model and most opf the members of the group were of the view that this model is not very parctical

CCC's

- Different models of CCCs were discussed.
- Psychosocial roles of CCCs and DICs are duplicated; here there was a discussion about the role of DIC and CCC. Convergence is needed between various programmes under NACP (DLN, DIC, LWS, outreach components of other programmes) for care & support component.
- The group also indicated the need for linkages with various department , ministries and social welfare schemes for mainstreaming of care support activities
- The findings of the CCC assessments were also discussed. The group felt that quality of services at the CCC is an issue of great concern
- So, CCCs may be scaled down in phased manner based on need & functioning of the CCC

COE

- Number to increase to 25 including the training centers of excellance
- RPCs will be >> Pediatric centers of excellence(Pediatric COEs)

Training/ Capacity Building

- Induction training to all
- Training for all the health care workers (doctors, nurses, Data Entry operators, Pharmacists, counselors)
- Refresher training: may be Online;
- Distance learning using the abode pro connect or video conferencing
- Fellowship programs and Diploma courses for doctors and nurses
- On site mentoring
- FAQs, Warmline etc
- In addition to the existing training NACO trainings , it was also proposed that NACO Master Trainers and NACO CST modules to be merged with training programmes conducted health system (for all staff) for mainstreaming and integration of the program.

Lab component

CD4 tests;

- Facilities to do CD4 cell counts will be scaled up optimally to manage 800000 PLHIVs on ART and all Pre-ART patients.
- Nearly 325 CD4 machines will be required

- The existing CD machines will be utilized optimally . the existing poor management skills will be addressed; the machines will be utilized optimally to cater the increasing needs)

- The total number of tests needed over the NACP-IV period …. Will be about 3200, 000 (800,000 PLHIVs x 4 tests for each PLHIV)

- Quality control of CD4 TESTING will be addressed

Lab component

Viral load (HIV-1) tests:

- The total number of tests needed over the NACP-IV period …. Will be about 50,000 TESTS (30,000 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,)
- The availability of lab facility at 112 Government facilities (though not optimal) was discussed
- The utility value of Private labs was also discussed
- Quality of tests also was stressed

Supply Chain management

- Drug estimation committee was established at NACO

- ART drugs need assessed > Indent by NACO > supplied to SACS > Distributed to ART centers

- Decentralization of supply chain: The capacity of SACS to manage the supply chain will be strengthened (pharmacist at SACS, SPACE for storage, Store manager, space and computers etc.)

  Challenges at SACS level was discussed in detail….stock outs, IEC material distribution was underutilized….in appropriate storage of diagnostic kits discussed….

  vs

- NACO to manage the supply chain was discussed; the advantages >> lot of experience, successful for many years except last few months, so…Strengthening the system at NACO was suggested.

The system followed in RNTCP program also was discussed

Structure for CST: NACO, SACS

- Appropriate structure of SACS with
  - JD (CST)
  - DD (CST)
  - AD (CST)

- Staff strength at NACO also was discussed; especially
  - need for increase in at NACO level inview of upscaling of services
  - the need for 4 PO's at NACO level one for each region (N,S,E ,W)
  - Increasing the number RCs to 25

Points yet to be discussed…

*The following points as mentioned in the **Terms of Reference** were not discussed due to paucity of time:*

- PPP models (bullet number 3 in the *Terms of Reference**)***
- Need for introduction of viral load, drug resistance and TDM in the ART programme (bullet number 6 in the *Terms of Reference**)***
- The level of decentralization ((bullet number 8 in the *Terms of Reference**)***
- The review of role of NGOs in care , support and treatment with special reference to adherence issues (bullet number 10 in the *Terms of Reference**)***
- Review the existing approaches for community and home based care centers and suggest strategies for scaling of successful models (bullet number 11 in the *Terms of Reference**)***
- Training plans.. year wise (bullet number 14 in the *Terms of Reference**)*** and

Thank you