Working Group on CST for NACP –IV

Report of 1st round of consultations

The first meeting of CST working group was held on 29th April 2011. The TORs for the meeting are at **Annexure "A".**

Goal:

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

Objectives:

Objective 1: To upscale access to Anti Retroviral Treatment, prophylaxis and treatment of Opportunistic Infections inc. Pediatric 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. Also to main stream with other key departments and ministries.

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

Strategies to achieve the above objectives:

Objective 1: To upscale access to Anti Retroviral Treatment, prophylaxis and treatment of Opportunistic Infections for adults, adolescents and children.

- 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).
- Increased coverage for HRG: Strategies- by developing effective referral mechanisms to access care services. The members suggested to have a policy to test all HRG members after appropriate counselling and those found to be HIV seroreactive need to be mandatorily referred to the ARTC. We should also consider strategies to enhance uptake of testing by the HRG members like mobile ICTC, campaigning for observation of HIV testing Day, collection of blood samples for HIV testing at the HRG-TI site or other appropriate places so that the problem of non-attendance of a large proportion of HRG members can be addressed.
- ART to all those who are eligible as per the national guidelines

- Regular follow up and monitoring of patients in HIV care
- Improved quality of life of all PLHIVs
- Reduction of stigma and discrimination in both at the health care facilities and in the communities
- Strengthening and the decentralization of the supply chain management of drugs and consumables
- Target for ART in public sector including children : 800,000 including 50,000 children
- Total number of ARTCs : 600 at the end of NACP IV from the present day figure of ~ 300 Centres.
- Optimal number of patients per ARTC: 1000-1500.
- Monthly dispensing 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)
- Every district of the country needs to have either one ARTC or one LAC Plus center
- LAC and LAC PLUS centers: 1500 LAC and up- gradation of 50% of LACs into LAC Plus centers in high prevalence places in a phased manner
- Mainstreaming to be initiated at LAC level; two views – this can be initiated at (option-1) at Low prevalence States (likely to be a challenging one!); (option-2) high prevalence States
- ART training to be done to MO in health system by NACO (alone or in collaboration with NRHM/health system?), which facilitate integration @ the earliest
- The role of CCCs has to be shifted from social aspects to medical aspects with more emphasis on adherence
- As CCCs 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 like hypertension, diabetis etc. This proposition could also be acceptable to NRHM as they are also focused on care of HTN, DM in the community level. Moreover, with reduction of stigma by adopting an inclusive approach for the CCC, it's expected that the community participation & community owning will rise over period of time. And finally, it may be possible for the community to run it by itself without much external financial assistance . **Role of CCCs to be redefined, it could be a multi disease, palliative care center but many members were not in favour of this.**
- Psychosocial roles of CCCs and DICs are duplicated; Convergence is needed at this level.
- **Different models of CCCs may be practiced:**

1. Bagalkot model: the Government Hospital was provided with all support to provide CCC facility; so CCCs may be established within the Government health facilities/hospitals; this action may help in integration with general health system early. (This actually is not a CCC concept; ideally it should have been the responsibility of the hospital itself to offer clinical care services including in-patient care for needy PLHIV in the government hospital. Additional manpower has helped them in areas of counselling etc. CCCs should be away from the hospital and in the midst of the community where

its services can also be utilized for community awareness and community sensitization.
2. Kolar Model: District level Government facility was provided with partial support; a PPP Model
3. Existing well functioning CCCs may be allowed to continue their good work

So, not well functioning CCCs may be abolished in phased manner and it should be need based

As CCCs were not cost effective (as per the discussions) and its partial duplication of activities with drop in centers (DIC), there may be a need for more DIC according to size of PLHIV in a region. Strengthen DIC as outreach source and where the PLHIV will be getting change for livelihood, legal & peer support and many more.

In the last two years or so NACO & PFI has conducted some performance assessment of CCC by some structured tool. Following that the CCCs have been categorized in 4 categories. The evaluation was never designed to assess the cost-effectiveness of CCC model. So, we need to be very much careful about loosely telling that the "CCCs are not cost-effective".

In low prevalent states, if we look in to the number of PLHIV who received in-patient care from the government hospitals attached to the ART Centres and the linked CCCs, I'm afraid, the number will definitely be more with the CCCs as still there is some apathy existing in the Government Medical Colleges & District Hospitals. That's may be the reason to find sick / very sick patients often being admitted in the CCC (in contrast to the national guideline for CCC!) as they are being referred by the ARTC SMO/MOas they fail to admit the cases in their hospital for different reasons Even a large section of ART MOs prefer to continue with the CCCs.

So, I believe, we need to take a cautious path before declaring to phase out the CCC altogether (Chairperson comments).

Dr. Phanindra Babu from PHI made following observations:

1. Although, it is mentioned that not well functioning CCCs may be abolished in phased manner, what is not clear is whether CCC as a mechanism should exist by end of NACP IV or not.
2. Although, the group felt that CCCs are not cost effective, we need to propose a study to scientifically assess whether they are cost effective. This could be part of special studies/evaluation studies

COE's

Increase the number to 25 including the training centers of excellence, and pediatric centers of excellence (upgrading RPCs into Pediatric COEs). The exclusive RPC/Pediatric COE concept has to be relooked. They should function as

a family centric care, support & Treatment facility with inclusion of adult HIV patients.

Lab component:

CD4 tests;

- Facilities to do CD4 cell counts will be scaled up optimally to manage 800000 PLHIVs
- 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

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) will be utilized as per the needs and availability as per NACO standards
- The utility value of Private labs will also be looked into.

Supply Chain management: (ARV and OI drugs)

- ART drugs need to be assessed > Indented 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 and Store manager at SACS, Space for storage at SACS , and computers with manpower etc.)
- Dr. Suresh Shastri: Many states have regional ware houses to store drugs and there should be a mechanism to store drugs here instead of SACS wherever the facility is available.
- Drugs for OI prophylaxis > State budget > through SACS ; other avenues like central purchase of OI drugs & distribute to ART centers also will be looked into.

- "ART Center specific" estimation will be discussed

- 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.

- Phased decentralization also was discussed…in rotational cycle….

- The system of automated red alert and green alert also was discussed

- Out sourcing also was discussed

- The supply chain management system similar to RNTCP programme could also be adopted for HIV programme.

- Further detailed discussion is need on this issue before concluding.

Mr> Sanjeev K Sinha, PD BSACS

1. Specifications of items to be procured at natonal/state levels may be prepared at NACO level.
2. Testing of items at natonal/state levels may be arranged/coordinated at NACO level.

I am not sure whether our group needs to address HR related issues. We did discuss about training aspects but we have not discussed about the process of recruitment, transfer/posting of contractual staffs, increment, reservation etc. If these aspects are within the ambit of our group, I think we need to spend some time on this.

Unless there is a separate group looking in to the HR issues, the relevant part for the CST division has to be discussed by us.

Objective 2: To strengthen linkages between ART, ICTC, PPTCT, RNTCP, STI, CCC, Key populations and other services

- 95% of diagnosed HIV positive clients at ICTCs to be linked to CST services
- *How we are going to link that's need to be elaborated more? by strengthening the existing the paper-based referral mechanism. In addition, we could also think about some software based system so that when a PLHIV gets registered at the ARTC, the referring ICTC automatically gets a confirmation of that etc.*
- *Strengthening the linkages with HRG-TIs to ensure coverage to CST services (100% coverage)*
- *Nutritional counseling and linkages to other Govt. and social schemes.*
- *Integration (and Mainstreaming) with Govt. Health system- NRHM, Govt. Health system, Public Private Partnerships and Other agencies. (Railways, Defense ESI).*
- Jahnabi Goswami was off opinion that we have totally left outreach and peer counseling thing that need to be include in CST pregame. Without outreach and peer support it's very much difficult to linkage with CST. With peer support we can trash LFU as well as adherence.

- Appoint peer counselor and out reached worker its and every ART center.

  Currently, the ORW of CCC & DLN are involved in retrieving the LFU & Defaulters; other field level workers like Link Workers, ASHA etc. can also be roped in tracing out the LFU cases in the community.

Objective 3: To strengthen and mainstream care & support services to improve drug adherence

- Maintain high level of adherence (>95%) through treatment literacy
- (involvement of Peer Counsellors will be of help in enhancing treatment literacy which is a ongoing activity rather than a onetime affair.

Objective 4: To build capacities and strengthen Health System for mainstreaming and long term sustainability of services

Training

- Scaling up of the training centers of excellence
- NACO Master Trainers and NACO ART MO modules to be merged with General health system
- The Health and Family welfare training centers to be roped in for various NACO trainings for mainstreaming. This will ensure owning up by the health department.
- Induction training to all ART MOs
- Refresher training to all MOs; may be Online
- Distance learning using the abode pro connect or video conferencing
- Fellowship programs and Diploma courses for doctors and nurses
- IGNOU/NACO Diploma in HIV Medicine: 50% of the candidates would be supported by NACO.
- Training for all the health care workers (doctors, nurses, Data Entry operators, Pharmacists, counselors) based on NACO curriculum
- On site mentoring (Discussion point: Do the CoE have the capacity to provide mentoring support to other ARTC- staff positions, What mentoring model be effective etc..) Well coordinated onsite mentoring by COE/RC/CST Officials of SACS should receive priority to improve the quality of ART services in the country. It could be supplemented by other modes like telephonic consultation with experts at COE, e-mail discussion, e-chat etc.
- FAQs, Warmline etc. to be established
- Revision of training modules in-accordance with new guidelines and IEC materials for all health care provider
- Rapid adoption of New ART guidelines both in public and private health facilities

Structure of SACS and NACO

- Appropriate restructuring of SACS with JD (CST), DD (CST) and AD (CST) was discussed
- Staff strength at NACO also was discussed; especially (1) doubling the staffs at NACO, (2) the need for 4 regional PO's,(3) Increasing the number RCs to 25

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

- 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.
- Quality control of CD4 Testing and HIV-1 viral load will be addressed.
- Early warning indicators and Drug resistance surveillance.
- Operational Research and clinical research relevant to the national program.

Dr.Vinay Kulkarni felt that we had not deliberated upon the role and inclusion of private sector but that is also completely missing from objectives too. Both participation as well as regulation of private sector is vital. There were at least 2 representatives from private sector in the group. The only time the question of its contribution came was about utilization of their established laboratory capacities for the national program, and unfortunately it was brushed aside.

The entire focus was on ART, i.e. treatment part of care, support and treatment. The CS part is very largely and significantly missing. We haven't discussed much about the Care & Support components. Further discussion is needed on issues like nutritional supplementation, social support facilities, free conveyance etc.

Other Comments from Dr. Phanindra Babu.

Appropriate reporting mechanism both for public and private health sector.

– Identify a focal person at the district level who will be responsible for collation of the information

Harmonize monitoring framework of NRHM and NACP IV.

Assess currently quality assurance plan:

- Develop and implement comprehensive quality assuranceplan based on the assessment findings.
- Develop appropriate indicators for monitoring quality.
- Develop standard operating procedures.
- Establish/strength supportive monitoring at different levels including state, district, site and community level.
- Monitor systems, training, service provision, follow-up, supplies and program management.
- Strengthen the feed back mechanisms and use of data.
- Include community monitoring.

Dr.Ajithkumar's comments:

1. we are still working on an NACP-3 template. Unless we try actively and consciously we may end up with just making small changes and presenting NACP-4 document. So there is a definite need role for some lateral thinking.
2. as far as second line and first line failure is concerned it is possible that the current strategy may require new mid term re-evaluation because of
   a) Failure of large proportion of second line patients
   (2 availability of newer drugs like darunavir etc)

3. Change of first line ART to ten based regimen.
4. More evidence to say that more frequent VL testing can detect resistant early.

5 years is a long period in HIV medicine so we will be discussing these possibilities bit more and prepare the NACP document for that.

One another way to integrate state govt is to involve them more in PPTCT and OI care etc

There are some technical issues which we need to discuss in the TRG on ART and thereafter, once decided by the TRG, scale up has to be thought off e.g. PVL at 6 months following first line ART initiation etc.

Comments by Mr. Sanjeev K Sinha, PD BSACS

I am not sure whether our group needs to address HR related issues. We did discuss about training aspects but we have not discussed about the process of recruitment, transfer/posting of contractual staffs, increment, reservation etc. If these aspects are within the ambit of our group, I think we need to spend some time on this.

Annexure A

- Review the prevailing ART/OI management facilities under the public health system and suggest measures for improved quality and coverage.
- Review the available HIV related diagnostic capabilities of the health system and suggest measures for strengthening the same.
- Review use of existing private sector facilities to support the programme at various levels from PHC onward for outsourcing.
- Review HIV, TB, co –infection and support and provide suggestions for improving collaboration and quality of coverage.
- Review the existing care and support services both for children and adults including ART with special reference to issues relating to coverage, logistics and adherence.
- Need for introduction of viral load, drug resistance and TDM in the ART programme.
- Design a strategy for maximizing synergy between prevention and care and support
- Study the scope for expansion of quality ART services and their mainstreaming with the primary health care system. The group should explore the feasibility, advantages and disadvantages of the decentralisation of ART services and suggest the level of decentralization to be done in 5 years, and pre requisite for the same.
- Assess the implication of expanding 2nd line ART in the light of maturing epidemic with special reference to TRIPS and other issues related to drug pricing.
- Review the role of NGOs in care, support and treatment with special reference to adherence issues
- Review the existing approaches for community and home based care centres and suggest strategies for scaling up of successful models.
- Suggest measures for effective community mobilization for care, support and treatment.
- Suggest ways of strengthening the surveillance system for reporting AIDS cases and AIDS deaths.
- Identify training needs for care and support, ART and OI management and suggest a technical support plan for capacity building. In particular the potential role of Centers of Excellence for comprehensive HIV care
- Expansion of fellowship programme, inclusion of ART centres in dept. Of medicine by MCI and inclusion of HIV into MBBS curriculum

- Elaborate an operational framework / scale up over 5 years to implement the continuum of care, ensuring smooth transitions and amalgamation of services for the spectrum – PMTCT-EID-pediatric and adult ART.
- Suggest the scale up of activities under the care and treatment unit to be undertaken in NACP IV, with clear mention of targets that are achievable, objectives that are SMART and also comment on the possible financial implications (yearly)
- Strategy for forecasting ARV needs, Drug calculations , kits for CD4 , Viral Load and other related supply chain management issues
- Develop strategic approach on care, support and treatment for NACP – IV.
- Suggest innovations in implementation
- Explore the possibilities of integration activities with NRHM

Annexure B

List of participants

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