CHALLENGES IN HIV/AIDS PREVENTION, CARE AND TREATMENT PROGRAMME IN INDIA

Policies and Priorities under National AIDS Control Programme Phase-III (2007-12)

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ABSTRACT

This paper explores the pertinent challenges of Government's HIV/AIDS prevention, care and treatment program in India. Study is mainly based on observations made during field visits, discussion during review meetings at various levels and during training programmes of various functionaries from April 2007-November 2009. The paper also takes into account the observations made on the conclusion of the Mid-term Review conducted by the Government of India in during July-December 2009 after completion of first 2.5 years of the 5-year plan of NACP-III. Additionally, interactions with key program managers involved in implementation and management of HIV/AIDS Program at the state, district and facility levels. Though numerous efforts have been made and continued by the Government and partners, HIV prevention, care and treatment services have not been able to reach to the most-at-risk population, specifically in the rural population. Socio-cultural and managerial issues are the key challenges reported by the most of the key implementers. There is an urgent need to address and strengthen the whole spectrum of health systems through a collaborative approach to achieve the millennium development goals of universal access to prevention, care and treatment services in India.

INTRODUCTION

Human Immunodeficiency Virus (HIV) has been a growing challenge worldwide from the last two decades.[1] A total of 33 million people are estimated to be living with HIV across the globe, 2.7 million people became infected with the virus and 2 million have lost their life due to AIDS. Every day, more than 6800 people become infected with HIV and more than 5700 die, mostly because they have no access to HIV prevention, care and treatment services.[2] The United Nations included HIV in its sixth millennium development goals which stated in combating and reversing the spread of HIV/AIDS by 2015 as well as to achieve universal access by 2010.[3,4] India, being committed to the Millennium Development goals, phase-III of National AIDS Control Program (NACP-III) was launched with the ultimate goal to reverse the HIV epidemic through various efforts for providing HIV prevention, care, support, and treatment services.[5]

India's epidemic is concentrated in 195 districts, most of them in six states-where HIV prevalence was more than one percent[6]. Evidence suggests that HIV epidemic has now stabilized in the country and some states like Tamil Nadu have witnessed decline in the prevalence.[7,8] The epidemic is still concentrated in high risk groups and vulnerable population. However, information that the epidemic is spreading in new pockets in northern low prevalence states and in the rural areas, is a matter of concern. Prevention of HIV/AIDS through public awareness programmes, change in behaviour, use of condoms, blood safety and prevention of mother to child transmission are important interventions to prevent HIV infections. At the same time those who have got the infection and AIDS need to be provided care, support and treatment without any stigma and discrimination.

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The Government of India, with support from multi-lateral, bilateral and other partners, is implementing various activities in the field of HIV/AIDS. Despite the progress that has been made, many issues and challenges remain unidentified and not addressed at program management, implementation and service delivery levels in India. The number of new HIV infections continues to increase despite current efforts made to control the epidemic. There is an urgent need for systematic review to ensure effective response to achieve the ultimate goal of NACP-III. Therefore, an attempt has been made to primarily explore the pertinent challenges in HIV/AIDS prevention, care and treatment program in India to help the policy makers, program managers and health care providers to tailor, implement and manage the program in a better manner.

METHODS

The present study is mainly based on observations made during field visits, discussion during review meetings at various levels and during training programmes of various functionaries from April 2007-November 2009. The paper also takes into account the observations made on the conclusion of the Mid-term Review conducted by the Government of India in during July-December 2009 after completion of first 2.5 years of the 5-year plan of NACP-III. Additionally, interactions with key program managers involved in implementation and management of HIV/AIDS Program at the state, district and facility levels.

RESULTS AND DISCUSSION

Collectively, specific management issues and challenges in the implementation of prevention and treatment programs on HIV/AIDS were identified. These issues were organized into nine thematic categories including capacity building, monitoring and evaluation, finance and others.

1. Strategic Planning and Management:

The National AIDS Control program is structured and well designed. Many officers pointed out that the programs have been devised as a national response to HIV/AIDS under one uniform action framework. There are operational guidelines for SACS, DAPCU and all facilities to maintain quality and standards of the services uniformly across the country and monitor the programs consistently to assess progress against the national goals. These guidelines work as referral document for implementing units and service delivery systems.

Most of the officers agreed that strategic and programme interventions are evidence-based and local priorities are taken into consideration. Some states seemed to be satisfied with the current set up and admitted that there is considerable flexibility and scope for innovation in the program whereas others were of the opinion that program should be more flexible. Local needs and evidence should be taken into consideration while planning.

The state level officers also admitted that setting up of DAPCU has made program management and implementation easier, which has helped in better monitoring, linkages within the program and with general health systems at the district level. Officers of many SACS were of the opinion that all districts should have DAPCU irrespective of categorization of district based HIV Sentinel Surveillance alone. Districts not having DAPCU should have some alternate arrangement for monitoring at district level. DAPCU should be set up in a need-based and state specific manner depending upon the size the district, extent of the problem and estimated number of high-risk population.

Majority of the officers suggested that strong leadership is important for the program. There was consensus that the program suffered a lot due to frequent changes of Project Directors. In metros like Delhi, a peculiar problem is of four types of health institutions owned/run by: (i) Delhi Government (ii) Municipal Corporation of Delhi (iii) New Delhi Municipal Corporation (iv) Central Government. It is very difficult to coordinate with different kind of health institutions as they are implemented by different agencies and have different level of hierarchy. The dissemination of information also becomes tough in such circumstances.

It was found that in states like Karnataka, DAPCU were well placed and functioning for the last two years. DAPCU officers were aware of their roles and responsibilities and prepare District annual action plan as per the local context. The major focus was to establish linkages within the program and

coordination with other national health programs. As far as implementation of the program is concerned, there are not many problems as HIV program in high prevalence states like Tamil Nadu, Karnataka and Maharashtra where the program received top priority. The interventions started early in these states and have now taken a definite shape. All high prevalence districts in these states have all the facilities: Targeted Interventions, Integrated Counseling and Testing Centres (ICTC), and Treatment and Care facilities (ART Centres and Community Care Centres), and therefore linkages and referral system within the programs are easier.

At facility level, the nodal officers of the ART Centre shared that Treatment program is quite systematic. Nodal officers at ART Centres reported that more clear directions are required regarding finances whereas nodal officer from ICTC pointed out that there is too much of compartmentalization of the program at the District level. The different facilities run independently and therefore implementation of the program as envisioned is not possible. However, majority of the health care providers opined that the systems have become better.

2. Human Resources:

In spite of two and a half years implementation of NACP-III, many states have vacancies at state and facility levels. It was indicated by most of the officials that human resource planning has been done in a very realistic manner by grouping states into different categories on the basis of disease burden. Some of the officers from SACS suggested that staffing in each component of the program at state level should be need-based and related to number of facilities being implemented in each state. It was also found that that the reporting by the Technical Support Units and Consultants appointed at SACS needs to be more streamlined. It was indicated that it is difficult to get good staff in the prescribed salary range. It was also observed that attrition rate amongst the contractual staff is high. All the contractual staff at state, district and facility levels revealed that there is sense of job insecurity. Moreover the salary package particularly at state and service delivery level is neither very attractive nor has any additional allowances and devoid of any promotional avenues. Similar opinion was also shared by the regular staff.

Many senior officers both at central and state level suggested that the some authority or financial power may also be given to the divisional heads to avoid delays in taking routine decisions.

DAPCU officers highlighted the need of authority to district level officers. Due to contractual position of district program mangers, they are not in position to take any decisions. It was highlighted by majority of the respondents, that regular staff does not follow the instructions of the contractual officers.

Staffing at the facility level is based on volume of case load. Staffing is adequate but the attrition rate is very high. The staff is appointed on contractual basis and there is a sense of job insecurity. Most of the staff from various facilities included in the study has complained of the lower salary status and no other benefits. It was also found that there are no growth avenues particularly for contractual staff. Higher level SACS officials were of the opinion that program implementation suffers a lot due to high staff turn over of contractual staff. It was suggested that salaries of the contractual staff should be at par with other staff with same qualification in general Health system in the concerned state. Many health care providers at facility level informed that there were frequent delays in payment of the salary.

3. Capacity building:

Most of the personnel agreed that the training programs are very well designed. The staff who have worked with other health programs earlier or have regular interaction with other national programs expressed that training component of NACP III is stronger and intensive. There are both induction as well as in-service/ refresher training for most of the health care providers. But at the same time it was observed that there are no formal trainings for staff at SACS. Non-availability of any training modules for them makes it difficult for them to understand the program and their job responsibilities.

DAPCU offices were of opinion that some of them were provided induction training but few of them have no clarity of their responsibilities. It was found that all the district supervisors were given induction training. The DAPCU staff was of the opinion that more intensive trainings were required especially in quality

data management and Computerized Management Information System (CMIS). The DAPCU officers suggested need for refresher training to update their knowledge on the national program and strategic planning.

Majority of the staff expressed their satisfaction on the ongoing training program. Most of the staff had undergone training. There was a very good response on the team trainings. The Medical officers from ART suggested that revision and updation in the curriculum was required as new initiatives such as 2nd Line ART and alternate first line are being rolled out. Some of the nodal officers and Medical Officers from ART also suggested that there were separate training from time to time for various components such as Pediatrics, 2nd line ART, alternate first-line ART, M&E, HIV-TB etc. To attend training repeatedly causes lot of inconvenience to the staff as well as to the patients. They suggested that there should be planned refresher trainings with standard and consolidated modules on all new updates. The staff nurses at LAC expressed they are given team training by Nodal Officers but it would be better if a more thorough training could be given to them on ART. The TI NGO in Delhi indicated that there were too many training programs which need to be streamlined.

4. Coordination and Linkages within the program:

Better Coordination and linkages are required between various services notably by Targeted Interventions for (TI) High Risk and vulnerable population. Under NACP-III, all TIs are attached to nearest ICTC. The linkages and referral from targeted interventions to testing and counseling services are not up to expected levels as all clients from TIs do not come to ICTC. Some TI NGOs mentioned difficulty to take High risk groups to ICTC due to timing problems. The problem is more severe with IDUs as most of the times these people are intoxicated and tend to run away. Funds are not sufficient enough to bear travel cost to take such people to ICTC. The FSW TI NGOs shared that the day timings of the ICTC are not suitable as most of the FSW tend to sleep during day hours. The SACS Officers in Delhi informed that Mobile ICTCs are being encouraged for testing and reporting on the same day.

PPTCT coverage and follow up is low. The PPTCT health care providers shared that the major reason for this low number of institutional deliveries. Most of the women go to their maternal houses for delivery.

The linkages are improving between testing and treatment services. It was informed that there has been a continuous rise in the number of HIV positives accessing ART services. It was shared by some of the district level staff and ICTC staff that in some of the ART Centers, CD4 test is done once a week for limited time. Patients have to go at least twice, once for registration and the next time for CD4 testing. This leads to additional costs to the patients. Also the patients from HRG find it difficult to access ART services due to problems of timings.

5. Coordination and Linkages with other Health Systems:

Most of the SACS officers were of opinion that coordination with Health Systems was difficult because of multi-structured Health systems. However it was observed that there was good integration between NRHM and NACP-III in those states where the coordination between Project Director, SACS and Mission Director, NRHM. In such settings linkages between various health programs and systems became easier.

Many of the senior level officers at SACS indicated that in general, there is good cooperation from Nodal officers but since these officers are Head of their Departments, it is very difficult for them to supervise day-to-day activities of the facility. It was suggested that nodal officer should not be selected by virtue of being Head of the Department. Alternatively, Head of Department should depute one of the officers from the department to monitor day-to-day working of the facility.

All program officers and health care providers unanimously accepted that linkages with RNTCP are good. District Supervisors attend District TB Officer meetings. The cross referrals from HIV into TB and from TB into HIV are quite satisfactory. The linkages at program as well as facility level are relatively good. The ICTC Health care providers informed that with the implementation of Provider-Initiated HIV Testing

and Counseling of Tuberculosis patients under the TB Control Program (PITC) has improved the referral to HIV services, detection of new cases and initiation of ART. It was also informed that all patients at ART Centers are screened for TB and if found positive are referred to RNTCP.

The DAPCU staff shared that in hospital settings more referral clients were coming to ICTC from other departments. This indicated that the health care providers are sensitized on the need of HIV screening in patients with risk behavior. Majority of the officers from DAPCU emphasized the need for integration of NACP III Services with NRHM & General Health Services at gross root level.

6. Procurement and Supply Chain Management:

During the study it was found that ART drugs, CD4 kits and HIV test kit (Antigen 1, Elisa) are provided centrally. PEP drugs, HIV Kits Antigen 2 & 3, Nevirapine are to be procured by states and supplied to facilities. States suggested that there were problems in procurement at state level due to the procedures as well as lack of capacities.

Some of the SACS staff indicated that procurement of all kits should be done by NACO. This will help to manage the supply chain and also procure goods at competitive rates due to large volume. Rate contract will perhaps be better option for procurement of drugs whereby NACO can fix up the rates and SACS can procure them as per requirement. This will improve the supply chain management and reduce storage problems. It was also suggested by some officers that procedures like e-tendering (where open bids are available) can also be adopted. It will make procurement process more transparent. It was observed during the study that procurement is weak in several states. On discussion, it was informed that though there were no major issues with global fund procurement but some there were definite delays in procurement under the World Bank funded procurement.

Most of the DAPCU reported shortage of space for storing kits. Majority of the DAPCU officers depicted that decentralization of supply chain management at DAPCU Level is required. This is particularly true for large states with large number of ICTCs in each district. The transportation causes a lot of inconvenience and maintenance of cold chain is also difficult. It was suggested that Warehouse System is required at the district level for storage of kits and other consumables.

It was found that supplies of ART drugs are regular and systematic. The process is centrally controlled by NACO. Relocation of Drugs is done as per requirement. There were problems regarding the supplies of OI drugs. ART Centres staff told that recently some funds were released to procure OI drugs. In the ICTCs, there were problems of erratic supplies of kits, drugs and consumables. The TI and CCC NGOs are given grants to buy drugs and consumables.

7. Monitoring and Evaluation:

NACP III is based on three ones principle and has a national Monitoring and Evaluation (M&E) plan. It aims at developing a consolidated Strategic Information Management System (SIMS) at national and state levels to focus on strategic planning, monitoring, evaluation, surveillance and research. It is aimed to provide effective tracking response to HIV epidemic. This will be a web-based system networking all facilities developed/supported under NACP-III.

The program officers implementing various programs pointed that M&E systems are well placed at SACS and M&E officers compile, upload and analyze the data. The M&E officer of few states also revealed that the reporting from some units was low, for example: blood bank, TI, CCCs. Some officers also raised concerns about the quality of data due to inadequate training of the staff at primary data collection units. Many program officers at SACS also informed lack of routine feedback from NACO to SACS and from SACS to primary data collection units. At DAPCU level, it was found that M&E officers were available in many states but they need intensive training in data management, analysis and report generation so that the data can be used to focus program intervention. It was observed that ART Centers are computerized and have PLHA Software. Soft copy of report is directly sent to NACO with a copy to SACS. The staff at ART Centre complained of too much of documentation and recording. The Medical officer at one of the centers said that it was very difficult to maintain all record and reports with such high load of patients.

ICTC are under the process of computerization. All reports (physical copy / soft copy) are first received at SACS and then checked and compiled and sent to NACO. Postal delay in getting information is also a problem. Reporting from facilities is very poor. Constant reminders are required. Blood banks do not feel accountable to SACS. Reports are sent physically and then collated at SACS.

The DAPCU officers reported lack of coordination from NGO led TIs and CCCs. The CCC staff in some of the states pointed that they have to maintain two kinds of records, one prescribed by NACO and the other suggested by implementing agencies. The reporting was not very streamlined in case of TI NGOs also. One of the TI staff reported that the reporting formats were frequently changed and it is difficult to keep pace with them.

8. Supervision of the Program:

Senior Officials at SACS mentioned that regular review meetings are conducted at the Central level for all components to assess the performance of each state. These meetings also serve as forums where states can share their problems and seek guidance from NACO. It was also told that there are continuous supervisory visits of the senior officers from Centre to the SACS and facilities to look into the gaps in implementation. Majority of the officers said that the visits help to maintain the quality of services and help to sort out issues related to other health departments.

It was also found during the study that regular staff meetings are conducted at SACS level headed by the Project Director. The SACS also conducts component wise meetings within the state to disseminate information, review the progress, get an update on implementation and plan future strategies.

There are monthly reviews of DAPCUs by SACS. All District Supervisors are given quarterly plan. The District supervisors also shared that there were quarterly review of all ICTC Counselors of the state. In addition, the district supervisors conducted monthly meetings of counselors. The District Supervisors also brought forth the issue of daily reporting to SACS and NACO but they find it difficult due to lack of Computer/ Laptop. The district supervisors are also given motor bikes to be in continuous touch with facilities.

The Health care providers at ART Centers and CCC revealed that Regional Coordinators appointed by NACO provide constant mentoring and supervision. For Targeted intervention program, TSU provided guidance to the NGOs. ICTC staff shared that they got guidance from the District Supervisors. The district level monthly meeting of the ICTC also provided forum to discuss and sort out local issues. In addition, there were quarterly meeting of the ICTC at SACS which helped ICTC to plan their action. In the LACs it was found that regular supervision was missing.

9. Finance:

It was revealed by SACS that the entire program is centrally funded. The funds are allocated to states based on their annual action plan. The finance officers at SACS pointed that there was flexibility to re-appropriation of funds in a given component under various heads. The program officers revealed that there is provision of even submitting the new proposals or change in the program strategies even in the midst of the year provided there is sufficient justification. Majority of the officers pointed that fund flow from centre to SACS is fine. Approval has to be taken for already approved activities. Fund utilization at the facility level is disorganized. Funds from SACS are released to the accounts of the Medical Superintendent/Head of the institution. Any flow of funds to the facility level is done through Finance department of the institution. It is very difficult for Nodal Officers get the funds mobilized under such cases. Many times, the nodal officers are not aware of the availability of the funds and financial reporting from the institutions is very chaotic. Most of the DAPCUs did not mention any problem regarding fund flow.

CONCLUSION

The current study provides an opportunity to assess the HIV response to understand what must be done to ensure that India is on course to achieve the goal of universal access to prevention and treatment.

A systematic and comprehensive approach based on scientific and programmatic evidence is the key for successful implementation of Public Health Programs. The NACP-III is guided by the three-ones principle and this acts as a unifying factor for the national response

and helps to set standards of quality for HIV /AIDS prevention and treatment programs.

Strategic and program interventions are evidence-based and result-oriented with scope for innovations and flexibility. Priority is accorded to specific local contexts and interventions planned accordingly. Study findings conclude that program is well–structured and well–tailored considering the national as well as local needs, ensuring full implementation of evidence-informed policies and programs. Being a large country with wide variations in social, geo-physical and health service patterns across the States and regions, it was necessary to prepare a plan that is technically sound and uniform but allows flexibility and adaptability at the local level.

A number of challenges and gaps have been identified, namely: low reporting by primary data generation units; lack of skills to appropriately use information generated through CMIS; poor quality of data due to inadequate training of the primary data collection units; lack of routine feedback from NACO to SACS and from SACS to primary data collection units. The convergence of decentralized delivery system with other health system is helpful in long term sustainability of the program. The main challenge lies in increasing the availability of prevention and treatment in resource-limited countries. The expansion of HIV prevention and treatment services is currently hindered by weak infrastructure, limited human and financial resources, and poor integration of HIV-specific interventions within broader reproductive and child health services. Technical staff appointed for program implementation and service delivery is contractual. The attrition rate of contractual staff is very high due to job insecurity, lack of benefits and incentives and lack of growth options. High turnover of staff and frequent transfer of regular staff especially Project Directors is also a constraint in some States. There is need to strengthen monitoring and supervision and training of program managers at SACS and DAPCU to take informed decisions.

Our study is based on observations of a few program sites, DAPCU & SACS Offices as representativeness of sites was not the goal of the study. However, recently held mid-term review has revealed similar problems in many States. It would be important to examine these issues at national and State levels and take corrective actions to achieve the goal of halting and later reversing the epidemic of HIV/AIDS in India.

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