

Guest Editorial**HIV Counseling and testing - entry point for prevention and care: Gujarat Experience.**Kadri AM¹, Kumar Pradeep²

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National AIDS Control Organization (NACO) under the Ministry of Health and Family Welfare (GOI) is implementing the HIV/ AIDS control program in the country and in Gujarat the program is implemented by Gujarat State AIDS Control Society (GSACS) formed by H & FW Department of Government of Gujarat.

India had an estimated 2.3 million HIV positive persons with adult HIV prevalence of 0.34%; same figures for Gujarat are 1.38 lakhs and 0.38 percent respectively (2007). National AIDS Control Program in its ongoing phase III (NACP III) (2007 – 11) aims to detect all these positives and put them on anti retro viral therapy (ART). NACP-II (1999-2004) evolved upon the investments made in NACP I (1992-1999), for slowing the spread of HIV and reducing the morbidity, mortality and impact of HIV/AIDS. NACP –III aims to halt and reverse the HIV epidemic by 2012. Accordingly National AIDS Control Organization (NACO) is focusing on the scaling up of testing and treatment services and ensuring their maximum uptake by the target population. The idea is to detect every HIV positive whether he/ she belongs to high risk group (HRG) or a pregnant woman or a patient of tuberculosis or reproductive tract infection (RTI) approaching the health system for health needs and refer him to nearest ART centre. NACP Phase III is making substantial progress in scaling up of the various services for preventing new HIV infections and in lowering the annual number of AIDS related deaths in India. The two namely testing and treatment facilities are complimentary to each other and testing services are rightly considered as the gateway to the treatment facilities.

Evolution of Counseling and testing Services

It is important that an HIV-infected individual becomes aware of his/her status as otherwise he/she could unknowingly transmit the virus to others. Thus knowing of HIV status enables an individual to initiate/maintain several behaviors to prevent acquisition or further transmission of HIV, gain early access to HIV-specific care, treatment and support, access interventions to prevent transmission from mothers to infants, better cope with HIV infection, plan for the future. Also it helps community at large by reducing the denial, stigma and discrimination that surround HIV/AIDS and mobilizing support for appropriate responses.

Counseling and testing services were started in 1997 as Voluntary Counseling and Testing Centers (VCTCs) and became first ever tangible service to the people under the Program. Its journey began with medical colleges, moved to the District Level Hospitals. Its reach and role remained limited till Anti Retroviral Treatment (ART) was included in NACP in 2004. With expansion of ART services creation of wider network of counseling and testing services also gained momentum. In 2005, the screening of ante natal care (ANC) cases for HIV and covering positive mother and newborn with single dose Anti Retroviral Drug for Prevention of Parent to Child Transmission (PPTCT) is included in counseling and testing services. To support the densing of the ART network, two scale-up drives for counseling and testing services were carried out in the year 2006-07 and 2008-09. Gujarat had 49 centers in 2005 – 06 which increased to 190 (2006 – 07) and 314 (2008 – 09). These centers include dedicated fully supported VCTC general, PPTCT and integrated – providing both services and facility integrated (with partial support in terms of kits, training etc at PHC, UHC and private or trust run hospitals (under PPP model). By the end of March 10 Gujarat has total 480 centers which include 290 fully supported dedicated centers and 190 as FICTC at PHC/ UHC (103) and at trust/ private hospitals (183). These centers have evolved at all levels of the public health-care system and established themselves an independent service than merely a supportive laboratory services.

Testing services have back up of ART services as they act as feeders to the latter. ART services started in the state in 2005 with only 1 ART center (ARTC) at BJ Medical College, Ahmadabad and the number by March 2010 has gone up to 14 ARTC, 23 Link ART centers (LAC) and 12 Community Care Centers (CCC). Today, more than 14,900 persons with HIV/ AIDS (PLHA) are availing free first line ART while a total 41,395 positives are registered at various ART centers (pre / ART registration. This number is a quantum jump from was only around 1208 and 1714 respectively in 2005 – 06 with only one centre in the state. This shows that two services go hand in hand and while addressing the felt needs of PLHAs complement each other.

Shift in approaches and philosophy in NACP III:

The challenge before us has been to make all HIV-infected people in the state aware of their status. But

still it is believed that at the most only 60 percent of the people living with HIV/ AIDS (PLHA) know their HIV status. This can be said on the basis of the fact that the estimated PLHAs in Gujarat as per the NACO estimates have been 138000 in 2007 while the cumulative PLHAs detected by March 2010 has been around 80000 with some unavoidable duplication. At the country level, NACP-III, it is planned to have 22 million clients counseled and tested every year. An equal number of clients are to be counseled and tested in the private and “not-for-profit” health sector. The reach of PPTCT services is also to be expanded to provide access to 7.5 million pregnant women every year. Keeping this in mind in 2007 operational guidelines were rewritten.

Integrating VCTC & PPTCT services:

The earlier Voluntary Counseling and Testing Centers (VCTCs) and facilities providing Prevention of Parent-to-Child Transmission of HIV/AIDS (PPTCT) services are now remodeled as a hub to deliver integrated services to all clients under one roof and renamed as “Integrated Counseling and Testing Centers” (ICTCs). This change is brought in during NACP III upon huge scaling up the services at sub district hospitals and Community Health Centers. Rationally behind is that, looking to the work load at sub district level no separate two centers are required at same premises. Further instead of two counselors (one male & one female), at sub-district level under ICTC only one counselor is provided in anticipation of lower workload. Thus this modification has reduced the human resource requirement from total 2 - 3 counselors & 2 laboratory technicians to only one counselor and one laboratory technician. However provision is kept for increase on additional staff on rational work load on case to case bases. This is a good example of rationalizing the resources and thus ensuring the optimum utilization of the counseling & testing services in a cost effective manner. Gujarat state has gone one step further which also speaks about its integration with general health system. Many Community Health Centers (CHCs) with ICTC have several other lab technicians (LT) from other programs such as RCH, Malaria, RNTCP etc. The workload at such places do not justify hiring of multiple LTs. Therefore, it is decided to have only one LT from any of the department and a LT from NACO for ICTC purpose is given only when justified by the in charge of the centre. In other words, a LT is trained to perform all duties of ICTC, Malaria, TB and RCH.

Provider Initiated HIV testing:

Another major shift in the philosophy of counseling and testing services in NACP III is the thrust on Provider Initiated Counseling and Testing (PICT). Here patients are referred from medical providers such as those with tuberculosis, STIs as well as

pregnant women and actively screening irrespective of their risk behavior. This shift is based on the guideline recommended by the WHO in 2007. These measures not only strengthen the prevention and control of HIV/AIDS but also lead to clear benefits to the health outcome of PLHAs. In NACP III as a policy and strategy, HIV Counseling and Testing (C&T) services for High Risk Groups (HRGs) as well as screening of all STI, TB & ANC client for early identification HIV infected is being encouraged under Provider Initiated HIV Counseling and Testing.

Shared Confidentiality:

The third major shift in the philosophy of the counseling and testing services adopted is shared confidentiality, where HIV positive status of the client can be shared with health care providers; hence the better medical care like chemoprophylaxis for opportunistic infections (OI), TB treatment etc can be rendered. This became essential after expansion of the PPTCT services and the roll out of intensified HIV TB package in the state from April 2009 whereby every case of tuberculosis has to be screened for HIV and every HIV positive shall be referred to TB facility for the screening. This cross referrals essentially required to share the HIV status with people from RNTCP. This sharing became also essential if the PLHAs are to be extended certain other benefits such as travel assistance to PLHAs for taking ART services or for taking financial support as nutritional assistance. Consequent to shared confidentiality within health sectors provide the opportunity to other health providers to work with HRG population and PLHAs which in long run reduces the stigma and discrimination prevailing (against PLHA) in all sections of society with no exception to health department.

Community based HIV Testing:

In 2010, NACP has decided to expand counseling and testing services from four walls of the clinics to the people. Community based HIV testing is the latest strategies evolved under which by “whole blood finger prick method” screening of pregnant women for HIV will be carried out at field level. ANM and staff nurses during their “Mamta Diwas” and “direct walk in labor” respectively shall administer the test in the field, and based on the result the suspected positive mother will be sent for confirmation of HIV at nearest ICTC for counseling and testing in laboratory. Gujarat had target of starting 110 Facility Integrated (FICTC) at 24 X 7 PHCs in 2009 – 10 and could start 107. This year the target is to start 388 such facilities but we are hopeful to go beyond this by including all PHCs. While Ahmedabad district has already done it for its all 33 PHCs (data started arriving for Mar 2010), other districts are also on the way.

Testing Performance Gujarat Scenario:

ICTC-General: ICTCs (General) focus at clients with at high risk of contracting HIV infection, mainly the people with high risk sexual behavior, STI cases, TB cases and suspected AIDS cases. In the year 2002, in Gujarat total 45911 people were tested for HIV which increased to 508266 in 2009-10 against the target of 400000. The HIV positives detected also increased by more than 10 times from 3,436 (2002) to 15038 (2009 -10).

ICTC-PPTCT: Parent to Child Transmission is the most significant route of HIV transmission in children (< 15 years). The chance of HIV transmission from infected mother to child is 30-40 %, which can be reduced to 7% by early identification and administration of Nevirapine at the time of delivery. In Gujarat in 2005, total 22193 pregnant women were counseled and tested yielding 173 pregnant women found as positive while Nevirapine could be administered to 83 mothers and baby MB pairs). Coverage in 2009 – 10 has increased to 388824. Out of this 931 pregnant women were found positive and 68 underwent MTP. Out of total live births, 505 MB pairs were given. MB pair coverage has increased from 42.2% (2002) to 58.5% (2009-10). This improvement is not acceptable as the goal is to ensure the administration of MB pair to all positive pregnant women with institutional delivery. Similarly the coverage of only 3.88 lakhs pregnant women against 1.2 – 1.3 million annual pregnancies (30 %) in the state is another area which needs attention.

HIV-TB Coordination: Tuberculosis is the commonest opportunistic infection reported in AIDS cases in India and also leading cause of death in AIDS patients. To pick up the early AIDS Cases and reducing the mortality in the AIDS cases due to TB, in the state HIV-TB coordination is initiated, in the year 2006-07. In the first year total 3231 clients were crossed referred and total 430 people were identified as co-infected. In the year 2009-10, total 63,634 people are crossed referred and 1237 (till Feb 10) were identified as co-infected. However, the current estimate of such co infected cases will be between 3600 – 4000. Our aim in 2010 - 11 is to provide the F-ICTC type facility at every Designated Microscopy Centre (DMC) under RNTCP to pick up the rest of co infected cases as well.

ICTC ART Linkages: In Gujarat with presence of 14 ART centers (3 more to start within month) and almost 500 testing facilities this linkage is showing the improvement. It is strongly emphasized with ICTC staff to ensure the referral of every positive person to the nearest treatment facility. The scheme of Project “Jatan” by state government for providing travel assistance to PLHA to reach at ART centre has also been helpful. This referral percentage for newly

detected HIV positives has been between 89 – 93 percent in various quarters of 2009 – 10.

Formation of DAPCU:

Till 2008 – 09, NACP did not have any district structure and thereafter a small structure called District AIDS Prevention and Control Unit (DAPCU) was created in 10 including 6 A category (Surat, Navsari, Mehsana, Dahod, Surendranagar) and 4 B category (Ahmadabad, Vadodra, Rajkot, Bhavnagar) districts of Gujarat. DAPCU comprises of one District Program Officer, one District Supervisor, three divisional assistants and one helper and works under the chairpersonship of Chief District Health Officer (CDHO) in District Health Society. Looking to the special disease load and epidemiological factors of HIV in Surat city, a special unit called Surat AIDS Prevention and Control Unit (SAPCU) has been created with the support of Surat Municipal Corporation – another example of mainstreaming and integration with main system and local ownership. Later on in 2009-10, DAPCU like mechanism was created in all other C and D category districts where one officer from District Health Team was assigned additional responsibility. This opportunity is best used for developing the system in district over and above continuing the efforts mentioned previously. The success so far achieved especially in the area of testing has been possible by mainstreaming the services with General Health System which has been possible largely through operationalization of DAPCUs and SAPCUs.

Challenges faced:

Counseling and testing services in the state started way back in the year 2002, but with two spells of huge expansion and changes in the strategies as well as thrust areas lots of challenges came/coming in maximizing the benefits of these services. Few of the important challenges faced are listed here..

- Demand generation and acceptance by the community.
- Owning of the ICTC services by CHC or hospital authorities.
- Making availability of separate counseling room with audio-visual privacy.
- Preventing unnecessary testing at counseling and testing centers (routine pre operative testing).
- Ensuring quality of counseling.
- Ensuring coverage of mother & baby through Nevirapine.
- Follow up of Infant for HIV testing up to 18 months of age.
- Integrating the services with Primary Health Care.
- Back up of wider network of care, support and treatment services
- Stigma and discrimination to HIV positive person within health sector.

- Expansion of the counseling and testing services in Private facilities and ensuring its protocol in the private sector.

Gujarat's Response

Counseling and testing services is expanded below the district and now NACO is harboring an ambition to have a community based HIV screening program Presently National AIDS Control Program was having no district structure till year 2008-09 and subsequently a small structure at selected 10 Districts (Category – A & B districts). The success so far attained could be attained by mainstreaming the services with General Health System and various innovative approaches.

Before DAPCU formation:

- All awareness materials printed, activities linked with counseling and testing services were carried out centrally from GSACS.
- For first two year of scaling up Centers /districts were given grant for local awareness about availability of service centers.
- Sensitization meetings of the ICTC in-charges, district health official.
- Quarterly Regional review by senior officials of GSACS (APD or JD) under the chairpersonship of Regional Deputy Directors (senior official looking after 5-6 districts) where presence of ICTC in charge was mandatory.
- A senior pathologist/microbiologist was identified as District Nodal Officer (ICTC) for monitoring and providing technical support to all ICTCs in the district. They are working at the district hospitals – medical colleges an having experienced as an VCTC in charge since year 2002
- Peer Support Group (PSG): A group of 36 senior counselors were identified and trained to provide technical support to fellow counselors, especially new and poorly performing centers.
- Regular field visits by GSACS officials

After formation of DAPCU

- Capacity Building of DPOs and District Supervisors.
- Scope of HIV-TB coordination meeting (held on every 7th of the month) is expanded to Monthly ICTC review meeting from year 2008-09 which is further expanded to C & D districts in the year 2009-10.
- A structured format for the review is developed.

- All officials from the ICTC Division attend monthly review meeting at different districts in rotation.
- Line Listing of ANC is stringently implemented for PPTCT services.
- Line listing for PLHA is developed for ART linkages and spousal-child testing.
- Developing coordination mechanism with Targeted Intervention of the districts, like implementation of TI-ICTC coordination form and participation of TI representative in monthly ICTC review meeting.
- Tracking of HIV testing through HRG line listing at TI project.
- Coordination with STI is improved at the institutes where a STI clinic is present.
- Implementation of the Intensified HIV TB Package in two phases, (in category A & B in year 2008-09 and in category C & D in year 2009-10).
- Post of PPTCT Out Reach Workers (ORWs) sanctioned for high prevalent districts are relocated to high prevalent Talukas (blocks) of other districts. However, now this scheme has been discontinued from march 2010.

Future steps.

- In Category C & D districts, support for the District Supervisor and 2 PPTCT Outreach Workers (for each districts) is sought for the year 2010-11 in the state PIP.
- Community Based HIV screening of pregnant women by ANM through whole Blood Finger Prick method.
- Establishing F-ICTC in all remaining CHC and primary health centers in phased manner over three years. In first year priority will be given PHCs with Designated Microscopic Center (DMC).
- Inclusion of the PPTCT related fields in the Mother & Child Health (MCH) software being prepared under RCH for tracking HIV positive mothers and exposed babies.

Over the time period, journey of the counseling and testing centre has moved from the Medical college to community doorsteps, from “opt in” to “opt-out”, from voluntary to provider initiative, from diagnosis to prevention. It is an uphill task but coordination, collaboration, innovation and integration are the pillars on which the edifice of the program can grow, consolidate and sustain successfully.