ICTC strategies for NACP-IV

Counseling and Testing services

Strengths

- ICTCs in multiple models
  - Stand alone, F-ICTCs, mobile
  - National policy for C&Testing
  - Programme structure for service delivery
  - EQAS

Weakness

Branding ICTC- stigmatising if stand alone

Dilution of HIV counselling –if integrated without commitment and ownership by NRHM

Cumbersome M& E system with duplicate recording processes adding to workload

Supply Chain management issues

Poor links with blood bank , STI services

Poor access/utilisation by HRGs and other vulnerable community

Gaps between ICTC and ARTCs

Private sector involvement not encouraging

Opportunity

Testing policy (more inclusive)

Community mobilisation (DLN, DIC, NGOs for continuum of care

ICTC- ART linkages

Integration of NACP –ICTC component within NRHM

Threat

Time bound external Funding

Resistance from NRHM to integration and ownership

Counseling and Testing services

- 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
- Simplify M& E system avoiding duplicate recording processes which add to the workload
- Focus on Couple couseling, family couseling and contact tracing
- Address supply Chain management issues- use NRHM systems (Eg: TB programme)
- Strengthen links with blood bank , STI services
- Increase access/utilisation by HRGs and other vulnerable community

  (**X**pand services with TIs,)
- Increase community involvement (DLN, DIC, NGOs for continuum of care and peer counseling)
- Use of ELISA in high load ICTCs

Increasing access

- Expand services with state specific strategies
- Community based screening
- Flexible timings of ICTCs

INTEGRATION

Strengths

- Technical expertise built
- Rights based services in HIV prog- a first
- Existing HIV related services are (all) in general health facilities
- Involvement of communities (DIC,CCC, ORWs etc)
- HIV-TB linkages

Weakness

- Varying capacity of state health system
- Demand for integration only from HIV sector – Not from general health system
- Limited allocation for HIV services from National budget
- Access to counselling and testing services poor specially in low prevalence states

Opportunity

- Leverage funds from NRHM- state PIP
- Integration can be state specific in phases
- Transition towards integration possible in states with stronger health system
- Relook at lessons from integration of other programmes
- Available HR & functional system & management structure of NRHM more spread- scale up possible

Threat

- Job insecurity of existing staff in case of integration
- Strong reluctance of NRHM to integrate

PITC

Strengths

- Informed testing
- Well established in TB, ANC, STI

Weakness

M +E/ reporting
Training capacity / logistics
Referral (STI, Blood bank)

Opportunity

- high yield in some pilots studies
- Readily available clientele

Threat

- Rights
- Stigma and discrimination
- Consent/opt out

Recommendations

- Expand to priority OPDs in priority states and districts
- Training
- Intra – inter programme linkages
- To ensure opt out policy

Recommendations on use of epidemiological data from ICTC

- PPTCT data for ANC prevalence can be used when coverage is sufficiently (more than 60%?)
- Caution:
  - Address duplication
  - HIV case reporting at ICTC: Reporting from low burden states may not be representative of the epidemic in state
  - Reporting Quality of data from F- ICTCs (by Nurses)

Quality issues

- Better coordination between states and centre in NACP4; states and districts
- MD NRHM should be PD SACS
- **Sensitise** Principal Secy. Health, senior health officials, and at the district and at political leadership on HIV issues – address stigma in the system
- Counselling component in NACP- 4 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).
- **Logistic , supply chain management** strategy relooked
- **Rationalise salaries** of counsellors recognizing the important role they play
- **Strengthen monitoring** , supportive supervision feed back etc.
- Promote “ownership” and accountability of Hosp. superintend & district health officials in management and performance of ICTCs

HR and quality issues

- Address weakness in selection of best candidates (aptitude, attitude etc.) for counselling (bribery, favoritism etc), besides qualification
- Relook and define (quality, qualifications, experience, track record etc) while selecting senior management staff at SACS-
- Put in place performance appraisal system at all levels of progarmme and link this to career progression
- Job satisfaction and better pay- non monitory incentives, social recognition, participation in conferences etc.
- Clarify job descriptions- Rationalise staff structure

Capacity building

- Use round 7 institutes to train counsellors and Nurses
- Experiential Training of staff nurses in ICTCs
- Supportive supervision to nurses for counseling
- Prepare different training modules to train staff nurse and ANM

Innovations

- Sharing practical experience in the field
- PLHA mapping for making route maps for mobile ICTCs
- Supportive supervision for on going capacity building
- Pilot a quality assurance system of ICTC services- district focused. For eg: Monitoring tools – Developed by AP.

Other issues

- Improve the infrastructure of existing facilities
- Number of tests in packs of 10 tests
- Provision small refrigerator in labour room – NVP
- Quality of condom and distribution of lubricants
- Use of new testing technology
- IEC materials with more themes – display boards

Proposed studies

- Mobile ICTCs
- Linkages – barriers
- Piloting HIV testing of all OP and IP patients in one or two districts
- Assessment of F-ICTC
  - OR –recording and reporting
- Quality of counselling –methodology
- HIV testing of TB suspects
- Access to testing of HRG