

A SINGLE WINDOW COMPREHENSIVE HIV PREVENTION AND CARE FACILITY: THE NEXT STEP IN HIV PROGRAMMING



Sunil S Solomon^{1,2}, Prof Suniti Solomon¹, Allison M McFall², Aylur K Srikrishnan¹, Santhanam Anand¹, Shobini Rajan³, Vinita Verma³, Canjeevaram K Vasudevan¹, Pachamuthu Balakrishnan¹, Elizabeth L Ogburn², Prof Lawrence H Moulton², Muniratnam S Kumar¹, Kuldeep Singh Sachdeva⁴, Oliver Laeyendecker², Prof David D Celentano², Prof Gregory M Lucas², Prof Shruti H Mehta²

EXECUTIVE SUMMARY

The National AIDS Control Programme (NACP) envisages ending AIDS as a public health threat by 2030 and has adopted the Fast Track targets of 90-90-90 to be achieved by 2020 that is 90% of People Living with HIV (PLHIV) who know their status; 90% of PLHIV who know their status on Antiretroviral Therapy (ART) and 90% of PLHIV on ART with suppressed viral load. Despite significant progress in the coverage of the HIV programme in India over the past two decades, there are still a considerable number of people who are left behind i.e they are not yet reached by the national programme efforts. Today, the ART centres are thought to be overburdened, and the NACP proposes models of ART decentralization and ART incorporation with other essential services for PLHIV and other at-risk/vulnerable populations.

The National Collaboration on AIDS (NCA) study was conducted by Johns Hopkins University, USA, Yeshwanth Raghunath Gaitonde Centre for AIDS Research and Education (YRGCARE), and the National AIDS Control Organisation (NACO), India in order to test the feasibility and acceptability of a single window approach to improve HIV service delivery for Men Who have Sex with Men (MSM) and Injecting Drug Users (IDU). The NCA study was implemented across 22 Indian cities where Integrated Care Centres (ICCs) were established.

The study validated the feasibility of setting up a single window comprehensive health care model in both public sector and private sector venues. The ICCs provided a bouquet of HIV prevention and treatment services under a single roof and catered to a large number of clients, about a third of whom had not been reached through the traditional Targeted Intervention (TI) programmes. In conclusion, community-based care models that are non-Key Population (non-KP)-identified but in KP-enabling environments, delivering essential HIV prevention, treatment and other support services (e.g., mental health, non-communicable diseases) may potentially play a key role in ensuring India meets the 90-90-90 targets particularly for communities left behind, such as IDU, MSM and other Key Population (KP).



The NCA study was **implemented across 22 Indian cities** where Integrated Care Centres (ICCs) were established.



THE ISSUE

The NACP envisages eliminating AIDS as a public health concern by 2030 and for the same has adopted the Fast Track targets of 90-90-90 to be achieved by 2020 that is 90% of PLHIV know their status; 90% of PLHIV who know their status on ART and 90% of PLHIV on ART with suppressed viral load. Early initiation into treatment and retention in care and treatment results in effective viral suppression. With the PLHIV clinically stable, viral suppression significantly reduces the risk of ongoing transmission of HIV (i.e. treatment as prevention) and it also helps to reduce inflammation associated complications such as cardiovascular disease through immune mediation.

However, despite significant progress in the coverage of the HIV programme in India over the past two decades, there are still a considerable number of people who are not reached by the NACP efforts. It is also a matter of serious concern that the current 12-month ART retention rate in the national programmes is estimated at around 72%¹. Pill pick-up behavior of 67,622 PLHIV initiated on ART between January 2016 and May 2016 showed a significant decline in the retention rate among newly initiated PLHIV.

The NACP in India provides all the key services mainly through a centralized discrete service delivery model and the ART centres are currently believed to be overburdened. Community members, particularly KPs, have expressed a keen desire to access care and treatment services in decentralized settings in non-judgmental and enabling environments. Due to services being made available via independent venues, many community members desist from making multiple health visits to prevent loss of wages. Also, there are a large number of KP community members who would prefer to access services at non-KP identified venues that are non- TI settings.

A decentralized integrated "single window" HIV prevention and treatment services delivery model might address several of those concerns. The NACP is therefore, considering models for the decentralization and integration of ART with other essential services PLHIV and other at-risk/vulnerable populations may need.

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¹Analysis of dispensation data in IMS of PLHIV initiated on ART between Mar.-15 and Mar.-16 (except Dec.-15)

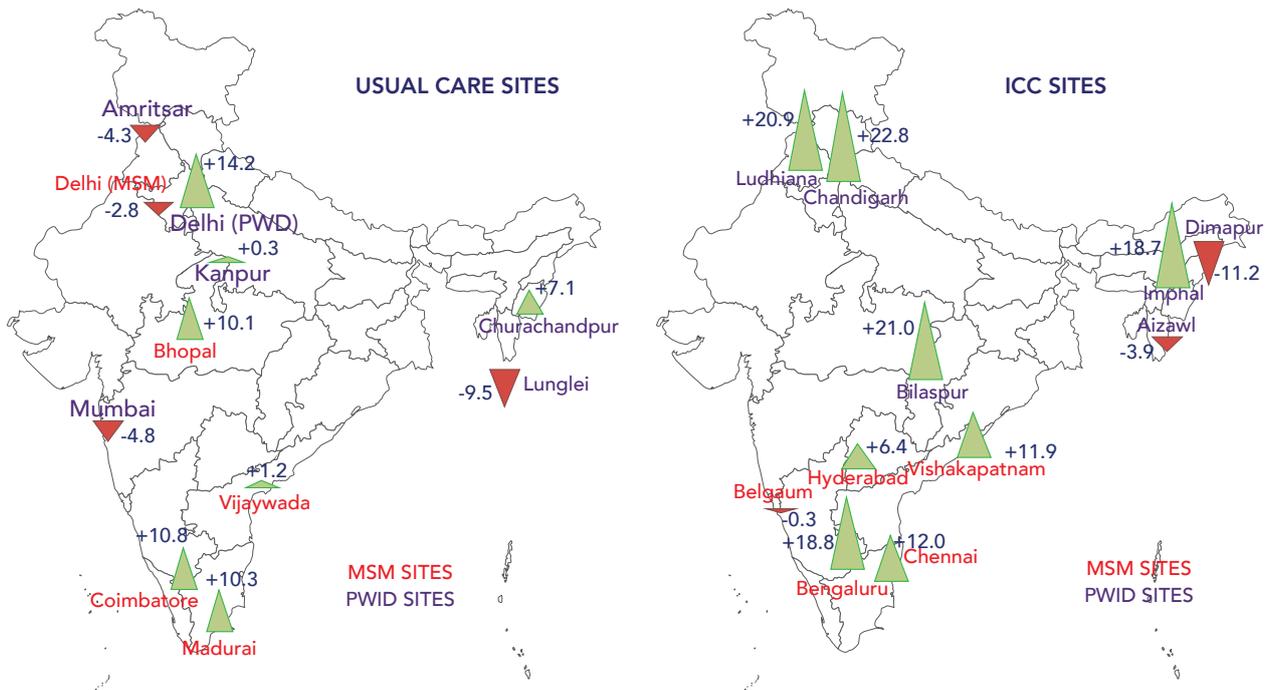


THE STUDY

The NCA study conducted by Johns Hopkins University, USA, YRGCARE, India and the NACO India tested the feasibility and acceptability of a single window approach for improving HIV service

delivery for MSM and IDU. The NCA study was implemented across 22 Indian cities where ICCs were established.

Figure 1. Study sites with change in absolute percentage point difference in community-level recent HIV testing.



THE METHODOLOGY

The NCA study was a cluster-randomized trial that was implemented across 22 Indian cities (Figure 1) where the intervention (ICCs) was nestled between two sequential cross-sectional surveys (i.e. baseline and evaluation surveys) conducted approximately three years apart (Figure 2).

The ICCs, positioned as a venue where KP could access services in a friendly enabling environment, offered a bouquet of HIV prevention and treatment services under a single roof. The ICCs were never identified as a KP-specific venue.

The staffing structure and roles/responsibilities of the ICCs are listed in Table 1.

Figure 2. Study Design and Timeline

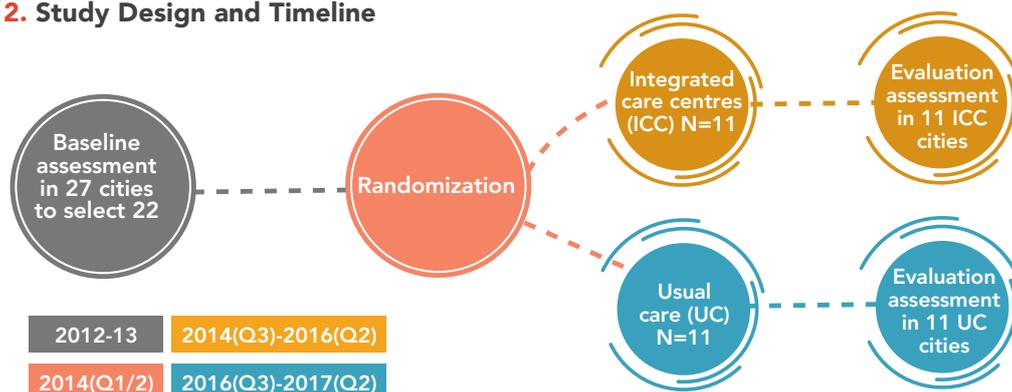


Table 1. Staffing at ICCs with responsibilities

Designation	Key responsibilities
Site coordinator	Overall Manager who manages various functions and external relations; coordinates with SACS, DACS and TSU; maintains records and supervises day-to-day operations of the site; ensures monthly and quarterly performance milestones are achieved; creates linkages to support services as needed collaborating with SACS, DACS, DAPCU.
Counsellor	Provides high quality counselling services ranging from risk-reduction to adherence counselling and motivation interviewing for PLHIV; facilitates spousal/partner testing and/or referral to health care as required; provides information to clients to ensure timely utilization of services.
Lab technician	Tests and provides results for HIV and other associated lab tests (e.g., HBsAg); coordinates with ART centres (for CD4) and ICTC (for confirmatory testing); ensures lab kits are not past expiry
Nurse	Provides nursing services (e.g., weight, height, blood pressure); screens for TB using 4-symptom screen; abstracts information from ART book to generate reminders for refill visits; remind client of next visit date to ART centre; screen for STIs and delivers NACO-approved STI test kits according to the symptoms elicited.
Logistics assistant	Ensures smooth client flow within ICC and transportation of samples to ART (for CD4) and ICTC (for confirmatory testing).
Outreach assistant	Work with NGO partners to set-up outreach meetings; conduct informal meetings with opinion leaders and provide feedback to the site-coordinator; develop peer educator groups amongst different social networks; track clients due for ART refill or repeat HIV testing.

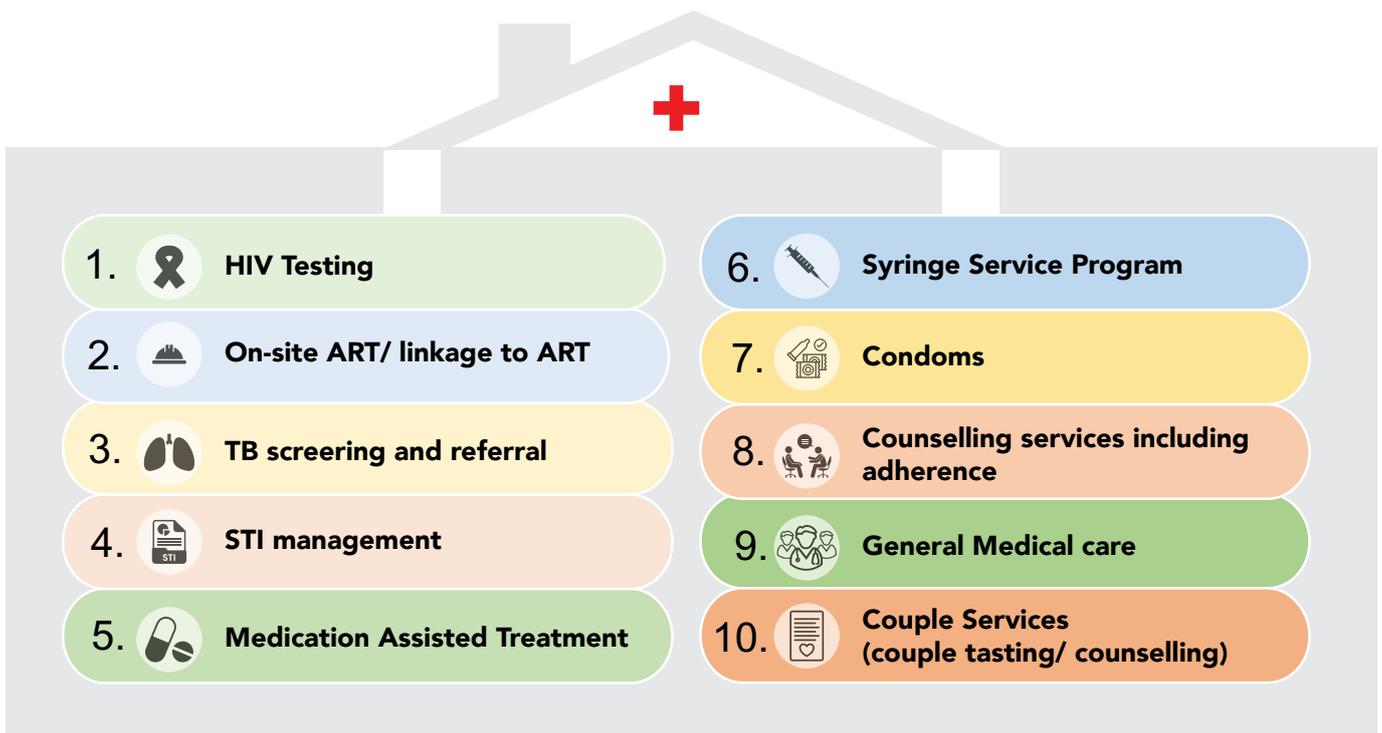
NOTE: Pay for all of the above is on par with current guidelines of NACO for TI personnel. SACS: State AIDS Control Society; DACS: District AIDS Control Society; TSU: Technical Support Unit; DAPCU: District AIDS Control Prevention Unit; HBsAg: Hepatitis B Surface Antigen; ART: Antiretroviral therapy; ICTC: Integrated Counselling and Testing Centre; TB: tuberculosis; STI: sexually transmitted infections;

The various services provided included: (1) HIV testing; (2) on-site ART (Aizawl) or linkage to ART/provision of refills; (3) medication assisted therapy; (4) syringe service programme (in the field); (5) general medical care; (6) TB screening and referral; (7) counselling services including adherence counselling; (8) condoms; (9) management of STIs; and (10) couple services (e.g., spousal testing, etc.). All of these services were made available via the existing programmes by coordinating supplies with the States AIDS Control Society (SACS) (Figure 3). The staff at the centres (ICCs) were sensitized to the challenges faced by KP while accessing services.

Two critical components that were novel to the ICC model were: (1) development and implementation

of an electronic health management system which tracked clients using biometric data (fingerprints); and (2) client satisfaction surveys that were used to improve service delivery at the ICCs. Four MSM and three IDU ICCs were integrated into existing public sector venues – in the North-East all IDU ICCs were established within existing government funded TI Non-Governmental Organisations (NGOs) as the majority of Medication Assisted Therapy (MAT) deliveries in the North-eastern states occur via NGOs. Hyderabad was the only city where an MSM ICC was established in a private sector venue.

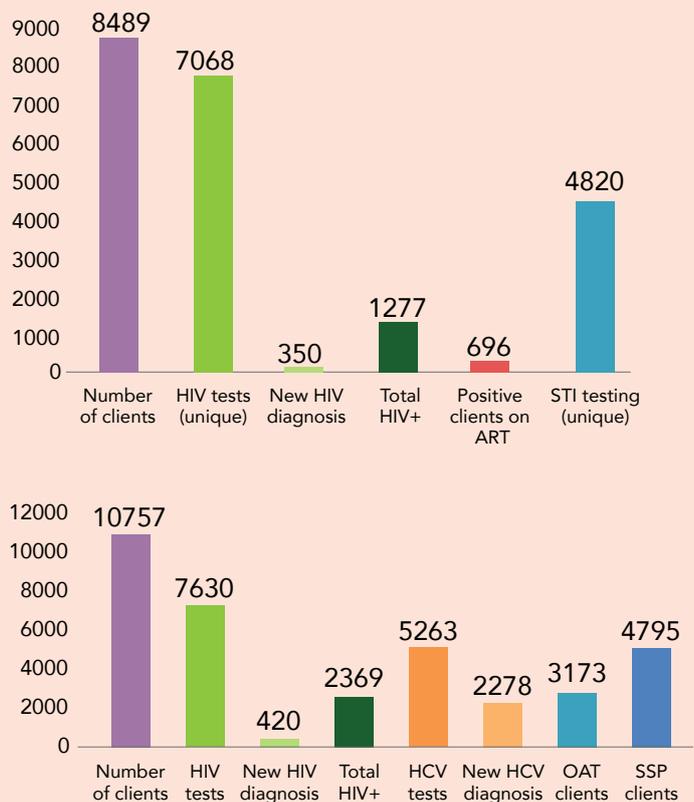
Figure 3. ICC Model



FINDINGS

- A total of 8,489 unique clients visited the five MSMs ICCs and 10,757 unique clients visited the six IDU ICCs (Figure 4).
- Almost all the clients were satisfied with the services and the environment at the ICCs (Figure 5).
- There was a total of 21,949 and 7,06,798 unique visits to the MSM and PWID ICCs, respectively. In some of the IDU ICCs, there were over 500 clients visiting the ICC every day for MAT (Figure 6).
- Overall, there was an 8-percentage point increase in testing at the community-level at the ICC cities compared to the control cities; among the IDUs, the improvement was 11-percentage points and among the MSM the increase in community-level testing was 4-percentage points. None of these findings achieved statistical significance.

Figure 4. Client footfall and service utilisation at the ICCs



- On an average, only about 26% of the KPs in a city visited an ICC, highlighting the need for demand-creation strategies to be incorporated into HIV programming. However, KPs who visited an ICC were three and a half times more likely to have been recently tested for HIV compared to KPs who did not visit the ICC.
- Clients who visited the ICC were also more likely to be aware of their status and initiate ART (Figure 5). The cities with the higher coverage of KPs via the ICC were also the cities with the larger increase in the community-level testing. For example, in Imphal, where the ICCs are believed to have reached over 50% of the IDUs, a 19-percentage point increase in recent HIV testing among IDUs was observed.
- None of the 60,000 MSM/IDUs sampled throughout the duration of the study refused biometric data capture. Some refused to provide a thumb impression but were willing to provide other data.
- NGO partners reported that a considerable number of the clients (20-40%) reached during Respondent Driven Sampling (RDS) and the ICC service delivery period were new clients

and were not part of the TI line listing (Figure 6). This results is consistent with results from other projects which demonstrated that there are a large number of KPs who do not want to be identified as KPs and prefer to go to venues that are non-KP identified.

- An electronic health management system with automated reporting allowed for easier monitoring of the programme as well as assisted site-staff in identifying clients who were due for ART refills, HIV re-testing, etc.

Figure 5. Client satisfaction surveys at the ICCs

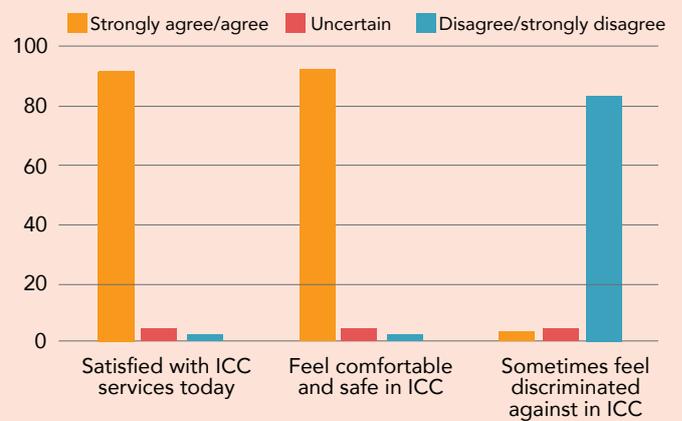


Figure 6. Clients waiting for MAT and other services at the ICC in Ludhiana

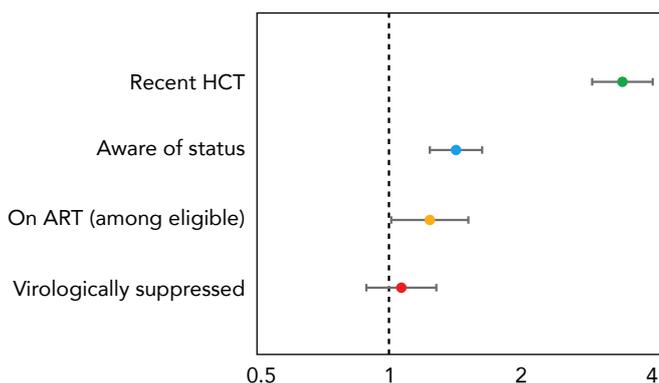




LEARNINGS

- This cluster randomized trial validated the feasibility and acceptability of establishing a single window comprehensive health care model in both public sector and private sector venues.
- The traditional TI programmes did not reach about one-third of ICC clients partially because the clients did not want to go to traditional TI venues for fear of being identified as MSM or IDU (Figure 7). In some ICCs, the clients also brought their spouses in for HIV testing – this was particularly common in the ICCs in the North-eastern states.
- Biometric data can be used as unique identifiers even among KP in India and will allow patients to be tracked across a variety of service delivery points while at the same time avoiding double counting them.
- The electronic health system that was also implemented as part of the ICC study served as a useful tool to identify clients who were in need of services and prompted the site coordinator and service staff to track those clients.
- The utilisation of client satisfaction surveys gave the clients a sense of ownership of these venues.
- Clients often requested making other services available such as blood grouping and screening for blood sugar and hypertension.

Figure 7. Care cascade comparing clients who visited vs. did not visit the ICCs (restricted only to the 11 ICC sites)



RECOMMENDATIONS

- Implement community-based care models in non KP-identified but in KP-enabling environments, delivering essential HIV prevention, treatment and other support services (e.g., mental health, non-communicable diseases) via a “single window model”. It would play a key role in ensuring that India meets the 90-90-90 targets particularly for the populations left behind such as IDU, MSM and other KP.
- Adopt strategies e.g., Enhances Peer Outreach Approach (EPOA) to improve utilisation of these ICCs and demand-creation strategies that would be incorporated into HIV programming.
- Explore collecting biometric data from KPs as IDU and MSM across 22 Indian cities did not have any major concerns providing biometric data to track service utilisation.
- Establish an electronic database linked to a unique identifier as it permits tracking of clients across service venues while avoiding double counting them.
- Undertake client satisfaction surveys as it provides clients a sense of ownership of the facilities that they utilise. While this is currently not the norm in public sector facilities, it could assist in improving the quality of services while giving communities and PLHIV a sense of ownership of the facilities.
- Start thinking beyond HIV through the integration of other services that PLHIVs and KPs would need into these models (e.g., high blood pressure and blood sugar testing, social support services, and management of non-communicable diseases). Integrating such low-cost health services into this model could further enhance the effectiveness of the model.
- Recognise need for an alternate/additional strategy to target services to these KP who do not want to be identified as KP.
- Leverage on other strategies such as the EPOA, which was recently adopted as part of the TI-revamping programme. It may enhance the effectiveness of the ICCs.

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Note: For any information on the study, kindly contact Dr Sunil Solomon, Chairman, YRG CARE at sss@yrgcare.org and/or Ms Vinita Verma, Programme Officer (Evaluation & Operational Research), National AIDS Control Organisation at vinitaverma.naco@gmail.com

