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National AIDS Control Program (NACP III) India - Program Evaluation & Comparative Analysis.

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ABSTRACT

Background: HIV/AIDS currently plagues all parts of the world however some countries are more affected than the others. India has the highest number of people living with HIV in the world, ranks third in terms of number. An estimated 2.1 million people are HIV infected, with a prevalence rate of 0.34%. In its struggle against HIV/AIDS, India developed and implemented the Third National AIDS Control Program (NACP III). One of the major strategies under NACP III is increased HIV testing. According to the WHO, health outcomes can be significantly improved with appropriate local HIV testing strategies. This study analyses and compares HIV testing aims and strategies in the NACP III (2007-12) and the 2001 United Kingdom National Strategy on Sexual Health and HIV. The aim is to evaluate whether the Indian HIV testing guidelines resonate with the international standards. **Methods:** This study attempted to examine the contents of the Indian national policy document against AIDS, the National Aids Control Programme (NACP-III) to discuss if the set objectives have been achieved. A cross-country analysis of Indian national HIV/AIDS policy and the UK policy was done, based on a framework which is an adaptation of Bardach's eightfold path for policy analysis. **Results:** This includes eight simplified and practical steps. NACP testing aims and strategies will also be compared with the international/WHO protocols against AIDS and differences & similarities discussed. Possible alternatives that might inform policy change will be explored. **Conclusion:** The review of the NACP III reports impressive improvements in health outcomes; however, although explicit at the document level, the policy falters at the implementation level in some aspects. The UK policy is comparatively more successful at the implementation level and is better in keeping with the WHO protocols and standards than the NACP III. In summary, the NACP III is undermined by poor infrastructure, low economic and human resources.

Keywords: AIDS control India, NACP III.

INTRODUCTION

This article attempts to broadly examine the contents of the National AIDS control policy of India (NACP III) and specifically focus on the HIV testing aims, targets and outcomes. It aims at content analysis of the policy and to discuss if the set objectives have been achieved. Some aspects of policy making process also were considered such as factors influencing decision making & outcomes including key stakeholders, political and social factors. Policy Analysis is a technical tool for evaluation of policy, monitoring the implementation and assessing progress & effectiveness of the policies in achieving set goals.[1] For this purpose, the study incorporates a simplified adaptation of Bardach's Eightfold Path framework proposed by Collins,[2] with a qualitative methodology approach. Some inferences have been drawn relating to long term health outcomes of people living with HIV/AIDS from the analysis of the HIV testing aims and strategies enshrined in the NACP III. This was compared with policy contents of UK's National Strategy for sexual health and HIV.[3]

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By the end of 2008, global statistics on HIV/AIDS epidemic put the total number of HIV infected people at an estimated 33.4 million. Of which 2.8 million were new infections and the total number of deaths due to AIDS in 2008 were reported to be about 2 million.[4] 60% of the world's population lives in Asia, which is second only to sub-Saharan Africa in the number of people living with HIV. India accounts for about half of Asia's HIV prevalence at 0.31%, however this translates into a large portion of the global HIV burden due to the massive population of the country. An estimated 2.4 million people were living with HIV/AIDS in 2009 with an incidence of 120,000 in the same year, children accounting for 3.5% and women for 39% of the cases and 170,000 deaths due to AIDS related causes.[5] In a country which is plagued with poverty, illiteracy, poor health and social stigmas, HIV/AIDS presents a daunting

task. It is one of the most threatening challenges to development and social progress of India. The epidemic exacerbates poverty and inequality, and increases the burden on the most vulnerable people in society i.e. the elderly, the women, children and the poor. Presently, HIV/AIDS affects all sections of the society in India and not just the groups it was originally associated with; sex workers and truck drivers.[6]

According to the WHO, an estimated 55% of the resources are required by the health sector alone from the total allocation to HIV/AIDS. Its HIV/AIDS program is based primarily on five strategic directions, one of them is to enable people to know their HIV status.[7] The HIV/AIDS imbroglio gets more complicated due to the fact that many of those infected with HIV are unaware of their status. Thus the WHO program directs the integration of HIV testing into a broader range of services, by working with stakeholders and partners to expand HIV testing and counselling. This can be achieved through co-ordination, advocacy, standardized protocols and technical support. The WHO identifies HIV testing and counselling to be of paramount importance in both prevention and treatment of HIV/AIDS.[8] It further notes that the testing services have poor reach in low and middle income countries. Only 10% of the people who might have been exposed to HIV infection have access to voluntary counselling and testing in these countries. The document also reports high ratio of non-uptake of testing services even in settings where they are offered. It asserts the hard fact that stigma and discrimination still prevent people from taking the HIV test. In response to this, the mainstay of the up-scaled HIV testing services includes strategies and measures to tackle stigma and discrimination. This is compounded with improved access to integrated preventive, treatment and care services. The setting in which people undergo HIV testing should be based on the tenets of respect for individual rights, confidentiality and ethical conduct.[8] The WHO guidance on HIV testing and counselling aims to bring together medical ethics, human rights and clinical & public health objectives in synergy to achieve better outcomes.[9]

The WHO categorizes HIV testing and counselling into two main types,[9] Client Initiated Testing and Counselling (CITC) and Provider Initiated testing and counselling (PITC). HIV testing has been provided primarily as a client-initiated voluntary counselling and testing service around the world, but the use of provider-initiated approach in clinical setting is also being increasingly promoted. In its policy statement, the WHO avers that HIV testing should be offered by health care providers in a context where there is assured provision of,[8] and/or referral to effective prevention and treatment services. Provider-initiated testing is the norm in many European countries. The testing guidelines recommend that individuals aged 16 years and older who seek evaluation and treatment in STI services or dermato-venereology clinics, should be offered advice on testing for HIV.[10] The UK is an example of open access to provider-initiated HIV testing, offered and promoted at Genito-Urinary Medicine (GUM) clinics.

"Policy making is not just about making a decision at a certain point in time, but needs to be understood from the context of ongoing interactions and conflicts among institutions, interests and ideas. As a result, politics, ideology and ignorance have greater influence on HIV policy than do evidence and best practice. Thus analysis which identifies the obstacles and opportunities to evidence informed policy should constitute a core feature of every national HIV response".[11] Examining the interactions among institutions, interests and ideas in HIV policy of India will bring out a clearer picture of what has let to particular outcomes of HIV testing.

Strategy under NACP III:

NACP III aims to achieve to achieve its goals by a four-pronged strategy:

1. Prevention of new infections,
2. Provision of greater care, support and treatment to the already infected,
3. Strengthening of infrastructure, systems and human resources, and
4. Development of strategic information management systems (SIMU).

HIV testing is an integral part of each of the strategy. Among other interventions, prevention of new infections also requires the infected person to know his status to prevent further transmission. Second strategy holds good after a person is tested and is HIV positive. Strengthening of infrastructure includes provision of better testing services. Development of SIMU includes improved reporting & management of HIV test results. NACP III proposes to merge VCTC with antenatal services and other related treatment facilities such as tuberculosis centers, renamed as Integrated Counselling and Testing Centers (ICTC). ICTCs will provide basic information on HIV prevention and referral services.[12]

MATERIALS AND METHODS

This study is based on Policy Analysis as the principal research method. The process in which alternative programs/policies are identified and evaluated with an intention to resolve economic, physical and social problems is called Policy Analysis.[1] It is a technical tool for evaluation of policy, monitoring the implementation and assessing progress & effectiveness of the policies in achieving set goals. According to Spicker,[13] this involves practical application of social-science principles, which helps in making effective judgment about public policy. There is analysis of policy, which seeks better understanding of an existing policy, its context and implications; and there is analysis for policy, which seeks understanding of the prevalent

context and conditions for improvement of an existing policy and/or to inform future policy planning. And there are analyses that involve both the activities.[13] This study is carried to determine the relationship between stated goals in the policy and the outcomes, and to identify alternative policy statements and goals that successfully achieve the target.

This research is an example of 'Content Analysis', which are largely retrospective and descriptive studies. They look back at particular perspectives and strategies, exploring how & why they made their way into the policy and to assess if & how they have achieved the set goals.[14] This differs from analysis for policy, which is generally prospective; carried out either to inform policy formulation or to anticipate the outcomes of a policy. This method analyses content of the policy and not the process of the policy.[15] The prime focus of this study is the analysis of the contents of policy (NACP III), with critical examination of a significant policy issue (HIV testing) and ways to efficiently address it are explored. In agreement with Bardach's view, Collins further posits that when looking at policy analysis, it is between analysis of policy process and the analysis of policy content.[2] The main focus of process analysis is policy formulation and the main focus of content analysis is the substance of the policy. Content analysis examines a significant policy issue and explores the options to tackle this issue, as is attempted in this study.

RESULTS & DISCUSSION

From the evaluation of the HIV testing aims, it was evident that the mainstay of NACP III was integration of programs for prevention, care and treatment to achieve the overall objectives. It urged the utilization of non-governmental and private health institutions to aid the purpose. Another important strategy is the decentralization of services for better outreach.[12] The UK policy advocates providing comprehensive local HIV services by setting up of more specialized health centers. It acknowledges the fact that HIV testing and counselling is an essential element of sexual health care; which according to the current good practice, should be available in every general practice setting.[3] Since the healthcare system in UK is well-regulated and centralized, reaching out to every GP (General Practitioner) setting and GUM clinic was possible. In stark contrast, the healthcare system in India is highly unregulated, with large scale privatization and thus satisfactory outreach of the HIV related services is very difficult, which calls for a strategy reconsideration.

The NACP III documents VCT as the one of the main strategies in prevention of HIV transmission. India has modified the VCT approach and adopted the new 'Integrated Counselling & Testing' (ICT), which is a coalesced facility that undertakes HIV testing, counselling and referral services for all sections of the population that access it. A uniform standard is provided at these ICT centers by adherence to the central operational guidelines and quality is monitored through the External Quality Assurance System (EQAS).[16] According to the WHO,[8] although the primary model of HIV testing in low and middle income countries including India has been CITC, PITC approaches in clinical settings are also being increasingly promoted. The UK policy is an example of this approach, where the aim is to reduce the number of undiagnosed HV infections by improving the sexual health services and better provision of HIV testing facilities. In Europe similar PITC services are offered in STI clinics, which helps in reducing HIV transmission to others following a positive diagnosis and in identifying infected individuals and linking them to appropriate care.[10]

Erasmus and Gilson have described the importance of power settings in health policy implementation.[17] They posit that power lies embedded in health settings such as hospitals and clinics and is a key factor in health policy processes; however it is rarely examined. This is in resonance with fact that in India, there is a general low quality of these services, which is a reflection of the relative failure in identifying the importance of power in health settings for the success of a policy. The WHO notes with concern that in low and middle income countries like India only 10% of those who need VCT have access to it.[8] However, Yeatman observes that there is little evidence to prove that large scale shift from voluntary to routine HIV testing has resulted in better outcomes.[18]

Another concern is the fact that due to stigma and discrimination, very few avail these services even in settings where HIV testing is routinely offered. Both the UK and Indian policies reiterate the need to reduce stigma and discrimination against people with HIV. This is reflected in its clear statement as one of the main strategies in the both the policies. It is noted in its pursuit of improving national testing services, the UK HIV policy document exhibits a stated commitment to improve human capacity. It promotes the empowerment of GPs to reduce undiagnosed HIV cases in the UK. On the other hand, the NACP III is relatively mum on focusing on strengthening the outreach to general population by involving private GPs in the implementation of strategies. Whatever collaborating efforts with the private GPs exist, come from NGOs,[19] not from the government which only liaises with private hospitals.

According to WHO protocols, it is recommended that new and innovative approaches be used to scale-up and expand access to VCT services. These, the WHO suggests, should optimize client convenience, decentralize services and provide testing & counselling in a wide variety of settings.[9] One of

the innovative HIV testing approaches that have been tried is home-based testing, as documented by Bateganya et al The study shows that home-based HIV testing and/or home delivery of test results, rather than doing at clinics resulted in better uptake of testing.[20]

Creek et al reported that explicit statement of routine HIV testing strategies in the national policy led to considerable increase in the uptake of HIV testing and prevention services in Botswana.[21] During the same policy period, there was also a surge in the number of HIV infected pregnant women knowing their sero-status, from 47 to 78%. In line with these findings, explicit statement of HIV testing strategies in the policy documents of India and the UK led improved health outcomes as is evident from the declining figures of prevalence in the respective review documents.

Parkhurst posits that responsible policies are vital component in the success achieved so far in reducing the prevalence of HIV worldwide.[22] However, it is difficult to single out a specific policy that actually worked on its own and is free from any weakness. The NACP III, although explicit and comprehensive on many fronts, has its shortcomings as well. The Targeted interventions (TI) for the high-risk groups and vulnerable populations require better coordination and linkage within the program. The TIs are attached to the nearest ICTCs however the linkage between the two is not optimal.[23] Some notable issues this study found with HIV testing services were: ICTC working hours might be inconvenient for some high risk groups (for example sex workers tend to sleep during the day, truck drivers are on the move in daytime), possible unpredictable behavior of IDUs as they are quite often high on drugs, and lack of provision of monetary allowances to bear costs for the people who need to travel to these centers from peripheral areas. Due to the multi-structured health system and integration of various services into ICTC, coordination between different programs appears to be an issue; which has been inadequately addressed under the NACP III. A recent study reported discrepancies in the procurement, supply and storage of drugs and testing kits. There were also concerns among many officers about the quality of the monitoring and evaluation data as most of the staff at the primary data collection levels were undertrained and poorly qualified.[24] To add to the woes, there is a very high load of patients at public hospitals and facilities. The NACP III also falls short of adequately addressing the domain of private doctors and hospitals, who hold the major share of healthcare delivery in India. They need to be better integrated into the programs to improve HIV testing outreach and more importantly there is a need for strict regulation of the private sector. Insisting on HIV tests before hospital admission or surgery, breach of confidentiality of HIV status and testing patients without specific consent are the common violations of national policy guidelines by private doctors in India, as noted by Sheikh and Porter.[25]

One of the main strategies under NACP III was the setting up of SIMU; this involves computerization of testing centers for more accurate and timely reporting. However, given the low general literacy rate in India, computer literacy & proficiency could be an issue. Proper training needs to be provided to the operators, this seems to have been overlooked in the policy. Presently, data is posted through mail, which is another problem due to delivery delays. Sogarwal et al found that reporting to primary centers is not prompt,[24] constant reminders are needed. There is poor remuneration of the staff, most of them hired on contracts leading to sense of insecurity; lack of benefits & incentives and low scope for growth compound the problem. It might be noted that an employee has greatest productivity when there is job satisfaction. This might partly explain the poor quality of services at these facilities. Only 30% of the funding for the HIV/AIDS programs in India comes from the government, rest from international support and donations. The relative lack of funding and poor regulatory system are barriers to efficient implementation of the policy. The problem is further elevated with the Indian federal budget capping the amount that foreign donors can contribute to HIV/AIDS.[26] Thus, some states requiring more resources are denied them; the government argues this is to prevent one disease receiving favor over another in terms of resources. Furthermore, the intervention programs under the NACP III largely focus on 'high-risk' groups and inadequately address the young population and monogamous women. There is an urgent need for proper HIV/AIDS information and services and sexual & reproductive health programs targeted specifically at youth.[23] On a final note, UNAIDS suggests that access to these comprehensive services is far from complete.[27] The national HIV policies or strategies fail to address many central aspects of testing, care and support because of the lack of clarity about what comprises comprehensiveness.

The implementation of the NACP III in India was undermined by the mismanagement of financial and human resources, poor quality of public health services and overall low funding of the program. However, there are also evidences that have shown that contextual differences do not significantly alter the effectiveness of standard interventions such as HIV testing.[28] Although more effort and resources are needed, the Indian Government's response reflects a sincere, intensive, and long-term commitment to effective HIV prevention and care. These efforts show that India is not complacent about the problem of HIV/AIDS.

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