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Editorial

HIV / AIDS CONTROL: SCALING UP, DEMAND GENERATION AND MAINSTREAMING IN CONTEXT OF GUJARAT

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Per se, there is no permanent structure to run the HIV/ AIDS control activities in the various states of India, as it is visualized that these activities will be integrated with General Health System (GHS) in the long run. Currently, Gujarat State AIDS Control Society (GSACS) established by the Government of Gujarat (GOG) under the Health and Family Welfare Department oversees the implementation of these activities in the state. GSACS at its Ahmadabad headquarters has staff strength of 66 persons where except for 8 – 9 persons on deputation from state government, rests all are contractual. The different activities are implemented through various governmental and nongovernmental organizations (NGOs) with technical and financial support from National AIDS Control Organization (NACO) of the Ministry of Health and Family Welfare (MOH & FW) at Government of India (GOI). Currently we are in the middle of National AIDS Control program (NACP) phase III (2007 – 12). NACP has evolved from phase II (1999 – 2007) to phase III (2007 – 12) with a stated goal to halt and reverse the epidemic over the next five years. The objectives are (1) Prevention of new infections (saturation of HRG coverage and scale up of interventions for the general population), (2) Increased proportion of PLHA receiving care, support and treatment, (3) Strengthening capacities at district, state and national levels and (4) Building Strategic Information Management Systems (SIMS).

Like any other program, HIV control program in Gujarat is on an expansion and accordingly it is undergoing scaling up, demand generation and mainstreaming. I would like to share our experiences of this journey in Gujarat.

NACP phase III has moved beyond Information, Education and Communication (IEC) and awareness generation to Behavior Change Communication (BCC) to target audience), scaling up of various services such as HIV testing, STI management, treatment to HIV positives, quality Blood Transfusion Services (BTS) and last but not the least the quality implementation of Targeted Intervention (TI) amongst core (female sex workers - FSW, men having sex with men - MSM & Injecting Drug Users - IDU) and bridge (clients of sex workers, single male migrants - SMM & long route truckers) populations.

Scaling up of services: A huge and unprecedented scale up of testing and treatment services has occurred in Gujarat. The scaling up of the services has to go hand in hand with demand generation (services offered are not wasted & are optimally used), with interlinking of different services within GSACS's activities (for example from TI to STI to ICTC & from ICTC to ART) and with general health department. HIV TB coordination (between ICTC & TB division) and condom promotion with Reproductive and Child Health (RCH) division are two good examples in this regard.

Table below shows the scale up experienced by Gujarat in the last 3 years, mainly in two areas namely the Integrated Counseling and Testing Services (ICTC) and provision of Anti Retroviral Treatment (ART).

Table: status of testing and treatment services in Gujarat (2008 – Till Oct 2010)

	2008–09	2009-10	2010–11 (till Oct)
Testing services			
No of Centers	314	483	800
General population tested (lakhs)	2.68	5.10	3.75
Found positive (% positive)	14673 (5.5)	15143 (2.9)	8171 (2.2)
Pregnant women tested	2.55	3.90	2.96
Found positive (% positive)	786 (0.31)	931(0.24)	551 (0.19)
Treatment Services			
No of ART centers	9	15	20
No of Link ART Centre	14	21	29
Total PLHA registered for ART (PreART)	26353	39713	52066
Patient on ART	9126	14906	18186

Demand generation: This huge scale up has been possible due to the support from GHS which at the same time has also put up the responsibility of demand generation (for these services) necessitating massive IEC and its integration with GHS. Actually speaking these two need to go hand in hand. Therefore, a mix of mass, mid media approach is tried for this demand generation. Needless to say that the content and approach of IEC change with target audience (ranging from core

to general population) as the ultimate aim of any IEC is to facilitate the adoption of healthy behavior (safe sex) and discordance of undesired behavior (reducing high risk behavior). Some of the materials developed by GSACS for Oriya migrants and MSM in this regard have been appreciated at national level. The theme of all these materials is to ensure safe behavior and uptake of the services. Annual observance of state level functions on World AIDS Day, Voluntary Blood Donation Day and National Youth Day in different district headquarters by rotation is an attempt in the same direction. Celebrities from different walks of life are invited in these programs to endorse the desired practices and to generate interest of masses The journeys of Red Ribbon Express (2008 – 9) and (2009 – 10) in the state with its accompanying bus and cycle caravans have done a tremendous job of awareness/ demand generation in interiors and difficult to reach terrains of Gujarat. Inter District Campaign (IDC) in 2009 – 10 covered 1500 villages of 22 districts of Gujarat; the same is being done this year from January 2011 on a larger scale covering some 2250 in all 26 districts. Salient messages passed on in this are as follows:

1. How HIV spreads (to avoid getting infection),
2. How it does not spread (HIV positives are not stigmatized),
3. All those at risk (HRG population, TB patients, STI cases, symptomatic & volunteers) come forward for testing at any of more than 800 testing facilities
4. All pregnancies irrespective of background undergo HIV testing during the antenatal care (ANC); positive pregnancies have institutional deliveries with administration of mother baby (MB) pair of Nivierapine,
5. All HIV positives detected should go to any 1 of 20 ART (nearest) center for initiation of treatment; once stabilized on ART, for further treatment shall go to even nearer any of 29 Link ART Center (LAC),
6. To address blood route of transmission, promotion of Voluntary Blood Donation (VBD) through repeat and non remunerative type

It is needless to mention, that these activities have been helpful in demand generation which is evident from the accompanying table.

Integration and mainstreaming with GHS: Most of our facilities (stand alone ICTC, Facility Integrated ICTC, ARTC, LAC, STI clinics, Blood banks, Blood Storage Centers) are run in government facilities, therefore it is essential that local authorities in these institutes take full ownership of facilities and mainstream their activities. The success of the scale up has been possible in the state only due to this integration at all levels starting at the level of office of Commissioner (Health), where the Commissioner Health is also the Project Director of GSACS to down at the level of ANM and ASHA worker who are involved in testing of pregnancies and tracking of positive pregnancies. Integration has to be accompanied by decentralization which has been done in Gujarat by operationalization of District AIDS Prevention and Control Units (DAPCU). We have full-fledged 12 such DAPCUs (10 A & B category districts, Surat City in partnership with Surat Municipal Corporation and Valsad with UNICEF support). These units have dedicated Program Officer from GHS with District Supervisor (1), Divisional Assistants (3) and helper (1). However, a DAPCU sort of mechanism has been developed in rest of the districts as well where a medical person from Zila Panchyat has been assigned this work as an additional charge. DAPCUs are the extension and representation of GSACS in district. Data collection, distribution of materials (kits, consumables, posters etc), monitoring of peripheral units, review of program, preparing action plan, collecting utilization certificates (UCc) and liquidating advances are some of the activities which are being done by DAPCUs in our state.

We must understand that the integration also has a price tag too. At places the HIV program loses its priority amongst other health programs especially when some epidemic occurs. The reluctance of local authorities ("one more program to look after") is also an issue. At places (CHC/ hospitals) the activities are still perceived as that of GSACS and staff expect/ request for extra allowances for GSACS related activities. Though at most places the local ownership has developed quite well. Advantages in this regard clearly overweigh the disadvantages as the program picks up the steam on its own and becomes local one (own program). The type of targets which have been envisaged in NACP and which we are striving for cannot be achieved through the vertical structure of GSACS and the ingeneration is the only way to for it.

While surmising I can say that we are on a right path of following the scaling up, demand generation and integration and mainstreaming.

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