



National AIDS Control Organisation

India's response to HIV & Sexually Transmitted Infections
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in



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Ministry of Health & Family Welfare
Government of India



Sampoorna Suraksha Strategy

Process Document



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FOREWORD

Under the National AIDS and STD Control Programme Phase V, the Goal 1 on reduction of annual new HIV infections by 80% focuses on approaches to cover the 'at-risk' HIV negative through comprehensive prevention packages to keep them negative. The Sampoorana Suraksha Strategy is one such crucial initiative for individuals at high-risk of HIV and STIs that integrates prevention, testing, treatment, and care. This strategy implemented through Sampoorana Suraksha Kendras, utilizes an immersive learning approach and a single-window service model for tailored healthcare delivery. This strategy is vital to India's goal of ending the AIDS epidemic by 2030, aligning with UNAIDS' 95-95-95 targets.

The approach addresses not only health care needs but also the broader social determinants impacting at-risk and vulnerable communities. It strengthens linkages between health systems and communities and ensures services are responsive to individual needs. The Programme's focus on innovation and community engagement offers valuable insights for future strategies, reinforcing our national response to these public health challenges.

The Sampoorana Suraksha process document serves as a crucial learning tool for scaling and refining similar interventions, especially for long-term HIV prevention and control. It systematically records the strategy's evolution, challenges, and solutions, enhancing real-time decision-making and creating a knowledge repository for replicating best practices. This documentation promotes improved service delivery, accountability, transparency, and knowledge sharing among stakeholders, thereby strengthening healthcare systems

nationwide. By capturing these insights, we ensure that future initiatives are well-informed and more effective, ultimately enhancing the overall impact of the HIV response and improving Programme efficiency and service quality and highlights the need for inclusive and client-centered strategies that help reduce new infections, close service gaps, and ensure equitable access to life-saving healthcare, advancing the vision of an AIDS-free India.

(V. Hekali Zhimoni, IAS)



PREFACE

The National AIDS and STD Control Programme, in its Fifth Phase, emphasizes accelerating the reduction in new annual HIV infections through a basket of strategies tailored to the high-risk, at-risk, and low-risk population groups. The strategy specifically for at-risk HIV-negative individuals is the Sampurna Suraksha Strategy (SSS), which marks a significant leap in the integration of healthcare services, targeting this most vulnerable population affected by HIV and related health challenges. Through its single-window model, SSS brings together prevention, testing, treatment, and ongoing care under one roof, addressing individuals' health and social needs holistically. While the strategy represents a breakthrough, the development and implementation process is equally transformative.

This process documentation is dedicated to documenting the journey of SSS from its inception to its scale-up under the Programme. The process documentation is valuable as it provides a detailed roadmap of the strategy's evolution, capturing the successes, challenges, and lessons learned. Every phase of implementation has offered valuable insights, from the initial design and community engagement efforts to the intricate process of integrating services across diverse health systems.

The documentation serves as a critical tool for reflection and replication. By meticulously recording each step in the journey of SSS, it is a resource for policymakers, Programme implementers, and healthcare professionals. It offers the framework for scaling successful interventions and ensures that future iterations of the Programme benefit from the lessons learned in the field. Additionally, it underscores the importance of flexibility and adaptability in responding to the evolving needs of the communities we serve.

As we continue to push the boundaries of healthcare integration and inclusive service delivery, the lessons from SSS will resonate far beyond the immediate context of HIV care. The strategies, models, and processes developed during the implementation of the strategy hold the potential to shape a new era of healthcare in India and beyond. It captures their collective wisdom, innovation, and commitment to making healthcare accessible to all. We hope that the documentation of this process will inspire and guide future endeavours in public health, ensuring that no one is left behind.

(Nikhil Gajraj, IAS)



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MESSAGE



The Sampoorna Suraksha Strategy (SSS) represents a transformative model in healthcare delivery, offering a comprehensive, single-window approach that integrates prevention, testing, treatment, and ongoing care. The success of such an initiative lies not only in its innovative design but also in the meticulous documentation of each step in its development, implementation, and adaptation.

For SSS, this process documentation serves as a valuable tool to inform scale-up efforts, enabling the replication of this immersion learning model in other regions or other healthcare contexts. By systematically recording the process, the document as a blueprint offers clarity on each component—from service integration to community engagement—that can be tailored to the specific needs of diverse populations. This documentation ensures that the lessons learned are not lost, but rather become part of a living framework for continuous improvement.

Within the framework of the National AIDS and STD Control Programme (NACP) Phase 5, the role of process documentation becomes even more critical, wherein the Programme emphasizes the integration of services and the removal of barriers between different health interventions. The detailed account of SSS conceptualization, testing, and scale up, provides invaluable insights for future Programmatic decisions. These learnings can drive innovation and guide policy shifts, ensuring that the national response to HIV remains flexible, inclusive, and effective.

Technical aspects of this strategy, along with the human side of healthcare—how communities are engaged, how health systems are linked, and how vulnerable populations are served are detailed. I am proud to contribute to this process, knowing that these records will serve as a foundation for future healthcare interventions.

(Dr. Shobini Rajan)



MESSAGE

On behalf of the United States Agency for International Development (USAID), I am pleased to introduce India's "Sampoorna Suraksha Strategy" — a key initiative under the National AIDS Control Programme (NACP-V). Translated to "Complete Protection Strategy", the initiative aims to prevent HIV infections among individuals at risk, especially those who may not recognize themselves as high risk for HIV and sexually transmitted diseases.

Through the U.S. Government's President's Emergency Plan for AIDS Relief (PEPFAR), USAID is proud to partner with India's National AIDS Control Organization (NACO) in the fight against HIV and AIDS. Our partnership addresses response gaps with an evidence-based and person-centered approach.

India's HIV response is globally recognized as a model, and NACO's work in HIV epidemic control through prevention strategies is a key component of the country's overall HIV and AIDS response. The "Sampoorna Suraksha Strategy" provides a comprehensive package of support services designed to help at-risk individuals stay healthy and HIV-negative.

As the United States and India partner to advance and achieve global development goals, USAID is proud to support the implementation of the "Sampoorna Suraksha Strategy" through targeted technical assistance and capacity-building efforts. This report captures valuable insights, experiences, and lessons learned from implementing the strategy across different regions. It details how these individuals can receive a cyclical, need-based, and comprehensive package of supportive services to help them remain HIV-negative and maintain their overall health.

The U.S. Government is proud to partner with India as it accelerates its progress toward ending HIV/AIDS. This report will serve as a model for community engagement and

empowerment, offering both local and global stakeholders a framework firmly grounded in health equity principles.

Michelle Lang-Alli, Health Office Director, USAID/India



MESSAGE

Through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the U.S. Centers for Disease Control and Prevention (CDC) has been a strategic technical partner to the National AIDS Control Organization (NACO) in India's HIV response for over 20 years. Leveraging its scientific expertise, advanced technology, and ability to translate science into practical policy, CDC and India have established a sustainable government-to-government partnership.

PEPFAR supports the Government of India's commitment to achieving the Sustainable Development Goal of ending HIV/AIDS as a public health threat by 2030. To address the first 95 gap, India has implemented evidence-based, person-centered strategies through the Sampurna Suraksha Strategy (SSS), a flagship prevention intervention supported by the Global Fund grant under NACP V. The aim is to improve universal access to STI/RTI services for at-risk and vulnerable populations and contribute to an 80% reduction in new infections as targeted by NACP.

SSS employs an "Immersion Learning Model" that refines approaches based on real-time feedback and field experiences. Its goal is to expand comprehensive HIV prevention services to at-risk individuals, including those outside high-risk groups, by offering a cyclical, needs-based package of supportive services that help them remain HIV-negative and healthy.

PEPFAR is proud to support NACO's SSS initiative and has provided technical support in defining the SSS process. This guidance aims to enhance the quality and reach of HIV prevention services, ensuring they are comprehensive, effective, and promote health equity for all. Ultimately, this collaboration contributes to reducing new HIV infections and improving health outcomes for all. On behalf of PEPFAR and CDC, we express our deepest gratitude to NACO leadership and all divisions for their unwavering guidance in ensuring the effectiveness of this document and alignment with our shared goals.

Laurie Fuller, Deputy Country Director, Division of Global HIV & TB, India, CDC



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Acknowledgement

The development of the Sampoorna Suraksha Strategy (SSS) process document, under the National AIDS and STD Control Programme (NACP) Phase V was made possible through the contributions of various stakeholders. NACP Phase V aims to provide comprehensive prevention packages for 'at-risk' HIV-negative population, reducing new infections and promoting early detection, particularly among high-risk groups such as Female Sex Workers, Men having Sex with Men, Hijra/Transgender persons, People who Inject Drug, Migrants and Truckers. This effort, under the Global Fund Grant (2021-24), developed the Immersion Learning Model, known as the Sampoorna Suraksha Strategy (SSS). The Process Document of SSS was developed under the guidance of NACO's leadership.

We extend our heartfelt gratitude to Ms. V. Hekali Zhimomi (IAS, Additional Secretary & Director General, NACO) for her exemplary leadership and dedication to this initiative. Special thanks to Shri Nikhil Gajraj (IAS, Joint Secretary, NACO) for his critical contributions in defining the scope of this project. Our sincere thanks also goes to Dr. Anoop Kumar Puri (DDG, NACO), Dr. U.B. Das (Sr. CMO (SAG), DDG, NACO), and Dr. Chinmoyee Das (PHS Grade I, ADG, NACO), for their invaluable technical inputs and strategic guidance.

Special thanks to Dr. Shobini Rajan (Sr. CMO (SAG), DDG, NACO), for steering this activity, vital in framing the document and for her continuous guidance throughout the development of this process document.

We are also deeply grateful to Dr. Bhawani Singh (DD, NACO) and Dr. Bhawna Rao (DD, NACO) for providing technical expertise and sharing their experiences in enriching the document.

The success of the Sampoorna Suraksha Strategy process documentation was made possible through the cooperation and support of numerous experts. We acknowledge the critical role played by the 20 SACS who are implementing SSS in their respective districts through SSKs along with their District officials, SSK Staff and Hospital authorities. Our deepest appreciation is also extended to the Community Representatives who participated in the process and shared their experience on SSS.

The contribution of Working Group chairperson Dr Naresh Goel, members Dr Sundersundar Raman and Dr Vanita Gupta was noteworthy.

A sincere thanks to PEPFAR India (USAID and CDC) for delegating Ms. Sukhvinder Kaur of USAID, Dr Sudhir Chawla and Dr Upma Sharma of CDC who worked tired-lessly and contributed in the designing, development and finalization of the process documentation. And very thankful for the contribution of the PEPFAR implementing partners JHU, ITECH, PATH India, CHAI, WHO, YRG Care for their valuable contribution during the Tool development and data collection in the field.

Our deepest appreciation is also extended to NACO team Dr Vibhavari Deshmukh, National Consultant BSD, Dr Vishal Yadav, Consultant STI, Ms Vinita Verma, National Consultant SI, Ms Ira Madan, Technical Expert for reviewing the document and Dr. Payal Sahu, Technical Lead SSS was very instrumental in conceptualization, ensuring the quality and completion of this Process Document.

The hard work put in the Process Documentation of SSS has been immense and we sincerely acknowledge valuable time, experience and expertise of all the contributors. The list of contributors towards the successful release of this document given in credits.

(Dr. Saiprasad P. Bhavsar)

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
ARTC	Antiretroviral Therapy Center
ASHA	Accredited Social Health Activist
CSC	Care and Support Center
CST	Care, Support and Treatment
DAPCU	District AIDS Prevention and Control Unit
DCRG	District Community Resource Group
DISHA	District Integrated Strategy for HIV/AIDS
DSRC	Designated STI/RTI Clinic
ECP	Emergency Contraceptive Pills
FSW	Female Sex Workers
FY	Financial Year
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HOD	Head of Department
H/TG	Hijra/Transgender
Hep	Hepatitis
HIV	Human Immunodeficiency Virus
HR	Human Resource
HRG	High Risk Group
ICTC	Integrated Counselling and Testing Center
IDU	Injecting Drug Users
IEC	Information, Education and Communication
KP	Key population
KPI	Key Performance Indicator
LWS	Link Worker Scheme
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
MS	Medical Superintendent
MSM	Men who have Sex with Men
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NGO	Non-Governmental Organization
NHM	National Health Mission
NORMS	National Online Reporting and Monitoring System
NTEP	National TB Elimination Programme
NVHCP	National Viral Hepatitis Control Programme
OB/GYN	Obstetrics and Gynecology
OPD	Outpatient Department

ORW	Outreach Worker
OST	Opioid Substitution Therapy
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PPP	Public Private Partnership
PrEP	Pre-exposure Prophylaxis
PWID	People who use Injecting Drugs
RCH	Reproductive and Child Health
RPR	Rapid Plasma Reagin
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SA-ICTC	Stand Alone Integrated Counselling and Testing Center
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goals
SETU	Strategic Expertise Technical Unit
SI	Strategic Information
SOCH	Strengthening Overall Care for HIV beneficiaries
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SSK	Sampoorna Suraksha Kendra
SSS	Sampoorna Suraksha Strategy
SS ORW	Sampoorna Suraksha Outreach Worker
STI	Sexually Transmitted Infection
TB	Tuberculosis
TI	Targeted Intervention
TG	Transgender Individuals
ToR	Terms of Reference
ToT	Training of Trainers
TSU	Technical Support Unit
UN	United Nations
WG	Working Group

Executive Summary

National AIDS and STD Control Programme Phase-V (NACP-V) strategy document recommends coverage of 'at-risk' HIV negatives through comprehensive prevention packages to keep them negative, as there are other population groups apart from high-risk groups (Female Sex Workers, Men having Sex with Men, Transgender persons, Injecting Drug Users, Migrants and Truckers) who are 'at-risk' of acquiring HIV or STIs, due to high-risk behaviour among their communities and partner/s. Under the Global Fund proposal for National AIDS Control Organisation (NACO) for grant period 2021-24, this vision entailed the development of a "New Model" to provide comprehensive prevention, reduce new infections, and provide early detection of HIV by reaching out to "At Risk population" for HIV and STIs not associated with NACP's Targeted Interventions (TIs) and Link Worker Schemes (LWS) and are possibly at risk of getting infected. This new form of Immersion Learning Model was envisaged as "Sampoorna Suraksha Strategy (SSS)" under Global Fund Grant 2021-24.

To devise the strategic and operational framework of SSS and to develop the implementation roadmap, a two-day National Consultation was organized by NACO in August 2021 with community and civil society representatives, multilateral and bilateral developmental partners, SACS representatives, and subject matter experts. The objective of the consultation was to seek valuable inputs and feedback from all stakeholders on the core elements of SSS, including the population in need, design of a service package, outreach models, strategy for reaching out to virtual populations, training, and Monitoring Evaluation and Reporting.

Following the National Consultation, a series of consultations/working group meetings were conducted/constituted with stakeholders and the target population; the comprehensive package of services, approaches, and data management tools was agreed to be developed unanimously. These consultations and the composition of working groups were very inclusive. The target population included uncovered HRGs, uncovered Bridge population, uncovered spouses and partners of KPs including discordant couples, virtual population, and at-risk general population; and the comprehensive package of services segregating "Essential and Desirable" at States/Districts was based on the resources available and local HIV epidemic arrangements. The data management and reporting were through the online

"NORMS portal" till a dedicated module of SSS came under NACO's National MIS system known as SOCH.

NACO, under the SSS, was able to achieve the Global Fund Disbursement Linked Indicator (DLI) for the period 2021-24, through the establishment of 150 SSKs and making them functional till 2024. All SSKs started providing services to the SSK Clients per their needs and were reporting in NORMS. Till March 2024, 150 SSKs registered 1,04,911 "at-risk" HIV-negative clients (80% achievement against the target of 1,31,000).

Further, in the next cycle of the Global Fund grant period 2024-27, 339 more SSKs will be established and made functional, expanding to 489 SSKs across the country. The target for the Financial Year 2024-25 is set for registration of new 1,89,000 "at-risk" HIV-negative clients for the provision of comprehensive services through SSKs.

In this document, the entire journey from 2021-24 is being documented to enhance the understanding from conceptualization to development of the strategy and taking it to the implementation level and reporting. The document presents the information gathered to develop the Process Document via field visits conducted by the PEPFAR India country team and their Implementation Partners (a few states covered virtually) in 20 States (districts/facilities) implementing SSS in Phase-I and II. The field teams interacted with State SACS officials, DISHA, and SSK staff. The field interactions reflected SSS's thoughtful and inclusive approach to health and non-health service delivery, particularly for vulnerable at-risk populations. SSK came out as a substantial opportunity in the field to "Break the Silos and Build Synergies" as an entry point for the provision of better health services.

Forward-thinking by NACO under the aegis of the Ministry of Health and Family Welfare, Government of India, led to the execution of SSS in its ability to adapt and respond to the unique needs of at-risk HIV-negative populations. However, challenges in implementation, mainly related to infrastructure, staffing, awareness, and coordination, require ongoing attention and continuous improvement to realize the strategy's potential fully, which is key to the sustained impact of the SSK initiative. By addressing the identified challenges through targeted recommendations, the Program will continue to evolve, ensuring that it remains a vital component of the broader public health response. Strengthening of single window

service delivery under one roof for HIV, Syphilis, Hepatitis, SRH, mental health needs etc can enhance service uptake and opportunity for HIV prevention and early detection, focusing on availability of commodities, enabling customized services as per client needs, structured and meaningful engagement of communities, mobilizing clients through community outreach and engagement is imperative under SSS. Discontinuing verticals among many verticals and developing one "Operational Guideline" for the prevention services under the ambit of SSS is the mainstay of this document and was clearly reflected by the respondents during the listening exercises in the field.

CHAPTER 1 Background

As a signatory to the United Nations' Sustainable Development Goals (SDG), India is committed to ending AIDS as a public health threat by 2030. The National AIDS and STD Control Programme (NACP) also adopted the 2025 fast-track target of 95-95-95 across the care continuum. The elimination of AIDS as a public health threat necessitates concerted efforts for the prevention of new infections. Based on the HIV Estimates 2023 Factsheets, the estimated adult HIV prevalence (15-49 years) has declined from 0.55% in 2000 to 0.20% in 2023. The annual new HIV infections in the country have decreased by 44.23% from 2010 to 2023. While this is significantly higher than the global average of 38%, it is evident that there is a need to arrest the spread of HIV further to reach the Programme targets, thus necessitating rigorous efforts to reduce the new infections further. As per NFHS-5 data, 3.2 crore people (approx. 4% of the reproductive age population) engage in risky behavior, of which 1.10 Crore (Urban & Rural) are covered via ~1577 TIs, 155 LWS & 74 OSCs². 1.10 Crore population who are at risk and yet to be reached through newer interventions and differential strategies.

The National AIDS and STDs Control Programme (NACP) Phase-V was initiated in alignment with the fifteenth Finance Commission for 2021-26 of the Government of India. "Break the Silos and Build Synergy" is one of the eight guiding principles of NACP Phase-V. Covering 'at-risk' HIV-negative persons through a comprehensive prevention package and keeping them negative through "Sampoorna Suraksha" is an essential strategy under NACP Phase-V to achieve the goal of reducing annual new HIV infection by 80% from the baseline of 2010³. NACP Phase-V will maintain the DSRC and ICTC model while augmenting its role to anchor newer initiatives like Sampoorna Suraksha Strategy (SSS) and integrated service delivery tailored to the local contexts.

Under its prevention services, the Programme focuses on interventions for High-Risk Groups (HRG). However, while coverage of HRGs has increased significantly over the years, a gradual yet continuous decline has been observed in the testing yield, indicating the need to identify individuals who are at disproportionate risk for HIV and STIs but may not necessarily identify themselves as part of the HRGs.

B

ased on the guidance from the NACP-V document, SSS was envisaged to cover the gap in reaching out to those not identifying as HRGs or with high-risk behaviour. SSS was designed and implemented by NACO under Global Fund Grant 2021-24 as a form of “Immersion Learning Model” for the provision of a comprehensive package of service delivery for at-risk HIV-negative people. This strategy aligns with NACO’s vision of building an integrated response by reaching out to diverse populations - where everyone is safe from HIV and AIDS, is treated with dignity, and is heard and reached out to while ensuring access to Integrated Counseling and Testing services and quality care to live a healthy and safe life. SSS is envisioned as an evidence-based cyclic and comprehensive prevention service package that is customized to geographies and vulnerable populations.

SSS, under the Global Fund Grant period 2021-2024, established 150 Sampoorna Suraksha Kendras (SSKs) in 20 States. However, the conceptualization started in 2020 and will continue until implementation in 2022. The grant period ended in March 2024.

To provide an overview of the conceptualization, implementation, and establishment of SSKs in the two rounds in India, the need to develop a process document was paramount. This document will support stakeholders/States/Districts in replicating, improving, modifying, or conducting risk mitigation in advance as needed. The document outlines the methodologies implemented in developing the SSS over time while capturing experiences and feedback collected through field visits to the SSKs in selected districts.

CHAPTER 2

Process Documentation

This Process documentation is a collation of information that outlines the steps taken to initiate and complete the activities from conceptualization to project implementation. The technical documentation is created to provide a clear understanding of processes undertaken to establish SSK and implement SSS.

Process documentation includes:

- Detailed activities undertaken for rolling out the strategy
- Flowcharts/ process maps: Visual representations of the steps, sequences, and decisions of a process
- Step-by-step activities under for the establishment and implementation of SSS.
- Documents that were created under the project for its smooth implementation.

2.1 Purpose of SSS Process Documentation

The essential purpose of the SSS Process Documentation is to provide an overview of the conceptualization, implementation, and establishment of SSKs.

The document outlines the methodologies implemented in developing the SSS over time. The process document also captures experiences and feedback collected through field consultations in selected States/districts. These field-based listening exercises gathered information regarding the operations, effectiveness, learnings, best practices, and challenges from different stakeholders (viz. National AIDS Control Organization, State AIDS Control Society, District Integrated Strategy for HIV/AIDS, community representatives, multilaterals, partners, SSK staff and clients).

The SSS process document guides the Programme in facilitating course correction and scale-up of the intervention while also documenting the learnings from the initial phases of this Immersion Learning Model, which provided a delicate balance of guidance from the National level with space for contextualized models to be implemented at each State/district, thus allowing for greater ownership, accountability, and innovation. It also shares the experiences with different Programmes/geographies as they attempt to adopt a similar service delivery model within their ecosystem. Further, the document guides SACS and

district officials towards establishing/improving implementation of SSKs in their respective states in phase III and the development of Operational Guidelines 3rd version at the National level. This process documentation will support strengthening service delivery, contribute to the NACP Phase-V goals, and strengthen the various processes and systems involved in the implementation of SSK on the ground.

2.2 Objectives of the Process Documentation

The overall objectives of process document are to:

- 1) Document the whole journey of implementing the Strategy from conceptualization to development of the SSS and its implementation plan in phases.
- 2) Document the major achievements, challenges and the lessons learned for establishing/improving implementation of SSS in the States.
- 3) Revise the Operational Guidelines and publish the third version based on findings and recommendations.
- 4) Give actionable suggestions and recommendations to improve the implementation of SSS.

The readers of this process document will also benefit from understanding the diversity and uniqueness of the immersion learning process that led to the standardization of various systems during the implementation of SSK. The document will also provide an opportunity to explore the health-systems approach that NACO undertook in setting up these SSKs, the forward-thinking decisions taken by the parent institutions where SSKs are housed, as well as the ownership built by DISHA.

CHAPTER 3

Evolution of Sampoorna Suraksha Strategy

3.1 Vision of SSS

Under NACP, the prevention services primarily focus on individuals from High-Risk Groups through Targeted Interventions (TI) Projects and Link worker schemes (LWS). Over the years, the Programme has had great success in preventing HIV among Key Populations (KP) through these interventions. However, new infections have been emerging in individuals, including adolescents and young populations, who are at risk and do not identify themselves as a key population. As per HIV estimates in 2021, more than 30 percent of new HIV infections in India were found in youth below the age of 24 years. Driven by evolving risk behavior (including virtual engagements) and fluid distinctions among risk categories, a need was observed for focused interventions to cater to these population groups via the expansion of prevention services to prevent new infections and arrest the epidemic.

After a series of in-depth discussions at the National AIDS Control Organization (NACO) during 2020-21, the proposal on SSS was drafted as part of activities under the Global Fund by NACO for the grant period of 2021-24, under the guidance of NACO leadership and with inputs from all divisions. The proposal on SSS was developed with the vision of providing preventive and other related services under one roof, considering the patients' 360-degree health needs comprehensively. It relies on rigorous outreach, follow-up with clients, and leveraging virtual platforms through various applications and other strategies.

3.2 Objectives of SSS

SSS is envisaged as a comprehensive package of preventive services for “at-risk” clients who do not identify as HRGs or are not associated with TI/LWS. This new form of service delivery aims to provide a cyclical, need-based, and comprehensive package of supportive services (relevant testing, counseling, and other health services/social welfare services referrals and linkages) that help them stay negative and stay healthy, set with the following objectives:

- Identify and increase focus on at-risk HIV negative people
-

- Keep at risk HIV-negative individuals engaged to ensure they remain negative
- Destigmatize HIV service-seeking by bringing it under an umbrella of comprehensive services for STI/RTI

3.3 National Consultation

To design the Strategy, a two-day National Consultation was organized by NACO in August 2021 to devise the strategic and operational framework of SSS and the implementation roadmap. Various stakeholders, including community representatives, civil society, Bilateral and multilateral organizations, developmental and implementing partners, and subject matter experts participated and provided inputs on the core elements of SSS, including the design of a comprehensive service package, outreach models, strategy for virtual populations, training, and monitoring and evaluation (M&E).

The recommendations for the SSS, was outlined in this National Consultation included the following:

- SSS model was envisaged as **people-centric** and designed to provide **holistic essential health services**, including but not limited to Hepatitis B, Hepatitis C, STIs including Syphilis, mental health, reproductive and child health (RCH), social security schemes, government welfare services, legal services through referrals and linkages.
- SSKs was envisioned as a **one-stop window** for providing and/or referring clients to the above services, through appropriate screening and assessment of clients for health service needs, treatment, and follow-up/longitudinal tracking mechanisms to ensure long-term prevention and testing services, including other wrap-around services as per their needs.
- SSS model has a provision of **integration of physical and virtual services** for at-risk clients that prefer either physical access or initial access from virtual platforms such as social media, including public private partnership (PPP) models with private providers and other social networking/dating/informational platforms for e-referrals.

3.4 Constitution of Working Group

As a follow-up to the national consultation, NACO constituted a Working Group (WG) to further work on micro details of SSS including guidance and supervision on the development of documents and frameworks for SSS (*service package, M&E indicators, reporting formats, outreach model*), design operational framework and monitor implementational modalities.

The Working Group (WG) included senior officials from NACO, SACS, and technical public health experts. The WG has played a crucial role in designing the pillars of the SSS implementation framework, reviewing the progress, and providing guidance throughout the pilot and subsequent implementation.

3.5 Target Population of SSS

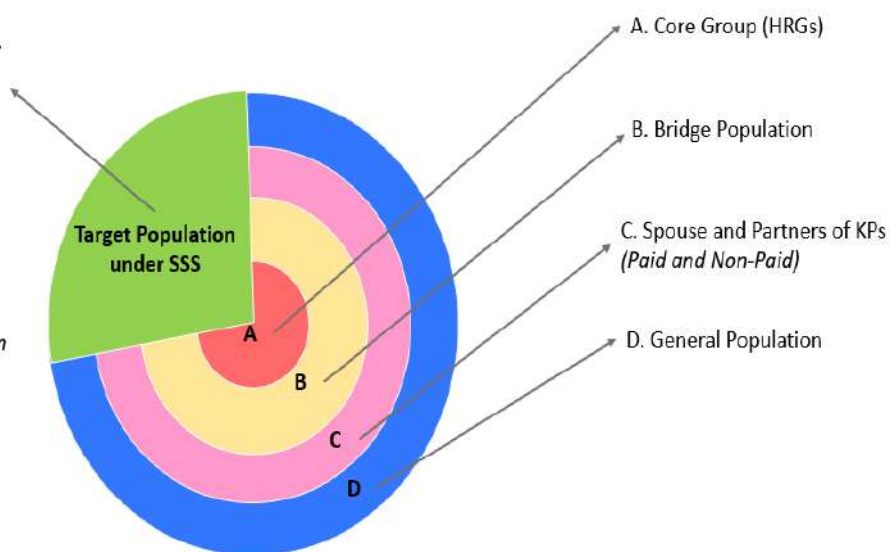
Any individual who is at risk of acquiring HIV or STIs due to their risky behaviour or that of their partner(s) constitutes the target group of SSS. This includes the uncovered core population, bridge population, their spouse / partners, and other populations who engage in risky behaviour¹. SSS focus is on all at-risk HIV negative clients including direct walk-in clients at Integrated Counselling and Testing Centers (ICTCs) and designated STI/RTI clinics (DSRCs) and their spouse and partners, adolescents and youth, and vulnerable population on virtual platforms.

“At Risk” Populations include:

- Self-initiated clients at ICTC with risky behavior
- Social and sexual networks of self-initiated clients / individuals
- Youth and adolescents at risk
 - Individuals having casual sexual relation with regular/non-regular partner/s
- STI/RTI clients visiting DSRC/STI Clinics with STI complaints
 - HIV negative but ‘at-risk’ clients identified through virtual outreach, NACO Helpline 1097 etc.
- Regular and Non-Regular Partner/s/Spouse of HRG (FSW, MSM, TG/TS) who are not associated / covered with TIs, LWS & OSC
- Needle/Syringes sharing Partners (IDU/FIDU) and their sexual Partners (who are not associated with TIs/ LWS/OSC)

"At-risk" population including Youth and Adolescents to be covered under SSS:

- a. Uncovered HRGs
- b. Uncovered Bridge Population
- c. Uncovered Spouse & Partners of KPs including Discordant Couple
- d. Virtual Population across all categories
- e. At-Risk among General Population



3.6 Comprehensive Service Package under SSS

Based on the discussions held during the National Consultation and inputs given by the participants, a *non-exhaustive list of Services and Commodities for Sampoorna Suraksha Service Package* was devised by NACO, categorized into two sub-parts, namely:

1. **Essential Services**, which must be provided at each SSK.
2. **Desirable Services** (non-exhaustive) which could be finalized by the States/UTs after mapping the needs of the clients and the scope services available under the existing local health system, by leveraging the "Facility Assessment Tool" devised at national level with inputs from the WG.

Further, these services could be provided either at the SSK, or via referral/ linkages as per available resources (*Refer to Annexure 2*) at state/district and *details of comprehensive service package is given in SSS Operational Guidelines 2nd Cut in Annexure 3.*

CHAPTER 4

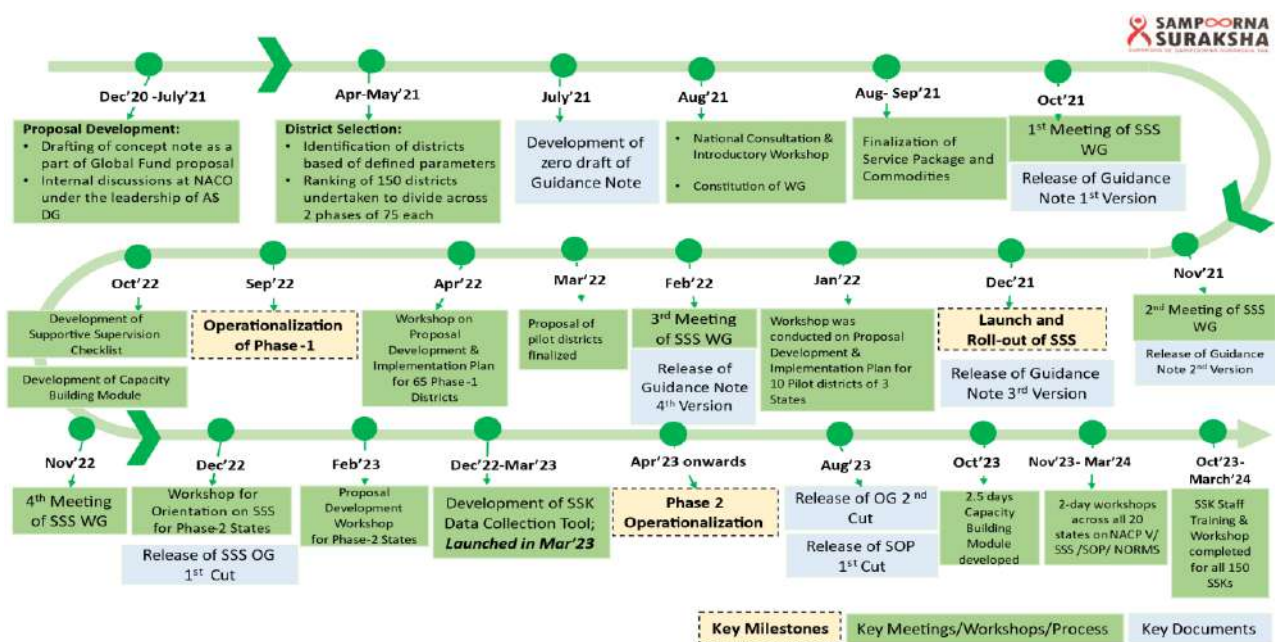
Sampoorna Suraksha Strategy from Ideation to Implementation

4.1 Overview

Under the aegis of NACO, SSS was conceptualized as an “Immersion learning model” in the year 2020. This entire process was a phased approach to the implementation of this new and promising strategy, gathering first-hand information on characteristics of need versus services and personnel capacity versus training required. NACO demonstrated that to implement any large-scale Programme in a country like India, there is a need for understanding the resource capacity, leadership, and cultural nuances.

Constitution of Working Groups, periodic convening of meetings, and participation of State/Provincial leaderships, subject experts, and other partner agencies have added value to this phase-wise implementation process. This approach also supports the SACS/DAPCU/DISHA in having a logical flow and best utilizing/right size their existing resources from the existing infrastructure of hospital premises/co-locating of services to task-shifting planning for existing human resources.

Figure 2 below depicts snapshot of key milestones and progress achieved under SSS



4.2 Districts for implementing SSS

For effective resource utilization and enhancing sustainability, SSS was implemented by re-modeling existing identified NACP facilities i.e., ICTCs or DSRCs into SSKs. **150 districts across 20 States/UTS were shortlisted for implementation of SSS**, divided across two phases of 75 districts/sites each. Further, 10 districts out of 75 Phase-I districts were identified as **pilot districts** to account for any refinements to the strategy based on the learnings and experiences, and towards strengthening scale-up across the remaining facilities. These facilities were further provided with additional staff to support the Programme implementation and facilitate additional comprehensive services to the at-risk HIV negative clients.

The following epidemiological parameters were defined for identification and selection of 150 districts:

- The Number of HIV-positive persons and positivity rates amongst different population groups such as pregnant women, general clients , reported at ICTCs and
- Syphilis positives and people with STI/RTI syndromes; reported/managed at DSRCs.

Rationale for selection of districts

NACO selected 150 districts in 20 states for the implementation of SSS based on the following epidemiological parameters:

- Number of HIV-positive cases and positivity rate amongst self-initiated clients at SA-ICTC;
- Number of HIV-positive cases and positivity rate amongst general clients at SA-ICTC;
- Number of HIV-positive cases and positivity rate amongst pregnant women;
- STI/RTI Syndromes managed at DSRC;
- Syphilis positivity reported at the DSRC.

Based on the above criterion, the shortlisted states and districts were further ranked as per the following indicators:

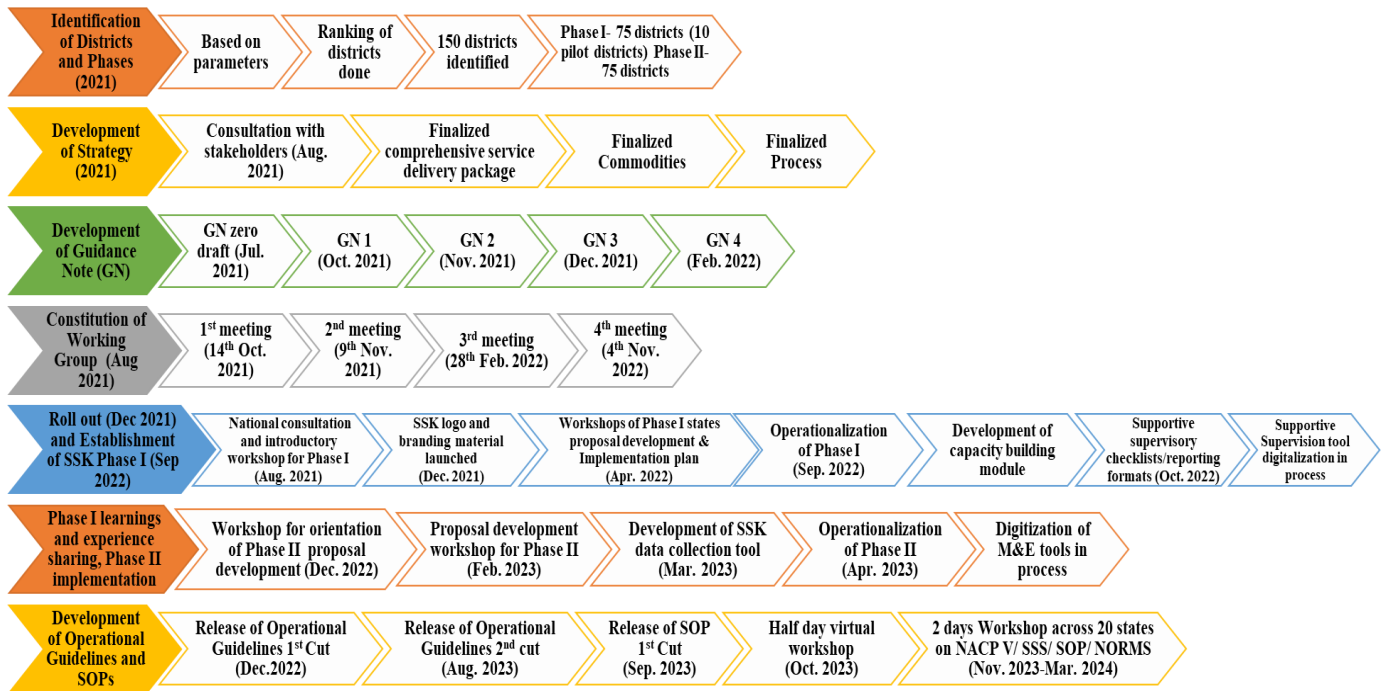
- HIV positivity:
 - Client-initiated

- Provider-initiated
- Co-infection rates:
 - Syphilis
 - TB
 - STI/RTI (Syndromic Management)
- No. of attendees at:
 - ICTC
 - DSRC
- Percentage of at-risk attendees at ICTC
- SRH Commodity usage / distribution:
 - Pregnancy test kits
 - Condoms
 - Emergency Contraceptive Pills (ECP)

Based on the above, 75 districts ranking at the top of the metrics were selected for Phase I of implementation. In addition to the above-mentioned criteria, states/districts from Northeast Region (Mizoram and Nagaland) were also included based on the geographical features (difficult terrains and limited access) and high percentage of population with high-risk behaviour. For implementation of SSS, additional 75 districts in Phase II (*Annexure 1*) were added to the existing 75 SSKs of Phase I.

At the National Level, as outlined in Figure 2, the approach to implement SSS across districts, detailing timelines of important activities like district identification in phased manner, conduction of various stakeholder consultation, development of strategy, identification of comprehensive package, development of series of guidance notes, working group constitution, development of capacity building module, branding material, operational guidelines and SOP templates were created during 2021 to 2024.

Figure 3: Process of initiating Sampoorna Suraksha Strategy (SSS) – National level



4.4 SSS Approaches

SSS followed approaches to facilitate the process of implementing the strategy smoothly. It was clear that SSS will not be implemented through a new vertical but would utilize the existing resources of NACP. The following approaches were envisioned:

4.4.1 Re-modelling of existing Facilities

SSS is envisaged as an Investment-light model under NACP with the strategy that unique field-level challenges need to be addressed locally using available resources by augmenting local collaboration, improving the net inflow of clients, capacity building, and leveraging existing human resources”. In light of these guiding principles, existing ICTC/DSRC facilities were remodelled as SSKs. SACS and DAPCU also negotiated with the hospital administration to identify and secure space for SSK. In the space provided by hospital administration, local-level alterations (such as partition) were supported by SACS to accommodate SSK in existing facilities, ensuring easy access

to ICTC/ DSRC/ARTCs from the SSK sites. A complete facility and infrastructure assessment guidelines were developed and shared by NACO with States under remodeling exercise.

4.4.2 Staffing or Human Resource for SSK

States/ UTs implementing SSS were provided with four approaches for recruitment of staff, as per OG. The states could select the facilities fit for SSK conversion based on high, medium or low load of clients as per their facility assessment results and accordingly adopt any of the following staffing plans:

- Plan A - Appointing new SSK Staff through Outsourcing/Third Party Agency
- Plan B – Task Sharing (Leveraging the existing Staff)
- Plan C - Hiring new Staff through TI NGO
- Plan D - Mixed Approach [*SSK Counsellor cum Manager may be from the existing staff (ICTC/DSRC Counsellor) as mentioned in Plan B (Task Sharing) and the SSORW is to be hired as per Plan A or Plan C]*]

States/UTs could choose the appropriate plan that allowed for the establishment of SSK in the most cost-effective and efficient manner. A detailed list of merits and demerits of each approach was also provided to the states for guidance and aid in decision-making. Further, detailed **Job Description** for each staff cadre at SSK was developed by NACO to ensure standardization and support States/UTs in hiring, expectation-setting, and operationalization.

4.4.3 SSS Branding and SBCC Package

During the conceptualization process, the SSS branding (Logo) and SBCC material discussion was initiated as existing identified facilities ICTCs/DSRCs are re-modelled as Sampoorna

Suraksha Kendras, are provided with additional staff i.e. one Manager and two Outreach Workers for additional activities of SSKs like follow up, outreach activities, and IEC activities.

Accordingly, facilities were provided with a budget for infrastructure modification for ensuring audio/visual privacy of the existing facility and furniture, procurement of IT equipment, SSS branding, for outreach activities and SBCC activities.

SSS Logo

consideration the established NACO logo, while aligning with the objectives of SSS. The

For branding of SSKs, a meticulously designed logo for SSS was developed, taking into SSS logo comprises an icon that combines the ribbon and a human figure. The symbolism of the logo is to show a healthy person (at-risk, HIV-negative) receiving complete in- and out-services for HIV and STIs. The color scheme was taken from the NACO logo, and the red dot denotes the "at-risk" population.

Figure 4: Sampoorna Suraksha Strategy – Logo



SBCC material

NACO developed the detailed SBCC Package on various topics for awareness generation, demand generation, and behavior change amongst clients and the general population. These were developed with the evolving media platforms and the wide-ranging at-risk target population in mind.

Detailed branding material was developed to ensure standardization and ease of access. These included signage, floor stickers, board designs, and Detailed SBCC material, which can be seen in the SSS Operational Guidelines 2nd Cut. The types of material developed are given in the figure 5 below. Theme-wise, the SBCC Package is given in Annexure 6.

Figure 5: SBCC Materials developed under SSS



4.4.4 Service delivery:

It was agreed that services can be bucketed into three categories –

- Comprehensive prevention (harm reduction),
- Differential testing (e.g., index testing, self-testing)
- Generic health (comorbidities).

SSS should not include services that are strengthening or duplicating existing services under the programme's purview (e.g., OST management). In addition, the essential service package should be kept to the bare minimum and expanded incrementally. The Programme may consider keeping all the services requiring referrals under the “essential” category, as these would not require specific skills.

From the outset of implementation, it was agreed that the essential service package should not only complement the existing services provided by the facilities (ICTC or DSRC), but also allow for the inclusion of desirable services chosen by the SACS/SSKs. This, along with the provision of vigorous follow-up by outreach activities and service delivery mechanisms contextualized by the State/UT, enhances the flexibility and customizability of the overall service delivery under the SSS, empowering you to tailor the programme to your specific needs.

Note: Essential and Desirable Comprehensive Service delivery description is covered in above sections.

4.4.5 Monitoring, Evaluation and Reporting:

During the initial conceptualization period, a brief telephonic survey was conducted with 30 high-priority facilities selected randomly, aiming to assess the on-ground reality of planning out SSS in existing facilities. Accordingly, it was identified that multiple ICTCs did not maintain records for HIV-negative clients, which would be crucial for providing services and follow-up with at-risk clients at SSKs.

SSS was a new initiative that focused on at-risk HIV-negative clients and provided them with comprehensive services, including NACP services and other health and non-health services through referrals, followed by outreach activities and follow-ups. Hence, it was decided to record data at SSKs in real-time digital format to enable faster data collection and collation, reporting, and recording in place of paper-based / manual reporting. To capture all the indicators of SSK, a web-based tool in NORMS for SSK data collection was developed by NACO as an intermediate solution to be filled only for at-risk HIV-negative clients and complement the existing reporting at the facilities. Further, a detailed data flow (in line with the client flow) was also designed to ensure standardization and smooth operationalization of the SSK data collection tool while ensuring continuity of reporting on existing data systems, i.e., NORMS.

CHAPTER 5

Establishment of Sampoorna Suraksha Kendra

5.1 Selection of Facility for Sampoorna Suraksha Kendra (SSK)

The districts for implementing SSS were identified at the national level keeping in mind specified parameters provided in Chapter 4.2. SACS were given the flexibility to select the one facility (ICTC or DSRC) in the shortlisted districts that could be re-modelled as an SSK. NACO developed a Facility Assessment Tool to support the shortlisting process for identifying one facility that can be re-modelled as SSK.

5.2 Facility Assessment

SACS conducted a rapid assessment using the Facility Assessment Tool, comprising three sections Operational Assessment, Client Survey and Service Mapping to identify the facility to be re-modelled as SSK for implementing SSS. The objectives of the assessment included:

1. Identifying key gaps in the existing service delivery mechanisms.
2. Determining a viable service package under SSS.
3. Developing recruitment and outreach plans.
4. Identifying HR personnel, infrastructure and hiring requirements for implementing SSS.

The process of development of the Facility Assessment Tool to enable states to collect relevant information developed by NACO included Field Testing of the tool in the states selected by SSS WG members with the objective of gathering insights to optimize the tool design further. The tool was pilot-tested in three districts in Gujarat, Telangana, and Nagaland. Further, one ICTC and one DSRC were selected for the field assessment based on client load (one high-load and one low-load). A team comprising members from partner organizations, DAPCU/Technical Support Unit (TSU)/ SACS, was created to pilot the tool. After incorporating feedback from the pilot testing exercise, the tool was finalized and used for facility assessments.

For details of SSK Assessment tool, please refer to Operational Guidelines (2nd Cut) August 2023.

The rapid assessment undertaken by the states included three broad steps:

- **Strategic Assessment** to identify unmet service needs of at-risk clients that could help alleviate HIV vulnerability through SSK services. It aimed to identify a superset of services, prioritization of the services as well as, identification of a subset of services that could be provided with the resources available at the state. This assessment was undertaken by conducting a client survey and service mapping.
- **Operational Assessment** towards developing an operational framework for SSS in the state by (a) identifying an appropriate facility to be remodeled an SSK, (b) assessing the recruitment need, and (c) evaluating the required infrastructural changes in the identified facility. This assessment was carried out by SACS for all ICTCs and DSRCs of the selected SSS districts.
- **Data Review** was conducted to provide insights on facility selection and HR requirements for SSS roll-out. The data from ICTCs and DSRCs of the selected districts were collated and synthesized across key metrics e.g. testing load, demand for sexual and reproductive health (SRH) commodities, number of STI cases

5.3 SSS Proposal and Implementation Plan

A comprehensive guidelines and template for development of proposal and implementation plan was designed by NACO to support the SACS in defining holistic implementational nuances for their districts in their respective States/UTs. This included identification of target population, facility selection, service package, outreach plan, recruitment plans and financial proposal, The Guidelines for submission of Proposal for Phase I is in *Annexure 4* and for Phase II the Guidelines and template were modified based on Phase I proposal submission, as in *Annexure 5*.

A series of meetings and consultations were organized to apprise and support the SSS Nodal Officers of SACS on the process for establishment of SSK and on the development of proposals and the implementation plan. Further, various meetings were conducted for sharing the learnings from SACS that conducted the Pilot exercise to Phase-I States/UTs, and consequently the learnings from Phase I States/UTs were shared with Phase-II

States/UTs to support in facility assessment, proposal development and refining their implementation plans.

For the establishment of SSKs and implementation of activities, a separate budget under Global Fund Grant 21-24 was allocated in the Annual Action Plans of the SACS by NACO. The budget heads included for each SSK are as mentioned below.

- **Establishment Cost for SSK:** This is a one-time budget provided for infrastructure strengthening for new Sampoorna Suraksha Kendra. The provision for purchasing laptop/ desktop, furniture, branding, and IEC is also included under this head.
- **Honorarium to Workforce:** Provision of paying honorarium to the new SSK staff/ incentive for the existing NACP staff is made under this head.
- **Capacity Building & Supportive Supervision:** The provision for conducting the Induction training, Orientation of SSK Staff, and for facilitating the Supportive supervision visits, meetings are made under this component.
- **Activity and Administrative Cost,** included Travel Cost for Programme Purpose, Internet and Mobile Charges, Advocacy Meeting & Sensitization Workshops, Health and General Camp, Consultation and Review Meetings, Navigation and Contingency

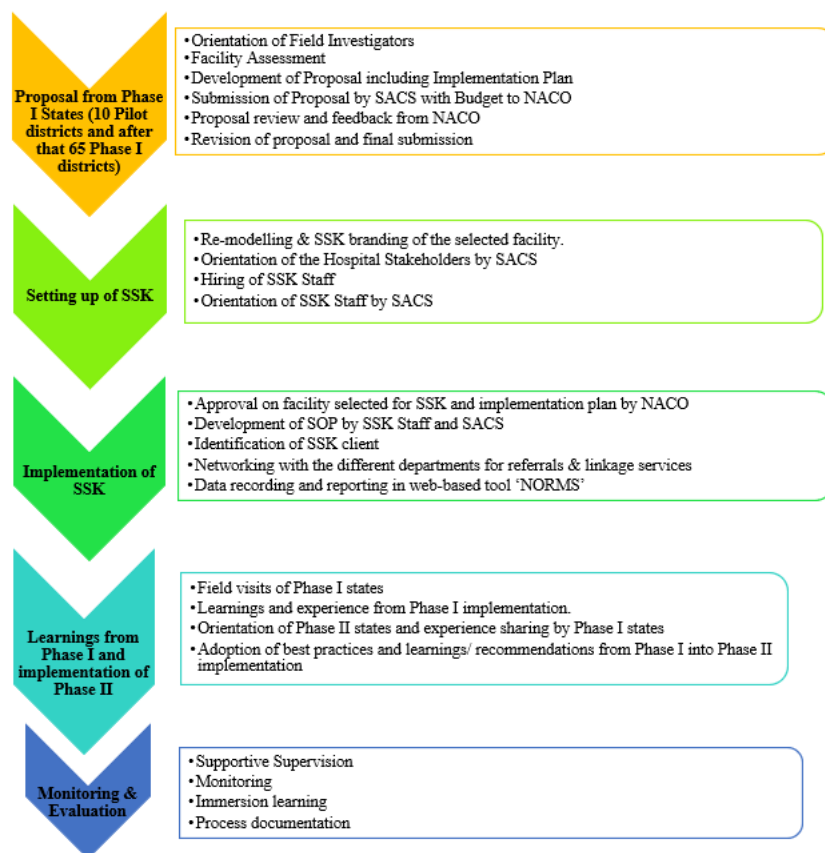
Hence, based on the Facility Assessment, the proposal and implementation plan were developed by SACS incorporating the details regarding shortlisted facility with the comprehensive package selected to be delivered from SSKs including essential and desirable services as per the availability of the same in the district. The State proposal also included the budget as per the number of SSKs allotted to the respective States/ UTs and approved in Annual Action Plan.

5.4 Process of Establishment of SSK I

The implementation of the SSK initiative followed a structured process across two phases. Initially, Phase I States/UTs focused on orienting field investigators, assessing facilities and shortlisting it, developing proposal including implementation plan. The setup of SSK involved

remodeling selected facilities, branding, and orienting hospital stakeholders and SSK staff. Implementation progressed under NACO's guidance, leading to the development of SOPs, client identification, inter-departmental networking for referrals, and data management. Throughout the process, guidance, monitoring, supportive supervision and immersion learning were key to ensuring effective implementation and continuous improvement (Figure 5).

Figure 6: Process of Establishing Sampoorna Suraksha Kendra (SSK)



5.5 Orientation and Capacity Building

NACO conducted a two and a half day (half-day virtual mode followed by two-days physical mode) training workshop to orient the on-boarded SSK staff (across all cadres) with the objective to develop their understanding on NACP V Programmes and interventions, SSS and its operational modalities, guidance on development of SOP and data entry in NORMS. The training workshop was also attended by SSK State Nodal Officers nominated by PD SACS and other concerned SACS Officers. Training sessions were conducted by experts f

rom NACO and respective SACS Programme Officers from respective divisions. Virtual training sessions were also conducted in batches, on the SSS, SOP & SSK data collection tool, to orient and train the SSK team.

Subsequently, a 2-day detailed workshop was organized at State-level to provide training on the above-mentioned concepts and key aspects. State SSS Nodal Officers further sensitized their States/UTs SACS officials on SSS and SSK.

5.6 Experiences and Learnings from Implementation (Phase I and II)

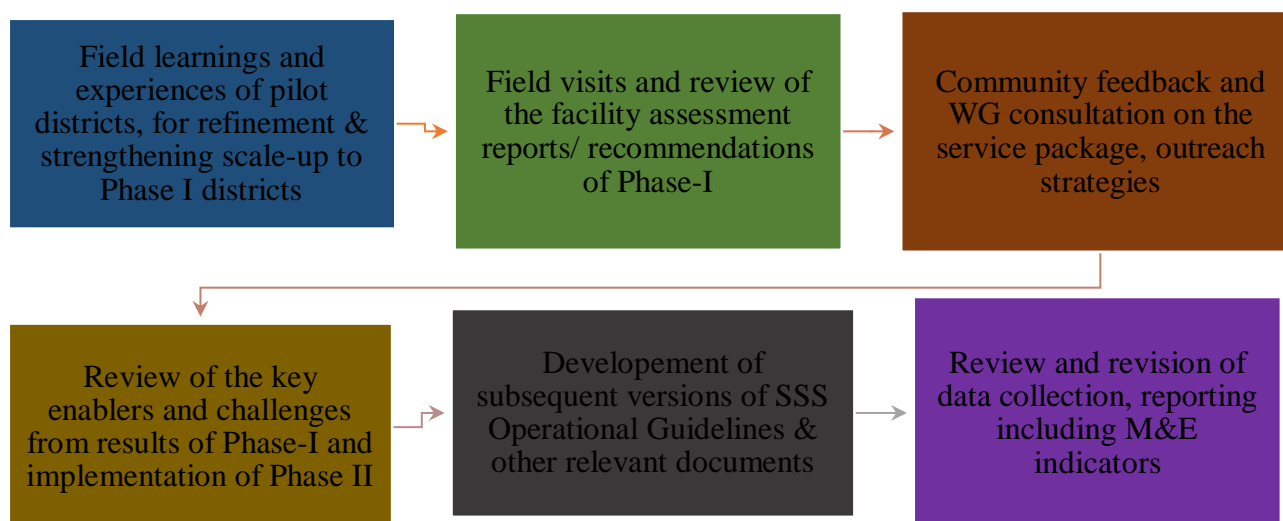
Learnings from the Phase I highlighted that the strategic shift in epidemic control is possible in high prevalence states ensuring effective use of existing resources. Significant ownership of the officials from States and Districts including collaboration with various stakeholders to deliver a comprehensive package of services for HIV-at risk and HIV-negative individuals is the key. Community structures like Community Resource Groups are critical for demand generation and improving the quality of services in Sampurna Suraksha Model.

Various mechanisms have been developed under SSS to ensure documentation of experiences as well as challenges/learnings experienced while establishment and implementation of SSS in a phased manner. Some of these include:

- a. Visits by National Team/State Teams to SSK (*aided with a **comprehensive Facility Visit Checklist** to document experiences across all components*)- *Annexure to be added*
- b. Leveraging workshops and orientation meetings as a platform for Stakeholders to share their experiences on SSK.
- c. Stakeholder Interviews were conducted to gather information on challenges and recommendations to further strengthen SSK service delivery.

Challenges and lessons learnt from Phase I were documented and incorporated in the 2nd Cut of the OG. Further, multiple steps were adopted across the course of implementation of Phase II, towards refinement of strategy and implementation framework, as indicated in Figure 7.

Figure 7: Steps of Phase-wise progress and Implementation of SSK



Learnings from Phase I of SSS implementation

Multiple visits were conducted by the National SSS team along with development partners, to various Phase I SSK States/UTs. The purpose of these visits were:

- To interact with SSK/ICTC/DSRC staff to gauge their understanding and their roles and responsibilities for SSK
- To observe the set-up and functioning of the SSK and accordingly orient and sensitize the hospital authorities, other health departments and SSK team on learning, recording and reporting as well and next steps to improve service delivery through SSK.
- To discuss any difficulties faced during the data entry process.

Designed on the principle of “**Immersion Learning Model**”, refinements were made continuously in the Programme to optimize operationalization in Phase II from the key observations made during field visits and in review meetings.

Implementation of Phase II

Learnings and experience from Phase I implementation were documented and recommendations to improve SSK service delivery were incorporated in Phase II

implementation. The key observations and recommendations from field visits from Phase I adopted in Phase II are as follows:

- It was recommended that significant ownership of the States and Districts, including collaboration with various stakeholders, is required to deliver a comprehensive package of services for at-risk and HIV-negative individuals.
- Community structures like Community Resource Groups are critical for demand generation and improving the quality of services in SSK in implementation, monitoring, and providing feedback and course correction.
- It was suggested that the development of referral mechanisms should be created to ensure tracking of services provided to the client at the referral facility, maintaining documentation of out-referrals, and following up with clients.
- SSKs may develop temporary data collection formats for reporting and client follow-up as a stop-gap solution until all required indicators in the data collection tool (NORMS) are being devised.
- It was observed as a good practice that may be adopted as applicable and appropriate that some of the SSKs could bring in a good number of walk-in clients by leveraging ongoing awareness campaigns for HIV/AIDS. Further, ANMs and ASHAs were also engaged to provide support in motivating people for testing and spreading awareness on HIV/AIDS. Timely orientation on SSS by SACS to the hospital team, DAPCU, SSK staff ensured awareness of SSK and its operationalities.
- The need was identified for leveraging other resources in the hospital to provide services such as testing and treatment of co-morbidities to at-risk SSK clients.
- Staff was observed to have limited awareness about services delivered through SSK. To address this, the national team would develop comprehensive SOPs (standard operating procedures) with detailed information about SSK activities and details about set-up and clients. Further workshops were conducted to train SSK staff on best practices and filling up SOPs.
- Collaboration with NHM and other stakeholders is critical to ensuring comprehensive service delivery as per the needs of clients, and a strong referral and linkage system needs to be established with a robust monitoring system.
-

- To improve follow-up and enhance visibility at the national level, a tracker was rolled out across all the SSK implementing states, soliciting information regarding the status of each SSK across different areas of recruitment, remodeling, data reporting
- Strengthened focus on assessment of risk of clients, establishing mechanisms for referral/linkage of clients, monitoring and supportive supervision by SACS. Routine and continuous review of data from SSKs at SACS level
- To mitigate any administrative issues, it was suggested that an external agency can be hired for SSK staff recruitment across the state.
- Improvisation in the NORMS was done and added new indicators per the field team's requirements.

In summary, the development of the immersion learning model for Phase II incorporated the key areas below; it was understood that 'one size will not fit all', and it is critical to be flexible with the service package and outreach model and undertake task-sharing as well as task-shifting roles. The Phase-II model was repositioned to ensure that field realities are further embedded in the SSK framework and M&E indicators are made robust based on the learning from Phase-I and working group meetings.

5.7 Supportive Supervision

Under SSS, a strong focus has been placed on supportive supervision to provide handholding to staff and to refine service delivery as per the client needs. An observational checklist was developed by NACO for recording observations during field visits by teams to ensure standardized process of supportive supervision.

Accordingly, guidance was provided by NACO to the state and district-level experts on the parameters for these supportive supervision field visits, along with clear timelines for the frequency of these visits.

Over the years, supportive supervisory visits have been conducted to the SSKs during the Phase-I and Phase-II implementation by the national, state, and district teams in order to identify the challenges, share experiences and learnings, ensure necessary training and resources are available, provide constructive feedback and handholding support to SSK staff

and relevant stakeholders for better understanding and implementation of SSS. These visits served as an opportunity to understand a) requirement, availability, and gaps in supply of SBCC material, b) infrastructural requirement and challenges, c) challenges for ensuring quality of services, regular follow-up, referral and linkages as per need of the client.

These field visits have supported the improvement of the quality of care and capacity of SSK staff and contributed to improving SSK service delivery. The visits also ensured documentation of all the challenges shared by clients or staff, appropriate solutions provided, and improvement of the overall performance of the SSK. As an immersion learning process, the feedback received was incorporated in the Operational Guidelines 1st Cut and revised OG 2nd Cut.

An excel based Supportive Supervision Tool was also developed and is in a process of digitalization.

5.8 M&E Framework

Collecting data and analyzing performance is a critical component of any health Programme. Since SSS was implemented as an immersion learning model, documenting challenges and monitoring the progress is important to take timely action to improve quality service delivery. A detailed list of M&E indicators (*Input, Output and Outcome*) was developed under SSS to ensure comprehensive progress tracking, which was revised and refined in Phase II based on field experiences, learnings, and data analysis from Phase I.

The risk assessments for the at-risk HIV-negative clients were conducted by Counselors at the SSK at every client visit for HIV testing. The data being captured in NORMS includes demographic profile, risk assessment, partners details, comprehensive services, follow up plan etc. (NORMS Data tables is given at *Annexure 6*). It was decided that eventually, this tool will be integrated into the SOCH platform (NACO's integrated data system, called SOCH: Strengthening Overall Care for HIV beneficiaries) to ensure a single portal for data reporting.

Based on the data required and collected by SSK, SSS Monitoring and Evaluation Framework was prepared to monitor the performance of SSKs further and analyse the data for mid-course correction. Please refer to *Annexure 7* for the SSS M&E framework with an expanded set of indicator

CHAPTER 6

Outcome of Process Documentation

Process documentation is incomplete without gathering the information from the field and from people who worked on its development and implementation. With this notion, the field plan was designed with a purposive selection of districts and facilities while ensuring coverage of all the 20 States/ UTs implementing SSS along with Key Informant Interviews. Details given in Annexure 3.

Based on a thematic tool (*Annexure 9*), a series of in-depth interviews were conducted across various levels. Respondents included SSK clients, site-level SSK staff, institution heads at SSK sites, DAPCU/DISHA staff, SACS Officials, NACO Officials, SSS Working Group members, representatives from UN and bilateral agencies and representatives from the communities.

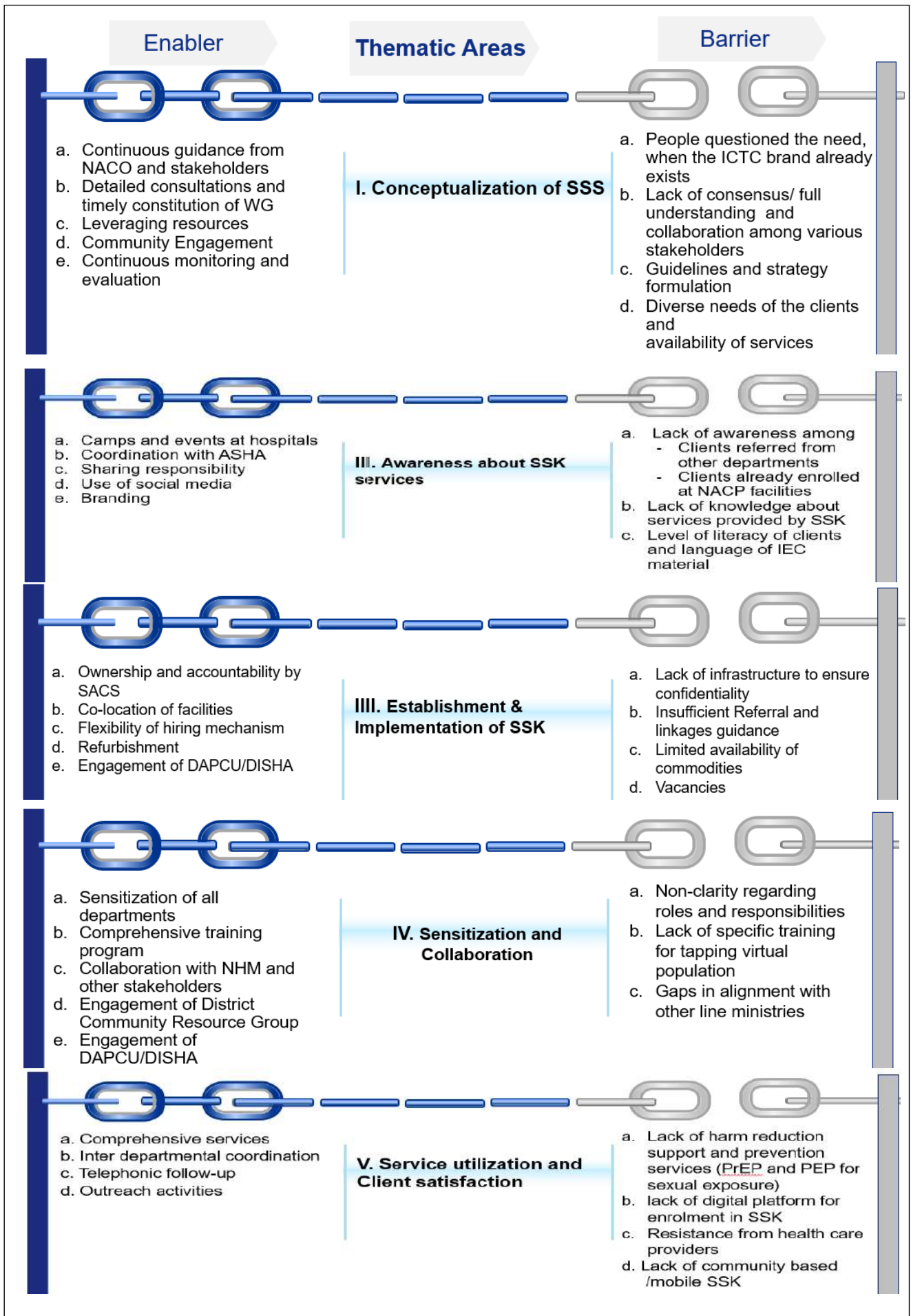
The semi-structured tool was administered to understand and document the following:

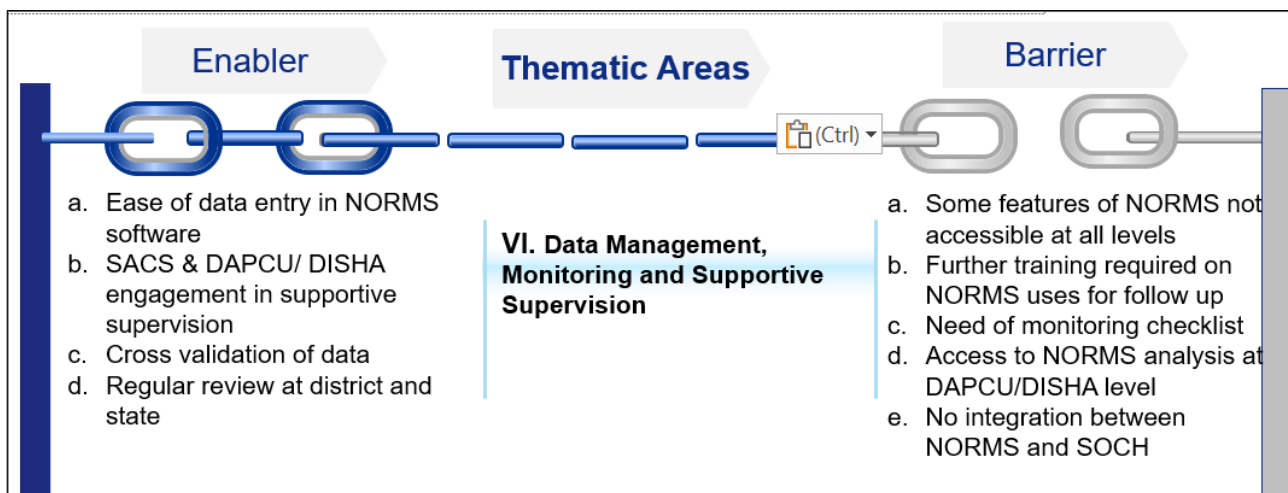
- The level of awareness and knowledge about the SSS intervention.
- Variety of services provided and the experience of accessing these services.
- The overall management and implementation experience of the SSS.
- Gaps, challenges, and enabling factors in the existing system.
- Lessons learned, best practices, and innovations.
- Recommendations for improvement.

The methodology of data collection and analysis plan is given in detail in *Annexure 10*.

The tool was divided in six thematic areas depicted in figure 8. Thematic analysis was conducted by examining the coded content from the compiled transcripts of all the interviews and the findings were incorporated across these thematic areas. Specific verbatim on theme-wise enablers and barriers, as identified through analysis of these themes are given at *Annexure 11*.

Figure 8 below shows the snapshot of Thematic areas of data collection tool for the Process Document





6.1 Conceptualization of SSS

SSS is characterized by inclusivity and meticulous planning aimed at reaching vulnerable populations. The origin and conceptualization of SSS was well understood among the participants. The participants had the clear idea about the initiation of SSS in 2021, with the understanding that “at risk” populations need to be covered through different strategies with a clear plan to reach out to them.

These individuals are provided with a cyclical, need-based and comprehensive package of supportive services that help them stay negative and healthy. This holistic approach aims to streamline assessments, providing integrated services under one roof, and referrals for clients.

Enablers: Continued guidance from NACO leadership and stakeholders, timely constitution of working group, multiple consultations at SACS, leveraging resources, community engagement and continuous monitoring and evaluation helped in smooth implementation of the SSS and are identified as enablers for the successful conceptualization.

The engagement of existing staff and infrastructure in the implementation of strategy was seen as a major enabler for the upscaling of the strategy. Flexibility has been extended to SACS in hiring of SSK staff, allowing SACS to adopt various staffing models tailored to their

specific operational requirements. Availability of budget sufficient for the implementation was a major enabler.

The core mantra of break the silos and build synergies and provisioning of cyclical preventive services to at risk population was understood by all levels of the program implementation.

Barriers: Concerns were raised about the need of SSK when established brand of ICTC exists. People felt that there is still a need for strengthened collaboration among various stakeholders and bringing everyone on board with a common objective, to create and share clear guidelines and SOPs as per the diverse needs of the clients.

The concerned staff at State and field level needed to be oriented for unlearning and then learning the newer strategies. Lot of handholding support for SACS, training of facility staff and counselors is required, to make everybody understand the role of SSK and responsibilities of each one of them.

Newer strategies like focussed risk assessment, outreach services etc. though were part of the implementation strategy but were barely focussed upon till the introduction of Sampoorna Suraksha Concept. The focus on these aspects of program had resistance in terms of incorporating it in as responsibility of the field staff and thus bringing in accountability and ownership.

6.2 Awareness about SSK Services

Most of the respondents understand the purpose of the SSK. Few indicated a need for further clarity on clients for SSK. While exhibiting IEC materials about SSK services in other health care facilities or distributing during outreach activities and health camps was found to be useful for creating awareness.

Enablers: SSK counsellor and manager made efforts to conduct multiple camps and awareness events within the hospital premises, and in community settings to improve the awareness of SSK facility. Responsibility sharing, coordination with other outreach teams (ASHAs), innovative approaches to increase reach (camps and events at strategic locations, reaching out to adolescent girls/women with ASHA), and sharing knowledge helped in improving coverage and footfall at SSKs. Social media, supported to boost public awareness

about SSK. There were some clients who were self-linked after reading the posters/IEC materials at the facilities.

Barriers: Clients referred from other departments often did not have a good understanding of the services provided by the SSK. The clients receiving regular care at the facility through ICTC prior to the formation of the SSK, were also found to be not aware of the transition of their care to this new department, or about the additional resources/services available under the SSK. The knowledge of services offered by the SSK was limited to HIV counselling and testing services among all clients. While some clients availed a slightly more expanded blood panel testing including HIV, STIs, and hepatitis testing. Most of the clients had received only HIV testing and do not have knowledge of other services. Additionally, IEC material was not accessible by all clients due to different levels of literacy and the language of the materials.

6.3 Establishment and Implementation of SSS at SSK

The SSK establishment process begins with identifying a strategic location that is accessible and central to the clients of SSK, with the needed infrastructure for providing the services. The SSK as a strategy provides a fine balance of guidance being provided from the national level with SACS playing major role in execution and facilities playing the role in implementing the strategy. The strategy allowed contextualized models to be implemented at each state/district, resulting in greater ownership, accountability, and innovation.

Enablers: Timely action in terms of feasibility assessment, procurement as per need and periodic 360-degree review by some SACS are cited as good examples of ownership. Ownership of the SSS by SACS and respective Institute along with supportive staff served as a firm enabler for better understanding and implementation.

The flexibility to select one out of four mechanisms for engaging human resources for the implementation of SSK, need-based expansion and refurbishment of existing facility improved access and utilization of SSK. Engagement of SETU, DAPCU and DISHA for orientation and coordination at the implementation level boosted activities at SSK. Availability of customized SOPs has enabled implementation of contextualized solutions, depending upon the client needs and service availability of different SSKs.

Barriers: There were concerns about confidentiality and privacy due to limited infrastructure and/or lack of a counselling room. Ensuring other health and non-health related service delivery through referral and linkages was also cited as a barrier. At times, due to stock-out of commodities in hospital and inconsistent availability of all commodities related to desirable services was cited as one of the challenges in successful implementation of SSK. It was noted that many positions were vacant under NACP (even before conceptualization of SSK) and SACS were not able to establish SSK at most suitable places due to the vacancies of these critical positions. Regarding the location and timing of SSK facilities, mixed feedback was received from the respondents. It served as an enabling factor for clients who reside in the vicinity of the hospital and get all the desired services available under one roof. However, for others, it was identified as a barrier in terms of the distance of SSK from their place of residence and the limited working hours of the facility.

6.4 Sensitization and Collaboration with stakeholders

Sensitization and collaboration with various stakeholders are critical components in strengthening services through SSK, as they foster a shared understanding and collective action among stakeholders. Sensitization involves educating and raising awareness among healthcare providers, policymakers, and the community about key health issues, challenges, and the importance of integrated efforts. This process helps align goals and creates a sense of urgency and commitment. Conversely, collaboration brings together diverse expertise and resources from government agencies, non-governmental organizations, and the community. These groups can design and implement comprehensive strategies that address healthcare gaps, improve service delivery, and promote sustainable health outcomes by working together. The synergy created through effective collaboration enhances resource utilization, innovation, and the overall impact of SSK initiative.

Enablers: Many respondents mentioned the usefulness of sensitization and training of all the departments on the establishment and purpose of the SSK to ensure inter- departmental collaboration. Comprehensive training Programmes conducted by NACO, and states helped NACP staff in improving understanding about SSK. District Community Resource Groups (DCRGs) are active in some of the districts and provide support for crisis management for clients referred from SSK. Engaging key stakeholders and leveraging resources from NHM,

SACS, DAPCU, DISHA and TI NGOs are important for ensuring collaboration in districts and for the smooth service delivery.

Barriers: Gaps in understanding of roles and responsibilities of ICTC, DSRC, and SSK staff and limited reach to the virtual population were noted. For service delivery provision, it was shared that SSK may not be able to provide certain services related to livelihood, nutrition, gender-based violence, hormonal replacement therapy, sexuality and a collaboration with concerned departments for mobilizing resources and ensuring service delivery needs alignment with concern line ministries.

6.5 Service utilization and Client Satisfaction

Service utilization at SSK and client satisfaction are closely intertwined, as the frequency and way services are used often reflect the quality of care provided. High utilization rates indicate that healthcare services are accessible, trusted, and meet the community's needs. However, it is not just about the number of visits; the client experience during these interactions is crucial. Factors such as timely access to care, clear communication with clients, and respectful and effective service delivery significantly determine client satisfaction. Satisfied clients are more likely to adhere to treatment plans, return for follow-up care, and recommend services to others, reinforcing a positive utilization cycle. Continuous assessment of client feedback and service delivery is essential for maintaining high standards of care and ensuring that, SSK remains responsive to the clients' needs.

Enablers: Clients regularly received comprehensive services inclusive of counselling services, testing for HIV, STIs, hepatitis and TB, as well as general health screening and provision of condoms from the SSK. Most clients report follow-up HIV testing every 3-6 months. Rigorous telephonic follow-up and outreach activities for adhering to their scheduled appointments were also noted. Clients are referred to other departments and facilities as needed based on symptoms and concerns raised. Some clients also reported to receive social support/protection and legal services through SSK. Several clients expressed satisfaction with the free provision of services at SSK, including referrals to other departments.

Barriers: Lack of harm reduction and prevention services (PrEP and PEP) through SSK was cited as a barrier by some of the respondents, especially in the Northeast region. The concerns were shared about limited funds for outreach activity, inability to enroll at SSK through digital platforms, lack of a community-based mobile SSK facility for people having limited access to healthcare. The initial reluctance of health care providers for SSK facilities was also cited as a barrier for service utilization by some of the respondents.

6.6 Data Management, Monitoring and Supportive Supervision

6.6.1. Data Management

Enablers: All the centers use National Online Reporting and Monitoring System (NORMS) for data reporting. Most of the SSK sites maintain the separate registers manually for master line list and client follow-up. They record the service deliveries in the same register and then enter data in the NORMS. Some of the sites either directly enter data in the NORMS or use ICTC records to input data into NORMS.

Barriers: While the NORMS software is easy to manage, staff at some sites faced challenges while entering data and also access at all levels. There is a need for further training on some of the functions of NORMS, such as creating a due list for follow-up and monitoring service gaps. As client data is entered in both SOCH and NORMS, data duplication is a major challenge. Most of the respondents from DAPCU expressed that they have not been trained completely on their roles and responsibilities with relation to the SSK including NORMS.

Some of the SACS respondents and most of the DAPCU/DISHA respondents requested a monitoring checklist with core monitoring indicators. Though few DAPCU/DISHA teams generate the data from NORMS during SSK site visits, most of the respondents from DAPCU/DISHA shared having no access to NORMS data which is required to ensure data quality, monitoring, and review. Some respondents also suggested having regular regional-level review meetings for cross learning.

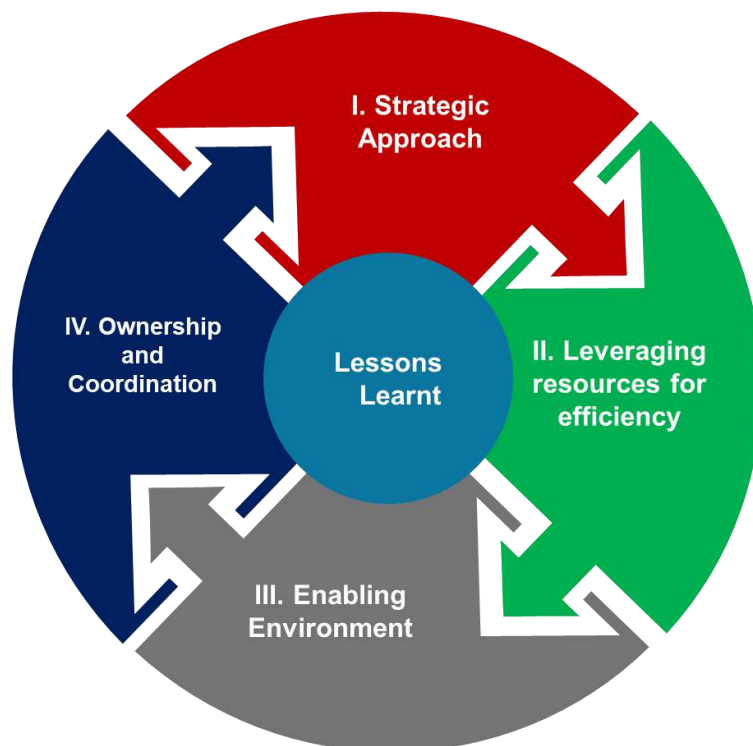
CHAPTER 7

Lesson Learned and Best Practices

In line with the NACP Phase-V Strategy guidance to cover ‘at-risk’ HIV negatives through comprehensive prevention packages, and keep them negative, the evidence generated under SSS from first **two** phases of Implementation demonstrates how at-risk populations are currently reached out in the program in a most structured manner.

During the two phases of Implementation so far, many operational challenges were faced. Some of these challenges were mitigated during the implementation while some were taken as lessons learnt to make the SSS more effective and efficient. These relate to conceptual design, its implementation, outreach strategy and optimum utilization of resources etc.

The figure 9 below highlights, by building on the learnings and enforcing integrity, SSS may well be the proverbial giant leap towards reducing new infections.



This section documents many initiatives pioneered by the States (not universal though) based on local/specific resources available during implementation of SSS; and formulates with the basic aim of facilitating knowledge sharing, adaptation and replication to localized contexts.

I. Strategic Approach

a. Comprehensive single window service delivery: The selection of sites by states based on availability of comprehensive services as per diverse needs of clients and ensuring availability under one roof at some places was proven to be critical step for successful implementation of SSK.

b. Strong consultative processes: SSS evolved through a consultative process by a National Working group with all key stakeholders, SACS, Community, CSO and partner organization representatives. Along-with National level, regular consultative meetings with state and district-level stakeholders to gather feedback on the implementation of SSS, conferred opportunities for improvement. Community Engagement was key to ensure people centric comprehensive health service delivery.

c. Resource Mobilization: Funds allocated to SACS were not fully utilized, however instances of mobilizing financial resources from hospital funds is noted as a strategic opportunity for sustainability.

d. Fostering a Client-Centered Approach: Focused rapport building and client-centered care to maintain high levels of client satisfaction, and regular feedback from clients into service improvement led to better outcome in reaching out to high-risk individuals.

e. Standardize Operating Procedures: Development of Operational guidelines at National level but customized package of services through a State led process, incorporated State ownership as per their choice/ needs.

f. Data management: The easy-to-use web-based reporting system “NORMS” is utilized by all the centers. Weekly tally of records between ICTC Counsellor and SSK Manager of the coded risk assessment form is done to check if all patients sent by ICTC have been

registered in NORMS". But Repeated training and hand holding for maintaining the quality of data entry and output need to be strengthened.

II. Leveraging Existing Resources

a. Optimum utilization of resources: Improved coordination with other health and non-health departments including NACP for leveraging resources available under different Programs, integrating comprehensive service delivery by leveraging Human Resource and commodities of existing facilities proved to be very productive in getting outcomes. At several places, through Inter department coordination syphilis screening kits were leveraged from Blood bank till kits were supplied by SACS to SSK. This practice however was not universal.

b. District Resource Group (DRG) platform: DRG platform is used for quarterly meetings by the district collector for community-to-Government interaction. It facilitates building rapport with line departments; at some places this platform was used by the DAPCU/DISHA to orient the stakeholders on SSK services.

c. Private hospitals/clinics: Leveraging resources and expanding SSK model into private sector facilities to engage currently unreached populations. SSK provided referrals to private sector appropriate to client needs, but this practice was not widespread.

III. Enabling environment for efficiency

b. Efficient Coordination: Facilities (ICTC/DSRC/ARTC) in same premises proved very helpful in-service utilization and implementation, also SSK ORW navigated patients to the OPD and follow up investigations, these accompanied referrals helped patients to cut through the crowd and access the services easily.

c. Utilization of Multiple Media platforms in local language: The use of digital platforms and social media proved useful to reach a broader audience, video and audio content tailor-made according to the local context and needs was very effective in engaging communities with varying literacy levels and language.

IV. Ownership and Coordination

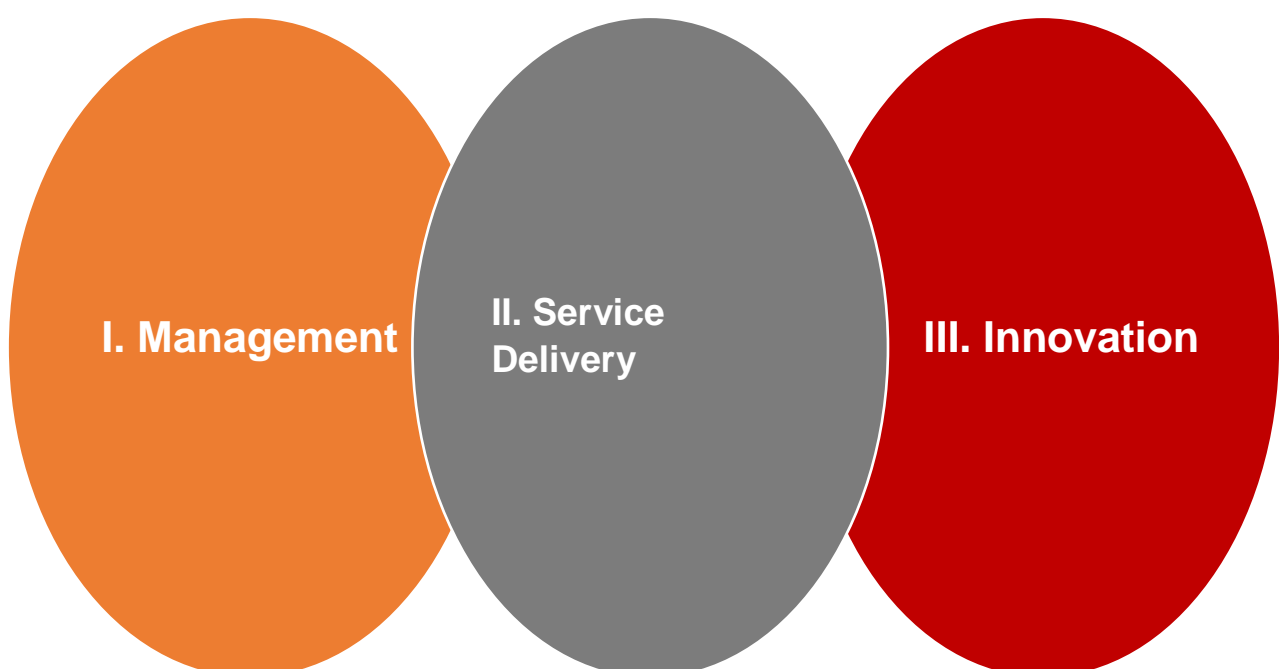
a. Ownership and accountability: Timely action in terms of feasibility assessment, procurement as per need and periodic review by some SACS are cited as good examples of ownership. But collaboration among divisions of SACS as well as delays in recruitment and training need to be further strengthened.

b. DISHA team engagement consistently coordinated for sensitization meetings and with various programmes including national Viral Hepatitis B and C Programme, enhancing collaboration and information exchange to better address the healthcare needs of the population. However, DISHA team need to play a more succinate role in sensitization, coordination, data reporting, monitoring and supervision of SSKs.

Best Practices

Innovative demand generation efforts and service delivery approaches have contributed to the significant progress in many States, which established SSKs in Phase I and Phase II.

Figure 10 below highlights as how the overall goal of achieving scale, quality and client satisfaction under SSS revolves around Management, Service delivery and being unique and innovative in approach.



I. Management of the program at the State and at the SSK site levels includes adequate manpower, infrastructure, location etc. but the key for ensuring effective management is that trained staff are available, and they are supported by robust systems of reporting, monitoring and supervision.

a. Staff selection is key to long-term outcomes:

Some of the States at Eastern Region of India, especially Malda in West Bengal implementing SSK in Phase II has demonstrated this agile process of using counsellors as SSK managers, leveraging their long-experience and competencies including better coordination with various services and stakeholders as against a new person considered as manager.

b. Local leadership played a key role:

At Punjab, DISHA team planned the site sensitization activity at the hospital level for orienting and capacitating the hospital doctors, paramedical staff, ANM, LT, ASHA, Anganwadi workers about all services provisioned under SSK supported by SACS. This initiative boosted the SSK activities in the districts; and supported coordination between Gynecology department, OPD, surgery department and at SSK staff, resulting these departments notifies about any reactive cases to the SSK.

Assam SACS during its Phase-2 implementation also explored the use of DISHA team for close coordination with the National Viral Hepatitis B and C Programme, enhancing collaboration and information exchange to better address the healthcare needs of the population.

b. Buy-in of the hospital authorities is critical

Although the guidelines recommend several approaches to improve better ownership and buy-in of the hospital authorities, but under Phase -2, Assam SACS adopted sensitization program and camps to have better buy-in and involvement of various departments/facilities in the hospital where SSK is located.

II. Service Delivery

a. Satisfied clients bring momentum and greater acceptance for services

The wide range of services provided through SSK facilities require optimum level of demand generation and quality of services to improve its reach and ensure retention of clients. SSK Bareilly in Uttar Pradesh implemented in Phase -1, has demonstrated the importance of client engagement. According to the client:

"I am quite satisfied with the support received from the SSK centre and is keen to support the outreach activities for IDUs, since there are hidden/unreached IDUs in her vicinity".

b. Follow-up improves quality and trust

SSK services are need based and they change periodically, hence continuous and meaningful engagement with the client is very important. Few clients from Ambedkar Nagar in Uttar Pradesh (implemented during Phase -1) shared that "received frequent calls from the staff and even we call staff whenever there are any problems/issues".

c. Making last-mile services reality

SSK services are aimed at keeping the high-risk clients HIV negative by adopting healthy behaviours and practices. SSK guidelines recommends various strategies to support last mile delivery of services. SSK Barwani in Madhya Pradesh during Phase -2 implementation has adopted a mainstreaming approach to make this reality. Sensitization of the ASHA workers and Anganwadi Sevika on SSK activities has helped in the mobilization of at-risk population during the mega camp.

Similar experience of clients mobilized by ASHA/ANM at rural and remote areas were shared by Uttar Pradesh (UP) and Delhi SACS. UP SACS highlighted, ASHA brings STI patients from village and peripheral level, coordinates with outreach worker and also engages with TI staff for identification of non-TI population; mobilizes STI and ICTC staff to cover high-risk pockets in area.

Delhi SACS also mobilized pregnant women and adolescents/college girls with the strong coordination between ASHA and ORWs at rural/slum areas.

III. Innovations:

a. Integrated approach in monitoring SSK activities

SSK services are cross-cutting, inter-departmental and collaborative. Maharashtra SACS considering its vast geography and need for better SSK implementation considered supervisory visit plan e.g 360-degree review of district-level program by the Joint Directors visiting the districts, these visits included review of the SSK activities.

b. One-stop solutions

SSK services mandates meeting the clients needs beyond the services provided in health facility. To meet those needs, SSK at Nashik implemented during Phase -1, has developed a resource directory of all stakeholders and kept at SSK to support the clients, link them to respective non-health services as per the need.

In future through the existing platforms of dissemination many such best practices from SSK will be shared widely for further scale-up and optimization of resources.

CHAPTER 8

Recommendations and way forward

The Sampoorna Suraksha Strategy is a well-structured and inclusive approach that emphasizes reaching out to vulnerable populations with a comprehensive set of health services. Below are the key recommendations emerged from the analysis of key informant interviews conducted for strengthening next phase/es of SSKs.

- A. Continue and Strengthen stakeholder engagement:** Ensure continuous involvement of all key stakeholders including community representatives in the SSK implementation, monitoring and supervision, to address emerging challenges and adapting the model as needed. Conduct regular consultative meetings with the stakeholders at State and District-levels, to gather feedback on the implementation of SSS and to identify opportunities for improvement.

- B. Enhance further flexibility in staffing models:** “One size fit all” strategy may not work, promote the adoption of flexible staffing models tailored to the specific needs of different regions and local contexts. This could involve allowing districts to pilot innovative staffing approaches that meet local demands.

- C. Engage Community Health Workers:** Strengthen the role of ASHA and other community health workers towards awareness generation for SSK services. Provision of additional training and resources will support in ensuring effectively communicating the benefits of SSK to the community. Use Community champions and include SSS in Community Led Monitoring. Improve upon virtual outreach and virtual intervention leveraging community to reach the unreached at-risk clientele.

- D. Improve utilization of multimedia platforms and distribution of IEC Materials:** Enhance the awareness on SSS through a multimedia approach. Increase the distribution of IEC materials across various healthcare settings and during outreach activities. It is also essential to ensure that IEC materials are available in local language, are culturally relevant and tailored to the literacy levels of the target populations, and confidentiality for audio-visual privacy of clients is non-negotiable.

- E. Develop HR light models for single window service delivery:** Expand the single-window approach to streamline access to all services under SSK, to be complemented with strong referral systems and effective follow-up mechanisms. SSS is indeed a transformative program with strong potential and wide scope to address comprehensive healthcare needs through integrated services. Its scope for innovation and scalability positions it as a pivotal initiative to accelerate progress towards achievement of 2030 targets. Furthermore, its scale-up is easier with domestic funding and sustainable given it is resource- light and implemented leveraging existing facilities
- F. Procurement and Supply Chain Management:** Dual kits as planned by NACO, could not be provisioned during SSS implementation. Establish a buffer stock system to manage unexpected demand surges or delays in procurement. Simplify and expedite procurement processes to prevent stock-outs of essential supplies such as condoms and RPR kits. Collaborate with NHM for leveraging commodities.
- G. Regular follow-up and coordination:** Frequent follow-ups with the clients and relevant stakeholders is a key for the improved utilization of services. Promote Outreach and mobile van use which were not fully leveraged during the two phases of implementations of SSS.
- H. Client satisfaction:** Overall client satisfaction at SSK facilities appears to be high, likely due in part is the rapport building by staff. Repeated telephonic reminders and follow-up by staff, turned out to be useful in appointment keeping by SSK clients and resulting in better outcome, but use of NACO helpline was sub-optimal. It is further recommended to
- a. **Adjust Operating hours:** Evaluate the operating hours of SSK facilities to better align with the needs of the local population. Consider flexible hours or provision of community-based or mobile services to reach clients who are unable to access health facilities due to diverse needs and challenges.
 - b. **Incorporate Tele-consultation:** Tele-consultation should be explored as an alternative, for clients uncomfortable with visiting facilities. This can help

maintain client confidentiality and improve service delivery to under-served populations.

- **Referral and Linkages:** Improve Interdepartmental linkages, accompanied referrals via engagement of community and regular follow-up with recipient centers for ensuring 100% referral and linkages.
- **Strengthen capacity building of counselors and mentor/ monitor towards change management:** Unceasingly arrange periodic refresher trainings with inclusion of need based sessions on the topics of mental health, stigma, methods to tap virtual networks of at-risk people **etc.** There is also gap to reach the hidden youth, non-binary population, which requires Improved sensitization for all health care staffs. Training and capacitation of DISHA/DAPCU and mainstreaming the Sampoorna Suraksha agenda in their work is to be strengthened.
- **Create Sampoorna Suraksha Client flow in SOCH:** The easy-to-use web-based reporting system NORMS is utilized by all the centers, but the merging of NORMS with SOCH is pending. Repeated training and hand holding is needed for maintaining the quality of data entry and output. The generation of due list for follow-up and auto populated dashboard for regular review and improvement in quality-of-service delivery are some of the requests from field. A truly “smart” IT enabled module under SOCH, enabling dependencies among many systems (including NACO helpline, virtual) with dashboards for data use to strengthen programme and service delivery is highly recommended
- **Expand access and quality of data:** SACS and DAPCU/DISHA officials were involved in monitoring and supervisory visits to the sites. The need of regular training for DAPCU/DISHA staff and access to NORMS and dashboard at District level are imperative for improving data driven monitoring and supportive supervision.
- **Accelerating the Change Movement:** Strengthening of **single window service delivery under one roof** for HIV, Syphilis, Hepatitis, SRH, mental health needs etc. can enhance service uptake and opportunity for HIV prevention and early detection. Create an enabling environment where the client flow is universal, as this will support in dissolving boundaries and focusing on the target population/population in need.

Way Forward

1. **Investment Light Model:** Transition to “investment light” model from grant funding to domestic funds with optimization of existing resources may ensure ease of scalability and sustainability.
2. **Capture of Sampoorna Suraksha Client flow in SOCH:** Transition from NORMS to SOCH to universalize data entry across all programmatic facilities implementing the strategy
3. **Demand Generation and Advocacy for SSS:** Strengthen referral linkages within and outside of NACP to foster an integrated approach
4. **Revision of Operational Guidelines (OGs):** Through a consultative process and a Working Group aligning with HCTS, EVTHS and STI guidelines
5. **Monitoring and Supportive supervision:** Periodic reviews, DAPCU/DISHA engagement and supervisory visits.
6. **Evaluation/Assessments:** After three years of implementation and periodic intervals thereafter to measure the progress made from baselines, providing insight into mid-course corrections and risk mitigation.

By addressing these areas, SSK services can be optimized to better serve the target population, ensuring increased service utilization and client satisfaction, while also strengthening data management practices to support Program effectiveness, scalability and sustainability.

ANNEXURES

Annexure 1: Services and Commodities under SSS Package

A. Essential Services

S. No	Category	Service
1	Differential HIV Testing	Social and Sexual Network Mapping
2		Client, Index and Partner Testing
3		Self-Testing (<i>once approved within the national programme</i>)
4	Comprehensive Prevention & General health	Co-morbidity screening, referral, and treatment
5		STI Management
6		Risk Reduction
7		Mental Health Counselling
8	Strengthening Services	OST, Abscess Management, Overdose Management, Harm reduction
9		Legal and Human Right services
10		TI and CCC referrals
11		Referral to community support centers
12		Referrals to drug treatment centers

B. Desirable Services (Non-Exhaustive)

S No	Category	Service
1	Comprehensive Prevention & General health	Gender transition related counselling and referral support (HRT, post GRS care, etc.)
2		Gender Counselling on Hormone Replacement therapy
3		Linkage with OPD of other communicable and non-communicable diseases
5		Screening and Treatment referrals for other medical conditions, including NCDs, HPV, cervical cancer screening, SRH, RCH, MCH, abortion etc.
6	Strengthening Services, or Other	Skill development / Vocational training
7		Social Security & Social Welfare Schemes
8		Next generation ACSM
9		Referrals and linkages to various Social Protection Schemes (SPS) and other government programmes run through NGOs- List them

Annexure 2:

List of districts for SSS Implementation (Phases I & II)

State/UTs	SSS Districts	Districts for Phase I
1. Haryana	3	Panipat, Sonipat, Hisar
2. Punjab	6	*Amritsar, Fazilka, Gurdaspur, Jalandhar, *Ludhiana, *Patiala
3. Chandigarh	1	Chandigarh
4. Uttar Pradesh	26	Agra, Aligarh, Ambedkar Nagar, Ayodhya, Azamgarh, Barabanki, Bareilly, Basti, Bijnor, Deoria, Gautam Buddha Nagar, Ghaziabad, Gorakhpur, Hathras, Jhansi, Kanpur Nagar, Lucknow, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Prayagraj, Rae Bareli, Sultanpur, Varanasi
5. Madhya Pradesh	7	Bhind, Bhopal, Hoshangabad, Indore, Jabalpur, Ratlam, Sagar
6. Gujarat	13	*Ahmedabad, Anand, Banas kantha, Bharuch, Bhavnagar, Gandhinagar, Kheda, Mehsana, Panchmahal, *Rajkot, Sabarkantha, *Surat, *Vadodara
7. Maharashtra	8	Aurangabad, Nagpur, Nashik, Pune, Satara, Solapur, Thane, Mumbai
8. Telangana	9	Adilabad, *Hyderabad, Karimnagar, Mahbubnagar, Medak, Nalgonda, Nizamabad, *Rangareddi, *Warangal
9. Nagaland	1	Kohima
10. Mizoram	1	Aizawl
State/UTs	SSS Districts	Districts for Phase II
11. Delhi	5	South, Northeast, Northwest. New Delhi, West
12. Jharkhand	1	Ranchi
13. Rajasthan	15	Udaipur, Jaipur, Jodhpur, Kota, Bikaner, Banswara, Bharatpur, Ajmer, Barmer, Sikar, Nagaur, Ganganagar, Alwar, Chittorgarh, Hanumangarh
14. Uttarakhand	1	Dehradun
15. Andhra Pradesh	12	Chittoor, West Godavari, Guntur, Krishna, Vizianagaram, East Godavari, Prakasam, Anantapur, Cuddapah, Kurnool, Visakhapatnam, Visakhapatnam, Nellore
16. Karnataka	7	Belgaum, Bangalore Urban, Mysore, Bagalkot, Bijapur, Bellary, Koppal

17. Bihar	8	Gopalganj, Gaya, Muzaffarpur, Madhubani, Patna, Purnia, Rohtas, Siwan
18. Madhya Pradesh	9	Shivpuri, Barwani, Rewa, Raisen, Seoni, Guna, Gwalior, Rajgarh, Vidisha
19. Assam	1	Cachar
20. Odisha	3	Khordha, Ganjam, Cuttack
21. West Bengal	13	Kolkata, South Twenty-Four Parganas, North Twenty-Four Parganas, Nadia, Hugli, Paschim Medinipur, Haora, Koch Bihar, Darjeeling, Murshidabad, Paschim Bardhaman, Maldah, Purba Bardhaman
20 States and UTs	150 Districts	

*Pilot districts

Annexure 3:

SSS SBCC Package Material Themes

S.No	Media	Material detail	Themes	Topic Covered
1		Wall Paintings	1. 1097 helpline	<ul style="list-style-type: none"> • National AIDS Helpline promotion and STI • Call to action 1097 & SSK
			2. Condom Promotion	<ul style="list-style-type: none"> • Prevention of HIV+STI through Condom use • Call to action 1097 & SSK
			3. Risk Reduction & Perception	<ul style="list-style-type: none"> • Prevention of HIV+STI through Condom use, NSEP and Testing • Call to action 1097 & SSK
			4. STI/RTI	<ul style="list-style-type: none"> • STI/RTI – symptoms of STI • Call to action 1097 & SSK
			5. Safe Sex Behaviour	<ul style="list-style-type: none"> • Condom use to prevent HIV and STI • Call to action 1097 & SSK
			6. SSK Benefits	<ul style="list-style-type: none"> • Services of SSK. • Call to action 1097 & SSK
2	Print material	Flyers	1. Condom Promotion	<ul style="list-style-type: none"> • Modes of transmission and prevention from HIV and STI. • Benefits of condom use and availability. • Call to action 1097 & SSK
			2. PrEP	<ul style="list-style-type: none"> • Information about PrEP • Use of PrEP • Benefits of PrEP • Call to action 1097 & SSK
			3. STI	<ul style="list-style-type: none"> • Information about STI • Modes of transmission • Testing for STI • Steps to prevent STI • Call to action 1097 & SSK
			4. Testing	<ul style="list-style-type: none"> • Information about testing and its importance • Availability of testing services • Risk behaviour and testing services • Call to action 1097 & SSK
3		Leaflet	Sampoorna Suraksha	<ul style="list-style-type: none"> • Information about Sampoorna Suraksha Kendra and its objectives. • Outreach of Sampoorna Suraksha Kendra

S.No	Media	Material detail	Themes	Topic Covered
				<ul style="list-style-type: none"> •HIV and STI testing and treatment services. •Testing services of Opportunistic Infections. •Call to action 1097 & SSK
4	Radio	Jingle	1. Testing	<ul style="list-style-type: none"> •Testing for HIV and Syphilis •Call to action 1097 & SSK
			2. Sampoorna Suraksha	<ul style="list-style-type: none"> •Testing services for HIV, STI, TB and Hepatitis. •Free counselling, testing and treatment services •Counselling on condom and PEP. •And Promotion of National AIDS helpline 1097 •Call to action 1097 & SSK
5	IPC Product	Posters	1. Prevent HIV & STI	<ul style="list-style-type: none"> •Safe behaviour and condom use •Call to action 1097 & SSK
			2. Safety	<ul style="list-style-type: none"> •SSK services for safety •Call to action 1097 & SSK
			3. PEP	<ul style="list-style-type: none"> •About PEP •Uses of PEP •Call to action 1097 & SSK
			4.HIV (Lead Safe life)	<ul style="list-style-type: none"> •Regular testing for HIV •Relation between and HIV and STI •Call to action 1097 & SSK
			5. Condom use	Condom use and its benefits Call to action 1097 & SSK
			6. Safe injecting	<ul style="list-style-type: none"> •Safe injecting •Call to action 1097 & SSK
			7. STI Prevention	<ul style="list-style-type: none"> •promotion of regular STI testing •Prevention from STI •Call to action 1097 & SSK
			8. OST	<ul style="list-style-type: none"> •Benefits of OST •Call to action 1097 & SSK
			9. Regular Testing	<ul style="list-style-type: none"> •Safe behaviour •Regular testing
			10. Stress	<ul style="list-style-type: none"> •Importance of mental and physical health. •Call to action 1097 & SSK
			11. Helpline 1097 promotion	<ul style="list-style-type: none"> •Information available on National AIDS Helpline •Call to action 1097 & SSK
6			1. Puzzle	<ul style="list-style-type: none"> •Regular testing •Risk calculation

S.No	Media	Material detail	Themes	Topic Covered
		IPC Games	2. Dart Board	<ul style="list-style-type: none"> •Regular testing •Risk calculation
7		Flipbooks	1. STI guide	<ul style="list-style-type: none"> •Information about STI infection. •Information about symptoms of STI •Risk behaviour •Counselling, Testing and treatment services •Call to action 1097 & SSK
8	Digital Media	Animated videos and Narramatic videos	1. Outreach Worker (ORW)	<ul style="list-style-type: none"> •Role of an outreach worker •Call to action 1097 & SSK
2. STI			<ul style="list-style-type: none"> •Information about STI •Modes of transmission •Risk behaviour •Testing for STI •Steps to prevent STI •SSK Services •Call to action 1097 & SSK 	
3. PrEP			<ul style="list-style-type: none"> •Information about PrEP •Use of PrEP •Benefits of PrEP •Call to action 1097 & SSK 	
4. SSK Benefits			<ul style="list-style-type: none"> •Information about Sampoorna Suraksha Kendra and its objectives. •Outreach of Sampoorna Suraksha Kendra •HIV and STI testing and treatment services. •Testing services of Opportunistic Infections. •Call to action 1097 & SSK 	
5. Safe Sex Behaviour			<ul style="list-style-type: none"> •Youth vulnerability •Risk perception •Condom use to prevent HIV and STI •HIV and STI testing and treatment services •SSK Services •Call to action 1097 & SSK 	
6. Follow up testing			<ul style="list-style-type: none"> •Youth vulnerability •Risk behaviour •Regular testing •SSK Services •Call to action 1097 & SSK 	

S.No	Media	Material detail	Themes	Topic Covered
9			7. Risk Reduction	<ul style="list-style-type: none"> • Information about risk behaviour • Risk reduction information • SSK Services • Call to action 1097 & SSK
			8. Counsellor	<ul style="list-style-type: none"> • Role of counsellor • Call to action 1097 & SSK
			9. OST	<ul style="list-style-type: none"> • Youth and drugs related harms • Testing & Treatment services (ART, OST) • SSK Services • Call to action 1097 & SSK
			10. Mental Health	<ul style="list-style-type: none"> • Youth vulnerability • Risk behaviour • Outreach, testing and treatment services of SSK. • Mental health issue • Call to action 1097 & SSK
			11. Self-Care	<ul style="list-style-type: none"> • Transgender • Safe sex practices. • Regular testing at SSK. • Call to action 1097 & SSK
		Short Videos	1. Condom Promotion	<ul style="list-style-type: none"> • Benefits of condom use and availability. • Correct and consistent use of condom. • Prevention of HIV+STI through Condom use • Call to action 1097 & SSK
			2. Testing	<ul style="list-style-type: none"> • Youth vulnerability • HIV test and its importance • Call to action 1097 & SSK
			3. Self-Care	<ul style="list-style-type: none"> • Youth vulnerability • Condom promotion • HIV and STI testing and linkage to SSK • Call to action 1097 & SSK
			4. PEP	<ul style="list-style-type: none"> • Harm of drug use • SSK services. • Counselling, Testing and PEP • Call to action 1097 & SSK
			5. SSK Benefit	<ul style="list-style-type: none"> • Information about Sampoorna Suraksha Kendra and its objectives. • HIV, STI testing and TB, Hepatitis counselling & treatment services. • OST and ART services

S.No	Media	Material detail	Themes	Topic Covered
				<ul style="list-style-type: none"> • Call to action 1097 & SSK
			6. OST	<ul style="list-style-type: none"> • Injecting drug use • Impact of injecting • Counselling & Treatment services (ART, OST) • Benefits of OST • SSK benefits and services • Call to action 1097 & SSK
10		GIFs	1. Condom Promotion	<ul style="list-style-type: none"> • Benefits of condom use • Call to action 1097
			2. PrEP and Condom	<ul style="list-style-type: none"> • Benefits of PrEP and condom • Call to action 1097
			3. STI infection	<ul style="list-style-type: none"> • STI symptom • Call to action 1097 & SSK
			4. Stress	<ul style="list-style-type: none"> • Stress/mental health • Call to action 1097 & SSK
			5. Prevention	<ul style="list-style-type: none"> • Prevention from HIV • Call to action 1097 & SSK
			6. HIV testing	<ul style="list-style-type: none"> • HIV Testing • Call to action 1097 & SSK
			7. Follow up testing	<ul style="list-style-type: none"> • Testing • SSK linkage and risk behaviour • Call to action 1097 & SSK
			8. Modes of transmission	<ul style="list-style-type: none"> • HIV transmission/Risk • Call to action 1097 & SSK
			9. National AIDS Helpline	<ul style="list-style-type: none"> • Promotion of National AIDS Helpline • Call to action 1097 & SSK
11		SMS/ WhatsApp messages	<ol style="list-style-type: none"> 1. Safe Sexual Behaviour 2. Risk reduction/Risk perception 3. Regular Testing 4. Follow up testing 5. Condom promotion 6. Needles & syringes 7. STI & RTI 8. Self-Care 9. Mental health 10. SSK Benefits 	<ol style="list-style-type: none"> 1. Safe Sexual Behaviour 2. Risk reduction/Risk perception 3. Regular Testing 4. Follow up testing 5. Condom promotion 6. Needles & syringes 7. STI & RTI 8. Self-Care 9. Mental health 10. SSK Benefits 11. 1097 Promotion 12. HIV testing <p>And call to action & SSK linkage in all messages.</p>

S.N o	Media	Material detail	Themes	Topic Covered
			11. 1097 Promotion 12. HIV testing	

Annexure 4:

Guideline for submission of proposal for Phase I



Guidelines for Submission of Proposal for Sampoorna Suraksha Strategy

IMPLEMENTATION PLAN

SACS are requested to submit the Implementation Plan for SSS as per the districts identified in their state. The list of districts is given in the Guidance Note **Annexure A**. While developing the Proposal **Guidance Note** is to be referred and accordingly all the sections need to be covered in the proposal. The following are the sections to be covered in the proposal.

The Deadline for the submission of the Proposal is **28th December 2021**

Sampoorna Suraksha Strategy (SSS) State Implementation Plan

Submitted by State (Name)- _____

Date of Submission- _____

A. Project Name: Sampoorna Suraksha Strategy

B. Detail of Districts (As per Annexure A) & Facilities (As per the Annexure B after conducting Facility Assessment)

S.No.	District/s	SSS Site/Facility Type and Name	SSS Site/Facility Address	Details of Contact Person of the Facility (Name, Designation, Contact No.)	Counsellor Name & Contact No.
1					
2					
3					

C. Implementation Plan includes the following:

1. **Background** of the State and district, High Risk Pockets
2. **Objective** of the project
3. **Target population** to be covered, process of identification of the *At-Risk* Clients,
4. **Method** of selecting the Facility/ies

5. **Reason** of selecting the Facility/ies
6. **Strategic Assessment** done for selecting the facility (*SOP for Assessment Tool placed at **Annexure B** is to be used for the same*)
7. **Services & Commodities (Refer Annexure C)**
 - a. *Essential*
 - b. *Desirable which are included, whether for all sites or different for different sites, please mention facility wise.*
8. **Detailed Outreach Plan** (*Please specify what & how outreach activities will be done physically/ virtually/ linkages & referrals, frequency of the outreach visits staff wise*)
9. **Engagement and/or repurposing of Project Personnel** (*Which Plan will be adopted, if different plan for different facility, please specify the same facility wise and also laid down the details as mentioned in the guidance note. Please refer **Annexure E** for the plan merits and demerits before selecting the Plan*).
10. **Training and Capacity Building of the Staff** (*What kind of training will be required and duration, who all will be trained, who will conduct the training, what topics to be included in the training*)
11. **Monitoring, Supportive Supervision and Reporting**
 - *Please mention the Monitoring plan, frequency of the monitoring visits, levels, what will be monitored, monitoring report etc.*
 - *Please mention how the Supportive Supervision will be done, who will do, what will be the frequency, format of supervision*
 - *Reporting flow, reporting format, frequency of reporting, what all to be included in SOCH, what more components needs to be captured*

D. Financial Proposal

1. Prepare the budget as per the guidelines given in the Guidance Note Annexure H.
2. The line items and cost is proposed/tentative, as per the requirement of the selected Facility, the budget is to be prepared accordingly.
3. The total cost of any one site should not increase from the total budget.
4. For no. of sites the cost is to be multiplied accordingly.

Annexure 5:

Guidelines for submission of proposal for Phase II



SACS LOGO

Guidelines for Submission of Proposal for Sampoorna Suraksha Strategy Phase II State

IMPLEMENTATION PLAN

SACS are requested to submit the Implementation Plan for SSS as per the districts identified in their state. The list of districts is given in the Operational Guidelines **Annexure 1**. While developing the Proposal **Operational Guidelines** is to be referred and accordingly all the sections need to be covered in the proposal. The following are the sections to be covered in the proposal.

The Deadline for the submission of the draft Proposal is **27th December 2022**

Sampoorna Suraksha Strategy (SSS) State Implementation Plan Submitted by State (Name)- Date of Submission-

A. Project Name: Establishment of XX (No. of SSKs) Sampoorna Suraksha Kendra (SSK) under Sampoorna Suraksha Strategy (SSS) of NACO.

B. Detail of Districts (As per Annexure 1 of OG) & Facilities (After conducting Facility Assessment as per the tool at Annexure 2 of OG). This table can be put up as Annexure.

Table 1

S.No.	District	Facility Type and Name (ICTC or DSRC)	Reason/ Rationale for selecting this facility	Facility Address/ Location	Incharge of Facility/ HOD (Name, Designation, Contact No.)	Counsellor of the facility (Name & Contact No.)
1						
2						
3						
4.						

C. Implementation Plan includes the following:

- 1. Background** of the State and district, High Risk Pockets, State/ District map, existing services available in and nearby the shortlisted institute etc.
- 2. Objective** of the project- As per the Operational Guidelines_1st Cut.

3. **Target population** to be covered (refer OG_1st Cut and mention the target group state will focus on district wise, if different population is being targeted in any district)

4. **Method of selecting the Facilities-**

How many facilities available in the districts? How many facilities undertaken for assessment? You may use the following table:

S.No.	District	ICTC		DSRC		Remarks
		No. of ICTCs	No. of ICTC shortlisted for Assessment	No. of DSRCs	No. of DSRCs shortlisted for Assessment	

5. **Strategic Assessment** done for selecting the facility (*Assessment Tool placed at Annexure 2 in OG is to be used for the same*)- Only findings of the assessment is to be provided here. The details of the Assessment Facility wise is to be provided as Annexure.

6. **Services & Commodities (Refer Annexure 3 of OG)**- Mention the services which state prefer to provide especially in the first year as per the assessment findings and availability. Also mention the services which will be provided through linkages and its availability (where and in which department it is available) within the districts. You may divide the delivery of services phase wise. The easily available services & commodities may be taken in Phase I i.e immediate and other services for which advocacy, stakeholder meetings, establishment of linkages and networking is required may be take in Phase II but you have to decide the timelines for both the phases.

a. *Essential as mentioned in OG, Annexure 3*

b. *Desirable which are included, whether for all sites or different for different sites, please mention facility/district wise. List of services may be seen in Annexure 3 of OG.*

8. **Detailed Outreach Plan** (*Please specify what & how outreach activities will be done physically/ virtually/ linkages & referrals, frequency of the outreach visits staff wise*).

9. **Engagement and/or repurposing of Project Personnel** (*Which Plan will be adopted, if different plan for different facility, please specify the same facility wise and also laid down the details as mentioned in the operational guidelines. Please refer Annexure 5 & 6 for the plan merits and demerits before selecting the Plan and Roles & responsibilities of the SSK Staff*).

10. **Orientation plan of the Stakeholders and of the Staff**- Please mention,

10.a Who all will be the prospective stakeholders of this project?

10,b, Orientation plan of these stakeholders including the timelines.

10.c Orientation of the staff to start the setting up of the Kendra and planning for the smoothly implement the strategy in their respective SSK.

11. **Monitoring, Supportive Supervision and Reporting**

- Please propose the Monitoring plan, frequency of the monitoring visits, levels, what will be monitored, monitoring report etc.
- Please propose how the Supportive Supervision will be done, level of supervision, what will be the frequency of supportive supervision.
*Note: You may give the flow chart

12. Timelines/Activity Matrix

S.no.	Key Activities	Q 1	Q 2	Q 3	Q 4

D. Financial Proposal

1. Prepare the budget line item wise as per the budget and guidelines given in the Operational Guidelines in **Annexure 7**.
2. The line items and cost is proposed/tentative, as per the requirement of the selected Facility, the budget is to be prepared accordingly.
3. The total cost of any one site should not increase from the total budget.
4. For no. of sites the cost is to be multiplied accordingly. (*Format is annexed*).

Annexure 6:

Sampoorna Suraksha Kendra

Visit Checklist

State	
District	
Date of visit	
Visiting Officer/ Designation	

Basic Information

SSK Hospital Name	
Type of Facility (ICTC/ DSRC)	
Officials/Staff Present during the Visit	
<i>Officers from the Hospital</i>	
<i>Name of the Staff:</i>	
<i>SSK Manager</i>	
<i>SSK Counsellor</i>	
<i>SSK Lab Technician</i>	
<i>SSK Outreach Worker 1</i>	
<i>SSK Outreach Worker 2</i>	
<i>Any other</i>	

Observations

1. Re-modelling of room for SSK completed? (Room Set-up, Seating Plan, A/V Arrangements, Furniture etc.)
2. Have the printer, desktop/laptop, and other relevant IT equipment in place? Smooth functioning of internet connectivity.
3. The branding of SSK done and is visible appropriately? Does SSK Signages and navigation visible at appropriate places in the hospital/facility?
4. Is SBCC material available with SSK in required/sufficient quantity and how SBCC material is being used in SSK and in outreach activities including digital material?
5. SSK has a counselling room in an enclosed setting.
6. Is Staff aware/understands SSS, SSK and the functioning (in terms of clientele, service package (at SSK/via referral), follow-up, outreach, and identification of clientele)? Was training/capacity building of SSK Staff is done by SACS (physical or virtual)?

7. Is staff aware of documentation and reporting to be maintained? Data entry status, Achievement V/S Target, if low achievement, reason thereof.
8. If the SSK is at ICTC, please check how many STI clients registered at co-located DSRC and how many HIV negative clients referred and registered in the SSK NORMS. (Reference: 100% STI clients tested HIV negative to be registered in SSKs).
9. Completed SOP is available at SSK and team is following the plan or not. If not, reason thereof.
10. How the linkages are being done with other service providers' health and for non-health? What is the referral & follow up mechanism and back reporting?
11. What outreach activities are done to identify new clients, partner identification? Like No. of camps/ types of camps/ reaching out to Adolescents & Youths, advocacy activities, virtual outreach etc.
12. Are there any suggestions/ feedback from SSK staff/ Nodal Officer that can help in the improvement in the implementation of SSK.
13. Any other observation may be added.

Overall Observation & Recommendation

SAMPOORNA SURAKSHA STRATEGY

**VISIT REPORT OF _____ & _____ SSS
DISTRICTS**

A National Team

B State Team

C.Places visited

D. Objectives of the Visit:

I. State-District SSK (_____)- _____ Hospital

District Team-

I. (A) Major Overall Observations

I. (B) Key Recommendation & Suggestions

II. State-District SSK (_____)- _____ Hospital

District Team-

II. (A) Major Overall Observations

i. .

II. (B) Key Recommendation & Suggestions

I. (C) State-District SSK (_____)- Observations and Recommendation Matrix-

CHECK LIST- DISTRICT, STATE

S.No	Category	Sub- Category	Yes/No	Remarks (Challenges/Best Practices/Feedback etc.)
1	Infrastructural	Re-modelling of room for SSK completed? (Room Set-up, Seating Plan, A/V Arrangements etc.)		
2		Furniture, if any, purchased and installed?		
3		Whether purchase and instalment on printer, desktop/laptop and other relevant items completed? Is internet available?		
4		Re-branding of SSK (IEC Materials) complete?		
5		Any equipment's have been procured?		
6		Cleanliness being maintained at SSK?		
7		SSK has designated waiting area for clients?		
8		SSK has counselling room in enclosed setting?		
9	Awareness about SSS	SSK Signage exists at the hospital/SSK?		
10		Do other providers/departments in the facility seem aware about the SSK?		
11	HR- related	Has the hiring process for all SSK staff completed?		
12		Has the orientation and training of SSK staff on 2-day module completed?		
13		Has orientation on SSK Data Tool been provided to SSK staff?		

14		Staff is well aware and understands SSS, SSK and the functioning (in terms of clientele, service package (at SSK/via referral), follow-up, outreach, identification of clientele)?		
15		Staff is aware about documentation and reporting to be maintained?		
16	Service Delivery	Is risk-assessment being conducted at SSK? (Check understanding of SSK Counsellor/Manager on risk assessment)		
17		Does staff seem aware on the expected client flow at SSK? (Distinction of client on the basis of referrals etc.)		
18		Is Partner information being solicited for at-risk negative client?		
19	Follow-up/ Outreach	Has Follow-up of SSK Clients/ Outreach of Partners/Outreach for Demand Generation been started?		
20		What is the mechanism of Follow-Up?		
21		Is monthly due-list for Follow-up and Partner Outreach being maintained at SSK?		
22		ORWs are making field visit/client virtual follow-up plan on weekly/fortnightly basis?		
23		Is virtual outreach/follow-up being conducted?		
24		Frequency of Follow-up of SSK Clients		
25		Frequency of Outreach of Partners		
26		Frequency of Demand Generation and other outreach activities		

27	Documentation and Reporting	Monthly Plan developed by SSK Manager?		
28		Linkages and Referral Register maintained?		
29		Outreach/Field Visit/ Field Activities register/ record maintained?		
30		Counselling Register maintained daily? (For not at-risk clients, and for clients whose registration could not take place real-time)		

Annexure 7:

NORMS Data Recording Tables

Tables/Sections to be recorded at SSK*

**Kindly note these tables/data-points are tentative and non-exhaustive. Further, the data- tables/sections/ tool his list might be revised and refined basis field experiences, learnings, and data analyses, as the SSS program progresses forward.*

Table 1A: Basic Client Details: HIV Counselling and Testing register- For all the clients visiting SA-ICTC (re-modelled into SSK)

Data Fields*		
1. S. No	7. HIV Test result	11.3 District
2. Date of Visit	8. Name	11.4 State
3. PID No.	9. Sex	12. Contact No.
4. Referred from/by	10. Age (in years)	13. Aadhaar No.
5. Consent (Sign/Thumb) to avail testing services and willingness to avail SSS services if HIV negative	11.1. House Address	14. Is Client Pregnant#
6. Date of HIV Testing	11.2. Block/ Taluk/Village	

Data Fields# (Additional Fields for Pregnant Client)	
1. MCTS Number	5. Whether a new case or known positive case?
2. Month of pregnancy (Completed Months)	6. Type of Individual
3. Gravida	7. Whether tested for Syphilis*
4. Whether Opted for MTP/Abortion	8. Result of Syphilis Test*

Table 1B: Basic Client Details: DSRC/STI register- For the clients visiting DSRC (re- modelled into SSK) * (As per DSRC/STI guidelines)

Data Fields*				
1. S. No.	9. STI/RTI Syndrome Diagnosis		14. Referred to	Name of Facility (ICTC, ARTC, RPR/VDRL etc.)
2. Date	10. Treatment Provided	Kit Provided		Outcome of Referral(s)
3. Patient OPD Number		Drugs Prescribed	15. Lab Investigations	RPR Test
4. PID No.	11. Whether Counselling Done			HIV Test
5. Name	12. No. of Condoms Provided			KOH
6. Age	13.	Whether Partner		Wet Mount

	Partner Management	Notified?	
7. Sex		Whether Partner Managed?	
8. In-Referral (with details)/ Direct Walk-in			

Table 2: Additional Client Details: For HIV positive clients

Data Fields*	
1. Date of post-test counselling	5. Education
2. Has TB Symptoms?	6. Occupation
3. Type of risk behavior	7. Out referrals
4. Marital Status	8. If Self-initiated, then source of Information on HIV Testing

Data Fields*	
Referred to ART	
ART registration no	
Spouse / Partner testing	Whether HIV Status of Spouse/ partner is known
	Date of follow up of Spouse/ sexual partner
	Date of HIV testing of Spouse/Partner
	PID no. of Spouse/Sexual partner
	HIV Status of Spouse/Sexual partner
	Referred to ART
	ART registration no
	Couple counselling Provided
If discordant couple date of next follow up of Spouse/ sexual partner	
Remarks	

Data Fields*: For Client Follow-up and Partner Outreach (For HIV positive clients)		
1	For Client Follow-Up	Date of Next Follow-up (Enter Multiple dates if applicable)
2		Whether follow-up attempted on or before the previous follow-up date?
3		If yes in Q2: Outcome of Follow-up
4		Remarks
5	For Partner(s) Outreach	Name
6		Address
7		Mobile No.
8	For Partner(s) Outreach	Date of Outreach (Enter Multiple dates if applicable)
9		Was able to Outreach Partner?
10		If yes in Q10: Outcome of Outreach
11		If Option-1# in Q10, enter Partner's PID number

Table 3A: Risk Assessment

Questions*	Response
1. Do you have the habit of using /sharing injecting drugs?	A. Used, B. Shared, C. No, D. Refuse to answer
2. What kind of sexual partner(s) you have?	A. Male, B. Female, C. TG, D. No sexual partner, E. Refuse to answer
3. Do you have any sexual relationship beyond your spouse/partner?	A. Yes/ B. No/ C. Refuse to answer
4. Have you bought sex in the past from a man, woman or TG using money, goods, favors or benefits?	A. Yes/ B. No/ C. Refuse to answer
5. Have you provided sex in the past in exchange for money, goods, favors or benefits?	A. Yes/ B. No/ C. Refuse to answer
6. Any STI symptoms in last three months?	A. Yes/ B. No/ C. Refuse to answer
7. Is your spouse or partner, a PLHIV?	A. Yes/ B. No/ C. Refuse to answer

Table 3B: Coded Risk Assessment Questions (for Paper-Based Format)

Risk Assessment Form
Client PID Number:

	A	B	C	D	E
1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

Tick or Check Mark ✓ responses across each questions

Table 4: Client Registration

Details recorded in Table 1 will be captured again in the Registration Tab (Will be taken by SSK data manager later from the counsellor using the PID number provided by client)

Note: This is a stop-gap solution, might be removed once IIMS/SOCH and SSS portals are integrated, as the fields can be auto-populated



Data Fields*	
Mobile Number of Client	
Risk Category during registration (<i>basis the slip provided by client</i>)	
	When was last Syphilis test conducted?

Client History-Taking For Syphilis, TB and Hep C	Syphilis Status during registration
	Treatment status
	Treatment through Benzathine Penicillin G?
	When was last TB test conducted?
	TB Status during registration
	When was last Hepatitis C test conducted?
	Hepatitis C Status during registration
Occupation	
Client's preference for follow-up method	
Details of SSK Client's social/sexual/injecting partners	Name of Partner
	Mobile Number of Partner
	Relationship with SSK Client
	Current Address of Partner

Table 5: Client Visit & Services

Data Fields*	
Date of current visit	
Is client pregnant?	
Risk Assessment of client (at regular intervals)	
Service(s) provided to the client (multi-select)	
For each test performed at SSK	Dates of test/ reporting result to client
	Test Result during current visit
	Referred site
	Details of Confirmatory Test (Result and Treatment Status)
For each treatment provided at SSK	Commodity used
	Qty. dispensed
	Next dispensation date (if applicable)
For each commodity dispensed at SSK	Commodity Available?
	Qty. dispensed
For each referral service	Referred site
	Accompanied referral provided?
	Services received at referred centre?
Services asked by client, but couldn't be provided	

Table 8: Follow-up details and outcome (for SSK Clients)

Data Fields*
Date of Next Follow-up
Whether follow-up attempted on or before the previous follow-up date
Outcome of last follow-up
Due date for visit to SSK

Table 6: Details of Partners for Outreach and Follow-up

Data Fields*
General Details of social/ sexual/injecting partners (Name/Contact Details/Address)
Age
Preferred Mode of Follow-up
Date of Outreach
Was Outreach successful?
Next date of outreach
Outcome of outreach
Has client been asked to visit SSK?

Table 7: Inventory Management

Data Fields*	
For each test kit/ drug/ commodity consumed /dispensed at SSK	Opening Stock
	Stock Received
	Usage
	Other reasons for Stock Reduction (Trainings/ Pilferage etc.)
	Closing Stock
	Details on Expiry Date and corresponding Qty stock

Annexure 8:

SSS M&E Framework

M&E indicators for SSS ¹	Numerator	Denominator	Frequency	Type of Indicator
<p>HIV Negative: No. of SSK clients who have maintained HIV negative status 1 year post registration at SSK²Note: <i>This indicator might be looked into, at different time intervals like 1.5 years, 2 years etc. Note: Might be evaluated for Syphilis as well</i></p>	<p>Number of clients who have been reported HI Vnegative 1 year post their registration at SSK</p>	<p>Number of clients who have been tested for HIV in 1 year post their registration at SSK</p>	<p>Cohort Tracking (Monthly/ Annually)</p>	<p>Impact</p>
<p>Partner Outreach: Of the total partners identified, % registered at SSK</p>	<p>No. of partners of SSK clients who were successfully outreached and linked to SSK during the period (1. May be calculated basis in- referral of SSS Outreach-Data Source: HCTS Table-1/ IIM S Beneficiary Registration, OR, 2. Basis question-How did you get to know about SSK)</p>	<p>Total number of partners identified during the period</p>	<p>Monthly/ Annually</p>	<p>Outcome</p>
<p>SSK Client Follow-up: (Range to be defined)</p>	<p>SSK Clients who turned up to the facility post follow- ups during the period</p>	<p>Total No. of Unique SS K Clients followed- up (and not number of follow- ups) during the period</p>	<p>Monthly/ Annually</p>	<p>Outcome</p>
<p>New Registrations: Total number of new clients registered at SSK</p>	<p>Total No. of New Registrations during</p>	<p>-</p>	<p>Monthly/ Annually</p>	<p>Output</p>

	the period			
Categorization by Source of Awareness (<i>How did you get to know about SSK?</i>)/ <i>Frequency Distribution</i>	Number of New Registration across each category (ex: Partner is a SSK client, 1097 Helpline etc.) during the period	Total No. of New Registrations during the period	Monthly/ Annually	Output
For HIV testing at SSK: % of clients who were tested for HIV during their visits	Number of HIV testing done during the period	Total Number of Visits (where HIV test was due) during the period	Monthly/ Annually	Output

M&E indicators for SSS ¹	Numerator	Denominator	Frequency	Type of Indicator
For HIV screening result status: Of the total clients who were screened for HIV, % of clients who were screened reactive	Number of clients who have been screened HIV reactive during the period	Number of Clients screened for HIV during the period	Monthly/ Annually	Output
For HIV confirmatory result status: Of the total clients who were screened for HIV, % of clients who were confirmed positive	Number of clients who have been confirmed positive for HIV during the period	Number of Clients screened HIV reactive during the period	Monthly/ Annually	Output
For Syphilis testing at SSK: % of clients who were screened for Syphilis during their visits	Number of Syphilis testing done during the period	Total Number of Visits during the period	Monthly/ Annually	Output
Syphilis Screening Test Result: % of clients turning Syphilis reactive/positive during the period (<i>Might be analyzed across Pregnant versus Non-Pregnant Clients</i>)	Number of clients who have screened reactive/positive for Syphilis during the period	Number of clients who have been administered test for Syphilis during the period	Monthly/ Annually	Outcome
Syphilis Re-infection: % of clients who have been re-infected with Syphilis	Number of clients who have been re-infected with Syphilis (<i>at least 3 months after previous treatment</i>)	Number of clients who have been tested reactive/positive for Syphilis earlier and were provided treatment	Cohort Tracking (Monthly/ Annually)	Outcome
For HCV test at SSK: Of the total clients who requested the service, % of clients who were provided	Number of Clients screened for HCV during the period	Total Number of Clients who asked for HCV testing during the period	Monthly/ Annually	Output
For HCV screening test result: Of the total clients who were screened for HCV, % of clients who were screened reactive	Number of clients who have been screened HC V reactive during the period	Number of Clients screened for HCV during the period	Monthly/ Annually	Output

<p>For HCV confirmatory result: Of the total clients who were screened reactive for HCV, % of clients who were confirmed positive</p>	<p>Number of clients who have been confirmed positive for HCV during the period</p>	<p>Number of clients who have been screened HCV reactive during the period</p>	<p>Monthly/Annually</p>	<p>Output</p>	
<p>For ever yreferral service (Ex: <i>Mental Health Counselling</i>) (To be replicated for other referral services)</p>	<p>Availability of Referral Service: Of the total clients who request ed referral, % of clients who were referred</p>	<p>Number of clients referred for Mental Health Counselling during the period</p>	<p>Total Number of Clients who asked for Mental Health Counselling during the period</p>	<p>Monthly/Annually</p>	<p>Output</p>
	<p>Receival of Service: Of the total clients provided referral, %of clients who were</p>	<p>Number of Clients received service at referred cent er during the period</p>	<p>Number of clients referred for Mental Health Counselling during the period</p>	<p>Monthly/Annually</p>	<p>Output</p>

M&E indicators for SSS ¹		Numerator	Denominator	Frequency	Type of Indicator
	received service at referred center				
	<p>Accompanied Referral:</p> <p>1. Out of clients who received service at referred center, % of clients who were provided accompanied referral</p> <p>2. Out of clients who did not receive service at referred center, % of clients who were provided accompanied referral</p>	Number of Clients provided accompanied referral during the period	<p>1. Number of Clients received service at referred center during the period</p> <p>2. Number of Clients who did not receive service at referred center during the period</p>	Monthly/ Annually	Output
<p>Indicators for each commodity (Ex: SRH Commodities) (To be replicated for other commodity dispensation)</p>	Of the total clients who requested SRH commodities, % of clients who were provided service	Number of Clients who were dispensed SRH commodities during the period	<p>Number of clients who requested dispensation</p> <p>(Clients provided + Clients who couldn't be provided due to commodity unavailability + Clients who couldn't be provided due to service not available at SSK)</p>	Monthly/ Annually	Output
<p>Client Demanded services (Cumulative): Table or % of requests across all services</p>	Frequency	Total Services Requested (Provided + Couldn't be Provided) across % (and absolute number) of responses	-	At the end of month/ year	Output

Average Services Asked: Average no. of services asked by each client (Can be cumulatively looked across all client-visits)	Total services requested (Provided+ Couldn'tbe Provided)	-	At the end of month/ year	Output
Average number of Outreaches per Partner: (before the partner arrives to the facility for the first time)	Total outreaches done across partners before they arrive at	-	At the end of month/ year	Output

M&E indicators for SSS ¹	Numerator	Denominator	Frequency	Type of Indicator
	the facility (Cumulative)			
Average number of Partners/Client:	Number of Partner details entered across all clients (Cumulative)	-	At the end of month/year	Output
<p>Analysis of modes of Follow-up: Frequency Distribution of follow-ups done against different follow-up modalities (Phone Call/SMS etc.)</p> <p>Out of the clients who did not turn-up for visit post follow-ups, frequency distribution of follow-up modalities</p> <p>Out of the clients who turned-up for visit post follow-ups, frequency distribution of follow-up modalities</p>			Monthly/Annually	Output
<u>Other Indicators for consideration:</u>				
<p>BPG Treatment: % Clients who were treated using BPG (can be separately analyzed across pregnant and non-pregnant population)</p> <p>Analysis of HIV +ve Clients:</p> <ol style="list-style-type: none"> 1. Frequency distribution of services asked by clients who turned HIV +ve (in terms of both, services asked & were provided, and services asked but couldn't be provided) 2. Analysis of HIV +ve clients by demographic factors, follow-up adherence etc. 3. Adherence Analysis <p>Co-infection rate for HIV/Syphilis, HCV/Syphilis, HCV/HIV, HIV/HCV/Syphilis</p> <p>TB: Analysis of clients who were positive for TB during registration</p> <p>Effectiveness of ORW/Outreach: Success of Outreach (Partners arriving facility) against various modes of follow-up (SMS/Phone Call/Home Visit)</p>			Monthly/Annually	Output

¹**Note:** Each of the indicators can be analysed across client demographic factors:

- Risk Typology (basis risk assessment)
- Age

- Gender
- Occupation

²**Note:** The indicator might also be looked on the basis of Client Visit timelines
(Ex: 4th visit/ 6th visit etc.)

DRAFT

Annexure 9:

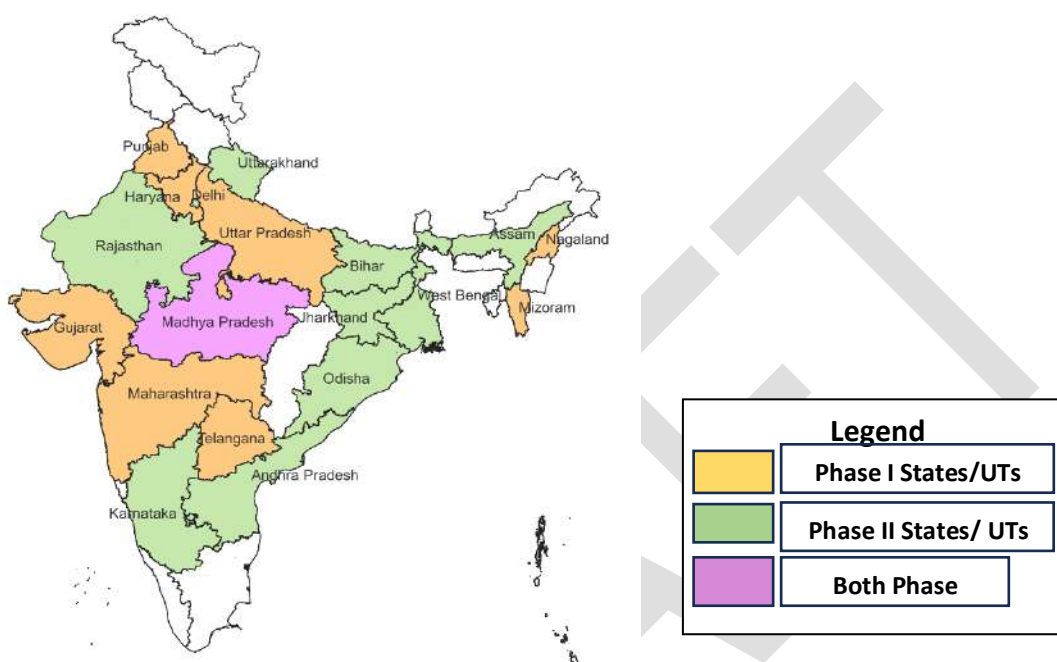
List of States & Districts for Process Documentation data collection

Region	States
North	Chandigarh, Delhi, Haryana, Punjab, Rajasthan, Uttarakhand
Central	Madhya Pradesh, Uttar Pradesh
East	Bihar, Jharkhand, Odisha, West Bengal
Northeast	Assam, Mizoram, Nagaland
South	Telangana, Andhra Pradesh, Karnataka
West	Gujarat, Maharashtra

S. No	State	District/SACS	Phase
1	Andhra Pradesh	Kurnool, APSACS	II
2		Krishna	II
3		Guntur	II
4	Assam	Cachar	II
5	Bihar	Gaya, Bihar SACS	II
6	Chandigarh	Chandigarh, MACS	I
7	Delhi	South Delhi, Delhi SACS	II
8		New Delhi	II
9	Gujarat	Gandhinagar	I
10		Bharuch	I
11	Haryana	Haryana SACS	I
12	Jharkhand	Jharkhand SACS	II
13	Karnataka	Karnataka, KSAPCS	II
14	Madhya Pradesh	Bhind	I
15		Barwani	II
16		MPSACS	I
17	Maharashtra	Nashik, MHSACS	I
18	Mizoram	Aizawl	I
19	Odisha	Khordha, OSACS	II
20	Punjab	Fazilka, Punjab SACS	I
21	Rajasthan	Udaipur, RSACS	II
22	Telangana	Mahbubnagar, TGSACS	I
23	Uttarakhand	Uttarakhand SACS	II
24	Uttar Pradesh	Ambedkar Nagar, UPSACS	I

25		Bareilly	I
26	West Bengal	Maldah	II
27		Murshidabad	II

Key Informants and Districts covered



Type of Respondents:

Levels	Respondents Details	Number of interviews
National Level	NACO Officials, SSS Working Group members, representatives from UN and bilateral agencies, representatives from Community	15
State/ UT Level	SACS Officials	19
District Level	DAPCU/DISHA Staff	20
SSK Level	Site level SSK staff and institution heads where SSK sites are established	24
	SSK Clients/ Beneficiaries	35
	Total Interviews	113

Annexure 10:

Interview Guide cum Tool for SSS Process Documentation

The area of inquiry would be around following levels-

Section A: Beneficiaries

Section B: District level

- Facility-SSK/Co-located DSRC or ICTC/TI or outsourced agency/other service provider
- DAPCU/ DISHA
-

Section C: State level- States AIDS Control Society

Section D: National level- National AIDS Control Organization/ Bilateral and Multilateral organizations/Technical Working Group members.

Common questions- Explain the responded about the activity and time required.

I. Are you willing to participate in this interview?

Informed Consent

Yes No

State**/SACS/National*/NACO	District**/DAPCU/DISHA	Facility Name -SA_ICTC /DSRC/SSK

*Note: * Indicate in case from Bilateral, Multilateral or Community representative;
**Beneficiary: Indicate State/district for Beneficiary getting attached/services to/from SSK*

II. Do you have any questions at this moment?

III. Date when interviewed: _____ Start time: _____ End time:

Section A: Questions for Beneficiary

A1. Participant socio-demographic details:

Age: _____	Gender: _____
------------	---------------

A2: Awareness and Knowledge about SSK services: How do you know about SSK and whether IEC materials displayed in the SSK enhanced your knowledge?

(Probe: Explore client's knowledge about SSK, specify if referred by facility/staff-Peers, social media, SBCC Material, Helpline1097, camps, TIs, LWS etc., and

services offered, if IEC materials were displaced and were helpful in locating/understanding SSK)

A3: Service utilization: How is your experience in accessing the services/commodities (if any) at SSK?

(Probe: Explore whether client received HIV or non-HIV services/commodities, whether services directly provided at SSK or received through referral and linkage; if any of the services provided was chargeable (how much s/he paid and where), and frequency of visiting SSK recommended by beneficiary)

A4. Client Satisfaction What makes you continue/ discontinued visiting the SSK? Any additional services you would like to be included in SSK?

(Probe: Enablers and barriers: variety of services, timing, proximity, time given by the staff, knowledge and behavior of staff, support extended, suggestions for improvement/additional services)

A5. Any suggestions and recommendations to improve the service delivery through SSK? (Open ended)

District level Section B1: Questions for Facility-SSK/Co-located DSRC or ICTC, TI or Outsourced agency/Other Service Provider

B1.1 Knowledge and Awareness about SSK How SSK is different from existing SA ICTC/DSRC?

(Probe: Explore respondent's role and responsibilities, awareness about SSK, role of SSK, sharing information with client before referring to SSK (applicable for DSRC, ICTC, other facility staff and TI))

B1.2 Infrastructure and Management of SSK site: What is the process followed for SSK establishment in your district?

(Probe: Explore process followed for re-branding and challenges faced, recruitment of staff, financial management, infrastructure set up for beneficiary and equipment, and trainings/workshops conducted)

B1.3 Service utilization, and Implementation: What are the activities being carried out by SSK?

(Probe: client flow (source and case load), services offered/availability, system in place for coordination across services (NACP and Non-NACP) through referral/linkage, demand generation, stakeholders and community involvement in implementation)

B1.4 Monitoring and Supportive supervision mechanisms What is the data collection and reporting mechanism being followed and how data quality is assured?

(Probe: tools used for data management and validation checks/rules for data quality; any more suggestions on tools, data collection, reporting and supervisory visits)

B1.5: Enablers and barriers: What according to you were enablers and barriers, and further suggestions to improve the provision of services at SSK?

(Probe: current challenges and gaps, lessons learnt, recommendations and suggestions about the further improvement in SSS)

Section B2: Questions for DAPCU/DISHA officials

B2.1: Establishment and management of SSK site: what are the processes followed in SSK establishment (agency and site selection) in your district?

(Probe: Explore according to him/her role of SSS, his/her role in SSK implementation, process for site selection, financial management; how SSK is different from SA-ICTC/DSRC, knowledge on guidelines and branding challenges, capacity building activities undergone/conducted)

B2.2: Service Utilization and Implementation: As per your knowledge, what are the activities SSK do in your district?

(Probe: Explore service provision, outreach camps, variety of services/commodities including HIV, STI or non-HIV health related (directly provided and services through referral and linkage). Major achievements and pain points during implementation)

B2.3: Stakeholder and community engagement/coordination: What was/should be the role of stakeholders and community in SSK implementation?

(Probe: Explore who are the stakeholders, stakeholders' contribution including community engagement in SSK establishment and implementation,]

B2.4: Monitoring and Supportive Supervision What is the data collection and reporting mechanism being followed in your districts and how data quality is assured?

(Probe: Explore Monitoring and supervision mechanisms for SSK sites, data quality assurance, data sharing mechanism with SACS, data use for planning and delivering services, supportive supervisory visits and review mechanisms, monitoring cross referrals (between SSK, DSRC, ICTC, TI) and' feedback mechanisms]

B2.5: Enablers and barriers What according to you were enablers and barriers, and further suggestions to improve the provision of services at SSK in your district?

[Probe: Explore requirement of changes (if any) in guidelines/protocol, type of service, implementation strategy, supply/infrastructure management, capacity building, finance management, any other)

Section C: Questions for State level- States AIDS Control Organization

C1: Establishment and management of SSK: what are the processes followed for SSK establishment in your State?

[Probe: Role of SACS and SSK nodal officer in SSK implementation, clarity and knowledge on guidelines/SOP, any system in place for ensuring commodities/supplies, branding, coordination between DAPCU/SSK, ICTC, DSRC, financial management, reimbursement, and advance cycle]

C2: Implementation experience: What were some of the major administrative and programmatic strategies while implementing SSK in your state?

[Probe: Major achievement and challenges, leveraging the NACP facilities for the implementation of the SSK activities, coordination between different departments in SACS and selected agencies, supply (of commodities) management]

C3. Stakeholder and community engagement and coordination What was/should be the role of stakeholders and community in SSK implementation in the State?

[Probe: who are stakeholders, how stakeholders are engaged in SSK establishment and implementation; community engagement and quality assurance, system in place to engage stakeholders and community]

C4. Monitoring and Supportive Supervision What is the data collection and reporting mechanism being followed and how data quality is assured?

[Probe: Data management, reporting mechanisms for NACO, data analysis, supportive supervisory visits, review mechanisms-programme and finance, critical indicators being monitored, monitoring cross referrals (between SSK, DSRC, ICTC, TI) and community level monitoring]

C5. Enablers and Barriers What according to you were the enablers and barriers, during implementation of SSK in your State?

[Probe: major administrative and programmatic successes and challenges around coordination, type of services, implementation strategy, supply/infrastructure management, capacity building, Finance management, any other]

C6. Suggestions and recommendations What are your suggestions to improve the provision of SSK services in your State and overall?

(Probe: lessons learnt, requirement or changes in guidelines/protocol, role of the SACS and SSK nodal officers/DAPCUs in improving the performance of SSKs, leveraging other health services in more productive way, strategies to take midcourse correction to improve the performance of SSK)

Section D: Questions for National level- National AIDS Control Organization/ Bilateral and Multilateral organizations/Working group members.

D1. Conceptualization of SSS and development of strategy: What you think about the whole process adopted in developing the strategy?

(Probe: Explore the information on origin of the concept, making of a brand, decision on logo, envisioning of the facilities to implement the strategy, duration of the whole process of conceptualization, development of guidelines, strategy, findings under immersion learning model, phasic transformation of SSS)

D2: Stakeholder and community engagement and coordination What was/should be the role of stakeholders and community in SSK implementation in State?

(Probe: constitution and consultations of/with working groups, Stakeholders/ experts and community engagement in SSK envisioning, establishment and implementation)

D3: Policy Considerations What were the key enablers and barriers in the process of conceptualizing SSS at policy level?

(Probe: Processes used to bring consensus including budget availability, decision on role of SACS, DAPCU, task shifting, key policy recommendations of SSS, better use of MoUs with line-ministries)

D4. Programme Planning and Implementation (Applicable for NACO officials)

What were some of the major administrative and programmatic challenges faced while implementing SSS? *(Probe: Enablers/barriers/lessons learnt, learnings in implementation at ICTC/DSRC level)*

D5: Future of SSS Overall suggestions and recommendations including future you envisage for SSS?

(Probe: Service package defined in the OG are sufficient or changes/innovations required, scale-up will impact branding, financial allocation, monitoring and mobilization of clients, institutionalization of SSS)

Annexure 11:

Methodology of Process Documentation

the guidance of the National AIDS Control Organization (NACO), a series of in-depth interviews were conducted across various levels. Respondents included SSK clients, site-level SSK staff, institution heads at SSK sites, DAPCU/DISHA staff, SACS Officials, NACO Officials, SSS working group members, representatives from UN and bilateral agencies, representatives from PLHIV and high-risk groups. The SSK clients were selected through convenient sampling from among those visiting the SSK for services on the day of interview.

Timeline and Steps

Nov' 2023	• Preparatory meeting to discuss the sampling method, methodology and tools by the sub-group of PEPFAR team
Dec' 2023	• Finalization of sampled sites and discussion with NACO for feedback
Jan' 2024	• Development of tools and discussion on the themes
Feb'2024	• Finalization of tools and discussion with the sub-group of PEPFAR team
Apr'2024	• Capacity building of the field teams and intimation to sites, SACS for the participation in data collection process
Apr and May 2024	• Field visits and data collection
June 2024	• Inputs, data analysis and discussion within sub-group of PEPFAR team, further discussion with NACO
June 2024	• Incorporation of feedback/inputs
July 2024	• Discussion on the flow of sections and review of the contents in line with the themes
Aug 2024	• Final report submission

Sampling and field work:

The field plan was designed with a purposive selection of districts and facilities. Thus, the inclusion criteria served as a guiding factor to initiate the Key Informant Interviews at the field level. Districts and facilities were also included based on additional confounding factors that stakeholders encountered during the implementation of Phase I and Phase II.

The fieldwork was conducted in 21 districts, selected based on the following inclusion criteria:

- i. Performance from April 2023 to February 2024: Districts are evaluated based on their performance within this specified timeframe.

- ii. Geographical Representation: Ensuring a comprehensive geographical distribution across both phases of implementation.
- iii. Implementation Model: Considering various models such as DSRC (Designated State Reference Center) and ICTC (Integrated Counselling and Testing Center).
- iv. Staff Recruitment Modalities: Recruitment methods include hiring through Targeted Interventions (TI), District AIDS Prevention and Control Unit (DAPCU), or other outsourcing agencies.

Data collection team

A two-member team comprising of experts from PEPFAR India and implementing partner agencies was formed. The team completed interviews with the identified respondents from national, state, district, and facility level. A google form was created for capturing state level experience from select 5 states.

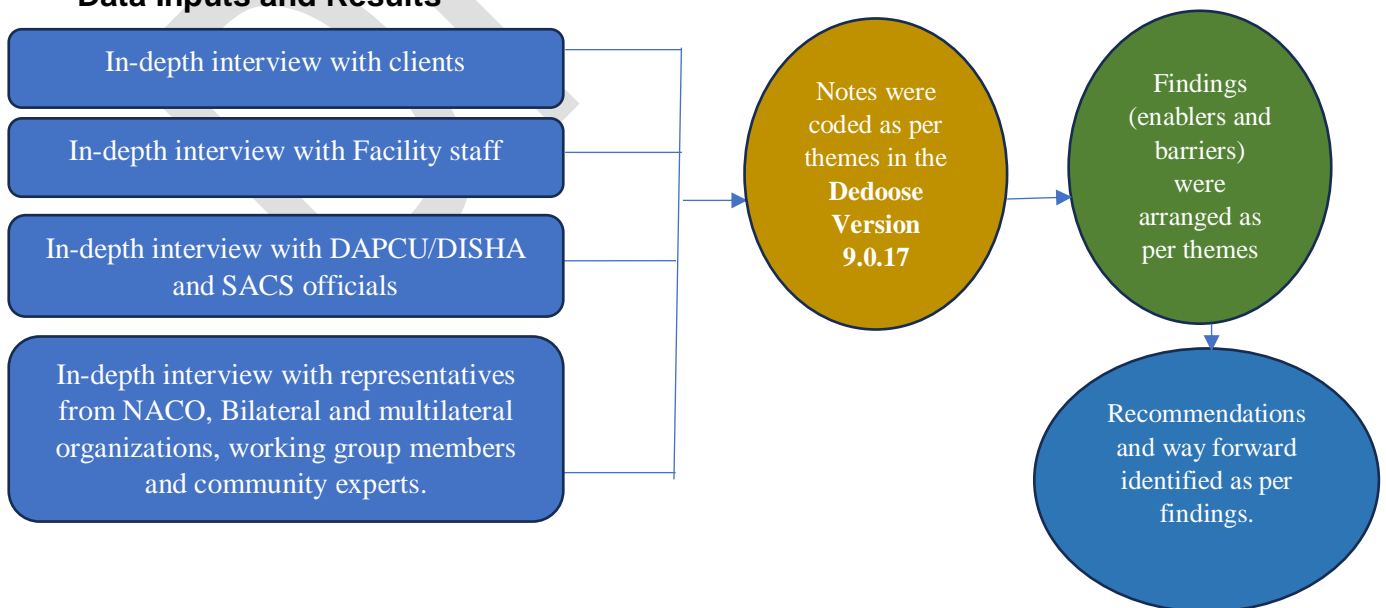
An In-depth interview guide was developed to guide data collection, with each version adapted to the specific respondent profile. All participants were briefed about the process documentation and the data collection process using semi-structured interviews. All participants provided informed consent and no incentives were provided for participating in this assessment.

The responses obtained during the interviews were manually summarized by a note taker who was present during the interview sessions.

Qualitative data analysis software:

Dedoose Version 9.0.17 was used to code the summaries systematically. Thematic analysis was then conducted by examining the coded content, and the findings were organized across key areas.

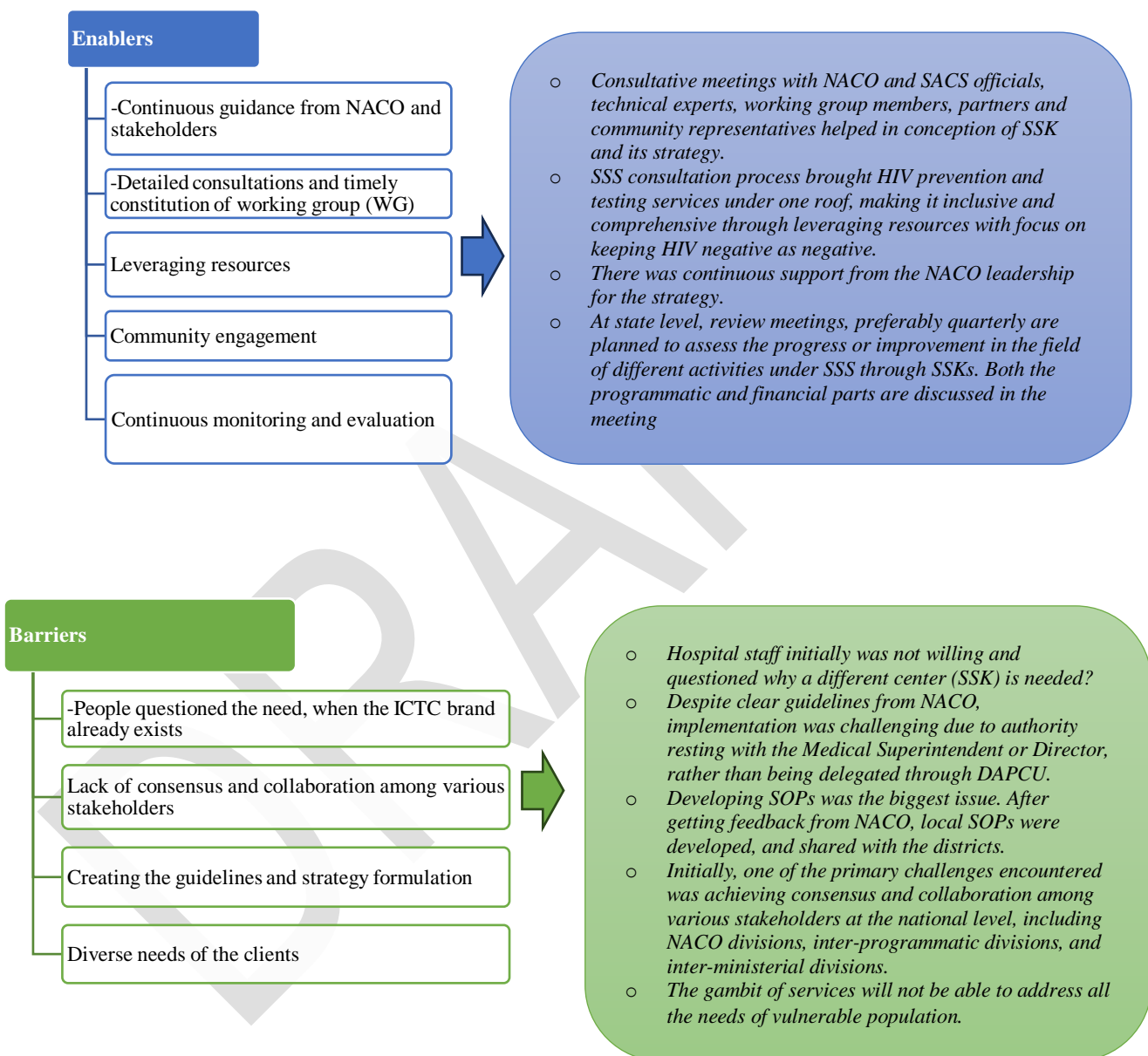
Data Inputs and Results



Annexure 12:

Verbatim from the Respondents (Theme-wise)

I. Conceptualization of SSS



II. Awareness

Enablers

-Camps and events in hospital

-Coordination with ASHA

Sharing responsibility

Use of social media

Branding



- SSK counselors conducted multiple camps and events in hospital to improve awareness about SSK services and referral facilities.
- Awareness about SSK services was generated through IEC materials displayed in SSK waiting area.
- Because of the coordination with ASHA workers, many women and young girls were referred to the SSK.
- ORWs conduct HIV awareness outreach approximately 15 days per month.
- The branding of SSK was done, as per the branding material provided by NACO.
- The "green" theme was adopted for all SSK IEC activities and materials to promote non-stigmatizing, comprehensive health services, with the strategy and logo launched in December 2021, supported by NACO leadership.
- Facebook account and Instagram account were used for SSK awareness.

Barriers

-Lack of awareness among clients referred from other department

Lack of awareness among already enrolled clients of ICTC

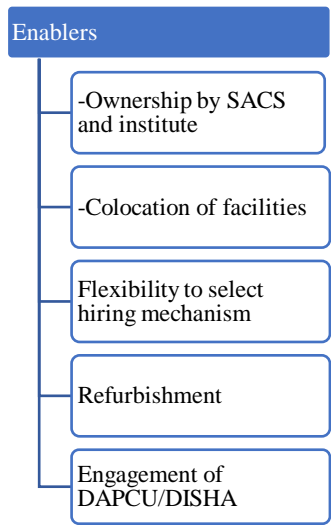
Lack of knowledge about services provided by SSK

Level of literacy and language of IEC material

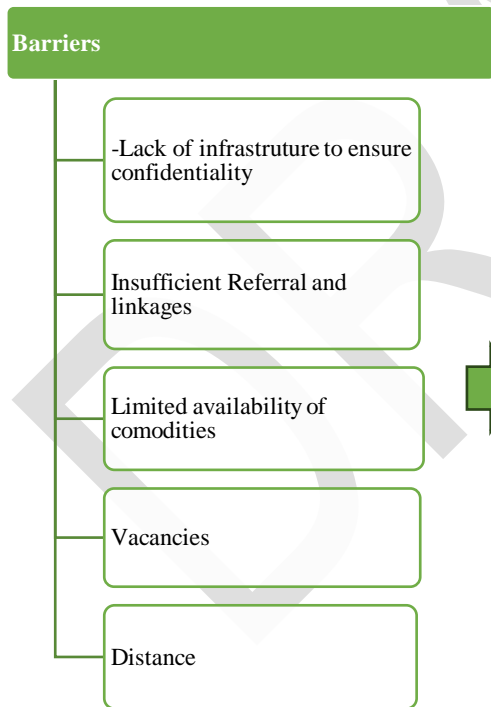


- The regular ICTC clients are not aware of any other services available or being offered in the SSK.
- Clients referred from other departments don't know about SSK.
- IEC materials displayed at SSK are not understood by illiterate clients.
- IEC materials in English language are difficult to understand.
- There was limited clarity on who should be included as SSK clients and whether all HRGs should be part of it, which could potentially be addressed by the IEC materials.
- The client is not aware of any other services except HIV testing available or being offered in the center.

III. Establishment and Implementation of SSK

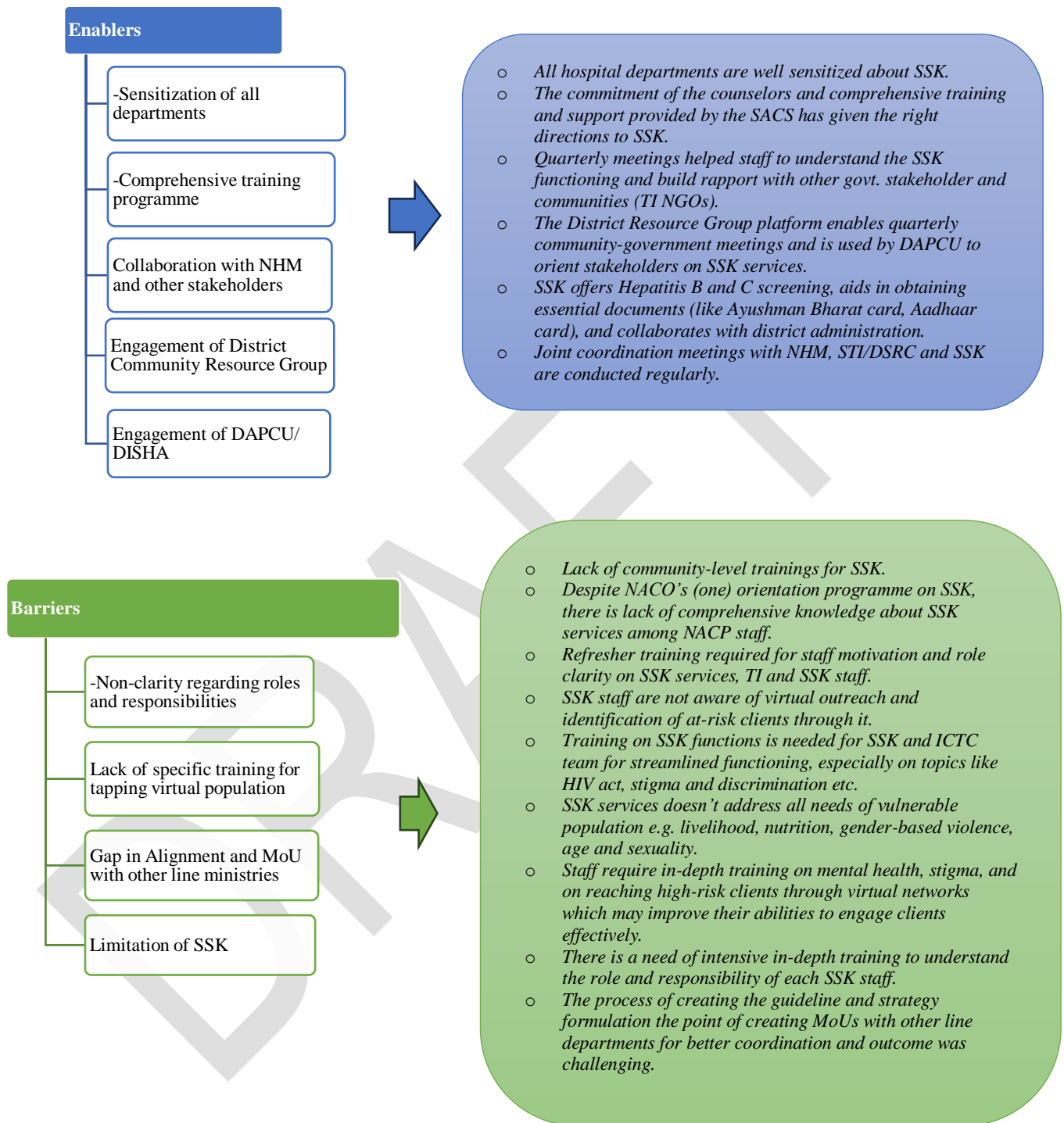


- *Ownership across SACS officials and better coordination within SACS facilitated the establishment of SSKs and implementation.*
- *Freedom to choose any one model out of four options for hiring staff was of great help and recruiting the staff became very easy.*
- *In ICTC-DSRC-SSK co-located facilities the coordination mechanisms are better.*
- *The DISHA team's orientation and coordination programmes at hospital level (full site sensitization) boosted SSK activities.*
- *Allocation of room for SSK and collocated DSRC and ICTC helps in facilitation of referrals between facilities.*
- *In district hospital, furniture and other general office materials was provided for SSK by hospital authority.*
- *Hiring one SSK manager and one outreach worker through outsource agency was easy.*

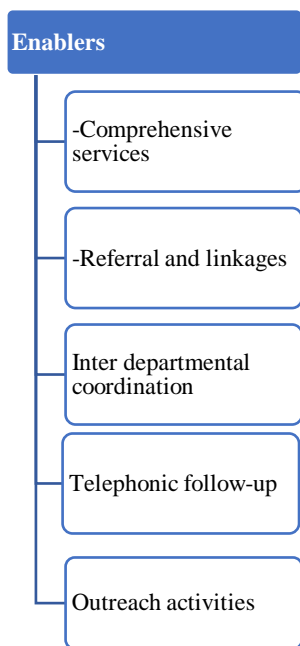


- *Lack of privacy and an open ICTC area hindered clients from speaking freely about their concerns with the counsellor.*
- *Liaisoning at grassroot level is needed with focus on out-referrals.*
- *Procuring HIV, STI, and hepatitis screening kits, and condoms at SSK is difficult, which limits SSK's performance.*
- *Sites with vacancies overburdened the existing staff's workload.*
- *Client needs to take at least half a day off work to visit the SSK, as the travel time typically takes 2-3 hours.*
- *Task accountability of SSK staff hired through NGO was difficult to monitor as these are often driven by NGO itself.*
- *HR of one SSK manager and 2 ORW is not enough especially in large districts where load of ICTC/DSRCs is high.*
- *We are still treading very thickly around the post exposure prophylaxis for sexual exposure.*
- *Advocacy with different departments and stakeholders is important for the developing referrals and linkages.*

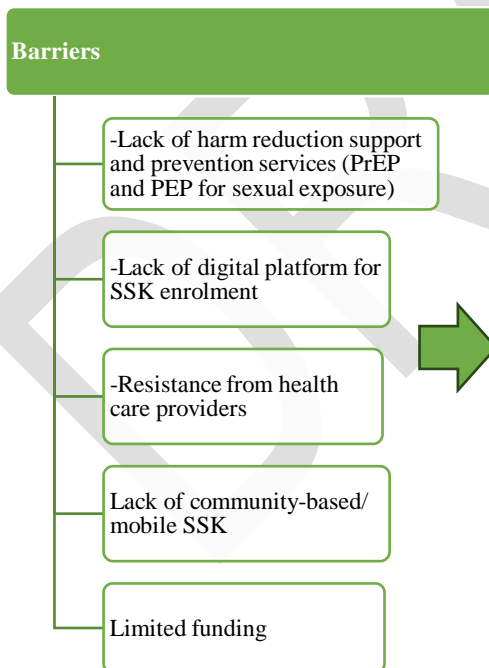
IV. Sensitization and Collaboration:



V. Service utilization and Client satisfaction:



- SSK concept, developed through extensive consultations with community and stakeholders, aims to provide a holistic, people-centric health services incl. referrals for (but not limited to) Hep B/C, mental health, RCH, social security schemes, etc. and specialized outreach services.
- ICTC counsellor informed about SSK services including safe sex practices and family planning.
- Spouse testing (of SSK clients) every 3 months is helpful, and such clients help create awareness, reducing stigma.
- Availability of free condoms is beneficial.
- SSK outreach, supported clients for state disability pension scheme.
- SSK staff facilitated in getting Ayushman Bharat Card.
- SSK provided a uniform platform with streamlined referrals.
- SSK staff frequently calls the clients for other health issues.
- Follow-up calls helped client visit the facility and get tested.
- Outreach activities, advocacy, mega and mini health camps helped in awareness generation and increase in direct walk-in clients.
- ORW has built great rapport and client felt very comfortable



- Needle Syringes, OST may be provisioned within SSK.
- Respondents recommended availability of PrEP and PEP to increase the uptake of service at SSK.
- Nonavailability of online platform for clients don't want to come to facility due to fear of breach of privacy is a major challenge.
- Reluctance of hospital staff to create SSK as a separate center was an issue.
- SSK ORW salary is not at par, leading to more vacancies. There are issues in disbursement of local conveyance to ORW.
- The issue was not budget availability but the time-consuming process of creating a new budget line for its utilization.
- Teleconsultation could be an alternative for home visits as many negative clients have not disclosed their at-risk status.
- Reaching the "at-risk" population who may not readily seek services requires effective outreach strategies. This could involve mobile centers and community-based testing initiatives.

VI. Data Management

Enablers

- All facilities using NORMS
- Easy to use software (NORMS)
- Engagement of SACS and DAPCU/ DISHA in supportive supervision
- Cross validation of data
- Regular review at district and state level



- Data entered in NORMS and followed up for provision of repeat services as recommended under SSS.
- SSK maintains the register of all clients (date of visit and follow-up), and data is entered in NORMS.
- Joint regional review meetings for experience sharing and cross learning at state, regional and national levels help to understand programme and strengthen further planning and implementation.
- State level quarterly review meetings assessed the progress of SSK activities, where both programmatic and financial issues are discussed.
- DISHA team undertakes monthly review of SSK, DSRC and ICTC where NORMS data is reviewed and cross validated.
- District Resource Group platform is used by DAPCU for quarterly meetings and building rapport with line departments including orienting them on SSK services.
- DAPCU promotes at-risk population referrals to SSK through regular meetings with DSRC, ICTC and ART.

Barriers

- Challenge of data entry in NORMS
- Need of further training on NORMS
- Need of monitoring checklist/ separate registers
- Access to NORMS analysis at DAPCU/ DISHA level
- No integration between NORMS and SOCH



- SSK does not have computer systems for recording data.
- NORMS works very slowly.
- Staff needs more in-depth training on software - NORMS.
- There is a need for development of auto-populated dashboards in NORMS to facilitate reviews at district and state level.
- NORMS should be integrated within SOCH and should be available offline.
- Since NORMS and SOCH are not interconnected, NORMS cannot verify if a client is already registered in TI.
- There is a need to provide access of NORMS portal/data to DAPCU to facilitate reviews.
- DISHA team does not have access to NORMS.
- There is a need for specific monitoring indicators for SSK to understand the progress and gaps.

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