NACO
National AIDS Control Organisation
India's response to HIV & Sexually Transmitted Infections
Ministry of Health & Family Welfare, Government of India
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Ministry of Health & Family Welfare
Government of India

Azadi Ka Amrit Mahotsav

Standard Operating Procedure

for reaching out to At-Risk Population for Screening/Testing and Linkages to Treatment of (STI, HIV, TB & Hepatitis B & C) through Hybrid Outreach Approach

National AIDS Control Organization
Ministry of Health and Family Welfare
Government of India

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आज़ादी का अमृत महोत्सव

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स्वास्थ्य और परिवार कल्याण मंत्रालय
भारत सरकार
National AIDS Control Organisation
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Foreword

In order to achieve the 95-95-95 targets particularly the gaps in the first 95, National AIDS Control Organization has designed an operational strategy for conducting Integrated Health Campaigns in high priority districts and states to reach out to the at-risk and vulnerable populations across the country.

The Integrated health campaign is designed as a multi-sectoral approach to be conducted in collaboration with NHM, key line departments such as NVHCP, NTEP for providing screening/testing and linkages to treatment for STIs, HIV, TB & Hepatitis B & C. In order to conduct health campaign, NACO has developed a Standard Operating Procedure (SoP) based on the learnings of few such campaigns conducted recently in Namsai district of Arunachal Pradesh.

The SoP describes the modus operandi for operationalization of Integrated health campaigns including various phases implementation i.e. pre-implementation phase which includes identification of prioritization of districts, villages, pre-publicity activities, implementation phase with static and outreach based health camps and post implementation phase for linkages to prevention and treatment services. It also suggests the package of services to be provided to beneficiaries which includes counselling with risk and vulnerability assessments, TB testing and treatment, HIV and Syphilis Testing with linkage to treatment, HBV/HCV testing with linkage to treatment, diagnosis of diabetes, hypertension, anaemia and any other ancillary services as per need and resource availability.

I congratulate and extend my best wishes to everyone who has been a part of developing this document and the health campaign conducted in Namsai District of Arunachal Pradesh. This SoP will benefit all its readers and stakeholders. It is expected that this Integrated health campaign will greatly benefit States towards achieving their 95-95-95 targets as well as increasing knowledge and awareness on HIV/STIs and other morbidities among the general population at large.

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Preface

India is committed to achieving the global target to end AIDS as a public health threat by 2030. Key to the achievement of this target is the improvement in the 95-95-95 targets i.e. 95% of people with HIV will know their status; 95% of people with HIV who know their status will be on treatment and 95% of people with HIV on treatment will be virally suppressed.

As per 2021 estimates, India has an estimated 2.4 million PLHIV with an adult prevalence of 0.21%. The districts with highest HIV prevalence in the country are situated in the northeastern region (Mizoram-2.7%, Nagaland-1.36% and Manipur- 1.05%). As per the district estimates, all 25 districts having ≥1% adult HIV prevalence are from Manipur (9), Meghalaya (2), Mizoram (8) and Nagaland (6). Further, it is observed that there is a high increase in percentage change in annual new infections during 2010 to 2021(Tripura-330.6%, Meghalaya-221%, Arunachal Pradesh-54.5%, Assam-26.2%, Sikkim-13.3% and Mizoram-3.5%). Being a region with high prevalence and vulnerability, the northeast states need enhanced strategies to improve their 95-95-95 achievements.

In this context, to address the gaps in the first 95 in all high priority districts in the north eastern region and high priority districts elsewhere in India, a Standard Operating Procedure (SOP) for conducting Integrated health campaigns has been developed which is intended to help the State AIDS Control Societies, National Health Missions, District Health Authorities, Technical Support Units, Civil Society Organizations and communities to plan a local response for their respective districts to identify the populations at risk, the index partners, at risk adolescents, bridge populations and provide them comprehensive prevention, testing and treatment services.

It is envisioned that the implementation of the Integrated health campaigns will not be restricted to identification and screening of the at risk populations but on building a comprehensive and sustainable response by leveraging the existing health infrastructure, the available trained manpower and appropriate allocation of resources through the general health system.

The cases detected during the health campaigns must be linked to prevention and treatment services such as ART Centers, Targeted Intervention and Link Workers Schemes, as well as Community Health Centers, Primary Health Centers, Health and Wellness Centers, the latter which can be re-aligned to serve as decentralized service delivery points for HIV prevention and treatment services in future.

I am confident that all the stakeholders will find this document engaging and use as a base document for providing services through Integrated Health Campaign in the selected geographies.

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Message

Based on the learnings of the Integrated health campaign conducted in Namsai district of Arunachal Pradesh, NACO envisages reaching out to the at risk and vulnerable populations in a similar manner and strategy which is expected to have a direct impact on the prevention, testing and treatment cascade under NACP Phase V.

Recent evidences suggest that HIV positivity, both urban and rural, is increasing among certain sub-groups of the population, adolescents and youth population in selected geographies in India. Often these geographies are not adequately covered with the NACP facilities and services and comprehensive knowledge and awareness is found to be very poor.

In order to reach out to these at risk and vulnerable populations in these vulnerable geographies, NACO envisages using differential outreach strategies by way of reaching out to their social, sexual and injecting networks. The early detection of undiagnosed infections will improve the case findings, treatment and bridge the gap of first 95.

In order to reach out to these population, a standard operating Procedure (SoP) has been developed as a reference document for the states. The specific objectives of this SoP is to provide an overview of the differential strategies to reach out to the at risk population, activities to be conducted at State and district levels, package of services to be delivered to the beneficiaries etc.

I am sure that this SoP will be extremely useful for all the State AIDS Control Societies and other stakeholders in developing state and district specific plans to implement the Integrated health campaigns in the selected districts based on evidence.

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Acknowledgement

The Standard Operating Procedure (SOP) for conducting Integrated Health Campaigns through Hybrid approach is a result of a shared effort between National AIDS Control Organization, Dept. of Health & Family Welfare, Govt. of Arunachal, other line departments and the contribution of various stakeholders in Namsai District of Arunachal Pradesh.

First of all, we would like to thank the Senior leadership of NACO Ms. Hekali Zhimomi, AS & DG, NACO, Ms. Nidhi Kesarwani, Director, NACO Dr. A.K. Puri DDG, NACO, Dr. U.B. Das, Sr. CMO (SAG), NACO, Dr. Shobini Rajan, CMO (SAG), NACO, Dr. Chinmoyee Das, ADG, NACO, Dr. Saiprasad P Bhavsar, DD, NACO and Dr. Bhawna Rao, DD, NACO for providing the strategic vision and leadership to roll out a strategy of Integrated health campaign in the high priority districts in the north eastern region and elsewhere across the country in close coordination with NHM/vertical programmes such as TB, Viral Hepatitis etc. with the objective to close the gaps of the 95-95-95 targets across the country.

Secondly, we wish to acknowledge the exemplary leadership of Shri. Vivek HP, Special Secretary Health, Government of Arunachal and the senior officials from Namsai including District Commissioner, Shri. C.R Khampa, District Commisioner, Dr. Surya Namchoom, District Medical Officer, Dr. Padi Tala, District AIDS Control Officer, Dr. Tope Yomcha, District RCH Officer, Dr. C.M. Thamoung, District Program Officer, NCD & NVBDCP, Dr. Sufajing Namchoom, MO I/C Chongkham CHC, Dr. Kayani Namchoom, Dr. Michi Monya, Epidemiology-Intelligence Officer, NVHCP, Ms. Rani Parme, Extra Assistant Commissioner, Ms. Frica Namshum, President, Mahila Welfare Society and members and the officials of Arunachal State AIDS Control Society led by Dr. Riken Rina, Project Director, Dr. Annong Borang DD-BSD/CST, Mr. Tashor Pali, DD-IEC, Mr. Marto Ette, DD-TI, Mr. Karjo Basar, AD-MS, Mr. Ebom Tatu, Attendant, VBDV in making the first Integrated Health campaign in Namsai District a tremendous success, of which the processes and learnings from the pilot have now been incorporated into this operational document.

We also extend our sincere appreciation to the different facilities staffs including the lab technicians, the MICTC team, staff nurses, ASHA, AWW workers, the Targeted Intervention team of Arunachal Pali Vidhyapith Society, Namsai and the important stakeholders such as village heads (Gaon Buras), youth leaders, volunteers and community representatives of Namsai for their unwavering dedication and hard work throughout the campaign.

We also extend our deepest gratitude to all the members of the Strategic Expertise Technical Unit (SETU) team in Arunachal Mr. Sanjib Chakraborty, Regional Team Leader, Mr. Arup Handique, Prevention Specialist, Mr. Dhrubajyoti Teron, Strategic Planning Information & Research (SPIR)-S, Mr. Suman Kalita and Ms. Nopnya Kamhua, Project Field Officers, Mr. Igo Nyori, M & E officer, for their immeasurable role in implementing the health campaign and in the development of this operational document for providing integrated health campaigns.

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Standard Operating Procedure (SOP) for Integrated Health Campaign (IHC)

I. Problem Statement:

National AIDS Control Organisation (NACO) covers key populations who are at risk of acquiring HIV, STI/RTI infections through flagship prevention initiatives such as Targeted Intervention (TI) and Link Worker Scheme (LWS). The Targeted Intervention NGOs are placed mostly placed in the urban areas whereas Link Worker Schemes are placed in rural areas to cover the at risk populations. The recent evidences have shown that the sites and districts which were hitherto considered low prevalence and less vulnerable have become highly vulnerable due to lack of awareness, changing dynamics surrounding sexual exposure, drug use, absence of prevention facilities and service delivery points etc. A comparative analysis of HSS 2017 and 2021 shows that the prevalence has increased among all the high risk groups from 6.26 % to 9.03 % among PWIDs, 3.14 % to 3.78 % among TG/H, 2.69 % to 3.26 % among MSM, 1.56 % to 1.85 % among FSW, 0.51 % to 0.89 % among migrants and 0.86 % to 1 % among truckers. Similarly, as per the India HIV Estimates 2021, it is observed that there is a high increase in percentage change of new HIV infections from 2010-2021 particularly in states such as Tripura (330.6 %), Meghalaya (221.0 %), Arunachal (54.5 %) Assam (26.2 %) Sikkim (13.3 %), Mizoram (3.5 %).

Despite the many achievements under NACP V, as shown by the current p-MPSE estimates it is observed that about 1.3 lakhs PWID population, about 1.6 Lakhs FSW population, 70 thousand MSM and 80 thousand TG/H population remain uncovered by TI services. Further, as per Sankalak 2021- 22, it is also reported that about 93 % of the new HIV infections in 2021-22 is among the non-TI population of which it is expected a considerable number would be from the uncovered HRGs and their sexual or injecting partners. A huge percentage of this population have remained unreached in NACP V for various reasons such as lack of definite mapping numbers since 2009 before p-MPSE estimates in NACP V and hence remained outside of the TI coverage area, being hidden, rural, new and young HRGs, geographical access difficulties such as in some districts of north-east, cross-border mobility, scattered populations etc.

These barriers of accessibility have hindered many HRGs from benefiting from prevention services. NACP has sought to reduce new HIV infections in India by promoting widespread HIV testing, linkage to care and ultimately higher rates of viral suppression to prevent onward transmission. However, as per Sankalak 2021- 22, only 77 % of people with HIV in India know their sero-status as of March 2022. To achieve the first 95 target, India has to reach all the persons living with HIV who are yet to know their status.

To address this gap in knowledge of HIV status and to achieve the NACP V goals in particular, new approaches are needed that enhance the efficiency and coverage of testing. Under NACP V with the commitment to end AIDS as a public health threat by 2030, it is envisioned that while the existing interventions will be sustained, optimized and augmented, newer strategies will be adopted, piloted and scaled up under the programme to respond to the geographic and specific community needs and priorities.

With this vision and evidences of rural vulnerabilities and uncovered populations in NACP V, it is envisaged to adopt the strategy of Integrated Health Campaigns focussing on the 'at risk populations' in priority districts across the high burden states. In order to standardize the conduct of these Integrated health campaigns, this Standard Operating Procedure (SoP) has been developed to help the State AIDS Control Societies (SACS) and other stakeholders as a reference document for conducting Integrated health camps in their respective states. This document provides the suggested strategies, packages of services to be provided, modalities for stakeholder engagement, monitoring, reporting and steps for follow up of the identified cases for treatment.

II. Purpose of the document:

The purpose of this document is to serve as a reference guide for conducting an integrated and comprehensive campaign to control and manage the rising HIV and related infection within a short time period (of around 3 months to 6 months) in a prioritised district with the support of the district administration and district health society and with the overall guidance at the state and national level (SACS and NACO).

As part of the NACP mandate, the TIs and LWS are actively working to cover the high risk populations, their spouses and partners in the urban and rural settings respectively with prevention, testing and treatment services. Additionally, self-referred or walk-in clients also come to the ICTC for accessing HIV testing and counselling services. However, the current conventional approach is not sufficient to bridge the gap of PLHIVs who do not know their status.

In response to the above and based on the first pilot of integrated health campaign conducted in Namsai district, Arunachal Pradesh, this operational document has been prepared which is intended to help the State AIDS Control Societies, National Health Missions, District Health Authorities, Technical Support Units, implementing partners, Civil Society Organizations and communities to plan a local response for their respective districts and blocks to identify the population at risk, the index spouses, injecting or sexual partners, at risk adolescents, bridge populations and provide them comprehensive prevention, testing and treatment services.

The at-risk population identified during the health campaigns also need to be linked to NACP facilities such as ARTC, F-ART, NGO/CBOs implementing Targeted Intervention and Link Worker Schemes, general health system facilities including Community Health Centers, Primary Health Centers, Health and Wellness Centers which can be re-aligned to serve as satellite service delivery points for HIV prevention and treatment services.

This document highlights a hybrid approach for identification of the target at risk population, screening them for HIV/STI/ TB/ HBV, HCV and other morbidities prevalent in the geographies through fixed site-static camps and strategic extended outreach activity involving key community groups and informants. It is envisioned that this document will help in identification of villages, and high-risk geographies through a triangulation of data from HMIS, ICTC, ARTC, p-MPSE, De-addiction and Rehabilitation centers, field intelligence from law enforcement agencies, civil society organizations and the community members at large.

For this integrated response, the engagement of the State and District health authorities, State AIDS Control Society, Civil Society Organizations, Key stakeholders such as Gram Burra, elected officials and representatives, women SHGs, Mahila Societies, Faith Based Organizations, ICDS, Education Dept. etc. is very crucial and important. The success of the interventions will depend not just on identification and screening of the at risk population but on building a comprehensive response by leveraging the existing health infrastructure, the available trained manpower and appropriate allocation of resources through the general health system.

III. Proposed implementation strategies:

The intended population to be covered under the health camps are the Key high risk groups (HRGs) and other at risk and vulnerable population in the age group of 15- 49 years who are into high risk injecting practices, high risk sexual behavior or part of high risk sexual / injecting networks etc.

The proposed implementation strategies will have the following combination approach:

a) Organising Integrated Health Camps at various locations has been designed to reach-out to the larger population with a Comprehensive Service Package to avoid any stigma and discrimination among the target population within a given district.

b) Conducting Extended Outreach: The Extended Outreach has been designed to reach-out to the Specific Population of KPs/ HRGs/their spouses/injecting and sexual partners/their networks and peers etc. within the given geographies or villages. The details of the Extended Outreach are covered in Annexure II.

IV. The Three (03) Phases: Modus Operandi (Operational Procedure)

The Standard Operating Procedure (SOP) for the Integrated Health Campaign (IHC) has been divided into the following three (03) phases:

I) Phase I: Preparatory Phase

II) Phase II: Implementation Phase

III) Phase III: Post Implementation Phase

V. Phase I: Preparatory Phase:

The Phase I is comprised of the following steps

STEP 01: Identification of the district/s for implementation of Integrated Health Campaign (IHC): This step will primarily involve analysis and triangulation of the district-wise Positivity data from Prevention Unit (like TI NGOs, OST Centre, LWS, Prison, One-Stop-Centre (OSC), etc. along with district-wise STI data, district-wise ICTC data and district-wise ARTC data). Highest Priority should be given to district/s showing high rates of positivity along with comparatively high volume of positive case detection for a rational decision on district identification for the implementation of Integrated Health Campaign (IHC). **Refer to ANNEXURE II: A**

STEP 02: Prioritisation of villages/ location for Integrated Health Campaign (IHC) in the identified district/s: The prioritisation of villages/ location for Integrated Health Campaign (IHC) in the selected district/s will further depend on the higher number of Positive Cases detected in the specific villages/ location in the recent years for around 3 to 5 years as per the data available through data triangulation from Prevention Unit (like TI NGOs, OST Centre, LWS, Prison, One-Stop-Centre (OSC), etc. STI data, ICTC data and ARTC data of the identified district/s. **Refer to ANNEXURE II: B**

STEP 03: Mapping of Facilities in the district at Local Level: Mapping of NACP Facilities (Preventions Units, OST Centre, LWS, ICTC, F-ICTC, STI Centre, ART Centre, Link ART Centre, etc.) General Government Health Care Facilities (like District Hospital, Community Health Centre, Primary Health Centre, Health and Wellness Centre, etc.), Private Health Care Service Providers, Integrated Child Development Services (ICDS), Schools, Community Halls, etc. for smooth implementation, referral, linkage and long-term sustainability of the programme

STEP 04: Identification of Major Stakeholders at District Level: Identification of Major Stakeholders at District Level like District Administration, District Health Society (DHS), Line Departments, Civil Society Organisations, Village leaders (Gram Bura), Panchayat Raj, Mahila Groups, Faith Based Organizations etc. for smooth coordination and execution of the programme.

STEP 05: Advocacy with Major Stakeholders at District Level: Advocacy Meeting with the Major Stakeholders at District Level to convince the district authorities about the purpose, the objectives and importance of this integrated health campaign at the district level along with the protocols and support anticipated for financial, logistic and programmatic areas are supposed to be communicated, mobilised and worked out at this stage. Tapping of Human Resources from Para-Medical College/ Institutions should be encouraged to provide additional support with regards to the execution of the programme. Advocacy, sensitization, creation of political will, followed by collaboration with all major stakeholders, covering the whole district, including District Administration, District Health Society (DHS) along with National Health Mission (NHM), Women & Child Development, Social Justice Empowerment and Tribal Affairs (SJETA), Civil Society Organizations (CSOs), Drug De-Addiction Centres (DDAC), Pressure Groups, Women's Group, Self Help Groups, Nehru Yuva Kendra (NYK), Educational Institutions through Red Ribbon Club (RRC), Panchayati Raj Institutions (PRIs) at village level, etc.

STEP 06: Assessment and Procurement Planning for Logistic Requirements: Proper Assessment and Planning for Mobile Vans (or Vehicles) along with POL (Petroleum Oil and Lubricant) as per local need is to be done at this stage along with overall requirements, provisioning, procurement plan and Supply of Kits, Consumables, General Medicines etc. are to be done at this that stage. Requirement Planning and Procurement of IEC Materials require to be addressed here. Moreover, effective planning, necessary coordination, official communication and rational utilisation of the related Human Resources including Medical Officers, Lab Technicians, Nurses, TI NGOs, STI Clinic staffs, SA-ICTC staffs, M-ICTC staffs; etc. are to be carried out at this stage. Provisions for water, tea/coffee, working lunch, etc. along with travelling and logistic support of the human resources require to be accounted here.

STEP 07: Macro-Planning at District level and Micro-Planning at Local Level: This process has to be divided into Overall Periodic Planning; and Specific day-wise Planning.

(i) Overall Periodic Planning (Around 15 to 30 days which may vary from district to district): according to the priority-set by the district level authorities for implementation of the programme at the district level covering the demographic profile, district level information including block-level, circle-level, and village level to facilitate effective implementation planning at village/ local level. **Refer to ANNEXURE II C**

(ii) Specific day-wise Planning and Team composition (according to the prioritised villages/ locations as decided at district level): covering Team-wise information (as per the number of teams allotted per day), Human Resource (HR) Planning, Roles and Responsibilities of the Team Members, Time Table, Duty Roster, etc. Considering the nature of work, it is suggested to have at least a minimum of 2 Teams (01 Static/fixed and 01 Outreach) during the campaign. However, based on the local requirement (expected footfall, Human Resources available, distances to be covered etc.) the number of teams may be increased accordingly. **Refer to ANNEXURE II D**

STEP 08: Identification of Secondary Stakeholders at Local Level: Stakeholders from line-departments, Village-Headman/Village-Headwoman (Gaon Bura/ Gaon Buri), Panchayat Raj Institutions (PRIs) Members, Self-Help Groups, Youth Groups and Women's Group, ASHA Workers, Anganwadi Workers, etc. will be identified for community mobilisation and smooth implementation of the programme

STEP 09: Sensitisation of the Major Stakeholders at Local Level: Sensitisation Meeting with the Major Stakeholders: orientation of service providers, orientation of health and line department officers/ staffs

STEP 10: Joint IEC Activities at District Level: Development of Prototype for Pre-Publicity and Mass Awareness on the Integrated Health Campaign (IHC) through SACS and subsequent dissemination to be led by Department of

Information and Public Relation (DIPR) by District Administration. Execution of innovative ideas for tapping cost-effective technology-driven methods should be encouraged at the district level for reaching out to the hidden and hard-to-reach Key Population (KPs) and At-Risk Population (ARPs)

STEP 11: Flag-Off Meeting: Formal launch and inauguration of the Integrated Health Campaign (IHC) at the district level to be executed under the leadership of the District Administration. To ensure maximum publicity and cooperation of the general public, the integrated health campaign should be flagged off by the Dy. Commissioner, Local MLA or any higher authority.

VI. Phase II: Implementation Phase:

STEP 01: Coordination with Stakeholder at Local Level: Communicate and coordinate with Local Level Stakeholders as per the planned scheduled (immediately after the Periodic Planning at District Level) to Panchayat Raj Institutions (PRIs) through Gaon-Bura/ Gaon-Buri (Village-Headman/Village-Headwoman) for space (preferably Community Hall or Govt School Premises) and facilitate the information dissemination and local community mobilization through ASHA Workers, Anganwadi Workers, Self-Help Groups, Youth Groups, Women's Group, etc.

STEP 02: Joint IEC Activities at Local Level: Miking, Mid-Media Activities (like Street Play/ Open Play, etc.) to be carried out at the intended villages/camp sites prior to the Health camp. Tapping of cost-effective technology-driven methods should be also encouraged at the Local Level for reaching-out to the hidden and hard-to-reach Key Population (KPs) and At-Risk Population (ARPs) both for the Fixed or Static Health Camp along with Extended Outreach

STEP 03: Set-up of Fixed or Static Health Camp (F/S-HC): Coordinate and set-up of the Fixed or Static Health Camp (F/S-HC) at the Villages/ Locations along with the logistic arrangement for the same with prior communication to all concerned for the smooth execution of the Health Camp.

STEP 04: Carry-out Extended Outreach Activities (EOA): Coordinate and carry-out Extended Outreach (EOR) at the hotspots or sites where the HRGs are available and feel comfortable. This will also include Index Testing of Spouse and Partners (Sexual & Injecting), other networks, peers.

STEP 05: Provide Comprehensive Service Package: The Comprehensive Package of Services are provided through in the Fixed or Static Health Camp (F/S-HC) which are complemented and supplemented through the Extended Outreach Activities (EOA). The Package of Services will cover Counselling, HIV/ Syphilis/ HBV/ HCV Screening, Diagnosis for Diabetes/ Hypertension/ Anaemia/ etc., Treatment, Referral and Linkage. Additional health services (like eye check-up, etc.) may be provided as per the needs and demand (through mobilisation of resources)

STEP 06: Confirmatory Testing of Reactive Cases (with further Referral and Linkage): Confirmation for HIV and Syphilis Reactive Cases are to be done immediately through the appropriate NACP facility staffs (SA-ICTC/ PPP-ICTC/ M-ICTC/ etc.), facilitate Sputum Testing for Suspected Tuberculosis, and further Referral and Linkage for Diabetic / Hypertensive/ Anaemic/ HBV Reactive/ HCV Reactive/ etc. Cases. All Confirmed HIV and Syphilis Cases are further referred for treatment at appropriate facilities.

STEP 07: Real Time Reporting at Local Level: Real Time Reporting are carried out by concerned NACP staffs with the overall supervision and handholding support of SACS/ SETU at the Local Level with the help of Android-supported Handset and User-Friendly Application Tool (like ODK: open Data Kit). All staffs involved in Offline and Online (Real Time) Reporting are supposed to sign the Data Confidentiality Agreement and all data are to be cleaned after the completion of the Integrated health Campaign (IHC).

VII. Phase III: Post Implementation Phase:

STEP 01: Linkage to Prevention Services: All newly identified Key Populations (KPs), Bridge Populations, Vulnerable Populations and At-Risk Populations (ARPs) reached through both static and outreach health camps should be linked to relevant Prevention Services either through new registration to TI/OST centres etc. or referrals to other NACP facilities. Additional information to be provided to clients who are reluctant to take Prevention Services immediately with further liaison/ connection to be facilitated by the TI, NACP facility staffs.

STEP 02: Linkage to Treatment and Index Testing: Baseline Investigation and initiation to treatment of all confirmed positive cases will be carried out with the necessary logistic support from the district level. The team will also conduct intensive Index testing for all identified positive cases if not managed during the implementation phase.

STEP 03: Follow-Up for Treatment Adherence: Follow-Up of PLHIV clients for stabilisation, their treatment adherence, tracking of irregular, pre-LFU cases, LFU tracking and providing regular counselling and formation of PLHIV support groups etc. All required information with regard to Confirmed Positive Cases are required to be coordinated and communicated as per the "Shared Confidentiality" and "Shared Responsibility" to Team 02 for further Linkage to Treatment.

STEP 04: Offline Reporting at District Level: The Offline Reporting for all Linkage to Treatment and further tracking of Index Case Testing (ICT) Clients will be coordinated, complied and reported by SETU to SACS, NACO and other stakeholders. All reporting as per NACO guidelines, norms and standard reporting like SOCH (IIMS) will be done as per normal procedure.

VIII. Recommended Package of Services:

i. Counselling with Risk and Vulnerability (R&V) Assessment

ii. 4S Verbal Screening and facilitate Sputum Testing of Suspected Cases

iii. HIV Screening and Testing with Linkage to Treatment

iv. Syphilis Screening and Testing with Linkage to Treatment

v. HBV Screening and Testing with Linkage to Treatment

vi. HCV Screening and Testing with Linkage to Treatment

vii. Diagnosis of Diabetic, Hypertensive, and Anaemic with Treatment

viii. Any other services as per local needs and local demand (through mobilisation of resources)

IX. Monitoring by NACO, SACS, District level:

i. NACO will be providing overall guidance and review from the National Level

ii. SACS under the guidance of the assigned Health Secretary will be providing necessary coordination and logistic support from the State Level with the technical support of SETU

iii. District Officials of District Health Society under the leadership of District Administration, will be providing day-today-day support from the District Level with the technical support of SETU

X. Reporting:

i. The data entry of the daily attendees, as recorded in all the formats and registers, along with the screening results will be entered using mobile handset with Android as an Operating System (OS) through ODK (Open Data Kit) available at Google Play Store free of cost.

ii. The data entry will be done on a daily (day-to-day) basis by the NACP Team (including TI NGOs), immediately after the completion of the health camps on the same day. The major advantages of data entry of the designed format through ODK are that there is no requirement of laptop and no requirement of any operational knowledge on MS-Excel under MS-Office. The user-friendly data entry through mobile handset which is largely available among staff members working in NACP facilities including TI NGOs makes the process easily available, acceptable, accessible, affordable (with no additional cost).

iii. This entered data will be reflected in the Google Drive of the IT (Information Technology) Administrator and finally reflected in the required Dashboard for major stakeholders on a daily basis. Data Confidentiality to be maintained as the Guidelines of the Strategic Information (SI) Division under NACO. All formats and registers, of the campaign should be stored later at NACP facilities of the district as per privacy and confidentiality norms.

XI. Rationalisation and decentralisation for universal access

Based on the findings and outcome generated during the course of the Health campaign and to ensure universal access of prevention and treatment services to those newly identified at risk populations, it is envisaged to adopt a flexible approach of creating a single window system of NACP facilities or decentralising the services through existing health infrastructure available in the area. The details are mentioned below:

i. Single Window Approach (OST-HCTS- F-ART)

To ensure universal access to prevention and treatment services, the nearest health facilities in the camp sites/villages/blocks should be assessed for the feasibility of setting up co-located prevention and treatment services for OST, HIV counselling and testing, F-ART under a single window model. The existing staffs working in the facilities will be provided capsular trainings for service delivery.

ii. Service Delivery through Health System (SDHS)

To ensure a more decentralised service delivery, the existing health infrastructures available at the primary level which includes PHC, Health and Wellness centres should be mapped and assessed to be used as potential satellite /secondary distribution, re-fill sites to cover the high risk populations identified during the camps. The resources available should also be mapped along with the modalities for engagement. Rationalisation of resources will be followed. For eg. the

medicine transportation to HCW to be used for transportation of essential kits (testing kits, STI medicines) for the purpose. It is therefore essential to look into the following aspects for decentralising the service delivery approach;

a. Identification of Site

b. Assessment of Site

c. Existing manpower and Training

d. Re-filling and Satellite delivery

e. Logistics

XII. Roles and Responsibilities:

The major roles and responsibilities of the major stakeholders at different levels are enumerated below:

Leadership	Stakeholder	Roles and Responsibilities
National Level	NACO	National AIDS Control Organisation (NACO) under Ministry of Health and Family Welfare (MoH&FW), Govt of India (GOI), under the leadership of AS&DG and the Director will oversee and regularly review the Integrated Health Campaign and provide time-to-time necessary guidance, support and supervisory visit through the various divisions:
	IEC and Mainstreaming Division	IEC and Mainstreaming Division will provide overall guidance on the following: IEC Materials; Advocacy and Sensitization; Involvement of Red Ribbon Club (RRC), Nehru Yuva Kendra (NYK), Faith-Based Organisation, Pressure Group, Women's Group; Direction to the State on Profiling of Villages and Pre-Publicity of the Comprehensive Campaign (as per changing dynamics among the various tribes/sub-tribes with different sub-cultures and social-economic background)
	Prevention Division	Prevention Division will provide overall guidance on the following: Mobilisation and Reach-Out to Key Population, Bridge Population, At-Risk Population and their Spouses and Partners; Direction to the State on follow-up of the Positive Cases (covering HIV, TB, STI, HBV, HCV, etc.); Review of the Partner Notification and Index Case Testing of the Stabilized Clients jointly along Basic Services Division
	Basic Services Division	Basic Services Division will provide overall guidance on the following: Availability of Kits and Consumables; Direction to the State on the effective and rational use of the related Human Resources including SA-ICTC and M-ICTC
	Care, Support and Treatment Division	Care, Support and Treatment Division will provide overall guidance on the following: Sustainable Baseline Investigation; Sustainable Treatment Linkage and Adherence; Direction to the State on CD4 Count Testing and Viral Load Testing of the HIV Positive Cases;

		Review of the Partner Notification and Index Case Testing of the Stabilized Clients along with Prevention Division
	Lab Services Division	Lab Services Division will provide technical guidance to the State on HIV Testing, CD4 Count Testing and Viral Load Testing
		National Viral Hepatitis Control Programme (NVHCP) will provide necessary guidance on free HBV and HCV Screening, Viral Load Testing and Treatment
State Level	SACS	State AIDS Control Society (SACS) will finalize, financially support and undergo monitoring visits to the Integrated Health Campaign under the aegis of the assigned Principal Secretary/ Special Secretary/ Health Secretary of Department of Health and Family Welfare, through the various component heads.
	IEC and Mainstreaming Division	IEC and Mainstreaming Division will provide field-specific support on the following: IEC Materials; Advocacy and Sensitization; Involvement of Red Ribbon Club (RRC), Nehru Yuva Kendra (NYK), Faith-Based Organisation, Pressure Group, Women's Group; Profiling of Villages and Pre-Publicity of the Comprehensive Campaign (as per changing dynamics among the various tribes/sub-tribes with different sub-cultures and social-economic background)
	Prevention Division	Prevention Division will provide field-specific support on the following: Mobilisation and Reach-Out to Key Population, Bridge Population, At-Risk Population and their Spouses and Partners; Supervise the follow-up of the Navigation of Positive Cases (covering HIV, TB, STI, HBV, HCV, etc.); Supervise the follow-up of the Partner Notification and Index Case Testing (of Spouses and Partners including Biological Children) of the Stabilized Clients jointly with Basic Services Division; provide required allowances for the same on account of travelling and logistic support to the TI/ OST/LWS staffs
	Basic Services Division	Basic Services Division will provide field-specific support on the following: Supply of Kits and Consumables; Effective and Rational Utilisation of the related Human Resources including SA-ICTC and M-ICTC; Allowances for the same on account of travelling and logistic support to the SA-ICTC and M-ICTC; Financing of POL (Petroleum Oil and Lubricant) for M-ICTC
	Care, Support and Treatment Division	Care, Support and Treatment Division will provide field-specific support on the following: Baseline Investigation; Treatment Linkage and Adherence; Blood Sample Collection and Transportation for CD4 Count Testing and Viral Load Testing of the HIV Positive Cases; Supervise the follow-up of the Partner Notification and Index Case Testing of the Stabilized Clients along with Prevention Division
	Lab Services Division	Lab Services Division will provide field-specific support for timely and quality HIV Testing, CD4 Count Testing and Viral Load Testing

	National Viral Hepatitis Control Programme (NVHCP)	National Viral Hepatitis Control Programme (NVHCP), at the state level, will provide field-specific support, including supply of Kits, Consumables, and its related Medicines, for free HBV and HCV Screening, Viral Load Testing and Treatment
	SETU	The technical support for overall-planning, communication, and reporting format will be provided by Strategic Expertise Technical Unit (SETU) under the guidance of NACO.
District Level	District Administration	The District Administration with the leadership of Deputy Commissioner (DC) will lead the Integrated Health Campaign and provide direction to the district functionaries for successful implementation of the programme along with its major activities and also be responsible for management of any adverse event that may affect the health camps.
	District Health Society (DHS)	The Nodal Officer of the Integrated Health Campaign will be the District Medical Officer/Health (DMO/H) will provide overall allocation of resources including required health-equipment for Medical Check-Up and monitoring visit including provision of general equipment and medicines under District Health Society (DHS) with the support of the following:
	National Viral Hepatitis Control Programme (NVHCP)	(a) District Reproductive Child Health Officer (DRCHO) cum Nodal Officer of National Viral Hepatitis Control Programme (NVHCP) will procure HBV and HCV Kits, Consumables and its related Medicines, and will involve ASHA Workers, will provide support through Health and Wellness Centre staffs and will share Duty-Roster of Lab Techs and Nurses.
	Non-Communicable Disease Control Programmes (NCDCP)	(b) District Programme Officer (DPO) of Integrated District Surveillance Programme (IDSP), National Vector Borne Disease Control Programme (NVBDCP), National Leprosy Eradication Programme (NLEP), Non-Communicable Disease Control Programmes (NCDCP) will procure Random Blood Sugar (RBS) Kit and will facilitate Medical Officers (MO) through Doctors Association.
	DTO cum DACO	(c) District Tuberculosis Officer (DTO) cum District AIDS Control Officer (DACO) will mobilize National AIDS Control Programme (NACP) staffs along with STI Syndromic Management Kits, Kits for Screening HIV and Syphilis, along with support for drinking-water, tea, snacks, and working-lunch.
	SETU	The technical support for micro-planning, coordination and online-reporting will be provided by Strategic Expertise Technical Unit (SETU) under the guidance of NACO.
Village Level	Panchayat Raj Institutions (PRIs)/ SHGs/ FBOs, Village elders/ICDS/ASHA	Panchayat Raj Institutions (PRIs) through Gaon-Bura/ Gaon-Buri (Village-Headman/Village-Headwoman) or Civil society Organizations/ FBOs where applicable will provide space (preferably

		Community Hall or Govt School Premises) and undertake dissemination and local community mobilization through ASHA Workers, Anganwadi Workers, Self-Help Groups, Youth Groups and Women's Group etc.
	NACP facilities along with Prevention Units	TI/ OST/ LWS staffs along with M-ICTC will support the Extended Outreach of Key Population, Bridge Population, At-Risk Population and their Spouses and Partners through Evidence-based Community Outreach focusing on Injecting and Sexual Network for reaching out to the specific population with high risk and vulnerability to HIV and related infections.

XIII. Impact Evaluation of the Campaign

The intended outcome of the campaign is to achieve the first 95 i.e. the number of at risk population able to know their HIV status. This will help in responding to the all three 95 targets in the state. As impact of the campaign, the number of persons screened and detected with HIV will help in strategizing further to expand the services to all the at risk and vulnerable populations and strengthen the HIV programme in the selected geography.

XIV. Additional Considerations under Implementation Phase

I) Multi-Pronged Approaches:

(1) Advocacy, sensitization, creation of political will, followed by collaboration with all major stakeholders, covering the whole district, including District Administration, active political party, National Health Mission (NHM), Women & Child Development, Social Justice Empowerment and Tribal Affairs (SJETA), Civil Society Organizations (CSOs), Drug De-Addiction Centres (DDAC), Pressure Groups, Women's Group, Self Help Groups, Nehru Yuva Kendra (NYK), Educational Institutions through Red Ribbon Club (RRC), Panchayati Raj Institutions (PRIs) at village level etc.

(2) Mass Awareness on the Integrated Health Campaign through Department of Information and Public Relation (DIPR) by District Administration.

(3) Counselling by NACP Team (including TI NGOs) of all the attendees with basic Risk and Vulnerability (R&V) Assessment for further screening of HIV and Syphilis.

(4) To avoid the stigma and discrimination of the Key Populations, Bridge Populations, Vulnerable Populations, At-Risk Populations, Pregnant Women, etc. covering Injecting Drug Users (IDUs), Package of Services is designed covering HIV Screening, Syphilis Screening, HBV Screening, HCV Screening along with Screening for Anemia, Diabetes, Hypertension, etc. focusing on: (a) HIV Screening of General Population within the age range of 15 to 49 years and (b) HIV Screening of Key Population, Bridge Population, Vulnerable Population and Pregnant Women.

(5) Extended Outreach at specific hotspots/ sites/ locations with the support of Community Outreach workers, peer educators along with Injecting and Sexual Networks for identifying areas with concentration of Injecting Drug Users (IDUs) for reaching out to the specific population with high risk and vulnerability to HIV and related infections.

II) Operational Plan: The day-to-day operational decisions with regards to the specific village, specific timing, number of villages per day, deployment of vehicles, route plan, allocation of manpower (both for medical and non-medical purpose like doctors, nurses, lab technicians, counsellors, nurses, outreach-support team, mobilisation-support team, logistic-support team, etc.) and other related resources including health-equipment, kits, consumables, medicines, commodities, etc. for medical check-up including stock status, communication/briefing of staffs/volunteers, will be

drafted and shared for 07 days to 14 days from the district level and modified at the district level according to the ground-level situation and the changing dynamics. The operational plan should have sufficient provision to mobilize the local community, provide counselling, to conduct risk assessments, prescribe medicines, collect sample as per established protocol, transport samples to the nearest designated place, referral and linkage to health facility and proper recording of information/data in formats/ registers for future course of action. Profiling of villages and pre-publicity is a pre-requisite for local target community mobilisation through various modes (in-person or any other medium) including folk-troupes, local volunteers, etc. as appropriate in the specific village for increased footfall.

III) Reviewing, Re-Strategizing, Re-Planning for Resource Allocation: The Integrated Health Campaign is a unique field-level programme to find out the real source of the high HIV and related infections (with districts depicting high HIV and related Positivity) without stigmatizing and discriminating the Key Population, Bridge Population, At-Risk Population, PLHIV Clients along their Spouses, Partners, and Biological Children. The Integrated Health Campaign Approach may be adopted in High Priority district depicting sudden uncontrollable and unmanageable rise of HIV and related infections without showing any significant decline of the infection through other time-tested methods.

The evidence generated will facilitate the Review and Re-Strategizing the Integrated Health Campaign. The following strategic decision may be required based on the evidence generated:

(1) For Instance, if the evidence depicts high HIV and related infections among Specific Key Population (like Injecting Drug Users or Sex Workers) but less HIV and related infections among General Population, then more resources should be mobilised on Extended Outreach among the identified Key Population (like focusing on People Who Inject Drugs or People who are into Sex Work) and less resources should be mobilised on reaching out to the General Population in the villages.

(2) Whereas, on the other hand, if the evidence depicts low HIV and related infections among Specific Key Population (like Injecting Drug Users or Sex Workers) but high HIV and related infections among General Population, then less resources should be mobilised on Extended Outreach among the identified Key Population (like focusing on People Who Inject Drugs or People who are into Sex Work) and more resources should be mobilised on reaching out to the General Population in the villages.

(3) However, if the evidence depicts high HIV and related infections among Specific Key Population (like Injecting Drug Users or Sex Workers) and also high HIV and related infections among General Population, then equivalent resources should be mobilised on Extended Outreach among the identified Key Population (like focusing on People Who Inject Drugs or People who are into Sex Work) and equivalent resources should be mobilised on reaching out to the General Population in the villages.

XV. Annexure I: Extended Outreach Guide

01: Introduction

The Concept of Extended Outreach is an essential component/ part of the Integrated Health Campaign (IHC) for reaching out to the **Specific Key Population (KP)** like Injecting drug users (IDUs) including Female Injecting Drug Users (FIDUs), Female Sex Workers (FSW), Males who have Sex with Males (MSM), Transgender (TG) **and other At-Risk Population (the person who is at risk of HIV or STI either by personal behaviour/habits or his or her partner or spouse irrespective of their association as KP/HRGs)** in that village/ area/ site/ etc. It is possible that a section of the Key Populations (KPs) may not turn-up at the Health Camp along with the general population for various reasons including stigma and discrimination, self or perceived stigma etc. Hence, a strategy has been developed to reach out to the Key Population (KPs) through specific teams dedicated to the Target Population or Key Population (KP). These teams will focus on reaching out to the Key Population (KP) as per the available information through p-MPSE Exercise, NACP Network (through TI/LWS/OST/Facility staffs, peer educators, volunteers, etc.), Local Community Networks, Field Intelligence, Snow-Balling Technique, etc.

02: Team Formation

Minimum of two (02) teams will be formed covering one (01) Outreach Team and one (01) Confirmatory Team which may be modified as per the local requirements. The number of teams may also be increased according to the target population concentration, available human resources, logistic support, etc.

03: Team Composition

There will be a minimum of two (02) teams composed of one (01) Outreach Team and one (01) Confirmatory Team which may be modified as per the local requirements. The number of teams may also be increased according to the target population concentration, available human resources, logistic support, etc. The team will compose of the following:

Team 01 (Outreach Team 01): This team will be focussed on extensively reaching-out to the Target Population / Key Population. The team will be primarily composed of Prevention Units and like TI/ LWS/ OSTC/ OSC/ SSK/ etc., as well as other facilities like NHM covering NTEP, NVHCP, NCD, NLEP, etc. as per local needs. The team will be composed of Program Manager (01), Outreach Worker (01), Counsellor (01), M&E Officer/ Data Manager (01), Peer Educator (01), Community Volunteers (03) either PLHIV or non-PLHIV, Representatives from other facilities, Lab Tech (at-least 01), GNM/ ANM Volunteers (may be mobilised from local nursing institutes, etc.). The team will be facilitated or coordinated by one of the competent, consistent officer to be nominated by either DMO or SACS as the **Team Coordinator:01 for Extended Outreach-Work.**

Team 02: (Confirmatory Team): This team will be focussed on Confirmatory Testing of the Reactive Cases after the Screening among the Target Population/ Key Population. This team will also focus on Index Case Testing of the PLHIV Cases among the Target Population/ Key Population. The team will be primarily composed of ICTC facility staff (preferably from M-ICTC or may be from SA-ICTC or PPP-ICTC). The team will also have lab support services for confirmation of HBV and HCV. The team will be composed of Counsellor (01), Lab Tech (at-least 01) and other related staff. The team will be facilitated or coordinated by one of the competent officer to be nominated by DMO or SACS as the **Team Coordinator:02 for Confirmatory Testing**

04: Modus Operandi (Operational Procedure)

[STEP-01]: The specific village/ area/ site/ etc. of the Extended Outreach will be according to the micro-plan and final communication of the Nodal Officer of the Integrated Health Campaign (IHC) to the whole team as per discussion and decision of District Health Society (DHS) representative (ideally district level representative like DMO/H or CMO/H or JD-DHS/ etc.), Sub-Divisional Commissioner (SDC) or Circle Officer (CO) or Extra Assistant Commissioner (EAC), DACO cum DTO, local SACS representative, local TSU/SETU representative, local Prevention Unit/ Civil Society Organisation (CSO) representative/s, Community Network Representative/s, Women's Group Representative/s, relevant Panchayat Raj Institution (PRI) representative/s, etc.

[STEP-02]: De-brief of the whole team in physical or virtual mode (whichever is convenient) will be carried out by the respective **Team Coordinators** with the support of DACO cum DTO and other related stakeholder for clear dissemination of roles of responsibilities of each team member.

[STEP-03 (i)]: Minimum essential Pre-Publicity as required (maintaining privacy and confidentiality) for the particular Extended Outreach of the overall Integrated Health Campaign (IHC) to the major secondary stakeholders will be executed through Panchayati Raj Institutions (PRIs) Representative: Gaon-Bura/ Gaon-Buri (Village-Headman/Village-Headwoman) who shall also provide space (preferably Community Hall or Govt School Premises) for the Health Camp.

[STEP-03 (ii)]: However, the maximum Pre-Publicity of the Extended Outreach among the Primary Stakeholder (focusing on Target Population or Key Populations (KPs)) will be executed through the Local Community Networks along with the available information through p-MPSE Exercise, NACP Network (through TI/ LWS/ OST/ facility staffs, Peer Educators, Volunteers, etc.), Field Intelligence, Snow-Balling Technique, etc.

[STEP-04]: The respective teams will proceed as per the plan (disseminated through debrief meeting) preferably via the assigned vehicle/s for cost-effectiveness, so that multiple vehicles are not used for motorable roads. Each team will have a minimum of one vehicle for onward, field travel and return journey.

[STEP-05]: After reaching the specified location/ destination they will focus on their respective roles and responsibilities and come back to their original location after completion of their activities.

05: Roles and Responsibilities

The Major Roles and Responsibilities of the minimum two (02) team members (which may be expanded according to the district need) are as follows:

Team 01 (Outreach Team 01): Team Co-ordinator (01), Program Manager (01), Outreach Worker (01), Counsellor (01), M&E Officer/ Data Manager (01), Peer Educator (01), Community Volunteers (03) either PLHIV or non-PLHIV, Representatives from other facilities, Lab Tech (at-least 01), GNM/ ANM Volunteers (may be mobilised from local nursing institutes), etc.

a) Team Coordinator:01 (for Outreach Work): Coordinate and lead the Team to Reach-Out to the ***Outreach Clients*** among the Target Population or the Key Population or At-Risk Population and provide Comprehensive Health Services Package along with Screening for HIV and related infection.

b) Outreach Worker (01): Lead the outreach team through identifying, prior planning, and prioritising sites and spots for reaching out to Outreach Clients among the Target Population or the Key Population or At-Risk Population. Support Peer Educators in providing correct/ proper information along with essential services and further report to the assigned Team Coordinator.

c) Counsellor (01): Assess the Risk and Vulnerabilities (R&V) of the Clients to be Screened through Extended Outreach, provide options and Counselling for Risk Reduction, STI Counselling, Pre-Screening Counselling, Post-Screening Counselling, 4S TB screening etc. Collect all the necessary and relevant information for further follow-up/ confirmation/

partner notification/ index case testing. Share all the necessary and relevant information with Team 02 (for Index Case Testing) Health Care Providers (HCPs) under the clause of "Shared Responsibility" and "Shared Confidentiality"

d) M&E Officer/ Data Manager (01): Collect all the data generated during the Outreach activities of Team 01 and report the findings as per the given formats designed for the Integrated Health Campaign (IHC) along with the Extended Outreach.

e) Peer Educator (01): Mobilise the Target Population or Key Population or At-Risk Population for Index Case Testing/ Screening through Community Networks, Local Intelligence, Snow-Balling Technique, 1-1 and 1-G interactions and provide information and essential services and further report to the assigned Outreach Worker.

f) Community Volunteers (03): Assist the team in identifying the Target Population or Key Population or At-Risk Population.

g) Lab Tech (at-least 01): Perform HIV Syphilis, HBV and HCV Screening through blood sample collection, Sputum Testing of suspected TB cases, recording of the results of the outreach clients for further follow-up and referral.

h) GNM/ ANM Volunteers (may be mobilised from local nursing institutes, etc): Support the Team 01 (Outreach Team) as support staff members in providing clinical and recording services

***Team 02: (Confirmatory Team)*:** Team Co-ordinator (01), Counsellor (01), Lab Tech (at-least 01) and other associated staff members.

a) Team Coordinator:01 (for confirmatory Team): Coordinate and lead the Team to Reach-Out to the ***Outreach Clients*** among the Target Population or the Key Population or At-Risk Population and conduct confirmatory testing as well as overall management for index testing and follow up activities. The Team co-ordinator of Outreach Team and confirmatory team can also be the same person where applicable.

b) Counsellor (01): Assess the Risk and Vulnerabilities (R&V) of the Reactive Clients (both Negative and Positive), provide options and Counselling for Risk Reduction, STI Counselling, Pre-Test Counselling, Post-Test Counselling, 4S TB screening, etc. Collect information for Index Case Testing through Mapping of Partners (both injecting and sexual), Spouses and Biological Children of Positive Clients, with data capturing as per the given formats. Share necessary information and data generated to relevant Health Care Providers (HCPs) under the clause of "Shared Responsibility" and "Shared Confidentiality".

c) Lab Tech (at-least 01): Perform Confirmatory Testing of Reactive Cases through Blood Samples Collection, Sputum Collection, Recording of the Results of the Reactive Clients for further follow-up and referral.

06: Training Sessions

At-least a one-day training session will be conducted for Team 01 and Team 02. The sessions will be facilitated by district level resource persons with the support of state level and regional level technical persons along with the guidance of national level officials. The sessions may be facilitated in the hybrid mode to make the process economic and cost-effective with the district level resource persons and staff members located in different locations to cover all team members covering the Peer Educators and Volunteers dispersed in various locations.

The topics to be ideally covered in the sessions will be focussed on: (i) Introductory and Interactive Session (covering Concepts/ Advantages/ Merits of Early Case Detection, Baseline Investigation and Linkage to Treatment, Adherence to Treatment, etc.) (ii) Basic Understanding on Harm Reduction (covering Benefits of Needles Syringes Exchange Programme (NSEP), OST Programme, Condom Use, etc.), (ii) Bio-Medical Waste Disposal Management, (iv) Basic Concepts/ Steps of Index Case Testing, (v) Use of Field Intelligence, (vi) Cultural and Social Sensitivity. The sessions may be modified and customised according to the local requirements and local dynamics. The training will be provided as per the available standard resources under the national programme.

07: Kits and Consumables

The supply of Kits, Consumables and related Medicines will be taken care by the respective district nodal officers. The Team Coordinators will be responsible for the necessary coordination with the respective departments and ensure that sufficient stocks of kits and consumables are available for the various activities under Extended Outreach.

08: Logistic Support

The Logistic Support of the assigned team for carrying forward the mentioned activities will be provided by SACS through assigned officials at district level (like DMO/H or CMO/H or JD-DHS/ DMO, DACO cum DTO, etc.). Minimum three (03) vehicles will be required to accomplish the assigned activities according to the number of teams formed. First (1st) vehicle (01) will support Team 01 (for Outreach Work) and will be extensively used for Extended Outreach activities and will reach out and screen the Target Population or Key Population or At-Risk Population. Second (2nd) vehicle (01) will support Team 02 (for Index Case Testing) and will be extensively used for Index Case Testing activities and will reach and screen the Target Population or Key Population or At-Risk Population. M-ICTC or Mobile Van will be extensively used for Confirmatory Testing activities and will reach out to the Reactive Persons for necessary confirmation (along with recording of all necessary information including their Risks and Vulnerabilities) for further referral and linkage. Third (3rd) vehicle (01) will be extensively used for Baseline Investigation of Confirmed Cases and referral and linkage to ART Services.

Refreshment and Working lunch will be provided to the members of the Extended Outreach Team as they will be travelling from early morning till late evening covering remote locations.

09: Reporting Protocol

Data (on daily basis) at the field or camp sites would be compiled with complete information from register/ format (hard copy) by the Counsellor of the respective team. The M&EO of the respective team will record all the data (on daily basis) in soft copy, enter the data in ODK (Open Data Kit) and/or submit the data (soft copy) as instructed, by strictly maintaining "data confidentiality" clause, to the district nodal officer of SETU for further processing maintaining

10: Mandatory Checklist for Extended Outreach Team

Target Group: All High-Risk Groups/ Key Population / At-Risk Population

Goal: "1. Know Your status", "2. Remain Negative if You Are Negative", "3. Take ART if You Are Positive"

Key Messages: 1. Know your HIV/HBV/HCV status; 2. Routes of HIV/HBV/HCV transmission, 3. Never share injecting equipment and paraphernalia 4. Use condoms

SL	Services to be conducted on the field	Tick if YES	Remarks
1	Verbal consent taken for participation in the health screening activity (basic purpose and activity to be explained)		
2	Basic Profile, Name, Age, Gender, Phone number taken		
3	Quick Risk Assessment conducted - Injecting and Sexual Behaviour, number of injecting partners, Quick assessment of awareness of risks of sharing N/S and Paraphernalia		
4	Quick Group Assessment of Knowledge of HIV (Basic routes of transmission of HIV, HBV, HCV, TB, STIs etc.		

5	Conduct a group session on the basics of HIV, HCV, HIV testing and need for knowing one's own status, importance of not sharing needle syringes and paraphernalia, risk reduction, basics of ART etc.		
6	Quick pre-test counselling, consent and sample collection		
7	Inform about TI and register the patient for prevention services and provide phone number of the TI staffs		
8	Inform about OST and motivate to come for treatment, provide phone number of OST staff		
9	If need for N/S indicated, provide N/S on the spot and explain the reason for providing N/S i.e. we don't want sharing and transmission of HIV/HCV etc.		
10	If need for assistance to stop injecting give options of OST , de-addiction, rehabilitation		
11	Distribute IEC materials and list of NACP facilities in the district		
12	If any barriers to accessing prevention services mentioned by HRG at the site, team to make note and write in remarks for future follow up		
13	If any volunteers from HRG willing to help prevention among their peers, team to take their names and phone numbers (Volunteers will be given training to spread prevention messages among their peers, best ones will be noted for future PEs and can be recommended for community champions)		
14	Team to enquire and make note of how many HRGs in the area who did not turn up for the outreach camp and note if the site requires follow up in remarks column		
15	Team to make note of nearest Health service delivery points eg. Health and Wellness Centres, potential Satellite OST sites, SDNS points etc. in discussion with HRGs in remarks column		
16	For positive HRGs, Team to provide counselling on treatment preparedness, positive prevention, motivate the individual for index testing of spouses, injecting partners, sexual partners		
17	Team to note if higher number of PLHIV, then they should be encouraged to form a support group for treatment literacy, adherence, Community ART Refill Group CARG can be an option for such groups		
18	Team to ask if participants have any further questions		
19	Team to say thank you to all the HRGs who agreed to participate at end of activity reminding them to stay safe till the next meeting		

XVI. Annexure II: Micro Planning Tools and Formats

ANNEXURE IIA: Identification of district/s for IHC

TABLE 1

State:	Cumulative TI/OST/LWS etc HIV Positive detection as per TI Reporting of the State (like MITR, etc.)													
Districts*	Cumulative HIV+ detection (General Clients)	Cumulative HIV+ detection (Pregnant Women)	Cumulative Syphilis detection (as per titration)	Cumulative FSW+ detection	Cumulative MSM+ detection	Cumulative TG+ detection	Cumulative IDU+ detection	Cumulative FIDU+ detection	Cumulative Truckers+ detection	Cumulative Migrants+ detection	Cumulative Spouses+/ Partners+/ etc. detection (Excluding Target Typology data)	Cumulative OST Positive (Overall)	Cumulative LWS Positive (Overall)	1st Remarks/ Comments # (Districts with Critical Concerns)
	ICTC data	ICTC data	DSRC data	TI data	TI data	TI data	TI data	TI data	TI data	TI data	TI data	OST data	LWS data	

*Districts in Descending Order of Cumulative HIV Detection (that is from Highest to Lowest) as per ICTC data of the State

ANNEXURE IIA: Identification of district/s for IHC

TABLE 2

State:	TI/OST/LWS/etc HIV Positive detection as per TI Reporting of the State like MITR, etc. for last 1 Year or 2 Years or 3 Years or 4 Years or 5 Years (as decided by the Team)													
Districts*	HIV+ detection (General Clients) (1/2/3/4/5)	HIV+ detection (Pregnant Women) (1/2/3/4/5)	Syphilis+ detection (as per titration) (1/2/3/4/5)	FSW+ detection (1/2/3/4/5)	MSM+ detection (1/2/3/4/5)	TG+ detection (1/2/3/4/5)	IDU+ detection (1/2/3/4/5)	FIDU+ detection (1/2/3/4/5)	Truckers+ detection (1/2/3/4/5)	Migrants+ detection (1/2/3/4/5)	Spouses+/ Partners+/ etc. detection Excl. Target Typology data (1/2/3/4/5)	OST+ detected (1/2/3/4/5)	LWS+ detected (1/2/3/4/5)	2nd Remarks/ Comments # (Districts with Critical Concerns)
	ICTC data	ICTC data	DSRC data	TI data	TI data	TI data	TI data	TI data	TI data	TI data	TI data	OST data	LWS data	

*Districts in Descending Order of HIV+ Detection (that is from Highest to Lowest) as per ICTC data of the State for last 1 Year or 2 Years or 3 Years or 4 Years or 5 Years (as decided by the Team)

ANNEXURE IIA: Identification of district/s for IHC

TABLE 3

State:

TI/OST/LWS/etc HIV Positivity (%) as per TI Reporting of the State like MITR, etc. for last 1 Year or 2 Years or 3 Years or 4 Years or 5 Years (as decided by the Team)

Districts*	HIV+ (%) Positivity (General Clients) (1/2/3/4/5)	HIV+ (%) Positivity (Pregnant Women) (1/2/3/4/5)	Syphilis+ (%) Positivity (as per titration) (1/2/3/4/5)	FSW+ (%) Positivity (1/2/3/4/5)	MSM+ (%) Positivity (1/2/3/4/5)	TG+ (%) Positivity (1/2/3/4/5)	IDU+ (%) Positivity (1/2/3/4/5)	FIDU+ (%) Positivity (1/2/3/4/5)	Truckers+ (%) Positivity (1/2/3/4/5)	Migrants+ (%) Positivity (1/2/3/4/5)	Spouses+/ Partners+/ etc. (%) Positivity Excl. Target Typology data (1/2/3/4/5)	OST+ (%) Positivity (1/2/3/4/5)	LWS (%) Positivity (1/2/3/4/5)	3rd Remarks/ Comments # (Districts with Critical Concerns)
	ICTC data	ICTC data	DSRC data	TI data	TI data	TI data	TI data	TI data	TI data	TI data	TI data	OST data	LWS data	

*Districts in Descending Order of HIV+ (%) Positivity (that is from Highest to Lowest) as per ICTC data of the State for last 1 Year or 2 Years or 3 Years or 4 Years or 5 Years (as decided by the Team)

ANNEXURE IIA: Identification of district/s for IHC

TABLE 4

State:

Districts*	Male (M)	Female (F)	Transgender (TG)	Estimated data for FSW	Estimated data for MSM	Estimated data for TG	Estimated data for IDU (incl. FIDU)	Programme data for FIDU	Programme data for Truckers	Programme data for Migrants	Male (15-49 Y)	Female (15-49 Y)	Transgender (15-49 Y)	4th Remarks/ Comments # (Districts with Overall Concerns)
	Census data	Census data	Census data	p-MPSE data	p-MPSE data	p-MPSE data	p-MPSE data	TI & LWS data	TI & LWS data	TI & LWS data	Census data	Census data	Census data	

*Districts in Descending Order of Population (that is from Highest to Lowest) as per Census data of the State

#DECISION ON DISTRICT/S IDENTIFICATION IS TO BE FINALISED BASED ON THE ABOVE TABULAR DATA: [SPECIFY THE IDENTIFIED DISTRICT/S FOR IHC: 1st/2nd/3rd/4th/etc.

ANNEXURE IIB: Prioritisation of village/s for IHC

TABLE 5

State: District:

Village/ Location	Circle/ Ward	Block/ Town	Household #	Male (M)	Female (F)	Transgender (TG)	Male (15-49 Y)	Female (15-49 Y)	Transgender (15-49 Y)	Estimated data for FSW	Estimated data for MSM	Estimated data for TG	Estimated data for IDU (incl. FIDU)	Programme data for FIDU	Programme data for Truckers	Programme data for Migrants	Number of HIV Positives in Village/ Location	Remarks/ Comments # (Villages with Critical Concerns)
	Census data	Census data	Census data	Census data	Census data	Census data	Census data	Census data	Census data	p-MPSE data	p-MPSE data	p-MPSE data	p-MPSE data	TI & LWS data	TI & LWS data	TI & LWS data	TI/ OSTC/ LWS/ ICTC/ ARTC/ etc.	

ANNEXURE IIB: Prioritisation of village/s for IHC

TABLE 6

Village/ Location	Major Source of Income of Villages	Presence of any Factory/ Manufacturing Unit	Presence of National/ State Highway (YES/NO)	Tourism (YES/NO)	Name of the Major Festival (leading to gathering)	Festival (Calender Month: JAN to DEC)	Name and Contact details of SHGs	Area of SHGs Coverage	Name and Contact details of Local Influencers/ PRI Members	Details of Health Facilities in the Village/ Location	Distance of the Neasest HIV Screening/ Testing facilities	Name and Contact details of the Drug De-Addiction Centers (DDAC)	Client Load of the Drug De-Addiction Centers (DDAC)	ICDS Center in the Village: (YES/NO)	Number of Secondary/ Higher Secondary Schools	Number of Colleges	Other relevant inputs based on local intelligence	Remarks/ Comments # (Information for Micro-Planning)
	Economic Survey data	Industry Office	PWD Office	Tourism Office	Tourism Office data	Tourism Office	SRLM/ SULM	SRLM/ SULM	PR&RD	District Health /NHM Office	DACO-DTO Office	SJE/ SW Office	SJE/ SW Office	Women & ChildDev	Inspector of School (IS)	Higher Education (HS)	TI/ OSTC/ LWS/ ICTC/ ARTC/ etc.	

ANNEXURE IIC: Micro-Planning for IHC

TABLE 7

State: District:

Village/ Location	Major Source of Income of Villages	Presence of any Factory/ Manufacturing Unit	Presence of National/ State Highway (YES/NO)	Tourism (YES/NO)	Name of the Major Festival (leading to gathering)	Festival (Calender Month: JAN to DEC)	Name and Contact details of SHGs	Area of SHGs Coverage	Name and Contact details of Local Influencers/ PRI Members	Details of Health Facilities in the Village/ Location	Distance of the Neasest HIV Screening / Testing facilities	Name and Contact details of the TI	Client Load of the TI	Name and Contact details of the OST	Client Load of the OST	Name and Contact details of the Drug De-Addiction Centers (DDAC)	Client Load of the Drug De-Addiction Centers (DDAC)	ICDS Center in the Village: (YES/NO)	Number of Secondary/ Higher Secondary Schools	Number of Colleges	Other relavant inputs based on local intelligence	Remarks/ Comments # (Micro-Planning for IHC)
	Economic Survey data	Industry & Commerce Office	PWD Office	Tourism Office	Tourism Office data	Tourism Office	SRLM/ SULM	SRLM/ SULM	P&RD	District Heath /NHM Office	DACO-DTO Office	DACO-DTO Office	DACO-DTO Office	DACO-DTO Office	DACO-DTO Office	SJE/ SW Office	SJE/ SW Office	Women & ChildDev	Inspector of School (IS)	Higher Education (HS)	TI/ OSTC/ LWS/ ICTC/ ART/ etc.	

ANNEXURE IID: Micro-Planning for IHC

TABLE 8

State: District:

Village/ Location	Circle/ Ward	Block/ Town	Name of Villages	Date of Fixed/ Static Health Camp (F/S-HC) along with Extended Outreach Activities (EOA)	Responsibility of M-ICTC (SACS will issue and order /notfication for M-ICTC)	Responsibility of TI Team with F-ICTC (SACS will issue and order for conducting HIV screening in every Village/Location of as F-ICTC along with M-ICTC)	Responsibility Health &Wellness Center (SACS will issue notification for all Health Wellness Center to act as F-ICTC during M-ICTC special intervention)	Responsibility of National Viral Hepatitis Control Program screening TEAM (DC will issue an notifiction to District Nodal Officer NVHCP for HBV & HCV screening during M-ICTC Intervention)	NTEP TEAM for Clinical Screening of TB (DACO cum DTO will send a Team for Clinical TB screening)	Mobile Medical Unit (MMU) from District NHM (DC/DMO Namsai District will issue notification to District NHM for supporting MICTC)	Blood Sugar Test (DC/DMO Namsai District will issue notification to District NHM for supporting MICTC)