GUIDELINES FOR ORGANISING

INTEGRATED STI, HIV, TB AND HEPATITIS CAMPAIGN

IN

PRISONS & OTHER CLOSED SETTINGs, DRUG REHBILITATION CENTRES AND JUVENILE HOMES

National AIDS Control Organisation
Ministry of Health and Family Welfare
Government of India
6th& 9th Floor, Chandralok Building
36, Janpath, New Delhi - 110001

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Annexures

GUIDELINES FOR ORGANISING INTEGRATED WELLNESS CAMPS IN PRISONS & OTHER CLOSED SETTINGS

1. Background

Globally, HIV interventions at correctional institutions are strongly recommended with 'prisoners' being identified as one of the groups at higher risk of HIV infection. In India, HIV prevalence in prisons was higher (1.93) than that in the general community (0.22). Of the 62.9thousand estimated new infections in 2021, the prisons in Mizoram (26.0), Punjab (7.5), Nagaland (4.6), Chandigarh (3.5), Andhra Pradesh (3.3), Telangana (2.5), Delhi (2.4) Manipur (2.3) and Assam (2.0) has reported higher prevalence than national prevalence (1.93).

National Strategic Plan (NSP) of National AIDS Control Program (NACP) has highlighted responding to the HIV/ AIDS epidemic among 'at-risk' populations as a critical element to achieve 'End of AIDS' by 2030.

Overall, two third (66.8%) of inmates in HSS 2021, reported to be aware of HIV AIDS. Having one uninfected sexual partner and consistent condom use as mode of HIV prevention was identified by 55.4% and 63.5% of the respondents respectively. Overall, only around one-third (35.5%) had comprehensive and correct knowledge about HIV AIDS.

Prison & Other Closed Settings intervention implemented PAN India during 2021 – 22 shows, 85% of Indian prisons were covered under the program and only 31% of inmates were contacted with IPC, whereas only 29% availed the HIV screen/ test services. Similarly, during 2022 – 23 till November 2022, 78% of prisons are covered under the intervention. During the period, around 40% of inmates are reached through IPC and 33.5% of inmates were provided with HIV screen/ test services. ***This point towards the gaps in coverage and unmet need of the HIV services in the prison.***

2. Rationale

As per PSI – 2021, the total number of prisons at national level has increased from 1,306 in 2020 to 1,319 in 2021, having increased by 1.0%. The actual capacity of prisons has increased from 4,14,033 in 2020 to 4,25,609 in 2021 (as on 31st December of each year), having increased by 2.8%. Against the total capacity 4,25,609 in 1,319 prisons, 5,54,034 prisoners were lodged, with an occupancy rate of 130.2%.

The challenge of overcrowding in prison as a legitimate source of worry and measures to combat the same in order to curb TB & HIV is a challenge. In the backdrop of the ultimate goal of reducing the infection by 80%, the challenges of over-crowding leads to increase of HIV and TB incidences in prisons.

HIV Sentinel Survey among inmates, 2021 indicates following risk pattern among inmates:

- 6.8 percent of convicted inmates and 4.6 percent of under-trial inmates reported inmates in prison do have sexual intercourse with other prisoners.
- In West Bengal 22.6% of inmates reported such practice whereas 12.9% and 10.2% respondents reported having sexual intercourse in Uttar Pradesh and Jharkhand, respectively.
- 6% inmates have reported having sex with paid female partner, whereas 2.8% reported to have sex with casual female partner in past one year.
- In Karnataka, Delhi and Telangana 11 – 17% of the respondents reported that their last sexual intercourse was with a paid female partner.
- In Telangana, 22.3% inmates reported that their last sexual intercourse was with a casual female

partner.
- 42.8% of sexual acts with paid female partner and 57.3% with casual female partner were protected.
- 2.3% of the inmates (1.7% of convicts and 2.7% of under-trials) reported inject drugs for pleasure.
- In Punjab, 20.2% of inmates reported that inmates in their prisons were injecting drugs.

Thus, the evidence clearly indicates it is of utmost importance that these inmates are brought under HIV intervention and there is an urgent need to reach out to inmates with HIV related services tailored for the group apart from the activities proposed in the upcoming Strategy Document.

During 2021 – 22, Rajasthan state covered all prisons, on a campaign mode, and screened/ tested 20,357 incarcerated population with 1.15% positivity result. Similarly, during August 2022, Haryana state covered all prisons in the state and screened/ tested 10,666 inmates with 0.95% positivity. It is evident that the positivity found among incarcerated population during campaign is far more than the prevalence in ANC, Migrants and Truckers

This shows that campaign mode screen/ test of inmates will be an opportunity to increase the yield and will help NACP in achieving first 95. In this regard, rigorous campaign is proposed to cover all Prisons and Other Closed Settings including Drug Rehabilitation Centers and Juvenile Homes PAN India. This will be an opportunity to cater to approx. 0.5 million incarcerated population, both in prisons and other closed settings, at one go, within a month.

Hence, intensive package of health and communication activities timed accordingly would reach out to maximum number of inmates. Positive inmates may in turn pave the way for their family outside incarceration. Positioning health services at their doorstep i.e., the prison and other closed settings, would also address the limitations of access to services by inmates at prison.

Each health camp will essentially offer but not be limited to:
- ✓ General Health Checkup facilities and provision of medicines
- ✓ STI Counselling, diagnosis and treatment
- ✓ HIV Counselling, screen, referrals of reactive cases for confirmatory test and linkage to ART of positive cases ensuring viral load testing of PLHIV on ART as per the guidelines
- ✓ TB screen, sputum collection for test of suspected cases and linkage of positive cases to DOTS for treatment
- ✓ Screening for hepatitis B & C and linkage for further management of those screened positive.
- ✓ Trimester wise Antenatal checkups for eligible female inmates

These services are to be linked up with mobile health /medical units of NRHM, Mobile ICTCs wherever available to ensure that the services are provided at a larger scale. While staffs of GFATM partners and TIs are involved for the prevention related services, Doctors, Nurses, ANMs, Lab Technicians and Counselors to be involved in delivery of services.

Strategies need to be developed at the district level for confirmatory test of all reactive inmates within seven days of the camp, and linkages to treatment facilities of positive inmates immediately, irrespective of basic tests results subject to absence of Opportunistic Infections. However, in case of hepatitis B and C screened positive inmates the basic tests (CBC including platelets, liver function tests) are a must for categorizing patients into complicated and uncomplicated case. The complicated cases should be linked to Model Treatment Centre (MTC –

referral treatment center) and uncomplicated cases to Treatment center.

The Guidelines given below give broad methodology of reaching out to incarcerated population. Project Director of SACS being the chairperson of SOC in consultation with other committee members, may modify these as per the need of the State.

3. Target Groups and sites for campaign

The Intensive Health and Communication Activities will reach **out to the incarcerated population**. The line listing of the inmates will be done by GFATM partners, TIs and LWSs, with support of P&OCS staffs and SACS, fifteen days prior the camp, as preparatory activities. This will help in taking stock of commodities to be used during the camp at the prison/ other closed settings. The draft line-listing format is enclosed as **ANNEXURE 1**. Completed line list need to be validated by P&OCS authorities, prior submission at the district level, for ensuring commodities for the particular campaign site.

Line listed inmates need to be mobilized and followed up during the camp, with minimal change (**released inmates, inmates appearing the court on the day of camp may be excluded, but new inmates to be included. Inmates availed HIV test service in last six month may be excluded for HIV service, but should be included for other tests as well except viral hepatitis. Testing should be offered to all inmates for hepatitis B and C except those who have been tested within last 12 months**).

Existing and functional prisons and other closed settings will be covered during the campaign and an expected of 5.5 lac inmates (**inmates availed HIV service in last six months are excluded and inmates tested for hepatitis B and C within last 12 months should be excluded**) will be benefitted from the ISHTH Campaign, from prisons and other closed settings including drug rehabilitation centers and juvenile homes PAN India. The details of prisons & other closed settings to be covered during the camp is placed at **ANNEXURE 2. In absence of Prison Statistics 2022, the number of prisons and inmates may vary.**

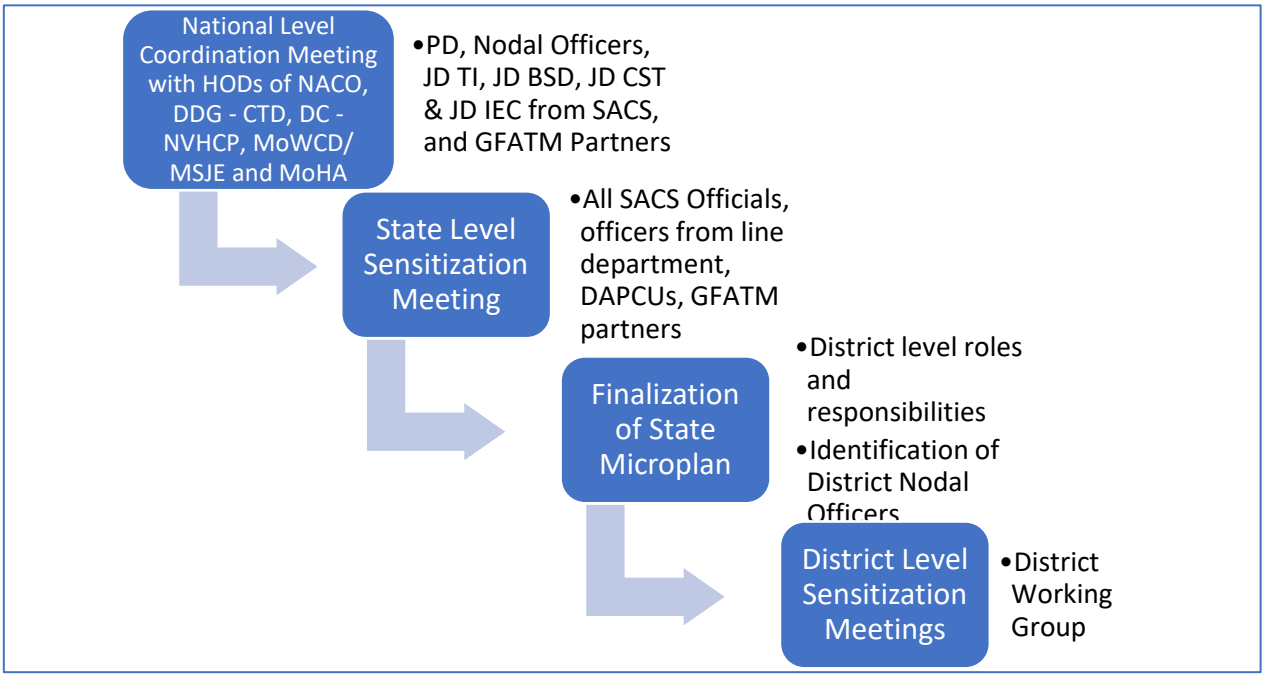
4. Implementation Strategy

4.1 National Level:

An implementation strategies plan with details on facilitators, beneficiaries, batches, preferable venue and material developed will be as:

The campaign will be led by NACO and all line ministries/ departments will comply their roles and responsibilities with regards to preparatory, during and after the camp. National Coordination Meeting with CTD & NVHCP under the aegis of NHM, WCD, MSJE, MoHA and GFATM partner agencies will be held for sharing the concept and developing strategies for implementation of the plan developed at National level. Involvement of WCD, MSJE and MoHA will be ensured for execution of the campaign through CTD & NVHCP under the aegis of NHM and GFATM partners. The same partnership will replicate at the state and district level as well.

Communication to states will be sent from center and sensitization of state officials will be done, initially virtual followed by physical in a gap of 15 days. All DM/ DC/ Collectors will be sensitized by state, and nomination of District Nodal Officers will be finalized after the first round of national sensitization. DNOs will develop the micro plans and share the same to DM/ DC/ Collector, who in turn will endorse to state for presentation at second level of national meeting.

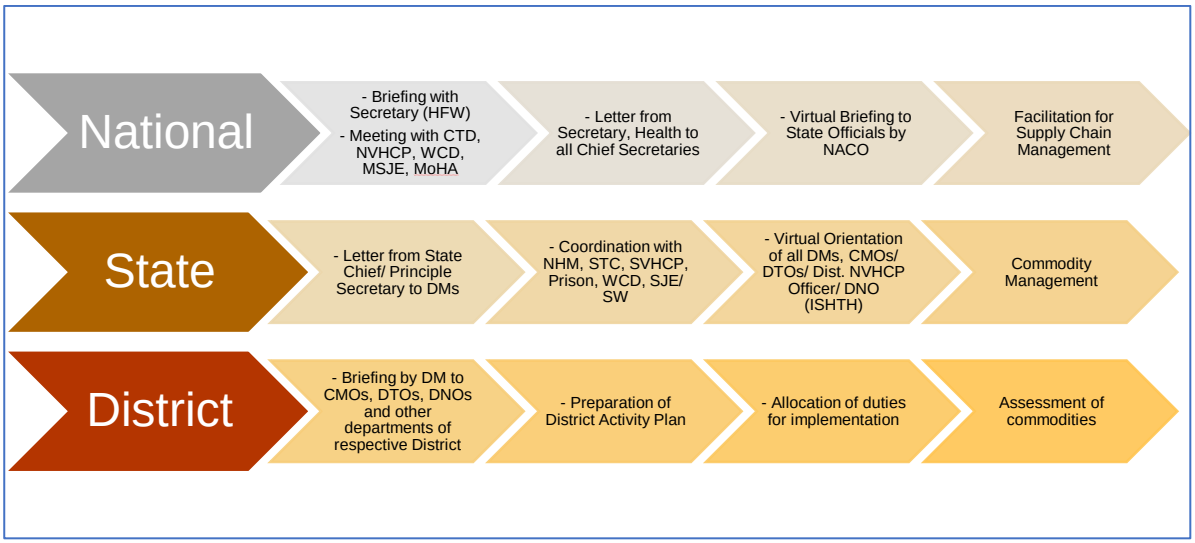


The major roles and responsibilities of each stakeholder at each level, with regards to preparatory, during and after the camp are as below:

NACO

Preparatory

- To convene first coordination and planning meeting with NHM including CTD & NVHCP, GFATM Partners, few State AIDS Control Society representatives, Ministry of Social Justice & Empowerment/ Ministry of Women & Child Development and Ministry of Home Affairs. The meeting will deliberate on the campaign and share overall campaign plan (draft guidelines, draft formats of line-list/ micro-plan/ reporting/ check-lists for national and state team members, protype messages, capacity building plan of Medical Officers on Syndromic Case Management) and seek respective departments to issue written communication to their state teams for coordination with SACS in development of micro-plan and deputation of trained manpower (Counsellors and ANMs/ Nursing staff/ LTs) and to ensure commodity arrangement. Prison department and WCD/ MoSJE to share the necessary formalities/ mechanism for the teams to get into the institutions during the campaign. [2 month prior to the onset of the campaign]



- NACO to facilitate a communication from Secretary, MoHFW to issue a letter to all Principal/

Chief Secretaries, State requesting to facilitate and issue necessary instructions to all related line departments at state level to coordinate and develop a micro plan under the guidance of SACS.

- NACO to ensure and follow up with SACS to check if State Oversight Committee meeting with all related departments is convened. [Within seven days post the national coordination meeting].
- Ensure that before the SOC meeting, SACS is ready with microplanning template and commodity calculation sheet including the test/ screen kits, medicines for treatment etc., in consultation with TB and NVHCP under NHM & share the same during the meeting (SOC).
- Ensure that at least 15 days in advance before the campaign date state wise micro plan is ready, reviewed by SACS and shared with NACO. This will mainly capture prisons and other closed setting wise camps to be organized, no. of teams (Medical Officer, Pharmacist, Counsellor, Lab Technician and supporting staffs from TIs/ LWSs/ GFATM) required, HR to be deployed, required consumables and estimated kits, mobile vans to ensure availability of confirmatory tests and treatment provision under the guidance of medical officer at prison site.
- If there are issues with commodity availability, get it resolved within 2-3 days to ensure smooth campaign rollout.
- To constitute teams of NACO, NHM officials & officials of other concerned ministries to participate in the State Oversight Committee meetings (SOC meeting).
- Prototypes of messages for pre publicity would be shared by IEC division.

During Camp

- Team from NACO to randomly visit the states to review 20% of the camps to review quality of camps (service provision) and post camp treatment linkages.
- Monitor review and analysis campaign data from all states on daily basis and if required share critical observations with SACS and other line departments.
- Share a weekly progress update against the micro plan with SACS and other line departments to further design/strengthen the remaining campaign duration.

After Campaign

- Prepare a state and district wise detail analysis report of key findings and coverage during the campaign.
- Share the findings with SACS for future program implementation in Prisons and OCSs.
- If required incorporate necessary amendments in National Prison Implementation Plan (Strategy Document) and share the revised document with SACS and Prison Officials after vetting it from National Working Group Meeting.

Central TB Department

Preparatory

- National representative from Central TB department to attend the coordination and planning meeting being organized by NACO for the upcoming campaign. Share TBs perspective, state & district level structures to support the campaign.
- Issue written directives to States and districts teams to coordinate with SACS to attend SOC meeting. Support in microplanning for the campaign to ensure that all camps in the prisons and other closed settings during the campaign have TB screening and confirmatory testing and treatment mechanism in place.
- Ensure sufficient quantity of testing facilities district wise and their linkages with prisons and other closed settings for confirmatory testing and initiation of treatment if required.
- Ensure calculations to derive upon estimated medicines required district wise and their timely delivery to TB positive inmates.

- Prepare a list of manpower district wise who could support in carrying out counselling and screening during the campaign.
- Ensure and follow up with state teams to check if they have micro plan and necessary HR and Commodity resources to support in the campaign. [Within 15 days post the national coordination meeting].
- To share the HR available to monitor the campaign with SACS so that comprehensive monitoring plan could be developed. This is also required for necessary permissions at P&OCS level.

During Camp

- Team from TB to randomly visit the states to review 20% of the camps to review quality of camps (service provision) and post camp treatment linkages.
- Monitor review and analysis campaign data from all states on daily basis and if required share critical observations with SoC including SACS, NACO and other line departments.
- Share a weekly progress update against the micro plan with SoC including SACS, NACO and other line departments to further design/strengthen the remaining campaign duration.
- If there are issues with commodity availability, get it resolved within 2-3 days to ensure smooth campaign rollout.

After Campaign

- Prepare a detail analysis report of key findings and coverage during the campaign state and district wise.
- Share the findings with SoC including SACS, NACO and other line departments for future program implementation in Prisons and OCSs.

NVHCP

Preparatory

- National representative from NVHCP to attend the coordination and planning meeting being organized by NACO for the upcoming campaign. Share NVHCP perspective, state & district level structures to support the campaign.
- Issue written directives to States and districts teams to coordinate with SACS to attend SoC meeting. Support in microplanning for the campaign to ensure that all camps in the P&OCS during the campaign have HCV and HBV screening kits and linkage mechanism of those screened positive is in place.
- Ensure calculations to derive upon estimated kits and medicines required district wise and their timely delivery to P&OCS.
- Prepare a list of manpower district wise who could support in carrying out counselling and screening during the campaign.
- Ensure and follow up with state teams to check if they have micro plan and necessary HR and Commodity resources to support in the campaign. [Within 15 days post national coordination meeting].
- To share the HR available to monitor the campaign with SACS so that comprehensive monitoring plan could be developed. This is also required for necessary permissions at P&OCS level.

Attached NVHCP Guidance Note at Annexure -11 may be referred for detailed activities

During Camp

- Team from NVHCP to randomly visit the states to review 20% of the camps to review quality of camps (service provision) and post camp treatment linkages.
- Monitor review and analysis campaign data from all states on daily basis and if required share critical observations with SoC including SACS, NACO and other line departments.
- Share a weekly progress update against the micro plan with SoC including SACS, NACO and other line departments to further design/strengthen the remaining campaign duration.

- If there are issues with commodity availability, get it resolved within 2-3 days to ensure smooth campaign rollout.

After Campaign

- Prepare a detail analysis report of key findings and coverage during the campaign state and district wise.
- Share the findings with SoC including SACS, NACO and other line departments for future program implementation in Prisons and OCSs.

NHM

Preparatory

- National representative from NHM to attend the coordination and planning meeting being organized by NACO for the upcoming campaign. Share NHM perspective, state & district level structures to support the campaign.
- Issue written directives to States (MD NHM) to coordinate with SACS to attend SoC meeting. Support in microplanning for the campaign to ensure that all camps in the P&OCS during the campaign have required travel arrangements (Mobile Medical Units/ Ambulance), manpower, especially Medical Officers and LTs, and commodities (medicines, kits and consumables).
- NHM to ensure smooth counselling and screening services are carried out without any interruption.
- Ensure calculations to derive upon estimated dual kits and medicines required district wise and their timely delivery to P&OCS.
- Develop a list of mobile vans district wise which could be available to support the campaign mainly to ensure confirmatory testing and treatment linkages post camp.
- Ensure and follow up with state teams to check if they have micro plan and necessary HR and Commodity resources to support in the campaign. [Within 15 days post national coordination meeting].
- To share the HR available to monitor the campaign with SACS so that comprehensive monitoring plan could be developed. This is also required for necessary permissions at prison and other closed settings level.

During Camp

- Team from NHM (CMO/MOs) to randomly visit in their respective districts to review 40% of the camps to review quality of camps (service provision).
- Mobility support (mobile vans) to ensure confirmatory test and treatment initiation.
- Support in treatment of OIs and ensure necessary medicines.

WCD

Preparatory

- National representative from WCD department to attend the coordination and planning meeting being organized by NACO for the upcoming campaign. Share WCDs perspective, state & district level structures to support the campaign.
- Issue written directives to States WCD teams to coordinate with SACS to attend SOC meeting. Support in microplanning for the campaign to ensure that all camps the closed settings during the campaign have screening and confirmatory testing and treatment mechanism in place.
- Prepare a list of manpower State/district wise who could support in carrying out counselling and screening during the campaign.
- Ensure and follow up with state teams to check if they have micro plan and necessary HR and Commodity resources to support in the campaign. [Within 15 days post the national coordination meeting].

- To share the HR available to monitor the campaign with SACS so that comprehensive monitoring plan could be developed. This is also required for necessary permissions at P&OCS level.

During Camp

- Team from WCD to randomly visit the states to review 20% of the camps to review quality of camps (service provision) and post camp treatment linkages.
- Monitor review and analysis campaign data from all states on daily basis and if required share critical observations with SACS and other line departments including NACO.
- Share a weekly progress update against the micro plan with SACS including NACO and other line departments to further design/strengthen the remaining campaign duration.

After Campaign

- Prepare a detail analysis report of key findings and coverage during the campaign state and district wise.
- Share the findings with SACS including NACO for future program implementation in OCSs.

MSJE

Preparatory

- National representative from MSJE department to attend the coordination and planning meeting being organized by NACO for the upcoming campaign. Share MSJE perspective, state & district level structures to support the campaign.
- Issue written directives to States MSJE teams to coordinate with SACS to attend SOC meeting. Support in microplanning for the campaign to ensure that all camps the closed settings during the campaign have screening and confirmatory testing and treatment mechanism in place.
- Prepare a list of manpower State/district wise who could support in carrying out counselling and screening during the campaign.
- Ensure and follow up with state teams to check if they have micro plan and necessary HR and Commodity resources to support in the campaign. [Within 15 days post the national coordination meeting].
- To share the HR available to monitor the campaign with SACS so that comprehensive monitoring plan could be developed. This is also required for necessary permissions at P&OCS level.

During Camp

- Team from MSJE to randomly visit the 60% states to review 20% of the camps to review quality of camps (service provision) and post camp treatment linkages.
- Monitor review and analysis campaign data from all states on daily basis and if required share critical observations with SACS and other line departments including NACO.
- Share a weekly progress update against the micro plan with SACS including NACO and other line departments to further design/strengthen the remaining campaign duration.

After Campaign

- Prepare a detail analysis report of key findings and coverage during the campaign state and district wise.
- Share the findings with SACS including NACO for future program implementation in OCSs.

MHA - Prison Department

Preparatory

- National representative of MHA to attend to attend the coordination and planning meeting being organized by NACO for the upcoming campaign. Share MHA perspective and instruct state & district level structures to support the campaign.

- Also share the security formalities for the teams to get into prisons during the one-month campaign period.
- Issue written directives to all IG/DG prisons of states to coordinate with SACS to support in microplanning for the campaign depending on the number of inmates and existing health infrastructure in respective prison or other closed settings.
- Prepare a list of para medical staff and medical staff prison wise who could support in carrying out services during the campaign.
- Ensure that medicines are available in stock during the campaign in sufficient quantities.
- Depending on the micro-plan clearly instruct SACS and Prison Nodal Person to ensure necessary documents of the teams entering the P&OCS during the campaign is submitted to IG/DG office or Respective Jail Superintendent for formal approval.
- Communication to prison and other closed settings for pre-publicity of messages

During Camp

- Team from MHA to randomly visit the 60% states to review 20% of the camps to review quality of camps (service provision) and post camp treatment linkages.
- Monitor review and analysis campaign data from all states on daily basis and if required share critical observations with SACS and other line departments including NACO.
- Share a weekly progress update against the micro plan with SACS including NACO and other line departments to further design/strengthen the remaining campaign duration.

After Campaign

- Coordinate with SACS to get the key findings and coverage analysis of the campaign to further strengthen the health component in the prison setup.

4.2 State Level:

SACS

Preparatory

- To convene SoC meeting with TB and NVHCP under NHM, GFATM Partners, Correctional Services, WCD/ SW/ SJE representatives and SETU. To deliberate on the campaign and share overall campaign plan and seek respective departments to issue written communication to their district teams for coordination with SACS in microplanning and deputation of trained manpower (counsellors and ANMs/ Nursing staff/LTs) and ensure commodity arrangement. [within seven days of National Coordination meeting]
- Identification and selection of District Nodal Officers in consultation with SOC members.
- SACS to also issue a letter to all DTOs, DISHA/ DAPCU, District NVHCP officer and District Nodal Officer to convene district level meeting with all departments to develop micro plan.
- Ensure and follow up with DISHA/ DAPCU/ District NVHCP officer and District Nodal Officer to check if district level micro-plan is finalized in consultation with all departments and every department has the copy of the plan along with specific support (HR and Commodity) required. [15 days prior the actual campaign]
- Compilation of all district level micro-plans and prepare state level plan for the campaign along with HR and Commodity plan. (All HR should have contact details, address and AADHAR)
- Develop a monitoring plan comprising of all human resource (all departments) available during the campaign and share it with Prison Nodal Officer at SACS to be further shared with DG/ IG Prisons
- The SACS Nodal Officer for Prison and OCS coordinates with district Nodal Officer to get in touch with respective DG/ IG – Prisons or WCD/SJE Officer to ensure necessary approvals to enter the

prisons and other closed settings for the teams conducting the camps and monitoring teams to review the activity.
- Prison Nodal Officer at SACS to ensure necessary reporting compliance on core indicators with support from district nodal officer who intern will ensure reporting through counsellors and PPMs (GFATM project).
- To constitute district wise teams of SACS officials to monitor the activities /camps during the campaigns.

During Camp
- Prison Nodal Officer at SACS in consultation with district nodal officer will ensure the designated camp teams arrived in the prison and other closed settings on day-to-day basis.
- Officers from TI, STI, BSD, CST, IEC divisions of NACO would be visiting for handholding and support during the camp.
- Team from SACS to randomly visit 20% of the camps to review quality of camps (service provision) and post camp treatment linkages.
- Monitor review and analysis campaign data from all states on daily basis and if required share critical observations with NACO and other line departments.
- Share a weekly progress update against the micro plan with NACO and other line departments to further design/strengthen the remaining campaign.
- If there are issues with commodity availability, get it resolved with support from NACO or other line department within 2-3 days to ensure smooth campaign rollout.

After Campaign
- Ensure treatment compliance for all positive cases which are not linked to treatment during the campaign period.
- Prepare a detail analysis report of key findings and coverage during the campaign district and P&OCS wise.
- Share the findings with Prison authorities for future program implementation in Prisons and OCSs.

State NHM

Preparatory
- State representative from NHM including STC and SVHMU to attend the SOC meeting being organized by SACS for the upcoming campaign. Share NHM perspective, & district level structures to support the campaign.
- Issue written directives to Director Health Services and districts (CDMO/ CMHO/Civil Surgeons) to coordinate with DTOs/ District NVHCP officer to attend DoC meeting.
- Support in microplanning for the campaign to ensure that all camps in the P&OCS during the campaign have required travel arrangements (Mobile Medical Units/ Ambulance), manpower, especially Medical Officers and LTs, and commodities (medicines, kits and consumables).
- NHM to ensure smooth counselling and screening services are carried out without any interruption.
- Ensure calculations to derive upon estimated screening kits and medicines required district wise and their timely delivery to P&OCS.
- Develop a list of mobile vans district wise which could be available to support the campaign mainly to ensure confirmatory testing and treatment linkages post camp.
- Ensure and follow up with state teams to check if they have micro plan and necessary HR and Commodity resources to support in the campaign. [Within 15 days post national coordination meeting].

- To share the HR available to monitor the campaign with SACS so that comprehensive monitoring plan could be developed. This is also required for necessary permissions at Prison and Other Closed Settings level.

During Camp

- Team from NHM (CMO/DTO/ District NVHCP Officer/MOs) to randomly visit in their respective districts to review 20% of the camps to review quality of camps (service provision).
- Mobility support (mobile vans) to ensure confirmatory test and treatment initiation.
- Support in treatment of OIs and ensure necessary medicines.

TB department

Preparatory

- State representative from NHM to attend the SOC meeting being organized by SACS for the upcoming campaign. Share NHM perspective, & district level structures to support the campaign.
- Issue written directives to Director Health Services and districts (CDMO/ CMHO/Civil Surgeons) to coordinate with DTOs/ DVHO to attend DoC meeting.
- Support in microplanning for the campaign to ensure that all camps in the P&OCS during the campaign have required travel arrangements (Mobile Medical Units/ Ambulance), manpower, especially Medical Officers and LTs, and commodities (medicines, kits and consumables).
- NHM to ensure smooth counselling and screening services are carried out without any interruption.
- Ensure calculations to derive upon estimated dual kits and medicines required district wise and their timely delivery to P&OCS.
- Develop a list of mobile vans district wise which could be available to support the campaign mainly to ensure confirmatory testing and treatment linkages post camp.
- Ensure and follow up with state teams to check if they have micro plan and necessary HR and Commodity resources to support in the campaign. [Within 15 days post national coordination meeting].
- To share the HR available to monitor the campaign with SACS so that comprehensive monitoring plan could be developed. This is also required for necessary permissions at Prison and Other Closed Settings level.

During Camp

- Team from NHM (CMO/MOs) to randomly visit in their respective districts to review 20% of the camps to review quality of camps (service provision).
- Mobility support (mobile vans) to ensure confirmatory test and treatment initiation.
- Support in treatment of OIs and ensure necessary medicines.

State Prison Department (IG/DG Prison) AND Jail Superintendent

Preparatory

- IG /DG prison to attend the SoC meeting being organized by SACS for planning and coordinating this campaign. Also share the security formalities for the teams to get into prisons during the one-month campaign period.
- Issue written directives to all jail superintendents to coordinate with SACS team (DISHA/ DAPCU or District Nodal Officers) to support in microplanning for the campaign depending on the number of inmates and existing health infrastructure in respective jail.
- Prepare a list of para medical staff and medical staff jail wise who could support in carrying out services during the campaign.
- Ensure that medicines are available in stock during the campaign in sufficient quantities.

- Depending on the micro-plan clearly instruct SACS and Prison Nodal Person to ensure necessary documents of the teams entering the jail during the campaign is submitted to IG/DG office or Respective Jail Superintendent for formal approval.
- Communication to jails for pre-publicity of messages

During Camp

- Jail Superintendent to instruct warden to mobilize the inmates for the camp as per the micro-plan schedule.
- Ensure timely entry of the camp team in the jail to start the health camp on predefined time.
- Instruct internal medical and paramedical teams to support the campaigns as per the micro-plan.
- Coordinate with the line departments in confirmatory testing and treatment initiation as per agreed plan of action.

After Campaign

- Coordinate with SACS to get the key findings and coverage analysis of the campaign to further strengthen the health component in the prison setup.

WCD/ SJE/ SW State Level

Preparatory

- WCD/ SJE/ SW representative to attend the SoC meeting being organized by SACS for planning and coordinating this campaign. Also share the list of active homes with inmate population district wise along with the list of NGOs managing these homes.
- Issue written directives to all district teams and NGOs partners who are managing these homes to corporate with SACS and DISHA/ DAPCU or District Nodal Officers for this campaign to support in microplanning for the campaign depending on the number of inmates.

During Camp

- Superintendent/Counsellor at these homes to support in documentation and counselling of inmates during the campaigns.
- Reporting daily coverage to SACS as per agreed formats.
- Coordinate with SACS and other line departments in confirmatory testing and treatment initiation as per agreed plan of action.

After Campaign

- Coordinate with SACS to get the key findings and coverage analysis of the campaign to further strengthen the health component in the OCS setup.

4.3 District Level:

District Magistrate/ Deputy Commissioner/ District Collector

Preparatory

- Meeting with DNO, CDMO/ CHMO, DTO, DVHO, Prison Officials, DWCD/ DSWO, GFATM partners, DISHA/ DAPCU, SETU PFO, TIs and LWSs
- Facilitation for detailed camp micro planning and the plan to be submitted to the SACS
- Assessment of HR, commodities and travel arrangements for the camps, and ensure the required HR, commodities and travel arrangements are in place prior 2 – 3 days of camp.
- Issue written directives to all Superintendents/ Jailors/ Wardens of Prisons and Other Closed Settings to coordinate with SACS team (DISHA/ DAPCU or District Nodal Officers) to support in

microplanning for the campaign depending on the number of inmates and existing health infrastructure in respective institutions.
- Suitable communication to prisons and other closed settings for pre-publicity of activities are carried out for the campaign

During Campaign
- Monitor review and analysis campaign data from the district on daily basis and if required share critical observations with SACS and other line departments.

After Campaign
- Ensure treatment compliance for all positive cases for treatment during the campaign period.
- Share the findings with prison and homes authorities for future program implementation in Prisons and OCSs.

District Nodal Officer

Preparatory
- Planning of coordination meetings with all the concerned departments under the chairpersonship of DM/ DC/ Collector
- Facilitation and development of detailed camp micro planning and the plan to be submitted to the SACS duly endorsed by DM/ DC/ Collector
- Ensure all the necessary communication from IG/DG Prison and DM/DC/ Collector should reach to the district level prison and home authority.
- Assessment and finalization of the location in consultation with the Superintendent/Jailor and Homes for the health camp
- As per the plan ensure the necessary required HR (Medical Officer, Paramedical staff, ICTC counsellor, Lab Technicians, and TI staff, etc.) and necessary infrastructure like chair, bed, wash station, BMWM, consumables, cold chain, centrifuge in mobile van and rotor to the campsite.
- Arrangement of entry of the team into the prison based on the circular issued by IG/DG prison.
- Assimilation of resources in terms of medical equipment and non-medical equipment including consumables and other staff
- Ensure the availability of an NHM mobile van during the camp or after the camp for blood sample transportation.
- Ensure the pre-publicity activities for campaign are carried out in prisons and other closed settings.

During Campaign
- Ensure the COVID appropriate behavior and standard precautions are followed at camp site
- Ensure that the planned activities are smoothly conducted.
- Coordinate with Superintendent/ Jailor/ Warden to mobilize each and every inmate to avail the benefits of camp
- Daily monitoring of the camp activity if the camp is planned for more than one day by visiting the sites on a regular basis.
- Perform all other duties as assigned by the Project Director of SACS.

After Campaign
- Ensure the screened-positive inmates are confirmed for HIV and RPR after dual test being reactive and linked to the treatment services.
- Daily reporting to the SACS and to the NACO in the prescribed format.
- Briefing to DM/ DC/ Collector

DHO/CMHO/CMO/DTO/District NVHCP officer/DPO

Preparatory

- Participation in the coordination meetings with all the concerned departments under the chairpersonship of DM/ DC/ Collector
- Agreeing on and coordination for a detailed camp micro planning and the plan to be submitted to the DM/ DC/ Collector
- As per the micro plan ensure the necessary required HR of respective department to the campsite.

During Campaign

- Ensure that the planned activities are smoothly conducted.
- Daily monitoring of the camp activity
- Perform all other duties as assigned by the DM/DC/Collector or the SACS Nodal Officer

After Campaign

- Ensure the screened-positive inmates are confirmed and linked to the treatment services.
- Daily reporting to the SACS and to the NACO in the prescribed format.
- Briefing to DM/ DC/ Collector

Superintendent/Jailor – Prisons and Superintendent/ Warden – Other Closed Settings

- Provide necessary support in arranging the Integrated health camp as per directives of the health secretary, IG/DG of prison, Secretary – WCD/ SJE/ SW or SACS
- Allocate a safe place for conducting health camp
- Support in providing the list of inmates to the district nodal officer or his/her representative
- Allow doing IEC campaign before the health camp (Permission to use the AV system for doing propaganda of health camp)
- Issue necessary instructions to the wardens, and Health Care Providers to assist during the camp
- Provide the necessary infrastructure for the health camp (tables, chairs, tablecloths, etc.)
- Arrangement of necessary resources in terms of escorts and transport for HIV confirmatory tests and linkages to the treatment of positive inmates.

Medical Officer (MBBS)

- Ensure all medicines (General & STI) are available at the prison campsite.
- Orientation/ capacity building of MO on Syndrome Case Management
- Ensure all incarcerated individuals should be screened for diseases like STI, HIV, TB, HBV, HCV etc.
- Ensure the medical equipment (Weighing scale, BP apparatus, stethoscope etc.) are in working condition and available during the camp
- History taking of the inmates
- Physical Examination of symptomatic inmates
- Guidance to be provided to the inmates based on their disease history
- Documentation of the symptomatic cases

Counsellor

- Carry all the necessary recording registers to the campsite.
- Pre-test counselling of the inmates
- Post-test counselling of inmates (Prevention messages can be given in group counselling)
- Ensure the syndromic case managements treatment kits are available during the camp
- All the diagnosed symptomatic inmates are counselled and treated during the camp
- Individual inmate data to be recorded in the register

Lab Technician

- Ensure sufficient number of screening kits are available for the camp along with other consumables (Lancet, gloves, alcohol swabs etc.)
- Transportation of screening kits to the campsites in cold chain boxes.
- HIV, Syphilis, HBV, HCV screening of inmates and documentation
- If required blood samples need to be collected for HBV, HCV testing and HIV confirmatory test
- Ensure Bio-Medical waste protocol is followed during the camp (Puncture proof containers, red, yellow and blue puncture proof container are to be taken to the campsite)
- Ensure spill kit and first aid kit, necessary vaccum evacuated tubes

5. Proposed Plan

5.1 Pre-Campaign IEC

Messages for pre-publicity of the campaign will be developed and finalized at national level, in consultation with NACO, CTD and NVHCP. Focussed messages for inmates, both convict and under-trial, prison authorities/ staffs and health service providers will be developed to sensitize them and to ensure their active participation in the campaign.

Finalized messages will be shared with states for further dissemination at the state level stakeholders and districts, who in turn will disseminate with district level stakeholders for further dissemination at the prison and closed settings.

Finalized messages should be vetted by NACO/ SACS/ CTD/ NVHCP and the following has to be ensured:

- Be simple and specific
- Be stigma free and interesting
- Have a significant recall value
- Couched in General Health Messaging
- Highlight counseling and testing as free and confidential
- Benefits of early diagnosis and treatment

District Nodal Officer will ensure that messages reach Prisons and Other Closed Settings well in advance for, pre-publicize the health camps. These campaigns will need to be planned

- At least five days before the scheduled health camps at the designated area.
- Monitoring of these activities to be done by the district nodal officer of the district or any other official designated by the district nodal officer.

5.2 Sensitization of the key stakeholders and implementers:

The sensitization of key stake holders and implementers are essential to bring in role clarity, coordination, monitoring and reporting of the activity. The sensitization plan will follow a cascade model with a capacity building workshop at NACO involving PD, APD, all divisional heads from SACS, GFATM partners, and officers from NACO.

These officers will undertake sensitization at SACS level involving other divisions of SACS, officers from State Government departments such as Health &FW, NRHM, WCD/ SJE/ SW, Prisons etc. The outcome of the State level meeting is to ensure that the micro-plan for the State is developed with clear cut understanding of the roles and responsibilities of different departments. As well as the nodal officers for different districts are well versed with the required coordination mechanisms for district level implementation.

Further the nodal officers will undertake sensitization at District level through a committee chaired by District Collector/ District Magistrate and involving representatives from different departments. The outcome of the meeting is expected to share the micro plan and dates for the health camps as well as assigning responsibilities for smooth implementation and coordination at prison level.

6. Standard Operating Procedures for camp activities:

The following activities to be worked out at camp site level:

- **At least 10 days before** the list of inmates would be kept ready and the inmates to be informed by the prison and other closed settings staffs.
- **At least 2 days before** the nodal officer of SACS would be stationed at the camp site or nearby area to ensure that a last-minute meeting and stock taking is done about the arrangements.
- **At least 2 days before** pre-publicity activities are carried out in the prison and other closed settings, and visit is done by the district nodal officer of SACS.
- **At least one day before** required IEC materials, medicines, kits, consumables, mobile unit reaches the campsite.
- **On the day of the camp,** the camp activities should start by 9 am till the last inmate is covered. The activities should include general health check-up, counseling and testing services, IPC sessions, announcement or poster at camp site and referral services

The nodal officer needs to take the stock whether the inmates are reaching the camps. A draft activity chart is enclosed at **ANNEX 3 - 5.**

7. Monitoring and Reporting

- NACO nodal officers would be visiting to States before and during the scheduled health camps.
- The nodal officers of districts would be visiting to the prisons well in advance and ensure coordination is done.
- The nodal officers at National/ State/ District level detailed above will be responsible for proper planning and monitoring of various activities planned as part of the intensive health and communication activities. **A set of draft checklists is attached at ANNEX 7.**
- SACS are required to ensure daily monitoring, reporting and state / district wise documentation of the entire project in the respective state. **The draft reporting format is given as ANNEX 9**.
- Besides the reporting format the existing formats of STI programme would be used. The above format would be a consolidation of the existing formats. The existing patient registers, ICTC registers, referral slips would be used.
- **The counselors are expected to record the complete address of the inmates attending the health camps.**
- **In addition, kindly refer to NVHCP guidance note at Annexure -11**

8 Budgeting of the activities

SACS will be required to plan & meet expenses on the above activities from various components and from the already available budget at SACS.

9 State level report documentation

Each SACS TI division officer would submit a detailed report with analysis of daily/ each camp report along with photographs, trend analysis graphs etc. The detailed format would be shared with SACS.

ANNEXURE 1 – Line-list

Sl. no	Name of the Inmate	Age	Sex	Marital Status	Is he/she is Convicted? Yes/No	Is he/ she tested before for HIV? If yes, date	Is he/ she tested before for Syphilis? If yes, date	Is he/ she tested before for TB? If yes, date	Is he/ she tested before for Hepatitis B ? If yes, date	Is he/ she tested before for Hepatitis C? If yes, date	Excluded for HIV/ Syphilis/ TB/ VH: B & C

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ANNEXURE 2 – State/ UT wise Prisons, OCS, Drug Rehabilitation Centers and Juvenile Homes

Sl.	State/UT	OCS	Prisons	Observation Homes	MSJE		Total
					IRCA	ATF	
1	ARUNACHAL PRADESH	3	2	1	0	0	**6**
2	ASSAM	47	31	5	18	0	**101**
3	BIHAR	19	59	14	7	1	**100**
4	CHHATTISGARH	3	33	12	2	0	**50**
5	DELHI	2	16	4	10	1	**33**
6	HIMACHAL PRADESH	2	16	2	3	1	**24**
7	JHARKHAND	2	32	11	1	1	**47**
8	MEGHALAYA	2	5	3	1	1	**12**
9	NAGALAND	2	11	11	7	0	**31**
10	ODISHA	90	92	4	37	0	**223**
11	RAJASTHAN	20	144	38	18	0	**220**
12	SIKKIM	1	2	1	2	1	**7**
13	TRIPURA	4	13	3	0	1	**21**
14	UTTAR PRADESH	80	75	26	19	6	**206**
15	WEST BENGAL	50	60	10	7	1	**128**
16	CHANDIGARH	4	1	2	0	0	**7**
17	DNH & DAMAN DIU	0	2	0	1	0	**3**
18	GOA	3	1	2	0	2	**8**
19	GUJARAT	11	32	4	7	3	**57**
20	JAMMU & KASHMIR	4	14	2	1	13	**34**
21	LADAKH	0	2	0	0	0	**2**
22	MADHYA PRADESH	66	131	18	11	1	**227**
23	MAHARASHTRA	93	64	35	39	1	**232**
24	MANIPUR	34	5	4	25	0	**68**
25	MIZORAM	3	10	7	11	1	**32**
26	UTTARAKHAND	13	11	10	4	1	**39**
27	A & N ISLANDS	0	4	1	0	0	**5**
28	ANDHRA PRADESH	35	106	10	10	1	**162**
29	HARYANA	2	19	4	9	0	**34**
30	KARNATAKA	81	57	17	32	0	**187**
31	KERALA	34	56	9	17	0	**116**
32	LAKSHADWEEP	0	4	0	0	0	**4**
33	PUDUCHERRY	1	4	2	1	0	**8**
34	PUNJAB	3	26	4	7	0	**40**
35	TAMIL NADU	44	142	7	24	0	**217**
36	TELANGANA	29	37	4	10	0	**80**
	TOTAL (ALL-INDIA)	**787**	**1319**	**287**	**341**	**37**	**2771**

ANNEXURE 3 – National level monitors/ activity chart

Follow up shall be undertaken by Nodal Officers at NACO assisted by JD TI at SACS

Implementation planning at the district level would include following:

Activities	Responsibility	How to do	Timeline
Identification of Prisons and OCS within the district	**District Nodal officer** in consultation with the district collector, CMO and other relevant sources	• Meeting and consultation • Data sources from Prison department to Health department	At least before **30 days of the proposed camps**
Finalization of health facilities which would be used for camps	**District Nodal officer** in consultation with District health officials	• Available ICTCs, Mobile ICTCs, Mobile Medical/Health Units, DSRCs need to be used for these camps. • The available staffs, medicines, consumables, kits, reporting registers and funds available under these facilities.	At least before **15 days**
Route plan for health staffs, Mobile ICTCs, Mobile health/medical units	**District Nodal officer** in consultation with District health officials	• Based on the dates and communication facilities – a detailed map can be prepared and route plan can be prepared	At least before **10 days**
Sharing of route plan with Prison and Other Closed Settings officials	**District Nodal officer**		At least before **10 days**
District Level coordination meeting conducted	**District Nodal officer**	• Stock taking meeting and orientation of key staffs on the camp activities	At least before **10 days**

ANNEXURE 4: State level monitors/ activity chart

The **District Nodal Officer** should be from SACS/NHM. Further the **DISHA/ DAPCU, PPMs, PM TI and LWS DRPs** can be engaged to finalize the district micro plan – however the District Nodal Officer would be responsible for finalizing the district micro plans, monitoring and reporting to SoC including SACS.

Activities before 1 month of the camp would include following:

Activities	Responsibility	How to do	Timeline
Assessment of stock position of condoms, IEC materials, kits, consumables and staff positions in the district and camp site level	**PD, SACS in coordination with MD, NHM**	Review of District Plans along with the District Nodal Officers	At least **20 days**
Plan for supply of condoms, IEC materials, kits, consumables finalized	**PD, SACS in coordination with MD, NHM**	• Supply schedule and responsibility is worked out • Follow up plan and responsibility worked out	
Deputation and roster plan for staffs from NRHM and SACS facilities worked out	**PD, SACS in coordination with MD, NHM**	• Roster plan is circulated by NHM and SACS • Acknowledgement of staffs followed up	
Supply status of IEC materials, condoms, kits, consumables reviewed	**PD, SACS in coordination with MD, NHM**	A detailed report is asked from the district nodal officers and a status report is sent to NACO	At least **10 days**

Activities before 2 days of the camp would include following:

Activities	Responsibility	How to do	Timeline
Pre-publicity activities on messages	**Prison Officials**	Messages should also include the venue of the camp, the services provided and why it is important get checked up (a specific message content is to be given to the prison officials).	**At least 2 days**
Review at district level about the availability of medicines, kits, consumables at the camp or adjacent health facility including the roster of staffs	**District Nodal Officer**		

Activities on day of the camp would include following:

Activities	Responsibility	How to do
Camp timings	District Nodal officer	Should preferably tuned with local requirements
Counseling and Testing facilities	Deputed Health Staffs (ICTC/ DMC/ District NVHCP officer)	HIV, Syphilis, TB, Hepatitis B and C screening for inmates and pregnant women in these closed settings. The facility for rapid test for HIV, Syphilis, HBV and HCV including counseling would be made available. There should be facility for counseling and check up at the camp site.
General health check-up and counseling services to be provided	Health Dept. staffs	

ANNEXURE 5: Overseeing Mechanism

Overseeing mechanism at NACO and SACS level

	Nodal Officer	Responsibility
NACO level	TI division officers	• Support SACS in developing district level plans Visit to districts which require support for smooth implementation • Report to DDG on weekly basis from States
State level	Project Director, SACS	• Overall Coordination and management
	MD, NHM, Director – H&FW, State RCH officer Prison Department, WCD/ SW/ SJE	• Communications to be sent to District level departments for finalizing the micro plan as well as to ensure coordination
	Officers of TI, BSD, STI	• Provide support to Nodal officers and district teams to plan, implement the activities • Ensure availability of IEC materials, exhibition materials at district level • Ensure availability of kits and STI medicines
	Nodal officer for each district to be selected among the above officers	• Provide support in liasoning with district health administration, follow up with district teams. • Provide support for district teams to ensure that team is well oriented on their roles and tasks • Mobilize inmates for health check-up and screen/ test. • Develop district mobility plan and resource plan for screen/ test, STI clinic doctor availability, availability of medicines. • Ensure linkages with district administration for support • Visit to the districts and provide support for smooth implementation • Report on daily and weekly basis to SACS M&E division • M&E division to report to NACO on weekly basis by Friday
District Team	PPM, TI NGO, LWS NGO, DAPCU, HIV Nodal officer, ICTC & STI staffs, NHM DPM, District Health Officer	

ANNEXURE 6 – Micro Plan

Part A

Name of the State:		Name of the State Nodal officer:				Contact no.		Email			
Districts identified for Camp	Camp site identified	Number of inmates to be covered	Probable dates for health camps	Whether mobile health units available in the district	Name and contact details of the medical officer/doctor to be deputed for the camp	Whether ICTC is available with staffs in the Jail/ OCS	Stock position of kits and consumables	Name of the Counselor to be deputed (SACS/ NTEP/ NVHCP)	Contact number	Name of the LT to be deputed (SACS/ NTEP/ NVHCP)	Contact Number
1	2	3	4	5	6	7	8	9	10	11	12

Part B

District details related to Health Campaign							
Name of CMO		Contact no.		Name of Prison Official		Contact no.	
Name of DTO		Contact no.		Name of DSWO/ DWCDO		Contact no.	
Name of DNVHCPO		Contact no.		Name of Project Team		Contact no.	
Name of DAPCU DPM		Contact no.		Name of TI/ LWS		Contact no.	

Jail/ OCS Name	No. of inmates (last month)	Name of nearest Health Unit	Name of MO In-charge	Contact No.	Name of Prison/ OCS Official	Contact No.

ANNEXURE 7 – Checklist

First checklist for State and National level

Geography and timeline of the proposed activities

State	Districts	Prisons	OCS	Proposed Dates by SACS
TOTAL				

Nodal Officers from SACS for various districts

Name of the District	Nodal officers	Contact Details

Checklist of NACO Nodal Officer

Preparatory Phase (to be reported before 10 days of starting the program)

Activities	Performed (yes/no)	If no, what is the action taken
State and district level planning:		
Whether the plan is shared		
Nodal officers for districts identified		
Availability of STI medicines, screening kits, waste management systems, Counselor, Lab technicians at proposed districts		
Communications to District Administration sent		
Communication to District Health Administration sent		
District teams identified and oriented on their roles and tasks		
Meeting with district administration and district health administration/ communications shared about the activities		
Information sent to the PPM, local TI NGO, LWS NGO		
Information sent to the DAPCU/ HIV nodal officer of the district		
Supply of IEC materials at the designated health camp site		
The STI clinician, Counselor and Lab technician is informed		
Supply of STI medicines, General medicines		

During visit:

Activities	Performed (yes/no)	If no, what is the action taken
Meeting with State Nodal officers and stock taking		
Meeting with district and stock taking		
Availability of medicines, IEC materials, screening kits, staffs for counseling and testing, water facilities		

Checklist of SACS Nodal Officers

Preparatory Phase (to be reported before 10 days of starting the program

Activities	Performed (yes/no)	If no, what is the action taken
State and district level planning:		
Availability of STI medicines, screening kits, waste management systems, Counselor, Lab technicians at proposed districts		
Communications to District Administration sent		
Communication to District Health Administration sent		
District teams identified and oriented on their roles and tasks		
Meeting with district administration and district health administration/ communications shared about the activities		
Information sent to the PPMs, local TI NGO, LWS NGO		
Information sent to the DAPCU/ HIV nodal officer of the district		
Supply of IEC materials at the designated health camp site		
The STI clinician, Counselor and Lab technician is informed		
Supply of STI medicines, General medicines		
Arrangements for health camps		

ANNEXURE 8 – State level logistics

Sr.	Activity	Yes/No	Remarks
1	Sensitization of State Officials		
2	Identification of District Nodal Officer		
3	Stock taking at State: • HR at districts • Finalization of sites for campaign • Arrangement of transportation • Availability of kits, medicines, consumables ○ Dual kits for HIV & Syphilis ○ Hepatitis B screening kits (HBsAg) ○ Hepatitis C screening kits (Anti HCV) ○ Medicines for general ailments ○ STI Medicines		
4	Communication to districts for campaign		
5	Sensitization of District Officials		
6	Training of Health Care Providers to be engaged in campaign at district level		
7	Sharing of formats for micro planning at districts		
8	Availability of registration records		
9	Sharing of reporting format		
10	Messages for publicity		
11	Availability/ Printing of Line-list formats		

ANNEXURE 9 – Reporting format

Reporting format for Integrated STI, HIV, TB and Hepatitis Campaign Activities			
Name of the State		Name of the District	
Type of P/ OCS		Name of the camp site	
District Nodal Officer name		Contact no.	
Date of the health camp		Date of reporting	

Service Uptake by Gender					
Name of the services available		**Male**	**Female**	**H/ TG**	**Total**
1	**General Health check up**				
2	**Antenatal check up**				
3.a	**STI Check-up**				
3.b	**STI Diagnosed**				
3.c	**STI treated**				
4.a	**HIV Screened**				
4.b	**HIV reactive**				
4.c	**HIV confirmed positive**				
4.d	**HIV positive linked to ART**				
5.a	**Syphilis Screened**				
5.b	**Syphilis reactive**				
5.c	**Syphilis treated**				
6.a	**TB Screened**				
6.b	**TB suspected**				
6.c	**TB tested**				
6.d	**TB positive**				
6.e	**TB positive put on DOTS**				
7.a	**Screened for Hepatitis B (HBsAg)**				
7.b	**Hepatitis B screened positive (HBsAg)**				
7.c	**Hepatitis B positive eligible for treatment**				
7.d	**Hepatitis B positive eligible for treatment put on treatment**				
8.a	**Screened for Hepatitis C (Anti HCV)**				
8.b	**Hepatitis C screened positive (Anti HCV)**				
8.c	**Hepatitis C positive eligible for treatment**				
8.d	**Hepatitis C positive eligible for treatment put on treatment**				

STI Syndrome					
Diagnosis	**Male**	**Female**	**TG/TS**	**Total**	**Number Treated**
Vaginal/ Cervical Discharge (VCD)					
Genital Ulcer (GUD)-non herpetic					
Genital ulcer(GUD) – herpetic					
Lower abdominal pain (LAP)					
Urethral discharge (UD)					
Ano-rectal discharge (ARD)					
Inguinal Bubo (IB)					
Painful scrotal swelling (SS)					
Genital warts					
Other STIs					
TOTAL					

The counsellors are expected to record the inmates attending the health camps and report.

Any other information regarding planning of the health camps:

(Counsellor Name) **(Head of Prison/ OCS Name)** **(District Nodal Officer Name)**

ANNEXURE 10– Time-line

Sr.	Major Activities	W 1	W 2	W 3	W 4	W 5	W 6	W 7	W 8	W 9
1	National Coordination meeting									
2	Finalization of formats & IEC messages.									
3	Virtual meetings with State									
4	SOC Meeting at State									
5	Development of draft micro plans									
6	Identification of DNOs									
7	Physical meetings with State									
8	Development/ finalization of micro plans									
9	Visit to States by NACO team									
10	Sharing of micro plans with SACS & NACO									
11	Camps									
12	Daily reporting									
13	Compilation of reports and analysis									
14	Sharing the report with National Coordination Committee									

Ministry of Health and Family Welfare
National Viral Hepatitis Control Program
An integrated approach for Hepatitis B and C management in prisons and other closed settings

Introduction

Viral hepatitis is a major public health problem in India. Various etiological agents (hepatitis A, B, C, D and E viruses) have been implicated that can lead to acute, chronic or sequel of chronic infection. While hepatitis A and E are often the cause for sporadic outbreaks of hepatitis, hepatitis B and C can either clear spontaneously or can lead to chronic infection and thereafter sequelae like cirrhosis and hepatocellular carcinoma(HCC). The major route of transmission of hepatitis B virus (HBV) is from mother to child and hepatitis C virus (HCV) is unsafe injection practices.

National Viral Hepatitis Control Program (NVHCP) was launched in 2018 under the aegis of National Health Mission (NHM) towards the attainment of the Sustainable Development Goal (SDG) 3 "…. combat hepatitis." The program provides measures for prevention, and free diagnostics & drugs for management of hepatitis B & C through the existing health system. In addition, the program establishes linkages with other existing national programs for optimal utilization of resources.

Currently, the services under NVHCP are being extended to the prisons, drug de-addiction & rehabilitation centres. Since available data suggests higher vulnerability of inmates for HIV, Tuberculosis (TB) and STIs, it is proposed to integrate with NACP & NTEP for comprehensive screening and management in closed setting like prison, juvenile homes, drug rehabilitation centres etc.

Implementation Plan
Sensitization

At the outset, all the stakeholders of state and district including administrators, program officers of NVHCP, NACP & NTEP; and authorities and staff of prison and other closed settings should be sensitized about the vulnerability of the population for infections like hepatitis B & C, HIV, STIs and TB for necessary awareness of the infections amongst the inmates. Early detection through screening of these infections among inmates can help in timely initiation of appropriate management and reduce complications and transmissibility of these infections. Further, advocacy for an integrated approach for screening and management of these infections would avoid duplication of work and benefit the inmates especially those who are co-infected for early interventions.

Testing should be offered to all inmates for hepatitis B and C except those who have been tested within last 12 months. After an informed consent (for hepatitis B & C - Annexure -1) and counselling (for hepatitis B & C - Annexure- 2), the inmates should be screened for hepatitis B & C, HIV, and STIs by a trained laboratory technician using venous blood specimen/ finger prick whole blood specimen. Relevant specimen collection for TB testing after detailed risk assessment will be carried out. All testing using blood as a specimen should be conducted routinely/ fixed day in the closed setting depending on the availability of laboratory technician.

Testing guidelines:

Sample collection:

A trained laboratory technician/phlebotomist should collect the specimen. All material required for specimen collection example cotton swabs, adhesive bandages/tape, tourniquet, alcohol wipes, needles, evacuated vacuum tubes-red cap tube, gloves, needle disposable unit, syringes etc. must be available. All specimen must be labelled and relevant records maintained before sample collection is done. Ensure all biosafety precautions and biomedical waste management practices are followed.

Screening test

Screening can be done using either whole blood or serum. Details on procedure to conduct the test is placed at Annexure -3.

a) Whole blood based: The testing should be done using whole blood obtained by finger prick following all aseptic precautions. In case the test is positive for HBV/HCV, a fresh venous sample (5ml in plain evacuated vacuum tube – red cap) should be drawn. The specimen should be centrifuged / allowed to stand at room temperature for serum separation and aliquot for storage at 2-8^{o}C for upto 7 days. In case centrifugation/storage is not possible, specimen must be transported to the designated mapped site within six hours of collection. (Figure-1: Flow chart for whole blood based testing for hepatitis B&C)

b) Serum based: The testing should be done using a venous blood sample (5ml in plain evacuated vacuum tube – red cap). The specimen should be centrifuged/ allowed to stand at room temperature for serum separation which should be tested by RDTs for HBV & HCV. In case the test is positive for HBV/HCV, the serum should be aliquoted for storage at 2-8^{o}C for upto 7 days. As far as possible effort should be made to do the screening in the closed setting. In case testing/ storage is not possible, specimen must be transported to the designated mapped site within six hours of collection. (Figure-2: Flow chart for serum based testing for hepatitis B &C)

Sample storage

Serum samples of all screened positive for hepatitis B & C must be in labelled aliquot and stored at 2-8^{O}C for not more than 7 days by which they should be transported for viral load testing in cold chain. In case the specimen needs to be stored beyond 7 days and upto 28 days, the storage temperature should be -20^{o}C. Store at -80^{o}C beyond 28 days

Sample Transportation

The sample should be transported in triple layered packing to a mapped designated site maintaining cold chain at temperature of 2-8^{O}C. The details of the samples should be filled in the relevant fields of annexure-6 and sent along with the samples.

Viral load testing for Hepatitis B /C:

All positive samples should be subjected to viral load testing in a designated laboratory (in a closed platform).

Figure-1: Flow chart for whole blood based testing for Hepatitis B & C

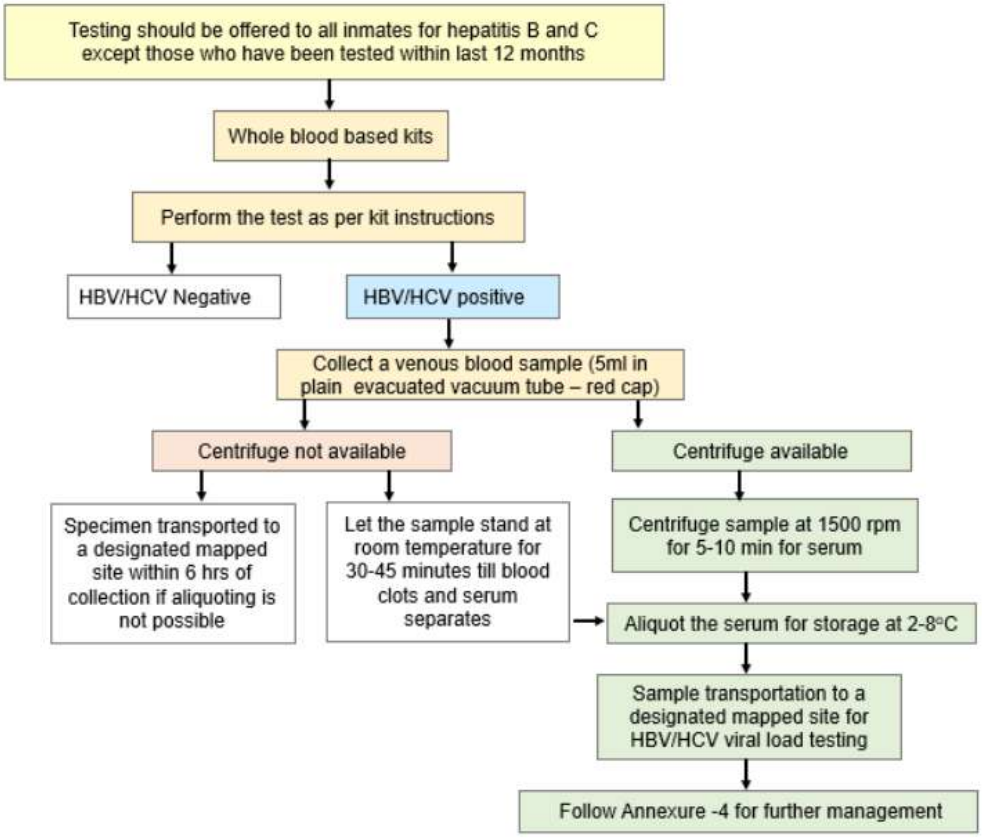
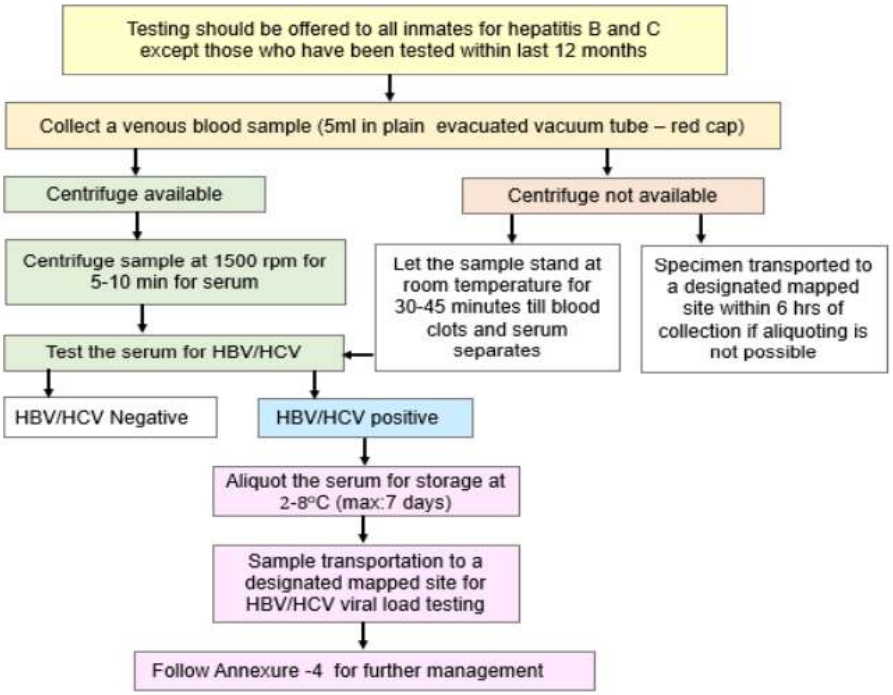


Figure-2: Flow chart for serum based testing for hepatitis B & C



Management of hepatitis B & C

The management of hepatitis B and C should be done as per the standard treatment protocol under NVHCP placed at Annexure 4 (Hepatitis B – Annexure -4a; Hepatitis C – Annexure – 4b). Patients can be categorized into uncomplicated and complicated cases based on simple blood investigation as defined in Annexure –3. Only uncomplicated cases can be treated in the closed setting subject to availability of the Medical Officer.

a) In presence of a Medical Officer, these closed settings will be designated as 'Treatment Provider' site under NVHCP. Treatment of uncomplicated cases of hepatitis B or C should be initiated in these settings itself and complicated cases should be referred to Model Treatment Centre (MTC).
b) In case of Medical Officer is not available, those screened positive(s) should be linked to the designated mapped treatment site for management of hepatitis B and C as per Annexure -4.
c) Co-infected cases of hepatitis B and hepatitis C should be referred to Model Treatment Centre (MTC) for further management. Co-infection with HIV cases should be routed through ART centre and thereafter referred to MTC. Cases of hepatitis B and C with other comorbid conditions as per Annexure 4 should be referred to MTC.

In case of release or transfer of the inmate from the prison or closed setting, the incharge of these settings will inform the district NVHCP officer who will ensure linkage of the inmate to relocated site where inmate is transferred for continuing the management of hepatitis B or C.

Training

The Medical Officers, Laboratory technicians and person dispensing drugs in these settings should be trained on standardized diagnostic and treatment protocols for management of hepatitis B and C infection as a part of the comprehensive training under supervision of district NVHCP officer.

Intersectoral coordination

The designated state & district program officers of NVHCP, NACP & NTEP will coordinate amongst themselves and the closed setting authorities and share data on a monthly basis.

Logistics

The specific logistics for diagnosis and management of hepatitis B & C should be provisioned for these settings in the district by the district NVHCP officer in coordination with state NVHCP officer. Common collection material will be jointly arranged for between the health department, NACP and authorities of the closed settings.

Monitoring & Evaluation

The state/district NVHCP officer will be a part of the state/district oversight committee and contribute for effective implementation of this activity.

Recording and Reporting

The staff conducting the test and providing the drugs along with referrals should record the data duly signed by Medical Officer/Incharge of closed setting in the prescribed formats placed at Annexure –5,6 and shared with the Chief Medical Officer/ Civil surgeon/ Chief Medical Health Officer/any other nomenclature used by the state for onward dissemination to respective program officers for appropriate defined action at their end.

With regard to NVHCP, the Medical officer/ incharge of closed setting should maintain treatment cards of hepatitis B or C positive inmates and information should be shared with District NVHCP officer. (Annexure-7a, 7b) All relevant data should be entered into the NVHCP MIS portal under the supervision of district NVHCP officer. The information of those screened negative for hepatitis B or C should be captured as aggregate numbers.

Confidentiality

All data generated through the program activities shall be kept confidential. **No data should be shared with NGOs/CBOs or any other national/international organisation.**

Any breach in the above will be viewed seriously.

Activities and Roles & Responsibilities

Designation	Roles and Responsibilities
State administrators and program officers of NVHCP, NACP and NTEP (state oversight committee)	i) Coordination meeting for the planning & implementation ii) Sensitize the District program officers and administrators on the vulnerability of the population for infections like hepatitis B & C, HIV, STIs and TB and necessary interventions in these closed settings iii) Monitoring of the activities iv) Ensure confidentiality of data.
District administration and program officers of NVHCP, NACP and NTEP (district oversight committee/district health society)	i) Coordination meeting for the planning & implementation ii) Sensitize the authorities of the closed settings on the vulnerability of the population for infections like hepatitis B & C, HIV, STIs and TB and necessary interventions in these closed settings iii) Monitoring of the activities iv) Ensure confidentiality of data.
State NVHCP Officer	i) Coordinate with State administrators and program officers of NACP and NTEP for planning, implementation and monitoring of the activities ii) Coordinate with the district NVHCP officers for effective implementation of the activities and provision of kits and drugs to the district including these settings.
District NVHCP Officer	i) Coordinate with district administrators and program officers of NACP and NTEP for planning, implementation and monitoring of the activities ii) Coordinate with the State NVHCP officer for effective implementation of the activities and provision of kits and drugs in these settings iii) Coordinate with the Medical Officer/ Incharge of these settings for: a) effective implementation of the activities and b) to ensure availability of testing kits and drugs to these closed settings. c) receive the linelist of inmates for data entry into the NVHCP MIS portal under his supervision d) include the aggregated data of these setting in the monthly report of the district
Incharges of the Prison and other closed setting	i) Estimation of beneficiaries in coordination with Medical Officer and share it with district NVHCP officer: Inmates to be tested for Hepatitis B and C (excluding those tested within 12 months) in prison and other closed settings ii) Coordinate with Medical officer of the Prison and other closed setting and district NVHCP officer to ensure availability of testing kits and drugs as per requirement.
Medical officer	i) Estimation of beneficiaries in coordination with Incharges of the Prison and other closed setting and share it with district NVHCP officer: Inmates to be tested for Hepatitis B and C (excluding those tested within 12 months) in prison and other closed settings ii) Coordinate with Incharge of the Prison and other closed setting and district NVHCP officer to ensure availability of testing kits and drugs as per requirement. iii) Management of uncomplicated cases and referral of complicated cases/ coinfected cases as per NVHCP guidelines. iv) Share the linelist of the inmates with their test results (annexure 6) along with management details (annexure-7a&7b) with the district NVHCP officer v) Ensure confidentiality of data
Laboratory Technician	i) Conduct screening test for hepatitis B and hepatitis C ii) Prepare the linelist of the inmates tested with their test results and share it with the medical officer/ incharge of the closed setting. iii) Sample collection and transportation of the blood samples for viral load testing / routine testing in coordination with the designated mapped sites iv) Coordinate with the designated mapped site to receive the annexure 6 duly filled with viral load testing results.

Annexure - 1

INDIVIDUAL'S CONSENT FORM FOR TESTING AND MANAGEMENT OF VIRAL HEPATITIS

_____ (full name), daughter/son of _____ _____ (full name) age _____ resident of (address) _____ _____ have read/have been read over and explained (circle appropriate) the accompanying guidance and have understood the information provided to me related to the investigations and proposed management required (if available) I understand that the purpose of these tests is to:

- Establish my Viral Hepatitis status,
- Evaluate the presence of liver disease which may be associated with Hepatitis infection.
- I can allow the program to archive my specimen for further molecular testing related to viral hepatitis only in the interest of public health, provided that any information/data/detail relating to or emanating from my molecular sample shall not be divulged to any third party under any circumstances.

A breach of this condition shall automatically forfeit my consent and the program's right to retain such information and shall further render them liable to penal action and compensation. I understand that if a diagnosis of Chronic Hepatitis B/C is confirmed, I will be offered treatment as per the provisions in the initiative. I give my consent to the proposed management offered by the initiative subject to strict protection of my information.

Patient's Signature: _____ Date: _____
Staff member name obtaining consent: _____
Staff signature: _____ Date: _____

Annexure- 2

Key Messages - Hepatitis C
• Major route of transmission of hepatitis C is through unsafe injections. • Hepatitis C infection is usually asymptomatic. • Hepatitis C is a curable disease with 3-6 months' treatment. • Early detection and management of hepatitis C can reduce complications like liver cirrhosis and liver cancer. • Side effects of the drugs for management of hepatitis C are rare. • Diagnostic and treatment services for management of hepatitis C are available free of cost in designated government healthcare facilities under NVHCP.
Key Messages - Hepatitis B
• Major route of transmission of hepatitis B is from mother to child. • Hepatitis B infection is usually asymptomatic. • Hepatitis B is a vaccine preventable disease. • For prevention of mother to child transmission of hepatitis B, the new born delivered to a hepatitis B positive mother should be administrated birth dose of Hepatitis B vaccine along with Hepatitis B Immunoglobulin within 24 hrs of birth. • Early detection and management of hepatitis B with lifelong treatment can reduce complications like liver cirrhosis and liver cancer. • Side effects of drugs for management of hepatitis B are rare. • Diagnostic and treatment services for management of hepatitis B are available free of cost in designated government healthcare facilities under NVHCP.

Annexure –3

Procedure for Rapid Diagnostic Test

- Ensure that the test kit was stored at 2-8°C and is within expiry date. Follow first expiry first out (FEFO) principle. Record batch and lot number before opening fresh kit.
- Remove the test kit 30 minutes prior to use from cold chain and allow it to come to room temperature.
- Serum or Whole Blood finger prick RDT to be used for screening for Hepatitis B and C. Label the sample with at least two inmate's-specific identifiers. Acceptable identifiers include inmate unique ID, age, gender, the date and time of collection etc. and perform the test as per the instructions provided in the testing kit.

a) Serum based RDT

Sample collection:

- Collect 5 mL blood for HBV & HCV testing in plain vial labelled with inmate's unique identifiers.
- Centrifuge at 1500 RPM for 5-10 min for serum separation.
- In case centrifugation is not possible, let the sample stand at room temperature for 30-45 minutes for serum separation.
- In case the sample is positive for HBV/HCV, serum can be stored at 2-8°C (max 7 days) for viral load testing.

b) Whole Blood finger prick RDT

- Test should be performed on whole blood obtained after finger prick, immediately by RDT as per kit instruction.

Interpretation of result

- INVALID: When neither control line nor the test line appears on the membrane or if only the test line appears without the control line, the test should be treated as invalid. (figure-3 A & B)
- NEGATIVE: Appearance of one line in the control region "C" only, indicates that the sample is "NEGATIVE". (figure-3 C)
- POSITIVE: Appearance of two lines, one each in test region "T" and control region "C" indicates that the sample is "POSITIVE". (figure-3 D)

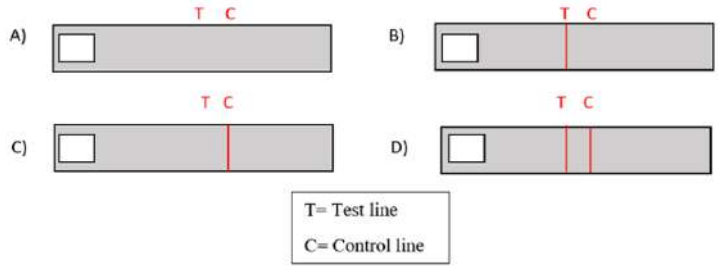
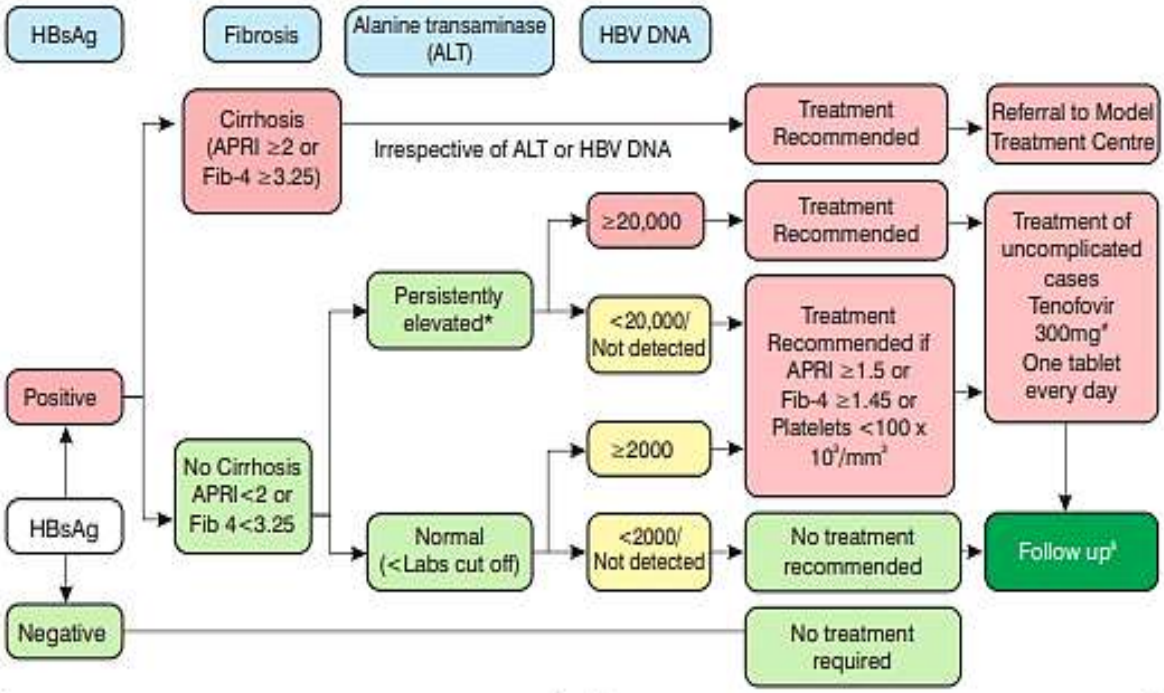


Figure-3: Interpretation of RDT kit – A & B) Invalid C) Negative D) Positive

Note: Put up a negative and positive control whenever a new kit is opened or every day if more than 20 tests are being done, or after every 20 specimens are tested to ensure that controls are sufficient. Document all records.

Annexure – 4a
Management of Hepatitis B

Hepatitis B is usually asymptomatic and can progress to complications like cirrhosis and hepatocellular carcinoma (HCC). The disease is manageable with lifelong treatment and preventable with vaccination.



$$APRI = \frac{\frac{AST}{AST(Upper\ Limit\ of\ Normal)}}{Platelet\ count(10^9/L)^{**}} \times 100$$

$$Fib\text{-}4 = \frac{Age(years) \times AST\ (IU/L)}{Platelet\ count(10^9/L)^{**} \times \sqrt{ALT\ (IU/L)}}$$

Monitoring the Treatment

	Base Line	6 months	12 months
Tests	Complete blood counts including platelet count (CBC)	Hemoglobin and Platelet count	Hemoglobin and Platelet count
	Liver Function Test (LFT) (at least ALT & AST)	LFT (at least ALT & AST)	LFT (at least ALT & AST)
	Ultrasound (USG) of abdomen	x	x
	HBV DNA Quantitative	x	HBV DNA Quantitative
	Renal Function Test	Renal Function Test	Renal Function Test

Referral to Model Treatment Centre

- Cirrhosis
- Ascites, Gastrointestinal Bleed, Encephalopathy
- Treatment experienced patients
- Renal Failure
- Children < 18 years
- Co-infection of HBV with HIV and/or HCV
- HCC
- Thalassemia
- Patient on chemotherapy
- Virological failure
- Hemoglobinopathies
- Co-morbidities including Tuberculosis, Diabetes, COPD and Hypertension
- Hemoglobin < 9 g/dL
- Seizures
- H/o alcohol consumption

APRI (AST-to-platelet ratio index); AST (Aspartate Transaminase); Fib-4 (Fibrosis 4)

[$] Persistently elevated - at least 2 values four weeks apart in the last 6 months, which are above the upper limit of normal

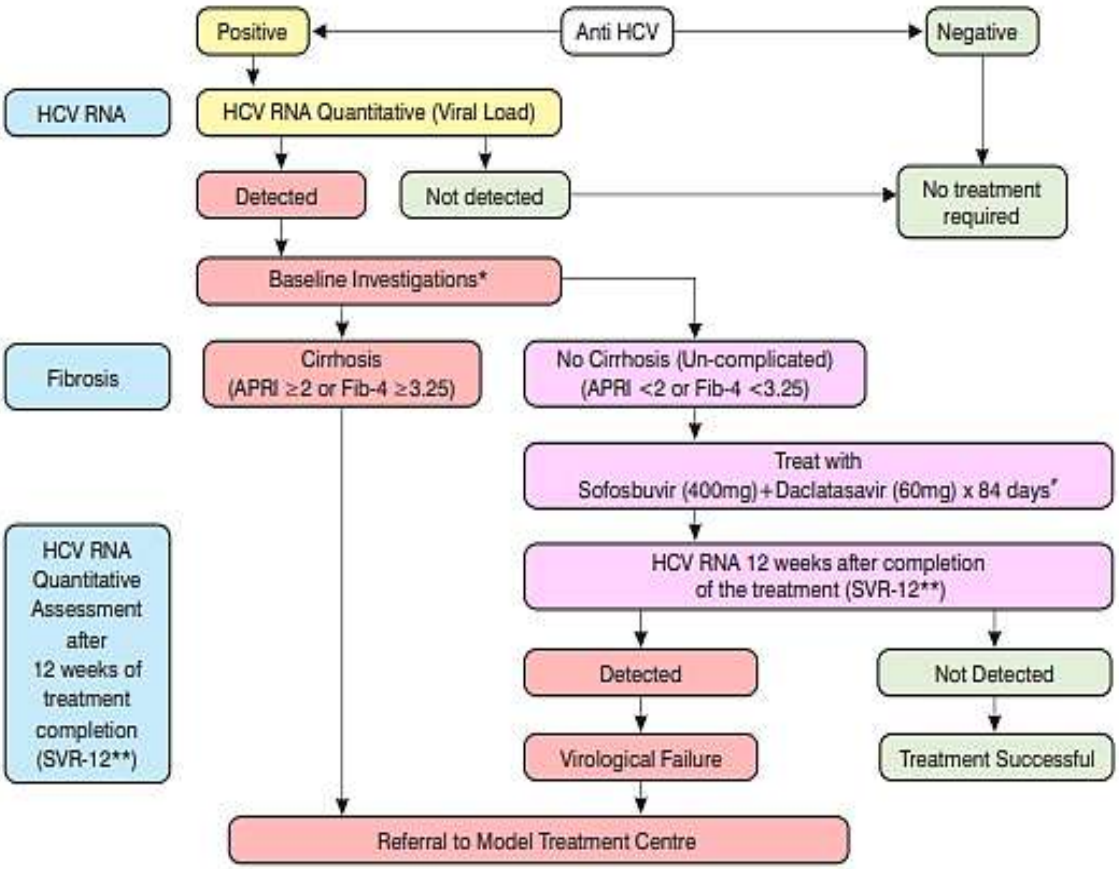
[#] In children 12 years of age and older, and weighing at least 35 kg

[$] All HBsAg positive patients should be monitored with HBV DNA quantitative on yearly basis (including those found not eligible for treatment)

[**] Calculate APRI / Fib-4 using platelet count in thousands. eg. 150000/ microlitre = 150 thousands. i.e. 150 will be used as denominator

Annexure 4b
Management of Hepatitis C

Hepatitis C is usually asymptomatic and can progress to complications like cirrhosis and hepatocellular carcinoma (HCC). The disease is curable with early diagnosis and treatment.



$$\text{APRI} = \frac{\frac{\text{AST}}{\text{AST(Upper Limit of Normal)}}}{\text{Platelet count}(10^9/\text{L})^{\#\#}} \times 100$$

$$\text{Fib-4} = \frac{\text{Age(years)} \times \text{AST (IU/L)}}{\text{Platelet count}(10^9/\text{L})^{\#\#} \times \sqrt{\text{ALT (IU/L)}}}$$

Monitoring the Treatment

	Base Line	Week 4	Week 24 (SVR-12)
Tests	Complete blood counts including platelet count (CBC)	CBC	HCV RNA Quantitative (Viral Load)
	Liver Function Test (at least ALT & AST)	Liver Function Test (at least ALT & AST)	
	Serum Creatinine	Serum Creatinine	

Referral to Model Treatment Centre

- Cirrhosis
- Ascites, Gastrointestinal Bleed, Encephalopathy
- Treatment experienced patients
- Renal Failure
- HCC
- Co-infection of HCV with HIV and/or HBV
- Thalassemia
- Patient on chemotherapy
- Virological failure
- Hemoglobinopathies
- Hemoglobin < 9 g/dL
- Co-morbidities including Tuberculosis, Diabetes, COPD and Hypertension
- Seizures
- H/o alcohol consumption

APRI (AST-to-platelet ratio index); AST (Aspartate Transaminase); Fib-4 (Fibrosis 4); ALT (Alanine Transamine); HCV- Hepatitis C Virus; SVR** - Sustained Virological Response

dose adjustments in PLHIV, renal insufficiency, etc

Calculate APRI / Fib-4 using platelet count in thousands. eg. 150000/ microlitre = 150 thousands. i.e. 150 will be used as denominator

Annexure -5

National Viral Hepatitis Control Program
Monthly Reporting Format

S. No	Indicators	Total
	Hepatitis B	
1.	Total number of blood samples screened for viral Hepatitis B i.e., HBsAg (excluding pregnant women)	
2	Total number of blood samples tested positive for Hepatitis B (out of those tested for HBsAg excluding pregnant women)	
3	Total number of positive blood samples for Hepatitis B i.e. HBsAg tested for HBV DNA (out of those tested positive for HBsAg excluding pregnant women)	
4.	Total number of patients found positive for HBsAg eligible for treatment for Hepatitis B (excluding pregnant women)	
5.	Total number of patients eligible for treatment for Hepatitis B put on treatment (out of those eligible for treatment excluding pregnant women)	
6.	Number of patients put on hepatitis B treatment continuing treatment	
	Hepatitis B in pregnancy	
1.	Number of pregnant women tested for HBsAg	
2	Number of pregnant women who are HBsAg positive (out of those tested for Hepatitis B i.e., HBsAg)	
3.	Number of pregnant women found positive for HBsAg referred to higher centre for institutional delivery	
	Hepatitis C	
1.	Total number of blood samples screened for viral Hepatitis C (Anti- HCV)	
2	Total number of blood samples tested positive for Hepatitis C (out of those tested for Anti-HCV)	
3.	Total number of positive blood samples for Hepatitis C screened confirmed by HCV RNA testing (out of those positive for anti-HCV)	
4.	Total number of patients put on treatment for Hepatitis C (out of those confirmed by HCV RNA i.e. HCV RNA detected)	
5.	Total number of positive Hepatitis C patients who have completed treatment	
6.	Total number of patients cleared for HCV RNA on sustained virological response at 12 weeks (SVR12)	

Annexure-6

Ministry of Health and Family Welfare
National Viral Hepatitis Control Program

State:…….. District:……

Name & address of the Closed setting…… Name of the Incharge / Medical officer:…….
Date: Phone number:

.

S No	Inmate ID	Age	Gender (M/F*/ others)	Date: Hepatitis B positive (Y/N)	Date: Hepatitis C positive (Y/N)	Date: Viral load Hep B (in IU/ml)	Date: Viral load Hep C (in IU/ml)	Remarks

*Mention pregnancy status in remarks section in case of female inmates.

Signature of the District Nodal Officer
Name:

Signature of the Medical officer/In-charge
Name:

Annexure- 7a

National Viral Hepatitis Control Program | Department of Health & Family Welfare -
Patient Record Copy – Hepatitis B

Patient Registration Details

OPD ID*: ..... NVHCP ID*: __-___-__-__-___ /_ _ _ _ _ _ Date of registration*: __/__/____

Patient type*: ☐ New ☐ Experienced If Experienced*: ☐ NVHCP ☐ Outside *If NVHCP is selected, please fill the details below*

State: ..... Facility: ..... Treatment Year: .....

Past Treatment UID: _ _-_ _ _-_ _ _-_ _-_ _ _/_ _ _ _ _ _

Name*: ..... Age*: ..... ☐months ☐years Gender*: ☐M ☐F ☐TG

Relative type*: ☐Father ☐Husband ☐ Guardian ☐Mother Relative's Name*: .....

Home Street and Address*: .....

.....

State*: ..... District*: ..... Block/Ward: .....

Village/Town/City: ..... Pin code*: ..... Contact Type*: ☐Mobile ☐Landline

Contact No: ..... Consent for Receiving Communication*: ☐Y ☐N

Patient signature/thumb impression:

Risk Factors: ☐High risk sexual behaviour ☐Occupation exposure to Blood/Body Fluids ☐Child born to HBV-positive mother ☐On chronic haemodialysis ☐Patient received organ transplant ☐Thalassemic/Haemophilic ☐Tattooing/Piercing ☐History of IDU (intravenous drug use) ☐Needlestick injury ☐History of blood transfusion ☐History of surgery ☐Patient received invasive dental treatment ☐History of receiving injection for therapeutic purposes ☐ Others .....

Screening Details

Test types	Screening test used	Date of testing	Date of result	Place of testing	Result
☐ HBsAg	☐ RDT ☐ ELISA ☐ Other.....	__-__-_ _ _ _	__-__-_ _ _ _	☐Govt. Lab ☐PPP	☐Positive ☐Negative

Baseline Test Details- Hepatitis B

Date of prescribing tests*: __-__-_ _ _ _ Date of issue of last investigation report*: __-__-_ _ _ _ Haemoglobin*: .....

S. Albumin*: ..... S. Bilirubin (Total)*: ..... ALT*: ..... AST*: ..... AST ULN*: ..... Platelet count*: .....

Weight (kgs)*: ..... S.Creatinine (mg/dL)*: .....

Cirrhosis Stage*: ☐ Uncomplicated ☐ Complicated *Criteria for evaluating cirrhosis*

☐ Ultrasound Ultrasound Date: *: __-__-_ _ _ _ ☐ Fibroscan Fibroscan Date: *: __-__-_ _ _ _ LSM value: .....Kpa

☐ APRI APRI score: ..... ☐ FIB 4 FIB 4 score: .....

Persistently elevated ALT levels?* ☐ Y ☐ N *(no need to fill if the patient is cirrhotic)* **Date of decision*:** __-__-_ _ _ _

Severity of Hep-B (If Cirrhosis stage is Complicated)*: ☐ Compensated ☐ Decompensated

PT INR*: .....

Variceal bleed*: ☐ Y ☐ N Ascites*: ☐None ☐Mild to moderate ☐Severe Encephalopathy*: ☐None ☐Mild to moderate ☐Severe Child Pugh Score*: ☐A☐B☐C

HBV DNA Test Details

Sample Drawn Date*: __-__-_ _ _ _ Sample stored:☐Y ☐N Sample Transported: ☐Y ☐N Sample Accepted*: ☐Y ☐N

If sample rejected, reason: ☐Leakage ☐Insufficient quantity ☐Hemolyzed ☐Incorrect labelling ☐Damaged vial ☐Cold Storage not maintained ☐Others.....

Result Date*: __-__-_ _ _ _ Result: ☐Detected ☐Not detected If detected, HBV DNA (IU/Ml)*: .....

Is treatment recommended?* ☐ Y ☐ N Date of decision*: __-__-_ _ _ _

If sample is stored, please fill the following details

Sample storage temperature (°C): ..... Storage duration: ☐ Less than 1 day ☐More than 1 day Storage duration: .....☐ hours ☐ days

If sample is transported, please fill the following details

Transport temperature (°C): ..... Transport date:__-__-_ _ _ _ Transported to:.....

Transported by: ..... Designation: .....

Receipt Date: __-__-_ _ _ _ Received by: ..... Designation:

.....

Known History Details

Please fill the following details if patient is treatment experienced

Previous regimen: ☐Peg. IFN ☐ TAF ☐TDF ☐Entecavir ☐Others *(select combination)* Duration prescribed: .....weeks/days

Previous treatment status: ☐Interrupted ☐Completed Duration completed (in weeks): ..... Last pill taken on: __ __- __ __ - __ __ __ __

Side effects from past treatment (if any): .....

Known history: ☐ Breastfeeding woman ☐Renal impairment ☐Active TB ☐Thalassemia ☐Patients on chemotherapy with deranged liver enzymes ☐Diabetes ☐History of alcohol consumption ☐Chronic obstructive pulmonary disease ☐Haemoglobinopathies ☐Anaemia<9 ☐HIV ☐HCV ☐Hepatocellular Carcinoma ☐Hypertension ☐Poorly controlled cardiac failure ☐ Entecavir related complications ☐ Tenofovir related complications ☐Coronary artery disease ☐Others (specify).....

If HIV is selected, HIV/ART regimen: ..... If Renal impairment is selected, CKD stage: ☐1 ☐2 ☐3 ☐4 ☐5 ☐Unknown

Last menstrual period: __ __- __ __- __ __ __ __ Pregnant:☐ Y ☐ N Expected date of delivery:__ __- __ __- __ __ __ __

Observations:.....

.....

Referral Details – Hepatitis B

Patient Referred:☐ Y ☐ N Referring doctor at DH/GMC*: ..... Signature*: ..... Referred to: .....

Date of referral: __ __- __ __- __ __ __ __ Treating doctor at referred facility*:.....

Prescription Details – Hepatitis B

Prescribing facility*: ..... Prescribing Doctor*: ..... Prescribing Date*: __ __- __ __- __ __ __ __

Place of dispensation*: .....

Regimen*: ☐ Tenofovirdisoproxil fumarate (TDF): .....mg;

☐ Tenofoviralafenamide fumarate (TAF): .....mg; ☐ Entecavir: .....mg

☐ Others: ..... (specify) Dosage: .....

Duration*: ☐ 30 days ☐ 60 days ☐ 90 days

☐Others ..... weeks

Reason (if others)*: .....

Dispensation Details – Hepatitis B

No	Date*	Advised Next Visit Date	Pills Dispensed	Pills Left	Reasons for low-adherence	Haemo-globin	Platelet	Comments	Signature of pharmacist	Signature/thumb impression of patient
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

Side effects: ☐No side effects ☐Headache ☐Fatigue ☐Nausea ☐Diarrhoea ☐Weakness ☐Rash ☐Depression ☐Others.....

Recorded during visit no: ....

Baseline and follow-up investigations

No	Date of visit	Haemoglobin	Platelet count	ALT	AST	S. Bilirubin	S. Albumin	PT INR	S. Creatinine	Weight (kgs)	APRI	FIB-4
1												
2												
3												
4												

Follow-up HBV DNA tests

No	Sample drawn date	Sample accepted?	Result date	Result	HBV DNA (IU/mL)
1		☐Y ☐N		☐Detected ☐Not detected	
2		☐Y ☐N		☐Detected ☐Not detected	

Interrupted Patient Information – Hepatitis B

Reason for interruption (select one only):	Reason for death/LFU:	Patient referred for:
☐Death	☐Liver related causes ☐Due to causes not related to liver ☐Don't know	
☐Loss to follow up	.....	
☐Others.....	.....	

Signature of medical specialist: ..... Name and designation: .....

Annexure- 7b

Treatment card – Hepatitis C

National Viral Hepatitis Control Program | Department of Health & Family Welfare -
Patient Record Copy

Patient Registration Details

OPD ID*: ..... NVHCP ID*: __ __ – __ __ __ – __ __ __ – __ __ – __ __ / __ __ __ __ __ __

Patient type*: ☐ New ☐ Experienced If Experienced*: ☐ NVHCP ☐ Outside *If NVHCP is selected, please fill the details below*

State: ..... Facility: ..... Treatment Year: .....

Past Treatment UID: __ __ – __ __ __ – __ __ – __ __ – __ __ / __ __ __ __ __ __

Name*: ..... Age*: ..... ☐months ☐years Gender*: ☐M ☐F ☐TG

Relative type*: ☐Father ☐Husband ☐ Guardian ☐Mother Relative's Name*: .....

Home Street and Address*: .....

.....

State*: ..... District*: ..... Block/Ward: .....

Village/Town/City: ..... Pin code*: ..... Contact Type*: ☐Mobile ☐Landline

Contact No: ..... Consent for Receiving Communication*: ☐Y ☐N

Patient signature/thumb impression:

Risk Factors: ☐High risk sexual behaviour ☐Occupation exposure to Blood/Body Fluids ☐Child born to HCV-positive mother ☐On chronic haemodialysis
☐Patient received organ transplant ☐Thalassemic/Haemophilic ☐Tattooing/Piercing ☐History of IDU (intravenous drug use) ☐Needlestick injury
☐Patient received blood transfusion ☐History of surgery ☐Patient received invasive dental treatment ☐History of receiving injection for therapeutic purposes
☐ Others .....

Screening Details

Test types	Screening test used	Date of testing	Place of testing	Result
☐ IgM Anti HAV	☐ RDT ☐ ELISA ☐ Other.....	__ __ – __ __ – __ __ __ __	☐Govt. Lab ☐PPP	☐Positive ☐Negative *Select below, is Positive selected* ☐Patient managed at the facility ☐Patient referred for management to higher facility
☐ HBsAg	☐ RDT ☐ ELISA ☐ Other.....	__ __ – __ __ – __ __ __ __	☐Govt. Lab ☐PPP	☐Positive ☐Negative
☐ Anti HCV	☐ RDT ☐ ELISA ☐ Other.....	__ __ – __ __ – __ __ __ __	☐Govt. Lab ☐PPP	☐Positive ☐Negative
☐ IgM Anti HEV	☐ RDT ☐ ELISA ☐ Other.....	__ __ – __ __ – __ __ __ __	☐Govt. Lab ☐PPP	☐Positive ☐Negative ☐Patient managed at the facility ☐Patient referred for management to higher facility

Viral Load Test Details

☐ Hepatitis-C

Sample Drawn Date*: __ __ – __ __ – __ __ __ __ Sample stored: ☐Y ☐N Sample Transported: ☐Y ☐N Sample Accepted*: ☐Y ☐N

If sample rejected, reason: ☐Leakage ☐Insufficient quantity ☐Hemolyzed ☐Incorrect labelling ☐Damaged vial ☐Cold Storage not maintained ☐Others.....

Result Date*: __ __ – __ __ – __ __ __ __ Result: ☐Detected ☐Not detected If detected, Viral Load (IU/Ml)*: .....

If sample is stored, please fill the following details

Sample storage temperature (°C): ..... Storage duration: ☐ Less than 1 day ☐More than 1 day Storage duration: .....☐ hours ☐ days

If sample is transported, please fill the following details

Transport temperature (°C): ..... Transport date: __ __ – __ __ – __ __ __ __ Transported to: .....

Transported by: ..... Designation: .....

Receipt Date: __ __ – __ __ – __ __ __ __ Received by: ..... Designation: .....

☐ Hepatitis-B

Sample Drawn Date*: __ __ – __ __ – __ __ __ __ Sample stored: ☐Y ☐N Sample Transported: ☐Y ☐N Sample Accepted*: ☐Y ☐N

If sample rejected, reason: ☐Leakage ☐Insufficient quantity ☐Hemolyzed ☐Incorrect labelling ☐Damaged vial ☐Cold Storage not maintained ☐Others.....

Result Date*: __ __ – __ __ – __ __ __ __ Result: ☐Detected ☐Not detected If detected, Viral Load (IU/Ml)*: .....

If sample is stored, please fill the following details

Sample storage temperature (°C): ..... Storage duration: ☐ Less than 1 day ☐More than 1 day Storage duration: .....☐ hours ☐ days

If sample is transported, please fill the following details

Transport temperature (°C): ..... Transport date: __ __ – __ __ – __ __ __ __ Transported to: .....

Transported by: ..... Designation: .....

Receipt Date: __ __ – __ __ – __ __ __ __ Received by: ..... Designation: .....

Testing Details- Hepatitis C

Date of prescribing tests*: __ __ – __ __ – __ __ __ __ Date of issue of last investigation report*: __ __ – __ __ – __ __ __ __ Haemoglobin*: .....

S. Albumin*: ..... S. Bilirubin (Total)*: ..... ALT*: ..... AST*: ..... AST ULN*: ..... Platelet count*: .....

Weight (kgs)*: ..... S.Creatinine (mg/dL)*: .....

Cirrhosis Stage*: ☐ Uncomplicated ☐ Complicated *Criteria for evaluating cirrhosis*

☐ Ultrasound Ultrasound Date: *: __ __– __ __– __ __ __ __☐ Fibroscan Fibroscan Date:_*: __ __ – __ __– __ __ __ __ LSM value: .....Kpa
☐ APRI APRI score:..... ☐ FIB 4 FIB 4 score:.....

Severity of Hep-C (If Cirrhosis stage is Complicated)*: ☐ Compensated ☐ Decompensated

PT INR*: .....

Variceal bleed*: ☐ Y ☐ N Ascites*: ☐None ☐Mild to moderate ☐Severe Encephalopathy*: ☐None ☐Mild to moderate ☐Severe Child Pugh Score*: ☐A☐B☐C

Known History Details

Please fill the following details if patient is treatment experienced

Previous regimen:☐Peg. IFN ☐ RBV ☐SOF ☐DCV ☐VEL *(select combination)* Duration prescribed (in weeks):☐4 ☐8 ☐12 ☐20 ☐24
Previous treatment status:☐Interrupted ☐Completed Duration completed (in weeks):☐4 ☐8 ☐12 ☐20 ☐24 Last pill taken on: __ __– __ __– __ __ __ __
Past treatment outcome: ☐ SVR Pending ☐ SVR achieved ☐ SVR not achieved

Known history: ☐ Breastfeeding woman ☐Renal impairment ☐Active TB ☐Thalassemia ☐Patients on chemotherapy with deranged liver enzymes ☐Diabetes ☐History of alcohol consumption ☐Chronic obstructive pulmonary disease ☐Haemoglobinopathies ☐Anaemia<9 ☐HIV ☐HBV ☐Hepatocellular Carcinoma ☐Seizure/Epilepsy ☐Hypertension ☐Poorly controlled cardiac failure ☐Previous ribavirin hypersensitivities ☐Coronary artery disease
If HIV is selected, HIV/ART regimen: ..... If Renal impairment is selected, CKD stage: ☐1 ☐2 ☐3 ☐4 ☐5 ☐Unknown

Last menstrual period: __ __– __ __– __ __ __ __ Pregnant:☐ Y ☐ N Expected date of delivery:__ __– __ __–__ __ __ __

Observations:.....
.....

Referral Details – Hepatitis C

Patient Referred:☐ Y ☐ N Referring doctor at DH/GMC*:..... Signature*:..... Referred to:.....
Date of referral:____– __ __– __ __ __ __ Treating doctor at referred facility*:.....

Prescription Details – Hepatitis C

Prescribing facility*: ..... Prescribing Doctor*: ..... Prescribing Date*: __ __– __ __– __ __ __ __
Place of dispensation*:.....

Regimen *: ☐Reg 1:.....Sofusbuvir + ...Daclatasvir ☐Reg 2: .....Sofusbuvir + ...Velpatasvir
☐Reg 3: .....Sofusbuvir + ...Velpatasvir + ...Ribavarin

Duration*: ☐12 weeks ☐24 weeks
☐Others..... weeks Reason (if others)*:.....
.....

Dispensation Details & End of Treatment – Hepatitis C

No	Date*	Advised Next Visit Date	Pills Dispensed	Pills Left	Reasons for low-adherence	Haemo-globin	Platelet	Comments	Signature of pharmacist	Signature/thumb impression of patient
1										
2										
3										
4										
5										
6										

Side effects: ☐No side effects ☐Headache ☐Fatigue ☐Nausea ☐Diarrhoea ☐Weakness ☐Rash ☐Depression ☐Others.....
Recorded during visit no: ....

SVR Details – Hepatitis C

Sample Drawn Date*: ___ __– ___ __– __ __ __ __ __ Sample stored:☐Y ☐N Sample Transported: ☐Y ☐N Sample Accepted*: ☐Y ☐N
If sample rejected, reason: ☐Leakage ☐Insufficient quantity ☐Hemolyzed ☐Incorrect labelling ☐Damaged vial ☐Cold Storage not maintained ☐Others.....
Result Date*: __ __– __ __– __ __ __ __ __ Result: ☐Detected ☐Not detected If detected, Viral Load (IU/Ml)*:.....

If sample is stored, please fill the following details

Sample storage temperature (°C): ..... Storage duration: ☐ Less than 1 day ☐More than 1 day Storage duration: .....☐ hours ☐ days

If sample is transported, please fill the following details

Transport temperature (°C): ..... Transport date:____ – __ __ – __ __ __ __ Transported to:.....
Transported by: ..... Designation: .....
Receipt Date: __ __ – __ __ – __ __ __ __ Received by: ..... Designation: .....

Interrupted Patient Information – Hepatitis C

Reason for interruption (select one only):	Reason for death/LFU:	Patient referred for:
☐Death	☐Liver related causes ☐Due to causes not related to liver ☐Don't know	
☐Loss to follow up	.....	☐ SVR ☐ None
☐Others.....	.....	☐ SVR ☐ None

Signature of medical specialist: ..... **Name and designation:** .....