NACO
National AIDS Control Organisation

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MINISTRY OF
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FAMILY WELFARE
सत्यमेव जयते

Standard Operating Procedures

for Reaching Out to the Unreached HRGs Operating at SPA/Massage Parlours, Through Network Operator and at Web-based Platforms under NACP

2024

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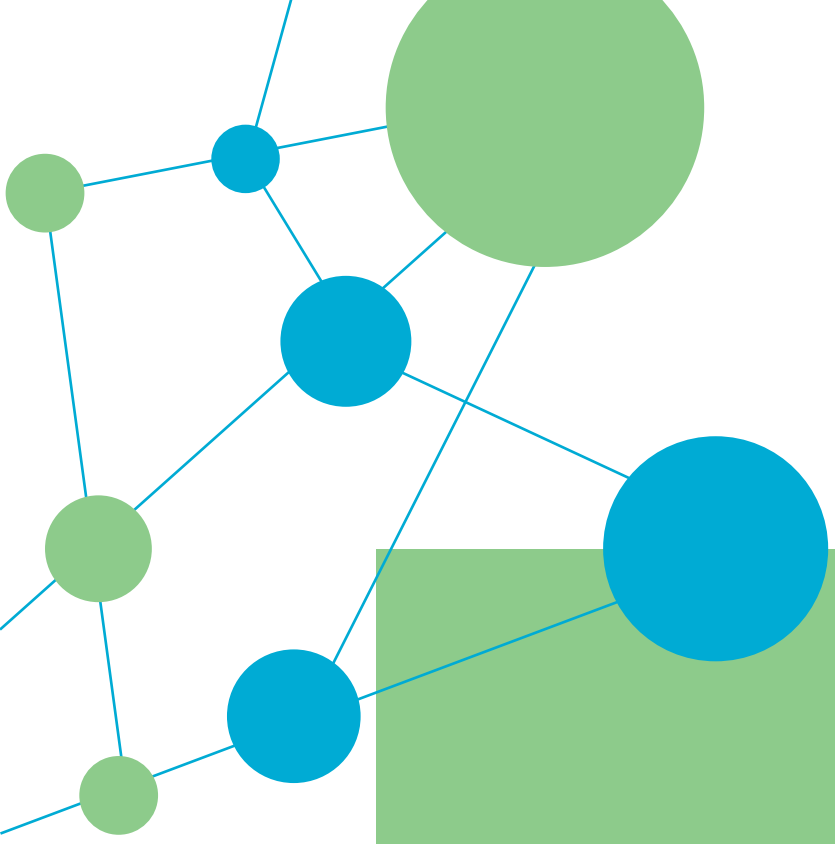

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Foreword

Under National AIDS and STD Control Programme Phase-V, the primary goal is to reduce annual new HIV infections and AIDS related mortalities by 80% by the year 2025 — 26. To respond to the ever changing dynamic of epidemic, different geographic and community specific needs and priorities, the program ensure that newer strategies are adopted, piloted, and scaled-up under the programme. Under Goal 1: the focus of the program is to continue and evolve the existing peer-led targeted interventions projects for integrated service provision to the priority population and implement comprehensive strategies that target both traditional and emerging risk behaviours.

Evidence suggests the emergence of uncovered HRGs at new physical and virtual spaces such as SPAs and Massage Parlours or web-based platforms where solicitation takes place. The sex work patterns have undergone a change owing to technology and social media including the dependence on mediators termed Network Operators for client solicitation. Therefore, designing HIV Interventions focusing on these specific key populations was of paramount importance to bridge the gap between this population and the HIV services.

Aligned with the above, the Standard Operating Procedure for reaching the unreached HRGs operating at Spa/Massage Parlours, through Network Operators and on Web Based Platforms under NACP V is developed. The document isdeveloped with the aim to implement strategies to reach out to the unreached high risk population not covered by traditional Targetted Interventions projects under the programme. I believe that the interventions for unreached HRGs operating at Spa and Massage Parlour, through Network Operators and on web based platforms under NACP - V will lead to attaining the goal of reaching out to first 95 towards early detection and universal access to health care primarily focussing on HIV and STIs.

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Preface

The National AIDS and STD Control Programme is evidence based with a focused approach towards HIV and STI prevention and control, committed to achieving the goal of ending the AIDS epidemic as a public health threat by 2030. In Phase V, the programme has taken a gigantic shift in the provision of integrated beneficiary-centric services, which would be customized and tailored to the target population and priority geographic location.

Apart from the existing street, brothel and home-based site of solicitation, there are now new physical and virtual spaces as well as new modalities through which solicitation takes place. Recognizing the changing landscape of high risk behavior, the programme acknowledges the need to address the emerging challenges such as soliciting partners through spa and massage parlours, network operators, and on web based platforms.

As this population is not covered by the traditional prevention intervention and projects, it necessitated the need for consolidating the learnings and evidences to develop strategies to reach out to the unreached high risk population to bridge the gap between them and the HIV and STI services under NACP. Hence, this Standard Operating Procedure Document was developed through a consultative process with the involvement of representatives from SACS, Technical Support Units, community representatives, bilateral and development partners who provided technical inputs as well as their experiences and expertise.

This document as a framework is the step towards providing clear guidance on strategies, protocols and best practices to effectively engage and serve key populations involved high risk behaviours. Wherein, our prevention program can effectively address these specific needs and challenges through a comprehensive and robust approach to reach the unreached to end the AIDS epidemic as a public health threat by 2030.

(Ms. Nidhi Kesarwani)

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Message

By prioritizing prevention as a core component of the program, the National AIDS and STD Control Programme Phase V aims to implement comprehensive strategies that target both the traditional and emerging risk behaviours. The Phase V also emphasizes the importance of adapting interventions to address evolving risk behaviours and ensuring universal access to quality services for our high risk populations.

As prevention is the core component under the program, the Targeted intervention projects have initiated various efforts to close the existing gap due to newer risk behaviours like soliciting partners through virtual platforms, through new spaces like Spa and Massage parlours, and through mediators like Network Operators. It is also evident that this at-risk group is not covered by the traditional TI projects HIV prevention program. Aligned with the evidences and learnings, the Standard Operating Procedure for reaching the unreached HRGs operating at Spa/Massage Parlours, through Network Operators and on Web Based Platforms under NACP V is developed. The document covers the rationale for the intervention as well as definitions of this new emerging high risk population. It also elaborates on the strategies for identification, outreach activities and provision of comprehensive package of services. The chapters also lays emphasis on community engagement and advocacy, with a special focus on maintaining confidentiality. The roles and responsibility of relevant stakeholders, along with reporting and monitoring indicators are also provided.

The document is expected to guide the implementation of strategies for Targeted Intervention projects to reach the unreached high risks groups operating at Spa/Massage Parlours, through network operators and on web-based platforms. This will support the SACS, DISHA/DAPCU and TI projects to strengthen, and enhance scale and coverage of high-risk groups for outreach and service delivery towards the achievement of the goal of 95 95 95 in National HIV and STI Response.

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Acknowledgement

We strongly believe that the Standard Operating Procedures for reaching out to the unreached HRGs operating at SPA/Massage Parlours, through Network Operators and at Web-Based Platforms under NACP will intensify the prevention, testing, treatment and care efforts through the Targetted Intervention Projects to achieve the goals set under the National HIV Response. This document is an outcome of a series of National Level Consultations and meetings with community representatives, State AIDS Control Societies, members of the Technical Working Group, NACO's Sex Worker Technical Resource Group and development partners.

We are grateful for the valuable guidance provided by Ms. V. Hekali Zhimomi (Additional Secretary & Director General, NACO), Ms. Nidhi Kesarwani (Director, NACO) provided her valuable experience in defining the content for the document. Dr. Anoop Kumar Puri, (DDG – IEC & MS, NACO), Dr. Uday Bhanu Das (DDG – PMR & Lab S., NACO) Dr. Shobini Rajan (DDG – TI, BSD and STI, NACO), Dr. Chinmoyee Das (PHS Grade I – CST, SI, IT & SCM, NACO), Dr. Bhawani Singh (DD – CST, PMR, SCM & Global Fund) and Dr. Bhawna Rao (DD – IEC & MS & Lab S, NACO) and SACS officials for their technical inputs and contribution in developing the document.

We extend our sincere appreciation towards Dr Ravi Verma, Chairperson and the all members of Sex Worker Technical Resource Group along with Dr. Sangeeta Kaul, Chairperson and all the members of the Technical Working Group for their contribution and support for developing this document.

We take this opportunity to acknowledge the efforts of Dr. Shantanu Purohit, National Consultant, Dr Purnima Parmar, Consultant, Ms. Ira Madan, Technical Expert, Dr. Payal Sahu, Technical Expert, Dr. Abhishek Royal, Technical Expert, Mr. Arvind Kumar, Associate Consultant and Ms. Rachna Shukhla, Associate Consultant. We extend our thanks to the consultant, Mr. Debashish Murkherjee for developing this document. The list of contributors towards the successful release of this document is enclosed.

Lastly, we acknowledge the technical support from India HIV/AIDS Alliance during this journey and for designing, editing and printing the document.

The Standard Operating Procedures for reaching out to the unreached HRGs operating at SPA/Massage Parlours, through Network Operators and at Web-Based Platforms under NACP is an attempt to recalibrate the current intervention in light of the changing dynamics making the HIV response comprehensive and contemporary.

(Dr. Saiprasad P. Bhavsar)

अपनी एचआईवी अवस्था जाने, निकटतम सरकारी अस्पताल में अपनी मुफ्त सलाह व जाँच पाएँ
Know your HIV status, go the nearest Goverment Hospital for free Voluntary Counselling and Testing

Content

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary Nurse and Midwife
ART	Anti Retroviral Therapy
CBS	Community based screening
CBO	Community Based Organizations
CCC	Community Care Centres
CSS	Community System Strengthening
DAPCU	District AIDS Prevention and Control Unit
DIC	Drop In Centre
DISHA	District Integrated Strategy for HIV / AIDS
DMC	Designated Microscopy Centre
DSRC	Designated STI/RTI Clinics
FICTC	Facility Integrated ICTC
FIDU	Female Injecting Drug Users
GIF	Graphics Interchange Format
GPS	Global Positioning System
H/TG	Hijras/Transgender
HCP	Health Care Providers
HIV	Human Immuno Deficiency Virus
HRG	High-Risk Groups
IBBS	Integrated Bio-behavioural Survey
ICTC	Integrated Counseling & Testing Center
IDU	Injecting Drug Users
IEC	Information Education Communication
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex people
LWS	Link Workers Scheme
MR	multi-risk
MSM	Men who have sex With Men
NA/AA	Narcotics Anonymous/ Alcoholics Anonymous
NACO	National AIDS Control Organisation
NACP	National AIDS and STD Control Programmes
NCD	Non-communicable diseases
NGO	Non-Governmental Organizations
NSP	National Strategic Plan
NWO	Network operators
ORW	Outreach Workers
OST	Opioid Substitution Therapy
PE	Peer Educator
PEP	Post Exposure Prophylaxis
PLHIV	People Living With HIV
PM	Program Manager
pMPSE	Programmatic Mapping and Population Size Estimation
POC	Point of Care
PPTCT	Prevention -of -Parent -to -Child – Transmission
PrEP	Pre-Exposure Prophylaxis
QRA	Quarterly Risk & Vulnerability Assessment
RS	responding subscribers
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SBCC	Social and Behavioural Change Communication
SMP	Spa and Massage Parlour
SNA	Site Need Assessment
SoP	Standard Operating Procedure
SRS	Sex Reassignment Surgery
SSK	Sampoorna Suraksha Kendra
SSSC	Sampoorna Suraksha Strategy Centres
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Workers
TB	Tuberculosis
TG	Transgender
TGW	TG women
TI	Targeted Interventions
TRG	Technical Resource Group
U=U	HIV Undetectable=Untransmittable

CHAPTER 1

Introduction

Background

NACP Phase-V is a Central Sector Scheme, fully funded by the Government of India. The NACP Phase-V aims to reduce annual new HIV infections and AIDS-related mortalities by 80% by 2025-26 from the baseline value of 2010. The NACP Phase-V also aims to attain dual elimination of vertical transmission, and elimination of HIV/AIDS related stigma while promoting universal access to quality STI/RTI services to at-risk and vulnerable populations.

The specific objectives of the NACP Phase-V are as below:

A. HIV/AIDS Prevention and Control

- 95% of people who are most at risk of acquiring HIV infection use comprehensive prevention.
- 95% of HIV-positive know their status, 95% of those who know their status are on treatment and 95% of those who are on treatment have suppressed viral load.
- 95% of pregnant and breastfeeding women living with HIV have suppressed viral load towards attainment of elimination of vertical transmission of HIV
- Less than 10% of people living with HIV and key populations experience stigma and discrimination.

B. STI/RTI Prevention and Control

- Universal access to quality STI/RTI services to at-risk and vulnerable populations.
- Attainment of elimination of vertical transmission of syphilis.

Under NACP Phase-V, while the existing interventions will be sustained, optimized, and augmented; newer strategies are being adopted, piloted, and scaled-up under the programme to respond to the geographic and community specific needs and priorities.

The HIV and AIDS (Prevention and Control) Act, 2017 will continue to be the cornerstone of the national response to HIV and STI epidemic in NACP Phase-V. The Act will be the enabling framework to break down barriers driving delivery of a comprehensive package of services in an ecosystem free of stigma and discrimination. 1

In keeping with the objective of '95% of people who are most at risk of acquiring HIV infection use comprehensive prevention', stress was laid on identifying the key populations that have hitherto been unreached.

'Since the last couple of decades, there has been a rapid transformation in the use of technology, and how it is influencing people's lives in various ways. Sex work is no exception. The traditional forms (National AIDS Control Organization (NACO) defined[2]) of solicitation practised by those engaged in transactional sex i.e Sex Workers (SWs), MSM, Hijra/TGs and also Female Injecting Drug Users (FIDU) are undergoing a major change and the role of mobile based technology, social media and intermediaries using these technologies have become crucial now. In addition, there has been a major shift of physical hotspot from the traditional brothels, streets, truckers halts, etc to the more discreet spaces like the SPAs and Massage Parlours. Hence, existing intervention strategies must be changed or modified to address the changing dynamics of female sex work in India.

[1]National AIDS Control Organization (2022). Strategy Document: National AIDS and STD Control Programme Phase-V(2021-26). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.
[2]NACO subcategorises FSWs into seven major categories, in the context of HIV interventions - brothel-based, street-based, lodge-based, dhaba-based, homebased, bar-based or and highway-based FSWs.
[3]Technical Brief on Changing trends in sex work, IDENTIFYING CHANGING TRENDS IN THE SEX WORK DYNAMICS AMONG FEMALE SEX WORKERS (FSWS) IN INDIA- Bal Rakshase, Priyanka Dixit, P. Saravanamurthy, Vinita Verma, Shobini Rajan
Available at: https://naco.gov.in/sites/default/files/Technical%20Brief%20on%20Changing%20trends%20in%20sex%20work.pdf

A study[3] was conducted in seven states of India to capture the characteristics of FSWs associated with Targeted Interventions (TI) and who operate in non-TI settings. The study aimed to identify current forms of solicitation, and analyse condom use and levels of comprehensive knowledge about HIV and associated safe sex practices among FSWs.

The study found that apart from the existing traditional forms of solicitation, there are now new physical spaces such as massage parlours or spas where solicitation takes place. Further, the use of mobile phones, WhatsApp and various social media platforms are now playing prominent roles in such solicitation.

The use of technology makes FSWs more independent and helps them to hide their identity, attract more customers, thus making it difficult for the TIs to reach them. The study also found that the FSWs not linked to or covered by the TI programme have more inconsistent use of condoms in various sexual activities including anal sex and also have inadequate knowledge about HIV and STIs and about other safe sex practices as compared to the FSWs who are associated with the TI programme.

The key recommendations of the study were as below:

- Reach out to FSWs, who are not covered, through TI interventions, to ensure better coverage, given the new modalities of sex work.
- Strengthen capacities of TI, NGOs/CBOs on virtual outreach and new physical venues of solicitation.
- Strengthen consistent use of condoms among the FSWs covered by TIs, and those not covered by TI, including messaging on consistent and correct condom use during anal sex.
- Offer differentiated prevention and support services (including IEC, testing, condom lubes, link to STI/RTI) for diverse sub-groups of FSW.
- Ensure better reach and coverage of HIV prevention, testing and treatment services.
- Design innovative strategies to involve those closely associated with FSWs and who influence their networks and sex work practices.

On the other hand, while traditional TI programmes have been aimed at covering only the SWs available at the physical hotspots. In recent times with the advent of smartphones and improved connectivity through texts, as well as graphics, FSW, MSM, Hijra/TG and IDUs providing sexual services have shifted towards virtual network-based client solicitation. Such sexual service providers, not soliciting in the physical domains often remain unreached as they are not congregating at any physical hotspots[4].

While network-based solicitation refers to a method employed mostly by FSWs it is often also used by MSMs and Hijra/TGs engaged in transactional sex to solicit clients establish and maintain communication with them and deliver services to clients through the assistance of network operators using mobile phones, messenger applications, and other digital communication platforms.

Instead of traditional street-based solicitation, they utilize these digital channels to connect with potential clients, leveraging the reach and convenience of modern technology. These platforms allow FSWs, MSMs and Hijra/TGs to establish

[3]Technical Brief on Changing trends in sex work, IDENTIFYING CHANGING TRENDS IN THE SEX WORK DYNAMICS AMONG FEMALE SEX WORKERS (FSWS) IN INDIA- Bal Rakshase, Priyanka Dixit, P. Saravanamurthy, Vinita Verma, Shobini Rajan
Available at: https://naco.gov.in/sites/default/files/Technical%20Brief%20on%20Changing%20trends%20in%20sex%20work.pdf
[4]THE NETWORK OPERATOR APPROACH- Strengthening the outreach of HIV & AIDS Prevention and Control Services for Female Sex Workers in Delhi, An Implementation Note 2020- India Health Action Trust. [5]White Paper on Strategies for Engaging with HIV at-risk populations in Virtual Spaces-NACO. [6]Changing Female Sex Work Patterns in Delhi: Geographical to Virtual Network. 2015, Delhi State AIDS Control and India Health Action Trust.

connections, negotiate terms, and arrange encounters with clients, providing a more discreet and efficient means of solicitation.

Network operators (NWO) play a crucial role in facilitating this process, acting as intermediaries and mediators between FSWs, MSMs and Hijra/TGs and clients within these digital networks. NWOs are also actively involved in virtual platforms such as Messenger Groups, websites, web-based apps and platforms.

Increased access to mobile phones and fast internet to browse online platforms are changing how Indians communicate, seek information, and identify their sex partners. This shift to digital interactions varies across sub-populations. Younger individuals, between the ages of 16-29, spend most of their time on internet in India compared to other age groups. High risk groups and other at-risk populations for HIV, particularly men who have sex with men, transgender individuals, and sex workers, are increasingly using virtual channels to find their sex partners as well as to build and maintain communities[5].

A 2015 study conducted in Delhi[6] by the Delhi State AIDS Control Society and the India Health Action Trust explored shifting modalities of sex work among females from in-person venues to digital networks. The study documented female sex workers' reliance on virtual networking to solicit partners, and the resulting increase in number of overall partners and decrease in regular clients. Female sex workers in India, or their pimps/managers, now use virtual platforms, particularly mobile-based applications like WhatsApp and dating platforms, to find clients, negotiate rates, arrange logistics as well as communicate with other pimps and FSWs[7].

Studies have also documented the increasing popularity of internet-based communication among MSM and TG women (TGW) in India. A study conducted in Maharashtra[8] in 2016 shows how the affordability and access to digital mediums increased the use of online networking applications as a method for MSM and TGW to seek casual sex partners and engaged with community. Participants reported a low level of HIV disclosure to partners found through online platforms, most commonly Planet Romeo, Grindr, and Gaydar.

Further evidence establishes the virtual realm as a viable and popular way for MSM and TGW to maintain community and social support as well as remain sexually active in India. Social media usage is increasing among these groups across all education and income levels, facilitating MSM and TGW to find partners quickly, conveniently, and in larger numbers than in-person dating methods.[9,10]

Evidences also suggests that there is practice of psychotropic substance use before or during sex to increase sexual pleasure. The concurrent or sequential injecting of psychostimulants such as amphetamines and opioids is of concern because of increased risk of HIV, overdose, and other negative health consequences.[11] A study that analysed National IBBS data, reported that 'One in 3 MSM (33.88%) in India were substance users, thus exhibiting "multi-risk" (MR) behaviours. Substance-use resulting in high-risk sexual behaviour was significantly associated with higher HIV prevalence among MR-MSM. Therefore, the study suggested to have an Integrated targeted interventions focusing on safe sex and safe-IDU practices among MR-MSM to end the disease transmission.[12]

[7]Changing Dynamics among Female Sex Workers in India: A Rapid Assessment. 2017, The HIV/AIDS Partnership: Impact through Prevention, Private Sector and Evidence-based Programming (PIPMPSE) Project: Public Health Foundation of India (PHFI) Technical Brief 03.
[8]Rhoton, J., et al., Sexual Preferences and Presentation on Geosocial Networking Apps by Indian Men Who Have Sex With Men in Maharashtra. JMIR Mhealth Uhealth, 2016. 4(4): p. e120.
[9]Ferguson, H. Virtual Risk: How MSM And Tw In India Use Media For Partner Selection. 2016.
[10]Changing Dynamics among MSM in Sex Workers in India: A Rapid Assessment. 2017, The HIV/AIDS Partnership: Impact through Prevention, Private Sector and Evidence-based Programming (PIPMPSE) Project: Public Health Foundation of India (PHFI) Technical Brief 03.
[11]Treatment Of Stimulant Use Disorders: Current Practices And Promising Perspectives Discussion Paper-UNODC.
[12]Substance use and risk of HIV infection among Men who have Sex with Men in India Analysis of National IBBS data, India -PradeepKumar,BHMSa, Santha kumar Aridoss, MSW, M.Philb,Malathi Mathiyazhakan,PhDb, Ganesh Balasubramanian,PhDb ,Nagaraj Jaganathasamy,MSc,PGDCAb, Manikandan Natesan,PhDb, Padmapriya V.M.,MDSb, Joseph K.David,PhDc, Shobini Rajan,MDa, RajatashuvraAdhikary,PhDd, Elangovan Arumugam, MSc,M.Techb.

Risks and vulnerabilities of these new groups

The Spa/Massage Parlours (SMP) workers, HRGs operating through Network Operators, and those on virtual platforms were found to engage into high-risk practices like:

- Having sex without a condom with a casual partner
- Sex with more than one partner
- Consumed alcohol or other drugs before sex
- Sharing needle for injecting drugs
- Having a sexually transmitted infection
- Having sex in exchange of goods or money without condom

Through profiling and risk assessment, it was found that these HRGs had low knowledge about HIV/ STI, had high alcohol and other drug use, reported gender-based violence, and low condom uptake. Most of these HRGs are not reached by any interventions and were at risk of STIs and HIV.

These challenges of facility access call for expanded approaches to reach all population groups at risk for HIV, especially groups involved in high-risk behaviours. The possibility of remote care through virtual strategies can overcome barriers of social stigmatisation which impede these groups from accessing conventional in-person HIV services. By engaging with online interventions, these groups can learn about HIV, receive services, and get support to stay in care from the convenience of their phone, computer, or laptop, thus avoiding uncomfortable environments or unwanted interactions.

Thus, the three newer settings of soliciting and engaging in sexual activities have been shown by evidence to be significant in reaching the unreached HRGs and are important stepping stones towards reaching the 95-95-95 goals. NACO is committed to expand the HIV prevention, treatment and care interventions into these domains for ensuring the coverage of the unreached HRGs.

This document provides the strategies developed at the national level to guide implementation of interventions at the State for reaching the unreached HRGs:

- At SPA/Massage Parlours
- Through Network Operators
- At Web-Based platform

The guidelines are provided in three separate sections- one, two and three:

- Section One- Standard Operating Procedures for reaching out to the Unreached HRGs operating at SPA/Massage Parlours
- Section Two- Standard Operating Procedures for reaching out to the Unreached HRGs operating through Network Operators
- Section Three- Standard Operating Procedures for reaching out to the Unreached HRGs operating on Web-Based Platforms

The common objectives of these SOPs are:

- To provide SACS with a framework for developing and facilitating HIV/STI prevention treatment and care services and help SACS facilitate interventions among the unreached HRG population operating at SMPs, through the NWOs and at web-based platforms

- To guide the TIs with a framework for planning and managing/implementing HIV/STI prevention treatment and care intervention and service delivery while working among the unreached HRGs at SMPs, through the NWOs and at web-based platforms.
- To link the unreached HRGs and at-risk population at SMPs, through the NWOs and at web- based platforms with mental health, TB, Hepatitis- B & C services treatment and rehabilitative services.

Guiding principle

In all the three types of interventions-i.e. SMP, through NWO and at Web-Based Platforms the primary approach of the intervention workers/TI staff should be to convince the owners/managers/operators to look at the interventions through a public health lens that also uphold the vision of individuals' safety and dignity. The intervention workers/ TI staff should motivate the owners/managers/operators to facilitate interaction of the HRGs with the PEs, ORWs and counsellors/ANM to help them be in regular contact with them and provide condoms and other commodities as may be necessary to reduce their risks.

Scope of the document

The document is expected to guide the implementation of strategies for Targetted Intervention program to reach the unreached high risks groups at Spa/ Massage Parlours, through network operators and on web-based platforms. This will support the SACS, DISHA/DAPCU and TI projects to strengthen, and enhance scale and coverage of high-risk groups for outreach and service delivery. This also will augment to achieve the NACP goal of 95 95 95 in HIV National Response.

CHAPTER 2

Section One
Standard Operating Procedures for reaching out to the Unreached HRGs operating at SPA/ Massage Parlours

Chapter 2.1.1 - Rationale

In India, Female Sex Workers (FSW), Men who have Sex with Men (MSM), Hijras/ Transgender (H/TG) people, and Injecting Drug Users (IDU), collectively referred as High-Risk Groups (HRGs) under National AIDS and STD Control Programme (NACP). Proportionately, they are more infected with HIV than the rest of the population. HIV prevalence in these groups is 9-43 times that of overall adult HIV prevalence of 0.21% as per 4th round of Sankalak[13].

Operational definition of the HRGs are as given below[14]:

- **Injecting Drug Users** - IDUs are those who used any drugs through injecting routes in the last three months[15]
- **Female Sex Workers** - An adult woman who engages in consensual sex for money or payment in kind, as her principal means of livelihood[16].
- **Men Having Sex with Men** - The term "men who have sex with men" (MSM) is used to denote all men who have sex with other men as a matter of preference or practice, regardless of their sexual identity or sexual orientation and irrespective of whether they have sex with women or not. Coined by public health experts for thepurpose of HIV/STI prevention, this epidemiological term focuses exclusively on sexual practice. This term does not refer to those men who might have had sex with other men as part of Sexual experimentation or very occasionally depending on special circumstances. It should be noted that not all of those who engage in male-to-male sex do not necessarily identify themselves as homosexuals or even men[17].
- **Transgenders** - A person whose self-identity does not conform unambiguously to conventional notions of male or female gender roles but combines or moves between these[18].

The Targeted Intervention (TI) projects is the flagship prevention initiative of the National AIDS Control Organisation (NACO) for HIV and STI prevention. It is targeted towards High-Risk Groups (HRG) and its implementation is funded from the National AIDS and STD Control Programme (NACP) II to the current National Strategic Plan 2017-2024 (NSP)[19]. The core elements of the targeted intervention are: community outreach, service delivery, commodity distribution and community system strengthening. These services aimed at prevention, diagnosis, treatment and care for STIs and HIV are differentially aimed at the needs of the HRGs and provided according to their needs mostly through peer led approaches. Evidence indicated the need for comprehensive interventions focusing at community level to reach out to unreached HRGs and vulnerable population to achieve the accelerated response under NACP.

The study on Identifying Changing Trends in the Sex Work Dynamics among Female Sex Workers (FSWs) in India[20], and other related ones[21,22,23], showed that spas were the new physical venues for solicitations. Interventions in various states, showed that Spa and Massage Parlour (SMP) workers male, female as well as transgender persons were into high-risk practices.

These HRGs have remained unreached in many places through the interventions initiated within the current framework of TI as well as LWS programmes. But in order to advance towards the 95-95-95 goals, it is requisite that these hitherto unreached population is covered with STI, HIV prevention, treatment and care services.

[13]https://naco.gov.in/sites/default/files/Sankalak_Report_1.pdf.
[14]National AIDS Control Organization (2020). Programmatic Mapping and Population Size Estimation (p-MPSE) of High-Risk Groups: Operational Manual. New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.
[15]http://naco.gov.in/sites/default/files/NACP-III.pdf - Targeted Intervention under NACP III Operational Guideline, 2007.
[16]http://naco.gov.in/sites/default/files/NACP-III.pdf - Targeted Intervention under NACP III Operational Guideline, 2007.
[17]http://naco.gov.in/sites/default/files/NACP-III.pdf - Targeted Intervention under NACP III Operational Guideline, 2007.
[18]http://naco.gov.in/sites/default/files/TG-%20OG%20%28new%29.pdf – Operational Guidelines for Implementing Targeted Interventions among Hijras and Transgender People in India, 2015.
[19]Revamped and Revised Elements of for HIV Prevention and Care Continuum among Core Population- NACO, Ministry of Health and Family Welfare, Government of India.
[20]Technical Brief on Changing trends in sex work, IDENTIFYING CHANGING TRENDS IN THE SEX WORK DYNAMICS AMONG FEMALE SEX WORKERS (FSWS) IN INDIA- Bal Rakshase, Priyanka Dixit, P. Saravanamurthy, Vinita Verma, Shobini Rajan.
[21]Understanding the HIV service needs of FSWs working in the Massage Parlors/Spa in Delhi: A Rapid Assessment, DSACS & DL TSU, 2018-2019.
[22]Understanding the HIV service needs of MSMs working in the Massage Parlors/Spa in Delhi: A Rapid Assessment, DSACS & DL TSU, 2018-2019.
[23]HIV Intervention in Spas and Massage Parlours in Delhi - Provision of HIV prevention, treatment and care services to FSWs and MSMs involved in sex work through Spas and Massage Parlours in Delhi- ihat.in/wp-content/uploads/2021/03/HIV-Intervention-in-Spas-and-Massage-Parlours-in-Delhi-An-Implementation-Note.pdf

A SPA and Massage Parlour (SMP) is a commercial establishment offering health and beauty treatment and massage and does not provide any clinical or diagnostic service. Any SMP worker engaging in sexual and other activities known to increase risk of acquisition and transmission of HIV and STIs should be considered as the population in need for intervention to reduce these risks and provide diagnosis and treatment for STIs or HIV as per their risk status and requirement.

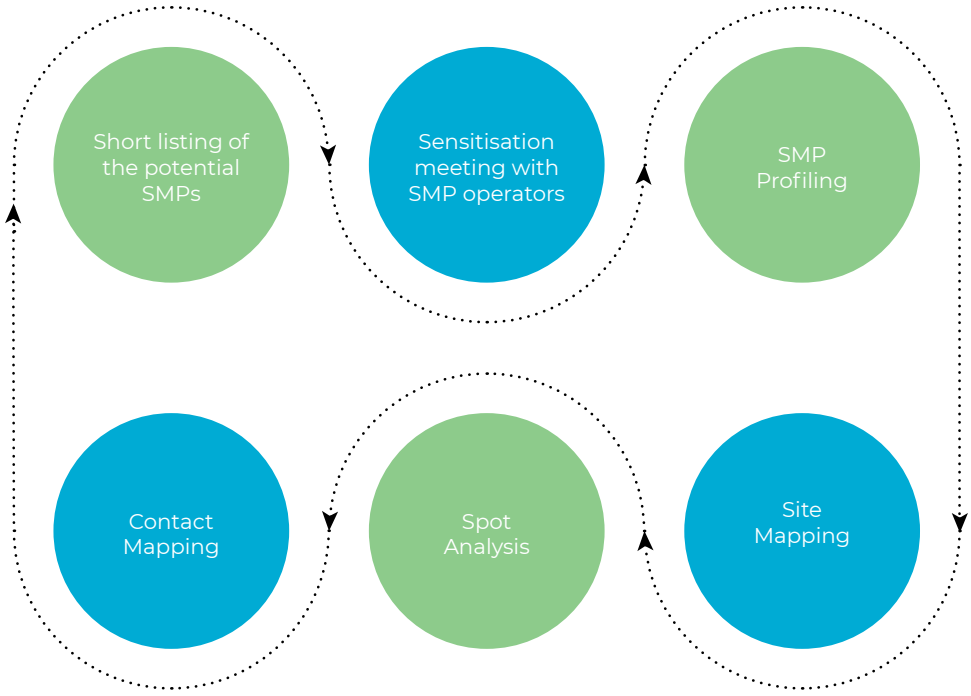
Definition of at-risk SMP worker: Any SPA/Massage Parlours (SMP) worker, engaged in sexual and other activities known to increase risk of acquisition and transmission of HIV and STIs.

The objectives of the SMP workers intervention are three pronged:
To reach out to the unreached SWs//MSM/Hijra/TG operating through spa and massage parlours soliciting or providing sexual services through TI interventions.
To make HIV/STI & other services accessible to the SPA workers and inculcate in them the health seeking behaviour required for prevention, treatment, and care of STIs and HIV.
To engage with the SMP owners, managers/operators to proactively encourage the HRGs working in their SMPs to seek/access to HIV and STI prevention, treatment and care services.

2.1.2 - Situation Assessment

The first step is to conduct a situational assessment by the targeted intervention (TI), which involves mapping and risk profiling of the SMPs and their workers. The situation assessment will also determine the population size and their risk behavioural practices. This chapter will focus on Mapping and Profiling- rationale for mapping & profiling, coverage, steps, guidelines, and SNA Tools details. The following process will be followed:

Figure 1:



Short listing of the potential SMPs

At first the ORWs conduct meetings with the local HRG population that they are in contact with and short list the potential SMPs where high risk behaviour practices may be going on. During this interaction the ORWs should also understand the needs of the SMP workers beyond the already defined comprehensive packages of services.

Sensitisation meeting with the SMP owners/operators

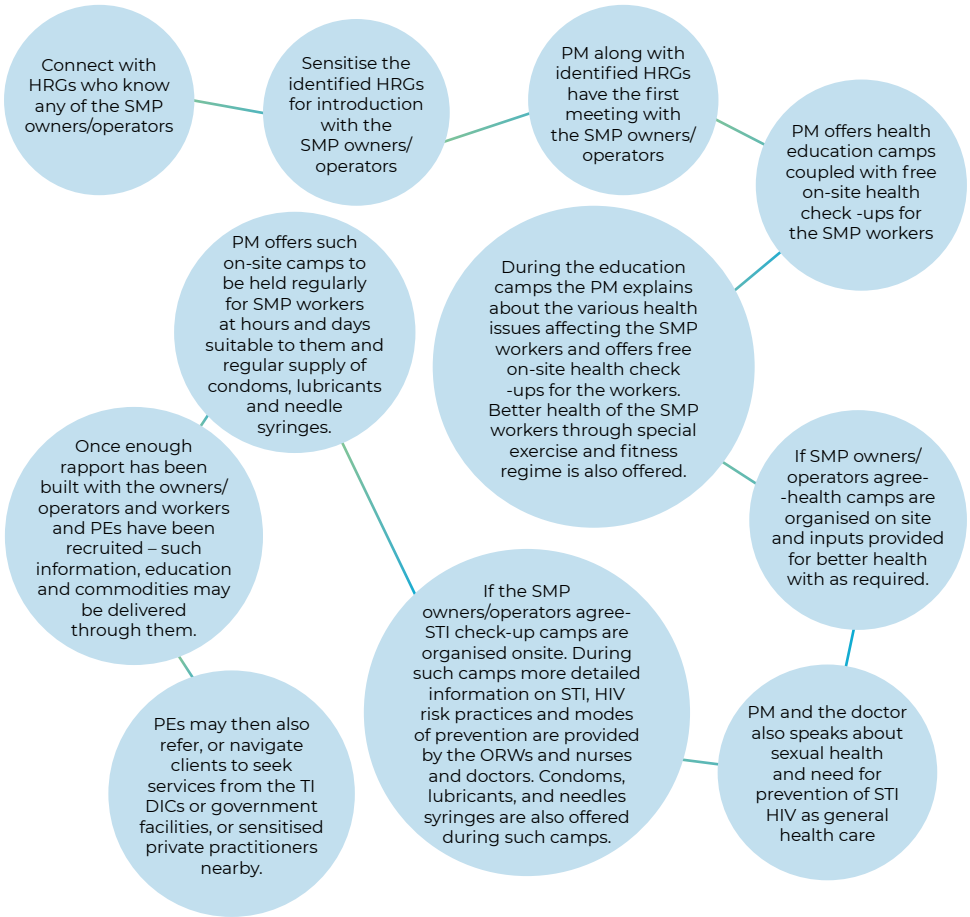
The PM follows up using this list by meeting the SMP operators.

The key objective of these meetings is to inform the SMP owner/ operators about:

- STI, HIV Intervention
- Experience of the (TI) organisation in the field of HIV/AIDS
- Need for joining the intervention by the SMPs and the health benefits that may be received for the workers.
- to motivate the SMP owner/operators to participate in the HIV/AIDS intervention.
- to let the intervention team, assess the risks and provide STI and HIV services to the SMP workers.
- to inform about the systems followed by the organisation in maintaining confidentiality about the SMPs and their workers.
- to develop referrals for safety and protection against iolence, as well as linkage with mental health and other service like TB, Hepatitis B and C.

The aim of these meetings in to convince the SMP owners/ operators to participate in the intervention.

Steps of sensitisation



Meetings with SMPs who are not convinced should be arranged once again in three months-time. Those who are not convinced should be given educational and handouts containing informational materials that also motivates to promote safe-sex practices and regular health check-ups for their workers.

SMP Profiling

Once the SMP operators/managers agree to join the intervention following the meeting with the PM, the ORWs visit the SMPs and gather primary information which includes:

- Informed Consent: Obtain Informed consent from SMP operators/managers before conducting the profiling. Ensure that they understand the purpose and use of the collected data.
- Number of staff engaged at various levels with gender disaggregation (male/female/transgender)
- Type of high-risk services provided (types of sexual services, and provision for alcohol or other substance use, if any etc.)
- Type of clients (age, gender disaggregated) and their numbers visiting these SMPs
- Frequency of visits by these clients and their preferred time slots

Site Mapping

This will be followed by mapping of the SMPs.

The mapping process provides a social map of the area of intervention with the following marked on them:

- SMPs
- Local landmarks - e.g. schools, colleges, markets, hospitals, police stations
- Brothels, known spots of home and street-based sex-workers and solicitation points for transgender and MSM.
- Type and number of TI services like DIC, condom depot, secondary distribution centres and private health care practitioners who have been sensitised.
- Other HIV services, STI clinics, ICTC, ART centre, TB, Hepatitis-B-C clinics etc. if within the jurisdiction, including other private health service providers.
- Local Key Contacts: List key contacts in the community who can facilitate access to HRGs and act as intermediaries for your program.
- The mapping should also include legal-aid providers, grievance redressal ombudsman for HIV stigma and discrimination related complaints and offices for accessing social protection schemes offered by the district administrations, the State and the Central Government.

Such maps will be developed by the ORWs under the supervision of the PMs and will provide visual maps for planning outreach.

Spot Analysis

The spot maps and the SMP profiles should be analysed to process the following information:

- List of SMPs in each location by type of HRG workers
- No. of SMP workers by HRG types available for outreach during a given time (morning, afternoon, evening, night)

This information will be used to plan outreach. The ORWs under the supervision of the PMs will be conducting this spot analysis.

Spot analysis should be conducted at the initiation of intervention and every time there is a change in the spot include change in -

- No. of SMPs in each locality,
- No. of SMP workers (by HRG types) in each locality
- Timing of their operation

If there are no known changes too, the spot analysis should be updated once every six months.

Contact Mapping

Contact mapping helps the intervention team in the following ways:

- Map and understand the TI team's contact/engagement with SMP workers in each spot
- Analyse their service needs
- Choose the best suited PEs and ORWs for a particular area.

Contact mapping is to be led by the ORW facilitated by PM.

After the spot analysis is completed, the names of the potential SMP workers by type of HRG should be listed in the contact mapping format (provided as Annexure 3). The names of the potential PEs by HRG types should also be listed and the process to be followed as per the National AIDS and STD Control Programme guidelines.

The group (of potential PEs and ORWs) will take the following steps:

- Each group starts with a map of their local area with an estimated number of SMPs in each spot.
- Each potential PE and ORWs are assigned a different colour code.
- They are requested to go through the list of the HRGs and mark with their colour if they are confident of reaching out to them with SBCC messages and services
- Counting the number of HRGs reachable by individual PEs and ORWs will help in selecting the PEs and ORWs with maximum reach in a given spot
- The following questions also need to be answered – where the contact is limited; the reasons for the limited contacts; and what can be done in each specific SMP to increase such contacts.

Chapter 2.1.3 - Outreach Activities

The outreach will be led by the ORW and supported by the PEs selected by types of HRGs present in the SMPs being covered.

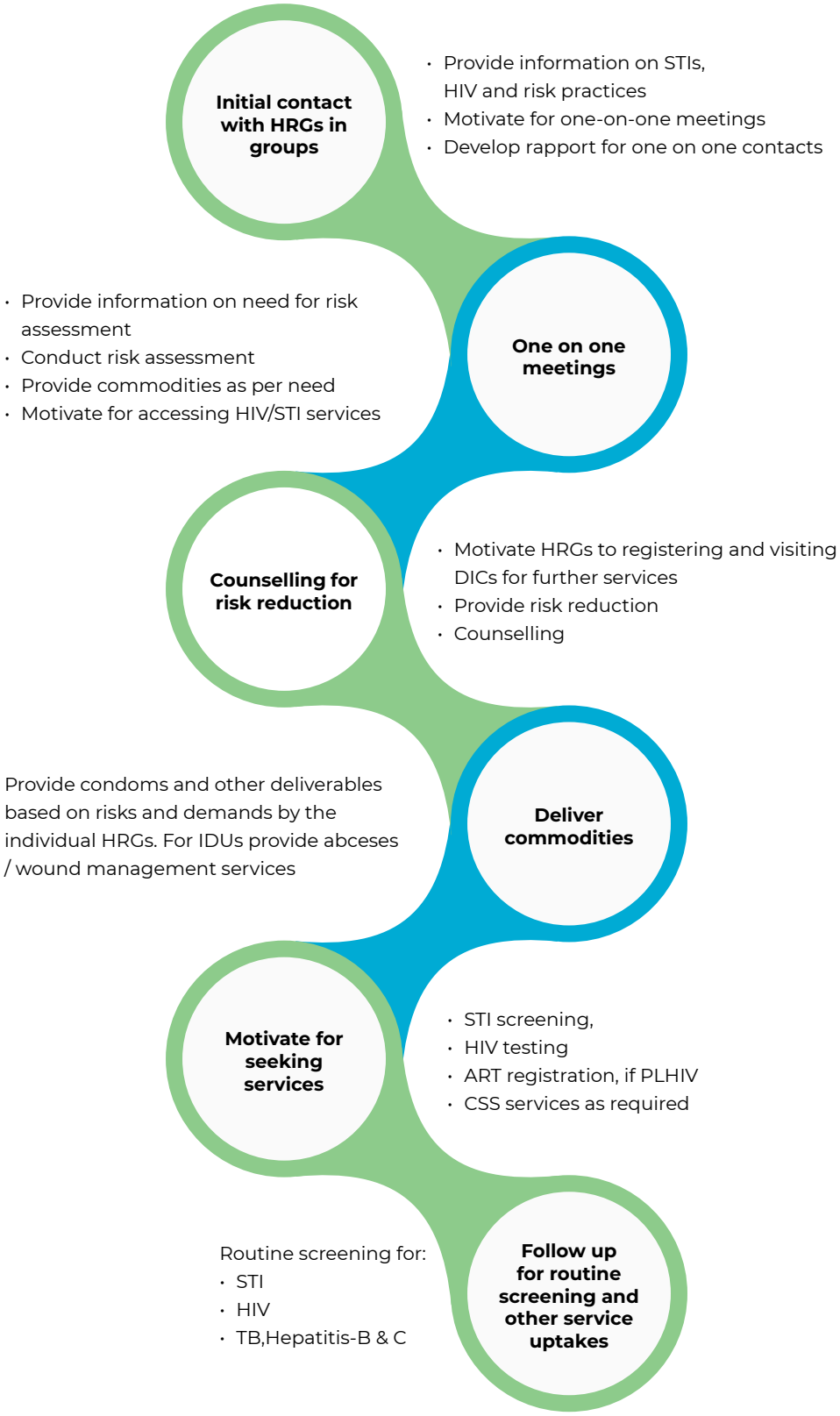
Based on the contact mapping, the PEs will be provided a list of SMPs and HRG workers to be outreached. The list will be further broken down into days and time of the day suitable for reaching the maximum number of HRGs. This should be done in consultation and in a participatory manner with ORWs and PEs.

During outreach the following services shall be delivered:

- SBCC
- Risk assessment
- Risk reduction counselling
- Condoms and Lubes

- Needle and syringes and OST
- Motivation for accessing further services at DIC
- Motivating for accessing services through referrals
- Health Education
- Psychosocial Support

Figure 2:



Initial contact with HRGs in groups

Once the initial meeting has been conducted between the PM and the SMP operators, the Program Manager should take lead in conducting the initial group meetings with the SMP workers. He/she should be supported by the ORW, PEs.

The key objective of these meetings is to motivate the SMP operators to provide information on high-risk practices, STIs, HIV -their diagnosis and treatment.

Such meetings may be held at the SMP premises or at the DICs, if the SMP operators permit.

Such meetings should be short and should provide information on high-risk practices and how they can cause STIs and HIV. How they can be prevented, diagnosed, and treated.

Such meetings should also highlight the need for seeking protection like condoms.

Such meetings should also try to motivate the SMP workers to individually undergo risk and vulnerability assessment and understand their personal risks.

The PM/ORW should also impress upon the SMP workers about how confidentiality will be maintained regarding information shared personally.

One-on-one meetings

The key objective of the one-on-one meeting/s with the SMP workers is to conduct risk and vulnerability assessment interviews with them.

The risk and vulnerability assessment enables the intervention team to assess the risks and vulnerabilities of the SMP workers as well as estimate the commodities required per month. The sample Quarterly Risk & Vulnerability Assessment (QRA) Format is provided as Annexure 4.

The ORWs shall be responsible for conducting the one-on-one meetings with the SMP workers for the risk assessment. It may also be conducted by the counsellors or ANM of the TI. The risk and vulnerability should ideally be conducted at the TI but may also be conducted at the SMP premises. Care should be taken that the place of the interview is a room with comfortable sitting provisions and for maintaining confidentiality and privacy throughout the interview. The option of using digital risk assessment form can also be utilised by the TI staff.

The risk assessment should be conducted once the initial rapport has been developed between the ORW/ANM/Counsellor and the SMP worker. The SMP worker should be confident enough to share personal and private details with the interviewer.

It will also be necessary to share with the HRG (SMP Worker) the need for this sensitive information. The information shared initially may vary in the subsequent sessions as the SMP workers share 'truer' information with growing confidence in the counsellor/ORW. However, it is very important to assure the SMP workers all through, (even if they are changing their versions) that they are being believed and trusted.

The risk and vulnerability assessment should be repeated once every quarter for every individual SMP worker.

Counselling for Risk Reduction

The aim of individual counselling is to provide risk reduction counselling for those reporting high-risk practices. Such counselling is to be provided by the Counsellor/ ANM at DIC. In case the SMP workers are not willing or motivated enough to visit the DIC, may be provided at the SMP site. But such counselling can only be provided in a space that offers total privacy and confidentiality to the SMP worker.

It is necessary to spend considerable time in building the rapport with the SMP worker before providing such counselling. Such risk reduction counselling is based on the inputs provided by the SMP workers during their risk and vulnerability assessment.

The components of risk reduction counselling are as given below:

- Safe sex
- Safe injecting drug practices/ alternatives.
- Importance of early diagnosis and treatment of HIV & STIs and about facilities where services are available.
- Importance of condom use and correct use of condoms
- Referral to Reproductive & Child Health services
- PPTCT
- Referral to address Gender Based Violence
- Referred for Tuberculosis, hepatitis B and C diagnosis and treatment
- Encourage Spouse and partner testing and treatment if tested HIV positive.

The components need to be tailored to the risks and vulnerabilities shared by the SMP workers.

In case the SMP worker is showing signs and symptoms of STIs of HIV- he/she needs to be referred for STI check-up or HIV testing as required.

Distribute condoms

(and demonstrate their proper use-teach negotiation skills)

All SMP workers should be provided with free condoms during all initial meetings.

They should be provided with condoms according to their needs once their average number of sex acts can be calculated based on their risk and vulnerability assessment. The ORWs and PEs shall be responsible for condom distribution on a regular basis. (as per the National AIDS and STD Control Programme)

Condoms shall be distributed to the SMPs based on their condom demands on a weekly basis. Condom distribution also gives an opportunity for the PEs to meet the SMP workers on a regular basis and discuss their health and other requirements. This also helps strengthen their ties.

Condom distribution should be preceded by demonstration of proper use of condoms and their hygienic disposal.

The SMP workers may also be connected with a condom outlet situated near the SMP for quick replenishment of stock as may be necessary.

Individual meetings with the SMP workers through regular outreach

The PEs should meet with the SMP workers regularly. The objectives of such meetings are to offer information of safer sex, safer injecting practices and STI, HIV diagnosis and treatment services to the SMPs.

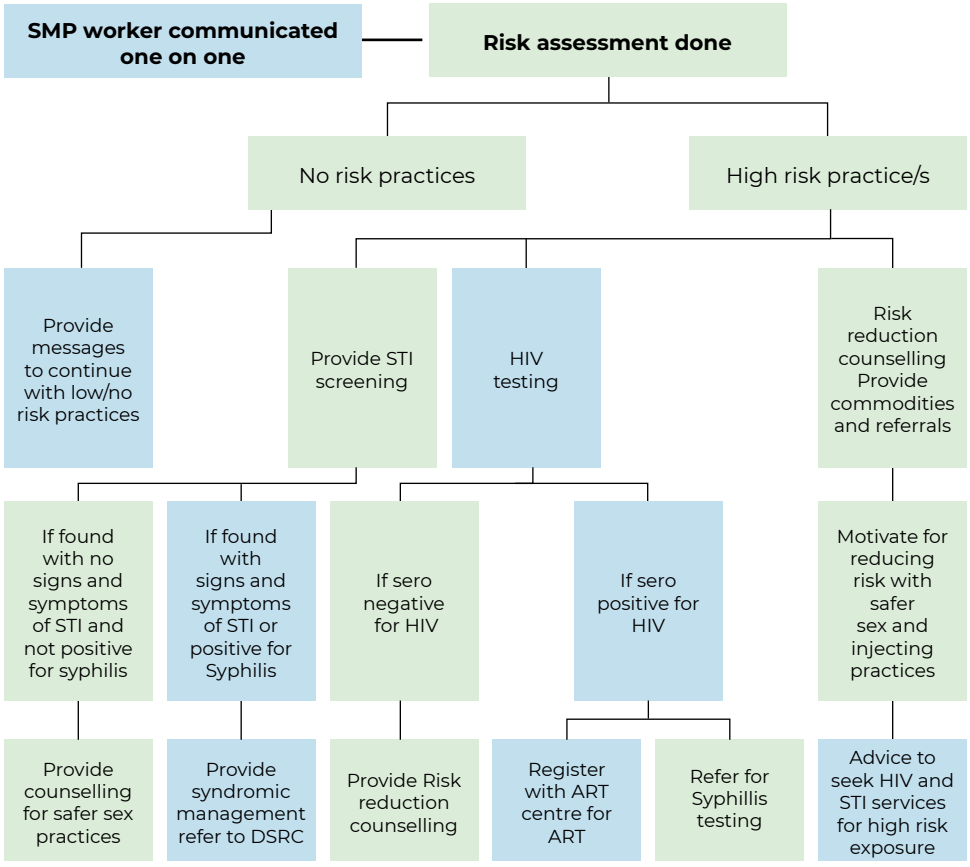
In case the SMP workers are SW,, MSM or H/TG, the meeting should be held at least three times a month, and in case of IDUs meetings should be held once a week .

During these meetings the following services need to be provided:

- information on sexual and injecting risks are to be provided and repeated regularly
- the commodities like condoms, lubes and needle syringes are to be distributed to the SMP workers
- motivation to be provided for seeking diagnosis and treatment for STI and HIV, in case signs and symptoms of STIs and HIV or episodes of high-risk practices (e.g. sex without condom with an unknown partner) are reported
- (in case of IDU), motivation is to be provided for seeking/continuing OST
- (In case PLHIV), motivation to be provided for seeking/continuing ART
- (in case pregnant), motivation to be provided for seeking PPTCT

Services:

A SMP worker will move through the various services in the following way:
Flow of services based on the client's needs: Figure 3:



[24]Revamped and Revised Elements of Targeted Intervention for HIV Prevention and Care Continuum among Core Population-NACO

STI check-up and treatment

In case of those with signs and symptoms of STIs and HIV or episodes of high-risk practices (e.g. sex without condom with an unknown partner) STI check-up needs to be conducted by a trained doctor. STI check-up is conducted at the TI, Government hospitals (DSRC) and by certain private health care providers who have been trained for the purpose. They also provide treatment if required based on the syndromic case management of STI/ RTIs recommended by NACO[25]. The frequency of check-up and treatment to be done as per the National AIDS and STD Control Programme guidelines.

In case the SMP worker is not prepared to come to the DIC, he/she/they should be referred to government hospital or private health care provider of their convenience. In the initial phases the PE may navigate the SMP worker to seek the test/s.

In case STI, is identified, the SMP worker will need to be referred for syphilis and HIV testing and also motivated through counselling to undergo the tests.

Both the referral and the results of the referral are to be documented.

Syphilis and HIV testing

SMP workers who are diagnosed with STI/RTI will be referred for syphilis and HIV testing to the nearest ICTC. The counsellor at the facility will explain the importance of syphilis and HIV testing to the patient and gives patient a referral slip after obtaining an informed consent. The PE will navigate the SMP worker to ensure that he/she/they reaches the ICTC for pre-test counselling. The SMP worker then undergoes pre-test counselling at the ICTC by the ICTC counsellor. The SMP worker thereafter goes to the ICTC laboratory and undergoes both HIV and syphilis test. After testing, he/she/they return to the ICTC counsellor for post-test counselling. During post-test counselling the ICTC counsellor provides the HIV and syphilis test report and counsels the patient to go to the DSRC for further follow up and advice, if required[26]. The frequency of check-up and treatment to be done as per the National AIDS and STD Control Programme guidelines.

ART registration, if HIV positive

In case a SMP worker reports as seropositive- he/she/they should immediately be linked to the ART centre through registration. The PE designate will provide accompanied referral to the nearest ART centre or the one chosen by the SMP worker and be registered.

While the ART centre will guide the SMP worker on the future steps- the TI PE will keep track of whether the SMP worker is initiated on ART and if initiated (or already on ART) will be tracked for continuity and prevention of dropout.

Tuberculosis (TB)

The TI Staff should provide information on TB during their regular interaction with the SMP workers and all SMP workers should be provided with 4S screening for TB during counselling and any medical check-up.

In case a SMP worker shows/reports signs and symptoms of TB (current cough, fever, weight loss or night sweats) or if he/she/they are suspected of having TB,

[25]Operational Guidelines For Programme Managers and Service Providers For Strengthening STI/ RTI Services-NACO 2011 available at: https://naco.gov.in/sites/default/files/STI%20Operational%20Guidelines.pdf

[26]Operational Guidelines For Programme Managers and Service Providers For Strengthening STI/ RTI Services-NACO 2011 available at : https://naco.gov.in/sites/default/files/STI%20Operational%20Guidelines.pdf

referral to the nearest TB centre or designated microscopy centre (DMC) for diagnosis by TI staff.

All HIV positive SMPs workers should be screened for TB and all TB cases for HIV testing.

In case a SMP worker is diagnosed with TB, he/she/should be provided with medication as per guideline and followed up by the PE to ensure complete treatment.

A SMP worker diagnosed with TB should also be referred for social welfare schemes for nutrition and special support as applicable.

Hepatitis B and C

All SMP workers should be provided with information on Hepatitis-B and C by the TI staff during their regular interaction. The SMP workers should be motivated for screening for Hepatitis B and C.

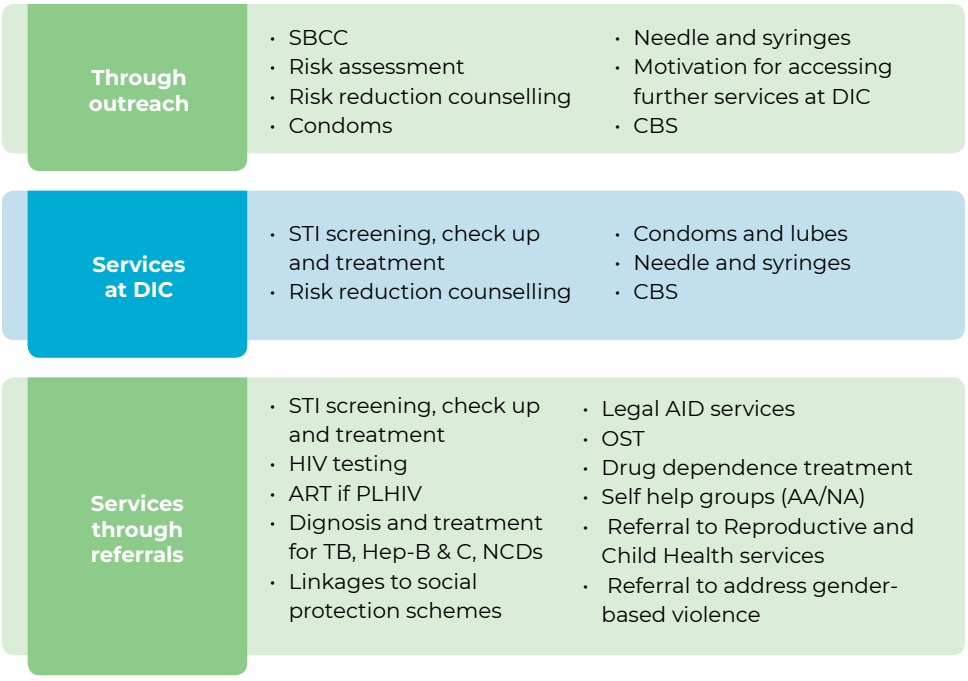
In case diagnosed with hepatitis B or C the SMP worker should be referred for treatment as per national guidelines[27].

Referral systems for HIV/STI testing, antiretroviral therapy (ART), and screening of syphilis, TB, and Hepatitis B and C should also be extended to the regular partners, male, female and transgender of the SMP workers.

Chapter 2.1.4 - Comprehensive Service Package

NACO has approved a set of services as comprehensive services for STI and HIV Prevention among the HRGs as seen in Figure 4. The following services have been recommended by NACO to be provided through TI directly and through linkages to the HRGs:

Figure 4:



[27]National Guidelines for Diagnosis & Management of Viral Hepatitis-MOHFW-2018. Available at: https://www.inasl.org.in/diagnosis-management-viral-hepatitis.pdf

Service package is to be tailored as per the needs of the type of HRG being catered to in order to provide them the relevant services as per their needs and time in order to prevent new infections among them and their partners.

Chapter 2.1.5 - Social and Behavioural Change Communication (SBCC) package

There are already existing messages developed by various SACS and NACO that have also been proven to have been very effective, they can be modified to suit the needs of the SMP workers and the operators.

Existing messages related to HIV and STI should also be modified for dissemination through WhatsApp and similar communication channels that may be discreetly accessed by the SMP workers and operators. The SMP owners/operators to be motivated to use and disseminate these messages.

SBCC materials developed by NACO on The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017, especially related to maintenance of confidentiality (disclosure), systems for grievance redressal mechanism, and stigma reduction.

CHAPTER 2

Section Two
Standard Operating Procedures for reaching out to the Unreached HRGs operating through Network Operators (NWO)

2.2.1 - Rationale

In the context of SWs, MSMs and Hijra/TGs, NWOs indeed play a significant role, not only in facilitating the solicitation of sexual services between SWs and clients but also in information exchange within their networks. The role of NWOs extends beyond mere facilitation in sex work. They also bear a responsibility for the safety and well-being of the SWs, MSMs and Hijra/TGs associated with them. This recognition highlights the potential of NWOs to engage with HRGs and promote access to HIV services.

To leverage this potential, the approach of incorporating NWOs into the targeted intervention (TI) program strategy is very important.

Definition of Unreached HRG through network operators

Network operators (NWO) are individuals from HRG communities or not from these communities but who are involved in facilitating sexual services to clients for FSW, or MSM/TG who are facilitating socialisation, information exchange and partner seeking for other males through their networks or IDUs who may or may not be practising but who are facilitating the participation of other IDU for exchanging information related to drug use, through their networks.[28]

The unreached HRGs who can be reached through the network operators (NWOs) are the Female sex workers who are currently using networks for soliciting clients for sex work, or males using networks for solicitation, socialization/seeking male partners/ information sharing, or IDUs who are using networks for exchanging information on availability of drugs, or injection and who have an extensive knowledge about the HRG operations and networking in the area.[29]

Please also note, during the pMPSE exercise conducted by NACO with support from SACS and TI projects, NWOs were identified and the lists are available with SACS for reference and further use.

Objectives

The NWO approach is designed to motivate the NWOs to proactively encourage the SW, MSM, Hijra/TG and IDUs community to seek/access HIV and STI prevention, treatment and care services and shift from high-risk behaviour to health-seeking behaviour. The objective is to reach out to the unreached SW, MSM, Hijra/TG and IDUs- currently not registered with the TIs and encourage them to adopt safe sexual and injecting practices by providing an enabling environment wherein they can avail HIV services and lead a life free from stigma and discrimination.

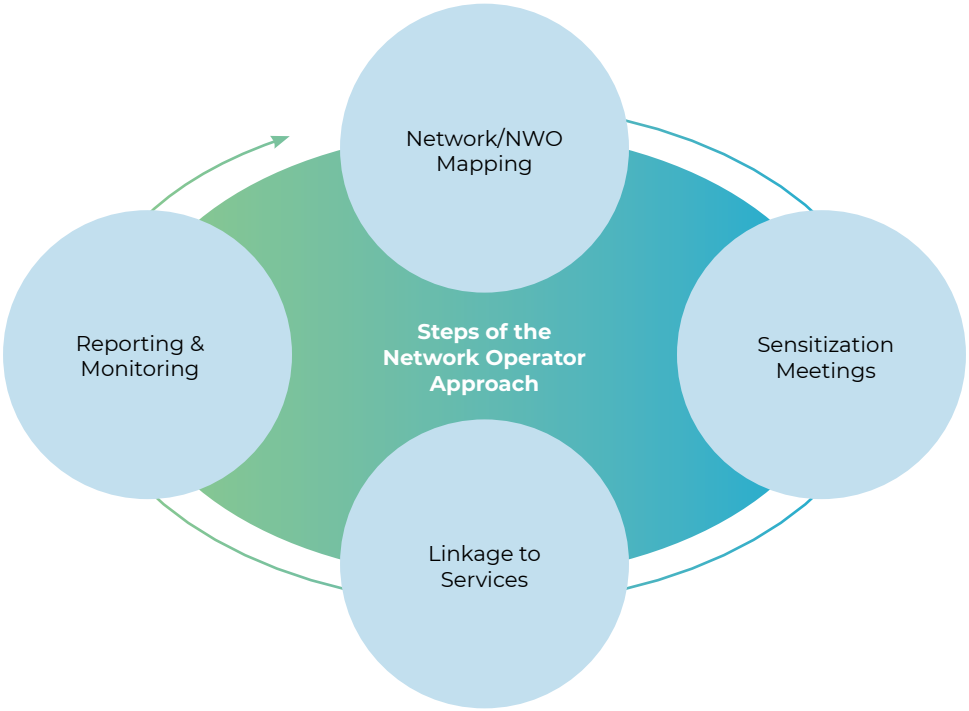
- To reach out to unreached SW, MSM, Hijra/TG and IDUs community members engaged in sex work and injecting drug use operating through Network Operators through the TI interventions.
- To make HIV/STI and other services accessible to SW, MSM, Hijra/TG and IDUs operating through NWOs and inculcate health seeking behaviour required for prevention, treatment and care of HIV and STIs.
- To engage with NWOs with the aim to create awareness and develop understanding of HIV amongst the SW, MSM, Hijra/TG and IDUs population, leading them to proactively opt for risk reduction practices/methods

[28]National AIDS Control Organization (2020). Programmatic Mapping and Population Size Estimation (p-MPSE) of High-Risk Groups: Operational Manual. New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.(pg 78)[29]National AIDS Control Organization (2020). Programmatic Mapping and Population Size Estimation (p-MPSE) of High-Risk Groups: Operational Manual. New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.(pg 77)

Chapter 2.2.2 - Outreach approach

The outreach approach for Network Operator intervention involves mapping the existing networks and NWOs and identifying and profiling SWs, MSMs and Hijra/TGs, IDUs associated with NWOs. This is followed by sensitising the NWOs about the services and benefits of the TI program and the need for service uptake for NWO beneficiaries. Through snowballing, information about different sex work networks and SWs, MSMs and Hijra/TGs engaged under these networks, is collected to reach out to them. Further, SWs, MSMs Hijra/TGs and IDUs who are contacted through this approach, are linked to the TI services. The implementation of the approach is reported and monitored using customised tools and job aids. (Annexures 7-11).

The sequential steps of the NWO approach include:
Figure 1:



Network Mapping

Mapping of Network Operators (NWO)[30]

Network mapping follows a multi-stage approach to identify and saturate the networks in the district. It follows sequential steps following the snowballing approach to identify an initial set of networks, profile them, and identify further networks from each original network, before profiling them. The stages are described in detail below.

Stage 1: Identify initial or starting points/connectors (Listing)

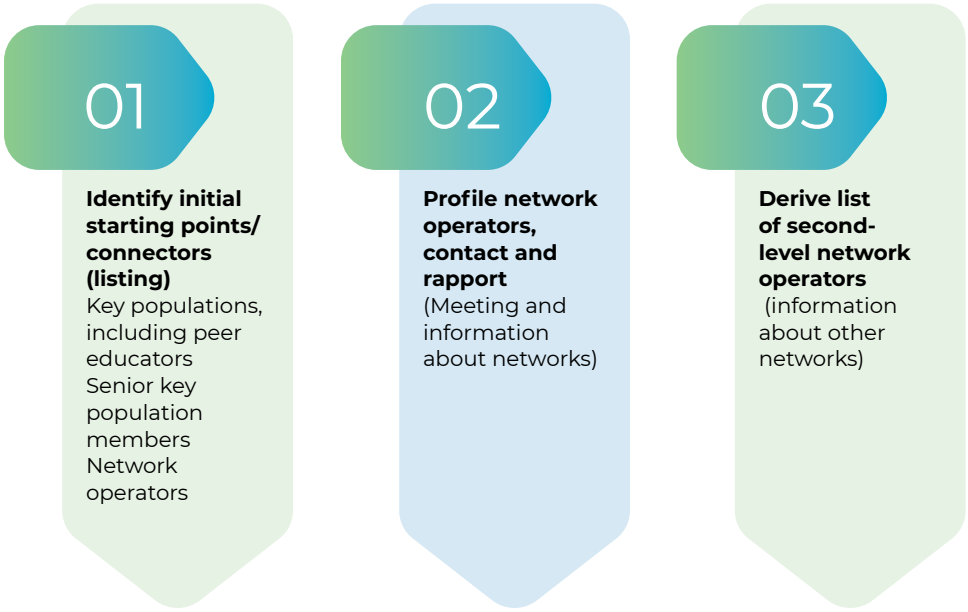
The first stage of network mapping is to identify the initial starting points or connectors or first set of NWO in the district. The process to identify these, involves conducting discussions/ meetings with members or individuals who are well connected with the HRG and know very well about the sex work, presence of MSM or IDU for solicitation/socialization/information seeking. For example, it identifies who may be networking for the purpose of exchanging information on availability of drugs or injection, and those who know the services offered through

[30]National AIDS Control Organization (2020). Programmatic Mapping and Population Size Estimation (p-MPSE) of High-Risk Groups: Operational Manual. New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.(pg 77)

HIV programmes. The connectors could themselves be network operators. Therefore, they can help identify a first set of NWOs following discussions/ meetings with different groups of HRGs or those associated with them as below.

1. Key populations, including peer educators from existing interventions among HRGs: Female sex workers who are currently using networks for soliciting clients for sex work, or males using networks for solicitation, socialization/ seeking male partners/ information sharing, or IDUs who are using networks for exchanging information on availability of drugs, or injection and who have an extensive knowledge about the HRG operations and networking in the area. It is important to identify HRGs who can contribute and are willing to support the network mapping.

Multi-stage approach to identification of networks:



2. Senior key population members: Senior key population members, who have left sex work but are very active in soliciting clients for other fellow sex workers, or senior MSM who may be facilitating socialization, information exchange and partner seeking for other active MSM or IDUs who may or may not be injecting but who are facilitating the participation of other IDU for exchanging information related to drug use.

3. Network operators: Individuals from HRG communities or not from these communities but who are involved in facilitating sexual services to clients for FSW, or MSM who are facilitating socialisation, information exchange and partner seeking for other males through their networks or IDUs who may or may not be practising but who are facilitating the participation of other IDU for exchanging information related to drug use, through their networks.

4. The main objective of these discussions/ interactions is to develop an initial list of NWOs. Therefore, existing knowledge of NWO, if any, can be used to identify the groups to be contacted to conduct discussions and interactions with the above connectors/ members/NWO and to map/list the NWOs before meeting and profiling each one of them.

Stage 2: Meet the network operator, contact and build rapport (Meeting and information about networks)

In the second stage, once a set of NWOs are identified, establish good rapport with them either meeting directly or through the programme/peer educators/ ORWs or seek appointment through other mediums, e.g. phone, etc. Explain in detail about the objective, purpose and the importance of their support and their engagement to help the programme. It is important to ensure confidentiality and how the network operators' participation is going to benefit the community.

At this stage, along with finding out more about the NWO and his/her area of operations, probe and elicit information on the total number of NWO he/she knows or is aware of and list out all the details of each individual network operator, including contacts and possibility of being introduced with them.

Stage 3: Consolidate the list of second level network operators (Information about other networks)

Consolidate all the names of the NWOs listed by the first set of NWOs. The consolidation is to list out all the unique NWOs listed by different level 1 NWOs. Once the list of second level NWOs are developed, establish rapport with them and profile each of them. As done previously, list out all the network operators they know or are in touch with. Consolidate again the listed names and continue the process until saturation of networks is achieved.

Once this process is complete, try to elicit information, in the Network Operator Format (annexure A, B, C and D), from each uniquely mapped NWO. Ensure that all questions are answered and enter this information in the p-MPSE web portal.

Sensitization Meeting

The Network Mapping exercise provides a line list of NWOs that became the base to carry out the program initiatives. Sensitization meetings led by the Program managers are then organised across all the SWs, MSMs and Hijra/TGs TI programme locations.

These meetings are aimed at strengthening rapport with the NWOs and providing them with a platform to express their concerns and elicit their views/suggestions on reaching out to more SWs, MSMs and Hijra/TGs/ and IDU under the purview of the TI program. The sensitization meetings are kept interactive and entertaining through ice breaking exercises, competitions (mehandi, dancing, singing etc) and games. Some SWs, MSMs and Hijra/TGs associated with NWOs are also invited in the meeting for building rapport. The TIs should also arrange a Free Health Clinic and provide HIV/STI services along with distribution of commodities (condoms, lubes etc. that attract the HRG) during the meetings. The meeting also includes a session on TI services, its significance and role of NWOs. The NWOs can be felicitated in these meetings for their support in the intervention. This meeting is important to strengthen the intervention and build the relationship and maintain a continued level of support/engagement from the NWOs.

Linkage to Services

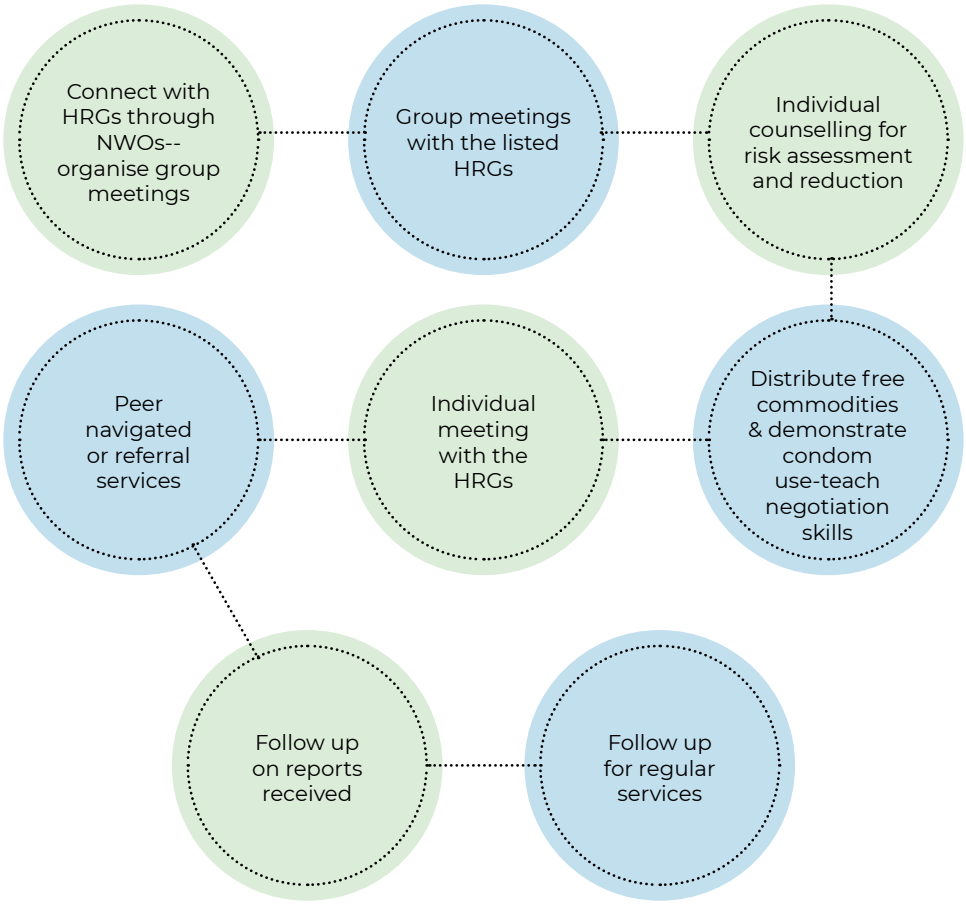
Through the NWO approach, the SWs, MSMs and Hijra/TGs, and IDUs, hitherto unreached through physical outreach can be reached and linked to the TI services and facilities. NWOs can facilitate the process of this linkage. Further, NWOs also

motivate the SWs, MSMs and H/TGs, IDUs associated with them to register with the TIs and take up regular NACP services. NWOs also facilitate the distribution of condoms and lubes; wherein the TI team provides and places free condoms as per requirement in sites designated by the NWOs.

Monitoring and reporting are covered in chapter 8

Chapter 2.2.3 - Service delivery mechanism approach

The following is the service delivery mechanism for the HRGs operating through the NWOs:
Figure 3



Connect with HRGs through NWOs- organise group meetings.

The Program managers contact with the NWOs supported by the ORWs and PEs. The counsellor/ANM, ORWs and the PEs should also be present at the meeting. Such meetings should be conducted at TI/DISHA/DAPCU levels.

The key objective of these meetings is to motivate the NWOs to let the TI team provide STI and HIV services to the HRGs operating through them.

The PM should introduce the TI and how they are connected to the National HIV programme. He/she should try to instil confidence that they are not here to affect the business negatively but would rather help them carry on their business with reduction of risk and better health of the HRGs and their clients making their 'business' profitable and sustainable in the long run.

PM should also share examples of how other NWOs (without naming them) have benefitted from partnering with the TIs.

The PM should also offer services for the NWOs themselves to be provided through the TI.

They should request the NWOs to allow the PEs, ORWs and Counsellors/ANM to contact the HRGs and talk to them and provide condoms and other commodities as may be necessary to reduce their risks. He/she should also share that they can provide general health care services too, if required by the HRGs.

In case the NWOs are not convinced- the PM should try to keep the communication channel open and request for further meetings soon. He/she should also share their contact details and request them to contact for any service they may be needing.

Meetings with NWOs who are not convinced should be arranged once again in three months-time.

Group meetings with the listed HRGs

Once the initial meeting has been conducted between the TI- Project Director / Program Manager and the NWO, the Program Manager should request for initial group meetings with the HRGs. He/she should be supported by the ORW, PEs.

The key objective of these meetings is to provide awareness on STI, HIV and how risk practices affect them. They will also provide the HRGs with information on diagnosis and treatment of STI, HIV, TB, hepatitis B & C and general well-being.

Such meetings may be held at the DICs, or other spaces where the HRGs feel comfortable.

Such meetings should be short and should provide information on high risk practices and how they can cause STIs and HIV. How they can be prevented, diagnosed and treated.

Such meetings should also highlight the need for seeking protection like the condoms.

Such meetings should also try to motivate the HRGs to individually undergo risk and vulnerability assessment and understand their own personal risks.

The PM/ORW should also impress upon the HRGs about how confidentiality will be maintained regarding information shared personally.

Individual counselling for risk and vulnerability assessment

The key objective of the initial individual meeting/s with the HRGs is to conduct risk assessment interviews with them.

The risk and vulnerability assessment enables the intervention team to assess the risks and vulnerabilities of the HRGs as well as estimate the commodities required per month. The sample Quarterly Risk & Vulnerability Assessment (QRA) Format is provided as annexure 1.

The ORWs shall be responsible for conducting the one-on-one meetings with the HRGs for the risk and vulnerability assessment. It may also be conducted by the counsellors or ANM of the TI. The risk and vulnerability should ideally be conducted at the TI but may also be conducted at any other place that the HRGs find suitable. Care should be taken that the place of the interview is a room with comfortable sitting provisions and for maintaining audio-visual confidentiality and privacy all through the interview. The option of using digital risk assessment form can also be utilised by the TI staff.

The risk assessment should be conducted once the initial rapport has been developed between the ORW/ANM/Counsellor and the SMP worker. The HRG should be confident enough to share personal and private details with the interviewer.

It will also be necessary to share with the HRGs the need for this sensitive information. The information shared initially may vary in the subsequent sessions as the HRGs share 'truer' information with growing confidence in the counsellor/ ORW. However, it is very important to assure the HRG all through, (even if they are changing their versions) that they are being believed and trusted. It is also essential to highlight that any information provided by the HRG will be completely voluntary and kept confidential at all times.

The risk and vulnerability assessment should be repeated once every quarter for every individual HRG.

Distribute free commodities

Distribute free condoms and demonstrate their proper use-teach negotiation skills. All HRGs should be provided with free condoms during all initial meetings.

They should be provided with condoms according to their needs once their average number of sex acts can be calculated based on their risk and vulnerability assessment. The ORWs and PEs shall be responsible for condom distribution on a regular basis. (as per the National AIDS and STD Control Programme guidelines)

Condoms shall be distributed to the HRGs based on their condom demands on a weekly basis. Condom distribution also gives an opportunity for the PEs to meet the HRGs on a regular basis and discuss their health and other requirements. This also helps strengthen their ties.

Condom distribution should be preceded by demonstration of proper use of condoms and their hygienic dispensation.

The HRGs may also be connected with a condom outlet situated at places of their convenience for quick replenishment of stock as may be necessary.

The NWOs may also be requested to keep a stock of condoms for emergency supply to the HRGs. Where the NWOs are distributing the commodities to the HRGs, PMs and ORWs are required to support in maintaining the stock information and monitoring the distribution. (As per the National AIDS and STD Control Programme guidelines)

Individual Meeting with HRGs

The aim of individual counselling is to provide risk reduction counselling for those reporting high risk practices. Such counselling is to be provided by the Counsellor/ANM at DIC. In case the HRGS and NWOs are not willing or motivated enough to visit the DIC, may be provided counselling at a suitable place onsite. But such counselling can only be provided in a space that offers total privacy and confidentiality to the HRGs connected through the NWOs.

It is necessary to spend considerable time in building the rapport with the SMP worker before providing such counselling. Such risk reduction counselling is based on the inputs provided by the SMP workers during their risk and vulnerability assessment.

The components of risk reduction counselling are as given below:

- Safe sex
- Safe injecting drug practices/ alternatives.
- Importance of early diagnosis and treatment of HIV & STIs and about facilities where services are available.
- Importance of condom use and correct use of condoms
- Referral to Reproductive & Child Health
- Prevention of Parent to Child Transmission
- Referral to clinic that addresses Gender Based Violence
- Tuberculosis, hepatitis B and C diagnosis and treatment
- Need for Spouse and partner testing and treatment

The components need to be tailored to the risks and vulnerabilities shared by the SMP workers.

In case the SMP worker is showing signs and symptoms of STIs or HIV- he/she needs to be referred for STI check-up and HIV testing as required.

Individual meeting with the HRGs through regular outreach

The PEs should meet the HRGs regularly. The objectives of such meetings are to offer information on safer sex, safer injecting practices and STI, HIV diagnosis and treatment services to the HRGs.

In case the HRGs are SW, MSM or Hijra/TG, the meeting should be held at least three times a month, and in the case of IDUs meetings should be held once a week[31].

During these meetings the following services need to be provided:

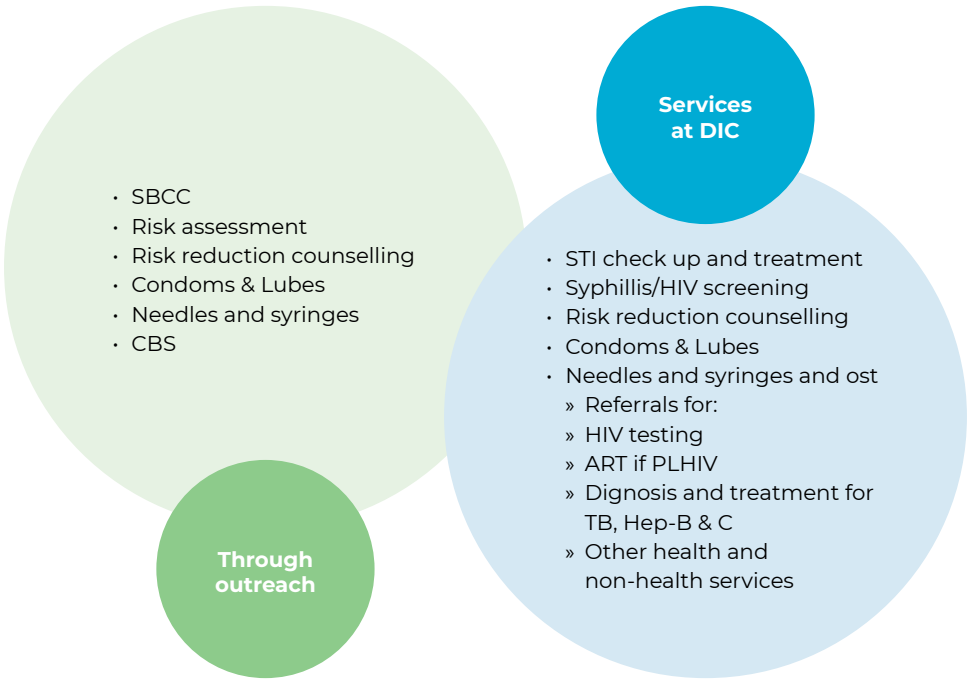
- information on sexual and injecting risks are to be provided with and repeated regularly
- the commodities like condoms, lubes and needle syringes are to be distributed to the HRGs as per their needs
- motivation to be provided for seeking diagnosis and treatment for STI and HIV, in case signs and symptoms of STIs and HIV or episodes of high-risk practices (e.g. sex without condom with an unknown partner) are reported
- (in case of IDU), motivation is to be provided for seeking/continuing OST
- (In case PLHIV), motivation to be provided for seeking/continuing ART
- (in case pregnant), motivation to be provided for seeking PPTCT

[31]Revamped and Revised Elements of Targeted Intervention for HIV Prevention and Care Continuum among Core Population-NACO

Service package

Comprehensive Service Package

Under the national program, a set of services as comprehensive services are provided for STI and HIV Prevention among the HRGs. The following services have been recommended by NACO to be provided through the TI directly and through linkages to the HRGs:



NACO also recommends that these services are provided through a differentiated approach which means that the services should be tailored to the varying needs of the HRGs based on their levels of risks and vulnerabilities .

Services:

STI check-up and treatment

In case of those with signs and symptoms of STIs and HIV or episodes of high-risk practices (e.g. sex without condom with an unknown partner) STI check-up needs to be conducted by a trained doctor. STI check-up is conducted at the TI, Government hospitals (DSRC) and by certain private healthcare providers who have been trained for the purpose. They also provide treatment if required based on the syndromic case management of STI/ RTIs recommended by NACO . The frequency of check-up and treatment to be done as per the National AIDS and STD Control Programme guidelines.

In case the HRG is not prepared to come to the DIC, he/she/they should be referred to the government hospital or private health care provider of their convenience. In the initial phases the PE may navigate the HRGs to seek the test/s.

In case STI is identified, the HRG will need to be referred for syphilis and HIV testing and also motivated through counselling to undergo the tests.

Both the referral and the results of the referral are to be documented with consent of the HRG

Syphilis and HIV testing

HRGs who are diagnosed for STI/RTI will be referred for syphilis and HIV testing to the nearest ICTC. The counsellor at the facility will explain the importance of syphilis and HIV testing to the patient and give patients a referral slip after obtaining an informed consent. The PE will navigate the HRG to ensure that he/she/they reaches the ICTC for pre-test counselling. The HRGs then undergoes pre-test counselling at the ICTC by the ICTC counsellor. The HRG thereafter goes to the ICTC laboratory and undergoes both HIV and syphilis tests. After testing, he/she/they returns to the ICTC counsellor for post-test counselling. During post-test counselling the ICTC counsellor provides the HIV and syphilis test report and counsels the patient to go to the DSRC for further follow up and advice, if required . The CBS for HIV and syphilis may also be offered at the preferred location if possible. The frequency of check-up and treatment to be done as per the National AIDS and STD Control Programme guidelines.

Point of Care (POC) testing

For those HRGs not willing to come to the DIC or government hospitals, POC testing may be arranged at a place suitable to them. Such places should be able to provide confidential services. POC services may also be provided using mobile ICTC services.

ART registration, if HIV positive

In case the HRG reports as sero-positive- he/she/they should immediately be linked to the ART centre through registration. The PE designate will provide an accompanied referral to the nearest ART centre or the one chosen by the HRG and be registered.

While the ART centre will guide the HRG on the future steps- the TI PE will keep track of whether the HRG is initiated on ART and if initiated (or already on ART) will be tracked for continuity and prevention of dropout.

Tuberculosis (TB)

The TI Staff should provide information on TB during their regular interaction with the HRGs and should be provided with 4S screening for TB during counselling and any medical check-up.

In case the HRG shows/reports signs and symptoms of TB (current cough, fever, weight loss or night sweats) or if he/she/they are suspected of having TB, referral to the nearest TB centre or designated microscopic centre (DMC) for diagnosis.

All HIV positive HRGs should be screened for TB and all TB cases for HIV testing.

In case a HRG is diagnosed with TB, he/she/should be provided with medication as per guideline and followed up by the PE to ensure complete treatment.

A HRG diagnosed with TB should also be referred for social welfare schemes for nutrition and special support as applicable.

[32]Revamped and Revised Elements of for HIV Prevention and Care Continuum among Core Population-NACO. Available from: https://naco.gov.in/sites/default/files/TI%20Strategy%20Document_25th%20July%202019_Lowres.pdf

[33]Operational Guidelines For Programme Managers and Service Providers For Strengthening STI/RTI Services-NACO 2011 available at : https://naco.gov.in/sites/default/files/STI%20Operational%20Guidelines.pdf

[34]Operational Guidelines For Programme Managers and Service Providers For Strengthening STI/RTI Services-NACO 2011 available at : https://naco.gov.in/sites/default/files/STI%20Operational%20Guidelines.pdf

Hepatitis B and C

All HRGs should be provided with information on Hepatitis-B and C by the TI staff during their regular interaction. The HRGs should be motivated for screening for Hepatitis B and C.

In case diagnosed with hepatitis B or C the HRG should be referred for treatment as per national guidelines[35].

Referral systems for HIV/STI testing, antiretroviral therapy (ART), and screening of syphilis TB and Hepatitis B and C should also be extended to the regular partners, male, female and transgender of the HRGs.

Chapter 2.2.4 - Social and Behavioural Change Communication (SBCC) Package

There are already existing messages developed by various SACS and NACO that have also been proven to have been very effective, they can be modified to suit the need of the virtual interventions.

Such messages should be modified for dissemination through WhatsApp and similar communication channels that may be easily accessed by the HRGs. The NWOs should also be motivated to communicate such messages through their channels.

SBCC materials developed by NACO on The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017, especially related to maintenance of confidentiality (disclosure), systems for grievance redressal mechanism, and stigma reduction.

[35]National Guidelines for Diagnosis & Management of Viral Hepatitis-MOHFW-2018. Available at: https://www.inasl.org.in/diagnosis-management-viral-hepatitis.pdf

CHAPTER 2

Section Three
Standard Operating Procedures for reaching out to the Unreached HRGs operating on web-based platforms

Chapter 2.3.1 - Background

For successful virtual approaches, interventions need to provide person centric, differentiated approaches to tailor messages and services to the variety of online behaviours and population groups, and offer seamless service linkage across the entire HIV cascade. Virtual strategies can enable India's National HIV & STD Programme to reach population groups in new ways, thereby working in tandem with physical environments to advance progress towards UNAIDS' 95-95-95 goals[36]

Definitions and key terms

Virtual Populations - The virtual population includes all individuals using various social media and web-based platforms and dating platforms for engaging in sexual and other activities known to increase the risk of acquisition and transmission of HIV and STIs and are not reached by TIs and other interventions.

Virtual (Web- based) platforms also called web applications (or web apps) are software that are accessed using a web browser and use the internet for various types of communication-based services. Such platforms may be accessed through computers or smartphones. This may also include various web-pages providing such communication-based services.

Social media are interactive platforms that facilitate the creation and sharing of information, ideas, interests, and other forms of expression through virtual communities and networks. While there are various types of social medial, some common features are:

- Social media are interactive Internet-based platforms.
- User-generated content- such as text posts or comments, digital photos or audio/ videos, and data generated through all online interactions—are the main contents of social media.
- Users create service-specific profiles for the website or app that are designed and maintained by the social media organisation.
- Social media helps the development of online social networks by connecting a user's profile with those of other individuals or groups.
- Some of the more commonly used social media
- Facebook, Instagram, Twitter, YouTube and WhatsApp are some of the most commonly used social media apps.

These online social media and social networking services can be accessed from devices with internet connectivity, such as personal computers, tablets and smartphones. Users can create personal profiles and update them from time to time. Social media are usually free and users need to register.

Facebook	Instagram	Twitter	WhatsApp	Telegram Messenger
Can select user 'friends' for contacting who also have to agree to be 'friends'	Can select user 'friends' for contacting who also have to agree to be 'friends'	Registration needs a valid mobile number or email id.	Registration needs a valid mobile number- registration may be carried over to new mobile numbers-only one number- at a time	Registration needs a valid mobile number
Join common interest groups	Join common interest groups		Join common interest groups	Join common interest groups

[36]White Paper on Strategies for Engaging with HIV at-risk populations in Virtual Spaces-NACO

Facebook	Instagram	Twitter	WhatsApp	Telegram Messenger
User can post text, photos, audio, video content for sharing with all or selected users	User can post photos, video content for sharing with all or selected users	User can post photos, video content for sharing with all or selected users	User can share photos, audio, video content with all, a group or selected users	User can share photos, audio, video content with all, a group or selected users
Can respond to content posted by friends or for 'open' users- with like, love, anger etc. emojis or comments- that can use texts, pictures, videos, emojis, Graphics Interchange Format (GIF) or stickers	Can respond to content posted by friends or for 'open' users- with likes, or comments- that can use texts and emojis.	Registered users can post, like, repost, comment and quote posts, and direct message other registered users.	Users can respond to contents (messages) sent to them using emojis, text, audio, video messages.	Users can respond to contents (messages) sent to them using emojis, text, audio, video messages.
Can communicate with 'friends' one- on-one- who also agree to be contacted through text messages, audio or video calls	Can communicate with 'friends' one- on-one- who also agree to be contacted through text messages	Can communicate with other registered users one- on-one- who also agree to be contacted through text, audio, video GIF messages	Can communicate with other registered users one- on-one, or group through text, audio, video GIF messages	Can communicate with other registered users one- on-one, or group through text, audio, video GIF messages
Receive notifications on activities of 'friends' and groups they follow	Receive notifications on activities of 'friends' and groups they follow	Receive notifications on activities of other registered users and groups they follow	Receive messages from other users or groups they have subscribed to.	Receive messages from other users or groups they have subscribed to.
Can attach documents, pictures, audio, video clips for sharing with other users	Can attach documents, pictures, audio, video clips for sharing with other users	Can attach documents, pictures, audio, video clips for sharing with other users	Can attach documents, pictures, audio, video clips for sharing with other users	Can attach documents, pictures, audio, video clips for sharing with other users

Dating apps- are online dating services presented through a mobile phone application (app), often using GPS location capabilities of the devices used, always on-hand presence, easy access to digital photo galleries and mobile wallets to enhance the traditional nature of online dating. These apps aim to simplify and speed up the process of sifting through potential dating partners, chatting, flirting, and potentially meeting or becoming romantically involved over traditional online dating services. Most of them may also be accessed using a personal computer.

Some of the more popular dating apps are discussed below:

Features	Grindr	Tinder	Bumble
Target	LGBTQIA+	LGBTQIA+, SW	LGBTQIA+, SW
Location	location-based	location-based	location-based
Subscription	Free and premium	Free	Free and paid Boost and Premium

Features	Grindr	Tinder	Bumble
Profiling	Text and photo	Text, photo, list of interests	Text and photo
Special conditions		Needs a two-way match before communication can begin	Only female users can make the first contact with their matched male users; in same-sex matches, either person can send a message first.
Sharing	Text, pictures, audio, video	Text, pictures, audio, video	Text, pictures, audio, video
Calling	Can also share video messages to other profiles and video call one another	Video calls as well as sharing video, audio messages to other profiles are allowed	Built-in Video Chat and Voice Call features so that one can easily talk face-to-face without handing out their number or any other personal info before one is ready.

Objectives of the SoP to reach the unreached HRGs on Web-based platforms

The virtual intervention aims to identify and link the HRGs and other at-risk populations using virtual platforms with various HIV and STI services. The objectives of virtual intervention are:

- To reach out to HRGs and other at-risk population with various STI and HIV prevention services
- To link the HRGs and at-risk population with STI and HIV screening, treatment and rehabilitative services
- To link the HRGs and the at-risk population with requisite services like mental health, Sex Reassignment Surgery (SRS), TB, Hepatitis-B&C services

Target Population

The target population is the virtual population and includes all individuals using various social media and web-based platforms and dating platfroms for engaging in sexual and other activities known to increase risk of acquisition and transmission of HIV and STIs and have not been reached through the TI and other interventions.

Defining unreached population

The virtual population that has not been reached through TIs with services is to be considered as the unreached population.

Spa and Massage Parlour workers who are also soliciting clients using the virtual apps and are not covered by the TI should also be considered as unreached and provided services as virtual population.

HRGs who are working through network operators and using virtual apps and not reached by the TI should be considered as unreached and provided services as virtual population too. Adolescents and young adults using virtual platforms also need to be covered.

At-risk groups to be targeted include not only sex workers but also their clients, who are considered inherently at risk. Additionally, the framework emphasises reaching out to gender non-conforming individuals, substance users, and those uncertain about their identity.

Chapter 2.3.2 - Strategies & Service Delivery Packages

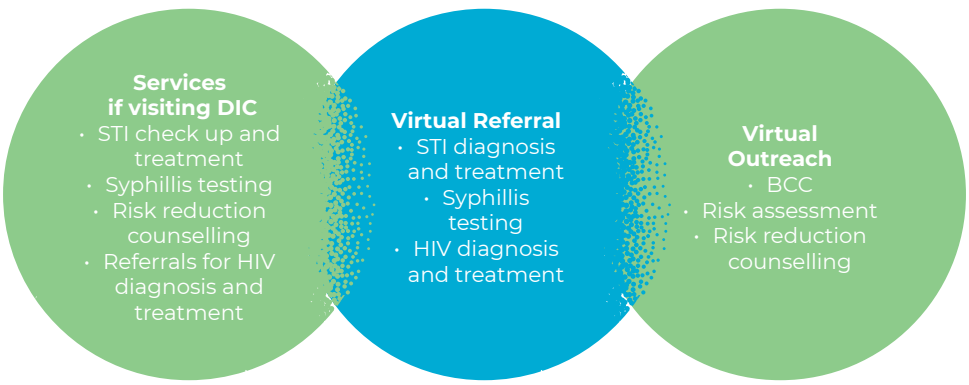
Strategies for reaching the unreached on web-based platforms

NACO recommends the following strategies in its 'White Paper on Strategies for engaging with HIV at-risk populations in Virtual Spaces'.[37]

Principle	Recommendation
Continuity across HIV cascade	Virtual strategies should ensure continuity across the entire HIV cascade, supporting linkage from awareness, to prevention/ testing, treatment, and ongoing follow-up for health-promoting behaviours. If the platform itself does not offer services across the cascade, it should integrate referrals to other platforms/resources for service continuity.
Tailored approaches	Messages and services promoted through online channels should be tailored and specific to the population group they are intending to reach. Phased targeted advertising is an approach to help reach the intended audience and retain the maximum number of viewers who are interested to take action.
Recommendation	Virtual platforms should work to promote the transition from awareness to action. Online outreach workers can be powerful motivators and tools to support client adoption of health-promoting behaviours and link clients to either online or physical health services.
Promote service linkage'	Virtual platforms should work to promote the transition from awareness to action. Online outreach workers can be powerful motivators and tools to support client adoption of health-promoting behaviours and link clients to either online or physical health services.
Community involvement	Engaging representatives from target population groups in the design, implementation, and evaluation of virtual interventions is key to optimise the acceptability and effectiveness of online HIV service approaches. Example community engagement activities include community advisory boards, interviews and focus groups, message pretesting, and engaging social media influencers.
Data monitoring and learning	Robust data capture and analysis is essential to learn from and improve virtual strategies, especially given the changing dynamics of communities and evolving technologies. Data collection and assessments should work to estimate virtual population sizes, understand trends in platform use, identify ways to improve service linkage and follow-up, and provide insights into user acceptability.
Privacy and confidentiality	Programmes should give comprehensive attention to client confidentiality, data privacy, and data security in their virtual strategies. Virtual interventions in India need to ensure the handling of data is in full compliance with the Information Technology Act of India and the HIV/AIDS Prevention and Control Act, 2017.

Comprehensive Service Package

NACO has approved a set of services as comprehensive services for STI and HIV Prevention among the HRGs. The following services can be provided to the virtual population through the TI: Figure 1:



[37]White Paper on Strategies for Engaging with HIV at-risk populations in Virtual Spaces-NACO

All identified virtual clients will be provided with virtual outreach services that will include the following:

- BCC-awareness on STI, HIV, risk practices and modes of preventing STIs and HIV
- Risk assessment-through virtual assistance, online calls/chats
- Risk reduction counselling- virtual counselling

Services if visiting DIC

All virtual clients will be provided the option of coming to the DIC run by the TI for services. Those who agree and visit the DIC will be provided with the following services:

- STI check-up and treatment
- Syphilis testing
- Risk reduction counselling
- Provision of condoms, NS, etc.
- Referrals

Virtual clients who do not want to visit the DIC can be provided with online or virtual referral.

Services through Virtual Referral

- STI diagnosis and treatment
- Syphilis testing and treatment
- HIV diagnosis and treatment
- TB, hepatitis-B&C diagnosis and treatment

In case of virtual referral, the client will be given options:

- Visit the DIC
- Seek services from government hospitals or Sampoorna Suraksha Strategy Centres (SSSC)
- Sensitised Private Health Care Providers (HCP)

They may choose the one most suiting them.

Referral directory

A referral directory should be created with the following details for the ease of referral. The document should be available digitally and also operational on smart phones. The ORWs can copy and paste the contact details with geo locations for the virtual clients.

Type of service provider (government, private)	Services provided	Geo location	Operating Days and time	Payment details (whether free or paid, charges)	Contact details: Name of the hospital/service provider/clinic, Address, Phone number,

Such directories should be updated every quarter, or whenever modification is required due to change in contact details, address or mode of service delivery so warrants.

Chapter 2.3.3 - Communication Strategy

Communication strategies

The following communication strategies are suggested for the various stages of virtual intervention:

Stages	Strategies
Awareness	• Online information, education and communication campaigns using multimedia content shared over social media sites, chat platforms, and dating platforms. These can include infographics, pictures, GIFs or videos. • Online risk assessments (whether administered online by counsellor/ ANM or assessed) • Online outreach workers or chat bots offering personal messaging to answer questions and provide information • Sharing information on comprehensive prevention services available and where to go for services • Awareness campaigns can have more robust impact through: » Consistent messages and branding » Incentive-based interactions- e.g. virtual quiz on health issues where a client may climb up through various levels of being aware » Virtual outreach counselling through chat, calls, or video chat • Information about 1097 and NACO mobile app
Service delivery Testing/ Prevention	• Outreach workers can provide online counselling to clients about prevention behaviours such as condom use, PrEP, or harm reduction strategies • Online awareness campaigns promoting testing as important prevention tool • Linking online clients to range of testing options • Offering support to find convenient testing locations (through location lists or peer-to-peer communication) • Links to online booking platforms for testing appointments • Offer to transition from online to in-person logistical or counselling support for testing process • Linkage to in-person testing services, both public and private ICTCs, FICTC • Linkage to STI testing, diagnosis, and treatment services • Linkage to PrEP, PEP, condoms, opioid substitution therapy, or syringe service programmes
Treatment	• Digital awareness campaigns to promote why early ART initiation and adherence is important to increase treatment literacy on concepts such as U=U, viral load, and CD4 counts • Online outreach workers trained to help PLHIV in identifying and overcome barriers of PLHIV to access and adhere to ART • Help for clients to access ART and other commodities conveniently from state/district/sub district/city/village level decentralized distribution sites as well. • Virtual follow-up methods (ex. phone calls, messages over SMS or social media chat application) to help/remind PLHIV to maintain ART stocks and overcome barriers to adherence. • Linkage to in-person facilities for ART initiation and long-term access – both public ART centres and private facilities, with information to understand their differences and help choose according to their conveniences
Follow-up	Who: • Online ORWs • Peers • Counsellors/ANM • Private Clinicians/doctors/ their health assistants • Chat bots How: • Internet-based messaging platforms (ex. WhatsApp) • Social media/dating application chat functions • SMS messages • Remote video communication • Automatic message reminders

Stages	Strategies
Cross-cutting	• Connect online clients to National 1097 Helpline • Offer linkage to telemedicine opportunities and remote counselling • Offer options for public providers • Chat bots/automated systems to help online users access information quickly, know where to navigate next, schedule or reschedule appointments, and offer a low-risk way to offer feedback

*The above information has been adapted from the 'White Paper on Strategies for Engaging with HIV at-risk populations in Virtual Spaces-NACO'

Process for development of SBCC Material

Social and Behavioural Change Communication (SBCC) messages will need to be developed based on the needs and stages of the intervention. Different messages will need to be developed based on the needs of the various types of audience.

Message development process will involve putting together the information that needs to be conveyed to the intended audiences for a specific behaviour change. Messages are likely to change with the audience, with different phases of the intervention and focus of behaviour change.

Well-designed messages are specific to the audiences and should clearly describe both the desired behaviour and the benefits that can be reaped by engaging in it.

There are already existing messages developed by various SACS and NACO that have also been proven to have been very effective, they can be modified to suit the need of the virtual interventions including using the media developed on channels like Youtube, Facebook, Instagram, etc. The SBCC materials developed by NACO to be also used on The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017, especially related to maintenance of confidentiality (disclosure), systems for grievance redressal mechanism, and stigma reduction.

Type of SBCC messages required for intervention among the virtual population at various stages of intervention.:

Setting/ time	Introduction	Initial phase	Motivating for risk assessment	Motivate to act on risk reduction
Content	Talk about general risk of STIs and HIV and how to prevent them	• Educate about the risk practices, • Educate about HIV and STIs • Increase the trust between the virtual population and the TI service providers • Reduce fear and stigma	• Educate about how to assess risk • Educate about reducing / managing risk	• Inform about risk-reduction behaviours • Promote risk-reduction behaviours and practices

Chapter 2.3.4 - Service Delivery Process

Step-by-step process of delivering virtual interventions

Selection of platforms and sites for reaching out.

ORWs will be conducting intensive discussions and consultations with the community members active on virtual platforms and develop a list of all the

virtual sites/platforms/apps used by the HRGs to meet their sex partners. A pre-structured format will be used to collect the information using virtual space assessment (annexure 1).

Methodology for selection of TI undertaking virtual intervention at a particular location.

The methodology for recruitment of NGOs will follow the Standard Operating Procedures (SOP) for NGOs/CBOs Selection to Implement Interventions/Projects in States/UTs under NACP 2022

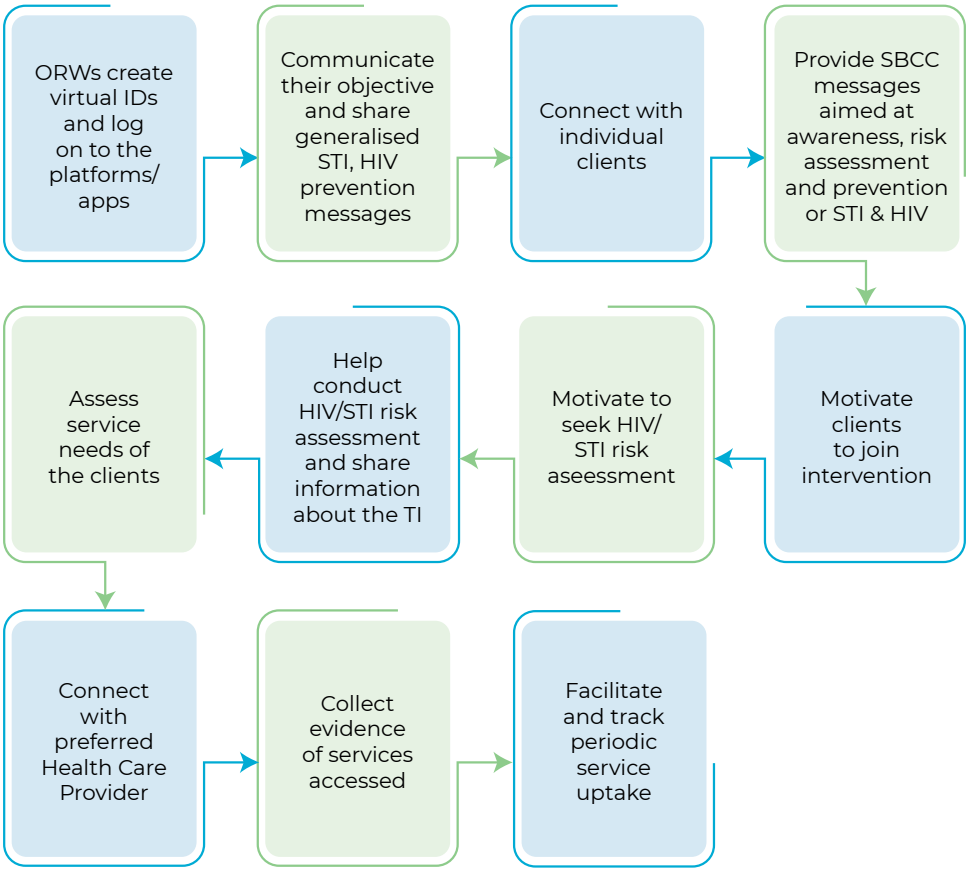
A TI will be selected for operation in virtual spaces using the following criteria:

1. A functional TI for at least 3 years (continuous)
2. Experience of: a) HIV/AIDS Project experience in carrying out Targeted Interventions/Link Worker Scheme with Core/ Vulnerable groups, Community Care Centres, Community Support Centre, Drop-In Centres (DIC) for PLHAs or any other activity as per guidance of NACO/SACS in last three financial year.
3. Experience of working in the virtual space/Network operators (will be preferred)

Chapter 2.3.5 - Virtual Outreach

The virtual ORWs will also need to be assigned for connecting with the HRGs, providing them with SBCC messages and navigating them through various services. The existing ORWs of the TIs may also be trained to take up these roles provided they are proficient with smart phone or computer-based communication.

The following steps need to be taken for effective outreach on the virtual networks:
Figure 2:



Step 1: Virtual ORWs create virtual IDs and log on to the platforms/apps
Virtual ORWs create IDs of their own on the social media and dating apps/ platforms that have been shortlisted for intervention. The choice of platforms/apps will depend on which are the ones being used by people in their geographical locality.

The ORWs will follow guidelines for ID creation for individual apps as mandated by the app admins. Check if an app needs special permission for sharing health related information. If required one should request for such permission before initiating communications with other subscribers. One may be disqualified as a member- without such permission.

Step 2: Communicate objective and share generalised STI, HIV prevention messages
Once set in an app as a subscriber with permission to share health care information, The ORWs will introduce themselves as health workers and post messages on STIs, HIV- their prevention and treatment options. They will also provide messages on the risks of using alcohol and other drugs before sex or for enhancing sexual performance/pleasures. The messages may be capsuled as brief text/audio/video/graphic based messages of short duration.

All such messages should have links/provisions for response or request for further information.

Step 3: Connect with individual clients
All subscribers who respond (responding subscribers- RS) to the generalised messages will be followed up through chats by the ORWs for individualised rapport building. The messages will be aimed at building rapport mainly by answering any questions that the subscribers may be having or providing them with further information on risk practices and STI, HIV, how they can be prevented and provisions for diagnosis and treatment that are available.

Apart from providing additional information, the communication at this stage should be aimed at building bridges of trust, by telling them about the organisation/TI and how they are connected with the NACP run by the Government of India. The ORWs should also stress on the need for maintaining confidentiality and explain the processes that are followed at personal, TI and National programme levels for maintaining confidentiality.

The ORWs, at this stage should try to connect at least once in a day with the RS to maintain the communication going.

Step 4: Provide SBCC messages aimed at awareness, risk assessment and prevention or STI & HIV
The next stage is about intensifying the SBCC messages aimed at generating further awareness on risk practices and how they may affect STI and HIV and means of preventing them. Such messages should be packaged as more personalised and individualised ones.

Step 5: Motivate clients to join HIV intervention and avail services
At this stage the ORWs should try to motivate the RS to join the HIV intervention

and avail services. The ORWs should provide options to the RS to join virtually or register at the TI personally and explain the benefits of both. The ORWs should not push the RS to choose either of the two but accept any one he/she/they prefer to choose.

In case a RS is not willing to get registered with the TI, he/she/they should not be pressurised to do so but continued with regular communication. At this stage if a RS not registered with the TI wishes to seek some STI, HIV service he/she/they should be provided with it. And the ORW will keep track of such RS separately in their diaries or notebooks.

Step 6: Generate Unique ID when they join

Upon registering with the TI- whether as virtual client or as a direct client they should receive a Unique Id. While the clients registering personally will get their Unique Id as per the TIs system, those registering online/virtually should have a separate pre-fix- 'VR' or a unique 'numeric code' that helps track them out during various MIS processes.

Step 7: Motivate to seek HIV risk assessment

At this stage the ORWs, start motivating the clients to get their personal HIV risk assessment conducted. The ORWs should stress on the importance of risk assessment for HIV. The ORWs should explain how necessary it is to understand the practices that can put one at risk of STIs and HIV. The ORWs should also explain how seeking early diagnosis and treatment can help in better health.

Step 8: Conduct HIV risk assessment and share information about the TI/ other NACP facilities

While it is best to conduct the risk assessment at the TI DIC, it may also be conducted at any other physical space that the client finds suitable. In case the client is not comfortable the assessment can be done virtually over a audio/video call or text chats. The risk and vulnerability assessment can be conducted using the- Risk assessment tool (Annexure 2).

It is better to share a copy of the questionnaire with the client before conducting the assessment so that he/she/they can follow the queries- ponder over them and answer.

Step 9: Assess HIV/STI related service needs of the clients

If the client fulfils any of the following criteria, then the client is in need for HIV/ STI services.

- Having sex without a condom
- Sex with more than one partner or group
- Had chemical stimulant for 'high fun' se
- Shared needle for injecting drugs
- Having a sexually transmitted infection
- Consumed alcohol before sex
- Had sex in exchange of goods or money

The ORWs should also ascertain, if the client has received any of the following services within the last one month.

- STI screening
- Testing for Syphilis
- HIV testing

If the client, self- declares/reports that he/she/they is HIV sero-positive, then the ORW should try to find out whether he/she/they is on ART.

Step 10: Connect with services required by the client.

Based on the findings from the risk assessment, the ORWs will inform the client about his/her/their service needs and also offer the options to the clients for their preferred mode of service delivery which may be provided from:

- The TI (if the clients are willing to come to the DICs)
- Government hospitals and Sampoorna Suraksha Kendra (SSK)
- DSRC for STI/RTI services
- ART centre (if sero-reactive/positive HIV)
- The sensitised private health care providers

Contact details and GPS location (if possible), for various services, as per requirement, should be provided to clients who seek services from private sector providers. The ORWs should be able to provide such links through online chats and other messages for the referral directory that is developed and maintained.

Step 11: Connect with preferred Health Care Provider

He/she/they is then connected through e-referral/referral with their preferred type of service providers for the various HIV related services.

- Regular medical check-up for STI and Syphilis and syndromic treatment, if needed.
- Counselling for safer sexual practices and or drug use
- Screening Services: regular HIV screening/testing services to HRGs
- TB Screening and treatment
- Screening for Hepatitis-B, C
- ART for PLHAs
- Treatment for drug use related problems
- Opioid Substitution Therapy (OST) for people who inject drugs for reasons other than medical
- Social Protection and Legal Support

Step 12: Procure evidence of services accessed

The ORWs should follow up with the clients for signed referral/e-referral slips and request them to send by WhatsApp/other web-based platforms to the ORW for record and follow-up

Step 13: Facilitate and track periodic service uptake

Based on the services accessed and their results the ORWs will be following up for adherence as required. He/she/they will also facilitate the service delivery, in case the client faces problems in accessing any.

Chapter 2.3.6 - Ethical consideration

Internet-based systems collect a generous amount of information from

people who use them. Programmes and interventions therefore need to give comprehensive attention to data privacy and data security in virtual strategies. Programmes should be open to clients as much as possible about what personal information is being gathered by the TI when engaging with online interventions and how it will be used, offering clients the chance to opt-out.

Programmes should also ensure that virtual platforms they use protect against vulnerabilities for unauthorised access and use of information being collected from clients. It is the responsibility of programmes to use data secure systems at all stages of the intervention, from data collection, transfer, and storage.

Virtual interventions in India need to ensure the handling of data is in full compliance with the Information Technology Act of India and the HIV and AIDS Prevention and Control Act, 2017.

Programs should establish standard operating procedures outlining how strategies and staff will remain in compliance and maintain the privacy of clients.

With the sensitive nature of HIV-related behaviours, programmes should consider how to ensure the confidentiality of clients engaging with virtual strategies. Programmes should build in ways to ensure confidentiality to any extent possible, working to protect identities and ensure that client information shared online will remain confidential.

Online outreach workers should be trained on client confidentiality, emphasising the sensitivity of their role given HIV-related stigma and discrimination which clients may experience. For people practising risky behaviours or PLHIV, willingness to participate in an online intervention may depend on their perception of privacy protections and level of precautions to maintain confidentiality. Informed consent procedures for virtual approaches should include clear explanation of confidentiality protections[38].

Chapter 2.3.7 - Sustainability and Scaling-up of Virtual Interventions

Since these virtual interventions will be conducted by the Tis who are designated by the SACS, they will be under the NACP and will be funded by the programme. The sustainability and scaling up will be in accordance with evidence informed decisions made by the programme.

[38]White Paper on Strategies for Engaging with HIV at-risk populations in Virtual Spaces-NACO

CHAPTER 3

Maintaining confidentiality

The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 outlines the obligation of establishments in protection of data related to HIV and AIDS. This data also includes HIV status related information about individuals and their family members. The Act also clearly states that-

- no person shall disclose or be compelled to disclose the **(not only the)** HIV status or **(but also)** any other private information **(related to sex, sexuality, sex partners, drug use practices)** of other person imparted in confidence or in a relationship of a fiduciary nature, except with the informed consent of that other person or a representative of such another person obtained in the manner as specified in section 5 **(INFORMED CONSENT)**, as the case may be, and the fact of such consent has been recorded in writing by the person making such disclosure:

Information about HIV status can only be communicated to the patient and treating healthcare workers, and otherwise is kept strictly confidential. It is not disclosed to a patient's family except with the explicit informed consent of the patient and fulfilment of four prerequisites as mentioned under the HIV and AIDS (Prevention and Control) Act, 2017.

A healthcare provider, who is a physician or counsellor, may disclose the HIV positive status of a person under his direct care to his or her partner, if such healthcare provider—

a. reasonably believes that the partner is at the significant risk of transmission of HIV from such person; and
b. such HIV positive person has been counselled to inform such partner; and
c. is satisfied that the HIV positive person will not inform such partner; and
d. has informed the HIV positive person of the intention to disclose the HIV positive status to such partner:
e. Provided that disclosure under this subsection to the partner shall be made in person after counselling:
f. Provided further that such healthcare provider shall have no obligation to identify or locate the partner of an HIV positive person:
g. Provided also that such healthcare provider shall not inform the partner of a woman where there is a reasonable apprehension that such information may result in violence, abandonment or actions which may have a severe negative effect on the physical or mental health or safety of such woman, her children, her relatives or someone who is close to her.

Thus, maintaining confidentiality is of prime importance in STI, HIV Interventions.

Chapter 3.1 - Maintaining confidentiality while working among SMP workers

All information regarding SMPs contacted and brought under intervention will remain confidential- with only the concerned PEs, ORWs and PMs having access to the details- including contacting information.

ORWs and PEs working in their teams should maintain confidentiality about the HRGs they meet and should limit the flow of private information regarding-

sexual orientation, sexual preference and types of sex acts practised, drugs used etc., confidentially shared with them. All diaries and notes and data collected should be kept under lock and key with limited access to the personnel -who need to know any information.

All health reports (HIV, STI,TB etc.) shall be similarly maintained under lock and key and only shared with people concerned.

Chapter 3.2 - Maintaining confidentiality while working with HRGs through Network Operators

All information regarding NWOs contacted and brought under intervention will remain confidential- with only the concerned PEs, ORWs and PMs having access to the details- including contacting information.

ORWs and PEs and the other personnel will keep information related to NWOs as well as the HRGs confidential.

Chapter 3.3 - Maintaining confidentiality on virtual platforms

The ORWs for the virtual platforms should maintain a ring of confidentiality among themselves and abide by it strictly. ORWs can be sharing among themselves the details about the virtual clients they have met online and are following or in communication with so that there is no overlapping by the other ORWs. The online ORWs should be meeting once every week and sharing the online ids (names used on virtual platforms) of the virtual clients they are communicating with. Once communicated- the virtual client will be registered with the said ORW and the other ORWs should not be contacting the same client.

The online ORW registered with a given virtual client will maintain all communications as confidential and not share them with the other online ORWs or with any other personnel. Sharing of such information is also a breach of confidentiality. However, screenshots or chat records may be maintained for the purpose of documentation, monitoring or capacity building. But care should be taken to hide the names/ids (virtual or otherwise) before sharing with others or for keeping records.

No health reports (STI, HIV etc.), if shared by the virtual clients, shall be shared with other ORWs. However, for the need of treatment and continued services such reports may be shared with the doctors and other medical service providers as required while maintaining the chain of confidentiality.

CHAPTER 4

Partnerships and collaboration

It is necessary to engage with the community at various levels and key stakeholders for sustainable interventions. The steps of engagement will involve advocacy and partnership.

Chapter 4.1 - SMP Operators/Managers

The SMP Operators/Managers often act as the gatekeepers, thus it is crucial to partner with them and involve them in the intervention process. Engagement with them is often the entry point for interventions among SMP workers.

The Program manager along with ORWs and PEs should meet the SMP operators and explain the importance of facilitating STI/HIV prevention treatment and care services for the SMP workers. The process may involve multiple meetings wherein the TI staff visit the establishments on a regular basis and develop rapport with the SMP operators through active listening, trust building, providing information about the TI programs, STI/HIV, high risk practices.

During these meetings the TI staff shall also stress on their code of maintaining confidentiality about the SMP operations and the workers associated with them. They will also share about the benefits of accessing the Government's HIV/AIDS program services and schemes.

With consistent interactions and assurance on the beneficial aspects of the programme, the SMP operators in due course confirm the practice of sex work and other high-risk activities in their establishments.

Once rapport is developed the ORWs can collect detailed information about the SMPs using the profile of spa/massage parlour form along with the nature of their operations, and details of HRGs associated with them.

Meetings with the SMP Managers/owner should be held once or twice in a year to assess how the HIV interventions were going and listen and address any concerns or feedback. Through a reward and recognition program, SMP Managers who have been most productive and receptive should be provided an in-kind gift as appreciation.

Chapter 4.2 - Network Operators

Network operators[39] (NWOs) play a crucial role in soliciting or facilitating connections between high-risk groups (HRGs) and their clients or sexual/injecting partners. They provide valuable support, including establishing secure long-term partnerships, ensuring confidentiality, assisting new HRGs in finding clients, and offering protection in challenging situations. The Identification of network operators involves specific steps, and state-wise data reveals the distribution of network operators across different typologies.

The TI team led by the ORWs and supported by the PM shall initiate the interactions with the Network Operators. During these meetings the PM shall talk about STI, HIV, the practices that put one at risk and modes of prevention, treatment, and care. The PM should also discuss maintaining confidentiality about the NWOs as well as the HRGs engaged through them.

[39] **Network operators** (NWO) are individuals from HRG communities or not from these communities but who are involved in facilitating sexual services to clients for FSW, or MSM who are facilitating socialization, information exchange and partner seeking for other males through their networks or IDUs who may or may not be practicing but who are facilitating the participation of other IDU for exchanging information related to drug use, through their networks.

Meetings with the NWOs should be held once or twice in a year to assess how the HIV interventions were going and listen and address any concerns or feedback. Through a reward and recognition program, NWOs who have been most productive and receptive should be provided an in-kind gift as appreciation.

Chapter 4.3 - Virtual platforms and Web-based Applications

While communication with clients at the web-based platforms are often virtual- it will be necessary to involve some of the HRGs in the physical domain to short list the apps and platforms that are being frequently used by their peers.

The PM supported by the ORWs need to organise a meeting with the HRGs they are in contact with physically. During the meeting the PM will explain the importance of the exercise and request them to give the names of the apps, web-based platforms that they use/frequent for soliciting, connecting with sex partners.

Once the ORWs have created their ids in the selected platforms- the HRGs (in physical contact) can be requested to help disseminate the messages initiated by the ORWs.

Chapter 4.4 - Community Engagement

Community engagement plays a vital role in implementing targeted interventions for SMP workers, through network operators (NWOs) coordinating with SWs, MSM, Hijra/TG and IDUs and also for web-based platforms. By actively involving the community, the interventions can be catered to the specific needs, challenges, and cultural context of the HRGs and NWOs. Here are some aspects of community engagement in this process:

- **Stakeholder identification:** Identifying and involving relevant stakeholders is essential. This includes representatives from the SWs, MSM, Hijra/TG and IDUs community, NWOs, community-based organisations, local leaders, health service providers, law enforcement agencies, and other key community members. Their diverse perspectives and expertise can contribute to quality mapping and designing effective interventions.
- **Participatory approach:** Adopting a participatory approach ensures that the community is actively involved in decision-making and implementation. This includes engaging community members in program planning, designing outreach strategies, and setting priorities. Their input can provide valuable insights into local dynamics, preferences, and barriers to accessing services.
- **Community mobilisation:** Mobilising the community creates a sense of ownership and empowerment, fostering a supportive environment for intervention implementation. This can involve organising community meetings, awareness campaigns, and workshops to disseminate information about HIV prevention, services, and the role of NWOs. Peer educators and community leaders can play a crucial role in mobilising and engaging community members.
- **Culturally sensitive approaches:** Considering the cultural context and social norms is essential for effective engagement. Sensitivity to cultural practices, beliefs, and taboos helps build trust and acceptance among community members. Cultural mediators or respected community leaders can facilitate communication and bridge gaps between interventions and local customs.

- **Training and capacity building:** Community engagement includes capacity building initiatives for various stakeholders. Providing training to NWOs, peer educators, and community volunteers enhances their knowledge and skills related to HIV prevention, safe sex practices, condom use, and stigma reduction. This empowers them to effectively engage with HRGs and NWOs and deliver appropriate services.
- **Peer support and networks:** Encouraging the formation of peer support networks among HRGs and NWOs can create a platform for sharing experiences, challenges, and best practices. Peer-led activities, support groups, and mentoring programs can strengthen the community's ability to address HIV-related issues and provide mutual support

Chapter 4.5 - Advocacy

The PM shall take lead in advocacy efforts of the TI. The PM supported by the ORWs and counsellors will conduct a stakeholder analysis to understand the various levels of stakeholders who can positively as well as negatively affect the SMP interventions.

This will be followed by media analysis to understand the type of media used by the various stakeholders identified and their reach and effectiveness. They will also need to identify change agents who can motivate the desired change among a group of stakeholders and can carry the various messages to the targeted audience. the development of advocacy messages will be the next step, as the messages will be prepared for each target group separately as per the medium to be used.

Advocate with local police and other law enforcement agencies. The topics to be discussed:

- Need for STI, HIV prevention among SMP workers, HRGs reached through NWOs and Web Based Platforms and their implication on health of the general community.
- Engagement of law enforcement can support the SMP and NWO interventions.

Advocacy with local political and community leaders, youth leaders and faith-based organisations. Topics to be discussed:

- Need for STI, HIV prevention among SMP workers, HRGs reached through NWOs and at Web based platforms and their implication on health of the general community.
- How can the local community leaders, youth leaders and faith-based organisations support the SMP and NWO interventions

Advocacy with SMP operators. Topics to be discussed:

- How STI, HIV intervention can make a SMP a safer place for workers, and management too.

Advocacy with the NWOs. Topics to be discussed

- How STI, HIV, can affect the HRGs engaged with the NWOs, the practices that put them at risk and how transmission of STIs and HIV be prevented. What options are available with the TIs for prevention, treatment, and care of STIs and HIV. How confidentiality of the NWOs and the HRGs shall be maintained.

Chapter 4.6 - Engaging with Government facilities

Many services cannot be provided from the TI window and need to be accessed from the government facilities e.g. ICTC, ART etc. It is necessary to build rapport with the personnel at such centres to help in smooth and service delivery and easy accessibility. The PM will need to take lead- supported by SACS for the following advocacy to be conducted:

- With government hospitals and other service providers to arrange special service slots/windows for virtual clients:
  - Schedule time slots for clients to access services without in long queues
  - Need for being sensitive to the virtual clients
  - Providing services through e-referral/ tele-counselling
  - Providing online reports
  - Providing continued services based on diagnostic reports received

- Sensitising private health care providers and their associations etc. for providing services to those referred from the TI or approaching personally:
  - Need for being sensitive to the virtual clients
  - Respecting the HRGs and not stigmatising them
  - Need for using language sensitive to the HRGs
  - Providing services through e-referral
  - Providing online reports and documenting them
  - Providing continued services based on diagnostic reports received

CHAPTER 5

Roles and Responsibilities

Chapter 5.1 - Roles and Responsibility of NACO, SACS and DISHA/DAPCU

NACO's role in the intervention would be two- fold (a): to provide overall guidance on policy and planning and (b): facilitate smooth implementation by addressing administrative and financial bottlenecks. Specific responsibilities include:

- Provide policy level support and enabling environment in the implementation of the program, through Liaoning with various other line ministries/departments and facilitating their cooperation in implementing the project on the ground.
- Coordination with SACS and Technical Resource Group (TRG) to ensure adequate technical support to the program as well as ensure quality implementation across.
- Conducting regular review meetings at the national level to assess performance of the project on the ground.
- Provide support for SBCC package specific to the needs of the unreached HRGs

SACS will be responsible for overall coordination and implementation of the intervention within the state. Following are the key responsibilities of SACS:

- To guide the DISHA/DAPCU and TIs on the implementation of the program including defining geographies, implementation modalities, etc.
- Ensure provision of SBCC materials tailored to the HRGs and their needs
- Ensure provision of commodities under the program.
- Facilitate coordination of district functionaries (ICTC, TI, CCC etc.) with implementing NGOs/CBOs
- Conducting regular monitoring meetings with implementing NGOs/CBOs
- Regular field level monitoring visits
- Coordination with Kshmta Kendra for training to implementing NGOs/CBOs
- Coordination with DISHA/DAPCU to provide hand holding support to the implementing NGOs/CBOs.
- Ensure timely reporting, documentation and analysis of the data generated from the field.
- Liaison and advocacy with various line departments for mainstreaming of HIV to ensure easy access to HIV services.
- Facilitate coordination between other prevention interventions within the state.

DISHA and DAPCU play a vital role in providing monitoring and technical assistance to NGOs/CBOs implementing the intervention. Some of the responsibilities include:

- Conducting regular visits to NGO/CBOs sites,
- Offering technical support to intervention staff during field visits,
- Serving as resource persons during staff training,
- Providing daily guidance and oversight of TIs.

Chapter 5.2 - Roles and responsibility of the TI Staff

(Expanded Roles and Responsibilities of the TI Staff implementing SMP, NWO and Virtual intervention)

The roles and responsibilities of TI staff engaging in the above-mentioned interventions are as below:

Project Director

S. No	SMP	NWOs	Virtual Interventions
1	Take lead in initiating the networking with SMP Managers/operators	Take lead in initiating the networking with network operators	Take lead in initiating the networking for mapping of HRGs on web-based platforms
2	Support in conducting advocacy and sensitising SMPs on the need for working together with the TIs and motivating the SMP service providers (SWs, MSMS, Hijra/TGs) to seek STI and HIV services	Support in conducting advocacy and sensitising NWOs on the need for working together with the TIs and motivating the NWOs and HRGs (SWs, MSMS, Hijra/TGs) to seek STI and HIV services	Support in conducting advocacy and sensitising with stakeholders and community to seek STI and HIV services
3	Supervise and monitor the programme and the team		
4	Overall planning and management of the intervention.		

Program Manager

S. No	SMP	NWOs	Virtual Interventions
1	Take lead in initiating the networking with SMP operators	Take lead in initiating the networking with NWOs	Conduct advocacy and sensitise various stakeholders on the need for working on the virtual spaces and linking them to the TIs
2	Conduct advocacy and sensitise SMPs on the need for working together with the TIs and motivating them to join the intervention	Conduct advocacy and sensitise NWOs and HRGs in their network on the need for working together with the TIs and motivating them to join the intervention	Prepare the typology wise line listing of the Virtual HRGs in their allotted geographical area.
3	Orient the team on the mapping & risk profiling tool for the SMPs	Orient the team on the mapping & risk profiling tool for the NWOs and HRGs in their network	Orient the team on the mapping & risk profiling tool for the Virtual Population
4	Identification of the SMPs for the intervention based on the mapping exercise	Identification of the NWOs for the intervention based on the mapping exercise	Sensitisation of the private health care providers
5	Prepare the typology wise line listing of the SMPs in their allotted geographical area.	Prepare the typology wise line listing of the NWOs in their allotted geographical area	
6	Assess the capacity building requirements of project staff and communicate the same with DISHA/DAPCU and SACS.		
7	Supervise and monitor the programme and the team		
8	Analyse the progress of the project activities.		
9	Maintain liaison with the DISHA/DAPCU and SACS on behalf of the organization		
10	Overall management of the intervention.		

Monitoring & Evaluation Assistant cum

a. Accessing and collating data as per the MIS systems provided including SOCH based reporting.
b. Informing PM and ORWs on targets and achievements
c. Maintaining accounts

Counsellor

S. No	SMP and NWOs	Virtual Intervention
1	Conducting risk assessment	Provide online chat-based information of STI, HIV- their diagnosis and treatment
2	Providing counselling for risk reduction including condom education	Conducting risk assessment online or telephonically
3	Motivating for seeking STI and HIV prevention, treatment and care services	Provide over the phone (call) information and motivate clients for seeking services
4	Providing counselling for HIV and STI screening, testing, treatment and follow up	
5	Providing HRGs with condoms and lubes as per demand	

Auxiliary Nursing and Midwifery

S. No	SMP and NWOs	Virtual Intervention
1	Conducting risk assessment	Provide online chat-based information of STI, HIV- their diagnosis and treatment
2	Providing counselling for risk reduction including condom education	Provide over the phone (call) information and motivate clients for seeking services
3	Motivating for seeking STI and HIV prevention, treatment and care services	Conducting risk assessment online or telephonically
4	Providing medicine as prescribed by the TI doctor	
5	Motivating for seeking STI and HIV prevention, treatment and care services	
6	Providing counselling for HIV and STI screening, testing, treatment and follow up	

Outreach Worker

S. No	SMP and NWOs	Virtual Intervention
1	Supporting PM in mapping exercise to the SMPs and their workers, the NWOs and HRGs in their network	Supporting PM in mapping exercise of HRGs in their allocated areas
2	Supporting PM in reaching out to the SMPs and their workers, and NWOs and HRGs in their network	Create Ids on selected virtual platforms for virtual interventions
3	Supporting PM in developing the line listing of the SMP workers, NWOs and HRGs in their network as per their vHRG category	Identify virtual population at risk of STIs and HIV using virtual platforms
4	Conducting risk assessment with identified HRGs	Communicate with the virtual population using smart phones/ computers as necessary in the given setting about problems of STIs and HIV and means of preventing them

S. No	SMP and NWOs	Virtual Intervention
5	Motivating the identified HRGs to seek risk reduction counselling	Motivate virtual population to seek risk assessment and related services for diagnosis and treatment of STI and HIV
6	Assessing risk reduction commodity demands of the HRGs	
7	Motivating HRGs to use condoms through demonstration of correct condom use	Supporting PM in developing the line listing of the HRG category on web-based platforms.
8	Providing HRGs with condoms and lubes as per demand	
9	Providing SBCC messages to the SMP workers, NWOs and HRGs in their network and HRGs identified on web-based platforms	
10	Maintaining field records	

Peer Educators

S. No	SMP/ NWOs/ Virtual Intervention
1	Reaching out to the SMP workers, the NWOs and HRGs in their network with SBCC and risk reduction messages
2	Supporting ORW in collecting information for line listing of the HRGs
3	Delivering condoms and other deliverables as per the needs of the HRGs
4	Reporting field activities to the ORWs for field records

Current TOR of the TI Staff is as per the National AIDS and STD Control Programme.

CHAPTER 6

Training and Capacity Building

As these interventions are an extension to the existing TI interventions to cover the uncovered target population, the approach and strategy for reaching out to this target population will be little different. HRGs at SMP are neither a brothel base nor floating or street sex workers, NWOs and the HRGs in their networks who do not operate through the traditional spaces or modalities and HRGs operating on web-based platforms. Hence, to reach out to the HRGs at this new type of locations i.e. SMPs, virtual platforms and through NWOs, this intervention will help the staff to reach out to them and include them in the program.

Capacity building of the TI staff is very crucial for the intervention. All TI staff should receive orientation on SMP intervention, NWOs and virtual intervention, whether newly recruited or pre-existing with the TI.

The staff will be trained on the following components:

<table>
<tr><th>SMP and NWOs</th><th>Web Based Platforms</th></tr>
<tr><td colspan="2">Orientation on SoP for intervention with SMP workers, HRGs through NWOs and on web-based platforms</td></tr>
<tr><td colspan="2">Orientation on sexuality and gender and the dynamics of sex work among SWs, MSMS and Hijra/TGs including SMP workers, NWOs and on web-based platforms</td></tr>
<tr><td colspan="2">Orientation on alcohol and other drug use and their effect on sexual risk and HIV/STI</td></tr>
<tr><td colspan="2">Skills on communicating SBCC messages to the HRGs, including identification of local influencers, use of SACS/NACO online portals and messages developed.</td></tr>
<tr><td rowspan="3">• Hands on practice for learning to use the following:
• Situation assessment tools
• Risk assessment
• Sensitisation of the SMP owners/ operators and NWOs
• Demand analysis for comprehensive services and commodities
• Outreach planning tools for SMP interventions
• MIS Tool</td><td>Skills on active communication on the virtual spaces</td></tr>
<tr><td>Conducting situation assessment through virtual platforms</td></tr>
<tr><td>Outreaching through Virtual platforms</td></tr>
<tr><td>Orientation on microplanning (outreach planning, condom, and lubricant demand calculation)</td><td>Communicating with the virtual clients for generating awareness on HIV/STI -their prevention, diagnosis and treatment services</td></tr>
<tr><td>Orientation on outreaching among SMP workers, NWOs and the HRGs in their networks</td><td>Motivating the virtual clients for generating awareness on HIV/STI -their prevention, diagnosis and treatment services</td></tr>
<tr><td>Information about the range of referral services</td><td>Following up with virtual clients for continued risk reduction services</td></tr>
<tr><td>Basics on how to ensure safety for self and clients when carrying out outreach operations among SMPs</td><td>Ensuring safety for self and clients when carrying out outreach operations on the virtual platforms</td></tr>
<tr><td colspan="2">Stigma and discrimination of HRGs and those affected by STIs, HIV and means and modes of minimising them including on the HIV/AIDS Act 2017.</td></tr>
</table>

Such training should be provided at the initiation of the intervention and whenever new staff joins the programme. Refresher training should also be provided to the staff once a year or whenever there is a major change in the intervention guidelines.

Specific to SMP owners/operators/managers: Once the SMPs are identified, the owners/operators/managers should also be engaged to undergo brief orientation & to participate in the capacity building workshops. They should also be provided such trainings at the initiation of the intervention and whenever new SMP or SMP administrative staff joins the interventions

Specific to interventions for reaching out to HRGs on web-based platforms, there is also a need to include capacity building training for Private Health Care Providers. The following components should be included in training of the Private Health Care Providers:

- Being sensitive to the virtual clients
- Respecting the HRGs and not stigmatising and discriminating against them
- Need for using HRGs sensitive language and terminologies
- Providing services through e-referral and documenting them
- Providing online reports and documenting them
- Providing continued services based on diagnostic reports received
- Maintaining confidentiality

CHAPTER 7

Reporting & Documentation

Reporting is crucial for successful implementation of interventions for reaching out to HRGs in SMPs, through NWOs and on web-based platforms.

Multiple tools have been developed and approved by NACO, to record and monitor all the steps of the approach:

SMP intervention:

- Profile of spa/massage parlour (SMP) records information about the SMPs participating in the intervention
- Spot analysis records the details about the HRGs in a given spot
- Contact mapping provides details about contacts PEs and ORWs have with the HRGs
- Risk assessment form is used to assess the levels of risk practices in HRGs
- Outreach sheet captures information on regular outreach done with SMPs by the TI staff to collect information on the SWs, MSMs and Hijra/TGs associated with them and plan for service delivery.
- Individual SWs, MSMs and Hijra/TGs tracking sheets capture information on SMP workers being reached out by TI staff on a regular basis and the service uptake.
- Condom outlet sheet traces the availability and supply management of commodities and ensures uninterrupted supply to SMP workers as per their requirement mentioned.
- Lead tracker highlights SMP workers in a specific geographical area. The sheets track the quality of member enrolment/network mapping approach followed by the implementing agency.

MIS formats to be filled up as per the following time periods:

Time period	Form name	Staff mainly responsible	Annexure
At the initiation of the intervention and once in every six months (May need to be conducted in case of significant changes in the SMPs)	Profile of spa/massage parlour (SMP)	ORW/PE	Annexure 1
	Spot analysis	ORW/PE	Annexure 2
	Contact mapping	ORW/PE	Annexure 3
	Quarterly risk and vulnerability assessment	PE/ORW	https://naco.gov.in/sites/default/files/TI_Management%20Information%20System%20Tool%20(Full).pdf
During regular intervention (quarterly)	Quarterly Individual HRGs Tracking cum Risk Assessment Tool	ORW	
	Monthly Individual SMP (outreach) Tracking sheet	ORW	Annexure 4
During regular intervention (monthly)	Monthly Condom outlet sheet (filled in by ORW)	ORW	https://naco.gov.in/sites/default/files/TI_Management%20Information%20System%20Tool%20(Full).pdf
	Lead Tracker for SMP operators	ORW/PE	Annexure 5
	Lead Tracker for HRGs working at the SMPs (SMP workers)	PE/ORW	Annexure 6

[40]Developed by DSACS and DL TSU

Through NWOs:

- NWO Outreach sheet captures information on regular outreach done with NWOs by the TI staff to collect information on the SWs, MSMs, Hijra/TGs and IDU associated with them and plan for service delivery.
- Individual SWs, MSMs and Hijra/TGs tracking sheets capture information on NWO beneficiaries being reached out by TI staff on a regular basis and the service uptake.
- Condom outlet sheet traces the availability and supply management of commodities and ensures uninterrupted supply to NWOs and SWs.
- Lead tracker highlights the duplication of NWOs as well as the SWs, MSMs and Hijra/TGs in a specific geographical area. The sheets track the quality of member enrolment/network mapping approach followed by the implementing agency.

MIS formats to be filled up as per the following time periods:

Time period	Form name	Staff mainly responsible	Annexure
At the initiation of the intervention and once in every six months (may need to be conducted in case of significant changes in the SMPs)	Profile Network Operators	ORW/PE	Annexure 7
	Network profile analysis	ORW/PE	Annexure 8
	Contact mapping	ORW/PE	Annexure 9
	Quarterly risk and vulnerability assessment	PE/ORW	https://naco.gov.in/sites/default/files/TI_Management%20Information%20System%20Tool%20(Full).pdf
During regular intervention (quarterly)	Quarterly Individual HRGs Tracking cum Risk Assessment Tool	ORW	
During regular intervention (monthly)	Monthly Individual NWOs (outreach) Tracking sheet	ORW	Annexure 4
	Monthly Condom outlet sheet (filled in by ORW)	ORW	https://naco.gov.in/sites/default/files/TI_Management%20Information%20System%20Tool%20(Full).pdf
	Lead Tracker for NWOs	ORW/PE	Annexure 10
	Lead Tracker for HRGs through NWOs	PE/ORW	Annexure 11

Virtual platforms:

- Virtual space assessment captures information about the various virtual platforms included in the intervention and the number of HRGs involved
- Line listing of the virtual HRGs captures demographic and high-risk practices related practices of the enlisted HRGs-this is to be updated quarterly by the ORWs
- Lead Tracker for HRGs on virtual space captures information on contacts with the HRGs
- Risk assessment form is used to assess the levels of risk practices in HRGs

MIS formats to be filled up as per the following time periods:

Time period	Form name	Staff mainly responsible	Annexure
At the initiation of the intervention and once in every six months (may need to be conducted in case of significant changes in the SMPs)	Virtual space assessment	ORW	Annexure 12
	Line listing of the virtual HRGs	ORW	Annexure 13
	Risk assessment	Counsellor/ ANM/ORW	Annexure 14
During regular intervention (quarterly)	Quarterly Individual HRGs Tracking cum Risk Assessment Tool	ORW	https://naco.gov.in/sites/default/files/TI_Management%20Information%20System%20Tool%20(Full).pdf
During regular intervention (monthly)	Monthly Individual (outreach) Tracking sheet	ORW	
	Lead Tracker for virtual HRGs	PE/ORW	Annexure 15

CHAPTER 8

Monitoring Indicators

Chapter 8.1 - The Monitoring Indicators: SMP

No. of SMPs operating in the jurisdiction of the TI
No. of HRGs (by type) under each SMP
No. of SMPs contacted for intervention
No. of HRGs (by type) under each of these NWO
No. of SMPs participating in the intervention
No. of HRGs (by type) under each SMP participating
No. of HRGs (by type):

- Reached with SBCC
- Undergone risk assessment
- Line listed for intervention-with service needs assessed
- Services provided:
  - STI screening
  - Risk reduction counselling
  - Syphilis testing
  - HIV testing
  - No. of PLHIVs among them registered for ART
  - Commodity distribution
- Follow up:

No. of HRGs (by type) with services due in the upcoming month/quarter:

- STI screening
- Risk assessment update
- Syphilis testing
- HIV testing
- No. of PLHIVs among them registered for ART

Chapter 8.2 - The Monitoring Indicators: Through Network Operators

No. of NWOs operating in the jurisdiction of the TI
No. of HRGs (by type) under each NWO
No. of NWOs contacted for intervention
No. of HRGs (by type) under each of these NWO
No. of NWOs participating in the intervention
No. of HRGs (by type) under each NWO participating
No. of HRGs (by type) :

- Reached with SBCC
- Undergone risk assessment
- Line listed for intervention-with service needs assessed
- Services provided:
  - STI screening
  - Risk reduction counselling
  - Syphilis testing
  - HIV testing
  - No. of PLHIVs among them registered for ART
  - Commodity distribution
- Follow up:

No. of HRGs (by type) with services due in the upcoming month/quarter:

- STI screening
- Risk assessment update
- Syphilis testing

- HIV testing
- No. of PLHIVs among them registered for ART

Chapter 8.3 - The Monitoring Indicators: On web-based platforms

No. of virtual clients (by HRG type) contacted for intervention
No. of virtual clients (by type) responded to initial/introductory messages
No. of virtual clients in regular contact (at least once a week)
No. of virtual clients (by HRG type):

- Communicated with SBCC
- Undergone risk assessment
- Line listed for intervention-with service needs assessed
- Services provided (through DIC, Government hospitals, sensitised private practitioners and proof of services accessed provided to the ORW) :
  - STI screening
  - Risk reduction counselling
  - Syphilis testing
  - HIV testing
  - No. of PLHIVs among them registered for ART
  - Commodity distribution
- Follow up:

No. of HRGs (by type) with services due in the upcoming month/quarter:

- STI screening
- Risk assessment update
- Syphilis testing
- HIV testing
- No. of PLHIVs among them registered for ART

Annexures

Annexure 1 - Profiling Form

PROFILE OF SPA/MASSAGE PARLOUR NOTE: This form is confidential and should be kept at the NGO office. Information to be filled up after identifying the SMPs for the intervention and rapport has been established. (this is per SPA operation)			
Section A: Identification of Spa & Massage Parlours			
1. Name of the Spa/Massage Parlour:			
2. Address of the Spa/Massage Parlour			
Landmark:			
District:			
PIN Code:			
Contact number/s:			
Email-ID, if given:			
Website, if any:			
3. a. Name of the Manager/ Operator			
3.b. Contact number of Manager/Operator:			
4. a. Year of operationalization of the Spa/Massage Parlour?			
4. b Whether this is a new SMP established or have been shifted from some other location or taken over. If shifted, details of the same:			
b. i Previous Location			
b.ii. Year of establishment			
5. Are there any other branch/es of this Spa/Massage Parlour in any city town/district including the current city?	Yes No		
Section B: Profile of Spa/Massage Parlours			
7.a Working days of Spa/Massage Parlours:			
7. b. Peak Days			
8.a. Working hours of Spa/Massage Parlours:			
8.b. Peak Hours:			
9. Number of cabins/rooms:			
10. a. No. of SMP Workers in SMP How many staff currently working in Spa/Massage? 10.b. No of Sex Workers (Typology wise) in SMP 10.c. No. of other staff at the SMP	Female:	Male:	Transgender
11. How many staff were working last month in Spa/Massage?			
12. a. How many new staff joined in the current month in Spa/Massage Parlour? 12. b. Sex Workers 12.c Other Staff	Female:	Male:	Transgender
13. Average client load in a week in the Spa/Massage Parlour Last week data may be taken):			
14. Type of services offered to the clients from the SMP (List down the kind of services):			
15. Charges for the services (mentioned above with duration)			
16. For what service what commodities are used?			

Section C: Profiling on the HIV/STI or health services at SMPs			
SMP Respondent Name and Designation and Contact Details:			
15. Have you ever contacted/reached any organisation/ individuals for providing HIV/STI related or for any other health services to the Masseuses/Masseur?			
15.b. If yes, please tell the name of the organisation.			
15.c. What services were they providing? List down the services			
15 d. Are they continuing to provide the services? Y/N			
15.d Are you satisfied with the services and wanted to continue to seek services from them? If No., ask whether they wish to seek services from your organization	Yes No		
16. Would you like to be associated with the HIV related health services program to support the Masseuses/Masseur for their better health? If HIV services are not provided by any other organisation.	Yes No		
17. Would you like to link the Spa/Massage parlour workers with the program doctors/staff for regular health check-up at your doorstep?	Yes No		
17. b. If yes, what are the days and time suitable for the SMP for the same?			
Remark (Specific observations):			
PM / Counsellor/ ORW Name & signature :-	Date:		
Guidelines for filling the form: NOTE: The form is to be filled by the ORW (after ORW identifies a Spa/Massage in his/her site/area). The forms after filling up should immediately be handed over to Program Manager / MIS officer / Accountant for entering the information in the master list of Spa/Massage Parlours. NOTE: The individual SMP code number will be provided by the M&E officer at the TI level before entering the data into the Spa/Massage register and the same will be shared with the ORW/PE.			

Annexure 2

This form is filled up by each ORW with support from PEs for each outreach locality:

<table>
<tr><th colspan="12">Spot Analysis Form</th></tr>
<tr><td colspan="6">District</td><td colspan="6">Location:</td></tr>
<tr><td colspan="6">Site</td><td colspan="6">Date of analysis:</td></tr>
<tr><td colspan="12">Age</td></tr>
<tr><td colspan="4"><20</td><td colspan="4">20-30</td><td colspan="4">31-40</td></tr>
<tr><td colspan="12">No of HRGs working in the below given time:</td></tr>
<tr><td colspan="4">Daily</td><td colspan="4">Daily</td><td colspan="4">Daily</td></tr>
<tr><td colspan="2">2</td><td colspan="2">0</td><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="12">Time</td></tr>
<tr><td colspan="4">Morning (8-12)
Time</td><td colspan="4">Afternoon (12-18)
Time</td><td colspan="4">Evening
(18-22)</td></tr>
<tr><td>0</td><td>2</td><td>7</td><td>15</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Annexure 3

This is to be filled up for each spot with potential PEs: Site wise whoever knows most should be selected as PEs. (for selection of PEs and allotment of areas per PE)

This form has to be filled up for each category of the HRGs.

This is sample form:

Contact Mapping Form					
Site name (District/ Location):				Date:	
Estimated no. of people who engage in high risk practices (sex, injecting drug us) at the site)					
Contacted no. of with high-risk practices in the site					
Sl. No.	Name of the site	PE 1 No. of contacts	PE 2 No. of contacts	PE 3 No. of contacts	PE 4 No. of contacts

Annexure 4

Monthly Individual SMP/NWO Tracking sheet (filled in by ORW)

FORM C_1: Monthly Individual SMP/NWO Tracking sheet (filled in by ORW)														
Name of the ORW				ORW Code			Area			Month		May-19		
Source: Network Operator/ Spa Profile and master register					Source: If individual Network Operator or Spa Manager met, below column should be Updated					source: Form C				
Sr. No.	Name Of Network Operator		Nick Name of the Network Operator OR Name of the Spa/ Massage centre	Month in which NWO/ Spa profiling done (MMM-YY)	NWO/ Spa/ Peer Code*	How many Persons Currently associated with NWO/Spa	How many Persons Newly Joined in last Month	Do you know of any new Network Operator / Spa in the city if yes (Details)			No. of Persons Contacted during the month	No. of New Persons registered during the month	Remark (NWO/ Spa in-active, Re-active or shifted, New Persons Detail, Other important information)	ORW Code for sofy copy
	First Name	Last Name						Name	Contact Number	x				

Annexure 5

Lead Tracker for SMP operators

Lead Tracker for SMP operators

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Sr. No	ORW Code	Reporting Month (MMM-YY)	Lead source (NWO/ Spa/ Peer/ HRG/ Others)	Lead source Code (If lead source is others please specify)	Name Of Network Operator/ Spa Manager		Nick Name of the Network Operator or Name of the Spa/ Massage centre	Contact Number of the Network Operator/ Spa Manager	Area	Lead Status New/ Duplicate (If Duplicate Skip 12 to 14)	If New Lead in TI Area: Conversion Status		If lead beyond the TI area, shared with respective TI/DSACS	Remark
					First Name	Last Name					Reached By TI (1-Yes)	Unique ID If Profiling done		

Annexure 6

Lead Tracker for HRGs working at the SMPs (SMP workers)

Lead Tracker for SMP operators

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Sr. No	ORW Code	Reporting Month (MMM-YY)	Lead source (NWO/ Spa/ Peer/ HRG/ Others)	Lead source Code (If lead source is others please specify)	Name Of the HRG		Nick Name of HRG	Contact Number HRG	Site/ location/ Area	Lead Status New/ Duplicate (If Duplicate Skip 12 to 14)	If New Lead in TI Coverage Area: Lead Conversion Status		If lead beyond the TI area, shared with respective TI/DSACS	Remark
					First Name	Last Name					Reached By TI (1-Yes)	Unique ID If Profiling done		

Annexure 7

FORM A1: - PROFILE OF NETWORK OPERATOR

NOTE: This form is confidential and should be kept at the NGO office. Information to be filled up after identifying and rapport has been established.

Tool for mapping Network Operator Format for SW		
1. State		
2. District		
3. Name of Network Operator		
4. Contact Details		
5. Gender		
6. Age		
Section A: Network Size		
Sl. No	QUESTION	NUMBER
1.	Number of girls currently associated with/in your network	
2.	Among the girls in your network, how many of them are in other networks?	
3.	Among the girls in your network, how many of them also solicit at any physical hotspot e.g. brothel or street-based site/home/hotel/dhaba etc.	
Section B (List of Network Operator)		
Do you know any other network operators? If yes, please provide means to contact him or her.		
S. No	Contact	Details
A		
B		
C		
D		
E		
F		
Remark if Any:		
Counsellor/ORW Name and Signature:		

Tool for mapping Network Operator Format for MSM		
1. State		
2. District		
3. Name of Network Operator		
4. Contact Details		
5. Gender	1. Male 2. Female 3. H/TG	
6. Age		
Section A: Network Size		
Sl. No	QUESTION	NUMBER
1.	Number of boys/ MSM currently associated with/in your network	
2.	Among the boys/ MSM in your network, how many of them are in other networks?	
3.	Among the boys/ MSM in your network, how many of them also solicit at any hotspot e.g. brothel or street-based site/home/hotel/dhaba etc.	
Section B (List of Network Operator)		
Do you know any other network operators? If yes, please provide means to contact him or her.		
S. No	Contact	Details
A		
B		
C		
D		
E		
F		
Remark if Any:		
Counsellor/ORW Name and Signature:		

Tool for mapping Network Operator Format for H/TG			
1. State			
2. District			
3. Name of Network Operator			
4. Contact Details			
5. Gender	1. Male 2. Female 3. H/TG		
6. Age			
Section A: Network Size			
Sl. No	QUESTION		NUMBER
1.	Number of H/TG currently associated with/in your network		
2.	Among the H/TG in your network, how many of them are in other networks?		
3.	Among the H/TG in your network, how many of them also solicit at any physical hotspot e.g. brothel or street-based site/home/hotel/dhaba etc.		
Section B (List of Network Operator)			
Do you know any other network operator? If yes, please provide means to contact him or her.			
S. No	Contact		Details
A			
B			
C			
D			
E			
F			
Remark if Any:			
Counsellor/ORW Name and Signature:			

Tool for mapping Network Operator Format for IDU			
1. State			
2. District			
3. Name of Network Operator			
4. Contact Details			
5. Gender	1. Male 2. Female 3. H/TG		
6. Age			
Section A: Network Size			
Sl. No	QUESTION		NUMBER
1.	Number of IDUs currently associated with/in your network		
2.	Among the IDUs in your network, how many of them are in other networks?		
3.	Among the IDUs in your network, how many of them also inject at any physical hotspot?		
Section B (List of Network Operator)			
Do you know any other network operators? If yes, please provide means to contact him or her.			
S. No	Contact		Details
A			
B			
C			
D			
E			
F			
Remark if Any:			
Counsellor/ORW Name and Signature:			

Network profile analysis													
Source of Data: Network Operator Profile A1, Form C and Form C			Form A1: Q. No. 1	Form A1: Q. No. 1	Form A1: Q. No. 1	TI PM/ MEA	Form A1: Q. No. 1_A	Form A1: Q. No. 1_B	Form A1: Q. No. 1_C	Form A1: Remark	Form A1: Remark	Form A1: Q. No. 1_D	Form A1: Q. No. 2
S. No.	Name of TI NGO/ CBO	Month in witch Network operator profiling Done (MMM-YY)	First Name of Network Operator	Last Name of Network Operator	Nick Name of the Network Operator (If Any)	Network Operator Code*	Gender	Age in Years	Contact number (Network Operator)	Type of Network Operator FSW/Peer/ Pimp/ Others	If Others Please Specify	Main Occupation** (Social Identity)	Area of the Network Operator

Network profile analysis

Form A1: Q. No. 2_A	Form A1: Q. No. 2_B	Form A1: Q. No. 3	Form A1: Q. No. 4	Form A1: Q. No. 5	Q. No. 6	Form A1: Q. No. 7	Form A1: Q. No. 8	Form A1: Q. No. 9 (Count Table column 1)	Form A1: Q. No. 9 (Sum Table Column 6)	Form A1: Q. No. 9 (Count Table Column 7)	Form A1: Q. No. 9 (Table Column 6)	Form A1: Q. No. 9 (Sum Table Column 7)
District	PIN Code	Which state do you belong to?	How long are you being in Delhi? (In Years)	How many girls are currently associated with you?	How many girls were associated with you last month?	How many girls newly joined in your team in the last month?	How many men/ clients reached out to you for girls in the last week?	Do you know any other network operators in this city? If Yes How Many	No. of girls associated with them	How many network operators whom you connect with for the Girls in last month	No. of girls associated with the networks whom you connected with for the girls in last month	Among the girls in these network, how many did you connected in the last month?

Network profile analysis											
Form A1: Q. No. 10	Form A1: Q. No. 10	Form A1: Q. No. 11	Form A1: Q. No. 12	Form A1: Remark (Specific observations)	Form C_1	Form C_1	Form C	Form C	Form C	Form C	Form C
Have you ever contacted/ reached by any organization/ individuals for providing HIV related health services to the girls? (Yes/ No)	If Yes, Please specify Name	Would you like to associate with the HIV related health services program to support the girls for their better health? (Yes/No)	Would you like to link the girls with the program doctors/ staff for regular health check-up at your door step? (Yes/ No)	Remark (Specific observations)	Corrent Status of Network Opertaor (Active/ Drop-out)	No. of girls currently associated with network Opeartor (form Form C1 latest)	Among thease girls No. of girls contacted and information collected regarding association with other Network opeartors in last Month	No. of Girls Reported Association with one other Network operator in last Month	No. of Girls Reported Association with Two other Network operator in last Month	No. of Girls Reported Association with Three other Network operator in last Month	No. of Girls Reported Association with Four or more other Network operators in last Month

Annexure 9

Contact mapping form					
Site name			Date:		
Estimated no. of people who use drugs in the site					
Contacted no. of people who use drugs in the site					
Sl. No.	Name of the site	PE 1 No. of contacts	PE 2 No. of contacts	PE 3 No. of contacts	PE 4 No. of contacts

Annexure 10

Lead Tracker for Network operators

Lead Tracker for SMP operators														
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Sr. No	ORW Code	Reporting Month (MMM-YY)	Lead source (NWO/ Spa/ Peer/ HRG/ Others)	Lead source Code (If lead source is others please specify)	Name Of Network Operator/		Nick Name of the Network Opera-tor or Name of the Spa/ Massage centre	Contact Number of the Network Opera-tor/ Spa Manager	Area	Lead Status New/ Du-plicate (If Dupli-cate Skip 12 to 14)	If New Lead in TI Area: Conversion Status		If lead beyond the TI area, shared with respec-tive TI/ DSACS	Remark
					First Name	Last Name					Reached By TI (1-Yes)	Unique ID If Profil-ing done		

Annexure 11

Lead Tracker for HRGs working through the NWOs

Lead Tracker for HRGs working at the SMPs (SMP workers)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Sr. No	ORW Code	Reporting Month (MMM-YY)	Lead source (NWO/ Spa//Peer/ HRG/ Others)	Lead source Code (If lead source is others please specify)	Name Of Network Operator/		Nick Name of HRG	Contact Number HRG	Site/ location/ Area	Lead Status New/ Duplicate (If Duplicate Skip 12 to 14)	If New Lead in TI Coverage Area : Lead Conversion Status		If lead beyond the TI area, shared with respective TI/ DSACS	Remark
					First Name	Last Name					Reached By TI (1-Yes	Unique ID If Profiling done		

Annexure 12

Virtual space assessment

Name of the virtual site/app	Operational area (Global-1 National-2 State-3 Local-4)	If local provide details of the aperational area	GPS enabled (yes-1, no-2)	Subscription (required-1 Free-2)	If subscription required provide details-amount/duration	Whether HRG specific information available	If yes, which HRG/s are found online	SW	MSM	H/TG	IDU	Not identified	Remarks

Annexure 13

Line listing of the virtual HRGs

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8	Column 9	Column 10	Column 11	Column 12
S No	Virtual Platform / Site Code	ORW Name	ORW Code	Date of Registration	UID No	Name (virtual name) of HRG	Age	Sex	Address with and PIN Code	Phone No	Marital status

Column continue below

Continued from above column

Column 13	Column 14	Column 15	Column 16	Column 17	Column 18	Column 19	Column 20	Column 21	Column 22	Column 23	Column 24
If unmarried / others, has a Regular Sex Partner (Y/N)	No of children	Educational status	Employment status	Monthly Income	Primary HRG Typology	Sub-category of Primary typology	Secondary HRG Typology	Sub-category of Secondary HRG Typology	No of years of injecting drug use	Injecting Drug Use (last 3 months)	Primary Injecting Drug

Column continue below

Continued from above column

Column 25	Column 26	Column 27	Column 28	Column 29	Column 30	Column 31	Column 32	Column 33	Column 34	Column 35	Column 36
Average Injecting Episodes per month	Sharing of Needles and Syringes	Concomitant Alcohol Use	Sex acts reported per month at the time of registration	Whether engaged in Sex work	Sexual transactions reported per day at the time of registration (if engaged in sex work)	Number of years in Sex work	Whether engaged in same-sex behaviours	No of partners (if MSM / TG)	Condom Use with regular partner	Condom use with non-regular / paid partners	Whether Active or not (received any of the project services in last 6 months)

Column continue below

Continued from above column

Column 37	Column 38	Column 39	Column 40	Column 41	Column 42	Column 43	Column 44	Column 45	Column 46
If drop out, when declared dropped out)	If re-linked, period of dropped out	HIV Status	If HIV positive, ART Linkage	If linked with ART, currently on ART	Whether currently on ART	Linked with OST	HIV status	If HIV positive, ART Linkage	If linked with ART, currently on ART

Annexure 14

Risk Assessment Tool

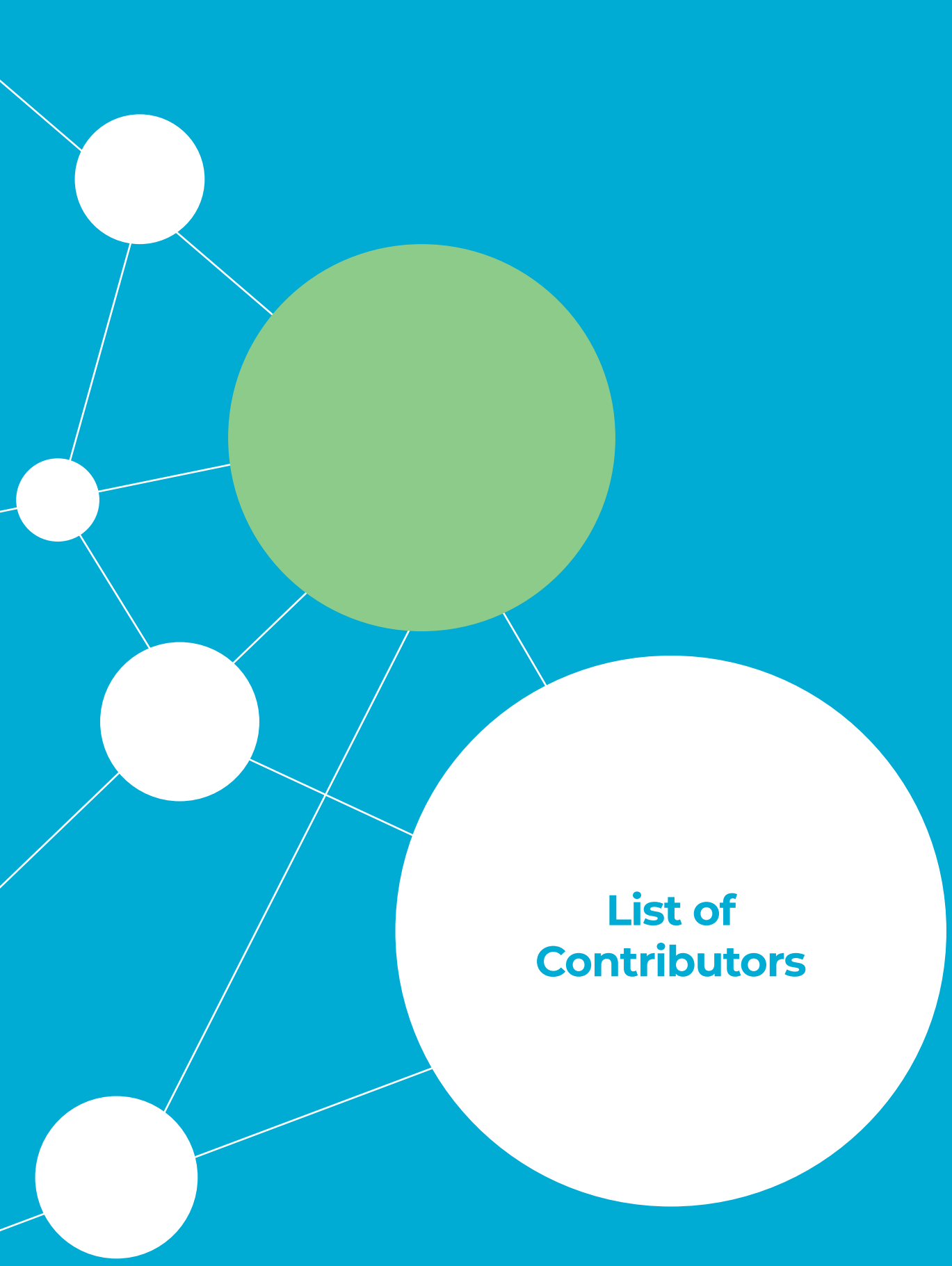
Risk & Vulnerability Assessment		
Injecting related factors		
Query	**Options**	**Response**
Currently injecting in last 3 months	(Yes = 1, No = 0)	
Injecting frequency in last 1 month	(Daily Injector = 2, Non-daily injector = 0)	
Total injecting episodes per month	(more than 30 = 2, 10-30 = 1, less than 10 = 0)	
Injecting in a group in last 1 month	(Yes = 1, No = 0)	
Sharing of needles/ syringes and other equipment in last 1 month	(No sharing = 0 Sharing with one partner = 1 sharing with more then one partner = 2)	
Sex-related Factors		
Sex with SW/MSM/Hijra/transgender in last month	(YES = 1, No = 0)	
Unprotected sex with non-regular partner / multiple partners in last 1 month	(Yes = 1, No = 0)	
Enagagement in other high-risk behaviours (Sex work in case of Female IDUs / Sex with same-sex partner in case of Male IDUs) in last 1 month	(Yes = 2, No = 0)	
STI symptoms / treatment reported in last 1 month	(Yes = 1, No = 0)	
Other factors		
Use of Alcohol and / or other non-injecting drugs in last 1 month	(YES = 1, No = 0)	
OST adherence in last 1 month	(Not on OST = 2, On OST but irregularly = 1, On OST regularly - 0)	
Frequent mobility from one hotspot to another / outside the TI catchment area within the last 1 month	(High mobility = 1, Low mobility = 0)	

Annexure 15

Lead Tracker for HRGs on virtual space

Lead Tracker for HRGs working at virtual spaces

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Sr. No	ORW Code	Reporting Month (MMM-YY)	Virtual Space name	Lead source Code (If lead source is others please specify)	Name Of the HRG		Nick Name of HRG	Contact Number HRG	Site/ location/ Area	Lead Status New/ Duplicate (If Duplicate Skip 12 to 14)	If New Lead in TI Coverage Area : Lead Conversion Status		If lead beyond the TI area, shared with respective TI/ DSACS	Remark
					First Name	Last Name					Reached By TI (1-Yes)	Unique ID If Profiling done		



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