



Ministry of Health & Family Welfare
Government of India



National AIDS Control Organisation

India's Voice against AIDS
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in



Revamped and
Revised Elements of
Targeted Intervention
for HIV Prevention and
Care Continuum
among Core Population

STRATEGY DOCUMENT

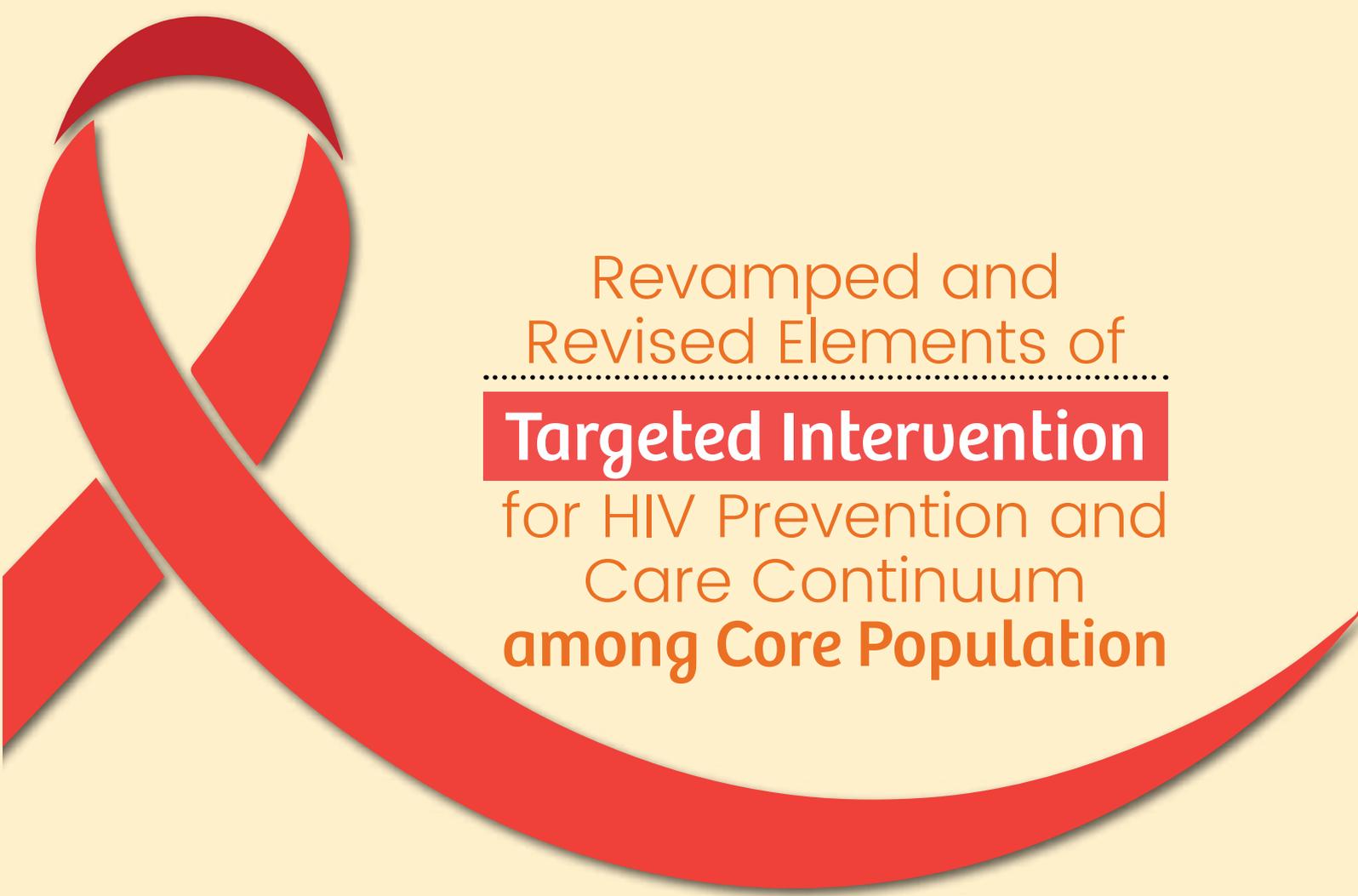


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FOREWORD



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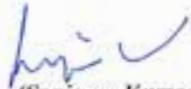
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FOREWORD

National AIDS Control Organization through its National AIDS Control programme aims to ensure access to treatment through meeting the 90–90–90 targets by 2020 and end the AIDS epidemic by 2030. The prevention of new infections among high risk groups is a major thrust in National AIDS Control Programme. The most effective means of controlling the spread of HIV in India is through the implementation of Targeted Interventions. Considering the concentrated nature of the HIV epidemic in the country, NACO has been targeting its preventive efforts towards High Risk Groups including injecting drug users, men having sex with men, female sex workers, hijras and transgenders through NGO/CBO led Targeted Interventions. Concerted efforts are also being taken to intensify the HIV/ TB intervention for people living in prisons and women living in closed settings such as Swadhar, Ujjawala and other State-run Homes.

The operational guidelines for the TI program was first issued by NACO in 2007. The NACP has followed these guidelines across the country and has shown that the TI approach has been effective in halting and reversing the HIV epidemic. However, over the last decade, evidence generated by HIV Sentinel Surveillance, Integrated Behavioral and Biological Surveillance and TI programmes has highlighted the changing landscape of risk due to sexual and injecting behaviours among HRGs. To effectively respond to the evolving epidemic, the TI programme need to adapt and revamp the existing strategies with a renewed focus on hard-to-reach populations.

I am certain that the strategy document of "Revamped and Revised Elements of Targeted Intervention for HIV Prevention among Core Population" would help NACO, State AIDS Control Societies, potential partners (NGOs, CBOs, and networks), programme managers and other staff working in TI projects and TSUs to achieve comprehensive and sustained progress to walk 'the last mile' in terms of the commitment made to 'end the AIDS epidemic as a public health threat' by 2030 under the Sustainable Development Goals. I thank the senior officers from various agencies for their active participation and contribution in developing this strategy document.


 (Sanjeeva Kumar)



PREFACE



आलोक सक्सेना
संयुक्त सचिव
Alok Saxena
Joint Secretary



राष्ट्रीय एड्स नियंत्रण संगठन
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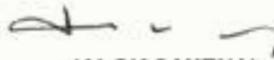
PREFACE

NACO has been providing a number of preventive services to high risk groups (HRG) through NGO/CBO led Targeted Interventions (TIs). At present, over 1450 such interventions are providing HIV prevention, treatment, care and support services to various HRGs including female sex workers, men who have sex with men, transgenders and injecting drug users. India is estimated to have around 87.58 thousand new HIV infections in 2017, showing new HIV infection decline by 85% since the peak of 1995 and by 27% between 2010-2017. Over a period of time, it has been identified that a sizable number of HRGs who avail these services have adopted positive behaviours. As a result of consistent condom use and health-seeking behaviours, majority of HRGs remain HIV negative.

The operational guidelines for the TI program were first issued by NACO in 2007. Targeted Intervention programme implemented through NGO/CBO reach out to female sex workers, men having sex with men, injecting drug users, Hijra and transgender in congregation points which are called "Hot Spots". In recent times, with advancement in technology and introduction of IT enabled services including mobile phones and social networks like WhatsApp/ Facebook/ Messenger and apps, HRGs registered with TIs and HRGs who are away from the ambit of NGO/CBO have started operating through social platforms. These changing landscapes pose challenges in reaching out to HRGs through conventional approaches.

The activities proposed in the strategy document of "Revamped and Revised Elements of Targeted Intervention for HIV Prevention among Core Population" will certainly help TIs to register new sets of HRGs for various HIV prevention services. HRGs who remain negative and maintain healthy behaviours will be provided differentiated prevention services, which would be different from the conventional TI approach.

The revamped and revised elements of Targeted Intervention strategy document is an outcome of a series of national-level consultations that we had with bilateral, multilateral, States AIDS Control Societies, Technical Support Units and other development partners. The revamped and revised elements of Targeted Intervention for HIV prevention among core population have been incorporated into the Annual Action Plan of 2019-2020. I am sure the renewed prevention strategies would complement NACO's efforts towards ending the AIDS epidemic by 2030.


(ALOK SAXENA)

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



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Acknowledgements

The revamped and revised elements of Targeted Intervention strategy document is an outcome of a series of national-level consultations that we had with bilateral, multilateral, States AIDS Control Societies, Technical Support Units and other development partners. The purpose of these consultations were to review the effectiveness and efficiency of the current programme through a desk review, which included recommendations of Mid-Term Appraisal (MTA), Prevention Summit, and aide memoire of World Bank related to prevention of HIV/AIDS, etc. The expert technical group also reviewed reports of new and innovative models demonstrated by SACS/TSU and partner NGOs.

Under the dynamic stewardship of Shri Sanjeeva Kumar, AS & DG (NACO & RNTCP), the strategy document of "Revamped and Revised Elements of Targeted Intervention for HIV Prevention and Care Continuum among Core Population" has been developed. Shri Alok Saxena, JS, NACO actively guided the team in organizing series of national-level consultations to seek comprehensive perspectives from varied stakeholders.

It must be emphasized here that the TI operational guidelines released in 2007 still have a key role and there are quintessential activities that need to be continued. Therefore, the strategy document of "Revamped and Revised Elements of Targeted Intervention for HIV Prevention and Care Continuum among Core Population" should be read in conjunction with the existing operational guidelines until NACO notifies otherwise. The expert technical group recommended to subsequently revise the overall TI guidelines to produce "New and Revamped" Targeted Intervention Guidelines to be followed by the SACS, the TSUs and the TI implementation units at the ground level, which would eventually supersede the existing guidelines.

I thank the senior officers from various agencies for their active participation and contribution. We commend Dr Bhawani Singh, Deputy Director (TI) and all the technical staff from TI Division, SACS, TSU and project staff of Sunrise, Linkages, Nirantar and Hridaya for their significant contributions in developing this strategy document.

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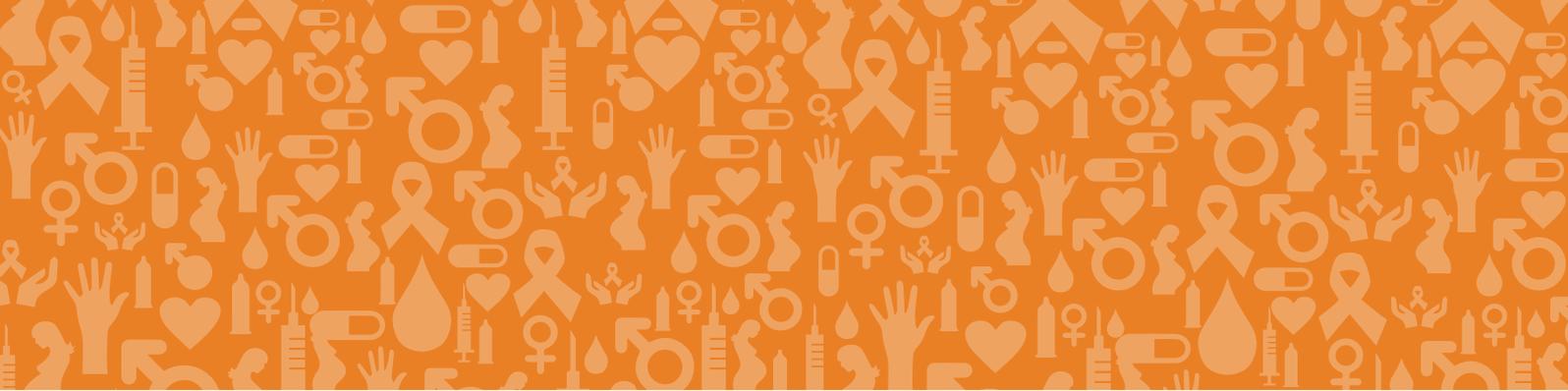
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ACRONYMS

ART	Anti-retroviral therapy
BCC	Behaviour Change Communication
CBARTD	Community-based ART Dispensation
CBS	Community-based Screening
CBO	Community-based Organization
CHC	Community Health Centre
CM	Community Mobiliser
CST	Care Support and Treatment
DLSA	District Legal Services Authority
DIC	Drop-in-Centre
FIDU	Female Injecting Drug User
FSW	Female Sex Worker
HTG	Hijra & Transgender
HCPs	Health Care Providers
HIF	Hotspot Information Format
HRG	High Risk Group
HSS	HIV Sentinel Surveillance
IBBS	Integrated Biological and Behavioural Surveillance
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User
IPC	Inter-personal Communication
ITS	Individual Tracking Sheets
JD	Job Description
LFU	Lost-to-follow up
LWS	Link Worker Scheme
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
MTA	Mid-term Appraisal



NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non-Governmental Organization
NSP	National Strategic Plan
ORW	Outreach Worker
OST	Opioid Substitution Therapy
PE	Peer Educator
PHC	Primary Health Centre
PHDP	Positive Health, Dignity and Prevention
PLHIV	People Living with HIV
PM	Project Manager
PM&SE	Population Mapping and Size Estimates
PO	Project Officer
RMNCH + A	Reproductive Maternal, Newborn and Child Health + Adolescent
RNTCP	Revised National TB Control Programme
SACS	State AIDS Control Society
SDNS	Secondary Distribution of Needles and Syringes
SIMS	Strategic Information Management System
SIMU	Strategic Information Management Unit
SOA	Strengthening of Outreach Activities
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections
TI	Targeted Intervention
TSU	Technical Support Unit
UHC	Universal Health Coverage
VL	Viral Load



BACKGROUND

Background

The Targeted Intervention (TI) programme is the flagship prevention initiative of the National AIDS Control Organisation (NACO) for HIV and AIDS prevention. It is targeted towards High Risk Groups (HRG) and its implementation is funded from the National AIDS Control Programme (NACP) II to the current National Strategic Plan 2017-2024 (NSP).

The operational guidelines for the TI programme were first issued by NACO in October 2007. The major thrust of this prevention initiative (then and now) has been a targeted focus on the prevention of new infections among the populations most at risk, also termed as the HRGs. It has been established that the most effective means of controlling the spread of HIV in India has been through the TI programme among HRGs, including female sex workers (FSWs), men who have sex with men (MSM), injecting drug users (IDUs) including female injecting drug users (FIDUs), and Hijras and transgender people (HTG). The operational guidelines were also issued to address the bridge populations and special groups, such as truckers, migrants and prisoners. These guidelines standardized the approach across the Country to scale up coverage and saturation of prevention efforts.

NACP has followed these guidelines across the Country and has shown that the TI approach has been effective in halting and reversing the HIV epidemic. However, it is also relevant to point out that over the last decade, evidence generated by HIV Sentinel Surveillance/Integrated Biological and Behavioural Surveillance (HSS/IBBS) and TI programmes has highlighted the changing landscape of risk due to sexual and injecting behaviours among the HRGs, bridge populations and special groups. To effectively respond to the evolving epidemic, the TI programme needed to adapt and revamp the guidelines to best provide Prevention and Care Continuum strategies to HRGs with a renewed focus on hard-to-reach populations. Further, to saturate the coverage of HRGs, the revamping efforts need to reach out to hitherto, the unreached HRGs living outside the TI geographic areas.

Over the last two years, NACO had commissioned several studies and reviews, which provided insight to revamp the targeted intervention and its guidelines. Many recommendations made in these studies and reviews have been successfully implemented in select geographical areas by donors, donor-supported organizations, State AIDS Control Societies (SACS) and Non-Governmental Organizations (NGOs)/Community Based Organizations (CBOs) within the Country. The work commissioned to revamp the TI, covered by this publication, has incorporated the validated models in different environments with different HRG populations.

The purpose of this publication is to provide information to the policy makers, programme planners and TI implementers on the new elements in the TI programme. This publication will also provide the Monitoring and Evaluation (M&E) indicators for all the new activities. This document will also provide guidance to SACS and other important stakeholders on the changes made in TI. This publication covers the essential elements incorporated to meet the challenges and the changing landscape for the sections of the population mentioned above.

Key programme elements of the TI are being retained and the new activities will fit within the programme elements central to the TI. The core elements of the targeted intervention are: community outreach, service delivery, commodity distribution and community system strengthening.

Core Elements of the Targeted Intervention



**COMMUNITY
OUTREACH**



**SERVICE
DELIVERY**



**COMMODITY
DISTRIBUTION**



**COMMUNITY
SYSTEM
STRENGTHENING**

Some of the new activities have been incorporated into the original four programme elements. This publication covers the new activities in the context of the specific HRGs. The overarching principle for the revamped and revised TI strategy is the “differentiated approach” towards prevention of HIV. This means that each TI is not universally applicable for all sections of the population receiving Prevention and Care services, but thoughtfully segment the HRGs to enhance emphasis of risk and vulnerability. This would help to mitigate transmission of HIV with a high degree of efficiency. While some of the activities mentioned in this publication are new, all are critical. However, all activities are not applicable to all the core population of the TI. The grid provided in the subsequent section gives at a glance the key elements of the TI programme.



The background is a dense, repeating pattern of various icons related to health, medicine, and biology. The icons are rendered in shades of orange and red. Recognizable symbols include syringes, pills, hearts, hands, ribbons, and various anatomical or biological shapes. The overall aesthetic is clean and professional, typical of a medical or healthcare organization's branding.

TI REVAMPING STRATEGIES

TI Revamping Strategies

NACO had convened a series of national level consultations, including consultation on TI Revamping and Restructuring (October 2018), Expert Technical Group Consultation (November 2018), and consultation with States AIDS Control Societies (SACS)/Technical Support Units (TSUs) and other development partners (December 2018). The purpose of these consultations was to review the effectiveness and efficiency of the current programme through a desk review of the documents, which included recommendations for Mid-Term Appraisal (MTA), Prevention Summit, and aide memoire of World Bank related to prevention of HIV/AIDS, etc. The expert technical group also reviewed reports of new and innovative methods and selected successfully demonstrated activities to include in this strategy document. It must be emphasized here that the guidelines released in 2007 still have a key role and there are quintessential activities that need to be continued. **Therefore, these strategies should be read in conjunction with the existing guidelines until NACO notifies otherwise. The expert technical group recommended to subsequently revise the overall TI guidelines to produce “New and Revamped” Targeted Intervention Guidelines to be followed by the SACS, the TSUs and the TI implementation units at the ground level, which would eventually supersede the existing guidelines.**

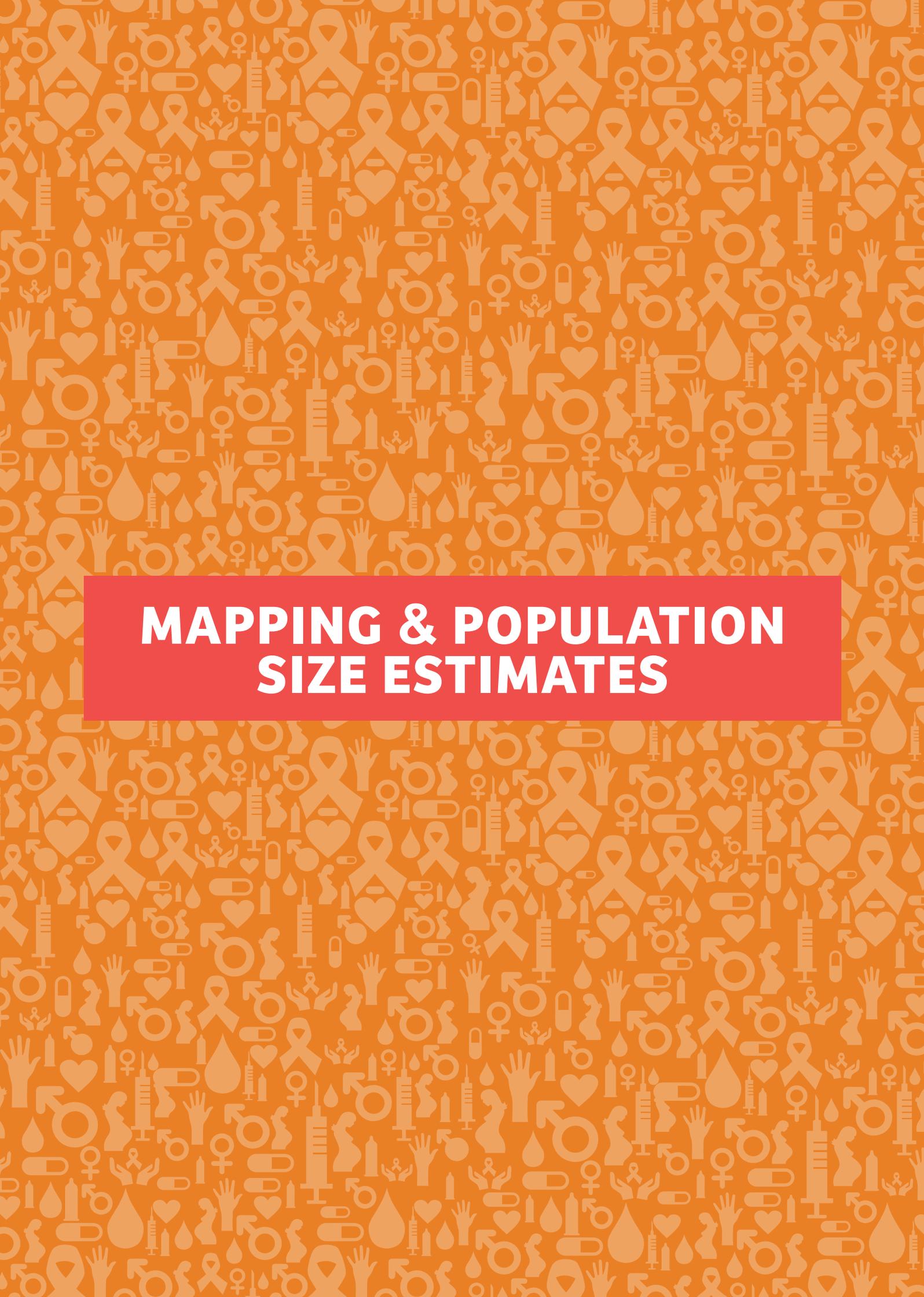
NACO has developed a plan to orient and train the relevant officials of SACS and TSUs to ensure implementation of new activities that are outlined in the subsequent chapters and taken up for implementation of TI among the HRGs.

Recommended Strategies

Principal Components	Sub - Components	Purpose
Population Mapping & Size Estimates (PM&SE)		To estimate the HRGs' population size
Community Outreach	Strengthen Outreach Activities	To increase coverage and cover HRGs by reaching out to the sexual and social networks of HRGs
Service Delivery	Differentiated Prevention	To optimize human and financial resources, decongest the TI and provide client-centred package of services
	Navigation	To improve linkages and adherence to ART and ensure viral-load monitoring
	Index Testing	To test spouses and sexual/injecting partners of HRGs' PLHIV index after ART initiation
	Community Based Screening	To test high risk population living in hard-to-reach and unreached locations
Commodity Distribution	Secondary Distribution of N/S	To improve access to Needle/Syringe exchange
	Satellite OST Centre	To improve access and adherence to OST
	Community Based ART Dispensing	To improve ART adherence through decentralized care
Community System Strengthening	Community Score Card	To seek feedback from community to continuously improve the quality of TI services

In order to increase the coverage and quality of services for HRG populations (since the first TI guidelines issued by NACO in October 2007), various approaches and innovations to TIs have been adopted across the Country. The technical expert group reviewed and validated the effective approaches to improve the outreach, service delivery and community system strengthening. The recommended strategies described below are applicable for implementation among all HRGs.

Services	Additional Components	Purpose	Integration with existing TI	Key Population Typology				
				FSW	MSM	H/TG	IDU	Spouses/partners of IDUs
Population Mapping & Size Estimates (PM&SE)		To estimate the HRGs' population size	Yes					
Community Outreach	Strengthen Outreach Activities	To increase coverage and cover HRGs by reaching out to the sexual and social networks of HRGs	Yes					
Service Delivery	Differentiated Prevention	To optimize human and financial resources, decongest the TI and provide client centred package of services	Yes					
	Navigation	To improve linkages and adherence to ART and ensure viral load monitoring	Yes					
	Index Testing	To test spouses and sexual/injecting partners of HRGs PLHIV index after ART initiation	Yes					
	Community Based Screening	To provide counselling and testing services for HRGs who are hard-to-reach	Yes					
Commodity Distribution	Secondary Distribution N/S	To improve access to Needle/Syringe exchange	Yes					
	Satellite OST Centre	To improve access and adherence to OST	Yes					
	Community Based ART Dispensing	To improve adherence to ART through decentralized care	No					
Community System Strengthening	Community Score Card	To seek feedback from community to continuously improve the quality of TI services	Yes					



MAPPING & POPULATION SIZE ESTIMATES

Mapping & Population Size Estimates

Background

In India, the HIV epidemic is concentrated in HRGs such as FSW, MSM, H/TG, and IDU who are at higher risk of contracting/transmitting infection. This population is often 'hidden' because their behaviours continue to be stigmatized, and in many countries, even illegal or criminalized. But this makes it even more important to have intervention strategies for this population with prevention and other measures to alleviate the burden of the disease.

Estimating the size of key populations is vital for assessing programmatic needs across different locations, and planning for prevention, care and treatment interventions. Having reliable estimates of HRG facilitates formulation of policies, programme and target settings. It also helps in budgeting or costing of programme interventions and ensures an efficient allocation of resources through advocacy with decision-makers (WHO/UNAIDS, 2011). Population-size estimations are also a critical input in epidemiological models like Spectrum which are used to produce estimations at national and sub-national level of core indicators, used to monitor and evaluate the response to epidemics.

However, estimating the size of HRG is a challenging task. Populations at high risk are not uniformly distributed across the country, and are largely hidden or purposely conceal their identity. As it is not possible to physically count all people belonging to various HRG, their sizes are estimated using a variety of methods. Different methods have been experimented with globally, and some methods used more than others. However, the choice of a size estimation method, or mix of methods, hinges on strategic information needs and the objectives for which population size estimates are developed at different levels. Experience accumulated over the years with implementation of population size estimations across the world has shown that there is no one single method which is suitable in every context. In addition, there is no best method, as each has its own strengths and weaknesses.

White Paper on MPSE

National level HRG size estimates were published in 2006 and 2009 (and 2013 for H/TG). Also, the approaches used had challenges and limitations, including lack of consensus on operational definitions of HRG, the changing dynamics of the HRG within physical and virtual space, methods to tackle duplication and mobility, process of extrapolation of local estimates for arriving at state and national estimates, and

uniformity of Mapping & Population Size Estimates (MPSE) methods used. Therefore, NACO felt the need for a concerted effort to critically review existing methods of HRG size estimation and to recommend a simple, standard, user-friendly approach, which would be applicable at the national level. This was recommended in the 2016 Mid Term Appraisal (MTA) of NACP-IV and further reiterated in India's National Strategic Plan (2017–2024) and Expert Consultations on HIV Surveillance and Estimations in India (2016 and 2018), which also emphasized the need for regular updates of PSE for HRGs, to facilitate strategic planning, costing, monitoring and evaluation, and reporting.

NACO commissioned a white paper on mapping and population size estimation (MPSE) to critically review the prevalent methods and provide the contour of MPSE to be implemented under NACP. The paper recommended to integrate the MPSE as a biennial exercise within targeted interventions under the active engagement and supportive supervision of institutions like 'Technical Support Units' as a community driven, sustainable and high-quality mechanism in Indian context. The paper also advocated for working out an interim estimate using available evidences till a full-fledged nation wise MPSE is done . The white paper also acknowledges the presence of HRG who are operating exclusively through virtual spaces and need for a standardized method to estimate their size. It also recognizes that fact that there will be periodic bio-behavioral surveillance under programme and wherever possible, methods like programme multiplier and capture-recapture of MPSE shall be built into such surveys to triangulate the estimates generated through community led MPSE.

MPSE under revamped TI model

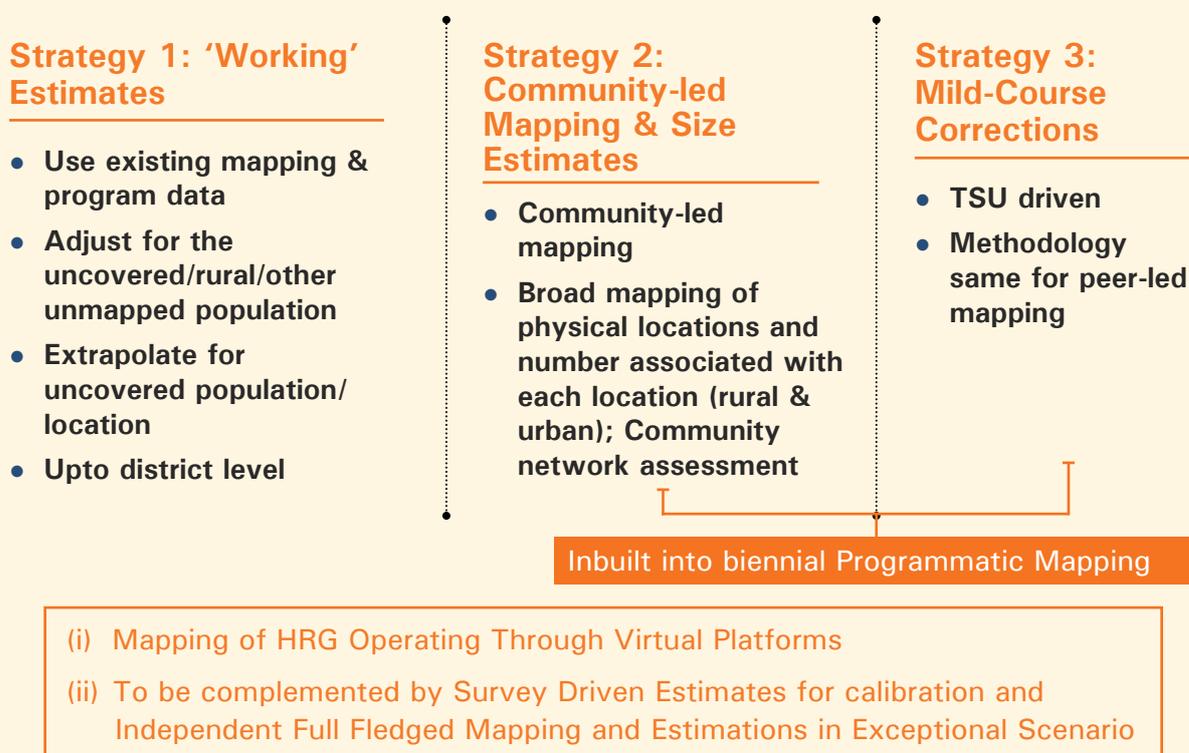
A three-pronged strategy for MPSE has been adopted for MPSE under NACP in line of recommendations of the white paper (Figure 1).

The first strategy focuses on developing of working estimates based on available evidences at town and village level from existing mapping and coverage evidences on HRG under National AIDS Control Programme. This will be done centrally by Surveillance & Epidemiology-Strategic Information (SI) Division engaging its robust institutional arrangements and with active support of State AIDS Control Societies and Technical Support Units. The estimates, thus generated will be used primarily to inform the epidemiological assumptions under disease burden exercises. However, the outputs will also serve the purpose of a lighthouse to the programme aiding its navigation towards maximum possible coverage.

The second strategy aims to do mapping of the hotspots and estimate the size using community peers and other institutional structures like Technical Support Units in a State. This MPSE will go beyond the locations and district being covered under the programme. The objective is to provide local areas estimates of the high risk group which can be used immediately for programme planning, implementation and monitoring.

¹National AIDS Control Organization (2019). White Paper on Mapping and Population Size Estimation of High Risk Groups for HIV in India. New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.

Figure 1: Three pronged strategy for MPSE under revamped TI guidelines of NACP-IV



The third strategy makes provisions for mid-course corrections in MPSE. As the programme implementation starts after community-led MPSE under strategy 2, there is a scope of variance to be observed in size estimates provided by MPSE and what the programme has been able to reach. The strategy makes provisions for taking into account significant variations, investigate them and then inform the MPSE through institutional arrangements for mid-course corrections.

The strategy 2 and 3 are in-built as biennial exercise into the revamped TI and TSU functions across prevention-detection-treatment care continuum under NACP.

The MPSE also recognizes the HRG operating through virtual platforms and envisions NACO and SACS led estimation of key population operating through virtual spaces. However, the methods for the same are still evolving and a more informed decision for a systematic approach responding to the size estimates will be taken later once the methods are mature enough.

The direct estimates through community led mapping under revamped TI strategy will be further complemented through multiplier and capture-recapture methods through independent survey whenever opportunity arises. Large-scale behavioural surveillance surveys, studies, etc be encouraged to include size estimation in local level data collection efforts subject to objective alignment and resource availability of such surveys. Depending upon the evidence-driven need, size assessment exercises with focus on specific location and population will also be undertaken to inform the PMSE under the programme.

Community-led PMSE

Community-led, institutionalized PMSE will be the foundation stone of the revamped TIs under NACP. The exercise is envisioned as biennial exercise though the frequency may be worked out further depending upon the experiences from the first round.

The community-led PMSE will be initiated with constitution of institutional structure of State PMSE Steering Committee under the chairpersonship of SACS project director to drive the project implementation in the State. Besides having the representatives of the programme divisions, the committee will also have representatives of the community (FSW, MSM, IDU and H/TG) as well as from the community medicine and social science disciplines. This committee will be complemented by community advisory boards in each of the district under consideration, which will not only ensure that community is fully onboard for smooth implementation of this exercise but will also provide critical intelligence to map and estimate the population which is not covered under the programme.

These structures will lead the planning and preparing for the MPSE at State and district levels. The key activities that will be covered during this step will include the training of the all of the TSU Project Officers as they will be the process owners of this exercise in their allotted districts (Figure 3). The training may also be attended by other relevant stakeholders. TSU PO's in turn will be training the community peer educators, outreach workers and other TI's personnel to implement the community-led mapping and population size estimates. The planning and preparation will detail the activity-timeline-responsibility-stakeholder matrix for each of the key activity for MPSE.

Figure 2: Project cycle of community-led PMSE



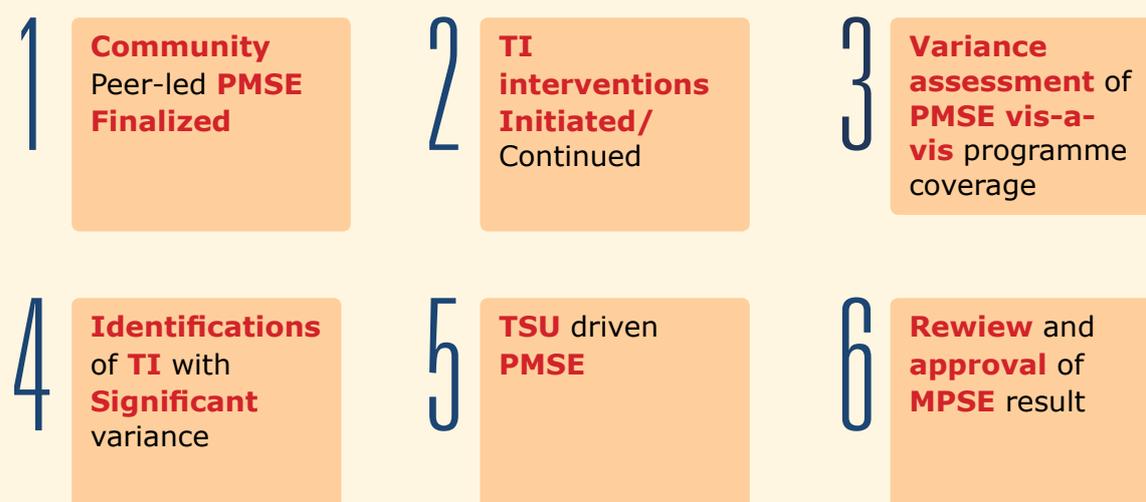
The MPSE envisions to provide estimates encompassing covered as well as uncovered areas. This will be done by covering all of the districts with TI under MPSE. The districts which are not covered under programme, will be stratified on vulnerability based on epidemiological evidences and MPSE will be implemented in select districts. The findings of MPSE in the select districts will be extrapolated to all of the uncovered districts based on their vulnerability stratum.

The data management under MPSE will be IT enabled. The results generated through MPSE shall be discussed with all stakeholders. Triangulating the data through programme coverage and working estimates as well as sharing the findings with stakeholders will not only augment robustness of the exercise but will also bring absolute transparency into the process. The results shall be finally reviewed and approved by the State MPSE Steering committee before sharing it with national structures.

Mid-course corrections

The MPSE exercise under revamped TI has been envisioned as a biennial event. As a part of in-built mid-course correction provisioned under MPSE, an assessment will be done to study the variance of the MPSE outcome vis-à-vis the programme coverage. This will be done at the TI level. The interventions where variations are significant, TSU-PO will implement full-fledged MPSE using the same method and tools as that of the community peer-driven MPSE. The estimates thus generated will be discussed with stakeholders, submitted to steering committee for their review and approval and then shared with NACO for mid-course corrections as appropriate.

Figure 3: PMSE Mid-course corrections under revamped TI





**COMMUNITY
OUTREACH**

Community Outreach

4.1. Strengthening of Outreach Activities

Targeted interventions have been providing various prevention services to HRGs and it has been identified that a sizable number of HRGs who avail these services have adopted positive behaviours over a period of time. As a result of consistent condom use and health-seeking behaviours, majority of HRGs remain HIV-negative at TI facility level.

Strengthening of Outreach Activities is an effort to reach out to the hard-to-reach, uncovered and hidden HRGs, including their sexual and injecting partners who are located outside the TI geographic areas. Each core TI is expected to undertake a maximum of 24 outreach camps and Community Based Screening (CBS) services in a year. To ensure monitoring and ownership by SACS/TSU, all camps are to be held only after prior approval of SACS.

The activities proposed by the TI programme will help TIs to register new sets of HRGs for various services for HIV prevention. HRGs who remain negative and maintain healthy behaviours will be provided differentiated service delivery, which would be different to the conventional TI approach and performance indicators will be modified according to the package of services proposed by TIs. Therefore, TI- NGOs have been advised to identify and recruit new and young HRGs who may need to use TI services in addition to providing services to the HRGs who are already registered.

TIs reach out to FSWs, MSMs and HTGs in congregation points which are called "Hot Spots". In recent times, with advancement in technology and introduction of IT enabled services including mobile phones and social networks like WhatsApp/ Facebook/ Messenger and apps like Grindr, Blue D, PlanetRomeo, etc. HRGs registered with TIs and HRGs who are away from the ambit of NGOs/CBOs have started operating through these social platforms. This resulted in HRGs (which were once visible in "Hot Spots") remains hidden and hard-to-reach through conventional approaches. These changing dynamics warrants new and out-of-the-box thinking to reach out to these HRGs.

It is a time-bound **activity to be continued** till the **coverage target** is **achieved**

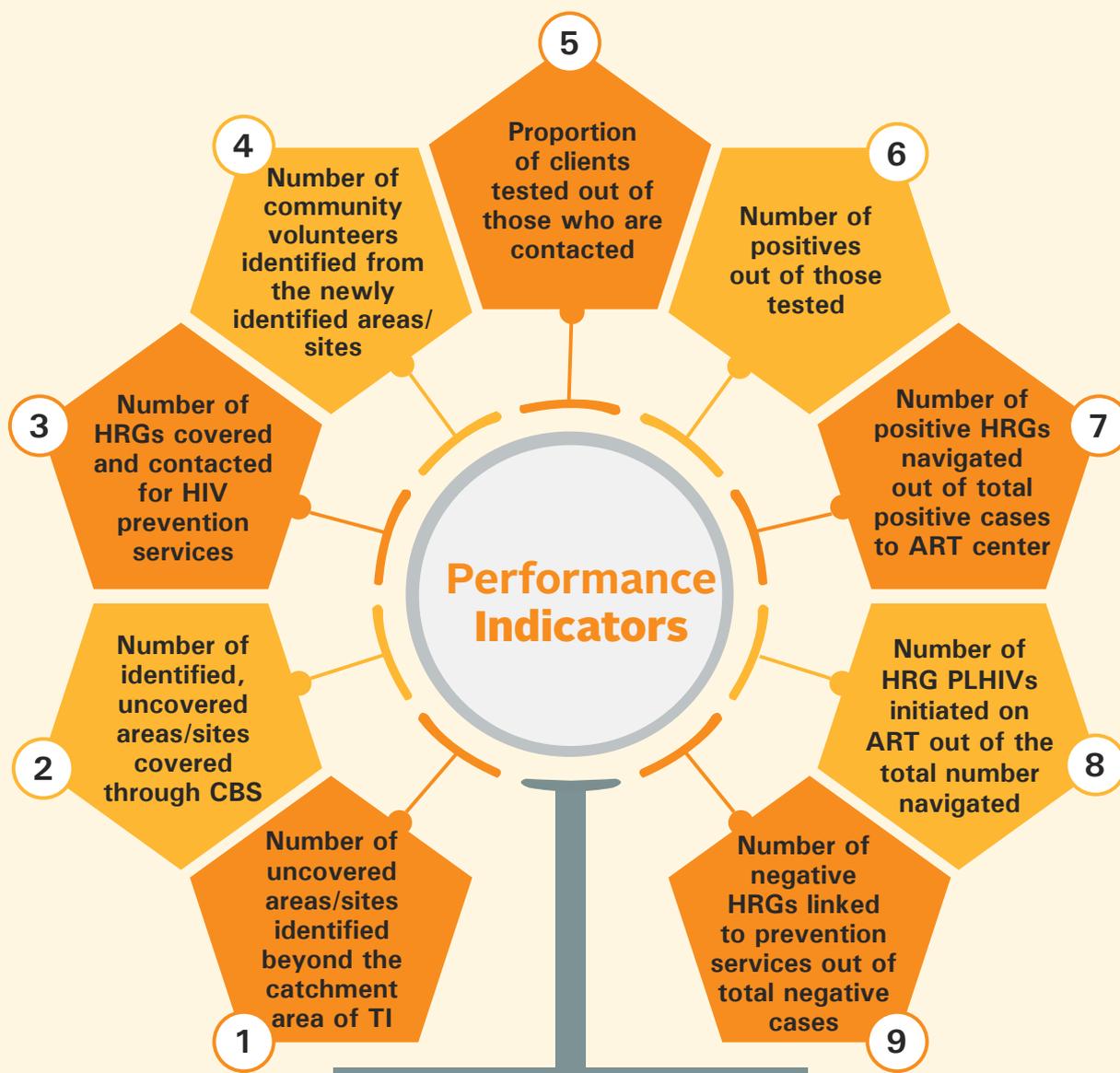
These **activities** will be **implemented** by **NGOs/CBOs**

Outreach staff will identify new and **unreached HRGs**

SACS to ensure uninterrupted supply of **HIV test kits**

Maximum of **24 outreach camps** and **CBS services** to be provided in a year

The following are the performance indicators which will help SACS and NACO to measure the outputs of activities implemented under "Strengthening of Outreach Activities":



To implement the activities under strengthening of outreach activities SACS and TSU (as applicable) will review the existing targets of TIs and accordingly consider implementation of these outreach strategies. Thus, it may require training on changing sex work patterns and skills to reach hard-to-reach HRGs.





SERVICE DELIVERY

Service Delivery

5.1 Differentiated Prevention

The differentiated HIV prevention service delivery strategy aims to maximize the reach, quality, effectiveness, efficiency and impact of HIV services and resources among key populations. The core strategy of a differentiated prevention is based on risk segmentation/categorisation of HRGs and accordingly allocate the human resources by the location, frequency, intensity for the planned intervention. HRGs will be segmented based on risks and vulnerability, the TI will use an Excel based risk segmentation tool every quarter. The HRG population will be stratified into five categories and the differential gradient of services will be provided as stated in the matrix below.

The following variables/indicators were used in developing this model:

1. Demographic/ Programme data

- Age
- Years in Sex work/Injecting practices
- Years in the TI Programme
- N/S distribution and returns
- Enrolment in OST

2. Sexual behaviours

- No. of sex acts/ injecting episodes per week
- Condom use
- Condom compromise
- Sharing of N/S and injecting paraphernalia
- Lubricants use
- Anal sex
- Group sex

3. Structural/ other vulnerability factors

- Alcohol use (before/during sex)
- Experienced (sexual) violence
- Mobility
- Polydrug use
- Overdose history

4. Biological outcomes

- Syphilis
- History of STI/RTI
- HIV

Steps:

- ✓ Collect information related to risks and vulnerability factors routinely every quarter.
- ✓ Use the risk segmentation tool to categorize the HRGs into four priority sub-groups (also see Service – Matrix below).
 - New & High Priority HRGs
 - Medium Priority (Maintenance)
 - Stable (Champions) and
 - HRG PLHIV
- ✓ Micro planning of outreach and service delivery – prioritizing the hotspots, HRGs, mechanism for combination methods for testing, and linking to treatment.
- ✓ Focus more on the high priority HRGs for intensive intervention, service provision, and risk reduction.

Service – Matrix

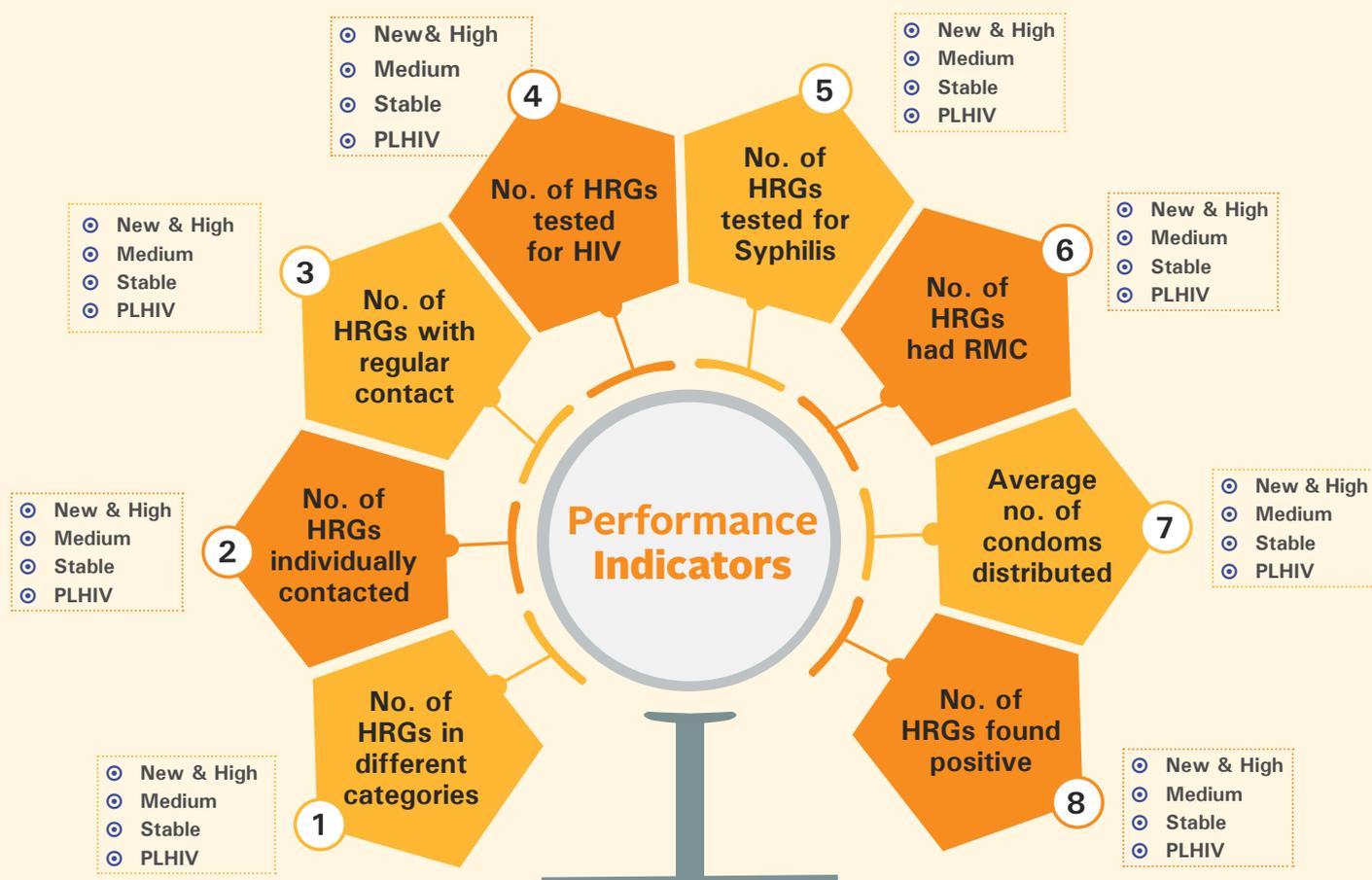
Services	New & High Priority HRGs	Medium Priority (Maintenance)	Stable (Champions)	HRG PLHIV
Contact (FSW, MSM & TG)	3 times a month	Twice a month	Once a month	Twice a month
Contact (IDU)	4 times a month	3 times a month	2 times a month	3 times a month
Clinic Visit/RMC	Each quarter	Each quarter	Half yearly	Referral to req. health services
HIV Testing	Once in six months	Once in six months	Yearly	-
Condom & Needle Syringes	Yes	Yes	Yes	Yes
Presumptive Treatment	Yes	Need based	Need based	-
BCC	Intensive DIC & Outreach Based	DIC	Hotspot Based	At facility
Priority service for PLHIV	-	-	-	ART Initiation & Adherence, Index Testing

Differentiated Prevention Strategies

New HRGs	High Priority	Medium Priority	Stable HRGs	HRG PLHIV
Outreach				
Contact four times in a month	Contact three times in a month	Contact twice a month	Contact once a month	Contact based on need and priority for linking with ART and tracking LFU
<ul style="list-style-type: none"> ▪ Focus on rapport building, risk assessment, and providing all essential services ▪ Equip the HRGs with knowledge and skills on STI/ HIV prevention in a step by step approach ▪ Counsel for behaviour change 	<ul style="list-style-type: none"> ▪ Focus on risk reduction and increasing service uptake ▪ DIC based intensive IPC/ Counselling and follow up outreach ▪ Greater engagement of ORW for intervention ▪ Risk reduction counselling 	<ul style="list-style-type: none"> ▪ Focus on retaining HRGs for existing services ▪ Outreach based IPC ▪ Risk reduction counselling 	<ul style="list-style-type: none"> ▪ Focus on keeping HRGs negative and motivate HRGs for sustained behaviour change ▪ Engage the community but with a lesser intensity ▪ Form a Champions Group and engage them in intervention activities ▪ Train members of community committees, as motivational speakers/ role model for behaviour change 	<ul style="list-style-type: none"> ▪ Navigation to ART centre for ART initiation ▪ Adherence support as well as step-up adherence counselling as per the need ▪ Priority for LFU Tracking ▪ Mobilizing for CD4 & VL testing
Services				
<ul style="list-style-type: none"> ▪ Condom/Needle syringe demand analysis and supply 	<ul style="list-style-type: none"> ▪ Condom/ Needle syringe demand analysis and supply 	<ul style="list-style-type: none"> ▪ Condom/ Needle syringe demand analysis and supply 	<ul style="list-style-type: none"> ▪ Exploring new models of condom distribution/ encouraging social marketing, if community prefers ▪ Establish new outlets/identify one champion as a volunteer for secondary distribution of condom, lubes and N/S as appropriate for the sub-pop 	<ul style="list-style-type: none"> ▪ Stock condom/ needle syringes at DIC ▪ Positive health, dignity and prevention (PHDP)

New HRGs	High Priority	Medium Priority	Stable HRGs	HRG PLHIV
<ul style="list-style-type: none"> OST counseling and navigation to OST centre for enrollment, link to support groups 	<ul style="list-style-type: none"> OST counseling and navigation to OST centre for enrollment, link to support groups Flexible timing at OST centres based on IDUs convenience 	<ul style="list-style-type: none"> Flexible timing at OST centres based on IDUs convenience 	<ul style="list-style-type: none"> To OST clients, provide retention counseling and follow up by OST centre staff on weekly basis If low priority IDUs (on OST) miss a dose for 3 days or more an immediate home visit/ follow up by OST counselor/ nurse be conducted 	<ul style="list-style-type: none"> Retention OST counseling to IDU PLHIVs Navigate IDU PLHIV on OST to ART centre for ART initiation.
Presumptive Treatment	<ul style="list-style-type: none"> Quarterly RMC Camp-based approach for STI in prioritized hotspots / populations 	Quarterly RMC	<ul style="list-style-type: none"> Encourage the HRGs to avail services in a self-initiated way 6 monthly RMC and need-based STI services 	<ul style="list-style-type: none"> Need-based referral to health services incl. STI services Linking with social protection schemes Other prevention services as per the guidelines
HIV Testing: Immediately after registration and within a month	<ul style="list-style-type: none"> HIV Testing: Once in six (6) months Community-based screening in prioritized hotspots / populations 	HIV Testing: Once in six (6) months	HIV Testing: Once a year	
Use network models for reaching sexual, injecting and social networks of HRGs and their sexual partners and spouses	Use network models for reaching sexual, injecting and social networks of HRGs and their sexual partners and spouses	Use network models for reaching sexual, injecting and social networks of HRGs and their sexual partners and spouses	Use network models for reaching sexual, injecting and social networks of HRGs and their sexual partners and spouses	Conduct index testing
				Navigation of HIV positive HRGs for ART initiation

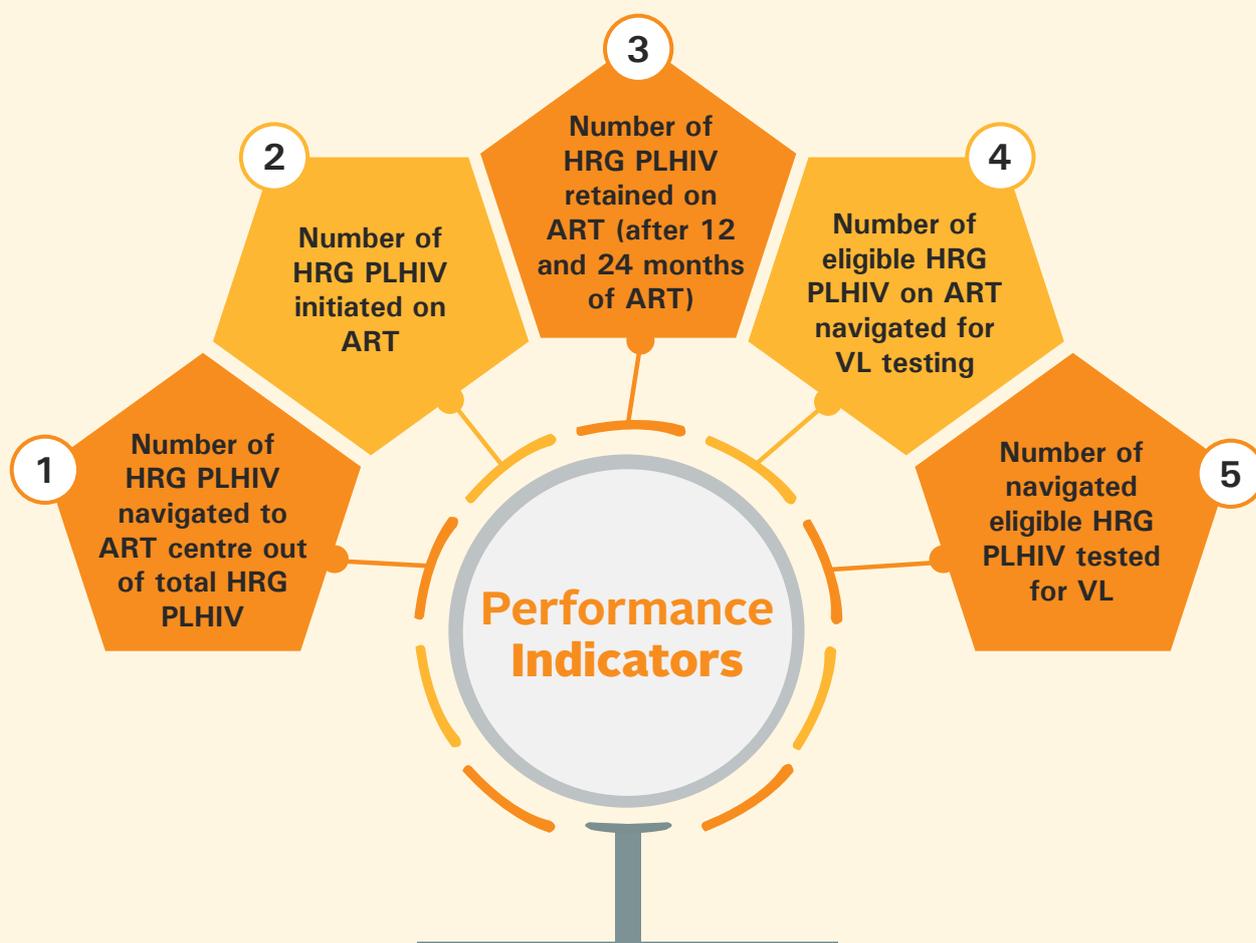
Referral for other health services and social protection schemes	Referral for other health services and social protection schemes	Referral for other health services and social protection schemes	Referral for other health services and social protection schemes	CD4 Test: Once in six months VL Test: Annually
Community Engagement				
Engage the community in the planning and implementation of all services	Engage the community in the planning and implementation of all services	Engage the community in the planning and implementation of all services	Engage the community in the planning and implementation of all services	<ul style="list-style-type: none"> Engage the community in the planning and implementation of all services Create / enhance community support groups
Implement community score card system to improve access and quality of services	Implement community score card system to improve access and quality of services	Implement community score card system to improve access and quality of services	Implement community score card system to improve access and quality of services	Implement community score card system to improve access and quality of services



5.2 Navigation

Navigation is one of the approaches recommended by Mid-Term Appraisal of NACP IV. Navigation is proposed to achieve the second and third 90 of 90:90:90 target. All HRG PLHIV detected at the TI level will be navigated to ensure linkages for ART initiation. Following are the key strategies for navigation:

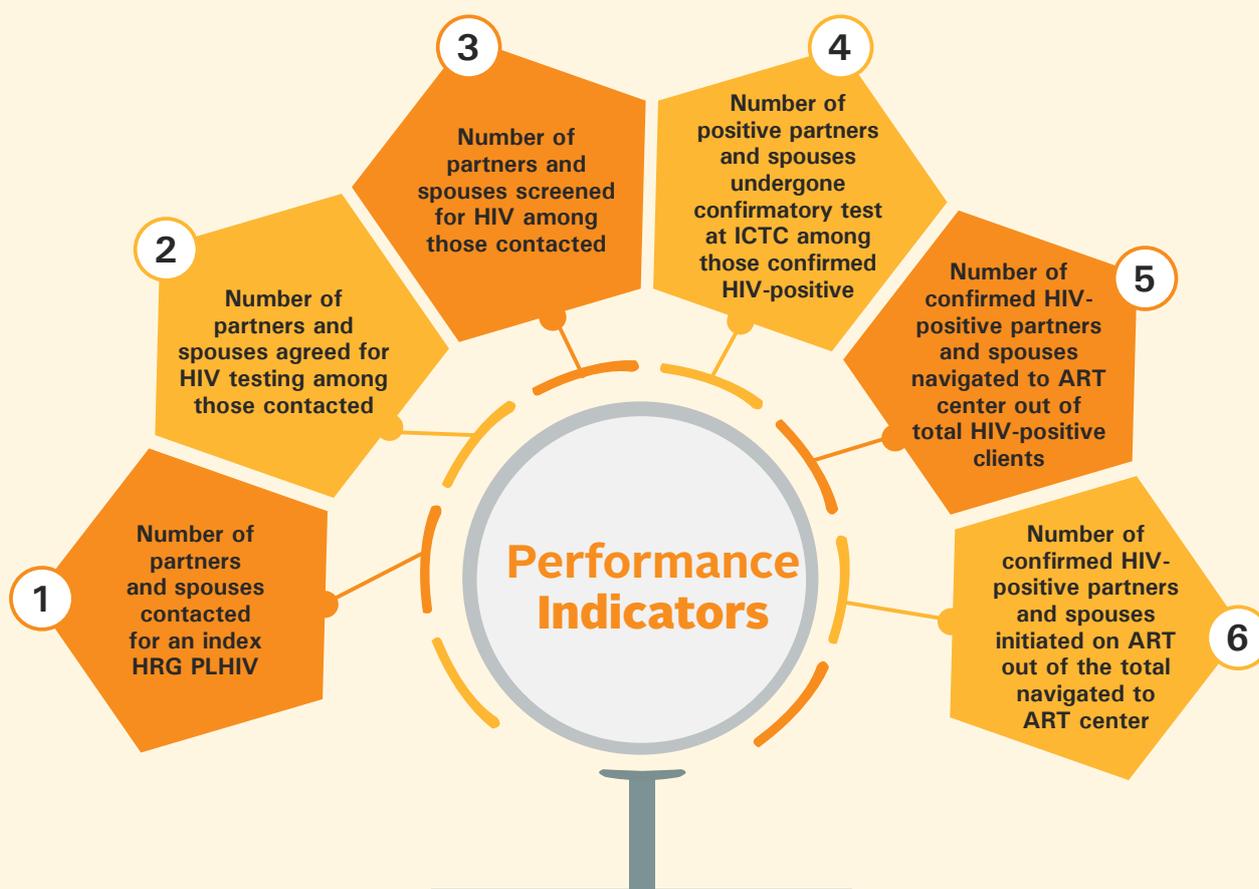
- Navigation to be implemented by TIs to navigate all the HRG PLHIV enrolled at TIs for ART and coordinate with ART staff for initiation of ART.
- A joint meeting of ART centre and TIs should be held for implementation of the peer navigation programme.
- Navigation will be carried out by all or two to three designated Peer Educators (PE). PEs /ORWs need to be oriented on the process of peer navigation including ART initiation.
- The counselor will need to provide the list of HRG PLHIV to the designated peer navigator who will educate the client and navigate them to the ART centre.
- The PE/ORW will also track the lost-to-follow up HRGs (in coordination with ART center, care and support centre and TIs) and link them to ART; support in ART adherence, retention and mobilization of all eligible HRG PLHIV for viral load testing.



5.3 Index Testing

Index testing is a highly recommended strategy to increase the reach and testing coverage of sexual partners, spouses, social and injecting networks of the index client. Index client is an HRG diagnosed HIV-positive, HIV testing is done through either voluntary or assisted partner notification after ART initiation and stabilization. Index testing increases HIV testing coverage of hidden HRGs and their sexual, social and injecting partners in the community. Index testing, as an approach is critical to achieve the 90:90:90 goals and to break the HIV transmission chain. The counselors/ANM employed with TIs will be responsible for managing index testing. The following activities should be ensured:

- Voluntary testing should be encouraged and confidentiality should be maintained (TIs to ensure).
- HIV screening should be carried out by trained staff and those reactive will be navigated to the nearest ICTC for confirmatory test. Counselor employed with TI will be responsible to manage index testing.
- The counselor/ANM should work closely with the PE and HRG PLHIV and adopt a person-centered approach ensuring that the HRG PLHIV are stabilized on ART first and then supported on partner notification.



5.4. Community Based Screening

In order to achieve the first 90 of the 90:90:90 target, it is proposed that community based screening (CBS) will be implemented through TI and LWS across the country. CBS is important for improving early diagnosis, reaching first-time testers and people who seldom use clinical services.

- ⊙ TI programme should ensure coverage of at risk populations for HIV screening, while prioritizing newly registered groups, groups of young people, groups that get repeated STIs, abscess, etc., or are not using condoms or clean needle/syringes regularly, regular partners, etc. or groups that have never been screened/tested.
- ⊙ HRGs should be identified and facilities (or alternative facilities) should be selected to suit the convenience of the groups.
- ⊙ Audio-visual privacy should be ensured and informed consent documented at all screening facilities.

Biomedical waste management plan

TI team should ensure that protocols are followed for maintaining universal safety precautions. During offsite camps, a lot of bio-medical wastes are generated, which should be treated and disposed of as per NACO's BWM Guidelines (2019)². All TI and LWS staff shall be trained on cold chain management and bio-medical waste management.





COMMODITY DISTRIBUTION

Commodity Distribution

6.1 Secondary Distribution of Needle and Syringes

Secondary Distribution of Needles & Syringes (SDNS) programme aims to establish new outlets in hard-to-reach and unreached geographies for distribution of needles/syringes (NS). SDNS outlets are established in government health facilities, shops, pharmacies, volunteers and other public facilities.



Health Facilities



Shops



Pharmacies



volunteers

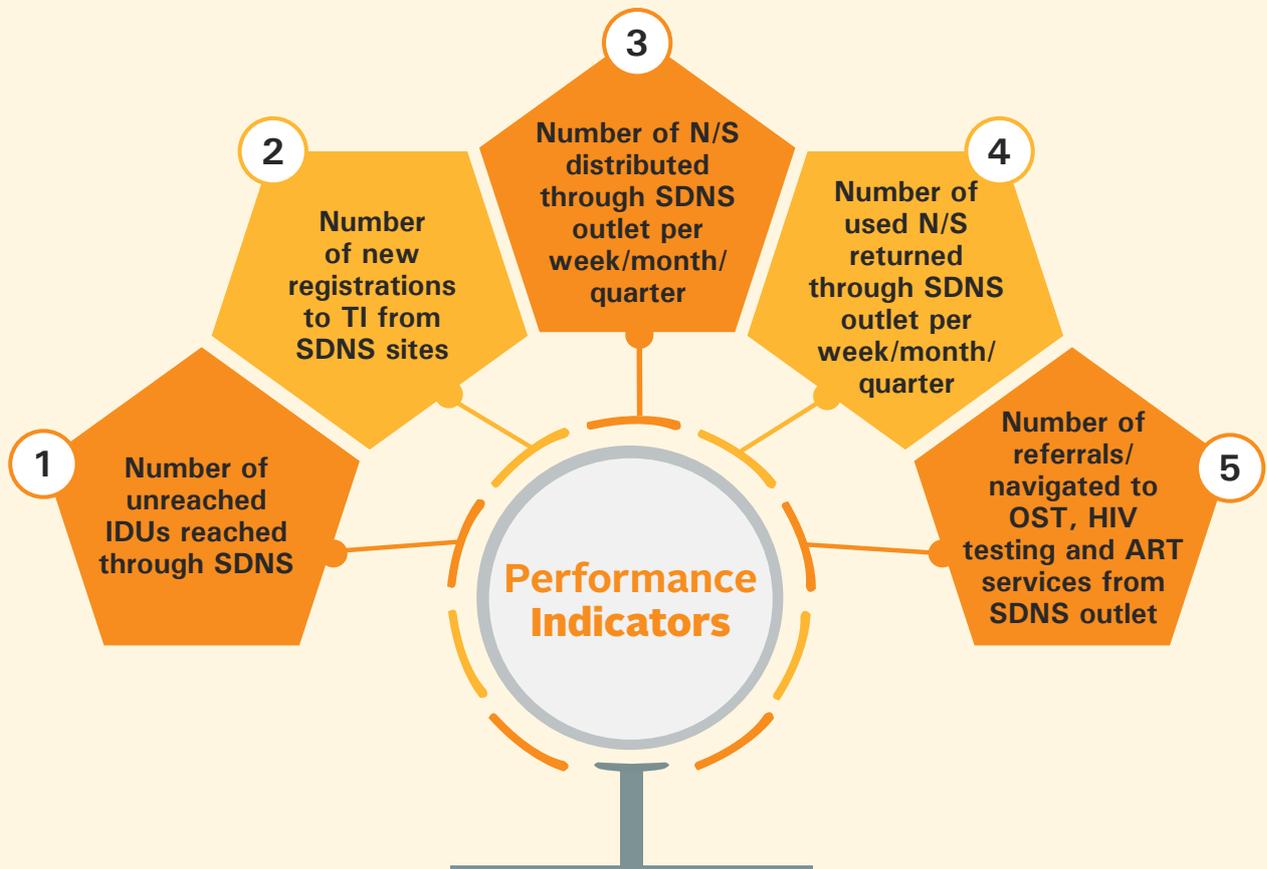


Public Facilities

Distribution of NS for IDUs can also act as an entry point for delivery of the comprehensive harm reduction packages. The following activities need to be implemented:

- ⦿ TI Project Managers (PM) will lead the process of establishing SDNS outlets. This includes site-specific community consultations, feasibility assessments and estimation of NS requirement of IDUs population at the identified sites.
- ⦿ PM need to designate outreach workers (ORWs) and PEs for providing onsite support to SDNS outlets.
- ⦿ ORWs need to conduct site-level sensitization and involvement of stakeholders in SDNS.
- ⦿ PEs/ORWs need to motivate and navigate the SDNS clients to Opioid Substitution Centres (OST) for enrolment.
- ⦿ TI needs to conduct HIV screening at SDNS site and navigate to Integrated Counseling and Testing Centres (ICTC) for confirmatory test.
- ⦿ HIV positive IDUs should be navigated to ART center to facilitate ART initiation.

- Unreached IDUs identified through SDNS need to be motivated for registration in TI.
- SACS/TSU need to train all IDU TIs on SDNS processes.
- Orientation of SDNS outlets/stakeholders for distribution of NS and maintenance of records should be done by TI PMs.
- Cost for consultative meetings and feasibility assessment can be met from the existing budget heads of (community meetings, DIC-level meeting and demand generation activities).
- SDNS sites should be monitored by SACS/TSU and TI- PM.
- Existing operational guidelines to be referred regarding collection of used needles/syringes and bio-medical waste management for SDNS.



6.2 Satellite OST Centre

The proposed intervention is to enhance the access of Opioid Substitution Therapy (OST) services to IDUs who are staying at distant places or far-flung areas. A satellite centre can be set up at the TI DIC or sub-DIC, PHC, UHC, CHC, private health facilities, stand-alone clinics or prison settings.



Health Facilities



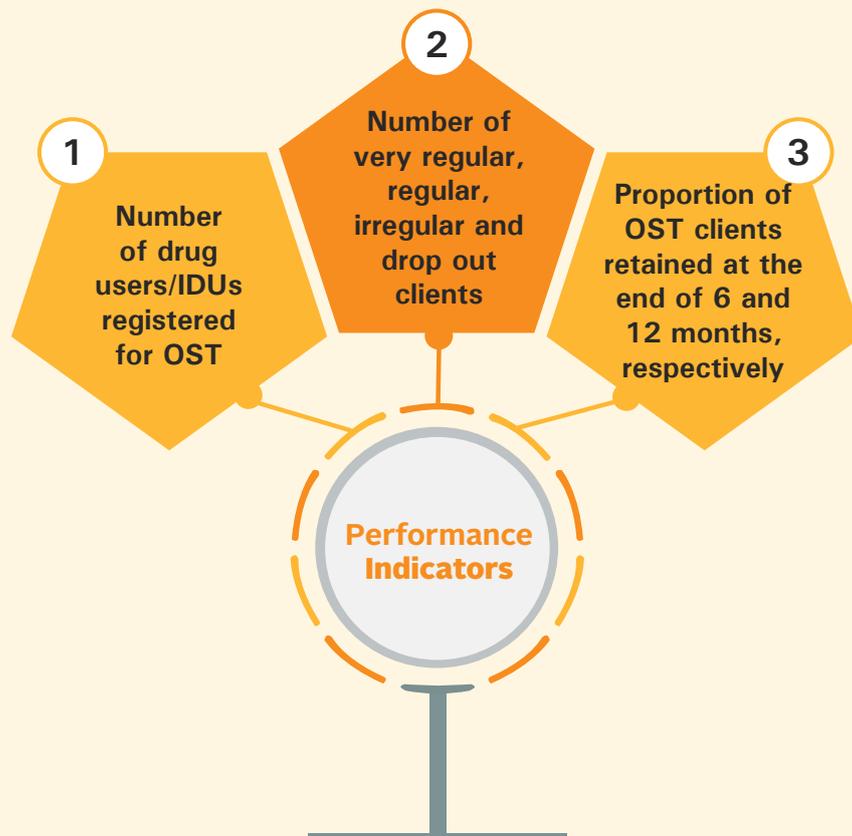
Stand-Alone Clinics



Prison Settings

The accredited OST centre will serve as the parent/base centre for providing medication and medical staff to satellite OST centres. There will not be any cost implications for setting up satellite OST centres except for training and medicine charges.

- ⦿ A feasibility assessment needs to be conducted by SACS in consultation with the TI.
- ⦿ The medical doctor (nodal officer) of the nearest parent OST centre will be responsible for OST induction, dosing, medical check-up and health care services at the satellite OST centre.
- ⦿ Stable OST clients from the base OST centres can be transferred (on doctor's advice) to satellite OST centres. In case of NGO OST centre, the follow-up is done by the doctor and ANM/counselor of IDU TI. In case of satellite OST centres located in public health facility, follow-up is done by doctor and counsellor of base OST centre on weekly basis.
- ⦿ Training to be provided to doctors and paramedical team located in prison if a satellite OST centre is proposed in such settings.
- ⦿ On-site mentoring needs to be provided using resource persons from existing OST centres and TIs.
- ⦿ Stocks are issued to satellite OST centres by the base OST centre once in two weeks.
- ⦿ Coordination meetings should to be conducted between the base and satellite OST centre every two weeks.
- ⦿ It is the responsibility of SACS to ensure that the staff of the selected satellite OST centre are trained on NACO OST guidelines and operational mechanisms.

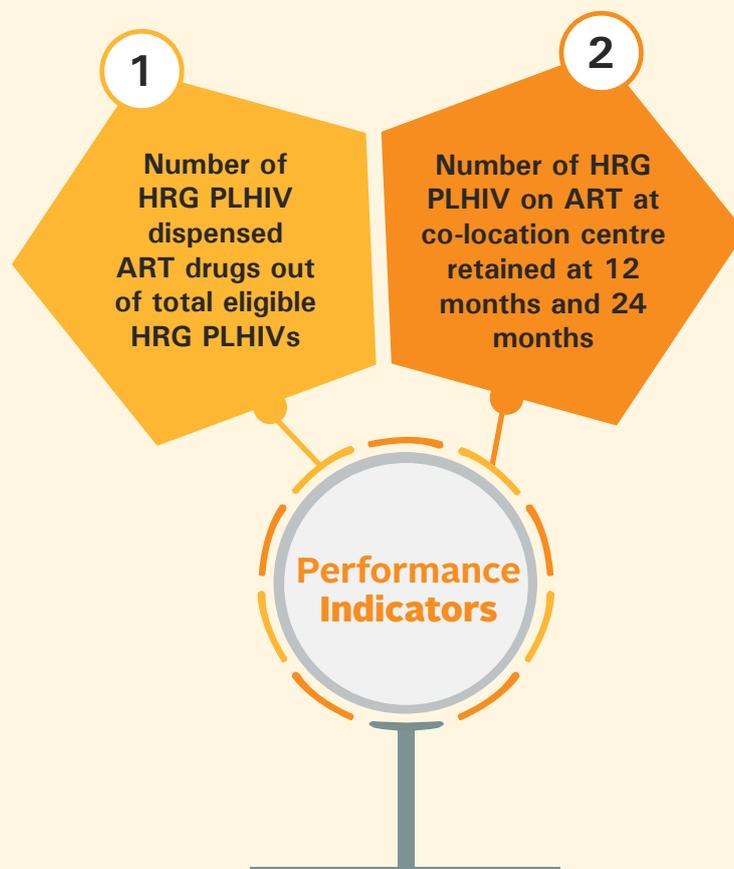


6.3 Community Based ART Dispensation

To ensure that 90% of the HRG PLHIV are retained for ART, community based ART dispensation based on eligibility criteria is required to be implemented jointly by TI and ART programmes as part of decentralized care. The following activities have to be implemented for this purpose:

- ⦿ To establish a co-located ART-TI centre vis-à-vis community based ART dispensation unit, a feasibility assessment will be conducted jointly by TI and CST division with support of TSU.
- ⦿ Training of TI team on the co-location SOP will be conducted jointly by TI and CST divisions.
- ⦿ TI part-time medical officer will conduct the clinical review of HRG PLHIV who meet the criteria for stable ART clients.

- ⊙ M & E officer will prepare the eligible line list.
- ⊙ A nurse will dispense the ART drugs and will be responsible for supply chain management.
- ⊙ Outreach workers including the peer educators will mobilize the HRG PLHIV for enrollment and will follow up for retention.
- ⊙ The clients need to be navigated to ART centre every six months for clinical review by ART medical officer.
- ⊙ The ART centre will provide the ART drugs to the NGO.





COMMUNITY SYSTEM STRENGTHENING

Community System Strengthening

7.1 Community Scorecard

One of the recommendations of mid-term appraisal of NACP-IV was to strengthen the community feedback mechanism. Community scorecard is an approach to receive systematic feedback from the community and service providers. This is to increase the engagement of the community in improving the quality of HIV service delivery. The key features of the community scorecard include:

- ⦿ Scores are given by the community and health care providers (HCPs) on a set of core/sub indicators separately and individual group(s) arrive at a consensus score.
- ⦿ An interface meeting between the community and the HCPs is conducted where the scores provided by the HCPs and the community is reviewed. An action plan is developed with concrete action steps for improving the service delivery, based on the discussions.
- ⦿ This exercise is repeated on a quarterly basis, to review the progress on action taken and develop the action plan for the next quarter.
- ⦿ Community scorecard will be implemented by SACS/TSUPO and facilitated by TI Project Manager.
- ⦿ SACS will have the overall responsibility to monitor the implementation of community scorecard system.

The background is a dense, repeating pattern of various icons related to health, medicine, and biology. The icons are rendered in shades of orange and red. Recognizable symbols include syringes, pills, hearts, hands, ribbons, and various anatomical and biological symbols like a female symbol, a male symbol, a DNA helix, and a microscope. The overall aesthetic is clean and modern, with a focus on medical and scientific themes.

OTHER STRATEGIES

Other Strategies

8.1 Clinical Services

Targeted Intervention are currently providing referral and linkages with various other facilities for treatment of STI and TB. In order to ensure timely diagnosis and treatment of STI and other co-infections, following need to be considered:

- ⊙ Establishing referral and linkages with existing programmes such as RNTCP, RMNCH+A and other general health services to increase access to comprehensive health services.
- ⊙ It is recommended that STI services for HRGs need to include the provision for sexual and reproductive health services.

8.2 Enabling Environment

Creation of enabling environment is a key component of any TI programme. The activities of enabling environment include advocacy with key stakeholders (gatekeepers, police, lawyers, local administration, local political leaders, and other government programmes), crisis response, crisis mitigation, stigma reduction and peer advocacy. The following activities need to be carried out:

- ⊙ TI should prepare a key stakeholders list in consultation with representatives of community members on annual basis and submit to TSU/ SACS.
- ⊙ Stakeholders meeting should be conducted every quarter. Minutes and actions should be documented.
- ⊙ The PO of the TSU should monitor the stakeholders meeting and provide necessary guidance to TIs.
- ⊙ Stakeholders should be sensitized on violence by partners/clients and methods to address the crisis including stigma and discrimination.
- ⊙ HRGs with leadership skills should be identified and trained for representing in stakeholder meetings.
- ⊙ ORWs/PEs should monitor crisis incidents faced by HRGs and the management of the crisis.

- ⊙ TI should identify PE with leadership skills to serve as Peer Advocate. She/he should also be trained on advocacy skills for liaising with existing local power structures.
- ⊙ TI should coordinate with DALSA to facilitate sensitization/training of the various stakeholders on legal awareness, human rights, women's rights, dissemination of legal cases of women in crisis situation etc.

8.3 Female Injecting Drug Users

Female injecting drug users (FIDUs) have significant barriers in accessing HIV services from the health facilities due to the stigma attached to it. The specific additional needs of FIDU population need to be recognized. Key themes of FIDU friendly services include mentoring services, congregation of multiple services at the TI including support groups, and specific guidance for satellite OST, co-location of ART and an enabling environment. The strategy for FIDUs include:

- ⊙ Single window approach of providing needles and syringes, condom, screening of HIV and syphilis, OST and the co-location of ART dispensation by the TI.
- ⊙ Index HIV testing by Counselor/ANM.
- ⊙ Navigation to ART centre and ART initiation.
- ⊙ Facilitate for the provision of night shelter facility in the drop-in-centre.
- ⊙ Facilitate formation of self-help/support group.
- ⊙ Facilitate linkages to income generation, social protection schemes, mental health services, and the provision of legal aid services.
- ⊙ Current standard IDU TI indicators are also applicable for FIDU TI.

8.4 Spouses and Female Partners of IDUs

Active involvement of female spouses and partners will enhance service uptake, regular clinical check-up, treatment adherence, etc. among the IDUs. There are specific services which spouses and partners can directly avail at the TIs while other services can be made available through appropriate referrals and linkages. The strategies for spouses and partners of IDUs includes the following:

- ⊙ Index testing of spouses and sexual partners.
- ⊙ Navigation of positive spouse to ART centre for ART initiation and follow up for ART retention.
- ⊙ Syphilis testing and treatment.
- ⊙ Linkage to social protection schemes.
- ⊙ Make spouse/partner part of the treatment team.
- ⊙ Serves as a SDNS for distribution of NS to spouse/partner.
- ⊙ Motivate injecting partner for OST enrollment, HIV testing, ART initiation and ART retention.

8.5 Dera/Gharana/Jamath Based

This strategy is suited for reaching the hitherto unreached HTG people in pockets where there is a strong network of Dera leaders. It is to be noted that there could be different names used by different states instead of Dera/Gharana/Jamath.

1. Dera leaders' meeting needs to be organized to make them understand the importance of reaching the unreached, about the risk and vulnerability factors involving HTG people, and how the Dera leaders support will be helpful.
2. Dera leaders' WhatsApp groups can be created wherein the leaders can actively participate in the discussion to emphasise the need for HIV testing to their followers.
3. Dera-led meeting, Dera-led community-based testing can be conducted under this strategy.

8.6 Event-Based

This is an event-based strategy to identify new H/TG people who are not part of the existing TI. The strategy proposes to recruit community mobilizers (CMs) and utilize HTG focused festivals such as Sitalasthi, Koovagam etc. to mobilize HRGs for availing HIV prevention services. Considering the geographical location of the districts wherein the HTG people are scattered, establishing leadership, smart outreach, community-based testing, mobilizing them through cultural events combined with different outreach approaches, leaders' messages on prevention through social media and WhatsApp groups are needed to make the event more successful.



National AIDS Control Organisation

India's Voice against AIDS
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in