



सत्यमेव जयते

# OPERATIONAL GUIDELINES For Care and Support Centres



National AIDS Control Organisation  
Ministry of Health and Family Welfare  
Government of India  
New Delhi  
August 2018





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भारत सरकार  
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Government of India  
Ministry of Health & Family Welfare  
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*Dated the 5<sup>th</sup> October, 2018*

Foreword

*The National AIDS Control Organisation envisions an India where every person living with HIV has access to quality care and is treated with respect. The Care and Support Centres (CSCs) functioning across the country since 2013 are part of our endeavour to improve the survival and quality of life of People Living with HIV (PLHIV). CSCs serve as a comprehensive unit for supporting more than a million PLHIV enrolled in the national ART programme, focusing on treatment adherence, positive prevention, timely detection and management of OIs, linkages with social welfare schemes and entitlements and bringing lost to follow up cases back to treatment.*

*Building on the lessons learnt from the first phase, the programme has adopted the differentiated care model to support the ART programme to achieve better retention of PLHIV in care and ensure their viral suppression. Differentiated care is a client-centered approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of PLHIV while optimising the functioning of the health system. Under this model, the CSCs will have focused interventions among those PLHIV who are yet to be put on ART, those who are newly initiated on ART, and those with less than 80% treatment adherence. This strategy is expected to help the national programme to achieve targets set under the National Strategic Plan (NSP) by 2024.*

*I hope this guideline will be useful to the policy makers, implementers, care providers and all stakeholders in providing excellent care to the people living with HIV.*

  
(Sanjeeva Kumar)







आलोक सक्सेना  
संयुक्त सचिव  
**Alok Saxena**  
Joint Secretary



### Message



राष्ट्रीय एड्स नियंत्रण संगठन  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
भारत सरकार

National AIDS Control Organisation  
Ministry of Health & Family Welfare  
Government of India

India is a vast country having varied geographical terrains and diverse population with different health care needs. Provision of free ART treatment has been an integral part of National AIDS Control Programme (NACP) since 2004. However, the program has identified the need of Care and Support Services along with treatment to improve the quality of care and life of PLHIVs.

Care and Support Centres (CSCs) have been working determinedly since 2013 with the goal of improving the survival and quality of life of PLHIV registered in ART centres. PLHIV networks have got vital role in implementing Care & Support programme across the country. The functions of CSCs comprehended with maximum number of PLHIVs linked to social welfare schemes, track back Lost to Follow-up patients, encourage spouse testing for HIV and community level TB screening among PLHIV.

Care and Support programme have moved to a new phase from January 2018. Based on the experiences and lesson learnt in the last phase, resources were allocated accordingly in current phase. Provision of 'Differentiated Care' has been adopted to address the diversified needs of PLHIVs. 'Prevention of new LFU' is the core objective of this phase in which both ART centres and CSCs will proactively engage with PLHIVs newly initiated on ART and those with less than 80% adherence.

Since the inception of CSCs Outreach activities are being considered as the backbone of the programme. Further new additions to the existing eMpower tablet has enhanced the LFU tracking outcomes.

NACO envisions both ART centres and CSCs continue to work in close coordination and result in increased number of PLHIV retained in the treatment with suppressed viral load. Detailed functions and provisions in new phase of CSCs are discussed in this guidelines. I assume this guideline will help for focussed reach out to PLHIVs to improve their quality of life through proper adherence counselling and better LFU track back outcome. Further, it gives a clear roadmap for health care provider's to deliver quality Care and Support services for all PLHIVs. Let us pledge for ourselves together for achieving this goal for the benefit of PLHIV care in India.

  
(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





भारत सरकार  
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**Acknowledgement**

The Operational Guidelines for Care and Support Centres was published by NACO in December 2013 following the roll-out of the programme in the same year. The December 2013 version has now been revised considering the changes in the approach and strategy over the last five years as far as the delivery of care and support services for PLHIV is concerned. The revisions have been made after a wide consultative process involving the PLHIV community and experts from all over the country.

I would like to express my sincere gratitude to Sh. Sanjeeva Kumar, AS&DG, NACO for his relentless support and guidance to Care & Support programme and to the PLHIV networks. I would also acknowledge the timely support and explicit direction by Sh. Alok Saxena, JS, NACO for all activities under Care & Support programme.

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We hope these guidelines will go a long way in implementing the Care and Support Centres in the country.

  
(Dr. R.S Gupta)



# Contents

Glossary	1
Key Definitions	3
<b>1. Introduction</b>	<b>5</b>
1.1 Brief Introduction to Care and Support Programme	6
1.2 Role of CSC in Meeting the Objectives of National Strategic Plan 2017-24	6
<b>2. Infrastructure and Human Resources for CSC</b>	<b>7</b>
2.1 Location and Access to CSC	7
2.2 Infrastructure Required at CSC	7
2.2.1 Reception cum Waiting Area	7
2.2.2 Project Office Area	7
2.2.3 Space for Relaxation	7
2.2.4 Counselling Room/Space	8
2.2.5 Information to be displayed at CSC	8
2.2.6 Furniture Provisions for CSC	8
2.3 Human Resources for CSC	8
2.3.1 Staff Selection Process	9
2.3.2 Staff Positions for CSC	9
2.3.3 TOR of Staff at CSC	
<b>3. Services Provided by CSC</b>	<b>15</b>
3.1 Registration of PLHIV in CSC	15
3.1.1 Registration Criteria:	15
3.1.2 Registration Cannot be Done under the Following Conditions	16
3.1.3 Documents Required for Registration at the CSC	17
3.2 Differentiated Care Model in CSC	17
3.2.1 Service Package under Differentiated Care Model	18
3.3 CSC Service Matrix	26
3.3.1 Counselling Services	28
3.3.2 Referral and Linkage Services	28
3.3.3 Support Group Meeting	31
3.3.4 Enabling Environment	32



<b>4. Outreach Services</b>	<b>33</b>
4.1 Outreach Strategy	33
4.1.1 Allocation of Outreach Workers	33
4.1.2 Minimum Standards to be Maintained	34
4.1.3 Activities to be Carried out During Outreach	34
4.1.4 Outreach Mapping	34
4.2 Inter-district LFU Tracking Mechanism	35
4.4 Outcomes of Outreach	37
4.5 Technology-enabled Outreach: eMpower Tablet-based Application	37
<b>5. Advocacy</b>	<b>39</b>
5.1 Stakeholders for Advocacy	39
5.2 Steps in Advocacy	40
5.3 Characteristics of Good Advocacy Messages	42
5.4 Information Centre	42
5.5 Discrimination Response System	42
5.5.1 Structure of DRT	43
5.5.2 Response to Discrimination Incident	43
5.5.3 Reporting Mechanism for DRT	43
5.6 Advocacy Meetings	43
<b>6. Care and support services for children and adolescents living with HIV/AIDS</b>	<b>45</b>
6.1 Special Provision for Children in CSC	46
<b>7. Care &amp; Support Services for Key Populations (KP)</b>	<b>47</b>
7.1 Care and Support Needs of KPs	47
7.1.1 Special Provision for KPs under CSC	47
7.1.1.1 Counselling Services	47
7.1.1.2 Outreach Activities to Ensure Better Reach to KPs	47
7.1.1.3 Support Group Meeting for KPs	47
7.1.1.4 Linkages and Referrals for Services	48
7.1.2 KP Service Matrix under CSC	49
7.2 Care, Support, Treatment for Transgender Populations	50
7.2.1 Transgender and HIV	50
7.2.2 Barriers in Accessing HIV Care and Support Services for TG	51
7.2.2.1 Personal and Social Barriers	51
7.2.2.2 Community Level Barriers	51
7.2.2.3 Health System Barriers	51



7.3 Transgender-specific CSC	52
7.3.1 Service package of TG-CSC	52
7.3.2 Functioning of TG-CSC	53
7.3.2.1 Operational Area of TG-CSC	53
7.3.2.2 Human Resource for TG-CSC	53
7.3.2.3 Coordination Mechanism between TG-CSC and General CSCs for Service Delivery	53
7.3.2.4 Reporting Architecture for TG-CSC	54
<b>8. Supervision and Monitoring of CSC</b>	<b>55</b>
8.1 Data Flow of CSC	55
8.2 Monitoring Framework	56
8.3 Reporting Architecture	57
8.4 Core Indicators for Monitoring of Programme Activity	57
8.5 Definition of Key Indicators in LFU tracking	58
8.5.1 Agreed to Visit ART Centre	58
8.5.2 Physically Taken to ART Centre	59
8.5.3 Death	59
8.5.4 Taking ART at other NACO ART Centre	59
8.5.5 Incorrect Address	59
8.5.6 Duplicate Entries	60
8.5.7 Migrated	60
8.5.8 Transferred Out	60
8.5.9 Alternative Medicine	60
8.5.10 Taking Private ART	61
8.5.11 Others	61
8.5.12 Reported back to ART Centre as Reported in MPR	61
8.6 Additional Indicators to be used for Monitoring Programme Performance	61
8.6.1 Coverage Indicators	61
8.7 Reporting Mechanism	63
8.8 Data Mharing mechanism between CSC, ART Centre, DAPCU and SACS	63
<b>9. Capacity Building</b>	<b>65</b>
9.1 Types of training	65
9.1.1 Induction Training	65
9.1.2 On-the-job Training	65
9.1.3 Re-orientation	65
9.1.4 Need-based Training	65

9.2 Training Methodologies	65
9.2.1 In-house Training	65
9.2.2 Virtual Training	66
9.3 Training Aids	66
<b>10. Governance and Role of Stakeholders</b>	<b>67</b>
10.1 CSC Governance Structure	67
10.1.1 National Coordination Committee	67
10.1.2 Key Functions of NCC	67
10.1.3 Profile of Members of NCC	68
10.1.4 Meeting of NCC	68
10.2 State Oversight Committee (SOC)	68
10.2.1 Key Functions of SOC	68
10.2.2 Member Profile of SOC	68
10.2.3 Quorum for SOC	69
10.3 Role of Stakeholders	69
10.3.1 National AIDS Control Organisation	69
10.3.2 State AIDS Control Society	69
10.3.3 District AIDS Prevention Control Unit (DAPCU)	69
10.3.4 Principal Recipient (PR)	70
10.3.5 Sub-Recipients (SR)	70
10.3.6 Care and Support Centres	70
10.4 Coordination Mechanism - CSC and ART Centres	70
10.4.1 Monthly ART-CSC Coordination Meeting	71
10.5 CSC and District AIDS Prevention & Control Unit (DAPCU)	72
<b>11. Establishment and Closure of CSC</b>	<b>73</b>
11.1 Establishing CSC	73
11.2 Eligibility Criteria for NGO/CBO Setting up a CSC	73
11.3 Selection Process of NGO/CBO for Setting up CSC	74
11.3.1 Promotion of Request for Proposal (RfP)	74
11.3.2 Community Consultations	74
11.4 Review of Proposals	74
11.4.1 Role of External Agency	74
11.4.2 Role of JAT	75
11.4.3 Final Selection and Contract Signing	75
11.5 Closure of CSC	75
11.5.1 Closure of a CSC: Points for Consideration	75

11.5.2 Conditions Necessitating Closure of CSC	76
11.5.3 Key Definitions	76
11.5.3.1 Misappropriation of Funds	76
11.5.3.2 Constant Poor Performance on Core Indicators over two Quarters	76
11.5.3.3 Non-compliance with CSC Guidelines	76
11.5.3.4 Fudging of M&E Data	76
11.6 Checklist for PR and SR on CSC Closure Process	76
<b>12. Financial Management of CSC</b>	<b>79</b>
12.1 Accounting and Book Keeping	79
12.1.1 General Accounting System	79
12.1.2 Method of Accounting	79
12.1.3 Books of Accounts	79
12.1.4 Updating of Books of Accounts	79
12.1.5 Access to Books of Accounts, Accounting and Financial Information	79
12.1.6 Chart of Accounts	80
12.1.7 Vouchers	80
12.1.7.1 Vouchers Type	80
12.2 Recording of Receipt and Expenditure	80
12.2.1 Receipts	80
12.2.2 Expenditure	80
12.2.3 Authorisation Limits for Approving the Expenditure	80
12.3 Month and Year-end Closure Accounting Process	81
12.3.1 Monthly Closure	81
12.3.2 Year-end	81
12.3.3 Adherence to Statutory Compliances	81
12.4 Policy and Procedure	81
12.4.1 Procurement Policy	81
12.4.2 HR Policy	82
12.4.3 Travel Policy	82
12.4.4 Staff Advances for Project Activities and Travel	82
12.4.5 Use of Private/Organisational Vehicle	82
12.4.6 Allocation of Common Costs	83
12.4.7 Conflict of Interest	83
12.5 Donor Compliance	83
12.6 Delegation of Authority	83
12.7 Governance Aspects	83



# Glossary

ANM	Auxiliary Nurse Midwife
ART	Anti-retroviral Therapy
APL	Above Poverty Line
ASHA	Accredited Social Health Activist
AWW	Aanganwadi Worker
BPL	Below Poverty Line
CBO	Community Based Organisation
CCC	Community Care Centre
CD4	Cluster of Differentiation 4
CST	Care, Support and Treatment
CSC	Care and Support Centre
CLHIV	Child Living with HIV
CSO	Civil Society Organisation
CST	Care Support and Treatment
DALSA	District Legal Services Authority
DAPCU	District AIDS Prevention & Control Unit
DIC	Drop-in-Centre
DLN	District Level Network
DHO	District Health Officer
DRT	Discrimination Response Team
DOTS	Direct Observed Treatment Short course
DTO	District Tuberculosis Officer
DQA	Data Quality Audit
FSW	Female Sex Worker
HRG	High Risk Group
JAT	Joint Appraisal Team
JD	Joint Director
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug Users
IEC	Information Education Communication
LFU	Lost to Follow Up
LSE	Life Skill Education

LWS	Link Worker Scheme
NACP	National AIDS Control Programme
NGO	Non-Governmental Organisation
NRLM	National Rural Livelihood Mission
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MSM	Men who have Sex with Men
MTH	MSM/Transgender/Hijra
OBC	Other Backward Classes
OI	Opportunistic Infections
ORW	Outreach Worker
OVC	Orphan and Vulnerable Children
PC	Project Coordinators
PD	Project Director
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PHC	Primary Health Centre
PPTCT	Prevention of Parent to Child Transmission of HIV
PR	Principal Recipient
PWID	People Who Inject Drugs
RFP	Request for Proposal
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SC	Scheduled Caste
SLN	State Level Network
ST	Scheduled Tribe
STI	Sexually Transmitted Infection
STO	State Tuberculosis Officer
SOC	State Oversight Committee
SOE	Statement of Expenditure
SR	Sub-Recipient
SRH	Sexual and Reproductive Health
SSR	Sub Sub-Recipient
TB	Tuberculosis
TG	Transgender
TI	Targeted Interventions
TOT	Training of Trainers
UC	Utilisation Certificate

# Key Definitions

- 1. Adherence:** “Extent to which a person’s behaviour - the taking of medication and the following of a healthy lifestyle including a healthy diet and other activities – corresponds with the agreed recommendations of the health care providers” (WHO, 2003).
- 2. Advocacy:** Advocacy is a method and a process of influencing decision-makers and public perceptions about an issue of concern and facilitating collective action to achieve social change and a favourable policy environment to address the concerns.
- 3. Balanced Diet:** Balanced diet consists of a variety of different types of foods which provide adequate amounts of nutrients necessary for good health.
- 4. CD4 Count:** CD4 cells are a type of white blood cells that fight infection. The CD4 count measures the number of CD4 cells in the blood sample. The CD4 count helps to understand how strong one’s immune system is, indicates the stage of HIV disease, guides treatment and predicts how the disease may progress. Keeping the CD4 count high can reduce complications of HIV and extend life.
- 5. Community Mobilisation:** A process through which individuals, groups or organisations plan, carry out and evaluate activities on a participatory and sustained basis to improve their health and other needs either on their own initiative or stimulated by others. This would lead to collectivisation and the empowerment of the community if adequately backed by capacity building.
- 6. Concordant Couple:** A couple in which both the partners are seropositive for HIV.
- 7. Disclosure:** It is the act of informing another person or persons of the HIV-positive status of an individual. Disclosure may be done by the clients themselves or with the help of another person such as a counsellor.
- 8. Discordant Couple:** A couple in which one partner is seropositive for HIV and the other is negative.
- 9. Discrimination:** It refers to the unjust or prejudicial treatment of different categories of people especially on the grounds of HIV status.
- 10. Documentation and Reporting:** The process of systematically recording the process and outcome of the project activities with the help of data analysis and interpretations wherever possible and sending them to the apex centres through proper formats and in time.

11. **Enabling Environment:** The component of an intervention that envisages planning and undertaking initiatives aimed at enhancing the supportive attitude of the existing structures.
12. **Home Visit:** Visit undertaken by an outreach worker with the consent of their clients to provide support and assistance as and when required by the client at their doorstep.
13. **Linkages:** The programme component that explores and establishes a functional partnership with different existing management and service delivery outlets of project related programmes and institutions in the project area.
14. **Monitoring and Evaluation:** Processes that together help the programme to assess the progress it is making towards its aims and objectives.
15. **Opportunistic Infections (OIs):** When someone is living with HIV and has a weakened immune system (shown by a low CD4 count), they are at risk of other illness. These are known as 'Opportunistic Infections' because they take the opportunity of the immune system being weak.
16. **Positive Living:** Acceptance of one's HIV status in a positive way and making plans to ensure a healthy lifestyle.
17. **Referrals:** Ensuring that project beneficiaries are sent to the appropriate service delivery outlets such as ART centres, STI clinics and a range of non-health services based on their need.
18. **Safer Sex:** Sexual activity in which people take precautions to protect themselves against any sexually transmitted infections including HIV.
19. **Self-stigma:** Refers to negative self-judgement resulting in shame, worthlessness and blame and represents an important but neglected aspect of living with HIV. It impacts a person's ability to live positively, quality of life, adherence to treatment and access to health services.
20. **Stakeholders:** Individuals and groups who are directly or indirectly benefiting from or influenced by any programme activities.
21. **Stigma:** A mark of disgrace associated with a particular circumstance, quality, person or disease.
22. **Viral Load:** A measure of the number of HIV viral particles present in the bloodstream.



# 1

## Introduction

India has come a long way in its HIV response from the detection of the first positive case in 1986 to 64% decline in the estimated number of new infections in 2015. National AIDS Control Organization (NACO) is successfully implementing various prevention, treatment, care and support interventions to control the epidemic. However, HIV/AIDS is still a complex disease which not only deteriorates the health condition of the persons living with it but also negatively impacts on their socioeconomic conditions. The stigma associated with the disease further makes conditions worse. HIV is contributing to increased health expenditure for the State, decreased household income and increased unemployment.

India is committed to the Sustainable Development Goals (SDG) of the United Nations and is a signatory to UNAIDS' '90-90-90 by 2020' targets which means India should have 17,00,000 People Living with HIV (PLHIV) out of the estimated 21,00,000 on Antiretroviral Therapy (ART) by 2020. As of April 2018, India has more than 11,00,000 PLHIV on ART which is 65% of the target to be achieved by 2020. The programme needs to enrol an additional 600,000 PLHIV for ART in the next three years. India has taken a significant step forward in this direction by adopting the "Treat All" policy that makes ART available for all irrespective of their CD4 count/clinical stage/age/population group. This is expected to increase the ART coverage significantly.

The ART services under the National AIDS Control Programme (NACP) expanded from eight centres in 2004 to 536 centres in 2018. The national ART programme provides free first, second and third line ART to more than 1.1 million PLHIV regularly. Increasing the pace of expansion of ART coverage and improving treatment adherence are the primary objectives of the programme to reach the targets of 90% detected cases on ART and retention of 90% in care with viral suppression. Retention of PLHIV in ART is a challenge considering that India has more than 1.1 million PLHIV on treatment. Currently, retention rate in the first year is close to 70%. Achieving 90% is still a major challenge. Therefore, the national programme adopted the 'Differentiated Care Model' for service delivery both in treatment and care and support programme with the objective of:

- a. Introducing person-centric approaches in HIV care
- b. Meeting the preferences and expectations of different PLHIV groups
- c. Enhancing efficiency of the health system and service providers

Under this concept, the strategic changes made in treatment programme include differentiated care model through dispensing ART for three months at a time to stable PLHIV and community-based ART distribution through TI, OST and care and support facilities. In line with treatment programme, care and support component also adopted the differentiated care model as a client-centred approach that simplifies and

adapts HIV services across the cascade to meet the preferences and expectations of various groups of PLHIV.

## 1.1 Brief Introduction to Care and Support Programme

Care and Support programme is a national initiative to provide expanded and holistic care and support services to PLHIV. Care and Support Centres (CSC) established under the programme expand access to essential services, support treatment adherence, reduce stigma and discrimination, and improve the quality of life of PLHIV across India.

**Goal:** The overall goal of CSC is to improve the survival and quality of life of PLHIV.

**Objectives:** Specific objectives of the programme include the following:

- Early linkages of PLHIV to care, support, and treatment services
- Improved treatment adherence and education for PLHIV
- Expanded positive prevention activities
- Improved social protection and wellbeing of PLHIV

## 1.2 Role of CSC in Meeting the Objectives of National Strategic Plan 2017-24

With reference to the National Strategic Plan (NSP) for HIV/AIDS and STI 2017-2024, NACO envisages 'attaining universal coverage of HIV prevention, treatment and care continuum that is effective, inclusive, equitable and adapted to the needs'. The basis of NSP is 'Three Zeros' - zero new infections, zero AIDS-related deaths and zero discrimination. NACO clearly stated vision, mission, goal and objectives of NSP with the aim of fast-tracking targets:

**Vision:** Paving the way for an AIDS-Free India

**Mission:** Attain universal coverage of HIV prevention, treatment to care continuum of services that are effective, inclusive, equitable and adapted to needs

**Goal:** Achieving zero new infections, zero AIDS-related deaths and zero discrimination

**Objectives:**

1. Reduce new infections by 80% by 2024 (Baseline 2010)
2. Link 95% of estimated PLHIV to ART services by 2024
3. Ensure ART initiation and retention of 90% of PLHIV for sustained viral suppression by 2024
4. Eliminate Mother-to-Child Transmission of HIV and Syphilis by 2020
5. Eliminate HIV-related Stigma and Discrimination by 2020

Keeping in view the goals and objectives of NSP, CSC will provide comprehensive and differentiated care and support services to PLHIV of different profiles and thereby support the national programme to meet the objectives of early linkage of PLHIV to treatment, retention in care, sustained viral suppression, and elimination of HIV-related stigma and discrimination.

# Infrastructure and Human Resources for CSC

The CSC will not only provide safe space to PLHIV but will also serve as a link between the community and other allied services required by them. Thus, CSC should be suitably located for PLHIV to access the services and have adequate space and facilities to provide the services to the community. The following are the essential features of the CSC structure to ensure the best operational systems.

## 2.1 Location and Access to CSC

Many CSCs will be catering to multiple ART centres. In such cases, CSC's location should be near the ART centre having the highest caseload, preferably at the district headquarter. CSC should be easily accessible to all PLHIV and well connected by public transport. Ideally, the CSC should be located within 2.5 km radius of the ART centre attached to it.

## 2.2 Infrastructure Required at CSC

CSC needs to be set up in a leased-out or rented space close to the ART centre. It must be housed in a permanent concrete/*pucca* building and have enough space for counselling, support group meetings and other activities of CSC. Good ventilation, clean and safe drinking water and clean toilets with running water are essential requirements. The following internal provisions are essential to set up a CSC:

### 2.2.1 Reception cum Waiting Area

This area should have sufficient space with enough provisions for people to wait. There should be a reception counter and table and chairs for the people to sit. There should be provisions for displaying welcome board, takeaway IEC materials, leaflets/pamphlets, suggestion box, first aid box and information on other related services available in the locality. A visitors' register should be maintained at the reception for all clients visiting the CSC to provide their feedback and suggestions. This area should make the client feel welcome and give a positive feeling.

### 2.2.2 Project Office Area

This area needs to be devoted as workstations for the staff. The office area ideally should have sufficient space to keep furniture like almirah, cupboards, chairs, tables, etc. required for the staff. This area should have sufficient space to keep the other assets, documents, records and for conducting team/review meetings.

### 2.2.3 Space for Relaxation

This area is devoted for PLHIV to rest and conduct infotainment activities. There should be enough space for people to rest and conduct Support Group Meetings

(SGMs). Recreational facilities like TV, indoor games, toys/game materials for children, newspapers, books, magazines etc. should be kept there. Condom box should be placed for the PLHIV to access free condoms. A referral directory with the details of referral centres, services available, contact details, etc. should be available in this area. Rest and relaxation services to clients can be provided only during daytime and overnight stay should not be allowed at the CSC.

#### **2.2.4 Counselling Room/Space**

Every CSC should have a separate space for counselling with complete audio-visual privacy and provision for storing confidential records. This area should be spacious enough to conduct family/group counselling sessions. Condom demonstration kit, IEC materials and posters on nutrition and positive living, referral forms, and job aids should be available in the counselling room.

#### **2.2.5 Information to be displayed at CSC**

- Confidentiality statement
- Do's and Don'ts of ART
- Clients' rights and responsibilities
- Staff designation and contact details, including emergency contacts
- List of Link ART Centres (LACs) attached to the ART centre
- Contact details of Discrimination Response Team (DRT) members
- All services of CSC, including days and timings for important activities

The information display should ideally be in the local language and in pictorial form as much as possible.

#### **2.2.6 Furniture Provisions for CSC**

The CSC should have essential furniture as required for its optimal and adequate functioning. Following are some of the essential furniture required at the CSC:

- Armed lightweight and comfortable chairs for visitors
- Office tables and chairs
- Computer tables and chairs
- Cupboards with locking facility to store important documents
- Weighing machine and height measuring chart
- Water dispenser and glasses

### **2.3 Human Resources for CSC**

The day-to-day functioning of the CSC shall be supported by a team comprising of the Project Coordinator, Peer Counsellor, Outreach Workers (ORWs) and Accountant. To enhance community participation and ownership, it is necessary for the CSC to recruit at least 50% of the staff from the PLHIV community. Not more than two members from the board of the organisation implementing the CSC can be employed in the programme. Close relatives of the board members also cannot be employed in the programme. Peer Counsellor must be from the community and as far as possible, ORWs also should be selected from the PLHIV community. It is preferred to identify at least one ORW from the Key Population (KP) groups in order to understand their special needs better and provide services accordingly.

### 2.3.1 Staff Selection Process

CSC should advertise the vacancies at least for 15 days in their office, ART centres, Link ART Centres and offices of other HIV programme implementing partners. For each position, minimum three candidates need to be interviewed. The interview panel should consist of an officer from District AIDS Prevention Control Unit (DAPCU)/ART Centre, representative of the Sub-Recipient (SR) agency and the Project Director of the CSC. Under the evidential circumstances of not getting candidates as per the eligibility criteria, the panel can decide on relaxing educational qualification and experience required for the positions. The criteria for selection is relaxed for members from PLHIV community and key population groups from master degree to the level of degree, from degree to plus two/pre-university, and from plus two/pre-university to matriculation. However, the final decision lies with the interview panel in this regard and no concession should be given beyond what is specified above. The CSC shall issue a contractual service agreement to the selected candidate which could be renewed on a yearly basis subject to satisfactory performance and requirements of the programme.

### 2.3.2 Staff Positions for CSC

Name of the Position	Essential Qualification and Experience	Sanctioned Number of Positions	Reporting to	Reported by
Project Coordinator	Post graduate with two years of relevant experience or graduate with more than three years of experience in HIV programmes	One	Project Director of CSC	Peer Counsellor, Outreach Workers, and Accountant
Peer Counsellor	12 <sup>th</sup> pass with relevant experience and essentially from PLHIV community	One	Project Coordinator	None
Outreach Worker (ORW)	8 <sup>th</sup> pass with the basic understanding of care, support and treatment programme for PLHIV. The candidate should be preferably from the PLHIV community.	Depending upon the population covered by the CSC	Project Coordinator	None
Accountant (Part-time)	B.Com with working knowledge of accounting software, especially Tally.	One	Project Coordinator	None

### 2.3.3 TOR of Staff at CSC

Name of the staff	Key Responsibilities
<b>Project Director (Honorary Position)</b>	<ul style="list-style-type: none"> <li>● Overall responsible for the functioning of the CSC</li> <li>● Provide supervisory support to the CSC staff</li> <li>● Conduct minimum one review and planning meeting in a month with the CSC team</li> <li>● Ensure staff welfare and development</li> <li>● Ensure safety and security of staff and infrastructure</li> <li>● Support CSC team in addressing stigma and discrimination cases, undertaking advocacy activities and local resource mobilisation</li> <li>● Establish and maintain good coordination with the ART centre, other HIV-related service delivery facilities in the district/region, TB programme and other local stakeholders</li> <li>● Represent the CSC in important meetings with all key stakeholders</li> </ul>
<b>Project Coordinator</b>	<p><b>Key Functions:</b> The Project Coordinator will be responsible for implementation of the programme under the guidance of the Project Director.</p> <p><b>Specific roles and responsibilities of PC:</b></p> <ul style="list-style-type: none"> <li>● Establish and maintain linkages with the ART centre, ICTC, PPTCT, DOTS, STI clinics, TIS and other service providers in the district/region</li> <li>● Develop and support the implementation of the weekly and monthly work plan of CSC</li> <li>● Support all staff to develop their weekly and monthly work-plan based on programme priorities and targets</li> <li>● Distribute the operational area and clients among the ORWs to ensure optimal outreach services</li> <li>● Ensure availability of IEC materials and condoms for distribution at the CSC</li> <li>● Undertake occasional field visits with or without the ORW/Peer Counsellor to observe the activities in the field and provide handholding support</li> <li>● Oversee all the M&amp;E activities of the project. Ensure that all the data collected are entered in respective tools on daily basis and verify them on weekly basis to ensure data quality</li> <li>● Provide the CSC Unique Identification Number (UID) to all registered clients after verifying details captured in the Client Registration Form (CRF) and supporting documents</li> <li>● Ensure timely preparation and submission of quarterly and monthly reports to SR/DAPCU/ARTC</li> <li>● Arrange weekly and monthly meetings with the CSC team to identify the key issues in the project and initiate the efforts required to address them</li> <li>● Ensure action taken report within a month for the action points shared by the SR/PR/SACS or NACO after their supervisory visits</li> </ul>

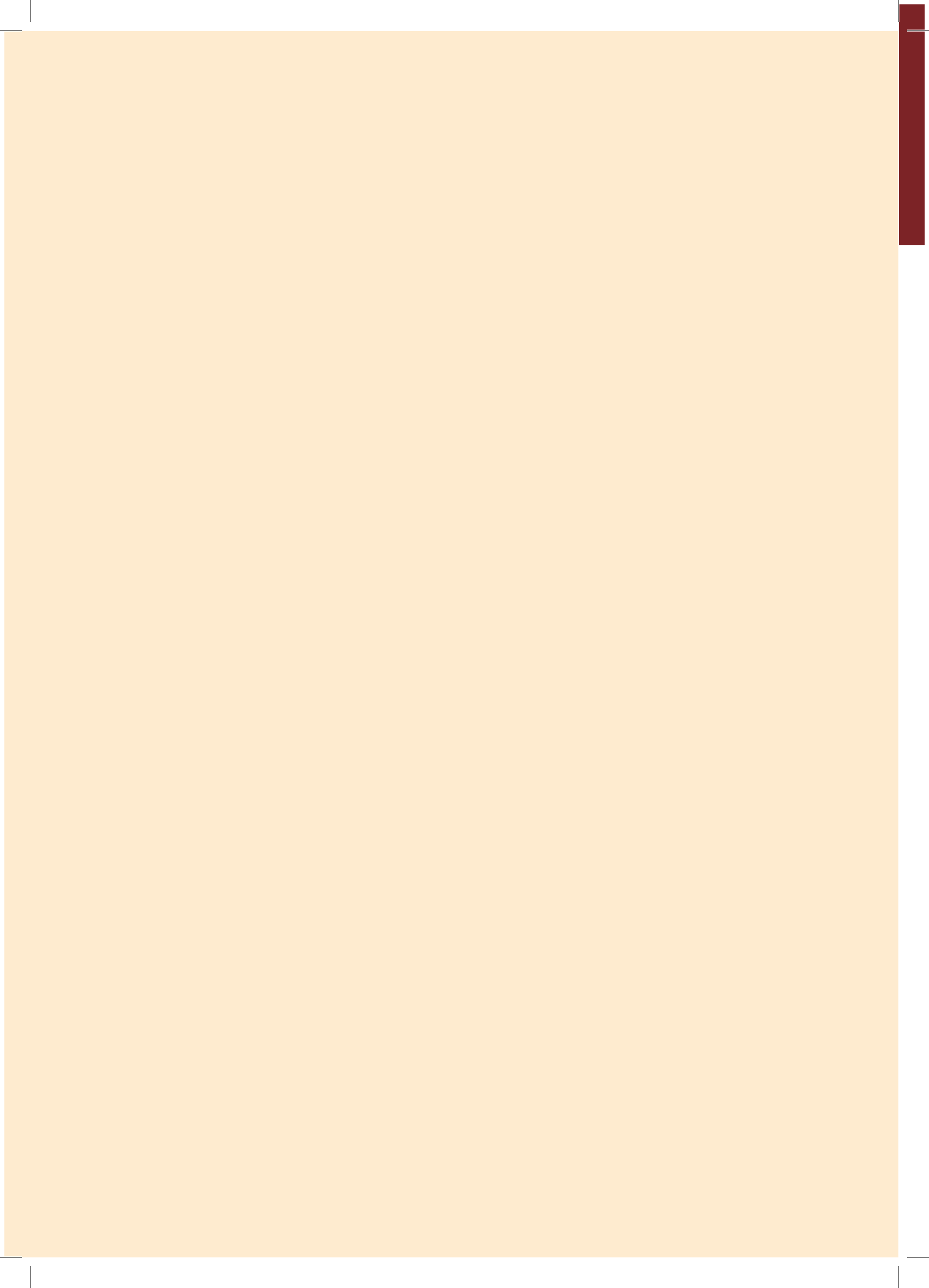
Name of the staff	Key Responsibilities
	<ul style="list-style-type: none"> <li>● Lead advocacy, networking and local resource mobilisation activities of the CSC</li> <li>● In coordination with the accountant, ensure that the financial transactions and expenditure patterns are in accordance with the approved budget</li> <li>● Facilitate visits from NACO, SACS, Donors and other stakeholders</li> <li>● Identify the capacity building needs of CSC staff and arrange in-house training</li> </ul> <p><b>ART-CSC Coordination:</b></p> <ul style="list-style-type: none"> <li>● Function as the focal-point for ART-CSC Coordination</li> <li>● Coordinate all the data sharing activities between the ART centre and CSC</li> <li>● After receiving the line list of LFU/MIS cases from ART centre, validate the information received to check duplications and errors</li> <li>● Allocate LFU/MIS tracking assignment to ORWs based on the client location and ORW allocation</li> <li>● Collect evidence for each case tracked and validate the same before submitting the track-back information with the ART centre</li> <li>● Ensure at least 10% outcome of LFU/MIS tracking submitted by the ORW is validated before submitting the tracker sheet/report to ART centres</li> <li>● Ensure LFU/MIS cases tracking details are shared with ART centres on a regular basis</li> <li>● Maintain ART-CSC Coordination meeting related documents including meeting minutes duly signed by the Nodal Officer/SMO/MO of the ART centre</li> <li>● Participate in DAPCU and ART coordination meeting to share CSC activities and priorities</li> </ul>
Peer Counsellor	<p>The Peer Counsellor functions as the link between the CSC and the community.</p> <p><b>Specific role and responsibilities of Peer Counsellor:</b></p> <ul style="list-style-type: none"> <li>● Visit ART centre to support newly initiated clients on ART to help them understand the benefits of treatment, address misconceptions and equip them with coping skills to manage possible side effects of ART</li> <li>● Popularise the services of CSC at the ART centre and motivate the newly registered clients to avail care and support services</li> <li>● Support clients in completing all baseline investigations and other mandatory tests from the hospital prior to ART initiation</li> <li>● Provide counselling on treatment adherence, positive living and related topics to clients during their visit to CSC</li> <li>● Support counselling of clients, dispensing of ART, maintaining drug dispensing details etc. in case the CSC is engaged in community-based ART dispensing</li> </ul>



Name of the staff	Key Responsibilities
	<ul style="list-style-type: none"> <li>● Facilitate support group meetings at CSC and ART centre</li> <li>● Organise community events with the help of Project Coordinator (e.g., health camps, fairs, festivals)</li> <li>● Organise and participate in advocacy activities, including rapport building with different stakeholders</li> </ul>
<b>Outreach Worker (ORW)</b>	<p><b>Key Functions:</b> ORW will lead the field activities of the CSC. They facilitate the registration of PLHIV at the CSC.</p> <p><b>Specific roles and responsibilities of ORW:</b></p> <ul style="list-style-type: none"> <li>● Develop weekly and monthly action plan with the help of the Project Coordinator focusing on the priority clients</li> <li>● Home visit to clients newly initiated on ART to provide information on treatment adherence, opportunistic infections, nutrition, healthy lifestyle and positive living and provide psychosocial support</li> <li>● Identify newly registered PLHIV in ART centres and register them at the CSC after providing at least one service as per guidelines</li> <li>● Referrals for health services and other needs of the PLHIV registered under the programme</li> <li>● Help PLHIV to address stigma and discrimination by the family members and the society</li> <li>● Support the PLHIV to avail social welfare schemes, entitlements and other benefits from the local authorities</li> <li>● Screening PLHIV for TB symptoms once in six months and referral of symptomatic clients to ART centre for diagnosis</li> <li>● Encourage the family members, spouse, children and sexual partners of PLHIV for HIV and TB testing</li> <li>● Based on the list of LFU and MIS cases received from the ART centre, plan field visits for tracking and motivate the clients to resume their treatment wherever possible, accompany them to the ART centre and other service delivery units.</li> <li>● Identify community volunteers in far-flung areas to support in the follow-up of LFU/MIS cases as and when required</li> <li>● Update the field activities in eMpower Application on a day-to-day basis and synchronise it once in a week with the CMIS</li> </ul>
<b>Accountant</b>	<p><b>Key functions:</b> Key position at the CSC for all financial matters. S/he will work closely with the Project Coordinator to ensure smooth conduct of financial matters.</p> <p><b>Specific roles and responsibilities of Accountant:</b></p> <ul style="list-style-type: none"> <li>● Book keeping: Recording of expenditure with proper supporting documents</li> <li>● Bank reconciliation on a monthly basis</li> <li>● Maintaining inventory of supplies/consumables and other materials</li> <li>● Maintaining and updating fixed assets and stock registers</li> </ul>



Name of the staff	Key Responsibilities
	<ul style="list-style-type: none"> <li>● Disbursing salary and making payments to vendors/suppliers in a timely manner</li> <li>● Maintaining attendance register and leave records</li> <li>● Preparing appointment letters for staff in consultation with Project Director</li> <li>● Maintaining HR files for all staff</li> <li>● Coordinating with finance staff from SR for periodic review and submission of monthly and quarterly financial reports</li> <li>● Providing required support in organising meetings and other CSC activities</li> <li>● Ensuring proper backup of accounting data on regular basis. This should be in a computer or device other than the one in which the accounting software is installed.</li> </ul>



## 3

## Services Provided by CSC

This chapter describes the criteria for registration of PLHIV in CSC and explains the services that are provided through the centre.

### 3.1 Registration of PLHIV in CSC

PLHIV registered in ART centre and under active HIV care will be registered in CSC for receiving care and support services. A UID will be assigned to each registered client. However, this can be done only after one of the following services has been provided to the client:

#### 3.1.1 Registration Criteria:

Criteria for registration of clients in CSC				
Sl. No	Services	Conditions for Registration	Means of Verification	Responsible Team Member
1	Counselling at CSC	Client is provided with any type of counselling at CSC	eMpower Tablet Application	Peer Counsellor
2	Support Group Meeting in CSC	Client participated in the SGM conducted in CSC	Meeting Register	Peer Counsellor, ORW, PC
3	LFU tracked back to ART	If an LFU client is tracked and linked back to ART centre by the CSC	ART-CSC Tracker Sheet	ORW, Peer Counsellor
4	MIS case tracked back to ART	If a MIS client is tracked and linked back to the ART centre by the CSC	ART-CSC Tracker Sheet	ORW, Peer Counsellor
5	ART Registration	If the client is not registered in ART centre and a CSC staff refers him/her for registration and completes the registration process at ART centre	Referral Slip (Part-C)	Peer Counsellor, ORW, PC
6	CD4 Follow Up	If the baseline/follow-up CD4 test of the client is due and s/he is referred for testing by the CSC and the test is conducted	ART-CSC Tracker	Peer Counsellor, ORW, PC
7	Link to Targeted Intervention (TI) Programmes	If a PLHIV from any key population groups not linked to TI, is successfully linked to avail services	Referral Slip (Part-C)	Peer Counsellor, ORW, PC

Criteria for registration of clients in CSC				
Sl. No	Services	Conditions for Registration	Means of Verification	Responsible Team Member
8	HIV testing of Sexual Partners/ Spouse, Children and Family Members	If a partner/spouse, children and family members of the client is/are eligible for testing but not tested, referred for testing by the CSC and testing conducted	Referral Slip (Part-C)	Peer Counsellor, ORW
9	Hospital / Clinical Referrals	If a client is referred to treatment for OI or any other general ailments in any health facility and received treatment	Referral Slip (Part-C)	Peer Counsellor, ORW, PC
10	Support for Legal Aid	If a client requires legal aid and CSC staff supports him/her to avail legal aid	Referral Slip (Part-C)	Peer Counsellor, ORW, PC
11	Social Welfare Schemes	If a client requires any social welfare scheme and the CSC facilitates successful application	Referral slip  Copy of the application submitted with receipt note	Peer Counsellor, ORW, PC
12	Social Entitlements	If a client requires any social entitlement and the CSC facilitates successful application	Referral slip  Copy of the application submitted with receipt note	Peer Counsellor, ORW, PC
13	TB Screening for PLHIV at the CSC	If a PLHIV verbally screened for TB symptoms at the CSC	Section K (Printout from the CMIS portal)	Peer Counsellor, ORW

### 3.1.2 Registration Cannot be Done under the Following Conditions

- If the client receives an information session from CSC staff
- If the client visits the CSC only for rest and relaxation
- If the client is given a condom in the field
- If the client receives counselling services in the field
- If the client is contacted in the ART Centre/ICTC and given information on CSC services
- Registration cannot be done in mass social entitlement events or camps

At CSC, Project Coordinator or Peer Counsellor will facilitate the registration whereas, in the field, ORW can do this following standard protocols and guidelines. They have to collect the required information in Client Registration Form (CRF) and submit the filled format along with documentary evidence of the service provided to the Project Coordinator. After verifying the information in CRF and the supporting documents, the Project Coordinator will generate UID for the client (**Refer to Annexure I for CRF**).

### 3.1.3 Documents Required for Registration at the CSC

- Copy of identity and address proof of the client, preferably Aadhaar
- Copies of HIV testing report and ART Green Book
- Documentary evidence of the service provided

UID number is an eleven digit number with the first six digits representing the State, District and CSC Code and last five digits represent the Registration Number of individuals starting with 00001 in each CSC. This number will allow easy tracking of the client life-cycle through the project. This number must be written on the ART Green Book of registered clients to ensure better coordination with ART centres. Moreover, in case the client migrates to another district or state, duplication of registration in the programme will be avoided.

When a client is enrolled in CSC, s/he will be given a family ID as well. The same family id will be given to other members of the family if they get registered in the CSC. Each ORW will cover the geographical area allotted to him/her. First two digits of Family ID has the ORW number, followed by a four-digit serial number starting with 0001 (For example ORW01-0001). This number will also help in tracking the services provided to the client's family members who may not be HIV positive. The Project Coordinator will generate the family ID.

## 3.2 Differentiated Care Model in CSC

Differentiated care is a client-centred approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of PLHIV while optimising the functioning of the health system. By following the differentiated service delivery model, the health system can reallocate resources to those most in need.

Differentiated care aims to enhance the quality of services. It puts the client at the centre of service delivery. It also ensures the health system functions in both a medically accountable and an efficient manner. The central driver to adapting service provision is the client's needs.

In line with WHO guidelines, clients are categorised into three major categories based on their clinical characteristics, vulnerabilities, gender, age and socio-economic conditions as explained below:

CATEGORY 1	CATEGORY 2	CATEGORY 3
<p><b>High Priority Clients:</b></p> <ul style="list-style-type: none"><li>● Clients who are yet to be put on ART</li><li>● Clients newly initiated on ART</li><li>● Clients with less than 80% treatment adherence</li><li>● LFU/MIS cases</li><li>● Newly TB detected PLHIV</li><li>● Pregnant Women</li></ul>	<p><b>Moderate Clients:</b></p> <ul style="list-style-type: none"><li>● Children</li><li>● Adolescents</li><li>● Discordant couples</li><li>● PLHIV from Key Populations</li><li>● LFU reinitiated on ART</li><li>● Clients reportedly faced stigma</li></ul>	<p><b>Stable clients:</b></p> <ul style="list-style-type: none"><li>● No adverse drug reactions</li><li>● No current opportunistic infection/illness</li><li>● Clients not received at least one social welfare scheme</li><li>● Clients who are regularly visiting ART centres and are having good adherence history</li></ul>

### 3.2.1 Service Package under Differentiated Care Model

Service package					
Category of Clients	What	Why	How	When	Who
Category 1	Type of service	Reasons for the service	Mode of service	Frequency of service	CSC staff responsible for service
Clients yet to be put on ART	Treatment preparedness & peer counselling	To address the issues of misconceptions about ART, self-perceived stigma, sense of wellbeing without ART	<p>List of clients registered at CSC who are yet to initiate ART will be generated on priority for treatment preparedness counselling</p> <ul style="list-style-type: none"> <li>ART centre will provide the list of clients newly registered but not yet initiated on ART to CSC for tracking</li> </ul> <p><b>Essential Services:</b></p> <ul style="list-style-type: none"> <li>Treatment preparedness counselling</li> <li>Tracking, referral and follow-up till ART initiation</li> </ul>	Once in a month till the client is initiated on ART	<p>PC to ensure availability of the list of clients on eMpower Tablets and help ORW/ Peer Counsellor to plan their field work</p> <p>Peer Counsellor/ ORW will contact the clients over phone or meet them at their home or at the ART centre</p>

Service package					
Category of Clients	What	Why	How	When	Who
Clients newly initiated on ART	Intensified peer support services will be provided to the clients at least for the initial 3 months for better treatment adherence	Current national data shows 30% clients who initiate ART are likely to miss their treatment and become LFU within 3 months  Some medicines may cause initial side effects which client perceives as an issue with the medicines  Client may not visit to ART centre due to stigma and discrimination or fear of disclosure	<ul style="list-style-type: none"> <li>ART centre will provide newly ART initiated clients' list to CSC as per prescribed timelines</li> </ul> <p><b>Essential services in first 3 months:</b></p> <ul style="list-style-type: none"> <li>Treatment preparedness and treatment adherence counselling will be done during home visits by ORW or as per the convenience of the client. Peer Counsellor will reinforce the same message in counselling during second month</li> <li>Basic information about side effects and OI management will be provided during client's visit to CSC</li> <li>Referral of family members/spouse for HIV testing will be done during the home visit</li> <li>Address verification of the client will be done</li> </ul> <p><b>Optional services in first 3 months:</b></p> <ul style="list-style-type: none"> <li>Client and family members will be screened for TB symptoms during the home visit</li> <li>Once the client is registered at the CSC, s/he will be shown in the list of high priority clients and followed up by the ORW/Peer Counsellor</li> </ul>	<p>Monthly contact for three months from ART initiation</p> <p>ORW will make one home visit during the first month</p> <p>Other two contacts can happen either in CSC or in field. If client is not agreeing for home visit, telephonic contact will be made.</p>	<p>Peer Counsellor (who will visit to ART centre and field on every alternative day)</p> <p>ORW (home visit is the primary responsibility of ORW)</p>

Service package					
Category of Clients	What	Why	How	When	Who
Clients with less than 80% treatment adherence	Improving treatment adherence and retention in care which should result in more than 80% adherence	<p>Clients who are less than 80% adherence are most likely to become LFU</p> <p>Poor adherence can lead to resistance or treatment failure</p> <p>Poor adherence will also result in high viral load in which client becomes more vulnerable for OIs and risk of HIV transmission is also high</p>	<ul style="list-style-type: none"> <li>ART centre will provide the list clients whose adherence is less than 80% to CSC once in a month during ART-CSC coordination meeting</li> </ul> <p><b>Essential Services:</b> Understanding the reasons for poor adherence and intervention package will be decided accordingly:</p> <p><b>Lack of information/ignorance:</b> counselling on treatment adherence and treatment benefits</p> <p><b>Side effects or OIs:</b> Educate the client on side effects and OI management. Refer the client to ART centre for medical attention</p> <p><b>Possible treatment failures:</b> Refer client back to ART centre</p> <p><b>Lack of nutritional support or financial support:</b> Link the client to social welfare schemes and individual donors</p> <p><b>Optional services:</b></p> <ul style="list-style-type: none"> <li>Referral of family members/partner for HIV testing will be done during the home visit</li> <li>Client and family members will be screened for TB during the home visit</li> </ul>	Monthly contact for three months	<p>Project Coordinator (ART CSC coordination, telephonic contact)</p> <p>Peer Counsellor</p> <p>ORW</p>



Service package					
Category of Clients	What	Why	How	When	Who
LFU/MIS cases	Tracking MIS/LFU cases back to ART	Poor adherence and missing the treatment completely will enhance the disease progression and also result in high morbidity and mortality	<ul style="list-style-type: none"> <li>ART centre will track Month 1 MIS cases and M2, M3 and LFU cases will be shared with the CSC</li> </ul> <p>Essential services:</p> <ul style="list-style-type: none"> <li>If phone number is available, CSC team will try to contact the client over phone and convince him/her to restart ART</li> <li>If phone numbers is not available, ORW will make home visit to convince the client</li> <li>Priority will be given to MIS and most recent LFU cases</li> </ul> <p><b>Optional service:</b></p> <ul style="list-style-type: none"> <li>Brought back client needs to be followed up for 3 months to ensure that s/he is retained in the treatment</li> <li>Linking the client to social welfare schemes</li> <li><b>Information Capturing:</b> Tabs would be used for prioritising those clients for ORWs and Peer counselling for intensive follow up</li> </ul> <p>ORWS and peer counsellor would be using the priority listing for follow up of clients</p>	Every month till a definite tracking outcome is available for the client	Project Coordinator (ART CSC coordination, telephonic contact)  Peer Counsellor  ORW

Service package					
Category of Clients	What	Why	How	When	Who
PLHIV clients newly diagnosed with TB	Ensuring the client is coping with both ART and ATT and adhering to treatment	<ul style="list-style-type: none"> <li>The risk of developing Tuberculosis (TB) is estimated to be between 16-27 times greater in people living with HIV than the other populations</li> <li>The highest TB transmission risk is from household contacts, such as children and HIV-positive partners</li> <li>The risk of MDR-TB infection may be increased if effective and uninterrupted TB treatment is not ensured</li> </ul>	<ul style="list-style-type: none"> <li>ART centre will provide line list of co-infected clients to CSC once in month</li> </ul> <p><b>Essential service:</b></p> <ul style="list-style-type: none"> <li>CSC will follow-up clients for 6 months till s/he completes ATT</li> <li>CSC will provide counselling and information on: <ul style="list-style-type: none"> <li>Treatment adherence</li> <li>Side effects management</li> <li>Treatment fatigue and pill burden</li> <li>TB prevention for family members and</li> <li>Information about the nutrition along with TB treatment</li> </ul> </li> </ul> <p><b>Optional service:</b></p> <ul style="list-style-type: none"> <li>Referral of family members for HIV testing</li> <li>Screening of family members for TB</li> </ul> <p><b>Information capturing:</b> Data capturing would be done in CRF –K case history and accordingly through TAB this follow up would be done.</p>	Till completion of TB treatment	Peer Counsellor  ORW

Service package					
Category of Clients	What	Why	How	When	Who
Pregnant women	Ensuring treatment adherence, regular ANC check-up, institutional delivery and post-natal follow-up ( <i>wherever feasible these clients will be linked to PPTCT programme</i> )	To eliminate parents to child HIV transmission	<ul style="list-style-type: none"> <li>ART centre will provide list of newly enrolled pregnant women to the CSC</li> </ul> <p><b>Essential service:</b></p> <ul style="list-style-type: none"> <li>Ensuring treatment adherence, regular ANC check-up, institutional delivery and PNC follow-up till 2 DBC</li> </ul>	Till the completion of EID process	Peer Counsellor
<b>Category 2</b>					
Children	Ensuring the treatment adherence	<ul style="list-style-type: none"> <li>Pill burden</li> <li>School and ART timings are not matching</li> <li>Dependence on caregiver if they are orphans</li> <li>Stigma and discrimination in school and community</li> </ul>	<p><b>Source of Information: eMpower</b></p> <p><b>Essential services:</b></p> <ul style="list-style-type: none"> <li>Treatment education</li> <li>Linkages with social welfare schemes</li> </ul> <p><b>Optional services:</b></p> <ul style="list-style-type: none"> <li>Linkages with social welfare schemes</li> <li>Linkages with nutritional and educational support from local NGO and individual donors</li> </ul>	Follow-up once in three months	Peer Counsellor

Service package					
Category of Clients	What	Why	How	When	Who
Adolescents	Ensuring treatment adherence	<ul style="list-style-type: none"> <li>• Pill burden</li> <li>• School/college and ART timings are not matching</li> <li>• Dependence upon caregiver if they are orphans</li> <li>• Stigma and discrimination in school/work place</li> <li>• Sexual and Reproductive Health (SRH) issues</li> </ul>	<p>Source of information: eMpower</p> <p><b>Essential services:</b></p> <ul style="list-style-type: none"> <li>• Treatment education</li> <li>• Linkages with social welfare schemes</li> </ul> <p><b>Optional services:</b></p> <ul style="list-style-type: none"> <li>• Linkages with social welfare schemes</li> <li>• Linkages with livelihood programme</li> <li>• Linkages with nutritional and educational support from local NGO and individual donors</li> </ul>	Follow-up once in three months	Peer Counsellor
Discordant couples	Discordant couples should remain discordant	<ul style="list-style-type: none"> <li>• Condom promotion and consistent safer sex practices</li> <li>• Disclosure</li> <li>• Family planning issues</li> <li>• SRH issues</li> </ul>	<p><b>Essential services:</b></p> <ul style="list-style-type: none"> <li>• ART initiation without any delay for the positive partner</li> <li>• Reinforcing positive prevention messages</li> <li>• Six-monthly follow-up HIV test for the negative partner</li> </ul> <p><b>Optional services:</b></p> <ul style="list-style-type: none"> <li>• Referral to fertility centre if couple want to have a child</li> </ul>	Follow up once in six months	ORW and Peer Counsellor

Service package					
Category of Clients	What	Why	How	When	Who
PLHIV from Key Populations	Ensuring treatment adherence	<ul style="list-style-type: none"> <li>High risk behaviour</li> <li>Issues in practicing safer sex due to occupational hazards</li> <li>Stigma and discrimination</li> <li>Inability to reach ART during working hours, especially for IDU and FSW populations</li> <li>Insensitivity of service providers towards the key communities</li> </ul>	<p><b>Essential service:</b></p> <ul style="list-style-type: none"> <li>ART initiation without any delay</li> <li>Alternative arrangements for delivering drugs to KPs</li> <li>Spouse/partner testing</li> <li>Linkages with TIs for community-specific services</li> </ul> <p><b>Optional service:</b></p> <ul style="list-style-type: none"> <li>Conducting SGM in TI hotspot</li> </ul>	Follow-up once in three months	ORW
<b>Category 3</b>					
Stable clients	Taking health status updates and assess service needs	Since they are stable clients, it is assumed that they are aware of the importance of life long treatment. Hence their health status updates will be taken once in six months	<ul style="list-style-type: none"> <li>Take routine health status update</li> <li>Assess adherence, CD4 levels and viral load</li> <li>Assess presence/symptoms of OIs, especially TB</li> <li>Assess the needs for other services and linkages</li> </ul>	Follow up once in six months	Project Coordinator  ORW

### 3.3 CSC Service Matrix

Services	Activities	Infrastructure Resources and Supplies Required	Expected Output
<b>Counselling Services</b>	<ul style="list-style-type: none"> <li>One-to-one counselling</li> <li>Group/ couple/family counselling</li> <li>Specialised counselling for children and pregnant women</li> <li>Counselling for key populations</li> <li>Outdoor counselling (through outreach)</li> </ul>	<ul style="list-style-type: none"> <li>Facilities for individual and group counselling</li> <li>Audio-visual equipment, DVD, etc.</li> <li>Information, Education and Communication (IEC) materials</li> <li>Demonstration models, condoms (male and female) for demonstration and distribution</li> </ul>	<p>Clients get support and information on:</p> <ul style="list-style-type: none"> <li>Psychosocial support</li> <li>Treatment literacy</li> <li>Treatment adherence</li> <li>Nutrition</li> <li>Sexual and reproductive health issues (contraception, condom demonstration and promotion, unmet need for counselling on conception, medical termination of pregnancy, family planning for HIV positive couples, etc.)</li> <li>Positive living and positive prevention</li> </ul>
<b>Outreach Services</b>	<ul style="list-style-type: none"> <li>Follow up of PLHIV for ART adherence</li> <li>Follow up of various categories of PLHIV as per differentiated care model</li> <li>Reinforcement of key counselling messages as per client's need</li> <li>Disseminate information on signs and symptoms of OIs, especially TB</li> </ul>	<ul style="list-style-type: none"> <li>Micro-planning</li> <li>Social and geographical map</li> <li>IEC materials</li> <li>Referral slips and referral directory (<b>Refer to Annexure II for Referral Slip</b>)</li> </ul>	<ul style="list-style-type: none"> <li>Early linkage of PLHIV to care</li> <li>Improved treatment adherence and retention in care</li> <li>Periodic HIV testing of discordant couples</li> <li>Regular screening for TB symptoms among PLHIV and family members</li> <li>Ensuring treatment compliance among TB positive cases</li> <li>LFU and MIS clients are linked back to ART Centre</li> <li>Linkages to social schemes and entitlements</li> </ul>

Services	Activities	Infrastructure Resources and Supplies Required	Expected Output
<b>Referral and Linkage Services</b>	<ul style="list-style-type: none"> <li>Referral for treatment and health needs</li> <li>Referrals for social welfare schemes and entitlements</li> <li>Referrals for non-health needs</li> <li>Accompanied referral from and to ART centre and other facilities</li> <li>Referral and linkages between CSCs for inter-district and inter-state LFU/MIS case tracking</li> </ul>	<ul style="list-style-type: none"> <li>List of facilities, services and schemes</li> <li>Referral directory and referral slips</li> </ul>	<ul style="list-style-type: none"> <li>Successful linkages with service delivery points for medical and non-medical needs of PLHIV</li> <li>LFU tracking information successfully updated to ART centre</li> </ul>
<b>Life Skills Education and Vocational Training</b>	<ul style="list-style-type: none"> <li>Orientation on livelihood options and skill building</li> <li>Training on life skills for children and adolescents</li> <li>Vocational training through linkages with vocational training institutes</li> </ul>	<ul style="list-style-type: none"> <li>Database of livelihood/ vocational training options available in the operational area of the CSC</li> </ul>	<ul style="list-style-type: none"> <li>Clients motivated to be financially productive</li> <li>Clients undergone vocational training and linked with schemes having better livelihood options</li> </ul>
<b>Advocacy</b>	<ul style="list-style-type: none"> <li>Regular sensitisation meeting of all stakeholders</li> <li>Media advocacy</li> <li>Quarterly advocacy meetings</li> <li>Regular meeting of DRT</li> </ul>	<ul style="list-style-type: none"> <li>Advocacy meeting</li> <li>Workshops</li> <li>DRT meeting</li> </ul>	<ul style="list-style-type: none"> <li>Larger issues pertaining to PLHIV community are addressed through advocacy</li> <li>Discrimination and other issues faced by PLHIV are addressed</li> </ul>

Services	Activities	Infrastructure Resources and Supplies Required	Expected Output
<b>Support Group Meeting</b>	<ul style="list-style-type: none"> <li>Formation of support groups based on thematic areas</li> <li>Regular meetings</li> <li>Documentation</li> </ul>	<ul style="list-style-type: none"> <li>Space for meeting</li> <li>Reporting tools</li> <li>Minimum number of participants (10-15)</li> </ul>	<ul style="list-style-type: none"> <li>Platform for PLHIV to share their concerns and problems and learn from each other</li> <li>Capacity building of PLHIV through SGM</li> </ul>
<b>HIV-TB Collaborative Activities</b>	<ul style="list-style-type: none"> <li>TB screening of all PLHIV once in 6 months</li> <li>Referring symptomatic clients to ART centre</li> <li>Follow-up of clients on both ART and ATT for adherence and treatment progress monitoring</li> </ul>	<ul style="list-style-type: none"> <li>Field visits</li> </ul>	<ul style="list-style-type: none"> <li>All clients will be screened for TB symptoms once in six months</li> <li>Early detection of TB co-infection among PLHIV</li> <li>Treatment adherence will be monitored</li> </ul> <p><b>(Refer to Annexure I.a for TB Screening Form – Section K)</b></p>

### 3.3.1 Counselling Services

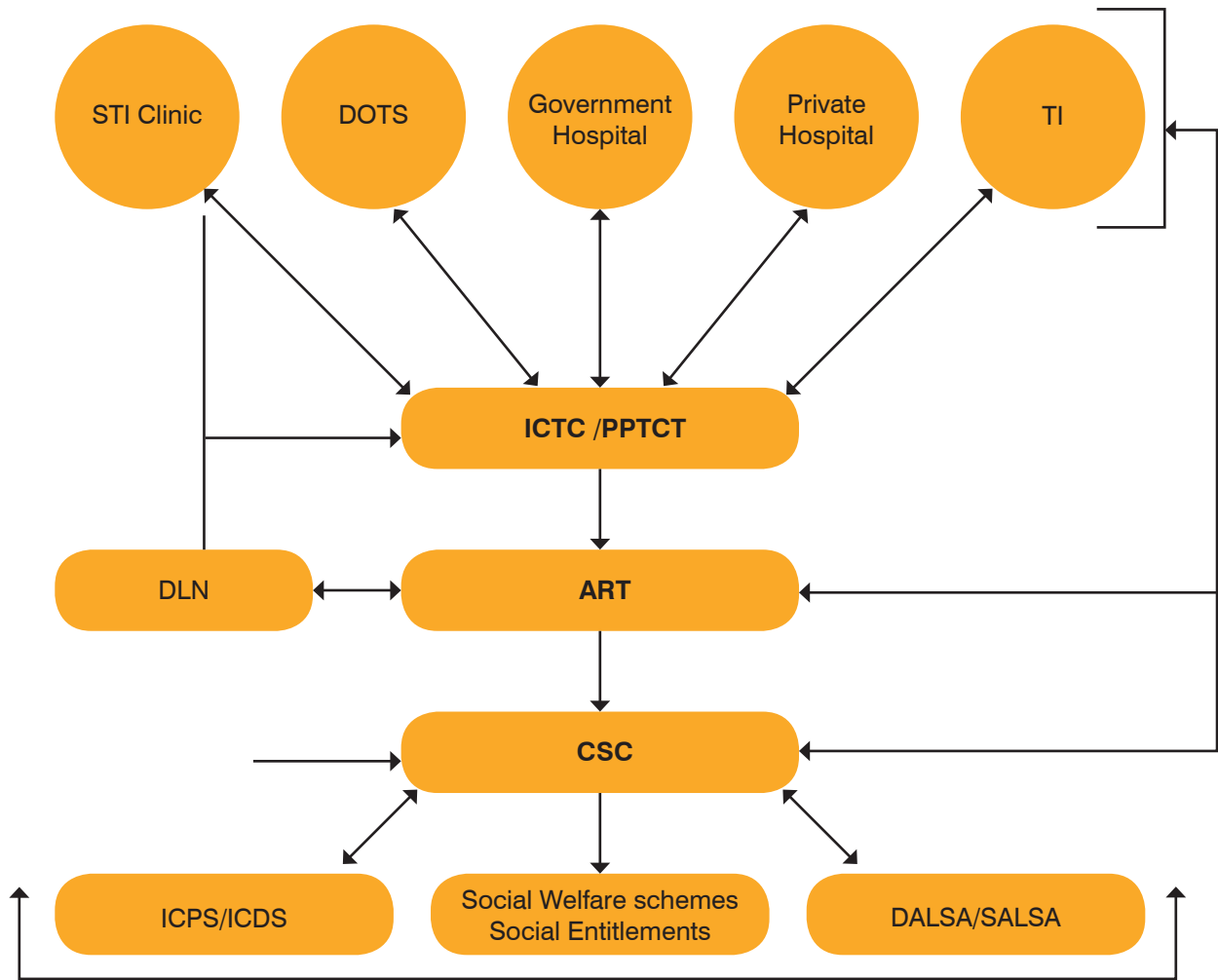
As a follow up of counselling service provided by the professional counsellor in ART Centre, the peer counsellor will provide counselling to the clients on ART adherence, positive living, positive prevention and any other pertinent issue of the client. Peer counselling service can be provided at CSC and field as per the convenience of the client.

### 3.3.2 Referral and Linkage Services

CSC will function as a referral hub from where the health and non-health needs of PLHIV will be addressed through referral to an appropriate facility. The programme will assess the needs of PLHIV under broad categories – psychosocial, legal, vocational - and identify the required resources in the region/district for addressing these needs. CSC will establish linkages with other health and non-health service delivery units in the district which will address some of the needs that cannot be addressed at the CSCs.



### 3.3.2.1 Referral and Linkage System

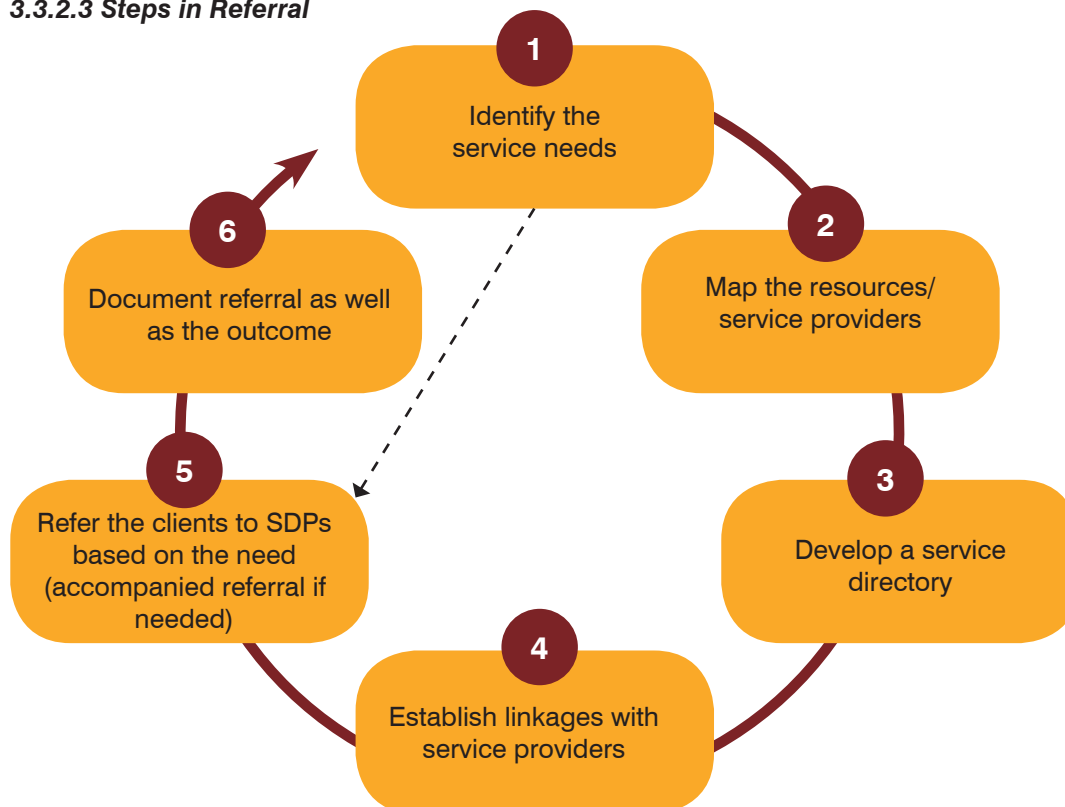


### 3.3.2.2 CSC Referral Matrix

	Referral centre	Purpose of referral		Referral centre	Purpose of referral
Health Needs	ART centre	<ul style="list-style-type: none"> <li>Registration</li> <li>ART initiation</li> <li>Baseline and routine CD4 tests</li> <li>Management of ART side effects</li> <li>Follow up</li> </ul>	Non-Health Needs	Government Department	<ul style="list-style-type: none"> <li>Social entitlements</li> <li>Social welfare schemes</li> </ul>
	ICTC and PPTCT	<ul style="list-style-type: none"> <li>HIV testing of spouse, partner and family members</li> </ul>		Legal aid	<ul style="list-style-type: none"> <li>Free legal aid to needy PLHIV</li> <li>Legal literacy</li> </ul>

	Referral centre	Purpose of referral		Referral centre	Purpose of referral
Health Needs	Government & Private hospitals	<ul style="list-style-type: none"> <li>• Early detection</li> <li>• OI treatment</li> <li>• Treatment for general health issues</li> <li>• Antenatal Care</li> <li>• Child care</li> <li>• Access to CPT</li> </ul>	Non-Health Needs	Income Generation Programmes (IGP)	<ul style="list-style-type: none"> <li>• Income generation programme for needy PLHIV</li> <li>• Vocational training</li> </ul>
	STI clinics	<ul style="list-style-type: none"> <li>• For STI testing and treatment</li> </ul>		Faith-based organisations (FBO)	<ul style="list-style-type: none"> <li>• To mobilise nutritional support</li> <li>• For meeting non-HIV needs of PLHIV</li> <li>• Spiritual counselling</li> </ul>
	OST centre	For the provision of OST to IDU populations		Corporate Social Responsibility (CSR)	<ul style="list-style-type: none"> <li>• To mobilise educational and nutritional support for the clients</li> </ul>

### 3.3.2.3 Steps in Referral



### 3.3.3 Support Group Meeting

The PC and/or Peer Counsellor of the CSC will organise SGM to provide support mechanisms for the clients. These meetings will provide the members with a platform to share their problems and concerns about confidentiality and learn from each other how to cope. The support groups will also help strengthen their knowledge on HIV-related issues and develop community voice to advocate for better policies. The SGM will be organised mainly at the CSC. The Peer Counsellor will also be organising SGM during field visit as per the needs of the clients.

#### 3.3.3.1 SGM Modalities

CATEGORIES	KEY FEATURES	VENUE	DOS
<ul style="list-style-type: none"> <li>• Clients newly initiated on treatment</li> <li>• Clients with less than 80% adherence</li> <li>• Children SGM</li> <li>• KP specific SGM</li> <li>• Discordant couple SGM</li> <li>• Single women or widow SGM</li> <li>• Pregnant women SGM</li> </ul>	<ul style="list-style-type: none"> <li>• Theme-based discussion</li> <li>• Provides emotional and social support</li> <li>• Facilitates the community to promote experiential sharing and learning</li> <li>• Well planned and documented</li> </ul>	<ul style="list-style-type: none"> <li>• Mainly at CSC or community friendly place in the field or DIC/hotspots of TI</li> </ul> <p><b>Size of the group:</b></p> <ul style="list-style-type: none"> <li>• 10-15 members should participate in each SGM</li> <li>• Efforts to be made to ensure 70% participants remain regular</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct maximum SGM in CSC</li> </ul> <p><b>DONTS</b></p> <ul style="list-style-type: none"> <li>• No monetary benefit is given to participants for attending the meeting</li> </ul>

#### 3.3.3.2 Good practices

ART centres can identify clients whose adherence level is below 80% and call them in batches to take the treatment. CSC can conduct SGM with these clients and reinforce the treatment goals, the importance of adherence and identify the reasons for their poor adherence. If poor adherence is due to any misconceptions or due to socioeconomic reasons such as loss of wage, poor nutritional support etc, CSC should use their referral network to support such clients. If poor adherence is due to extreme side effects or due to possible treatment failures, such clients should be made to meet the ART Medical Officer for further investigations.

#### Prerequisites:

- Every member of the support group is encouraged to bring their ART Green Card for the meeting to understand their clinical profile
- It is also suggested to take the details of weight, CD4 count, viral load, and treatment details of the participants
- Everyone will sign the meeting attendance sheet
- The minutes of each meeting must be recorded in the meeting register (**Refer to Annexure III for Meeting Register**)

### 3.3.3.3 Thematic areas for support group meetings can include the following:

<p><b>1. Basic Health &amp; Hygiene</b></p> <ol style="list-style-type: none"><li>Personal hygiene</li><li>Regular health check up</li><li>Importance of yoga and meditation</li><li>Positive living</li><li>Sexual and reproductive health</li></ol> <p><b>2. Basic HIV Information</b></p> <ol style="list-style-type: none"><li>Modes of HIV transmission</li><li>HIV life cycle and living with HIV</li><li>Disclosure issues</li></ol> <p><b>3. Diet and Nutrition</b></p> <ol style="list-style-type: none"><li>Balanced diet</li><li>Nutritional demo</li><li>Kitchen garden promotion</li><li>Timely intake of food</li></ol> <p><b>4. Home Based Care</b></p> <ol style="list-style-type: none"><li>First aid</li><li>Basic information to caregivers</li><li>Palliative care</li></ol> <p><b>5. OI Management and Co-infection</b></p> <ol style="list-style-type: none"><li>Types of OIs and their symptoms</li><li>Treatment for OIs</li><li>Follow up</li></ol>	<p><b>6. Treatment Adherence</b></p> <ol style="list-style-type: none"><li>Antiretroviral therapy, Tuberculosis &amp; STI</li><li>CD4</li><li>Treatment schedule</li><li>Viral load</li></ol> <p><b>7. Treatment Education</b></p> <ol style="list-style-type: none"><li>First line and second line ART</li><li>Side effects of ART</li></ol> <p><b>Positive Prevention</b></p> <ol style="list-style-type: none"><li>Safe sex</li><li>Positive prevention and condom promotion</li><li>Discordant couples</li></ol> <p><b>Social Events &amp; Livelihoods</b></p> <ol style="list-style-type: none"><li>Government schemes</li><li>Facilitation of local donor support</li><li>Income Generation Programmes</li></ol>
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### 3.3.4 Enabling Environment

The CSC will always try to achieve an outstanding level of best practice in creating and sustaining a positive and effective social environment. At the community level, partnerships with critical stakeholders will be created and strengthened for an enabling environment. Partnerships will be established with district-level service delivery facilities and governance systems and discrimination response team of the CSC to ensure stigma and discrimination-free services. Specific activities for this shall include:

- Community sensitisation meetings and developing community ownership
- Coordination meetings at the community level with Panchayats, Anganwadi Workers, ASHA, teachers and village health committees
- Activities at village and district level during special events such as World AIDS Day, World TB Day, Women's Day, Children's Day and other related events

## Outreach Services

Outreach activity is the backbone of care and support programme for PLHIV. The goal of conducting outreach activity is to reach out to the PLHIV and link them with care and support services that would improve their knowledge level, service uptake and ultimately result in improved adherence and better quality of life. Reaching out to PLHIV and their families in their own homes and communities acts as a catalyst in bridging the gap between the community and the service providers. Outreach to PLHIV is important because the prevailing stigma and discrimination often prevent them from accessing services or at times they are not even aware of the available services. The main reasons for LFU/MIS cases are either limited information on treatment adherence or socioeconomic problems such as poverty, poor accessibility, etc. An effective outreach will bridge these gaps by providing comprehensive information to enhance the knowledge, skills and also linking PLHIV to services which support them in accessing the required services beyond medical services. This will lead to reduced LFU/MIS cases and improve the retention in treatment. Outreach Worker and Peer Counsellor will spearhead the outreach activities in the programme. They will coordinate with the rest of the CSC staff to ensure that PLHIV derive the maximum benefits from the programme.

### 4.1 Outreach Strategy

#### 4.1.1 Allocation of Outreach Workers

The mandate of each CSC is to register and provide services to all PLHIV in active HIV care with the ART centre/s attached to it. In many of the ART centres, there may be many clients registered from the same district where the ART centre is located. There can also be clients from other districts and states. Hence, for developing an outreach plan and allot ORWs, it is important to map the geographical distribution of PLHIV registered in the ART centre covered by the CSC. ORWs are allotted on the basis of this exercise; they should be recruited from the areas having high caseload. No CSC is allowed to recruit all ORWs from the place where it is located. If the number of PLHIV from key population groups is high, at least one ORW can be recruited from any of these groups. The ORW must be willing to travel to the areas allotted to him/her. Consider the following points while allocating ORW to a particular area:

- ORW's familiarity with the area
- Language familiarity
- Rapport with the key stakeholders in the area

In the case of a CSC covering multiple ART centres, one of the ORWs can be allotted to the ART centre which is not directly linked to CSC. S/he will be the point person for the ART centre and will work in coordination with the Project Coordinator of the CSC and ART centre.

#### 4.1.2 Minimum Standards to be Maintained

- The CSC will take outreach consent in writing from clients at the time of registration for home visit by making him/her understand the importance of outreach (**Refer to Annexure IV for Consent Form**)
- An ORW will ideally spend a minimum of 20 days in the field in a month. One day in every week will be spent in the CSC for documentation, review and planning. For CSC in difficult terrains, ORW should spend one day in the CSC once every 15 days
- Each ORW is expected to conduct 4-5 home visits in a day. Families, in this context, are defined as all individuals staying under one roof and sharing the same kitchen (They may or may not have blood-relation)
- No outreach worker should spend their working hours at the ART centre

#### 4.1.3 Activities to be Carried out During Outreach

Prioritisation of clients for outreach will be done by ORWs as per the differentiated care strategy. For greater impact, the outreach staff of CSC should work in close coordination with outreach workers of other HIV programmes. This could include Community Care Coordinator of ART Centre, Counsellors of ICTC and ART centres, Peer Educators of TIs, Link Workers and volunteers from PLHIV community.

During outreach, ORWs will reach out to priority clients and provide them with required services. They will also contact other clients residing near to the priority clients to take their health status updates. In case clients or their family members require any service, ORWs will facilitate it. ORWs will also maintain a cordial relationship with all community leaders and stakeholders.

#### 4.1.4 Outreach Mapping

The Project Coordinator will guide the ORWs to map the PLHIV distribution and their locations within the geographical area allocated to them. If clients are residing in faraway places (hilly terrains, areas with fewer transportation options etc.), ORWs can seek support from Peer Counsellors to reach out to them at ART centres. They can also take support from other HIV programme implementing partners working in the state/region.

## 4.2 Inter-district LFU Tracking Mechanism

Roles and responsibilities of each stakeholder related to inter-district LFU tracking are given below:

### ART Centre

- Generate the list of LFU/MIS cases and share with CSC as per the agreed timelines
- Promptly update the ART database as per the tracking outcome and evidence submitted by the CSC
- Update both the source and destination address for clients who are migrants

### CSC

- Segregate district-wise the LFU/MIS data received from ART centre and share it with the CSC in the concerned district for follow-up
- Take support of other NACP partners to track cases in the districts having no CSC
- Develop and train community volunteers in hard-to-reach areas who can help in tracking LFU/MIS cases
- Share tracking outcome with evidence to the concerned CSC

### SR

- Facilitate inter-district LFU/MIS tracking by CSC and address the gaps and challenges
- Monitor data sharing, progress in tracking and reporting among CSCs
- Develop network and linkages with other NACP programmes for LFU tracking
- Provide regular feedback on LFU tracking and seek support from SACS in addressing coordination issues

### SACS

- Support SR in inter-district coordination for LFU/MIS tracking.
- Monitor the inter-district LFU tracking outcome and ensure update of ART database
- Involve other programme partners for better reach and timely tracking of cases

### 4.3 Inter-state LFU Tracking

There are clients accessing ART from centres in the neighbouring states. There is a possibility that clients may get registered in one ART centre and migrate to other places later on due to various reasons. Tracking these inter-state LFU cases is also an important task in the programme. Since CSCs are functioning in every state, data sharing with partners becomes a vital task in this process. Monitoring and evaluation officers at SR and PR will facilitate the process of interstate data sharing. Suggestive methods for interstate LFU data sharing and follow-up are given below:

Name of the activity	ART Centre	CSC	SR	SACS
Developing the list of inter-state LFU/MIS cases and sharing it with the SR by 5 <sup>th</sup> of every month	✓			
Sharing the list of inter-state LFU/MIS cases with concerned SR by 10 <sup>th</sup> of every month			✓	
Sharing the list of LFU/MIS cases from other states with concerned CSCs by 12 <sup>th</sup> of every month			✓	
Tracking the LFU/MIS cases as per the list received		✓		
Reporting back the status of LFU/MIS cases from other states to SR by 25 <sup>th</sup> of every month		✓		
Collating the tracked back information of LFU/MIS cases from other states			✓	
Sharing the details of LFU/MIS cases from other states who are tracked with respective SR and SACS			✓	
Sharing the details of LFU/MIS cases from other states tracked with concerned SSR and ART centre			✓	
Ensuring feedback given by CSC is promptly updated in ART records				✓
If work progress is not satisfactory, then facilitate coordination between source and destination state partners for understanding the tracking process and development by 20 <sup>th</sup> of every month			✓	✓
Identifying the most common source and destination states and developing strategies for effective LFU/MIS case tracking			✓	✓



## 4.4 Outcomes of Outreach

Following are the major outcomes expected of the outreach activity:

- Early linkage of PLHIV to ART and other related services
- At least one monthly follow-up for all newly initiated clients for three months
- PLHIV are empowered to cope with minor side effects and take precautions during the treatment
- Improved treatment education and adherence
- All clients report to the ART centre for CD4 test on a regular basis
- PLHIV are linked to various service delivery points for meeting health and non-health needs
- LFU/MIS cases tracked and brought back to the ART centre
- Retention of clients in HIV care is ensured
- Through home visits, the following purposes will also be served:
  - ◆ Family members of PLHIV are motivated to get tested for HIV
  - ◆ Treatment education/adherence support is given to family members and caretakers
  - ◆ Nutritional information will be given to family members and caretakers
  - ◆ Education is given to spouses/partners on positive prevention

## 4.5 Technology-enabled Outreach: eMpower Tablet-based Application

All the clients managed by an ORW may not require equal attention. However, prioritising clients who require immediate and frequent attention is a difficult task. In order to support the outreach team in this task, eMpower Tablet Application has been developed. eMpower application collects the basic data of the client from the programme CMIS and segregates it ORW-wise to help them deliver services effectively. This application supports client management through prioritisation, improves outreach services and ensures effective client follow-up by the programme.

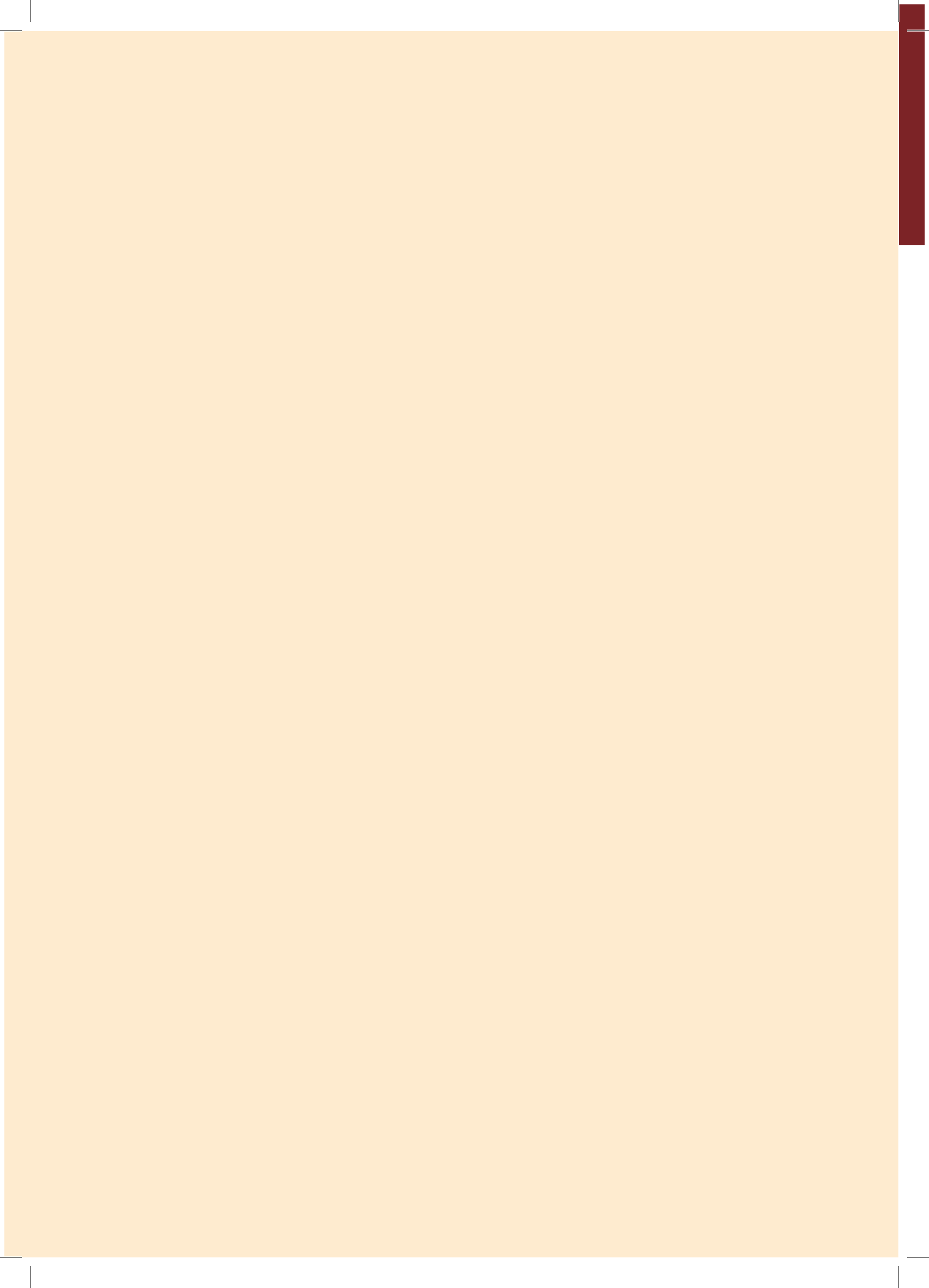
### Salient Features of the Application

**Client Prioritisation:** This application provides the list of clients to the ORW for follow-up as per the programme priorities e.g clients yet to be initiated on ART, clients newly initiated on ART, clients having less than 80% treatment adherence etc.

**Planning:** The application helps the ORW to plan their daily and weekly activities as per the programme priorities.

**Geolocation and Navigation:** This application has a unique feature which helps the ORW to use the offline map to reach the client's location and provide services.

**Data Accessibility:** The application helps the ORW to access all the registered clients' data on one platform which will help them provide services as per priority and requirement of the client.



## 5

# Advocacy

Advocacy is a method and a process of influencing decision-makers and public perceptions about an issue of concern and mobilising community action to achieve social change and a favourable policy environment to address the concern.

## 5.1 Stakeholders for Advocacy

Individuals or institutions having a direct or indirect link with HIV programmes, especially care, support and treatment services are stakeholders of the programme. While carrying out advocacy activities, various stakeholders at district, state and national levels need to be mobilised for their involvement.

The below-given table has an indicative list of stakeholders at the village, block, district, state and national level. CSC team may identify other relevant local stakeholders.

<b>Local/district level stakeholders</b>	PLHIV forums/community groups
	Affected family members
	District AIDS Prevention and Control Unit (DAPCU)
	District hospitals/Primary Health Centres (PHC)
	District Level Network of People Living with HIV (DLN)
	Service providers (health, social benefits, legal aid)
<b>State level stakeholders</b>	State AIDS Control Society (SACS)/State Health Authority
	Media
	State Level Network of People Living with HIV (SLN)
<b>National level stakeholders</b>	Ministry of Health & Family Welfare
	Ministry of Women and Child Development
	Ministry of Social Justice and Empowerment
	Ministry of Law

## 5.2 Steps in Advocacy

Advocacy is a continuous process that should be done systematically. The steps involved in the advocacy process are discussed below:

Steps in advocacy	How to do/process	What to do/activities under CSC
<b>Identify advocacy issues, goals, and objectives</b>	<p>Advocacy issues may be related to PLHIV community's access to healthcare facilities, social protection schemes, legal aid services and addressing stigma and discrimination</p> <p>For the identified advocacy issues, it is a must to gather evidences and relevant data. This will help evidence-based advocacy. The data should be presented in such a way that it supports the actions required by the decision maker</p> <p>For the identified advocacy issue, it is important to formulate the goals and objectives (what are the desired changes/results to be accomplished?)</p>	<ul style="list-style-type: none"> <li>• Community consultations to identify and prioritise the advocacy issues</li> <li>• Feedback from outreach, counselling and support group meetings to identify the issues of the community for advocacy</li> <li>• Analysis of discrimination response team report / relevant data to identify the common issues for advocacy</li> </ul>
<b>Determine target audience</b>	<p>Identification of target audience with whom advocacy is to be carried out; for example, for the above mentioned case, target audience are:</p> <ul style="list-style-type: none"> <li>• Medical Superintendent of the concerned hospital</li> <li>• CMO</li> <li>• Health Commissioner of the state</li> </ul> <p>Target audiences are the individuals who can take decision about bringing the desired change</p>	<p>Based on the advocacy issue as well as expected outcome of advocacy efforts, the CSC will identify primary and secondary audience for advocacy</p>

Steps in advocacy	How to do/process	What to do/activities under CSC
<b>Develop advocacy messages</b>	<p>Advocacy messages need to be tailored to specific target audience. It is important to reflect and decide:</p> <ul style="list-style-type: none"> <li>● Who are you trying to reach?</li> <li>● What do you want to achieve with the message?</li> <li>● What do you want the recipient of the message to do as a result?</li> </ul>	<p>CSC team can take the support from DRT members and SR in developing their advocacy messages which should be supported by evidences and should give concrete information about the advocacy issue</p>
<b>Build support</b>	<p>Stakeholders who can support the community in advocacy issues need to be identified. They can be the community leaders, CSOs, NGOs, professional associates, activists, donors, media and government departments</p>	<p>Based on advocacy issue, approach the identified organisations for support for the advocacy cause. Some of the important stakeholders who can be approached are DAPCU, DALSA, SR and community leaders</p>
<b>Choose communication channels</b>	<p>Select right methods and media for reaching target audiences. Some of them can be:</p> <ul style="list-style-type: none"> <li>● Face-to-face meetings</li> <li>● Briefing leaflets</li> <li>● Public rallies</li> <li>● Fact sheets</li> <li>● Policy forums</li> <li>● Policy briefs</li> <li>● Posters and flyers in public places</li> <li>● Petitions</li> <li>● Public debate</li> <li>● Press releases</li> <li>● Press conferences</li> </ul>	<p>It is always preferred to have one-to-one sensitisation meetings with different stakeholders and policymakers whom the programme considers as having the greatest influence on the uptake of services by PLHIV.</p>
<b>Implement activities</b>	<p>The implementation plan should consider tasks, issues and target audience who are responsible for time frames, expected outcomes and resources needed</p>	<ul style="list-style-type: none"> <li>● PC will participate regularly in DAPCU and other district level meetings</li> <li>● DRT will address the cases as and when reported</li> <li>● CSC will develop the quarterly advocacy plan and a progress report will be shared with SR and SACS</li> </ul>

Steps in advocacy	How to do/process	What to do/activities under CSC
<p><b>Monitor progress and outcomes along the way,</b></p> <p><b>evaluate progress, outcomes and impact</b></p>	<p>Determine how you will do the following:</p> <ul style="list-style-type: none"> <li>• Monitor your activities at the outset</li> <li>• Evaluate or measure the impact of your work</li> <li>• How will you know the situation has changed?</li> <li>• Process and impact measures (e.g., has the network worked well vs. has the network's work had an effect?)</li> </ul> <p>Some of the important indicators to assess the advocacy work are the following:</p> <ul style="list-style-type: none"> <li>• Increase in support from various sources</li> <li>• Resource mobilisation</li> <li>• Changes in the policies</li> <li>• Increased service uptake</li> <li>• Decrease in violence, stigma and discrimination.</li> </ul>	<p>SR will help the CSC to understand the outcome of advocacy efforts and help them in evaluating their activities</p>

### 5.3 Characteristics of Good Advocacy Messages

- Simple
- Concise
- Tone/language consistent with the message
- Use of appropriate language
- Credible messenger (spokesperson)

### 5.4 Information Centre

Every CSC will have an information centre. This information centre will have the details of various social benefit schemes for PLHIV, application procedures for such schemes, documents required to apply for such schemes as well as the contact details of concerned officers. Any PLHIV walking into the CSC will get information about all the schemes available. They can also avail the application form from the information centre. CSC staff, mainly PC and Peer Counsellor, will facilitate the filling up of application forms and also educate the PLHIV on how to get the supporting documents required.

### 5.5 Discrimination Response System

Addressing discrimination is a key aspect of reducing vulnerability as well as fostering quality of life. In order to address discrimination, every CSC will have a community-led

Discrimination Response System (DRS). The purpose of DRS is to establish an effective and sustainable mechanism to address cases of discrimination faced by PLHIV community. Under this system, a Discrimination Response Team (DRT) will be set up.

### **5.5.1 Structure of DRT**

DRT will consist of community volunteers, outreach worker and peer counsellor, and legal resource person familiar with the legal issues surrounding harassment of PLHIV. The team will be supported by the PC and the Project Director of the CSC.

The team may have 7 – 15 members, depending on need (the frequency of incidents, size of the area to be covered). There should be representation of members from key population groups as well.

### **5.5.2 Response to Discrimination Incident**

When a community member informs on one's behalf or on behalf of another member who gets harassed, the member of the DRT responding to the information is to get in touch with the affected person by calling or in person to confirm the issue. S/he also will contact other team members to apprise them of the situation. It is important to provide immediate moral support and give the message that the person is not alone in this situation and the person has support from the programme.

External stakeholders (lawyers, other NGOs, district administration officers, health care providers, etc.) are to be involved to resolve the issues.

Inform issues related to stigma and discrimination to the following depending upon the nature and severity of the issue:

- The Police Department
- DAPCU
- Block/District level administrative officers
- Gram Pradhan
- Media

### **5.5.3 Reporting Mechanism for DRT**

Documenting any incidence of stigma and discrimination happening in any setup is very important as these documents will be directing and supporting the advocacy initiatives. The documented cases will be good advocacy tools. The incidents will be recorded in DRT register (*Refer to Annexure V for DRT Register*).

## **5.6 Advocacy Meetings**

Each CSC has to conduct advocacy in a need-based manner. This meeting will be used as an opportunity to sensitise various stakeholders on PLHIV issues. The meeting can happen in any place which is convenient to all the stakeholders. In the advocacy meeting, the community needs will be put forward to the stakeholders to mobilise their support.





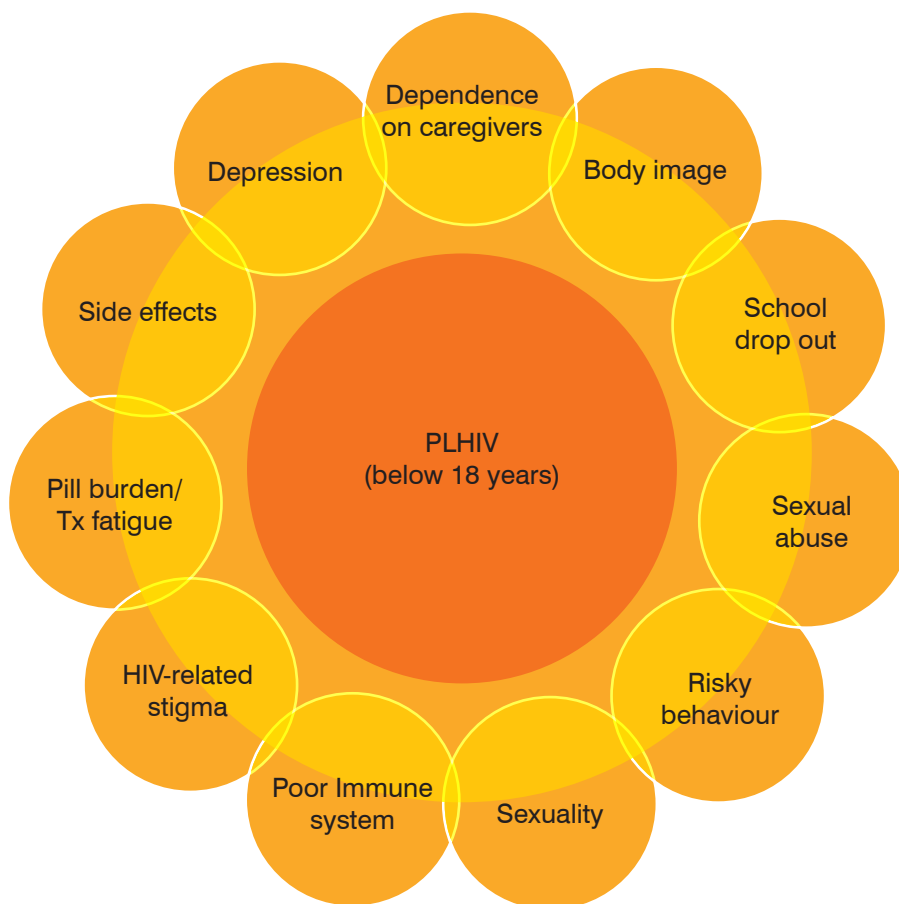
# 6

## Care and support services for children and adolescents living with HIV/AIDS

### Introduction

There are 45,572 male and 35,232 female children below 15 years of age living with HIV and in active care with the ART centres in India as of December 2017. It is nearly 6.5% of the total population in active HIV care. Issues and challenges faced by these children and adolescents are different from the elders. Their problems multiply if they are orphans. Some of their key issues are captured below:

CSC may not be in a position to address all these challenges but will play a catalyst's role in linking needy children and adolescents to various services.



## 6.1 Special Provision for Children in CSC

The resting/relaxing place can be made child-friendly. One of the walls of the room/hall can be painted with cartoon pictures, nutritional pyramid, and pictures of fruits and vegetables. This room should also have indoor play materials for children who are visiting the centre along with their parents or caretakers. The key strategies for catering to the needs of children and adolescents through the CSC are the following:

Needs of CLHIV and Adolescents Living with HIV (ALHIV)	Role of CSC	Referral Centre
<p><b>Counseling issues and needs:</b></p> <ul style="list-style-type: none"> <li>● Treatment counseling</li> <li>● Dealing with HIV status</li> <li>● Healthy lifestyles</li> <li>● Dealing with stigma and discrimination</li> <li>● Coping with changes in the body including menstruation</li> <li>● Dealing with sexual exploitation</li> <li>● Career counseling</li> <li>● Loneliness and dejection from family</li> </ul>	<ul style="list-style-type: none"> <li>● Peer Counsellor will talk to each child and adolescent either during ART centre visit or during their visit to CSC to identify their counselling needs. S/he will give some basic information and then refer the client to appropriate services.</li> <li>● If there is a need, s/he will also counsel their parents and caretakers.</li> </ul>	<ul style="list-style-type: none"> <li>● Pediatrician in the hospital</li> <li>● ART Counsellor</li> <li>● Clinical counsellor in the hospital</li> <li>● Career counseling centres</li> <li>● Life skill education centres</li> <li>● Vocational training centres</li> </ul>
<p><b>Education:</b></p> <ul style="list-style-type: none"> <li>● ART centre and school timings are the same</li> <li>● Basic requirements such as school fee and education kits</li> <li>● Discrimination in school</li> <li>● Lack of motivation to go to school</li> <li>● Dropouts either by self or due to parental compulsion</li> </ul>	<ul style="list-style-type: none"> <li>● CSC to negotiate with ART centre to provide flexi-timing for school-going children to collect their ART</li> <li>● Mobilise local resources to support needy children in their education</li> <li>● Address stigma and discrimination cases in the school immediately and sensitise school authorities on HIV/AIDS related issues</li> </ul>	<ul style="list-style-type: none"> <li>● Block Development Officer for education</li> <li>● School Development Authorities</li> <li>● Residential counsellors in hostel</li> </ul>

# Care & Support Services for Key Populations (KP)

National AIDS Control Programme, through its Targeted Interventions (TI) amongst Key Populations (KPs) such as PWID, MSM, FSW, and Transgender; and bridge-populations such as Truckers and Migrants focus on prevention of HIV infection, early detection and linkages of identified positive KPs to ART. However, there are various other care and support needs for PLHIV from KP groups. Some of them are counselling on positive prevention, positive living and linkages to social protection schemes and entitlements. CSC will give special focus to address these unmet needs through appropriate strategies.

## 7.1 Care and Support Needs of KPs

Key populations, by the virtue of their living circumstances and the behaviour associated, are different from the general populations and have different needs. Hence, CSC must ensure special provision for them to create a friendly and conducive environment to access the services provided at CSC.

### 7.1.1 Special Provision for KPs under CSC

#### 7.1.1.1 Counselling Services

- As a part of induction training, CSC counsellors will be sensitised towards KP issues and concerns. They will be trained to provide counselling services addressing specific concerns of KPs.
- CSC counsellors will prioritise need-based counselling services for KPs both at the CSC and during the home visit.

#### 7.1.1.2 Outreach Activities to Ensure Better Reach to KPs

CSC team, while developing an outreach plan, will give priority to the following:

- Reach out to all KPs registered at CSC
- Identify new KPs through peer counsellors during outreach
- Collaborate with TI partners to scale up the reach to KPs in hard-to-reach areas

#### 7.1.1.3 Support Group Meeting for KPs

The CSC team will identify peer positive speakers amongst different groups of KPs and encourage them to educate members of the group on KP-specific care and support issues and concerns such as disclosure of HIV status to spouses, positive prevention, ART adherence, addressing stigma and discrimination, etc. Few of the group-specific issues and concerns to be addressed through the support group meeting are as follows:

**a. Female Sex Workers (FSW)**

- Negotiation for safer sex with clients
- Dealing with children of sex workers
- Overcoming self-perceived stigma and discrimination
- Dealing with substance abuse and harassment
- Response to crisis such as police raid and sexual harassment
- Reproductive and sexual health issues and concerns

**b. MSM, Transgender and Hijras**

- Sexual identity issues and concerns
- Overcoming self-perceived stigma and discrimination
- Dealing with substance abuse and harassment
- Response to crisis such as police raid and sexual harassment

**c. PWID**

- Care for PWID, their spouses and children
- Safer injecting and sexual practices
- Counselling on safer sex
- Co-infection with HIV and Hepatitis C and/or STI
- Counselling support for those who want to remarry
- Assistance in legal issues

**7.1.1.4 Linkages and Referrals for Services**

- a. Linkage with TIs and OST centres:** PLHIV who are PWID and in need of OST services will be referred to TIs for OST, needle syringe exchange programme and PWID-specific counselling services. Additionally, all newly contacted KPs during field visit, community outreach or by any source of referral to CSC will also be referred to TI NGOs and OST centres.
- b. Referral of partners and spouses of HIV positive KPs to ICTC:** Peer counsellor will identify spouses and partners of positive KPs and motivate them to go to ICTC for HIV testing. Special emphasis will be given to discordant couples by ensuring referral of non-infected partner to ICTC once in six months.
- c. Social protection schemes and entitlements:** The needs of PLHIV coming to CSC may vary from health to social, economic, emotional, and legal needs. As CSC does not have provision to provide all these services for KPs, they will meet their needs through effective referral and linkages with different departments providing the required services.

### 7.1.2 KP Service Matrix under CSC

What	Why	How	When	Who
Developing linkage with TI NGO	<ul style="list-style-type: none"> <li>For cross-referrals</li> <li>Data sharing</li> <li>Positive prevention among KPs</li> <li>Linking positive KPs to care and support</li> </ul>	Regular meeting with TI team	Every month	Project Coordinator
Registration of positive KPs in CSC	<ul style="list-style-type: none"> <li>To provide care and support services</li> </ul>	<ul style="list-style-type: none"> <li>Obtain the line list from TI</li> <li>Provide any one service under CSC to positive KPs and register them with CSC</li> </ul>	Ongoing activity	Peer Counsellor/ORW
Participation in group meeting/FGD conducted by TI	<ul style="list-style-type: none"> <li>In TI FGDs, group meeting, CSC staff will get an opportunity to interact with all KPs</li> <li>To educate KPs on benefits of early detection and initiation of ART</li> </ul>	<ul style="list-style-type: none"> <li>Participate in group meeting at TI, Hotspots and STI clinics</li> </ul>	Ongoing activity	Peer Counsellor/ORW
Referral of KPs to TI	<ul style="list-style-type: none"> <li>To provide prevention services</li> </ul>	If ORW/Peer Counsellor reached KP who is not reached by TI, refer such cases to TI	Ongoing activity	Peer Counsellor/ORW
Referral to care ART and CSC	<ul style="list-style-type: none"> <li>Proportion of positive KPs registered in ART is less when compared to general population</li> </ul>	Regular follow-up with positive KPs who are LFU/MIS or who are not yet registered with ART with the support of outreach staff from TI	Ongoing activity	Peer Counsellor/ORW

What	Why	How	When	Who
Formation of KP-specific support groups and regular meeting	<ul style="list-style-type: none"> <li>Issues pertaining to KPs are different from general populations</li> <li>KP-specific issues, particularly care and support matters, to be discussed in SGM</li> </ul>	<p>Separate support group for FSW, MSM, PWID, Hijra/ Transgender to be formed wherever feasible</p> <p>Meeting can be held either in TI DIC, CSC office or in hotspot preferred by group members.</p> <p>Positive speakers and CSC staff will facilitate the meeting</p>	Ongoing activity	Peer Counsellor/ ORW
Focussed counselling	<ul style="list-style-type: none"> <li>Needs are different for different clientele</li> </ul>	<ul style="list-style-type: none"> <li>Through home visits</li> <li>While CSC visit of the client</li> </ul>	Need-based	Peer counsellor/ ORW
Mobilisation of support for positive KPs and their children	<ul style="list-style-type: none"> <li>High vulnerability to physical and psychosocial risks</li> </ul>	Link with available services	Need-based	Peer counsellor/ ORW

## 7.2 Care, Support, Treatment for Transgender Populations

### Who is Transgender (TG)?

In India, people with a wide range of transgender-related identities, cultures and experiences exist including Hijras, Aravanis, Kothis, Jogtas/Jogappas, and Shiv-Shakti. The term 'transgender' is generally used to describe those who transgress social gender norms. Transgender is often used as an umbrella term to signify individuals who defy rigid, binary gender constructions, and who express or present a breaking and/or blurring of culturally prevalent stereotypical gender roles. Transgender people may live full- or part-time in the gender role 'opposite' to their biological sex.

#### 7.2.1 Transgender and HIV

As per India HIV estimation 2015 report, adult HIV prevalence was estimated at 0.26% whereas HIV prevalence among transgender was 7.5%. Hence NACO considers them as a key population and designed TG-specific HIV prevention programme under NACP.

Among TG who are tested positive at ICTC, only 80.8% are linked to ART centres. As of May 2017, 6792 TGs were registered in ART programme but, of them, only 3506 were in active care which is 51.6% of total registration. Hence, it is evident that there is a need to link them back to ART.

## **7.2.2 Barriers in Accessing HIV Care and Support Services for TG**

Barriers for TGs in accessing care, support and treatment can be clubbed into three broad categories:

### **7.2.2.1 Personal and Social Barriers**

- a. Internalised Stigma:** Majority of TGs are out of their parental home. Either they live with their Gurus in Dhera or live in groups separately. Since they have already faced so much of stigma and discrimination from their families, educational institutions and society at large, their self-esteem is very low. They confine themselves to their surroundings and do not expose themselves much to the general public. Hence, they are hesitant to visit ART centres to collect their medicines. Moreover, many of them are also afraid of their identity being revealed to fellow TGs and people with whom they are closely associated.
- b. Lack of Social and Family Support:** Since they do not get any family and social support, they do not come forward proactively to seek treatment and solutions to their problems. They prefer to go to quacks or seek traditional healers' help for STIs and other ailments.
- c. Financial Concerns:** Many of the TGs are into sex work or begging. Taking time out of their profession and visiting a caregiver is another problem for them as they have to spare time as well as money to reach the hospital.
- d. Frequent Mobility:** TGs who are into sex work often move from one place to another. This makes it difficult for them to stick to a particular ART centre.

### **7.2.2.2 Community Level Barriers**

- a. Controlled Social Behaviour:** Since many TG are living in Dhera under a Guru, their day-to-day life is controlled. Even to visit a doctor, one has to take permission from his/her Guru. For some of them, sex work is the main source of income. Therefore, the Gurus generally don't wish to get any TG's HIV status disclosed in the community as it will have an impact on their earnings through sex work.
- b. Stigma at Community Level:** Revealing HIV status in their Dhera or community makes it difficult for TGs to practice sex work in their locality. Moreover, since ART needs to be taken every day, they are afraid that others will get to know about their HIV status.

### **7.2.2.3 Health System Barriers**

- a. Inconvenient Operating Hours:** Mostly hospitals operate from early morning hours till noon. This timing is not suitable for TGs, especially for those in sex work.
- b. Insensitivity of Care Providers:** ART centres are located mainly in public health institutions. Healthcare staff of these hospitals may not be very sensitive towards TG community. This makes both the service provider and the TG uncomfortable in hospital settings. If a TG faces any stigma or discrimination at health facilities, they are not likely to go back to the facility again.

- c. **Extensive Registration Process:** In the hospital setting, there is an extensive registration process wherein the client is expected to give socioeconomic profile and valid address proof, which most of the TGs do not possess.
- d. **Coordination and Navigation Issues:** In the ART centre, clients are asked to undergo various investigations periodically. The testing facilities are located in different departments of the hospital. At times, TGs find it difficult to navigate to these service delivery points and they hardly get any help in this regard.

## 7.3 Transgender-specific CSC

Various care and support interventions in the country attempted to provide care and support services to the TG community along with the general populations. However, the following gaps have been observed as far as the provision of CST services to TG is concerned:

- There is a gap in estimation and coverage of TGs in CST services
- TG populations do not have specific centres for OI treatment and they hesitate to go to public health facilities because of the triple stigma of being TG, sex worker and HIV positive
- There is no specific programme to reach out to partners of TGs with care and support services
- HIV positive TGs do not have support groups
- Treatment literacy among TGs is very poor. It results in poor treatment adherence

In order to address some of the issues discussed above, the national programme introduced TG-specific CSCs in states having a considerable number of TGs in HIV care. The objective of this initiative is to provide holistic care and support services to HIV positive TGs in a stigma-free environment and at their convenient time.

### 7.3.1 Service package of TG-CSC

HIV AND RELATED SERVICES	TG-SPECIFIC SERVICES
<ul style="list-style-type: none"> <li>● Referral services for health and non-health needs</li> <li>● Counselling services</li> <li>● Promotion of treatment literacy and adherence</li> <li>● HIV testing of sexual partners</li> <li>● Community-based HIV screening</li> <li>● Tracking of LFU cases</li> <li>● TB screening, testing and treatment</li> <li>● Support group meeting</li> <li>● Discrimination response system</li> <li>● Community-based ART distribution</li> </ul>	<ul style="list-style-type: none"> <li>● Mental health counseling and support</li> <li>● Sexual health services – STI treatment through referrals, condom promotion</li> <li>● Sharing of information on PrEP, feminisation, Sex Reassignment Surgery (SRS)</li> <li>● Skill building and referrals for employment</li> <li>● TG festival celebrations</li> <li>● Addressing issues related to substance abuse :Opioids, Alcohol, Gutkha</li> </ul>



## **7.3.2 Functioning of TG-CSC**

### **7.3.2.1 Operational Area of TG-CSC**

TG-CSC will not be attached to any particular ART centre. Operational area for TG-CSC will be decided as per the local context in consultation with the SACS. In cities like Mumbai and Thane where the number of TG are concentrated, TG-CSC may not cover the other districts of the state. Clients in those districts will continue to be taken care of by the respective general CSCs. In cities like Vadodara and Ganjam, where the numbers are comparatively low, efforts should be taken to identify the other districts of the state having considerable number of TGs in HIV care and ORWs need to be placed in such districts.

### **7.3.2.2 Human Resource for TG-CSC**

Staffing pattern for TG-CSC is not different from that of general CSC. Details can be found in Sections 2.5 and 2.6 of this document. Peer Counsellor of the TG-CSC should be from TG community. Outreach workers can be a mix of TG and MSM/Kothi populations. Project Coordinator of TG-CSC will have to coordinate regularly with all the general CSCs in their operational area for information sharing and addressing issues with the ART centres.

### **7.3.2.3 Coordination Mechanism between TG-CSC and General CSCs for Service Delivery**

The TG-CSC will function independently as far as registration, differentiated care and follow-up services for the clients are concerned. Tablets will be provided to the ORWs to record their work on a daily basis. The following steps need to be taken to ensure proper coordination with the general CSCs for data sharing and smooth functioning of the TG-CSC:

1. General CSCs functioning in the operational area allotted to the TG-CSC will transfer out all TG clients already registered with them to the TG-CSC. This will be done after obtaining the consent of the client. If the client's preference is to continue with the general CSC, that should be accepted.
2. Henceforth, general CSCs functioning in the operational area of TG-CSC will refer the newly identified HIV positive TG clients to the TG-CSC for registration. This should be an accompanied referral to ensure that the client reaches the TG-CSC. However, if the client prefers to avail services from the general CSC, s/he need not be referred to the TG-CSC.
3. List of LFU/MIS clients from TG community and those requiring follow up on priority under the differentiated care model needs to be shared with the TG-CSC regularly by the concerned general CSCs.
4. The outcome of LFU/MIS cases tracked needs to be shared by the TG-CSC with the concerned general CSC for reporting it back to the ART centre.
5. Data sharing between the general and TG-CSCs needs to be facilitated and monitored by the SR. Clear timelines need to be set for data sharing between the centres.

#### 7.3.2.4 Reporting Architecture for TG-CSC

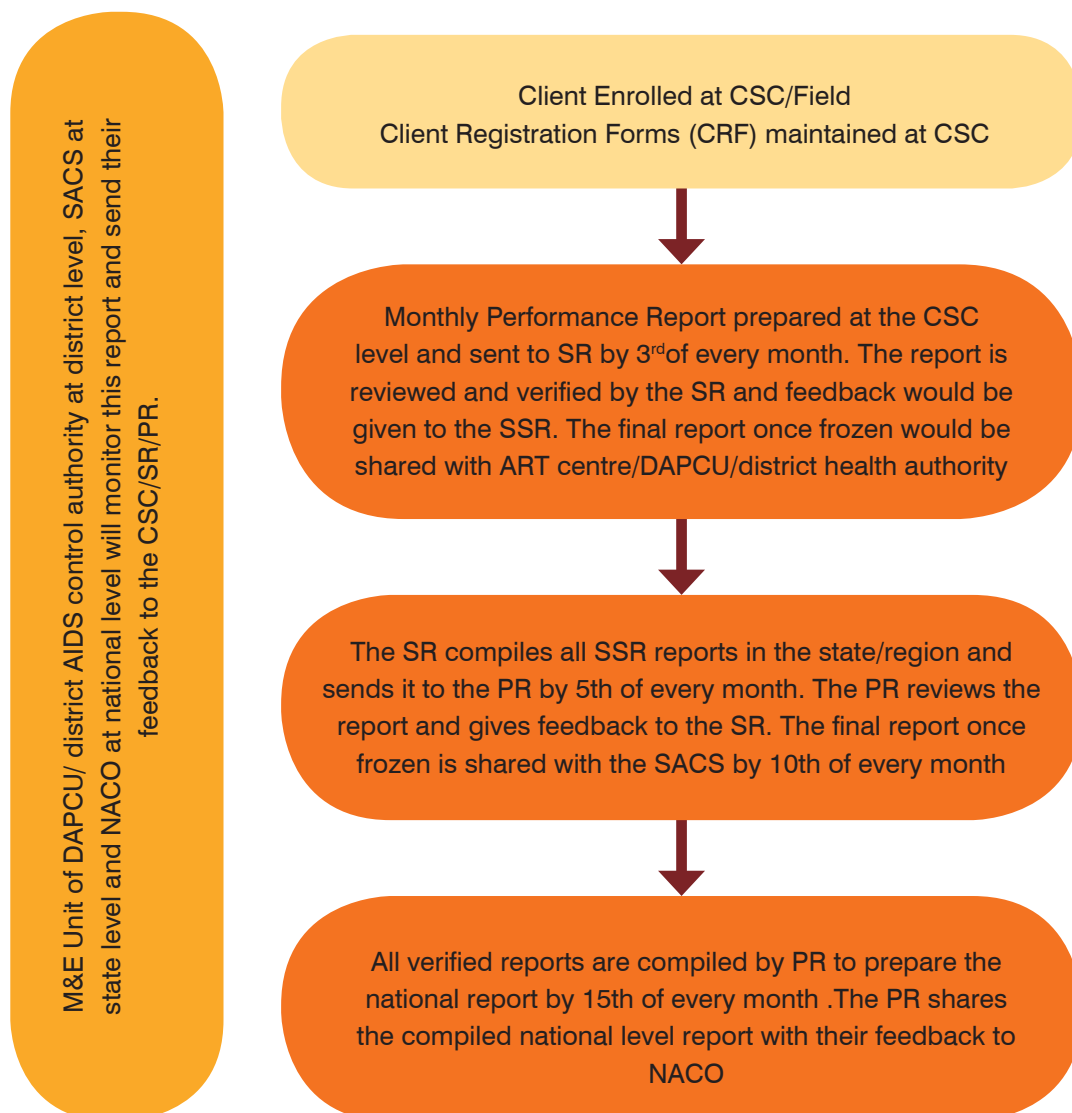
The physical recording and reporting tools for TG-CSC are the following:

Sl. No	Name of the tool	Purpose	Staff Responsible
1	Client Registration Form (CRF)	Client Registration	Project Coordinator
2	Meeting Register	To capture the details of support group and other important meetings at CSC	Project Coordinator
3	Discrimination Reporting Tool	To document incidents of stigma and discrimination faced by the community	Project Coordinator/ Peer Counsellor

# Supervision and Monitoring of CSC

The care and support programme has a rigorous monitoring and evaluation framework. Through a standardised MIS system, data is collected at CSC level on a regular basis. Each deliverable of CSC has a specific target and it is a time bound activity. The progress of the CSC against the target in a stipulated time will be rigorously monitored at every level.

## 8.1 Data Flow of CSC



## 8.2 Monitoring Framework

### a. Routine data collection, analysis and reporting

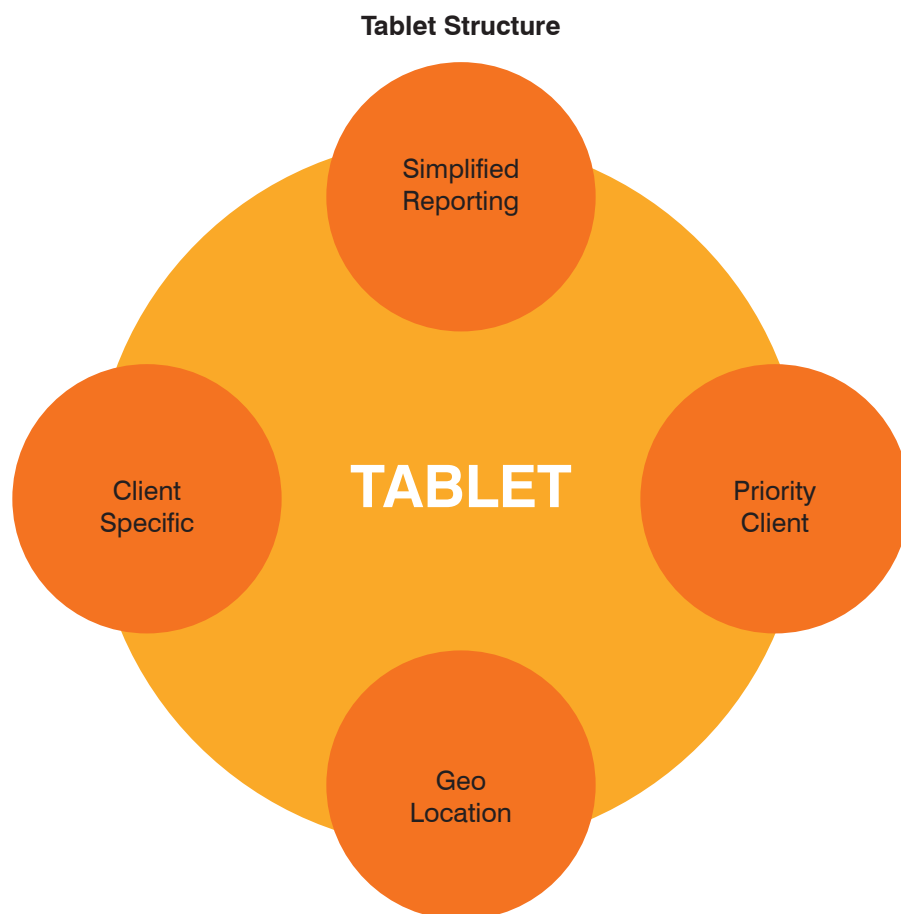
Routine data collection is done through client-based information generation system supported by simple reporting tools. There is a computerised management information system developed to store the data and for automated submission of reports. The project's focus is to develop a maximum paperless reporting system through Tablet Application-based reporting. Additionally, programme data analysis will be done at different levels of programme management at regular intervals to give feedback to the partners towards effective programme management and implementation. PR provides adequate capacity building support to SR partners so that the staff at the SR level are technically capacitated to analyse and use the data for decision making.

### b. MIS framework at the CSC level

There is a client-based reporting system through which data entry is done by the staff members using simple reporting tools to avoid duplication of data entry and to simplify the reporting and documentation processes. At the CSC, manual reporting has been replaced by tablet-based reporting.

### c. Tablet-based reporting system

A Tablet-based application called eMpower has been provided to ORWs and Peer Counsellors. This application is helping them in planning outreach effectively, monitoring of health indicators, easy compilation of activities and timely reporting.



eMpower application is the supportive additional hand for client management in the programme. The application collects basic client data from the CMIS and enables automated prioritisation of clients on the basis of their service needs.

## 8.3 Reporting Architecture

The reporting architecture for routine data collection will be as follows:

SI No	Name of the reporting tool	Purpose	Person responsible
1	Client Registration Form (CRF)	Client registration	Project Coordinator
2	Meeting Register	Support group meeting / advocacy/coordination meeting reporting tool	Project Coordinator
3	Discrimination Reporting Tool	Incidents of discrimination/ violence faced	Peer Counsellor/Project Coordinator

Training for SR and SSR staff on M&E systems and management is being done through online modules to build their capacity for effective understanding of MIS and enable them to submit quality reports in a timely manner. The regular monitoring of programmatic performance is done through a core performance framework and other programme indicators.

## 8.4 Core Indicators for Monitoring of Programme Activity

1.	<p><b>Number of people who were tested for HIV and received their results during the reporting period</b></p> <p>This indicator captures the number of PLHIV family members or sexual partners/ children referred for HIV testing and received test result. The family members/ partners of the registered client will be referred to ICTC for HIV test. PLHIV whose family members are yet to be tested for HIV will be identified for this activity. The eligibility will be determined on the basis of the information captured in Client Registration Form (CRF)</p>
2.	<p><b>Proportion of PLHIV on ART received differentiated care &amp; support services to retain them in treatment</b></p> <p>Under this indicator, PLHIV on ART will be provided the following differentiated care and support services on priority:</p> <ol style="list-style-type: none"> <li>1. Newly ART initiated clients will be visited by the ORW personally to promote treatment literacy/adherence and retain them in treatment. Intensified peer support services will be provided at least for the initial three months after ART initiation.</li> <li>2. Clients with &lt;80% ART adherence will be provided adherence support through monthly contact by the ORW for three months.</li> <li>3. Clients with &gt;80% ART adherence will also be provided the required services to retain them in treatment. They will be contacted at least once in six months.</li> </ol>

3.	<p><b>Percentage of people living with HIV in care (including PMTCT) who are screened for TB in HIV care or treatment settings</b></p> <p>All the PLHIV received differentiated care and support in CSC would be provided with TB screening through intensified case finding approach (ICF) by 4 - S (4 TB symptoms) at least once in a year. After screening, the suspected cases will be referred for TB testing and treatment to ART centre.</p>
4.	<p><b>Percentage of PLHIV who are LFU and missed to ART centre tracked back with definite outcome</b></p> <p>This indicator captures the outcome information on traceable LFU clients' list received from the ART centres. CSC aims to track back all alive and contactable LFU/MIS cases at ART centre through outreach with definite outcome.</p> <p>Denominator: Number of ART LFU/MIS cases received from ART centres (As reported in indicator 3.8 &amp; 3.9 of ART MPR).</p> <p>Numerator: Out of them number of LFU/MIS cases tracked back with definite outcome by CSC during the reporting period.</p> <p><b>Definite outcome</b> includes brought back to ART centre, confirmed death, transferred out, taking ART in other ART centres, taking ART in private hospitals, clients taking alternative medicine, clients migrated and clients opted out of treatment. Acknowledgement received from ART centre will be used as an evidence for this indicator.</p>

## 8.5 Definition of Key Indicators in LFU tracking

Definitions of key indicators in the LFU tracker sheet are given below:

### 8.5.1 Agreed to Visit ART Centre

Out of the cases contacted, those who agreed to visit the ART centre any time during the month will be reported under 'Agreed to Visit' category. Status of agreed-to-visit clients will be reviewed by CSC Project Coordinator and ART Data Manager during coordination meeting and will be updated in the MLL. Thereafter, it will be the responsibility of the ART centre to conduct the required investigations and restart treatment for the client.

- a. **How many times should these cases be followed-up by CSC?** Two physical visits after the initial visit when the patient is actually met. In the second visit, enquire why the patient did not come after the first visit. If the patient does not come even after three visits, s/he should be treated as 'opted out'. Three visits need to be carried out within three months.
- b. **How long we can keep such cases as "Agreed to visit"?** Three visits in three months by CSC ORW and one call by the ART counsellor after the second visit if the person does not show up at the ART centre.
- c. **What is the role of the ART centre in motivating such clients?** The ART counsellor will call them to further motivate them to visit the ART centre after the second visit by CSC ORW. If the phone number of the client is not available, the Project Coordinator/ Peer Counsellor of CSC will do a home visit.

### 8.5.2 Physically Taken to ART Centre

Henceforth, 'physically taken to ART centre' will be termed as 'Accompanied'. Those who are linked back to the ART centre and restart ART through the CSC's intervention, including those who are accompanied by ORWs to the ART centre, will be reported under this category.

- a. **Linked to ART centre or restarted on-ART?** Clients brought back to ART centre by CSC will be termed as 'linked to ART'. Thereafter, it will be the responsibility of the ART centre to conduct the required investigations and restart treatment for the client.

### 8.5.3 Death

If the death of any PLHIV from the list is confirmed by the family members/local authorities, it can be reported under the category of 'Death'. However, it needs to be supported with a copy of death certificate or any other valid document that can prove the death of the client. Confirmed death cases will be updated in the ART database and removed from the LFU list.

- a. **Source of information:** If the death certificate is not available, it can be obtained in writing either from the village headman or close family members who are ready to give their contact details for verification by ART centre.

### 8.5.4 Taking ART at other NACO ART Centre

If any PLHIV contacted during tracking confirms that he/she is taking ART from some other NACO supported ART centre, it can be reported in the tracker sheet under this category. However, it needs to be supported with a copy of the ART Green Card from the new centre.

- a. **Supporting documents required for confirmation:** Green Book of new ART centre
- b. **How to report such cases in MPR (especially when registered as new clients in another ART centre):** The old centre will show this as 'Transfer out' after the information is provided to the new centre and the new centre will show it as 'Transferred in'.
- c. **Opted Out of the Programme:** If any of the PLHIV contacted in the field during tracking is not willing to continue with NACO ART programme due to various reasons such as – lifelong treatment, side effects, OIs etc. s/he can be reported under the 'Opted Out' category. However, the patient's decision to opt out of the programme needs to be obtained in writing and shared with ART centre.
- d. **What is the role of the ART centre in motivating such clients?** The ART counsellor will call and confirm the client's decision to opt out. If phone number not available, the project coordinator/peer counsellor of CSC will do a home visit.

### 8.5.5 Incorrect Address

'Incorrect Address' is now termed as 'Wrong Address'. If the PLHIV in the LFU list is not found on the given address and informed by any neighbour or relative that he/she is not living in the given address, it can be reported as a wrong address.

- a. **How to determine that address is wrong?** Cross verification of ART and CSC records during monthly ART-CSC Coordination meeting for the possible alternative address. 10% of cases reported as having wrong address need to be visited by PD/PC of CSC. If the house is locked then two more visits to be made at different timings.
- b. **How often does the address have to be updated?** CSC should get updated information about the address of the client during every meeting and if there is a change in the address, same has to be updated with ART centre during ART-CSC coordination meeting.
- c. **Address verification for newly registered clients:** For every new client registered at ART centre address verification will be done by CSC outreach worker.

### 8.5.6 Duplicate Entries

If any reported LFU client is taking medicine in the same ART centre in a different credential (Pre-ART number and registration date) or the same client is registered under a different name and address, the client can be considered as a duplicate entry. Similarly, there are clients who are registered in multiple ART centres either with the same name and address or under different names and addresses. Some of them are LFU in one centre and regular client in another ART centre.

- a. **What is the evidence?** ART Green Book and address proof

### 8.5.7 Migrated

If PLHIV in the LFU list is not found on the given address and informed by any neighbour or relative that he/she has migrated to some other place within/outside the state, the case can be reported as 'Migrated'.

- a. **Source of information (verbal or written)?** During the outreach any neighbour or relative states that he/she is not living in the given address and migrated to some other place, it can be reported as migrated.
- b. **Steps to be taken to prevent such incidents in future:** Counseling and the person to take a transfer out and also take care giver's number.

### 8.5.8 Transferred Out

If any PLHIV in the LFU list is found to be a 'Transferred out' case from the parent ART centre to a new centre, it can be reported as 'Transferred out'. However, it needs to be supported with a copy of the ART Green Card he received from the new centre.

### 8.5.9 Alternative Medicine

Those who are taking alternative medicines will be reported under 'Opted Out'. If any of the PLHIV contacted in the field during tracking is found to be taking some alternative treatment instead of ART such as – Homeopathy, Ayurveda, and Siddha etc. Such cases can be reported under this category.

- a. **Source of information** (verbal or written?) - Verbal
- b. **What is the role of the ART centre in motivating such clients?** The ART counsellor will call and confirm the client's decision to take alternative medicine.
- c. **Further follow-up required?** No



### 8.5.10 Taking Private ART

Henceforth, those who are taking ART from the private sector will be reported under 'Opted out'. If any of the PLHIV contacted in the field during tracking are found to be taking ART from private sector hospitals, such cases can be reported under this category.

- a. **Source of information (verbal or written?)** - Verbal

### 8.5.11 Others

Clients who are not fitting under any of the categories mentioned above and not coming under the category of door lock, not found during two or three visits at the existing address or place, abused by the client, client refused for home visit, physically ill, out of station, socioeconomic problems etc.

- a. **For how many times does the CSC follow-up such cases?** Three times
- b. **How to validate the reported cases?** Telephonic confirmation by CSC Project Coordinator and ART- Counsellor

### 8.5.12 Reported back to ART Centre as Reported in MPR

Once the client reached the ARTC after outreach by CSC, it will be counted as reported back. However, this client may become an active client in ARTC monthly report as per the laid down procedures.

- a. **Linked to ART centre vs restarted on ART:** Clients brought back to ART centre by CSC will be termed as 'linked to ART'. Thereafter, it will be the responsibility of the ART centre to conduct the required investigations and restart treatment for the client.

## 8.6 Additional Indicators to be used for Monitoring Programme Performance

### 8.6.1 Coverage Indicators

1. Number of new clients registered in the CSC by providing at least one care and support service in the current month
2. Number of follow-up clients contacted in the current month by the CSC staff
3. **Counselling indicators**
  - a. Number of new clients received first-time peer counselling
  - b. Number of clients received follow-up peer counselling
4. **Differentiated care indicators**
  - a. Number of clients newly initiated on ART and registered in the CSC and received three consecutive services from the CSC in a financial year
  - b. Number of clients newly initiated on ART, registered in the CSC, followed up for three months and continued treatment after three months at ART centre
  - c. Number of clients with adherence <80% received three consecutive services from the CSC in a financial year
  - d. Number of clients with adherence >80% received one services in financial year

5. **LFU/MIS Case indicators**
  - a. Number of on-ART LFU cases contacted through outreach
  - b. Number of on-ART LFU cases contacted with definite outcome
    - i. Number of on-ART LFU cases reported died among the contacted
    - ii. Number of on-ART LFU cases reported transferred-out among the contacted
    - iii. Number of on-ART LFU cases reported as opted out
    - iv. Number of on-ART LFU cases reported as taking private ART
    - v. Number of on-ART LFU cases reported as taking ART at other NACO centres
    - vi. Number of on-ART LFU cases reported back to ART centre
  - c. Number of on-ART MIS cases contacted through outreach
  - d. Number of on-ART MIS cases contacted with definite outcome
    - i. Number of on-ART MIS cases reported died among the contacted
    - ii. Number of on-ART MIS cases reported as transferred out
    - iii. Number of on-ART MIS cases reported as opted out
    - iv. Number of on-ART MIS cases reported as taking private ART
    - v. Number of on-ART MIS cases reported as taking ART at other NACO centres
    - vi. Number of on-ART Missed cases reported back to ART centre
  
6. **Social welfare scheme indicators**
  - a. Number of PLHIV registered in the CSC linked to social entitlements during the reporting month
  - b. Number of clients availed services out of social entitlements linkages
  - c. Number of PLHIV registered in the CSC linked to social welfare schemes during the reporting month
  - d. Number of clients availed services out of social welfare schemes
  
7. **HIV testing indicators**
  - a. Number of family member/sexual partner eligible to be referred to ICTC
  - b. Number of family member/sexual partner referred to ICTC and received test result
  - c. Number of family member/sexual partner referred to ICTC and received test result and found positive
  - d. Number of family member/sexual partner referred to ICTC and received test result and found positive linked with ART centre and initiated on ART
  
8. **Discordant couples indicators**
  - a. Number of newly identified discordant couples tested for HIV
  - b. Number of discordant couples followed up for HIV re-test
  - c. Number of discordant couples became concordant
  
9. **TB indicators**
  - a. Number of registered PLHIV screened for TB symptoms (4S) by CSC staff through ICF (new/ follow-up)
  - b. Number of registered PLHIV found to have at least one symptom (4S) by CSC staff through ICF
  - c. Number of TB symptomatic clients among registered PLHIV referred to ART centre for TB testing and tested
  - d. Number of TB symptomatic clients among registered PLHIV referred to ART centre for TB testing and found TB positive

- e. Number of TB symptomatic clients who were found TB positive started on ATT
  - f. Number of TB symptomatic family members/partner of registered PLHIV referred to TB testing facility
10. **Stigma & discrimination indicators**
- a. Number of stigma & discrimination cases reported in the current month
  - b. Number of stigma & discrimination cases addressed within the current month
11. **Pregnant women indicators**
- a. Number of pregnant women newly identified
  - b. Number of pregnant women identified and linked with PPTCT

## 8.7 Reporting Mechanism

CSC will collect data related to above indicators in Tablet application and same will be collated and reported through following channels:

**Monthly Performance Report (MPR):** At CSC level, MPR will be generated every month and submitted in prescribed format to ART Centre, DAPCU, SR, SACS, PR and NACO *(Refer to Annexure VI for MPR Format)*

**Quarterly Performance Report (QPR):** At CSC level, QPR will be generated at the end of every quarter and submitted in prescribed format to ART Centre, DAPCU, SR, SACS PR and NACO *(Refer to Annexure VII for QPR Format)*

## 8.8 Data Mharing mechanism between CSC, ART Centre, DAPCU and SACS

Name of the agency	Type of report/data to be shared	Shared with	Purpose	Frequency
ART centre	a. Monthly registration and clients put on ART registration numbers b. PLHIV Newly initiated on ART c. PLHIV with <80% Adherence d. PLHIV yet to be put on ART	CSC	To understand the target and to develop outreach plan	5 <sup>th</sup> of every month
ART Centre	On ART MIS cases (M2 & M3)	CSC	For follow-up	Every Saturday
ART Centre	On-ART LFU	CSC	For follow-up	5 <sup>th</sup> of every month
CSC	On ART MIS case follow-up details	ART centre	Follow-up details submitted back to ART	Every Saturday

Name of the agency	Type of report/data to be shared	Shared with	Purpose	Frequency
CSC	LFU follow-up details	ART centre	Follow-up details submitted back to ART	Once in a month
CSC	Field visit plans	ART centre	Action plan submitted to ART centre for their information	Once in a week
CSC	Monthly report	ART centre, DAPCU SR	Monthly progress report	3rd <sup>th</sup> of every month to SR 10 <sup>th</sup> of every month to DAPCU/ART centre
SACS	ART MPR	SR	For target calculation and data triangulation	10 <sup>th</sup> of every month
SR	Monthly report	PR	To share the monthly progress report	5 <sup>th</sup> of every month
SR	Monthly report	SACS	To share the monthly progress report	10 <sup>th</sup> of every month
SR	Quarterly Report	PR	To share the quarterly progress report	10 <sup>th</sup> of subsequent month of the quarter
SR	Quarterly Report	SACS	To share the quarterly progress report	Within 45 days after end of quarter
NACO	ART MPR a. Newly initiated on ART b. Client with <80% Adherence c. Client not started on ART d. On ART LFU e. On ART MIS (M2 & M3)	PR	For target calculation	Once in a Month
PR	SR wise consolidated monthly report	NACO	To share the monthly report	10 <sup>th</sup> of every month
PR	SR wise consolidated quarterly report	NACO	To share the quarterly report	Within 45 days after end of quarter

(Refer to Annexure IX for ART-CSC Data Sharing Template)

# 9

## Capacity Building

Capacity building is an important component of the programme to strengthen the quality of services provided by CSC. Staff at different levels including SR and CSC will be capacitated through a series of training and supportive supervision initiatives. Training will be imparted to functionaries on organisational development and systems which include programme management, monitoring and evaluation and grant management.

### 9.1 Types of training

#### 9.1.1 Induction Training

Any staff newly joining the CSC should be given induction training within a week. This is the responsibility of the Project Director and Project Coordinator. SR team will provide them with the required training materials in local language and help them conduct the training.

#### 9.1.2 On-the-job Training

During the supportive supervision visits and interaction with staff, SR team will identify the training needs of each CSC. Before concluding their visits, a half-day orientation will be given to CSC staff as per their needs. Besides, the Project Coordinator will also provide hands-on training to the staff.

#### 9.1.3 Re-orientation

Training needs identified by the SR are collated and common issues will be identified at state/region level. Utilising the opportunities of review meetings, State Oversight Committee (SOC) meetings or any such platforms, SR can organise re-orientation to all CSC staff for half-day on thematic areas.

#### 9.1.4 Need-based Training

Based on the special needs, in-house training can be organised at the CSC level. ART medical officers, DTO, ART and ICTC counsellors can be called as the resource person for the training.

### 9.2 Training Methodologies

#### 9.2.1 In-house Training

Organised in the CSC or at the regional level with the help of SR

### **9.2.2 Virtual Training**

Based on the training requirement, SR and PR will organise virtual training using various platforms.

### **9.3 Training Aids**

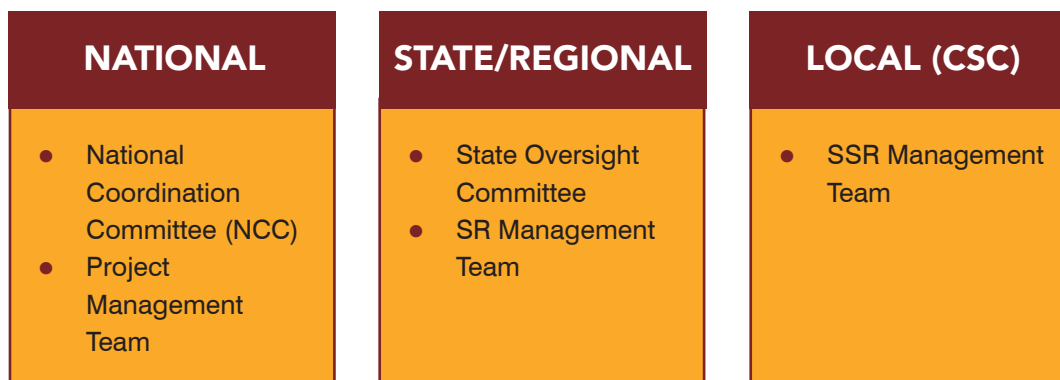
- Brochures/fact sheets
- PowerPoint Presentations
- Audio/Video clips (which can be developed locally)

# Governance and Role of Stakeholders

## CSC Governance

Good governance is a prerequisite for effective implementation of care and support programme that requires the involvement of various stakeholders at different levels. In order to ensure that CSC is community-friendly and working in synergy with all the stakeholders, a systematic governance system needs to be in place. The governance system adopted for the programme from the national level to local level is discussed below:

### 10.1 CSC Governance Structure



#### 10.1.1 National Coordination Committee

At the national level, PR works closely with NACO for smooth implementation of the programme. To review the progress of programme periodically and to ensure that it is aligned with national priorities and to suggest better implementation strategies, a 'National Coordination Committee (NCC)' is formed at the national level.

#### 10.1.2 Key Functions of NCC

- To provide technical and programmatic inputs for better quality services through the CSC
- To help align CSC implementation strategies with the goals and objectives of NACP
- To facilitate coordination and linkages with health and other line departments (especially for directives and orders from different ministries/departments)
- To facilitate synergies among stakeholders at the state level and provide technical inputs to State Oversight Committee
- Support the PR in carrying out national level advocacy

### **10.1.3 Profile of Members of NCC**

NCC membership will be informed by organisational affiliation and will include representation from the following departments/agencies:

1. DDG (CST), NACO (Chairperson)
2. Concerned officials from CST division
3. Representatives from other divisions of NACO
4. Representatives of Principal Recipient
5. SACS and SR representatives on a rotation basis

### **10.1.4 Meeting of NCC**

NCC is expected to meet quarterly. NACO will chair the meetings and the PR will coordinate it.

## **10.2 State Oversight Committee (SOC)**

SOC undertakes the review of the implementation of the CSC programme in the state and provides necessary guidance to the programme based on the local context.

It is a platform at the state level to share challenges or difficulties arising from the implementation of the programme and to seek support from SACS.

1. The SOC will meet half-yearly, more often if needed. Out of two meetings in a year, at least one will be attended by a PR/NACO representative.
2. The SOC will meet at the SACS premises as far as possible
3. Decision making will be guided by a majority vote, and it is suggested that minority objections be discussed and mitigated.
4. The SR will be responsible for meeting facilitation, preparing agenda for the meeting, material preparation and SOC meeting documents
5. In times of emergencies, three nominated members of the SOC need to be available for consultation at short notice.
6. Any travel or administration expenditure will be borne by SR. Minutes of the meeting will be shared with PR and NACO within one week of conducting the SOC.

### **10.2.1 Key Functions of SOC**

1. To review the implementation of the programme and provide necessary support to the SR and CSCs
2. To ensure regular coordination meetings between CSCs and ART centres
3. To address the issues of coordination with health and other line departments and facilitate active referrals and linkages to health and social entitlements
4. To provide inputs in addressing the issues of stigma and discrimination at various levels
5. To encourage sharing of best practices
6. Support the SR in carrying out state/district level advocacy

### **10.2.2 Member Profile of SOC**

1. Project Director of the SACS or a senior officer, APD/JD(CST) nominated by the PD (chairperson)



2. Joint Director (CST) /officer-in-charge of CST
3. Regional Coordinator (CST) for the state
4. GIPA Coordinator, SACS
5. A representative of Mainstreaming Unit, SACS
6. State TB Officer
7. SR PD (Member secretary and will provide secretarial support to the SOC chair)
8. Five SSRs will be SOC members on a bi-annual rotational basis (in case of less than five, all SSRs)
9. Any other development partners as decided by the members of the SOC

### **10.2.3 Quorum for SOC**

SOC meetings should ensure the presence of not less than two-thirds of the members, in addition to the mandatory attendance of at least one representative each from SACS and SR organisation.

## **10.3 Role of Stakeholders**

### **10.3.1 National AIDS Control Organisation**

- Regular communication with SACS to ensure local level support to SR in implementing the programme and regular data sharing between ART Centre and CSC
- Provide technical and programmatic inputs to PR from time to time
- Support PR in organising National Coordination Committee meeting regularly
- Supervise and monitor the performance of CSCs on a regular basis

### **10.3.2 State AIDS Control Society**

The JD/officer in-charge of CST in SACS is 'Nodal Officer' to coordinate with the SR in the state and s/he is also responsible for the programme performance in the state. The key responsibilities of the Nodal Officer are as follows:

- Support SR in organising periodic SOC meetings and facilitate approval of minutes by PD SACS
- Supervise and monitor CSCs in the state
- Facilitate coordination between CSC and ART centre for data sharing
- Collate, compile and forward any pertinent issues/information related to CSC to NACO and PR
- Participate in state-level training organised for SR/CSC staff for quality assurance and monitoring
- Organise and participate in reviews and assessment of CSCs as and when required.
- Provide support to SR in troubleshooting and crisis management
- Support advocacy initiatives of SR with other line departments

### **10.3.3 District AIDS Prevention Control Unit (DAPCU)**

- Facilitate data sharing by ART centres to CSC team
- Ensure participation of CSC in the monthly ART coordination meeting and in the District AIDS Prevention Coordination Committee organised by DAPCU
- Ensure regular supportive supervision visits to the CSCs

- Facilitate coordination of CSC team with other outreach workers in the districts such as PPTCT ORWs, Link Workers, TI staff, etc. for tracking of LFU and MIS cases

#### **10.3.4 Principal Recipient (PR)**

- Responsible for overall coordination with NACO, SACS, SRs, SSRs and other key stakeholders involved in the programme implementation
- Provide training to SR and SSR teams
- Provide technical support to SRs to enable them to provide support to SSRs and ensure adherence to financial and programmatic guidelines
- Supervise and monitor the performance of CSC on a quarterly basis
- Ensure timely fund release to SRs and to SSRs
- Facilitate effective coordination between SRs and SACS
- Report to NACO from time-to-time about the progress in programme implementation

#### **10.3.5 Sub-Recipients (SR)**

- Provide technical support to CSCs for their effective functioning
- Ensure timely release of funds to CSCs
- Support CSC to develop a quarterly and monthly work plan
- Supervise and monitor the performance of CSC on a monthly basis
- Support CSCs to accomplish programmatic goals and objectives
- Coordinate closely with SACS and DAPCU to ensure smooth data and information sharing between ART centres and CSC team
- Share the reports with SACS and PR on time
- Provide day-to-day management support to CSC and in handling conflict situations

#### **10.3.6 Care and Support Centres**

- Implement CSC smoothly and effectively
- Ensure accomplishment of programmatic targets and financial utilisation as per the approved annual plan for CSC
- Work in close coordination with ART centres, DAPCU and district level stakeholders
- Share monthly report with the ART centre, DAPCU and SR
- Attend monthly ART-CSC coordination meeting organised by the ART centre
- Attend meeting organised by DAPCU at the district level
- Carry out tracking of LFU and MIS cases and report back to the ART centre
- Mobilise need-based additional resources to scale up support services for clients registered at CSCs
- Carry out effective advocacy for successful linkages of clients for social entitlements and schemes available in the district

### **10.4 Coordination Mechanism - CSC and ART Centres**

CSC will work as an extended arm of the ART centre in providing holistic care and support services for PLHIV. Regular data sharing between the ART centre and CSC through active involvement of DAPCU is key to the programme. NACO/SACS will facilitate the data sharing between the ART centre and CSC.

### 10.4.1 Monthly ART-CSC Coordination Meeting

Name of the activity or responsible officer	Role of ART centre	Role of CSC
Coordinating Officer	SMO/MO of ART centre supported by Counsellor and Data Manager	Project Coordinator  (In case of additional ART centre: ORW)
Coordination meeting	Participation in coordination meeting	Participation in coordination meeting
Registration of PLHIV in care and support centre	<ul style="list-style-type: none"> <li>Referring all newly registered clients at ART centres to CSC for registration and services</li> <li>Sharing list of clients newly started ART to counsel them on treatment adherence</li> <li>Sharing list of clients having below 80% treatment adherence</li> </ul>	<ul style="list-style-type: none"> <li>Taking details of PLHIV registered in ART centre and registering them in CSC as per registration norms for providing services in CSC</li> <li>Ensuring address verification and intense follow-up for first 3 months</li> </ul>
Follow-up of MIS and lost to follow-up cases	<ul style="list-style-type: none"> <li>Providing the list of MIS cases on weekly basis to CSC</li> <li>Providing the list of LFU cases on monthly basis to CSC</li> <li>Providing any other support as and when required by CSCs in follow-up of cases</li> </ul>	<ul style="list-style-type: none"> <li>Obtaining the list of MIS and LFU cases from ART centre and developing ORW wise follow-up plan</li> <li>Motivating PLHIV who are MIS or LFU to receive their treatment and bringing them back to treatment</li> <li>In case of death cases or wrong addresses, reporting back to ARTC with supporting documents</li> <li>Sharing the status of MIS cases on weekly basis and LFU cases on monthly basis</li> </ul>
Advocacy	<ul style="list-style-type: none"> <li>Supporting CSC in district level advocacy issues, especially with health settings</li> <li>Coordinating with other departments in the hospital or other hospitals in ensuring treatment needs to PLHIV are catered</li> </ul>	<ul style="list-style-type: none"> <li>Bringing to the notice of Nodal Officer on district level advocacy issues or stigma in health care settings</li> <li>Seeking support of ART centre in addressing stigma and advocacy plan</li> </ul>
Linkage and coordination	<ul style="list-style-type: none"> <li>Inviting CSC for meetings and local events</li> <li>Letting CSC staff meet new PLHIV and follow up old at ART centre</li> </ul>	<ul style="list-style-type: none"> <li>Sharing CSC monthly report with ARTC on monthly basis</li> <li>Deploying ORW at ARTC for follow-up on rotation basis</li> </ul>

The CSC is expected to coordinate with the ART centre for regular monthly ART-CSC coordination meeting. CSC in coordination with ART centre can facilitate the participation of CSC and ART centre staff, counsellors of all ICTCs, district ICTC supervisor, President/ representative of DLN.

This meeting will have the following agenda:

- Referral of newly detected HIV positive cases to ART Centre
- Cross referrals between ART Centre and CSC
- Cross referrals between facilities of RNTCP and NACP
- Progress made on tracking of LFU/MIS cases
- Other locally relevant issues

The supervision will be through the review of monthly reports and mentoring/supervisory visits by DAPCU/SACS/implementing agency (**Refer to Annexure VIII for ART-CSC Coordination Meeting Reporting Template**)

## **10.5 CSC and District AIDS Prevention & Control Unit (DAPCU)**

CSC will work closely with DAPCU at the district level and report the programme activities to them. The main elements of coordination with DAPCU are discussed below.

- Project Coordinator will participate in DAPCU Coordination meetings at the district level and provide reports on CSC activities to DAPCU.
- DAPCU can also be part of the monthly coordination meeting between CSC and ART centre.
- CSC will invite DAPCU to be part of support group meetings as and when required.
- DAPCU will support CSC in district-level advocacy and also in addressing stigma and discrimination cases.
- DAPCU will conduct supportive supervision visit to CSC periodically.
- DAPCU will involve CSC in district-level activities especially DHS meeting, media orientation and sensitisation meetings for different stakeholders.
- CSC will report all coordination issues and advocacy issues primarily to DAPCU.
- DAPCU will assist CSC in crisis management.

# Establishment and Closure of CSC

## 11.1 Establishing CSC

The National AIDS Control Programme envisages that all ART centres in the country should have at least one CSC attached to it. All ART centres in the country will be attached to one or the other CSC. However, the number of CSC in a district will be based on the number of PLHIV in active care with the ART centres in the district/region. The selection of district for establishing CSC will be done through a consultative process involving NACO/SACS and the PR and SR. If the number of SSRs to be selected is more than 10, PR will undertake the selection process through an external agency. If the number is less than 10, respective SR will undertake the process in coordination with the SACS and PR. For the selection of any SSR, a uniform selection process will be adopted. Preference will be given to NGO/CBO/DLN having proven experience in the field of HIV/AIDS, especially in the area of care and support.

## 11.2 Eligibility Criteria for NGO/CBO Setting up a CSC

- The agency should be a non-profit organisation and legally registered under:
  - ◆ The Societies Registration Act of 1860 or an equivalent Act of a State; or
  - ◆ The Charitable and Religious Act of 1920; or
  - ◆ Indian Trusts Act of 1882 or an equivalent Act of a State; or
  - ◆ Section 25 C Company Act
- It should have a clearly defined organisational structure.
- The agency should also have all statutory requirement including 12 A and 80G certificates
- It should have established administrative and management systems.
- It should have sound financial track record with an established financial management system (three years audit reports and audited accounts required in the case of NGOs and one year report for CBOs).
- It should have a minimum of three years' experience in managing public health programmes or allied programmes in health.
- Experience in the field of HIV/AIDS, especially in the area of care and support, will have due weightage.
- The organisation should have been working for a minimum of three years in case of NGOs and one year in the case of CBOs in the same district and have a good track record in providing services.
- Readiness to make available adequate infrastructure deemed necessary to carry out all the activities planned in CSC.

## 11.3 Selection Process of NGO/CBO for Setting up CSC

### 11.3.1 Promotion of Request for Proposal (RfP)

The process of selection would be transparent, through an advertisement in the local newspapers with maximum circulation in the region and in the websites of PR, SR and SACS. The RFP should ideally be floated for a two-week period. Information on the RFP will be widely promoted during the community consultations and stakeholders will be encouraged to disseminate the RFP widely.

### 11.3.2 Community Consultations

Before starting any new CSC, SR has to conduct a community consultation in that area. These consultations should have representation from State Level Networks (SLN), District Level Networks (DLN), officers from SACS, and leaders from PLHIV community, representatives from any other organisations which are providing care and support services. In the community consultation meeting, the goals and objectives of the CSC model and strategies, management and CSC activities should be highlighted. Suggestions from the community will be asked on how to popularise the services among the community in the local area, what are their expectations from the CSC services, what are the unmet needs of the community, etc. This consultation meeting will support the programme in designing specific programme activities under new CSC in the district. Besides this, the selection process and RFP details for new CSC will be shared in the meeting and eligible organisations, including community-based organisations, will be encouraged to apply for new CSC.

## 11.4 Review of Proposals

### 11.4.1 Role of External Agency

- In case of more than 10 CSCs being selected across the country, external agencies hired by PR will shortlist the eligible applicants
- Wherever feasible, the external agency will take representatives from SACS and SR for site assessments
- The external agency will undertake site assessment of the shortlisted applicants using approved tools
- After the site assessment, the final list of the shortlisted applications will be submitted to PR
- PR will vet the final selection list with NACO and concerned SACS
- PR will communicate to successful applicants regarding the selection
- SR will work with the selected SSR for the establishment of CSC and to coordinate with district level stakeholders
- Whenever the selection process is for less than 10 CSCs, SR will form a Joint Appraisal Team (JAT) to facilitate a transparent and quality selection process. JAT will consist of three members:
  - A representative from PR/NACO
  - Representative from SR
  - External expert/SACS representative/DAPCU representative/ART Centre Representative

### 11.4.2 Role of JAT

- JAT will review applications received within the stipulated time (two weeks after the release of advertisement). Based on the information provided by the organisation, the JAT will scrutinise applications and enclosed documents and shortlist eligible organisations for field appraisal.
- Conduct site visits to assess the capacity and credentials of the shortlisted applicants.
- JAT will use the prescribed field appraisal tools for assessing the applicant. The summary of the findings and the recommendations of the JAT during the visits will be sent to PR, SACS and a copy to the head of the CST division in NACO.

### 11.4.3 Final Selection and Contract Signing

- On the basis of the recommendation of JAT, PR will complete the final selection process.
- PR will send a communication to the selected agency with a copy to NACO, SACS and SR.
- PR will communicate to SR to complete the contract signing with the selected agency within one week after the receipt of the communication from PR.

## 11.5 Closure of CSC

### 11.5.1 Closure of a CSC: Points for Consideration

- From the time of identification of CSCs which are poor performing or problematic, SR should ensure adequate support to the concerned CSC, need-based mentoring and guidance for three months. Simultaneously, SR should communicate to PR and seek timely guidance to address the identified gaps. If the performance is not improved over two consecutive quarters, the issue should be put up in the SOC seeking its recommendation. Closure of a CSC has to be the last option and a written permission from PR is to be obtained before a closure process is initiated.
- If there is proven fund misappropriation or fraud or any critical management issue, SR needs to immediately share the evidence with PR and SACS and an appropriate decision should be taken to protect the fund and assets. The whole incidences and process should be well documented.
- Opinion and guidance of SACS must be obtained much before arriving at a decision to close a CSC. In instances where SACS is proposing a closure, the decision must be taken in consultation with PR and a written approval needs to be obtained from PR.
- Documentation must be from the very first day of critical observation being made followed by the documentation of measures taken up by SR team to address the identified gaps, and timely communication to key stakeholders till the final decision is arrived. Systematic documentation of the CSC closure process is the most crucial point. A hard and soft copy of the document must be maintained by SR and PR.
- Smooth handing over process should be initiated once the decision of closure is taken. An interim plan/stop-gap arrangement is to be made to ensure continued uninterrupted service provision to the community until the establishment of new CSC is completed.



## 11.5.2 Conditions Necessitating Closure of CSC

Programmatic issues	Financial Issues	Management Issues
<ul style="list-style-type: none"> <li>• Constant poor performance on core indicators</li> <li>• Fudging of M&amp;E data</li> <li>• Non-compliance of CSC guidelines</li> </ul>	<ul style="list-style-type: none"> <li>• Fund misappropriation</li> <li>• Fraudulent practices</li> <li>• Non contractual compliance</li> </ul>	<ul style="list-style-type: none"> <li>• Voluntary handing over</li> <li>• Conflict in the board affecting CSC work</li> <li>• Governance Issues</li> </ul>

## 11.5.3 Key Definitions

### 11.5.3.1 Misappropriation of Funds

Deliberate use of project fund for activities which are not benefiting to project beneficiaries are considered as misappropriation, e.g. taking a kickback from staff, forging bills, claiming money without conducting events and meetings etc. Incidents such as wrong booking, mistakes committed without proper accounting knowledge etc should not be considered as misappropriation. In such cases, SR and PR cluster team must engage in building the capacities of the organisation and place the checklist to ensure such incidents are not repeated.

### 11.5.3.2 Constant Poor Performance on Core Indicators over two Quarters

If the CSC performance is below state and national average over two quarters, it can be considered as constant poor performing. If the poor performance is only because the staff do not want to perform or management is not serious about the project, very frequent staff turnover etc. can be considered as factors influencing performance and hold CSC responsible for the same. SR and PR cluster must consider any external factors that are influencing the performance such as difficult geographical conditions, lack of support from stakeholders like ART centre etc. In that case, the cluster must work closely with CSC for mitigation strategies.

### 11.5.3.3 Non-compliance with CSC Guidelines

Series of incidents where SR has evidence of CSC violating the guidelines in terms of CSC management, service to clients, rapport with stakeholders, reporting standards etc.

### 11.5.3.4 Fudging of M&E Data

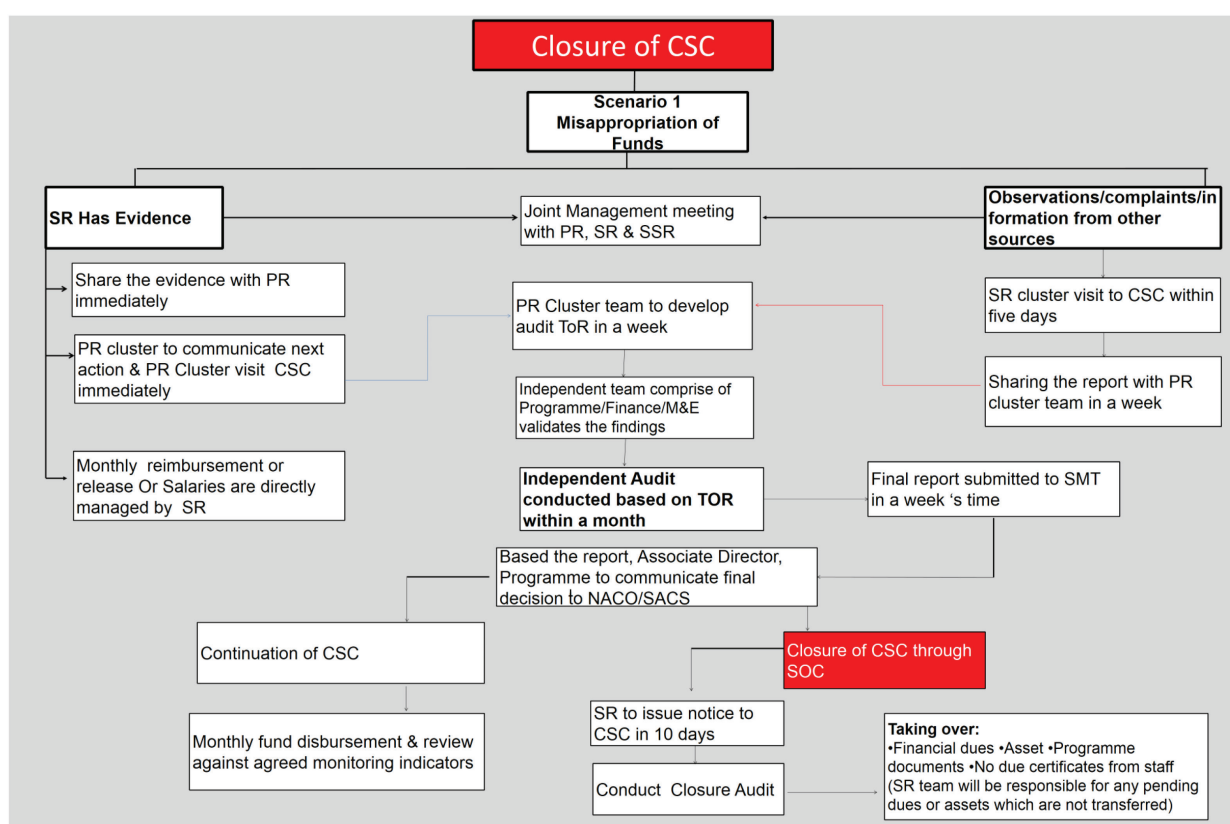
A deliberate act of CSC to fudge the data in reporting with malice intention of showing good performance without doing actual work. If it is reported for the first time, SR can give a strong warning and develop intense monitoring of CSC. If such things are repeated, CSC termination can be initiated.

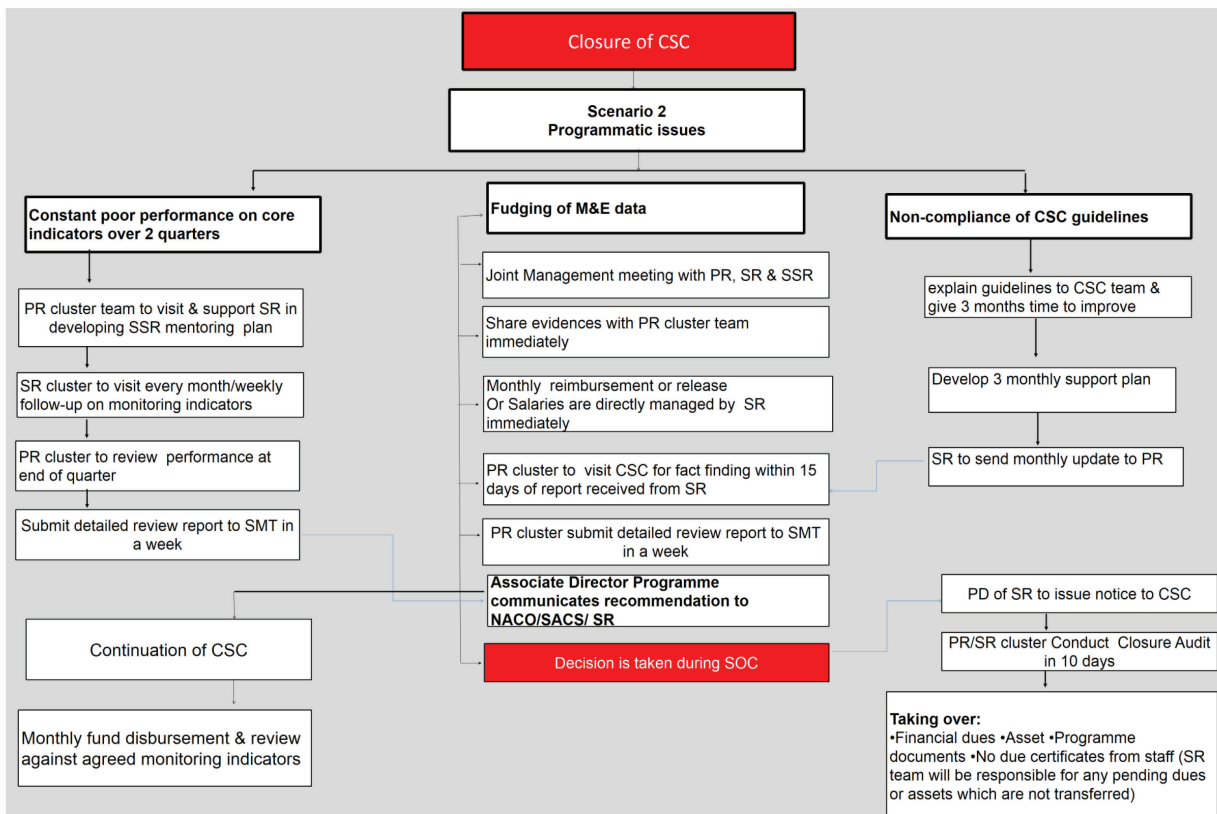
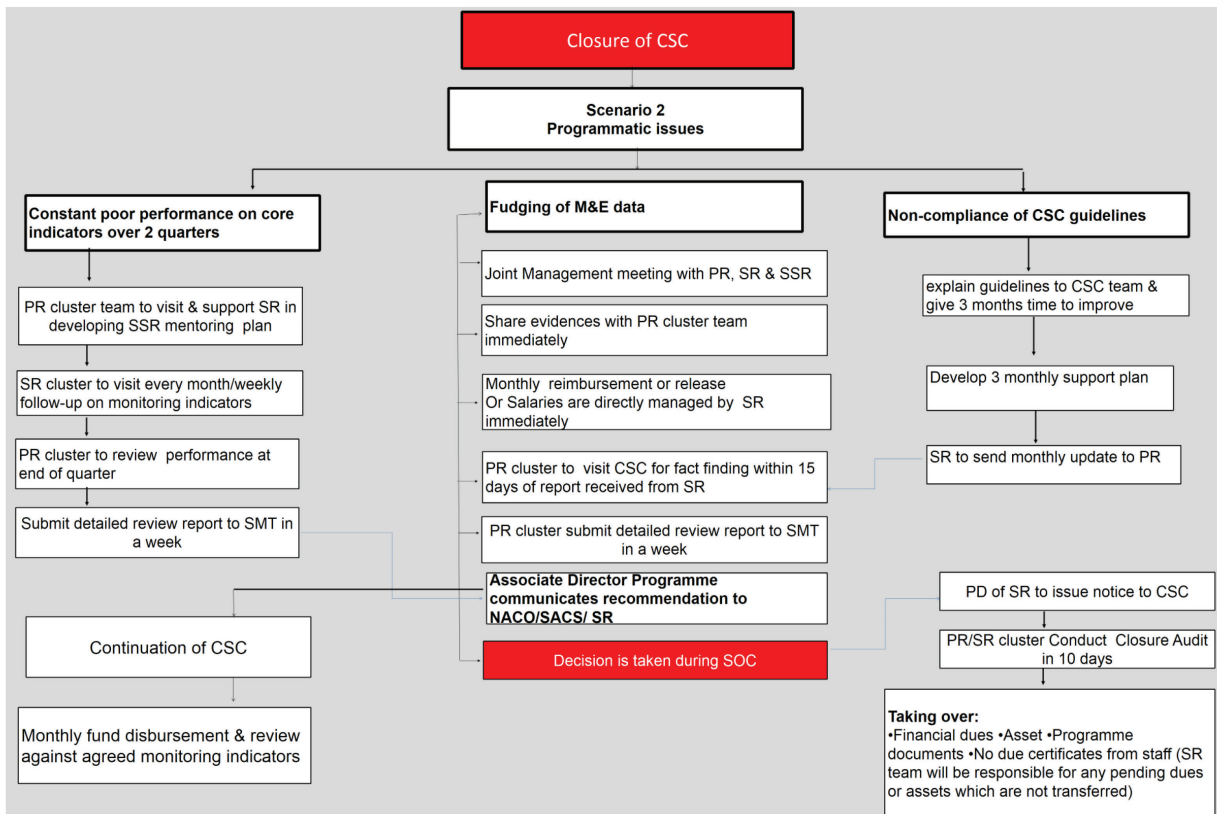
## 11.6 Checklist for PR and SR on CSC Closure Process

1. When did the issue arise?
2. Do we have all project and financial data, relevant evidence to support the problematic situation of the CSC functioning?



3. What did SR do to address the issue? What steps were taken by SR to provide support within a given timeline?
4. Was there a change in funding mechanism (quarterly to monthly or reimbursement mode) to safeguard the project funds? Are project assets safe? Do we have asset listing?
5. Has SR brought to the notice of SACS and PR on time through written communication?
6. What steps did PR take to provide support/resolve the issue?
7. Did PR ensure timely consultation with SACS and NACO through written communication?
8. Do we have concrete documentary evidence for closing down a CSC?
9. If all stakeholders (PR, SR, SSR) are informed and part of the process in a transparent manner?
10. Has the decision taken through SOC or by PR? Is there written communication from PR approving the decision of CSC closure?
11. What is the stop-gap arrangement to ensure services to the PLHIV community is continued?
12. Has the process been clearly documented sequence wise starting from the identification of issues till the decision is derived?





# Financial Management of CSC

## Objective

The objective of the guidelines is to capacitate organisation on strengthening accounting and book keeping systems. This guideline is intended to address systems for preparation of vouchers, cash book, and financial statements and follow the requirements specified by donors, improve timeliness to generate and submit financial statements, ensure maintenance of adequate records to reflect sound accounting practices leading to transparency within the organisation and to stakeholders.

## 12.1 Accounting and Book Keeping

### 12.1.1 General Accounting System

The accounting records shall be maintained in accounting software. It shall follow the double entry accounting system.

### 12.1.2 Method of Accounting

The books shall be maintained on cash basis. The expenditure will be recorded only when it is paid out.

### 12.1.3 Books of Accounts

The following books of accounts shall be maintained:

- Petty cash book register
- Ledger accounts (bank book, cash book, expenditure accounts etc.)

The following additional records are required to be maintained to support the books of accounts.

- Monthly bank reconciliation statements
- Salary register
- Inventory of supplies/consumables and printing materials
- Fixed assets and stock register
- Vehicle log book in case of vehicle owned by the organisation

### 12.1.4 Updating of Books of Accounts

Books of accounts shall be updated regularly.

### 12.1.5 Access to Books of Accounts, Accounting and Financial Information

Access to accounting software should be restricted to the accountant.

### 12.1.6 Chart of Accounts

The chart of accounts is a list of ledger accounts which gives brief information about account codes and account titles. It is expected that the same will be followed for day to day accounting and report generation.

### 12.1.7 Vouchers

A voucher is a documentary evidence in support of a transaction. All vouchers are required to be supported by supporting documents like original bills/invoices/cash memo, receipts etc. Such vouchers will form the basis of passing accounting entries.

#### 12.1.7.1 Vouchers Type

- a. Payment vouchers - cash and bank
- b. Journal vouchers
- c. Receipt vouchers
  - These vouchers should be serially numbered and duly approved by the authorised official. All bills and vouchers should be properly defaced by stamping as paid and should have reference to donor name.
  - For any rectification of entries, journal entry should be passed on the current date only.
  - In no case, accounting entries will be recorded backdated.
  - Any changes to the previous month reported data will be a serious concern.

## 12.2 Recording of Receipt and Expenditure

### 12.2.1 Receipts

- Funds received from the donor should be recorded as liability i.e. Grant in Advance.
- The Interest earned from banks on grant fund should be treated as project funds.
- In case of any other receipts, the accounting treatment should be dependent on the type of receipt e.g. donations, sale of newspaper and scrap material etc.

### 12.2.2 Expenditure

- All expenditure should be recorded after proper authorisation.
- Every expenditure should be supported by original documents.
- Payments above INR 1,000 should be made by bank transfers.
- Salaries shall be processed by bank transfers only.

### 12.2.3 Authorisation Limits for Approving the Expenditure

It is recommended to follow the below limits

Amount (INR)	Prepared By	Reviewed By	Approved By
Up to INR 5,000	Accountant	Project Coordinator	Project Director
Above INR 5,001	Accountant	Project Director	One more authorised person from board/authorised signatory

## 12.3 Month and Year-end Closure Accounting Process

It is important to maintain account books according to the financial year.

### 12.3.1 Monthly Closure

- Ensure all project expenditures are recorded in books of accounts.
- Prepare bank reconciliation statement.
- Extract monthly trial balance from accounting software and prepare monthly expenditure report for review and submission to the donor.

### 12.3.2 Year-end

Balance sheet, receipt and payment statement, income and expenditure along with utilisation certificate are recommended financials to be certified by an independent audit firm.

- It is recommended to obtain bank balance confirmation and balance confirmation from vendors at the end of the financial year.
- The fixed assets should be physically verified at the end of the financial year.
- Year-end cash balance certificate along with denomination need to be prepared and validated.

### 12.3.3 Adherence to Statutory Compliances

Ensure that statutory compliances in the form of returns or filings are duly met with e.g. TDS deposits, TDS returns, PF returns, Professional Tax returns wherever applicable, Income tax returns and FCRA annual returns.

## 12.4 Policy and Procedure

Below are the policies which are recommended for smooth functioning.

### 12.4.1 Procurement Policy

Procurement policy is to ensure that every purchase is done in a competitive and transparent manner.

- A detailed summary of the requirement of goods or services is prepared with specifications.
- Available budget for the same is considered.
- Requisite authority approves the specification and budget availability.
- Ensure bids are requisitioned and quotations obtained from at least three vendors.
- Comparative statement for quotations obtained is prepared and approved for selection of the vendor.
- A purchase order or works contract is issued to selected supplier.
- Goods received are duly entered in the stock register.
- The invoice submitted by the supplier is verified for quantity before submitting for further payment process.

### **12.4.2 HR Policy**

It must contain processes for the following:

- Positions available under project
- Advertisement and shortlisting of candidates
- Interview and selection of candidate
- Issuance of appointment letter
- Completion of the probationary period
- Performance evaluation
- Working days and hours
- Maintenance of timesheet
- Entitlement of leaves and list of holidays
- Termination of employment

### **12.4.3 Travel Policy**

It must contain processes for the following;

- Entitlement of the following during official travel
  - ◆ Mode of transport and class of travel
  - ◆ Accommodation limits
  - ◆ Classification of Per diem – day travel, meal entitlement
- Travel request form clearly mentioning dates of travel, destination, mode and purpose
- Approval of travel request before any travel is undertaken
- Advance for travel
- Minimum days advance intimation required for availing travel advance
- Treatment of advance in case the scheduled travel is cancelled
- Number of days within which the advance will be settled
- No further issuance of advance in case the previous advance is not settled
- Submission of travel expense report along with the trip report and all other necessary original bills/invoices
- Approval of trip report and travel expenses

### **12.4.4 Staff Advances for Project Activities and Travel**

- Each advance request will have support documents e.g. approved activity budget in case of project advance and approved travel request form in case of travel advance
- Advances should be settled within the specified period
- No further issuance of advance in case the previous advance is not settled

### **12.4.5 Use of Private/Organisational Vehicle**

- It is not recommended to use personal vehicle for official purpose
- However, in exceptional circumstances staff may have to use own vehicle and in such cases, the rate of reimbursement should be clearly defined in the organisation's policy
- If a vehicle owned by the organisation is used for project activities, a policy for reimbursement should be predefined along with maintenance of vehicle log book

### **12.4.6 Allocation of Common Costs**

Common expenses should be allocated to various projects on some rational basis with proper documentation.

### **12.4.7 Conflict of Interest**

The organisation must ensure that no person, members of the immediate family or his or her business participate(s) in the selection, award or administration of a contract, grant or other benefit or transaction funded the Grant, in which there is a conflict of interest.

If the organisation has the knowledge or becomes aware of any conflict of interest as mentioned above, shall immediately disclose the actual, apparent or potential conflict of interest directly to the donor and seek guidance.

## **12.5 Donor Compliance**

Any specific donor requirement has to be complied with and will have precedence over the existing policies.

## **12.6 Delegation of Authority**

It is extremely important that the authority to sign contracts, approve payments, sign cheques, provide the report to donors, sign on statutory documents etc. is clearly defined.

## **12.7 Governance Aspects**

- Registration of organisation under Indian Trust Act, Society Registration Act, or Association of Person should be available
- The relevant registration documents need to be in place along with validity for continuation
- Quarterly and annual board meetings need to be conducted as applicable or required by the registration entity
- Compliance with local state requirements and renewals if needed at regular intervals e.g. renewal of registration, the filing of annual accounts etc.
- Intimation of change in board members or chief functionaries of the entity needs to be intimated to the requisite authority and the respective donors
- Process for the election of the management committee and other board members need to be documented as per requirement of registration entity







