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India's response to HIV & Sexually Transmitted Infections
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OPERATIONAL GUIDELINES
Care and Support Centres

National AIDS & STD Control Programme

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

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Operational Guidelines

CARE AND SUPPORT CENTRES

National AIDS & STD Control Programme

JUNE 2025

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Foreword

The National AIDS & STD Control Programme (NACP) has been at the forefront of India's response to the HIV/AIDS epidemic. Under NACP, after being tested HIV positive at Integrated Counselling & Testing centres (ICTC), People Living with HIV (PLHIV) avail free lifelong treatment services through Antiretroviral Therapy (ART) Centres and outreach services through Care Support Centres (CSC). CSC have been established for ensuring equitable access to quality treatment, care and support services for PLHIV. Over the years, India has made significant progress in improving quality of care for HIV infected individuals and in reducing AIDS-related deaths.

CSC aim at providing outreach support services to address the gaps in ICTC to ART linkage, index testing, improve retention and adherence to treatment, tracking of treatment interruption cases, tracking of patients with unsuppressed viral load, follow up of HIV positive pregnant women and their babies. In addition, CSC also link PLHIV to social welfare schemes and undertake advocacy to reduce stigma and discrimination experienced by the PLHIV.

For standardization of CSC implementation process, it is imperative that all States follow the same operational guidelines. Considering the emerging needs of PLHIV, revised mandate of CSC and newer programme priorities like EVTHS, management of HIV comorbidities advanced HIV disease etc. the operational guidelines for CSC have been revised. The revised guidelines also includes details on the digitised data management of CSC.

This document will help health care providers, programme managers and stakeholders in strengthening the care support services across the country and in enhancing the quality of care provided to HIV infected individuals.

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आज़ादी का अमृत महोत्सव

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Preface

National AIDS & STD Control Programme (NACP) provides free Antiretroviral treatment along with counselling and outreach services to all People Living with HIV (PLHIV). For addressing gaps in linkage from testing to treatment centres and for ensuring treatment adherence and retention in care for HIV infected persons, the Care and Support Centres established under NACP compliment the services provided by ICTC and ART centres.

Over the years, in view of the emerging needs of the PLHIV, the priorities of NACP have changed and accordingly the mandate of CSC have been updated. Therefore, the earlier published CSC Operational Guidelines of 2018 have been revised with inputs received from various stakeholders. This document includes detailed guidance for establishment and implementation of CSC and stakeholder coordination. Specific section has also been added on evaluation of CSC under domestic budgetary support.

I congratulate all the members of the Working Group for their contribution in revision of Operational Guidelines and the stewardship of CST division of NACO in formulation of the guidelines.

The CSC Operational Guideline will serve as a reference document not only for healthcare providers, but also for programme managers at State and national level associated with care and support of PLHIV under NACP.

(Nidhi Kesarwani)

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ACKNOWLEDGEMENT

To address the evolving needs of care and support for PLHIV under NACP, the strategies and service delivery approaches through Care and Support Centres are reviewed from time to time. Accordingly, the Operational Guidelines for Care and Support Centres (CSC), last published in 2018, have now been revised to ensure that PLHIV are retained in care and also have a better quality of life.

The CSC Operational Guidelines have been revised after a wide consultative process involving PLHIV community, State AIDS Control Societies and technical experts from various organisations.

We would like to express our sincere gratitude to Ms. Hekali Zhimomi, AS & DG NACO and to Ms. Nidhi Kesarwani, Director NACO for the vision, leadership and guidance in implementing care and support activities under NACP. Their clarion call for ensuring holistic approach for amicable service delivery to PLHIV has been the key guiding principle while revising the CSC guidelines.

We are grateful to the Heads of Divisions of NACO - Dr. Anoop Puri, Dr. U.B. Das, Dr. Shobini Rajan, Dr. Tanzin Dikid - for their guidance and support, and to Deputy Directors of NACO - Dr. Bhawna Rao, Dr. Saiprasad Bhavsar and Dr. Sunny Swarnkar - for their inputs in revising the guidelines.

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We hope the Operational Guidelines for Care and Support Centres will provide the necessary guidance to all stakeholders, programme managers and field functionaries in effective implementation of the Care and Support Centres in the country, eventually for improving health outcomes of the PLHIV.

Chinmoyee Das

(Dr Chinmoyee Das)

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ABBREVIATIONS

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AIDS	Acquired Immune Deficiency Syndrome
ALHIV	Adolescents Living with HIV
ANM	Auxiliary Nurse Midwife
ART	Anti-Retroviral Therapy
ARV	Anti-Retro Viral
ASHA	Accredited Social Health Activist
ATT	Anti-Tubercular Treatment
AWW	Anganwadi Worker
CAPART	Council for Advancement of People's Action and Rural Technology
CBO	Community-Based Organization
CD4	Cluster of Differentiation 4
CDD	Community Drug Dispensation
CLH	Community Liaison for Health
CLHIV	Children Living with HIV
CSC	Care and Support Centre
CSS	Community System Strengthening
CSO	Civil Society Organisation
CSR	Corporate Social Responsibility
CST	Care Support and Treatment
DAPCU	District AIDS Prevention & Control Unit
DHO	District Health Officer
DIC	Drop-in-Centre
DISHA	District Integrated Strategy for HIV/AIDS
DLN	District Level Network
DLSA	District Legal Services Authority
DSDM	Differentiated Service Delivery Model
DRT	Discrimination Response Team
DTO	District Tuberculosis Officer
DQA	Data Quality Assurance
EAC	Enhanced Adherence Counselling
EID	Early Infant Diagnostics
EVTHS	Elimination of Vertical Transmission of HIV & Syphilis
GF	Global Fund
HEI	HIV Exposed Infants
FBO	Faith Based Organization
FSW	Female Sex Worker
PWID	People Who Inject Drugs
PWLHIV	Pregnant Women Living with HIV
RFP	Request for Proposal
RTI	Reproductive Tract Infections
SLN	State Level Network
SOC	State Oversight Committee
SOCH	Strengthening Overall Care for HIV beneficiaries
SOE	Statement of Expenditure
SSR	Sub Sub-Recipient
SC	Scheduled Caste

HRG	High Risk Group
ICTC	Integrated Counselling and Testing Centre
IEC	Information Education Communication
JAT	Joint Appraisal Team
JD	Joint Director
LAC	Link ART Centre
LFA	Local Fund Agent
LFU	Lost to Follow Up
LSE	Life Skill Education
LWS	Link Worker Scheme
MDR	Multi Drug Resistance
MLL	Master Line-List
MO	Medical Officer
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS & STD Control Programme.
NCC	National Coordination Committee
NGO	Non-Governmental Organization
NP-NCD	National Program for Prevention and Control of Non-Communicable Diseases
NRLM	National Rural Livelihood Mission
NTEP	National Tuberculosis Elimination Program
OSDV	On Site Data Validation
OI	Opportunistic Infections
ORW	Outreach Worker
OVC	Orphan & Vulnerable Children
PC	Project Coordinator
PD	Project Director
PEP	Post Exposure Prophylaxis
PHC	Primary Health Centre
PLHIV	People Living with HIV
PoC	Point of Contact
PR	Principal Recipient
SR	Sub-Recipient
SGM	Support Group Meeting
SACS	State AIDS Control Societies
SRH	Sexual and Reproductive Health
SSK	Sampoorna Suraksha Kendra
STI	Sexually Transmitted Infections
STO	State Tuberculosis (TB) Officer
TAC	Technical Advisory Committee
TB	Tuberculosis
TG	Transgender
TI	Targeted Interventions
ToT	Training of Trainers
UC	Utilisation Certificate
VL	Viral load

GLOSSARY

GLOSSARY

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 from a health care provider.
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. **Brought back:** PLHIV reaching the ARTC after outreach contact by CSC will be documented as brought back.
4. **Community Based Organisation (CBO)[1] :** An organization/society constituted by the Community members (PLHIV / FSW / MSM / TG / IDU) and legally registered (i.e. under Society Registration Act of 1860 or Charitable and Religion Act or The Indian Trust Act) and managed by the Community members for Communities' development and wellbeing.
5. **Community Mobilisation:** This is a process of engaging and empowering individuals within a community to actively participate in initiatives that address common issues or goals. This process is undertaken to build awareness, create safe spaces, facilitate collaboration, and sustain engagement of communities.
6. **Community system strengthening (CSS):** CSS is a strategy to establish and strengthen systems of community based/led activities to address the unmet needs of the communities and reach out to unreached populations.
7. **Disclosure:** It is the act of disclosing the HIV-positive status or any other private information of an individual to another person or persons. Disclosure may be done by the PLHIV themselves or with the help of another person such as a counsellor or a health care provider. For further details related to disclosure please refer to the relevant section of Gazette of India through this link- https://naco.gov.in/sites/default/files/HIV%20and%20AIDS%20Act-%20English.pdf
8. **Discordant couple:** When the spouse/sexual partner of an HIV-positive person is HIV-negative.
9. **Discrimination:** "Discrimination" means any act or omission which directly or indirectly, expressly or by effect, immediately or over a period of time,

   (i) imposes any burden, obligation, liability, disability or disadvantage on any person or category of persons, based on one or more HIV-related grounds; or

   (ii) denies or withholds any benefit, opportunity or advantage from any person or category of persons, based on one or more HIV-related grounds,
10. **Death:** Death of PLHIV due to any cause. Deaths reported after follow-up during field visit must be supported by a death certificate (from a health facility or issued by local authorities) or other valid documents (written certificates from the village headman or written statements from close family members, providing contact details for verification by the ART Centre), if a death certificate is unavailable.
11. **Elimination of Vertical Transmission of HIV and Syphilis (EVTHS):** Interventions adopted to prevent vertical transmission of HIV & Syphilis from mother to child, which can occur during pregnancy (in utero), childbirth (peri-natal) or postpartum through breastfeeding. The intervention will focus on tracking the PWLHIV and their children until 18 months of age/3 months after cessation of breast feeding, whichever is later.
12. **Enhanced Adherence Counselling (EAC):** This is a patient-centred approach to counselling that helps people living with HIV (PLHIV) identify and address barriers to taking antiretroviral therapy (ART). The goal of EAC is to facilitate good adherence to ART and viral suppression. In case of Children Living with HIV(CLHIV), the child and caregiver are both counselled to improve adherence to ART.

[1]https://naco.gov.in/sites/default/files/Revisied_Guidelines.pdf

13. **Fudging of M&E Data:** A deliberate act of CSC to manipulate the data in reporting with the malicious intention of showing good performance without doing actual work.
14. **HIV-exposed infants (HEI)/Children:** Infants/children born to mothers infected with HIV, until HIV infection can be reliably excluded or confirmed in them.
15. **Infant ARV prophylaxis:** HIV-exposed infant is given prophylactic ARV drugs to further reduce chances of HIV transmission during the perinatal period and breastfeeding.
16. **Home Visit:** Visit undertaken to a patient's home, with the consent of the patient, to provide support and assistance at their doorstep, as and when required by them.
17. **Linkages:** Establishment of processes and mechanisms that connect individuals or groups to the resources and services they need.
18. **Migrated:** A PLHIV is not found at the given address and ORW/CLH is informed by a neighbour or relative that they have shifted to some other place within/outside the state. If the name of the state, district and city to which they have shifted are available, PLHIV may be reported as migrated.
19. **Misappropriation of Funds:** When the funds allocated to the CSC are used in a way that is not permitted by the agreement that governs the funds. For example, 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.
20. **Monitoring and Evaluation:** Monitoring is the process of systematic collection and review of data on specified indicators while Evaluation is the process of collecting and analysing information to assess the relevance of objectives and efficacy of implementation that together help the programme to assess the progress it is making towards its aims and objectives.
21. **Non-Communicable Diseases (NCD):** Non-Communicable diseases are non-infectious health conditions that cannot be spread from person to person. These diseases generally last for a long period and are chronic in nature. A combination of genetic, physiological, lifestyle and environmental factors can cause these diseases. Some of the major risk factors include unhealthy/unbalanced diets, lack of physical activity, substance use disorders, smoking/tobacco use and excessive use of alcohol.
22. **Non-compliance with CSC Guidelines:** When the CSC violates the standard CSC guidelines in terms of CSC management, services to PLHIV, reporting standards etc., it is documented as Non-Compliance by the concerned SACS/SR, based on the evidence available.
23. **On ART lost to follow-up (LFU):** PLHIV on-ART with no clinical contact or ARV pill pick-up for more than 28 days since last due date (missed appointment)
24. **Opportunistic Infections (OI):** These are infections caused by microbial agents, in a person with a compromised host immune system. These infections are called opportunistic because they take advantage of a weakened/compromised immune system.
25. **Opted out**[2] If PLHIV express their unwillingness to continue ART services under national programme (even after adequate counselling and three documented contacts through home visits/phone calls, at least one of which is by the ARTC Counsellor/MO and is willing to give this in writing, such patients will be documented as 'Opted Out', by submitting the written undertaking. PLHIV taking medicines from the private sector or taking alternative medicines are also included under Opted out.
26. **Person-centred approach:** A person-centred approach is a treatment model that focuses on the individual's needs, abilities, and aspirations, rather than their condition or disability. Differentiated service delivery adopts a person-centred approach and simplifies/adapts HIV services across the cascade of care, in ways that both serve the needs of people living with and vulnerable to HIV and optimize available resources in health systems.

[2]Operational Guidelines for ART Services 2021_final soft copy version.pdf

27. **Pre-ART LFU[1]:** PLHIV registered at the ARTC but not initiated on ART and with no clinical contact or visit to a health facility for more than or equal to 28 days.

28. **Post-exposure prophylaxis (PEP):** Post-exposure prophylaxis (PEP) refers to the comprehensive management instituted to minimize the risk of infection following potential exposure to bloodborne pathogens.

29. **Rapid ART initiation:** ART initiation within seven days from the day of HIV diagnosis, with proper treatment preparedness counselling.

30. **Recording and Reporting:** The systematic recording of 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 on time.

31. **Stable on-ART Patients (children, adolescents and adults):**

    A. On ART for at least 6 months

    B. No adverse effects of ART that require regular monitoring

    C. No current illness/OI/medical condition that requires management or regular monitoring

    D. Suppressed viral load (in the absence of viral load monitoring, the rising CD4 cell counts or CD4 cell counts exceeding 200 cells/ mm3 and adherence ≥ 95% consecutively over the last 3 months)

32. **Transferred out:** Transferred out refers to a situation when a patient seeks transfer from one ART centre under the national programme to another. However, the PLHIV is labelled as "transferred out' only when the patient reaches the recipient ART centre and the "transfer in" has been accepted in SOCH by the recipient ART Centre. After confirmation of transfer by recipient ART centre, the parent ART centre will change the patient's status in their records as "transferred out".

33. **Taking ART at other NACO ART Centre:** These are PLHIV who are taking ART from another NACO-supported ART centre, without information to the parent ART centre/ICTC and confirm this when contacted during outreach. This outcome needs to be supported with a copy of the first page of the Green Book from the ART centre, where they are taking treatment currently.

34. **Taking ART from Private Sector:** PLHIV taking ART from private sector hospitals/private practitioners can be reported under this category. The source of information can be verbal /written. If available, a copy of the prescription/patient records can be collected and uploaded on the mobile application. This is a subset of Opted out patients.

35. **Taking Alternative Medicine:** All PLHIV taking alternative medicine (non-allopathic treatments) can be reported under this category. The term alternative medicine includes traditional medicine (healing practices indigenous and different cultures have used over time to maintain health and prevent, diagnose and treat physical and mental illness). Its reach encompasses ancient practices such as acupuncture, use of herbal mixtures etc. This is also a subset of Opted out patients.

36. **TB Preventive Therapy (TPT):** Administration of one or more anti-TB drugs to individuals with latent TB infection to prevent progression to active TB disease.

37. **Target not detected (TND) or Undetectable (Plasma viral load):** This means that the level of HIV RNA copies is too low to be detected or measured by the test being used. It does not mean that HIV has disappeared. HIV is still present in reservoirs within the body.

38. **Vertical transmission:** Transmission of infection from mother to child during pregnancy, delivery or breastfeeding

[1]https://naco.gov.in/sites/default/files/Revisied_Guidelines.pdf

39. **Virological failure:** Two consecutive HIV-1 viral load values of ≥ 1,000 copies/ml with the following criteria:
    i. After 6 months of ART initiation, and
    ii. Even after receiving enhanced/step-up adherence counselling, as per national guidelines and
    iii. having treatment adherence > 95% for 3 consecutive months.
40. **Virological suppression:** A viral load less than 1000 copies/ml or TND is defined as Virological suppression.
41. **Undetectable=Untransmittable (U=U):** Undetectable Viral Load helps in keeping PLHIV healthy as well as prevents transmission of HIV to their sexual partners and children (through vertical transmission). This concept is known as Undetectable = Untransmittable or U=U.
42. **Untraceable:** PLHIV who cannot be contacted due to incorrect/wrong /incomplete address & wrong phone number are termed as 'Untraceable.' This outcome should be submitted only after the ORW/CLH has made two attempts at telephonic contact and one home visit (if telephonic contacts could not be made) within one month of receiving the contact details.

INTRODUCTION

CHAPTER - 1

National AIDS Control Organisation (NACO) is committed to providing universal access to comprehensive, equitable, stigma-free, quality care, support and treatment services to all people living with HIV (PLHIV) in India. The ART programme was launched in 2004 and scaled up in phases providing free ARV drugs to PLHIV across the country through ART centres and link ART centres (LAC). With the launch of the 'Test and Treat' policy, routine viral load monitoring and differentiated service delivery models, the coverage of ART services has been expanded rapidly focussing on person-centric approaches.

Ensuring accessibility to ARVs remains key to improving treatment adherence and retention. However, retention in care remains a challenge keeping in view the financial constraints faced by PLHIV for travelling to health care facility, and due to other reasons, such as geographical barriers and psychosocial factors. Therefore, the national programme adopted the 'Differentiated Care Service Delivery Model' (DSDM) for service delivery across the spectrum of care, support and treatment components with the objective of:

- **A** Introducing person-centred approaches in HIV care.
- **B** Addressing the unmet needs, preferences and expectations of PLHIV including HIV positive KP subgroups
- **C** Ensuring access to HIV services and enhancing the efficiency of the health system and service providers.
- **D** Strengthening grievance redressal mechanisms and addressing stigma and discrimination.

Keeping in view the need of community driven and patient centric approaches to enhance treatment adherence and reduce stigma and discrimination related to HIV care, the National AIDS & STD Control Programme (NACP) responded by partnering with the community and other stakeholders to conceptualise a Care and Support Centre (CSC).

CSC is a community-based service delivery model which provides counselling, psychosocial support, outreach activities, linkages to welfare schemes and an enabling environment for PLHIV. CSC serves as an extension of treatment services for providing care and support to enhance retention, adherence, positive living, referral, and linkages to need-based services for PLHIV.

CSC play a vital role in reducing stigma and discrimination through effective treatment literacy activities in coordination with local PLHIV networks. The community-based CSC are an integral part of the national response to meet the needs of PLHIV, including those from High-Risk Groups (HRG) and women and children living with HIV.

1.1 Goal and Objectives of CSC:

Goal: The overall goal of the CSC is to support the efforts of NACP to end AIDS (Acquired Immune deficiency Syndrome) as a public health threat by 2030.

Objectives: The key objectives of CSC are aligned with the following objectives of NACP

1. 95% of people living with HIV know their HIV status
2. 95% of people who know their HIV status are on Antiretroviral treatment
3. 95% of those on Antiretroviral therapy are virally suppressed
4. 95 % of pregnant and breastfeeding women living with HIV have suppressed viral load towards attainment of elimination of vertical transmission of HIV.

1.2 Scope of Work of CSC:

The CSC complement the work done by the ART centres by providing critical support in reaching out to the PLHIV during outreach and creating an enabling environment to ensure long term retention in HIV care, improve survival and quality of life of PLHIV.

CSC serve as a safe space for PLHIV and act as a bridge to the entire continuum of care, support and treatment services. By facilitating knowledge sharing during peer counselling/support group meetings, the PLHIV are encouraged to adhere to the treatment.

Scope of work:

1. **Care and support for PLHIV**
    - Support the ARTC in reducing morbidity and mortality among PLHIV through improving retention in care and supporting regular viral load testing through follow-up.
    - Proactive follow up of Pregnant Women Living with HIV (PWLHIV) to ensure adherence to ART, viral load suppression towards elimination of vertical transmission of HIV (EVTH) including ARV prophylaxis and Early Infant Diagnosis (EID) for HIV Exposed Infant (HEI)
    - Supporting the (ARTC for Index) testing through active follow up with family members/partners eligible for HIV testing.
    - Serve as ART refill centres (special scenario) under the direction of ART centre, based on the local contexts and needs of the PLHIV.
2. **Psychosocial and Welfare Support**
    - Linkages to social protection entitlements and schemes.
    - Offering peer counselling
    - Exploring buddy systems for ART delivery for PLHIV from Key populations and in difficult to reach areas and during adverse conditions/natural calamities.
3. **Advocacy to create an enabling environment**
    - Undertake activities to reduce stigma and increase social acceptance.
    - Increasing local ownership for long-term sustainability.
    - Community System Strengthening (CSS) to ensure uninterrupted service delivery.

CARE AND SUPPORT CENTRE SERVICES AND IMPLEMENTATION FRAMEWORK

CHAPTER - 2

2.1 Activities undertaken by Care and Support Centre (CSC)

Care and Support Centre function as an extended arm of the ART centre to complement work done by ARTC for reaching out to PLHIV ensuring continuity of care through peer counselling and psychosocial support. Major activities/services given by CSC include:

(A) Outreach Services:

Reaching out to PLHIV and their families nearer to their homes and communities acts as a catalyst in bridging the gap between community and service providers. Hence outreach activity (call or home visit) is the backbone of care and support services provided by CSC for PLHIV. Outreach services also result in improvement in the knowledge level of PLHIV and service uptake by them, ultimately resulting in improved adherence and better quality of life.

The main reasons for LFU cases among PLHIV are either limited information on treatment adherence or socioeconomic problems such as poverty, poor accessibility, etc. An effective outreach will bridge these gaps and support PLHIV in accessing the required services, including those beyond medical needs. This will lead to reduced LFU cases and improve retention in treatment. The prevailing stigma and discrimination often prevent PLHIV from accessing services or at times they are not even aware of the available services. During outreach contacts, the CSC staff are able to understand these issues and support the PLHIV in overcoming these challenges.

(B) Peer Councelling:

CSC staff provide peer counselling/psycho-social support to the PLHIV referred to them by ARTC for adherence to ART, timely VL testing, understanding the concept of U=U, positive living, positive prevention etc. Peer counselling/psychosocial support is especially beneficial for PLHIV sub-groups such as key populations, children, adolescents, pregnant women, etc. Psychosocial support services help the PLHIV in coping up with the psychological, emotional, and social challenges faced by them during their diagnosis and adherence to treatment, and improve their overall quality of life.

C] Linkage with Social Entitlements/Protection/ Welfare schemes:

Linkages of PLHIV eligible for social welfare schemes and social entitlements will be ensured by CSC as per State norms. Further, CSC may undertake local resource mobilization for leveraging additional direct support services and sensitization of state and district level stakeholders to enhance access to social protection/welfare services for PLHIV, reduction of stigma as well as better livelihood options.

(D) Community based Link ART Centre (LAC):

The CSC may function as a community based Link ART center after special approval from SACS/NACO and provide refilling of ARV drugs to stable PLHIV. Refilling of ARV drugs will be done as per national guidelines for community based LAC and under advise of Medical Officer of the ART centre. This service will be provided by CSC for PLHIV in special circumstance and/or for those living in difficut geographical terrain based on the need.

Decentralized refilling will help to improve retention in HIV care by making ART available to PLHIV within their community settings, therefore providing the advantage of flexi timings, drug refill on holidays, fast track refills. This service also helps to lessen the issues around stigma and discrimination by involving community members in service delivery and shifting the responsibility of retention and management to community with the core support of the healthcare system.

2.2 Implementation Framework for CSC services

Framework provides the guidance on how the services will be delivered by the CSC

2.2.1 Outreach by ORW/CLH:

The Project Coordinator (PC) will map the PLHIV distribution and their locations within the geographical area with the support of the ORW/CLH from those areas.

(A) Strategy for Outreach

- Priority PLHIV groups requiring follow up through outreach will be identified based on the current need of NACP and the unmet needs of the PLHIV subgroups.
- The priority list will be shared with the CSC through mobile application and allocated to the ORW/CLH based on their geographical locations.
- During outreach, ORW/CLH will reach out to priority population, as per the list shared with them, and provide them with the required services.

(B) Allocation of ORW/CLH for CSC

ORW/CLH should be recruited from the areas having high caseloads and allocated based on the geographic mapping of PLHIV. CSC is not allowed to recruit all ORW/CLH from the place where it is located. If the number of PLHIV from key population groups is high, at least one ORW/CLH can be recruited from the respective Key Population. The ORW/CLH must be willing to travel to the areas allotted to them.

Points to be considered while allocating ORW/CLH to a particular area:

- They should be residing in the area where the maximum number of PLHIV allocated to them are to be reached for follow-up
- ORW/CLH's familiarity with the area
- Language familiarity
- Rapport with the key stakeholders in the area
- PLHIV should be given preference when hiring for the post of ORW/CLH
- ORW/CLH will also maintain a cordial relationship with all community leaders and stakeholders.

(C) Guidance to CLH/ORW for field activity:

- ORW/CLH will ideally spend a minimum of 20 days in the field in a month.
- One day will be spent in the CSC for documentation, review, and planning, every week. However, for CSC in difficult terrains, CLH/ORW should spend one day in the CSC once every 15 days.
- Each ORW/CLH is expected to conduct 1-2 home visits in a day. In difficult and hard to reach terrains, the number of home visits can be modified accordingly, in discussion with the PC.

(D) Guidance to CLH/ORW during ARTC working hours:

Placement of ORW/CLH at ARTC maybe based on need for provision of psychosocial support to PLHIV and proving assistance to the ART centre counsellor for PLHIV newly initiated on ART/those reengaged on treatment. This may be decided during ARTC -CSC monthly coordination meeting based on requirement.

2.2.2 Inter District/Inter-State tracking of PLHIV

(A) Inter-district Tracking:

If the ORW of the CSC while following up on PLHIV find out that they have migrated to another district of the same State, outside the geographical domain of the CSC then inter-district tracking will be done. Refer to table below for roles and responsibilities.

Table 1. Roles and Responsibilities of each stakeholder for Inter district tracking

CSC of ARTC (A)	• CSC ORW/CLH updates the migration status on the mobile app with address / contact details of the destination. • The PC validates this outcome and submits the final status on mobile app.
ART Centre (A)	• The data manager validates the outcomes submitted by PC (within 1 week of receiving feedback from CSC) • Generate district specific line list for Follow up. • ARTC (A) to share this list with ARTC (B).
ART Centre (B)	• On receipt of line list of PLHIV for interdistrict tracking from the ARTC (A), the data manager at the ART Centre (B), will cross check for duplication, different name enrolment, dispensation in transit and silent transfers in the records of own ART centre. • Update the data in SOCH of all those found in records. (Updated records will be visible to ARTC A) • Share the list of remaining PLHIV with linked CSC of ARTC (B) for tracking (within 1 week of receiving list).
CSC Of ARTC (B)	• The PC will segregate location wise PLHIV data received from ARTC (B) and share it with the ORW/CLH in the concerned locations for follow-up. • Take the support of other NACP stakeholders, taking care to ensure confidentiality, to track cases in the districts that do not have ORW/CLH (within 1 week of receiving list). • CSC will share the updated list with the ARTC (B).
SACS of State	Both the ARTC (A) and ARTC (B) keep their SACS updated till the status of all the PLHIV is updated and shared back.

Note: Refer Scenario 1 at Annexure 1

(B) Inter-State Tracking:

If the ORW of the CSC while following up on PLHIV find out that they have migrated to another state / outside the geographical domain of the CSC then inter-state tracking will be done. Refer to table below for roles and responsibilities.

Table 2. Roles and responsibilities of each stakeholder for inter State tracking of PLHIV:

CSC of State (A)	• CSC ORW/CLH updates the migration status on the mobile app with address / contact details of the destination. • The PC validates this outcome and submits the final status on mobile app.
ART Centre of State (A)	• The data manager validates the outcomes submitted by PC (within 1 week of receiving feedback from CSC) • Generate State specific line list for follow up. • ARTC of State (A) to share this list with SACS of State (A)
SACS of State (A)	• On receipt of Line list of PLHIV for Interstate tracking from different ARTC in the State, State specific line lists will be compiled and shared with respective SACS of State (B) for follow up. • Coordinate with the SACS of State(B) till the status of all the PLHIV is updated and shared back with the concerned ARTC of State (A)
SACS of State (B)	• On receipt of Line list of PLHIV for Interstate tracking, district specific line lists will be generated by SACS and shared with the concerned ARTC of State (B) • Coordinate with the ARTC of State B and SACS of State (A) till the status of all the PLHIV is updated and shared back with the concerned ARTC of State (A)
ART Centre of State (B	• On receipt of line list of PLHIV for interstate tracking from the SACS of State (B), the data manager at the ART Centre, will cross check for duplication, different name enrolment, dispensation in transit and silent transfers in the records of own ART centre. • Update the data in SOCH of all those found in records • Share list of remaining PLHIV with linked CSC of ARTC (B) for tracking (within 1 week of receiving list)
CSC linked to State (B)	• The PC will segregate location wise PLHIV data received from ARTC of State (B) and share it with the ORW/CLH in the concerned locations for follow-up. Take the support of other NACP stakeholders, taking care to ensure confidentiality, to track cases in the districts that do not have ORW/CLH (within 1 week of receiving list). • CSC will share the updated list with the ARTC of State (B).
SACS/SR/DISHA/ DAPCU	• Support CSC in coordination for interstate tracking. • Assign one Point of Contact (PoC) for inter-state tracking, coordination and arranging monthly meetings for the same. • Engage other program partners/stakeholders for better reach and timely interstate tracking. • Monitor data sharing, progress in tracking and reporting.
NACO/PR	• Facilitate coordination among all stakeholders for interstate tracking. • Review the outcome of inter-state tracking at regular intervals.

Note: Refer Scenario 2 at Annexure 1

Inter-district and Interstate coordination meeting:

SACS/NACO/PR/SR to ensure that the Inter-district and Interstate coordination meetings are held regularly on monthly basis for discussing tracking outcomes and issues in data sharing/update. The updates on the progress along with the necessary outcomes should be shared with SACS and ART centres. The minutes of the meeting should be documented.

ART-CSC coordination meeting:

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

Further, during ARTC-CSC monthly coordination meeting it should be ensured that the qualitative discussions and the quantitative validation of the outcomes are documented by CSC & ART centre. Further. tracking progress of priority cases and other relevant issues under discretion of MO. The minutes of the meeting should be maintained.

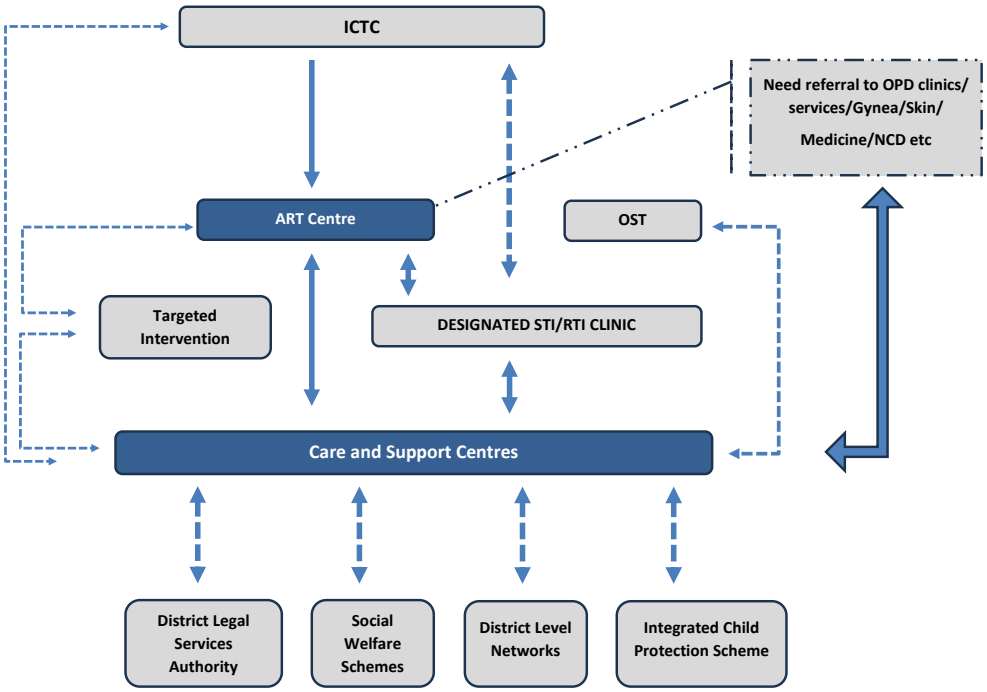
Supervision will be managed through a review of monthly reports and monitoring/mentoring visits by DAPCU/DISHA units/SACS/NACO/ PR/ SR.

2.2.3 Referral and Linkage Services:

The PC/CSC staff 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 address the health and non-health needs of PLHIV through referral to an appropriate facility. Referral to Targeted Interventions (TI) and Opioid Substitution Therapy (OST) centres for KP PLHIV is to be ensured, as and where required.

Most of the referrals for routine health needs will be routed through the ARTC where the PLHIV are registered. Referral for HIV testing under index testing strategy will be done to the nearest ICTC or to an ICTC preferred by the person being referred for HIV testing.

Figure 1 Referral and Linkage System



CSC will establish linkages with non-health service delivery units in the district which will address some of the needs that cannot be addressed at the CSC. CSC will link the PLHIV to appropriate services such as income generation schemes (if any) and other vocational training programmes. Necessary coordination maybe done for educational and nutritional support based on the availability in the district/state (if any).

The CSC staff should keep a list of all national/ state specific social welfare schemes for which the PLHIV are eligible and should establish contact with nodal persons at the government offices offering these welfare schemes. A referral directory listing the schemes, the office addresses of the concerned government offices and contact details of the nodal officers may be maintained at the CSC to facilitate the submission of applications for social welfare schemes by the eligible PLHIV

2.2.4 Support Group Meetings (SGM):

The PC of the CSC will organise SGMs at the CSC or other appropriate locations in the field to provide support mechanisms for the PLHIV. SGMs may also be arranged at the ART centre, ICTC or at other mutually agreeable, appropriate community-based sites. Min 08-15 members should participate in each SGM. Efforts to be made to ensure minimum 70% of participants remain regular.

These meetings will provide the members with a platform for cross learning/experience sharing and sharing other concerns related to stigma and discrimination. The support groups will also help strengthen their knowledge of HIV-related issue and develop a community voice to advocate for better services/policies. It should be noted that monetary benefits will NOT be provided for participants attending the support group meetings.

SGM with focus on children, key population, discordant couple, single women or widows, pregnant women, PLHIV with TB, NCD and unsuppressed VL etc. CSC can conduct SGM with the specific sub-group of PLHIV and reinforce the treatment goals, provide information as per the sub group on 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 PLHIV. If poor adherence is due to extreme side effects, such PLHIV should be facilitated to meet the ART Medical Officer for further management. The table below list the topics which can be covered during support group meetings.

Table 3. Key Topics for support Group meetings.

1 Basic Health & Hygiene

A) Personal hygiene
B) Importance of regular health check-up
C) Importance of yoga and meditation
D) Positive living
E) Sexual and reproductive health

2 Basic HIV Information

A) Modes of HIV transmission
B) HIV life cycle and living with HIV
C) Disclosure issues
D) Index Testing

3 Diet and Nutrition

A) Balanced diet
B) Nutritional demo
C) Kitchen garden promotion
D) Timely intake of food

4 Home Based Care

A) First aid
B) Basic information to caregivers
C) Palliative care

5 OI Management and Co-infection

A) Types of OIs and their symptoms
B) Treatment for OIs

6 Treatment Adherence and viral load suppression

A) Antiretroviral therapy, Tuberculosis & STI, other co-morbidities
B) CD4
C) Treatment schedule
D) Viral load
E) U=U

7 Treatment Literacy

A) First line, second line and Third line ART
B) Benefits/Side effects of ART
C) Risk Factors for NCD and their prevention

8 Positive Prevention

A) Safe sex
B) Positive prevention and condom promotion
C) Discordant couples

9 Social Events & Livelihoods

A) Government schemes
B) Income Generation Programmes

10 Elimination of Vertical Transmission of HIV

A) ANC Care & danger signs in pregnancy
B) Family Planning.
C) VL testing at 32-36 Weeks
D) Institutional Delivery
E) Breast Feeding& Feeding practices for the HEI/children
F) ARV Prophylaxis and CPT.
G) EID & immunization.
H) Positive baby care and ART retention.

Requisites for SGM Meeting:

- Every member of the support group is encouraged to bring their Green Book during the meeting to understand their clinical profile.
- It is suggested to take the details such as 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.

2.2.5 Differentiated Service Delivery by CSC

Differentiated service delivery is a person-centred approach that simplifies and adapts HIV services across the cascade of care to reflect the preferences and expectations of various sub-groups of PLHIV. The focus is on addressing needs related to vulnerabilities, gender, age, and socio-economic conditions.

To address the diverse needs of the PLHIV being provided services by the CSC, different models of differentiated service delivery may be adopted by them. For example:

(A) Community based Link ART centres to improve access to ARV drugs to certain subgroups of PLHIV or in difficult hilly terrains.

(B) Community based Screening (CBS) services at CSC, where decentralization of HIV screening services improves access for contacts of Index clients taking services from the CSC

Please refer to Table 4 below for details of service packages

Table 4. Service Packages

Subgroup	Service Package					
	Type of service	Why	How	When	Who	Outcomes
		Reason for service	Mode of Service	Frequency of Service	CSC staff responsible for service	
1) Newly diagnosed PLHIV not linked to ARTC within 7 days (ICTC to ART linkage loss)	Peer counselling on importance of Antiretroviral therapy and supporting linkage to the ART centre for initiation of ART	To promote early treatment initiation and prevent linkage loss.	Essential Services: √ Provide peer counselling to address the reason for not initiating ART √ Motivation for early registration of ART √ Tracking and follow-up till registration at ARTC.	Daily on-phone follow up with home visit, if needed, till the PLHIV reaches the ART Centre or till any other definite outcome is documented.	PC to ensure that the list of PLHIV is assigned to ORW/ CLH for tracking and linking back with ART. The ORW/CLH will contact PLHIV over the phone or meet them at their homes or a place convenient to PLHIV.	1. Linked with ART Centre 2. Opted out 3. Taking ART from Private Sector 4. Taking Alternate medicine. 5. Reported Death; 6. Untraceable (incorrect/incomplete contact details) 7. Migrated.
2) PLHIV newly initiated on ART.	Intensified peer support services will be provided to the PLHIV at least for the initial 6 months for better treatment adherence and retention in HIV care.	PLHIV newly initiated on ART are more likely to miss their treatment and become LFU within first 3-6 months after treatment initiation due to denial of the HIV status, clinical issues (Side effects, OI, comorbidities, IRIS) and psychosocial reasons.	Essential services in the first 6 months: √ Address verification- the ORW/ CLH will physically visit the address provided by the PLHIV and verify the address. √ Treatment adherence support will be provided during home/outreach visits by the ORW/CLH as per the convenience of the PLHIV. They will reinforce the same message during contact with PLHIV in the second month √ Basic information about side effects and OI management will be provided during the visit of PLHIV to CSC √ Adherence support for ART, ATT, TPT, CPT or for treatment for any other comorbid condition (TB, NCD/HBV/HCV). √ Promote positive prevention activities.	Monthly contact for first 6 months from ART initiation and capturing retention at end of 6th month by collecting date of medicine taken at ARTC ORW/CLH will make one home visit during the first month while other follow-ups can be done based on the needs (Telephonic or Home visit) of the PLHIV.	ORW/CLH	1. Address and contact details of the PLHIV and Caregiver verified and correct; 2. Address and contact details of the PLHIV and/or Caregiver updated 3. Untraceable (incorrect/incomplete contact details). 4.Reported Death 5. PLHIV retained in care 6. Opted Out 7. Taking ART from Private Sector 8. Taking Alternate medicine. 9. Taking ART from another NACO ARTC 10. Adherent to ART

Subgroup	Service Package					
	Type of service	Why	How	When	Who	Outcomes
		Reason for service	Mode of Service	Frequency of Service	CSC staff responsible for service	
			√ Encourage PLHIV for disclosure, if not done and referral of eligible family member/spouse/partner(s) for HIV testing, during the outreach. √ Support referral to ART centre in case PLHIV develops new symptoms or condition worsens	If the PLHIV is not agreeing to a home visit, telephonic contact will be made.		
3) PLHIV with CD4 cell count <200 cell/mm3	Intensified peer support services will be provided to the PLHIV at least till the CD4 count is more than 200 cells/mm3 or follow up is done for 6 months after receiving the PLHIV contact details by the CSC. whichever is earlier	These are PLHIV with advanced HIV disease and more prone to have OIs and other serious illnesses.	Essential Services: √ Treatment adherence support with focus on treatment literacy √ Adherence monitoring √ Basic information on the impact of irregular medication and the vulnerability to OIs. √ Linkages to social welfare schemes based on eligibility and linkage √ TB screening. √ Referral of eligible family members/ spouse/partners for HIV testing. √ Additional services: √ Referral to TI in case the PLHIV is from Key population for TI-related services √ Referral to Sampoorna Suraksha Kendra (SSK) for partners identified as HIV negative √ Referral to OST centre for PLHIV who are also PWID	Monthly follow-up for treatment adherence and psychological support till the CD4 count becomes more than 200 cells/mm3, or 6 months whichever is earlier. (Note: Monthly telephonic contact should be done and if required home visit can be conducted, under direction of ART Centre staff)	ORW/CLH and PC	1. Adhered to ART for 6 months and tested for CD4 count 2. CD4 count > 200 cells/mm3 3. Adhered to ART for 6 months but not tested for CD4 count 4. Opted out 5. Reported Death 6. Migrated 7. Non-adherent to ART 8. Taking ART from Private sector 9. Taking Alternate medicines. 10. Untraceable (incorrect/incomplete contact details)

Subgroup	Service Package					
	Type of service	Why	How	When	Who	Outcomes
		Reason for service	Mode of Service	Frequency of Service	CSC staff responsible for service	
4) Lost to Follow Up (Pre-ART and on-ART LFU) cases	Tracking LFU cases to link them back to ARTC	Some PLHIV register at the ARTC but are not initiated on ART due to clinical/ non-clinical reasons (Pre-ART LFU). While Poor adherence and missing the treatment will enhance the disease progression and also result in high morbidity and mortality in On-ART PLHIV who stop treatment and become LFU (on-ART LFU)	Essential services: √ If the phone number is available, the CSC team will try to contact the PLHIV over the phone. √ If phone numbers are not available or not reachable, the ORW/CLH will make a home visit to motivate the PLHIV for a visit to the ARTC. √ Monitor PLHIV who have been brought back to care for a period of 3 months to ensure they are retained in treatment and tested for VL. √ Promote positive prevention activities √ Linking the PLHIV to social welfare schemes √ Referral of eligible family member/ spouse/partner(s) for HIV testing √ Information Capturing: CSC will document the reasons for PLHIV being LFU. This information will be used to identify and respond to emerging needs effectively, ensuring better support and retention.	Every week till a definite tracking outcome is available for the PLHIV. For on-ART LFU cases brought back to the ARTC, follow up needs to be done once every month, for three months after re-initiation of ART, and till VL testing is done,	ORW/CLH Project Coordinator	1. Brought Back to ARTC 2. Opted Out, 3. Reported Death 4. Taking ART at other NACO ART Centre 5. Taking ART from Private sector 6.Taking Alternate medicines. 7. Migrated, 8. Untraceable (incorrect/incomplete contact details)

Subgroup	Service Package					
	Type of service	Why	How	When	Who	Outcomes
		Reason for service	Mode of Service	Frequency of Service	CSC staff responsible for service	
5) PLHIV with TB	Providing peer support for ensuring the PLHIV is coping with both ART and ATT and adhering to treatment.	The PLHIV on ART and ATT have a high pill burden and need regular follow up and support to ensure adherence to both ART and ATT. They may be more prone to side effects and need more frequent follow up. The risk of Multi Drug Resistance (MDR-TB) infection may be increased if effective and uninterrupted TB treatment is not ensured.	Essential service: • CSC will follow up with PLHIV till they complete ATT. • CSC will provide peer counselling and information on: √ Treatment adherence √ Side effects management √ Treatment fatigue and pill burden √ TB prevention for family members and √ Information about nutrition along with TB treatment.	Monthly contact till Completion of TB Treatment. (Note: Monthly telephonic contact should be done till treatment completion and if required home visit can be conducted, under direction of ART Centre staff)	ORW/CLH and PC	1. Adherent to ART & ATT 2. Not adherent to ART & ATT, 3. Adherent to ART but not to ATT, 4. Adherent to ATT but not to ART, 5. Completed the ATT 6. Reported Death 7. Opted out 8. Taking ART from Private sector 9. Taking Alternative medicines 10. Migrated 11. Untraceable
6) PLHIV initiated on 3rd line ART	Intensified peer support services will be provided to the PLHIV for better treatment adherence and timely pill pick up	These PLHIV may have issues related to adherence.	Essential Services: √ Treatment adherence support √ Adherence monitoring √ Basic information about side effects and OI management will be provided during the PLHIV's visit to CSC √ Linkages to social welfare schemes based on eligibility and linkage.	Monthly contact for treatment adherence and psychological support till VL testing is done at the end of 6 months after initiation of 3rd line ART	**ORW/CLH and PC**	1. Visited the ART Centre for pill pick up on due date 2. Tested for VL 3. VL test not done, 4. Reported Death 5. Migrated 6. Untraceable (incorrect/incomplete contact details).

Subgroup	Service Package					
	Type of service	Why	How	When	Who	Outcomes
		Reason for service	Mode of Service	Frequency of Service	CSC staff responsible for service	
7) Eligible for HIV test under index testing strategy -Family members, spouse, sexual/ injecting partners, biological children of PLHIV and biological parents of CLHIV/ALHIV (more than 18 months & <19 years of age	• Consent of the HIV-positive Index client for contacting family members/ spouse/ partners • Focus on elicitation of sexual and needle sharing contacts and biological children less than 19 years of age of the index client • Refer those eligible for HIV counselling and testing services in coordination with NACP facility. • Peer counselling & reinforce the HIV prevention messages. • If diagnosed HIV positive, facilitate early linkage to ARTC	The risk of transmission of HIV is higher in this group of people and hence regular screening/ testing for HIV in those eligible under index testing strategy can support early diagnosis of HIV and linkage to ART. To ensure that the HIV negative partner remains negative • Condom promotion and consistent safe sexual practices • Disclosure, if not done already • Family planning issues Sexual and Reproductive Health (SRH) issues	√ Counselling on positive prevention, condom usage & benefits of regular screening for HIV. √ Treatment literacy on benefits of adherence to ART to prevent transmission of HIV √ Facilitating HIV testing of eligible persons. √ Early linkage to ART centres for those diagnosed HIV positive. Essential services to discordant couples: √ Peer Counselling on U=U (Undetectable = Untransmittable) √ Six-monthly follow-up HIV test for the HIV negative partner √ Promote joint responsibility √ Counselling /support on FP issues	Monthly follow up till all eligible persons who agree for screening/ testing are tested at least once for HIV. Those tested HIV negative may be referred to the SSKs.	ORW/CLH and PC	1. Eligible persons Screened/Tested for HIV 2. Eligible persons not agreed for screening/ testing 3. Eligible persons not contacted/not able to contact 4. Migrated 5. Untraceable (incorrect/incomplete contact details) 6. Reported death.

Subgroup	Service Package					
	Type of service	Why	How	When	Who	Outcomes
		Reason for service	Mode of Service	Frequency of Service	CSC staff responsible for service	
8) Pregnant Women Living with (PWLHIV)	Ensuring treatment initiation in newly HIV diagnosed pregnant women , and treatment adherence, regular Antenatal care (ANC) check-ups, VL test between 32-36 weeks of pregnancy, institutional delivery for all PWLHIV and post-natal follow-ups	To Eliminate vertical transmission of HIV to the child	CSC Essential service: √ Promote treatment preparedness in newly HIV diagnosed pregnant women √ Ensuring treatment adherence, regular ANC check-ups and institutional delivery √ Follow up for viral load testing between 32-36 weeks of pregnancy √ Follow up with the mother at childbirth and during breast feeding for initiation and completion of ARV prophylaxis and till the child is 18 months old or 3 months after cessation of breast feeding, whichever is later. √ Referral of eligible family members/ spouse/partners for HIV testing. √ The ORW/CLH may adopt a family-centric approach to support the Woman living with HIV and the newborn baby(HEI)	ORW/CLH will make one home visit during the first month while other follow-ups can be done based on the needs of the PLHIV (Telephonic or Home visit). ORW/CLH will do follow up (Telephonic/ home visit) to ensure VL testing between 32-36 weeks of pregnancy.	ORW/CLH and PC	1. Taking ART 2. Brought Back to ARTC for VL testing 3. Tested for VL between 32-36 Weeks of Pregnancy 4. VL test not done between 32-36 weeks of pregnancy 5. Opted out 6. Taking ART from Private sector 7. Taking Alternative Medicines 8. Reported Death 9. Migrated 10. Untraceable (incorrect/incomplete contact details)
9) HIV Exposed Infants (HEI)	Ensuring linkage with and completion of ARV prophylaxis, EID testing and care	To prevent Vertical transmission of HIV	√ Ensure HEI receive the appropriate ARV prophylaxis, as prescribed, based on the risk of HIV transmission to the infant √ Refer for EID testing at 6 weeks, 6, 12 and 18 months or 3 months after cessation of breast feeding, whichever is later √ Psychological support and information to parents on overall wellbeing, maintaining hygiene and timely immunisation	1st Month follow up for ensuring ARV prophylaxis while other visits to be scheduled to ensure EID testing at 6 weeks, 6, 12 and 18 months or 3 months after cessation of breast feeding.	PC and ORW/CLH	1. Brought to ICTC for EID testing, 2. EID testing for HIV done 3. EID testing not done, 4. Reported Death 5. Migrated 6. Untraceable (incorrect/incomplete contact details)

Subgroup	Service Package					
	Type of service	Why	How	When	Who	Outcomes
		Reason for service	Mode of Service	Frequency of Service	CSC staff responsible for service	
			√ Peer counselling on breast feeding √ If HEI/child is detected HIV positive, linking with ART and providing support to caregiver/mother for adherence to ART			
10) PLHIV overdue for VL testing.	Peer counselling and psycho-social support for ensuring visit to ARTC for VL testing	Timely VL testing helps in monitoring the response to ART and identification of PLHIV with unsuppressed VL	√ Follow up to mobilize PLHIV who are overdue for viral load testing. √ Support PLHIV to visit ARTC so VL test can be conducted	Monthly telephonic contact should be done till VL testing and if required home visit can be conducted, under direction of ART Centre staff.	PC and ORW/CLH	1. Brought Back to ARTC for VL testing, 2. Tested for VL 3. Opted out 4. Taking ART from private sector 5. Taking Alternative medicines 6. Reported death 7. Migrated 8. Untraceable (incorrect/incomplete contact details)

Subgroup	Service Package					
	Type of service	Why	How	When	Who	Outcomes
		Reason for service	Mode of Service	Frequency of Service	CSC staff responsible for service	
11) PLHIV with Unsuppressed VL	Treatment literacy to ensure that PLHIV understand the importance of adherence to ART for suppression of VL and ensuring treatment adherence.	Adherence support for PLHIV who have unsuppressed VL helps in improved adherence to ART, viral load suppression & better health outcomes and prevents further transmission of HIV	√ Motivate the patient to attend the EAC sessions regularly at the ARTC √ Peer support for adherence to ART and treatment literacy to support the adherence plan made during the EAC sessions √ Link the eligible PLHIV for social protection schemes. √ Peer counselling on positive prevention. √ Referral of eligible family members/ spouse for HIV testing will be done.	Monthly follow-up for treatment adherence and psychological support, till repeat VL testing is done	PC and ORW/CLH	1. Brought Back to ART Centre for EAC 2. Visited the ARTC for repeat VL testing 3. Referred to SACEP/ CoE 4. Opted out 5. Taking ART from private Sector 6. Taking Alternative medicines 7. Reported Death 8. Migrated 9. Untraceable (incorrect/incomplete contact details)
12) PLHIV with unstable/ uncontrolled co-morbidities (Other than TB)	Ensuring that referrals are completed and peer support for adherence to ART and the treatment given for management of comorbidity	PLHIV with uncontrolled co-morbidities are referred to NCD clinics/ Medicine / Gynaecology OPDs for management and this helps in reducing the morbidity and mortality among PLHIV.	√ The CSC will support in completing the referrals, adherence to treatment for co-morbidity & ART till the co-morbid condition is controlled and PLHIV is referred back to the ARTC. √ Referral of eligible family members/ spouse/partners for HIV testing.	Monthly follow up contacts	PC and ORW/CLH	1. PLHIV with comorbidities completed their required referrals 2. Reported Death 3. Opted out 4. Taking ART from private sector 5. Taking Alternative Medicines 6. Migrated 7. Untraceable (incorrect/incomplete contact details)

In addition to the essential services provided to the key priority groups of PLHIV, CSC will also create and sustain a positive and enabling social environment through linkages and partnerships with district-level service delivery facilities and governance systems. Discrimination Response Team (DRT) of the CSC to ensure stigma and discrimination-free services. Efforts may be taken to leverage resources from other local organisations for vocational trainings, life skills education of PLHIV and for advocacy.

Specific activities for this shall include:

- Community sensitisation meetings and developing community ownership.
- Coordination meetings at the community level with Panchayats, Anganwadi Workers, ASHA, School 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, Cancer Awareness days and other related events. Regular sensitisation meeting of all stakeholders
- Quarterly advocacy meetings and media advocacy.
- Regular meeting of DRT (Discrimination Response Team)

2.2.6 Services for CLHIV, ALHIV and PLHIV from Special Populations:

A) CLHIV:

Understanding the key challenges among CLHIV and their family context is critical to achieving the expected treatment outcomes. Once a child is detected HIV positive, CSC staff in consultation with the parent/care giver of the child should ensure immediate linkage of the child to the nearest ART centre and facilitate early initiation of ART. For CLHIV who are retained in care but have un-supressed VL, CSC to engage parents/ caregivers of these children to improve adherence to ART and viral load suppression in them. Focus should be on providing amicable services in coordination with the ART centre.

Some options for addressing the challenges faced by Children Living with HIV are:

- To avoid changes in the children's daily routine, ORW/CLH may facilitate ART collection through the family approach if the parents/care givers are also taking ART.
- The children and the parent/caregiver can also collect the ART medicine from the CSC at flexi time to suit their convenience, if the CSC is providing ARV Drug refill services. For this the Project coordinator should coordinate with the Medical Officer of the ART centre.
- During every interaction, child/caregiver/parent should be provided psychological support about adherence to ART and gradually prepared for age-appropriate disclosure.
- Development of rapport between the child, caregiver and CSC staff using age-appropriate language to facilitate both communicating information to the child and space to express their feelings.
- Interactive tools such as drawing, storytelling, plays, drama are suggestive media through which children can be helped to express themselves.
- Care givers should be counselled on supporting treatment adherence in children

B) ALHIV:

Issues and challenges faced by Adolescents Living with HIV are different from those faced by the adults and elders. Some of the challenges faced are lack of information on safe sexual behaviour, school dropout, risk behaviour, depression, sexual abuse etc. Their problems multiply if they are orphans. CSC may not be able to address all these challenges but will play a catalytic role in linking eligible adolescents to various services. Hence, a need arises that tailored counselling messages are provided to ALHIV focusing on ART initiation, adherence and other messages based on the individual challenges.

Table 5. Addressing challenges faced by CLHIV and ALHIV

Needs of CLHIV and Adolescents Living with HIV (ALHIV)	Role of CSC
Counselling issues: √ Dealing with HIV status √ Dealing with stigma and discrimination √ Coping with changes in the body including menstruation √ Dealing with sexual exploitation √ Loneliness/dejection √ Lifelong Treatment and Adherence to ART √ Healthy lifestyles √ Career Choices	√ ORW/CLH will talk to each child and adolescent either during ART centre visit or during their visit to CSC to identify their counselling needs. √ They will give the basic information required by the Child/ Adolescent √ They will also counsel their parents and caregivers, if needed. √ Appropriate referrals to linked facilities
School Related Issues: √ ART centre and school timings are the same √ Basic requirements such as school fee and education kits √ Discrimination in school √ Lack of motivation to go to school √ Dropouts either by self or due to parental compulsion	√ CSC to explore differentiated care models to provide flexi-timing for school-going children to collect their ART √ Mobilise local resources to support needy children in their education, if required. √ Address stigma and discrimination cases in the school immediately and sensitise school authorities on the HIV/ AIDS (Prevention & Control) Act 2017. √ Referrals to locally available resources/ services

For details on issues related to CLHIV and ALHIV counselling, please refer chapter on Counselling for Children and Adolescents Living with HIV of National Guidelines for HIV Care and Treatment 2021.

C) PLHIV from Special Populations: PLHIV from Key Population have high-risk behaviour and face issues in practising safer sex/safe injecting behaviour many a times due to occupational hazards. Further, the challenges are exacerbated due to stigma and discrimination and the inability to reach during working hours of ARTC, especially for PWID and sub populations in sex work.

The special population may come in any of the priority indicators selected for outreach services. CSC should ensure that additional support and referral services may be provided based on their need. CSC to promote special counselling on ART treatment adherence and positive prevention among key population. CSC may explore alternative arrangements for delivering ARV drugs to KP PLHIV to retain them in HIV care. Spouse/partner testing should also be encouraged by the CSC ensuring consent and confidentiality.

MONITORING AND EVALUATION OF CSC

CHAPTER - 3

Monitoring and Evaluation (M&E) are critical components which ensure effective implementation, accountability, and continuous improvement in quality of services provided by CSC. The M&E framework is developed to systematically collect, analyse, and use data to monitor performance and outcomes. This enables the stakeholders to assess the effectiveness of interventions, identify gaps, and make informed decisions to optimize care and support for PLHIV.

The primary goals of M&E in this context are to track progress towards key objectives, assess the quality and reach of services, and ensure alignment with national response against HIV/AIDS. Regular data collection at various levels from CSC to State oversight level, ensures that emerging needs and challenges are identified promptly, enabling timely interventions. Furthermore, the M&E framework includes quantitative and qualitative indicators tailored to improve quality of life of PLHIV and adapting to evolving needs.

3.1 Monitoring of CSC:

NACO has developed a user-friendly digital system (called NACO-CSC mobile application) to minimize efforts in seamless data fetching from SOCH portal, work distribution among Outreach workers (ORW)/ Community Liaison for Health (CLH) for real time outcome compilation.

The time thus saved by using the digital application would be utilized for improving the quality of services (psychosocial support and peer counselling) offered by the CSC and will support the program in faster actions for eligible beneficiaries. It would also bring more transparency at each level of service delivery.

3.1.1 Key features of NACO-CSC mobile application

Real-Time Data Management: The application links live data generated by SOCH portal at ARTC/ICTC with CSC, ensuring seamless coordination. Supports manual and grid-based PLHIV assignment to ORW/ CLH, with options for efficiency enhancements.

Priority Sub-Group Management: Application aids to manage priority sub-groups for outreach services and linking/referring them to appropriate services facilities.

User Roles and Validation: CSC Project Coordinators assign cases to ORW/CLH based on geographical coverage via the mobile app. ORW/CLH conduct outreach and update outcomes, which PCs validate before submitting to ARTC/ICTC.

Enhanced Features: The application includes admin functionalities for user management by SACS M&E Officers, automated Monthly Progress Reports (MPR). It integrates with the SOCH database for comprehensive data management and generates customized outcome updates and dashboards for CSC/ SACS/NACO/SR/PR/ for performance monitoring.

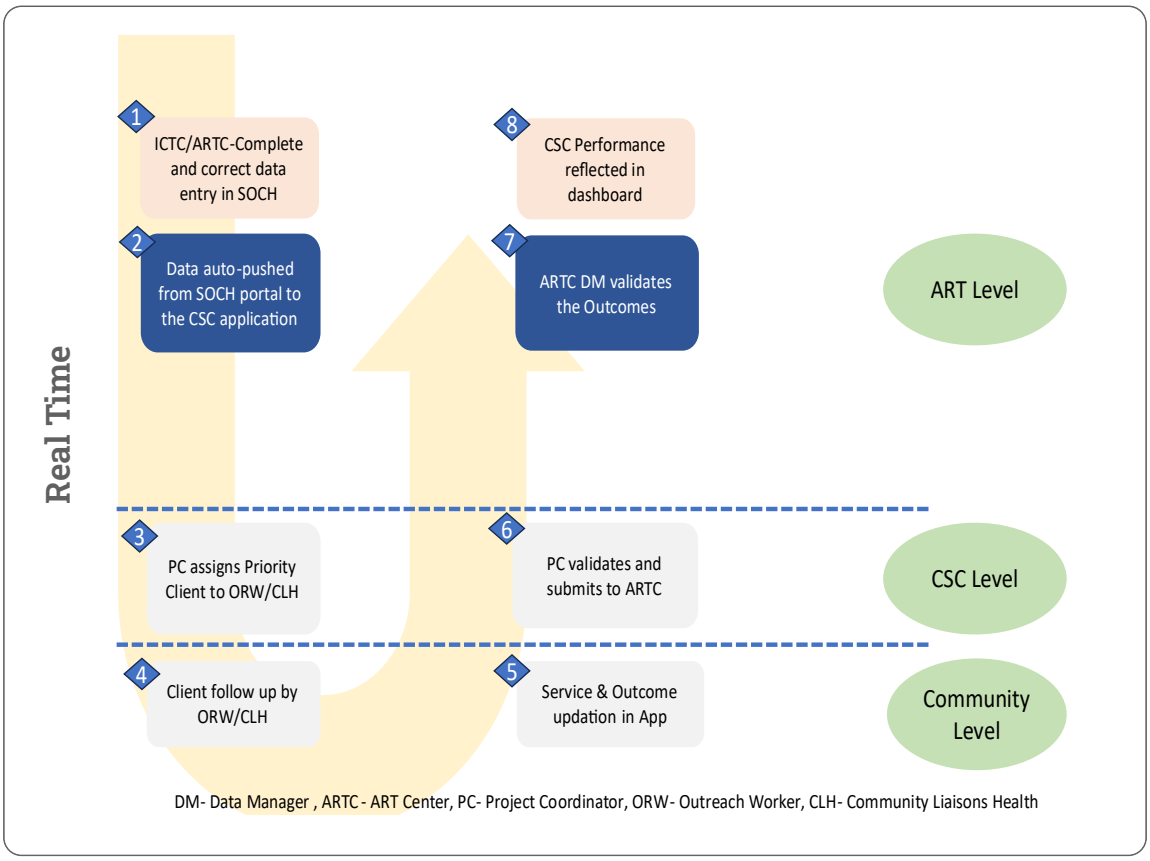
Prevention of Duplication: A mechanism to address duplicate entries is incorporated, ensuring accurate denominators and validated numerators.

3.1.2 The data sharing mechanism between ICTC/ARTC and CSC through SOCH

The priority line list of PLHIV from ICTC/ARTC will be shared with the CSC through the mobile application. The PC will allocate the cases to the ORW/CLH. They will use this information to plan and conduct outreach efforts aimed at achieving desired outcomes for the PLHIV.

- Routine data entry of CSC services provided to PLHIV or eligible beneficiaries is done and outcomes of outreach contact are submitted to the Project Coordinator, through CSC mobile based application
- The CSC Project coordinator will validate these outcomes and submit the verified results to the ARTC Data Manager for updating in SOCH.
- Once the ARTC data manager validates this information it gets updated in SOCH, for each PLHIV.

Figure 2. The data sharing mechanism for CSC:



A data quality assurance mechanism will be in place, ensuring high-quality data is delivered with the involvement of key stakeholders.

3.1.3 Monitoring mechanism through digital application on SOCH for CSC

Unlike the previous practices of hard-copy based, time-consuming recording and reporting system, the NACP now aims to utilize a dynamic digital and efficient system where minimum efforts are spent for data collection, distribution and outcome compilation. The time saved by using digital application would be utilized for improving the quality of services offered by the CSC and for quicker actions for eligible beneficiaries. It would also bring more transparency at each level of service delivery.

- Post-introduction of SOCH mobile application for the CSC, single registration system would be followed in HIV care setting. PLHIV registered in SOCH and referred to CSC in any of the priority lists for follow up, would be registered under respective CSC, using the SOCH ID provided on the mobile application.
- The system would allow direct and real time data transfer from each of ICTC/ART centre, whenever a beneficiary becomes eligible under any key priority indicator in the HIV care setting . Specific logic would be utilized by the system to assign a particular beneficiary to CSC Staff (PC and subsequently to ORW/CLH).
- The system will not be waiting for weekly/ monthly data flow, as previously, in excel based method but would be dynamic enough to send information in real time to CSC for required actions at community level.
- The CSC mobile application will utilize the mapping of State, District, CSC and related staff and assign beneficiaries in key priority lists to CSC in real time. However, it would be responsibility of the CSC to keep the mapping updated and rationalize the workload of ORW/CLH.
- Project/CSC Coordinator will play a critical role in distributing the priority clients among existing ORW/CLH on regular basis and would monitor the outcome updated by each of the ORW/CLH. Dashboard at various level would also reflect the performance of CSC for the services provided to eligible clients.
- After login credentials are entered, the landing page of the NACO-CSC mobile application would have the thematic groups of priority clients and clicking on a thematic group will display the list of clients. Clicking on any one of the patients in the list will display the patient details and the services to be provided. It is also possible that a single client might need multiple services, and the client's name may be included under different priority groups.
- ORW/CLH will track their daily workload based on the clients allocated to them by the concerned PC and would strategize to cover maximum clients each day. In case, there are clients who are untraceable due to any reason then the outcome should be submitted only after the ORW/CLH has made two attempts at telephonic contact and one home visit (if telephonic contact could not be made) within one month of receiving the contact details, An additional section would be kept for remarks where specific details can be entered by ORW/CLH.
- It is quite possible that the PC finds that some of the client details might be incomplete or incorrect, in which case, there would be an option to refer the patient back to ART Center, on the mobile application. Same should be discussed in the monthly ARTC-CSC Coordination meeting. ICTC and ARTC team will try to update the correct details on SOCH portal so that valid details are shared with the CSC and services are provided optimally.
- To standardize the outcome in digital system, each of the outcome will be having a unique identity number and that will remain common across all priority client lists. When the ORW/CLH provides a particular service to the client, option from a simple dropdown would be selected for providing the outcome that would be instantly available to CSC PC. Once the PC validates the information submitted by the ORW/CLH and submits it on the mobile application, it becomes visible to the data manager of the ARTC.
- Once the ARTC data manager validates the information, it becomes updated on SOCH and becomes visible to ARTC staff.

3.1.4 Recording & Reporting Tools

The mobile application developed will replace most of the tracker sheets used separately for data sharing between, ICTC/ARTC and CSC. However, the tools which will still be in use are:

Table 6. Recording & reporting tools to be used by the CSC

Sl. No	M&E tool	Purpose	Frequency	Who is responsible	Level of Documentation
1	Discrimination Reporting Tool	To record incidents of discrimination/ violence faced by PLHIV and action taken by DRT	Realtime	Project Director of CSC/ Project Manager/ Coordinator/Project Coordinator	CSC
2	Drug refill - Monthly Report, wherever applicable	To report PLHIV provided service through CSC	Monthly	Coordinator/Project Coordinator	CSC
3	Community Based Screening Monthly Report, wherever applicable	Screening of the family members at the CSC	Monthly	Coordinator/Project Coordinator	CSC
4	Supportive supervision visit form (Annexure 2)	On-site mentoring to improve the quality of the outreach services	Monthly	Officer from SACS/ SR	SACS/DISHA unit /Partner Supporting agency/SR

Apart from these, each CSC will maintain a meeting register to document meetings facilitated/attended by the CSC staff (Support Group Meeting, Staff monthly/ weekly meeting, ARTC-CSC Co-ordination meetings, orientation meeting etc)

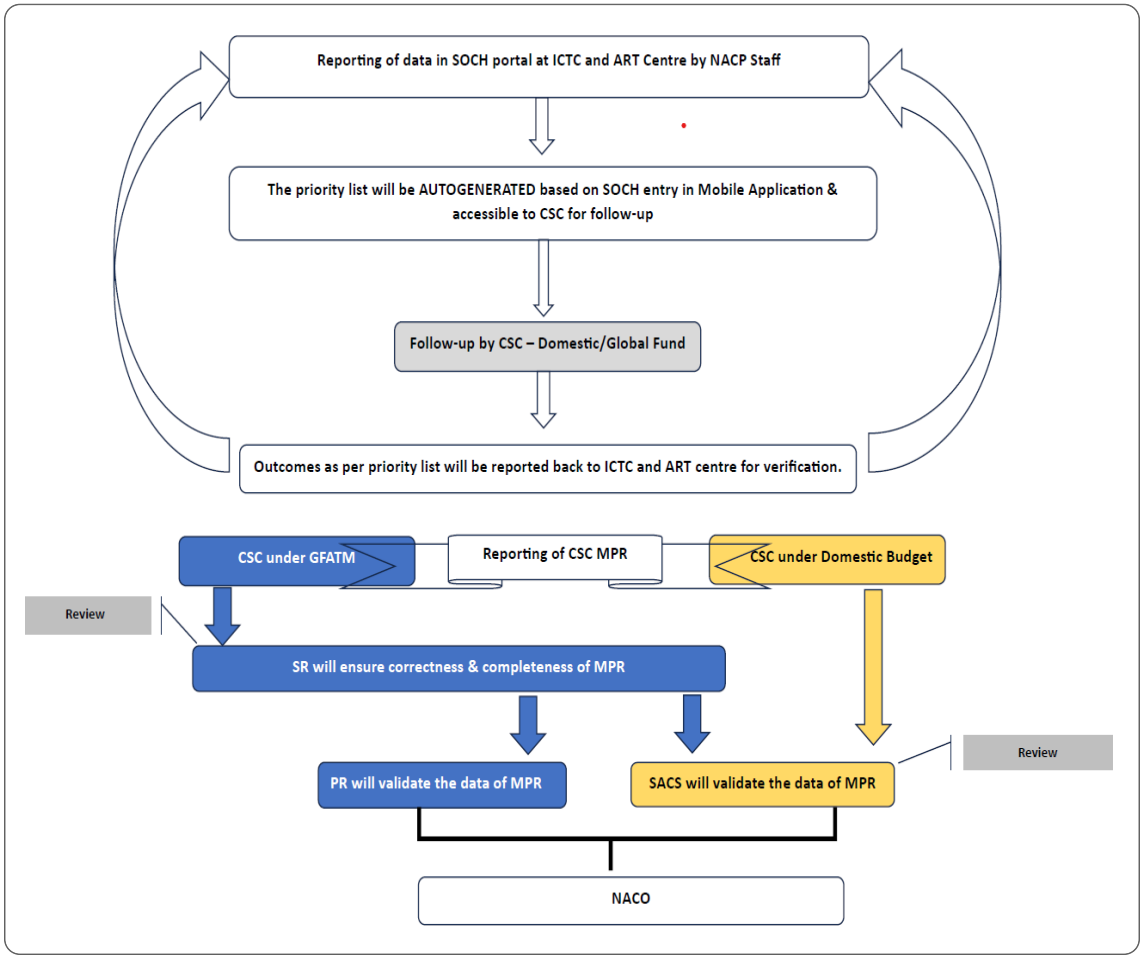
3.1.5 Reporting Mechanisms

CSC will update data related to indicators in the mobile application and the same will be collated and reported through the following channels:

Monthly Performance Report (MPR):

At the CSC level, MPR will be auto generated every month, from the CSC mobile application and submitted to SACS/SR immediately at the end of the month in real time. Further. State level reports will be compiled by SACS/SR and shared with NACO/PR latest by the 3rd of next month.

Figure 3. CSC reporting Mechanism



3.1.6 Monitoring Framework

The Monitoring framework aims to establish a robust monitoring system in alignment with the proposed goals and objectives. This framework prioritizes real-time data analysis and information sharing, enabling proactive strategies to address programmatic challenges. It incorporates performance indicators and standardized data collection tools, aligning program goals with National response against HIV/AIDS. Data quality is proposed to be enhanced through onsite data verification and supportive supervision visits, emphasizing accurate reporting at the national, state, and district levels.

The reporting structure involves regular progress updates to stakeholders, with monthly and quarterly reports shared with SACS/NACO and SR/PR.

To support implementation, capacity-building initiatives will be conducted focusing on data management skills for implementing staff. Stakeholder engagement and community-led monitoring also ensure that services meet quality standards and address the needs of PLHIV effectively. Insights generated from monitoring activities will be utilised for ongoing improvements and enhance the program's impact.

- SACS and Global Fund supported partners (SR and PR) provide adequate capacity-building support so that the staff at the CSC level are technically capacitated to analyse data and use the analysis for decision-making.
- Programmatic data analysis is being done periodically, at different levels of programme management units to give feedback to the stakeholders towards effective programme management and implementation.
- NACO/Principal Recipient (PR) provide adequate capacity-building support to SACS/Sub-Recipient (SR) partners so that the staff at the SACS/SR level are technically capacitated to analyse and use the data for decision-making.
- SACS/SR in turn build the capacity of NGO/CBO/SSR for all thematic components of CSC Implementation including performance monitoring and data for action. Similarly, a dashboard has been developed which will provide real-time achievement for each indicator and against targets at the CSC level with disaggregation at individual ORW/CLH level.
- The regular monitoring of programmatic performance is done through a core performance framework and other programme indicators.
- Service Delivery provision to eligible PLHIV as per the CSC mandate, review of existing gaps at multiple levels and documentation of steps taken to address those gaps would be a critical activity for all stakeholders.

Note: Refer to Table 4 for more details on Priority PLHIV for follow up with definite Outcomes.

Table 7. Actions to be taken by CSC and ART Centre on tracking outcomes

Tracking outcome	Action to be taken at CSC before providing outcome	Action to be taken by ART Centre after receiving outcome	Conclusive outcome
1) Opted Out	Ensure all efforts are made and sufficient evidence is available in alignment with the definition of opted out. ORW/CLH should inform the Project coordinator (PC) of the CSC. The PC should try to counsel the patient and try to resolve the reason for not wanting to continue ARTC under the national program. If the patient is still not willing, the CSC staff provides this information to the ARTC Counsellor. The outcome of such patients would be submitted as "Opted Out" in the mobile application, provided the patient gives in writing in the prescribed format (placed at Annexure 3) and upload the same in the mobile application. The digital image of the signed "opted out form" should be uploaded on the mobile application, as evidence of the attempts made to resolve the issues expressed by the patient. Patients taking treatment from private or taking alternate medicines shall also be considered as "Opted Out"	Once information on these patients is received by ART centre, counsellor and medical officer will reach out to the patient through phone call and counsel them to continue ART services. If not reachable by the ARTC staff, another visit through ORW/CLH/ should be attempted. Once this outcome is received by the ARTC, Data Manager will validate this information and ensure updation in other ARTC records. The completed and signed OPTED out form should be attached with the white card. Note: Atleast 3 documented attempts by CSC/ART centre to contact the patient and resolve the reason for not continuing ART services under national programme.	Opted Out (even after adequate counselling and three documented contacts through home visits/phone calls, at least one of which is by the ARTC Counsellor/MO)

Tracking outcome	Action to be taken at CSC before providing outcome	Action to be taken by ART Centre after receiving outcome	Conclusive outcome
2) Taking ART from private sector/ Taking alternate medicine	Ensure all efforts were taken in alignment with definition of opted out. Try to get the name of private provider/hospital any document of alternate medicine, if PLHIV is willing to disclose this information. The source of information can be verbal /written. If available, a copy of the prescription/patient records can be collected and uploaded on the mobile application.	Once this outcome is received at the ARTC, SOCH and other records of the PLHIV will be updated accordingly.	Opted out (even after adequate counselling and three documented contacts through home visits/phone calls, at least one of which is by the ARTC Counsellor/MO)
3) Reported Death	Ensure valid document is available in alignment with the definition of Death. Confirm that a digital copy of the valid document is uploaded on the mobile application when submitting Reported death as an outcome	The ARTC staff will undertake the death analysis for all reported deaths of PLHIV, as per NACO guidance, to arrive at a probable cause of death.	Death of PLHIV
4) Started ART at other NACO ART Centre	• Get ART number and a copy of the first page of the Current Green book and name of ART Centre where PLHIV is taking medicine. • Ensure upload of a digital copy of the first page of the current Green book issued by the ARTC before submitting the outcome as "Started ART at other NACO ART Centre." • For PLHIV who were diagnosed at ICTC and did not go to the ARTC to which they were referred, the recipient ARTC details will be uploaded on the mobile app by ORW/CLH	• Ensure recipient ART Centre accepts the patient as "transfer in" on SOCH, as per NACO guidance. Once the recipient ARTC accepts the patient as Transferred-in on SOCH, status in SOCH at parent ARTC will be auto updated to "Transferred out" accepted. • The ICTC will validate the information received on ART initiation and update the SOCH at its end, in coordination with the recipient ARTC.	Started ART/on-ART at a NACO ART centre
5) Migrated	Ensure state, district and city name are available before marking PLHIV as migrated. Updated phone number and complete postal address are desirable.	If latest address and contact details are provided, same should be updated in ART Centre records. ART Centre will then share the details of client with relevant SACS/ARTC for interstate/inter district tracking	The final outcome will depend on efforts taken for interstate/ inter district tracking
6) Untraceable (Incomplete/ Incorrect Address)	This outcome should be submitted only after the ORW/CLH has made two attempts at telephonic contact and one home visit (if telephonic contacts could not be made.) within one month of receiving the contact details. If the house is locked, then two more visits to be made at different times. CSC should get the correct address (verify with ART centre, ICTC, CSC records), check Aadhar number, or any other source for the correct current address, without disclosing the status of PLHIV	Take/recommend appropriate action, follow up in subsequent months. All efforts to be taken to retrieve PLHIV. Cross-verification of ART and CSC registration records during monthly ART-CSC Coordination meetings for possible alternative addresses. 10% of cases reported as having the wrong address need to be visited by the Project Manager/Project Director or Coordinator/Project Coordinator of CSC.	Untraceable

Tracking outcome	Action to be taken at CSC before providing outcome	Action to be taken by ART Centre after receiving outcome	Conclusive outcome
7) Not able to come	CSC staff will visit PLHIV and collect the information about reason for not being able to visit ART Centre. Document that reason and discuss with ART Centre for further action	ART Centre will examine reasons and provide appropriate guidance to bring PLHIV back. Continue efforts to re-engage PLHIV with ART Centre	The PLHIV will continue be in the current key priority list till the time definite outcome becomes available.
8) Brought Back	• If the phone number is available, the CSC team will try to contact the PLHIV over the phone. • If phone numbers are not available or not reachable, the ORW/CLH will make a home visit to motivate the PLHIV for a visit to the ARTC. • CSC will mark the definite outcome as brought back after confirming with the ART centre. • CSC will document the reasons for PLHIV being LFU. • Those PLHIV who remain LFU (Pre-ART & on ART) efforts will be taken every week till a definite tracking outcome is available for the PLHIV.	• Once this PLHIV visits the ART centre the Data Manager will validate this information and ensure status update in SOCH and other ARTC records. • ARTC staff will monitor PLHIV who have been brought back to care for a period of 3 months to ensure they are retained in treatment and tested for VL. • Facilitating Linkage of these PLHIV to social welfare schemes • Referral of eligible family member/spouse/ partner(s) for HIV testing.	Brought Back

Note:

- *CSC should confirm/ update the address and phone number during the home visits regardless of the outcome.*
- *Refer to the Glossary section for the definitions of the outcomes.*

3.1.7 Frequency of Performance monitoring of CSC:

1. **Monthly Performance review** by the MO-ARTC during the ARTC-CSC monthly review meeting
2. **Quarterly performance review** by SACS based on **Scorecard for CSC (Annexure 4)** and need based 'on-site' visits to the poorly performing CSC
3. **Six monthly review by NACO**, desk review of available program performance reports, Scorecards and visit reports submitted by SACS and planned 'on-site' visits to identified CSC

Performance reviews will be based on the key performance indicators (KPI), data quality, adherence to timelines and compliances.

Table 8. Key Performance Indicators (KPI) for Care & Support Centres

Sl. No	Key performance Indicators (KPI)
1	Out of ICTC-ARTC Linkage loss, Newly Diagnosed HIV cases linked to ARTC
2	Follow up of PLHIV Newly Initiated on ART (6-month retention and 1st VL test done)
3	PLHIV with CD4 cell count < 200 cell /mm3 followed up for 6 months/till CD4 count > 200 cells/mm3
4	Focused tracking of LFU cases (Pre-ART and on ART)
5	PLHIV with Viral load ≥1000 copies/ml (Unsuppressed viral load) underwent repeat VL testing
6	No. of PLHIV overdue for VL testing, brought back for VL testing
7	VL testing of PWLHIV between 32-36 week of gestation
8	PLHIV initiated on 3rd line ART Services (6 months on treatment adherence & VL testing at end of six month)
9	PLHIV with Co-morbidities (referrals completed and comorbidities controlled)
10	PWLHIV (Treatment adherence, routine VL-Testing & post-natal follow-up)
11	Follow-up of HEI for EID services
12	Index Testing (HIV screening of eligible spouse, sexual partners, biological children, etc)
13	Monthly ARTC-CSC coordination meeting conducted in the last 3 months (minutes shared with SACS)
14	CSC Mobile application usage (Login activities by CSC staff)

3.1.8 Recommendations based on Programmatic Performance Review:

The CSC will be graded based on their performance on the KPIs (Ref. Table 8), as per the scorecard developed for the CSC, once very quarter by the SACS/SR. Feedback will be given to the CSC based on the scores calculated every quarter and the findings of the six-monthly review led by NACO/PR. At the end of the year, the performance of all the four quarters and the six-monthly review will be considered to arrive at the recommendations for renewal.

Table 9. Recommendations based on Grading of CSC

Percentage Score.	Grade	Performance	Recommendation
>80%	A	Very Good	Recommended for Continuation for 12 months
61% to 80 %	B	Good	Recommended for Continuation for 12 months
41% to 60 %	C	Average	Recommended for continuation for 6 months
Below 40 %	D	Poor*	Recommended for External Evaluation

***Note:** From the time of identification of CSCs which are poor performing or problematic, SACS should ensure adequate support to the concerned CBO/NGO, need-based mentoring and guidance for three months. If the performance is not improved over two consecutive quarters, the issue should be put up in the SOC seeking its guidance

3.1.9 Data Quality Assurance:

Data Quality Assurance (DQA) will allow program managers and decision-makers to verify the quality of the reported data but also will provide periodic information on the underlying issues in data management and reporting systems for, at a minimum, program-level output indicators. DQA and supportive supervision —shall be conducted to assess the implementation of program activities and verify the quality, accuracy, and consistency of the reported data.

The On-Site Data Verification (OSDV)/Supportive Supervision will be conducted at the CSC/SSR, SACS/SR level.

Table 10. Proposed Plan for On-site data verification/DQA

Organization where the DQA / data verification takes place	Frequency	Carried out by	Documents to be reviewed
CSC/SSR level	Every month	CSC/SSR Project Coordinator	√ Programme records √ Reconciliation statement √ MPR √ All registers
CSC/SSR level	Once in every quarter	SACS/SR officers	√ Programme records √ Reconciliation statement √ MPR √ QPR √ All registers
CSC/SSR level	Any time within the project life cycle	NACO Representative/PR Technical Officer/ M&E officer	√ Programme records √ Reconciliation statement √ MPR & QPR √ All registers
SACS/SR level	Once in every quarter	NACO Representative/PR Technical Officer/ M&E officer	√ Programme records at the SR level √ Reconciliation statement √ MPR & QPR √ All registers
CSC/SSR level	Any time within the project life cycle	External Third party/NACO/ PR	√ Programme records √ Reconciliation statement √ MPR & QPR √ All registers

Organization where the DQA / data verification takes place	Frequency	Carried out by	Documents to be reviewed
SACS/SR level	Any time within the project life cycle	External Third party/NACO /PR	√ Programme records at the SR level √ Reconciliation statement √ MPR & QPR √ All registers

3.1.10 Review Mechanism:

The following review mechanisms will be adopted by each CSC:

Monthly review:

- A monthly review meeting will be conducted every month where all the CSC staff should be present to discuss monthly performance, challenges and feedback pertaining to priority indicators in their geography. Efforts should be made to address the challenges with focus on priority indicators.
- The ARTC-CSC coordination meeting should also be held monthly to understand the gaps in meeting the targets and validate the outcomes in coordination with the Data Manager and ART centre.

The following discussion/activities should be considered during review meeting:

- Number of PLHIV provided services for ART refill based on the local contexts and needs of the PLHIV.
- Number of PLHIV linked with social protection and welfare schemes.
- Number of PLHIV provided need-based counselling is provided by staff and documented in the mobile app/daily diary.
- Activities undertaken to reduce stigma & discrimination and increase in social acceptance.
- Discussion on the community perception and feedback on the CSC.
- Discussion on priority indicators for improving the programmatic performance (if required)

The key staff responsible for sharing information during the monthly meeting are:

Project Director of the CSC/Manager will be responsible for overall project performance, administrative and financial issues. The Project Director/Manager to ensure that performance on programmatic and financial activities are compiled and shared during the meeting. The Project Director/ Manager will ensure that the objectives of the meeting have been met and minutes are documented.

- The PC will analyse the data and identify the areas of poor performance/ achievement, prior to the meeting. PC/ Coordinator will be responsible for documenting programmatic barriers or field challenges, program gaps, and review meetings and follow-ups completed.
- Accountant will prepare financial status and SOEs,
- ORW/CLH should be responsible for the field-level performance, and challenges in the field with possible solutions and concerns

The Project Director/Manager is responsible for ensuring the quality of the review mechanisms adopted by the CSC:

- The review meeting dates should be fixed in a given month post-MPR submission which will give space for planning in conducting effective meetings.
- Project Manager should ensure that minutes of all review meetings are maintained and kept in safe custody.
- Action points emerging during the review meetings should be noted and Actions taken as per recommendations should be documented in the subsequent records.

3.2 External Evaluation of CSC established under Domestic Budget

All CSC established under SACS and funded through the domestic budget under the NACP shall be subject to an external evaluation prior to the completion of its **second year of contract period. The process of evaluation will be started by the concerned SACS, when the CSC has completed 18 months from the date of signing the contract with SACS.**

The evaluation shall constitute a third-party assessment and the key objective of the evaluation shall be to assess the quality and overall performance of CSC for taking a decision on renewal of the contract upon the conclusion of 24 months from the date of signing the contract with SACS.

This shall be contingent upon the recommendation of the external evaluation team and the final decision of the State Oversight Committee (SOC) of SACS. The findings of the external evaluation process shall determine whether a CSC is recommended for continuation, improvement, or discontinuation within the state.

Methodology for external evaluation: The evaluation process shall be led by SACS and it will be based on a set of pre-defined indicators/ list of indicators (Annexure 5). The evaluation will be conducted through document reviews, data validations, grading the performance of the CSC using the evaluation tool finalized by NACO, Key informant interviews and Focussed group discussions held with PLHIV, with their due consent, during the two-day field visit scheduled for that purpose.

3.2.1 Activities to be completed by SACS prior to field visits for evaluation:

1. Send a communication /letter to CSC well in advance to ensure all staff, all relevant documents both soft and hard copies are available for evaluation.
2. SACS will appoint one officer either from DAPCU/ DISHA unit, or one officers from CST division / any other division who will be coordinating the process during the entire period of CSC evaluation.
3. The appointed officer from SACS or DAPCU/ DISHA unit will not interfere in the evaluation processes and will ensure the logistics, support to the evaluators in conducting the evaluation smoothly.
4. The JD/DD/AD/ CST-In charge must share the copies of the following documents with the evaluation team:
   A. Project contract with SACS including the deliverables of the NGO/CBO
   B. Breakup of the Sanctioned Budget of the NGO/CBO for the current contract period.
   C. Monthly performance reports for the last 24 to 27 months as appropriate ..
   D. Monthly Indicators of CSC Reporting for last 24 to 27 months.
   E. List of updated project staff at the NGO/CBO level.
   F. Details of the funds released during the year.
   G. List of trainings conducted by SACS / ARTC.
   H. Share the last audit report by SACS and the compliance report submitted by NGO/CBO.
   I. Share all the relevant formats that are used for capturing any other data with respect to the State.
   J. Provide the information related to the innovations taken up by the State/CSC.
5 JD/DD/AD/ CST-Incharge shall organize a one-day orientation meeting of the evaluation team to explain about the process of evaluation and evaluation tool.

3.2.2 Activities to be conducted during the Field Visit:

Each CSC shall be evaluated on organisational capacity, financial management and programmatic delivery using the various tools and methodologies approved by NACO for this process, during the two-day scheduled field visits.

External Evaluation Team:

- Three external evaluators (Two subject experts and one finance person)

- Out of the two subject experts, one would lead the team to ensure smooth implementation of evaluation process and timely reporting to SACS.
- The external evaluators should be independent consultants and not to be associated directly or indirectly with any CSC project of the concerned State/NACO/development partners who are supporting the NACP.
- The Evaluators should be sensitive to the PLHIV and have a comprehensive understanding of their concern.
- One team should not be assigned to evaluate more than 5 CSC in a State.

√ Refer to ANNEXURE 6 for the detailed ToR of the External Evaluation Team

√ Refer to Annexure 7 for Process of Evaluation-Day-wise Breakdown

√ Refer Annexure 8 (A) for detailed Guidance on Ethics, FGD guide and Interviews. Further, refer Annexure 8 (B) for FGD Format and Annexure 8 (C) for Interview format

Evaluation Tool to be used during External Evaluation:

The evaluation tool is structured into three key components:

A. Organisational Capacity

B. Financial Management

C. Programmatic Delivery

The tool evaluates the three components, with results summarized in an evaluation matrix to ensure alignment with NACP objectives of enhancing retention, adherence, and quality of life for People Living with HIV (PLHIV).

√ Refer to ANNEXURE 9 for detailed explanation of the Evaluation tool and how to use it.

Table. 11 The CSC will be graded for their performance, based on the scores calculated as per the evaluation tool and the recommendations based on grading will be as follows:

Scoring	Grade	Performance	Recommendation
Below 40 %	D	Poor	Recommended for Discontinuation*
41% to 60 %	C	Average	Conditional Extension for six months with Mandatory Criteria to be fulfilled in a specified extension period.
61% to 80 %	B	Good	Recommended for Continuation for one year
>80%	A	Very Good	Recommended for Continuation for one year

**Note: CSC with scores less than 90% individually in either Organizational capacity or Financial Management assessment will also be recommended for Discontinuation.*

3.2.3 Reporting Formats for External Evaluation Reports:

The following evaluation reports are to be submitted after evaluating of the CSC by each Evaluation Team Leader to the SACS. The following table gives brief description of the reports to be submitted. SACS should provide the soft copy of the reporting formats & the evaluation tool to the evaluation team.

A soft copy of the Completed Evaluation tool should be mailed to SACS/SR along with these reporting formats.

Table 12. Reporting formats for External Evaluation reports

Name of Reporting Format	What the Report Contains
Reporting Format A (Annexure 10)	• The report contains the details of scoring done in each of the component for each CSC evaluated.
Reporting Format B (Annexure 11)	• The report contains qualitative information for each CSC evaluated. • The information is based on the observations made during the evaluation process.
Reporting Format C (Annexure 12)	• Contains executive summary of each CSC evaluated. • It contains critical observations made and recommendation suggested by the evaluation team

3.2.4 Activities to be completed by SACS after the field visits for Evaluation are completed

1. JD/DD/AD/ CST-In charge shall organize debriefing meeting at the end of evaluation process under the chairperson of the Project Director of SACS.
2. SACS has to share a copy of the evaluation report to the concerned CSC after finalizing the report.
3. SACS should ensure submission of the detailed report (both soft copy on the 3rd day of the evaluation and signed hard copy by the 7th day of completion for each CSC evaluation.
4. SACS should analyze each report and call out important action points for each CSC as well as summarize action points for State.
5. SACS should organize State level debriefing meetings for all NGOs/CBOs evaluated and the Evaluation Team Leaders would present their observations/ recommendations during this meeting. The date of debriefing to be intimated to NACO in advance.
6. Based on the recommendations of the External Evaluation teams and the final decision taken by the SOC and SACS:

   - The CSC may be continued, and the contract of the CSC will be renewed for One year
   - The CSC may be continued with conditional renewal of contract for six months with mandatory criteria to be fulfilled in the extension period.
   - The CSC may be discontinued with termination of Contract

   √ An interim plan/stop-gap arrangement is to be made to ensure uninterrupted service provision to the community until the process of on boarding of new CBO/NGO is completed.

   √ Smooth handing over process should be initiated once the decision of termination is taken.

3.2.5 Termination of Contract:

A. At the end of the contract period: The contract stands terminated on the last date of the contract duration.

B. During the period of contract:

- Contract can be terminated with mutual agreement by either party by giving a written communication with the notice period of three months.
- Contract may also be terminated by SACS as per the CSC Operational Guidelines in following situations:

  ✓ Financial misappropriation of funds

  ✓ Diversion of project funds

  ✓ If the organization is found to be black listed by the CAPART or any other government/donor agencies.

  ✓ Failure to adhere to terms and conditions of the grant award

  ✓ Repeated poor performance reports (At least two conditional six months' extension in the span of one year)

Note: Termination of Contract for Fund misappropriation/fraud/management issue:

- If there is proven fund misappropriation or fraud or any critical management issue, SACS needs to ensure the collection of evidence and an appropriate decision should be taken to protect the fund and assets. The whole incidences and process should be well documented.
- Documentation must be from the very first day of critical observation being made followed by the documentation of measures taken up by SACS to address the identified gaps, and timely communication to key stakeholders till the final decision is arrived at.
- Systematic documentation of the termination process is the most crucial point. A hard & soft copy of the document must be maintained by SACS and NACO should be kept in the communication loop.
- **Checklist to be completed by each SACS:** Answers to each of the following question should be documented by the SACS and maintained in its records for future reference, as and when needed:

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 SACS do to address the issue? What steps were taken by SACS 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 SACS brought to the notice of NACO on time through written communication?
6. Do SACS have concrete documentary evidence for termination of CBO/NGO?
7. If all stakeholders concerned are informed and part of the process in a transparent manner?
8. Has the decision taken through SOC?
9. What is the stop-gap arrangement to ensure services to the PLHIV community is continued?
10. Has the process been clearly documented in sequence wise starting from the identification of issues till the decision is derived?

HUMAN RESOURCE AND INFRASTRUCTURE

CHAPTER - 4

4.1 Human Resource

The day-to-day functioning of the CSC shall be supported by a team comprising of the CSC Coordinator/Project Coordinator, Accountant cum M&E and ORW/CLH. To enhance community participation and ownership, preference to the PLHIV community may be given, while recruiting the staff. No more than two members from the board of the organisation (NGO/CBO) implementing the CSC can be employed in the project.

The Project Director/Project Manager of CSC will provide overall strategic leadership and coordination with key government departments/SACS/NACO/SR/PR.

Close relatives of the board members cannot be employed in the CSC. ORW/CLH should preferably be from the PLHIV community. It is preferred to identify at least one ORW/CLH from the Key Population (KP) groups prominent in the catchment area of CSC to understand and address their special needs better and provide services accordingly.

4.1.1 Staff Selection Process:

CSC should advertise the vacancies at least for 15 days in their office, SACS, ART centres, Link ART Centres and offices of other HIV programme implementing partners. For each position, a minimum of three candidates should to be interviewed. The interview panel should consist of:

- **Project Director / Project Manager of CSC**
- **Medical Officer of ARTC**
- **Representatives from SACS/DAPCU /DISHA UNIT**
- **Representative from SR (If applicable)**

Under the evidential circumstances of not getting candidates as per the eligibility criteria, the panel can decide on relaxing the educational qualification and experience required for the positions. The criteria for selection are relaxed for members from the PLHIV community and key population groups from level of master's degree to the level of graduate 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. A copy of this contract should be maintained at the CSC and by the concerned staff. Staff appraisals should be conducted by the supervisors and approved by the Project Director/Project Manager before annual renewal of contract **(Formats for Staff appraisal are placed at Annexure 13)**

Table 13. Designation and number of human resources at CSC

Staff name	Number	Essential qualification and experience	Key Responsibilities
1) Project Director/ Project Manager -Part time (Honorary position)	ONE (One Project Director / Project Manager is allocated for each CSC)	Experience of managing projects / teams and advocacy with Government stakeholders.	The objective of the Position: Lead strategic planning for CSC, coordinating with government departments and stakeholders to enhance project visibility. Ensure alignment with organizational goals, monitor expenditure, recruitment, foster a positive working environment and take on additional responsibilities for the programme advancement. Key Responsibilities of Project Director/Project Manager: √ Oversee and contribute to strategic planning, execution, monitoring, and finance management of CSC. √ Coordinate with government departments, partners, and stakeholders for smooth implementation, representing CSC in meetings to enhance visibility and impact. √ Support the team in executing local-level advocacy initiatives. √ Ensure alignment of programme activities with the organization's strategic goals. √ Monitor and evaluate the financial aspects of CSC, ensuring prudent fiscal management. √ Foster a positive and collaborative working environment within CSC √ Ensure the staff appraisals before annual renewal of contracts √ Undertake any other Project related tasks assigned by the SR /SACS.
2) CSC Coordinator/ Project Coordinator.	ONE (number of CSC Coordinators may be modified based on model of CSC being implemented, subject to approval by NACO/PR)	Postgraduate with two years or graduate with more than three years of experience in HIV programmes; computer literacy and financial and data management experience are also required	The objective of the Position: The Coordinator/Project Coordinator will be responsible for implementation of the programme under the direct supervision of Project Manager/Project Director of their Organization and the overall guidance of CST lead in the SACS, overseeing capacity building, and ensuring compliance with CSC guidelines and NACP requirements. Key Responsibilities: √ Establish and maintain linkages with the ART centre, ICTC, NTEP, NP-NCD, DSRC, TI and other service providers in the district/region. √ Develop and support the implementation of the weekly and monthly work plan of CSC. √ Support all staff to develop their weekly and monthly work-plan based on programme priorities. √ Distribute the operational areas and PLHIV among the ORW/CLH to ensure optimal outreach services. √ Ensure availability of IEC materials and condoms for distribution at the CSC √ Undertake occasional field visits with or without the ORW/CLH to observe the activities in the field and provide hand-holding/mentoring support. √ Oversee all the M&E activities of the project. Validate all the outcome reported on the CSC mobile app by the ORW/CLH. (at least 5% of untraceable and 5% of opted out cases should be validated by PC through home / field visit for which documentation should be maintained). √ Ensure timely submission of monthly and quarterly reports to SACS/SR.

Staff name	Number	Essential qualification and experience	Key Responsibilities
			√ 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. √ Ensure action taken report is shared with SACS/NACO/SR/PR within a month. for the action points recommended during their supervisory visits √ Lead advocacy, networking and local resource mobilization activities of the CSC. √ In coordination with the accountant, ensure that the financial transactions and expenditure patterns are in accordance with the approved budget. √ Facilitate visits from NACO, SACS, SR, PR and other stakeholders. √ Identify the capacity building needs of CSC staff and arrange in-house training in coordination with ARTC/SACS/NACO/SR/PR √ Function as the focal-point for ART-CSC Coordination √ Coordinate all the data sharing activities between the ART centre and CSC √ After receiving the line list from ART centre and ICTC validate the information received to check for duplications and errors √ Allocate the PLHIV tracking assignment to ORW/CLH based on the PLHIV location and ORW/CLH allocation √ Collect evidence for each case tracked and validate the same before submitting the trackback information to the ART centre √ Ensure outcome of PLHIV tracking submitted by the ORW/CLH is validated before submitting the data in the CSC mobile app. √ Ensure updates on LFU cases tracking details are updated in the mobile app. on a regular basis √ Maintain ART-CSC Coordination meeting related documents including meeting minutes duly signed by the Nodal Officer/SMO/MO of the ART centre and PM of the CSC √ Participate in DAPCU/DISHA and ART coordination meetings to share CSC activities and priorities √ Collaborate with Accounts cum M&E officer, and ORW/CLH to implement and monitor the project effectively. √ Completer performance appraisal for all ORW/CLH before annual contract renewal √ Undertake any other Project related tasks assigned by the Project Director/Project Manager of CSC

Staff name	Number	Essential qualification and experience	Key Responsibilities
3) Accountant/ Accountant cum M&E / Monitoring, Evaluation & Finance Officer (MEFO)- Part time position	ONE (number may be modified based on model of CSC being implemented, subject to approval by NACO/PR)	Graduate with working knowledge of accounting software, especially Tally. M&E. Experience is also required	The objective of the Position: The accountant cum M&E will work closely with the Coordinator/Project Coordinator to ensure smooth conduct of financial/M&E related matters. Key Responsibilities: √ Book-keeping: Recording of expenditure with proper supporting documents √ Bank reconciliation on a monthly basis √ Maintaining inventory of supplies/consumables and other materials √ Maintaining and updating fixed assets and stock registers √ Disbursing salary and making payments to vendors/suppliers in a timely manner through the digital portal. √ Maintaining attendance register and leave records √ Preparing appointment letters for staff in consultation with Project Manager & maintaining a copy of the same at the CSC. √ Collection, validation and disbursement of travel reimbursements in consultation with Project Manager √ Maintain HR related files and records, including filled and approval appraisal formats. √ Maintaining indent file, requisition slips, order file, quotation file, challan, cash book, ledger book, voucher file, rent and service charges file, office operating cost file, communication (telephone/T.A.), bank transactions, and recording the daily cash flow chart. √ Represent the organization at meetings, conferences & workshops on financial matters √ Preparation of financial reports like Statement of Expenditure (SoE) and Utilization Certificate (UC) √ Coordinating with finance staff from SACS/SR for periodic financial review/audits and documenting the actions taken on the recommendations of the review/audit team. √ Submission of monthly and quarterly financial reports √ Providing required support in organizing meetings and other CSC activities √ Collaborate closely with the CSC Coordinator/Project Coordinator and other staff members of the CSC for timely submission of programme reports/ data, UC and SoE. . √ Take up any other work assigned by the CSC Coordinator/Project Coordinator.

Note: Peer Counsellor position has been discontinued at CSC and an extra ORW may be hired instead, based on the need of the CSC.
Further, all part time position specified will devote 20 -24 hours per week.

Staff name	Number	Essential qualification and experience	Key Responsibilities
4) ORW/CLH	FIVE/SIX per CSC (Based on outreach activities to be conducted by the CSC)	8th pass with the basic understanding of CST programme for PLHIV. The candidate should preferably be from the PLHIV community	The objective of the Position: The staff functions as the link between the CSC and the community. Facilitate the linkage of PLHIV to treatment services, particularly those who are listed as priority populations for the CSC program. Conduct follow-up of diverse groups to ensure the provision of comprehensive care. Monitor treatment progress closely and undertake initiatives to promote adherence, retention, and access to social entitlements/welfare schemes. They are responsible for conducting 15-20 home visits per month. A minimum of five ORW/CLH per CSC is recommended although the number can vary depending on the number of priority populations covered by the CSC. Key Responsibilities: ✓ Visit ART centre, in rotation, to support ART counsellors by providing peer counselling to PLHIV newly initiated on ART to help them understand the benefits of treatment, address misconceptions and equip them with information & coping skills to manage possible side effects of ART ✓ Give information regarding the services of CSC at the ART centre and motivate the newly registered PLHIV to avail care and support services ✓ Support PLHIV in completing all baseline investigations and other tests from the hospital at the time of ART initiation. Support ART refill in case the CSC is engaged in community-based ART dispensing ✓ Facilitate support group meetings at CSC, ART centre or other convenient sites. ✓ Provide peer counselling on treatment adherence, positive living and related topics during their visit to CSC ✓ Organize community events with help of PC (e.g, health camps, fairs, festivals) ✓ Organize and participate in advocacy activities, including rapport building with different stakeholders. ✓ Facilitate linkage of PLHIV diagnosed HIV positive at the ICTC- to the nearest ART Centre for ensuring rapid initiation of ART. ✓ Ensure systematic tracking of LFU cases and facilitate their link back to treatment. ✓ Provide support to the ARTC to verify the address of the PLHIV newly initiated on ART. ✓ Conduct proactive follow-up of PWLHIV to ensure treatment adherence, linkage to periodic ANC check-up, VL test during 32-36 weeks of pregnancy, institutional delivery, and post-natal care towards elimination of Vertical Transmission of HIV. After due consent from the PWLHIV, link them to ASHA / ANM and NHM facilities for ANC/PNC related care, ensuring confidentiality of the HIV status. ✓ Follow-up of HIV exposed infants (HEI), ensuring life-saving ARV prophylaxis drugs, and adhering to the EID test schedule for up to 18 months of age or 3 months after cessation of breastfeeding, whichever is later. ✓ Conduct follow-up of sero-discordant couples and follow up of PLHIV who are overdue for VL testing. ✓ Engage in follow-up with PLHIV to enhance treatment adherence and retention in HIV care. ✓ Facilitate form filling for social entitlements, collect them from households, and hand them to the CSC Coordinator/Project Coordinator ✓ Further, undertake any other project-related tasks assigned by the CSC Coordinator/Project Coordinator.

4.2 Capacity Building

Capacity building is an important component of the programme to strengthen the quality of services provided by CSC. A comprehensive capacity building plan for the staff of CSC should focus on enhancing skills, improving knowledge, and fostering team collaboration.

Training will enhance staff competency in treatment protocols, person- centric care for priority population, patient counselling, and data management, enabling timely interventions and personalized care. Additionally, training fosters better coordination with other health services, ensuring a holistic approach to care. Training needs to be provided on organizational development, program management, monitoring and evaluation and grant management. Capacity building of the ART staff will be undertaken for implementation of care and support activities in close coordination with CSC. At least one training/sensitization session should be conducted annually on gender, inclusion, and working with marginalized groups (e.g., PLHIV, key populations).

A needs assessment is essential for developing an effective capacity-building plan for CSC staff. SACS/SR needs to conduct regular needs assessments.

4.2.1 Types of training

Table 14. Details of the training Plan

Training Type	Description	Responsibility	Frequency
1) Induction Training	For new staff joining the CSC, focusing on role orientation and operational procedures. Training materials should be provided in the local language. Training in financial management to be provided to the project coordinator and the part time Accountant cum M&E/MEFO	Project Director/Project Manager and CSC Coordinator SACS/SR Team provides materials (preferable in local language) and supports training.	To be completed within one month of joining
2) Refresher Training	Periodic refresher courses to update staff on changes in HIV treatment guidelines, data management protocols, and new health strategies. Focus on reinforcing existing skills.	SACS/SR Team and CSC Coordinator identify training gaps. Resource persons and external experts may be invited.	Every 6 months (or as needed based on emerging needs or changes in protocols)
3) Re-orientation	Training based on identified common issues from SACS/SR visits and review meetings. Re-orientation on thematic areas for all CSC staff.	SACS/SR Team coordinates re-orientation sessions during review meetings or SOC meetings.	As needed based on identified needs
4) On-the-job Training/ Mentoring	Training/Mentoring during supportive supervision visits and daily interactions to identify and address staff needs. Includes half-day orientation sessions before concluding the visits based on identified needs.	SACS/SR team identifies needs and delivers training/mentors during visits. Project Coordinator provides hands-on training/mentoring.	Ongoing; during/after supportive supervision visits.
5) Need-based Training	In-house training for staff based on specific requirements, involving resource persons such as SACS/SR/ART medical officers, DTO/DNO and ARTC/ICTC counsellors.	CSC Coordinator organizes need-based training at the local CSC level.	As required; based on specific staff needs

4.3 Location and Infrastructure for CSC

Location of CSC The NACP envisages that all PLHIV should be provided the care and support services needed by them. For this purpose, all ART centres in the country will be linked to at least one CSC. The selection of a district for establishing CSC will be done through a consultative process involving NACO/SACS. In districts not having a CSC, PLHIV will be provided services by ORW/CLH, preferably hired from that district, attached to the CSC in the nearby districts.

Many CSC will be linked to more than one ART center. The location of the CSC can be decided based on the discussion with ARTC and SACS, depending on the local context and needs of the PLHIV. CSC should be easily accessible to the PLHIV and well connected by public transport.

Infrastructure Required at CSC

CSC needs to be set up in a leased-out or rented space, preferably, 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.

Furniture Provisions for CSC

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

Project Office Area

- This area needs to be devoted to 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, and records for conducting team/review meetings.
- This area should have sufficient space with enough provisions for people to wait. A visitors' register should be maintained at the CSC for all visiting PLHIV to provide their feedback and suggestions.
- There should be space for conducting SGM and for people to rest.
- A 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 at the CSC.
- A section of the room can be used for counselling with complete audio-visual privacy and provision for storing confidential records. A condom demonstration kit, IEC materials and posters on nutrition and positive living, referral forms, and job aids should be available in the CSC.

4.4 Information to be displayed at the CSC

- The information displayed should ideally be in the local language and pictorial form as much as possible
- Confidentiality statement and PLHIV' rights and responsibilities
- All services of CSC, including days and timings for important activities
- Staff designation and contact details, including emergency contacts
- Address and contact details of nearest ART centre
- List of Link ART Centres (LAC) attached to the ART centre
- Contact details of Discrimination Response Team (DRT) members
- Do's and Don'ts of ART
- Health awareness messages about HIV, STI/RTI, TB, Hepatitis, & other comorbidities
- Contact detail of the Ombudsmen and grievance redressal committee members
- 1097 helpline number and other social services information.
- Community advisory board details and Helpline number for mental health services – 14416 (TeleMANAS)
- List of Social welfare schemes

FINANCIAL MANAGEMENT

CHAPTER - 5

Implementation of standardized and efficient financial processes are to be ensured by the CSC staff. These include the preparation of vouchers, maintenance of accounts, and generation of accurate financial statements that meet stakeholder requirements. The ultimate aim is to enhance transparency, accountability, and integrity in financial management. Additionally, CSC should ensure timely financial reporting, comprehensive record-keeping, and sound accounting practices to strengthen governance and trust in the CSC' operations.

5.1 Assignment limit allocated for CSC implementation:

Each CSC is provided with specific financial allocations to support its operations. These funds are to be utilized strictly in accordance with prescribed guidelines issued by the NACO/SACS. Each CSC seeking Grants-in-aid should also certify that it has not obtained or applied for grants for the same purpose or activity from any other Ministry or Department of the Government of India or State Government.

5.2 Guidelines for Expenditure:

Recurring Grant is defined as one which is released periodically to the same organization for the same purpose. Nonrecurring Grant is one time release to an organization for a special purpose (which could be released in instalments). Every order sanctioning a Grant shall indicate whether it is recurring or non-recurring and specify clearly the objective for which it is being given and the general and special conditions, if any, attached to the Grant. In the case of non-recurring Grants for specified object, the order shall also specify the time limit within which the Grant or each instalment of it, is to be spent.

CSC would incur expenditure as per norms given hereunder:

- Contingency and operational cost per year (telephone, internet broadband, stationery, printer cartridge, postal charge, local travel etc.)
- Non-recurring one-time grant (computer & accessories, TV, furniture, almirah, storage racks etc.)
- Non-recurring one-time grant for refurbishment of the centre
- Annual recurring grant for standard precautions (universal work precautions)
- The salary of staff will start at the base of the salary range and for CSC supported under the domestic budget, salary shall be paid as per the latest NACO office memorandum regarding the remuneration pattern for CSC.
- The operational costs and funds for contingency and standard precautions (universal work precautions) shall be sent by SACS to the CSC. The guidelines for expenditure are subject to change from time to time. The SACS/CSC should follow the latest instructions from NACO in this regard.
- The instruction of Department of Expenditure regarding the use of PFMS portal for central sector schemes, issued from time to time, shall be strictly followed.

5.3 Key Components of Financial Management

5.3.1 Vouchers Preparation:

A voucher is documentary evidence in support of a transaction.

- All financial transactions must be supported by properly prepared vouchers.
- Each voucher must include a detailed description of the transaction, the purpose, the payee's name, date, amount, and attached supporting documents (invoices, receipts, approvals).
- Vouchers should be serially numbered and approved by designated authorities before payment.

5.3.2 Accounting and Book-keeping

Funds required for running a CSC are provided and are to be utilized as per the guidelines described below.

- **General Accounting System:** The Accounting records shall be maintained in accounting software as per NACO Guideline. It shall follow the double-entry accounting system.
- **Audit of accounts:** SACS will get the accounts of each CSC audited, at least once in a financial year. Statement of expenditure and utilization certificate of each CSC, in the prescribed format for the preceding financial year, should be submitted to SACS. Further release of grants would be subject to submission of these documents.

5.3.3 Accounting and Book-keeping

- All receipts (funds received) and expenditures (funds spent) must be recorded promptly and accurately in designated registers and/or accounting software.
- Each entry should reflect the date, source or purpose of the transaction, amount, mode of transaction, and relevant supporting documents.
- Receipts should be acknowledged while expenditures should be matched with approved vouchers and bills.

5.4 Month and year-end closure accounting process

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

5.4.1 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.

5.4.2 Year-end

Balance sheet, receipts and payment statement, income and expenditure statement along with utilisation certificate in the prescribed format must be certified by an independent audit firm. The fixed assets should be physically verified at the end of the financial year.

5.5 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, Income etc. wherever applicable.

GOVERNANCE AND STAKEHOLDER COORDINATION

CHAPTER - 6

6.1 Selection of CBO/NGO for implementing Care and Support Centres

This guidance is for the selection of CBO/NGO to implement CSC in their respective states and districts. The districts which do not have CSC will be covered through the ORW/CLH hired from that district by the CSC in the nearby districts. The selection process detailed in these guidelines will be followed for establishing the CSC, irrespective of the number of CSC to be established in a State.

Preference will be given to CBO/DLN/NGO having proven experience in the field of HIV/ AIDS, especially in the areas of care and support. The primary objective of involving potential NGOs, CBOs, and other organizations is to ensure their participation and contribution to NACP through a systematic and transparent process. This approach helps build a strong partnership framework, enhances the effectiveness of HIV/AIDS prevention and treatment initiatives, and ensures that the efforts align with the program's strategic goals. By involving diverse stakeholders through fair and transparent selection procedures, the program can leverage their expertise, foster community trust, and improve service delivery to target populations.

6.1.1 Eligibility criteria for an NGO/CBO to establish a CSC:

A) NGO: The agency should be a non-profit organization and legally registered under any one of the following:

- 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 8 under Companies Act of 2013 (or Section 25 C Company Act 1956)

B) CBO: An organization/society constituted by the Community members (PLHIV/FSW/MSM/TG/IDU) and legally registered (i.e. under Society Registration Act of 1860 or Charitable and Religion Act or The Indian Trust Act) and managed by the Community members for Communities' development and wellbeing. At least 70% of members of Governing board/Management Board/Executive Board/ Office bearers belong to the community and are elected by the democratic process as per Bylaws/ Memorandum of Association (MoA) can be considered as CBO[3].

The NGO/CBO should have:

- A clearly defined organizational structure.
- The agency should also have all statutory requirements 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)[3].
- 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 care and support, will have due weightage.
- The organization should have been working for a minimum of three years in case of NGOs and one year in the case of CBOs, preferably, 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.
- Registered on the Darpan portal of NITI Aayog and should have the registration number of the portal

[3]https://naco.gov.in/sites/default/files/Revisied_Guidelines.pdf

Table 15. Selection process for NGO/CBO for setting up CSC

Steps	Activities	Timeline / Days
Step: -1	Open advertisement-Expression of Interest/Request for Proposal (EOI)/(RfP)	21 Days/
Step: -2	Technical Advisory Committee (TAC)/SR will conduct desk review/ appraisal based on the documents submitted by the NGOs/CBOs to finalize the list for field appraisal.	14 Days
Step: -3	Field appraisal by Joint Appraisal Team (JAT) team and any other members nominated by PD-SACS/ APD-SACS. Report will be submitted to Technical Advisory Committee (TAC)/SR	30 Days
Step: -4	TAC/SR to finalize the list of CBOs/NGOs based on the filed appraisal reports/marks for approval of PD, SACS.	14 Days
Step: -5	PD, SACS will endorse and take the approval of competent authority on file.	15 Days
Step: -6	After approval, offer letter & award letter to be issued to the selected CBOs/NGOs. Rejected applications intimated by SACS/SR to the applicant organizations	7 Days
Step: -7	Capacity Building of Project Partners/ CBOs/NGOs	30 Days after Contracting
Step: -8	Monitoring of Project Partners, Evaluation	Regular
Step: -9	Renewal or Termination of Project Partners / CBOs/NGOs	First time contracting should be for one years; Renewal after one year based on quarterly performance grading by SACS and 6 monthly review by NACO. First comprehensive external evaluation before completing two years of CSC implementation-for renewal after completion of second year

Step 1: Open Advertisement EoI/RfP:

An EoI/RfP will be advertised in the local newspapers (minimum three), which have a maximum circulation in the region and the websites of SACS/PR/SR. The EoI/RfP should ideally be advertised for 21 days. Information on the EoI/RfP will be widely promoted through the existing NGO/CBO networks in the state/region and stakeholders will be encouraged to disseminate the EoI/RfP widely. The timeline for submitting a duly filled application by hard copy will be within 21 days of the advertisement of EoI/RfP.

Step 2: Desk Review of proposals Received: There are two modalities of desk review of the proposals received:

A) Technical Advisory committee (TAC) is constituted by SACS to carry out a desk review of all applications received and shortlist a minimum of three applicants per CSC to be selected

TAC Constitution: TAC for CSC services is formed under the Chairmanship of Addl. Project Director (APD), SACS. In case the post of APD is vacant, the officer nominated by the Project Director, SACS may chair the meeting.

Following are the other suggested members;

- In charge -CST (Convener)
- In Charge-Finance
- In Charge – Procurement**
- Regional Coordinator-NACO
- One NGO/CBO representative from the Executive Committee (EC)***
- One representative from the community****

Note:

**In the absence of a Procurement Officer of SACS, Programme personnel from any division of SACS. ()

***Conflict of Interest: Community members and NGO representatives are to provide a written undertaking to SACS, indicating that they are not part of any NGOs/CBOs currently or in the last here (3) years which may create a conflict of interest during the desk review and field appraisal of applications/EOIs.

****Minimum two community members, however, Project Director SACS has the discretion to increase the Community Members as per need/requirement, but not exceeding a total of THREE community representatives.

Key task of Technical Advisory Committee:

- Desk Review of proposals receive.
- Shortlist the organisations eligible for a field appraisal by JAT.
- Formation of Joint Appraisal Team
- Review of JAT Visit Reports
- Shortlisting of selected organizations based on defined criteria, for recommendation
- Submit the JAT report along with recommendation to PD SACS for approval.

B) The concerned SR team reviews the proposals and shares all eligible ones with the PR. The PR team then reviews the proposals received and shortlist the organizations for appraisal by the JAT.

Essential criteria for short-listing during the screening of applications:

All applications received will be screened by the Technical Advisory Committee (of SACS)/SR as per the criteria given below and the process should be completed within 14 days.

TAC/SR will screen each proposal majorly on:

- Organizational strength
- Financial strength
- Experience in a similar field (Especially in running CSC/HIV/AIDS prevention, testing and treatment programmes).

The TAC should assess if the NGO/CBO is a legally registered organisation by verifying if they are registered under any of the following:

A. NGOs/CBOs who are legally registered in India under any one of the following

- Societies Registration Act of 1860 or
- Charitable and Religious Trust Act, 1920 or
- The Indian Trust Act, 1920 or
- State specific Societies/Trust Registration Act

B. In case of NGOs, Minimum requirement is three years of registration as on due date of submission of EOI. In case of CBOs, Minimum requirement is one year of registration as on due date of submission of EOI. The CBO board members should be from respective community and should have been constituted as per the bye law of the relevant Act.

C. Agencies already having experience in social development sector with experience of working in similar projects as required in the scope of work i.e. experience of working with marginalized communities (HRGs, vulnerable groups such as women, elderly, children, sexual minorities, PLHIV, persons with different abilities), with field level operations (i.e. field offices and staffs) in the same geographical area.

D. Agencies are required to submit an affidavit indicating that they have never been blacklisted/ debarred by any agency (both government, private and World Bank/UN bodies).

E. In case the agency has been blacklisted/debarred in the past, the details of such blacklisting/ debarment should be provided in the Affidavit. The affidavit should also indicate that no staff or board member is part of any SACS/TSU staff currently (or in the past which may create a conflict of interest).

F. The annual report and audited account statement for 3 years in case of NGOs and of one year in case of CBOs.

G. The agencies with experience in Health and HIV sector especially with PLHIV would be preferred. The agencies should submit the details of the project/s implemented and presently implementing (name of the donor agency, nature of projects, project period, contract value, continuing/ completed).

H. Agencies should submit the details of projects supported by any SACS/DACS (name of the SACS/DACS, nature of projects, project period) continuing / completed/ terminated with any SACS in the country. If terminated reason for termination).

I. NGO/CBO should be registered on Darpan portal of NITI Aayog and registered number is to be mentioned in the application form.

Table 16. Preliminary Screening/Desk Appraisal of Applications: (Essential & Non-Negotiable criteria).

S.No	Essential Criteria (Non-negotiable)	Yes/ No	Remarks
1	Copy of the Society Registration Certificate / Trust Deed furnished (Latest certificate of registration, if the State has the policy of timely registration renewal)		
2	Copy of Memorandum of Association and Article of Association furnished.		
3	Copy of Audited Statement attached For NGOs – 3 years For CBOs – At least 1 year		
4	Activity Report/Annual Reports furnished. For NGOs – 3 years For CBOs – At least 1 year		
5	Credibility Check: Whether the organization has been blacklisted by a government agency or withdrawn by a donor in the last three years • If yes copies of the Affidavit need to be provided • Self-declaration /Affidavit should be submitted by the organization mentioning the organization is not blacklisted by the CAPART or any other government/donor agencies. • On the contrary to the above, if any organization is found to be blacklisted by any of the above agencies, awarded project will be terminated immediately.		
6	Income Tax Return document For NGOs-3 years For CBOs- At least 1 year		
7	Copy of the PAN Card/TAN/GSTIN		
8	Certified List of Board/Governing Body members with Contact details and occupation		
9	Copy of registration certificate/number of NITI Aayog-Darpan portal		
10	Identification document of Authorized signatory submitting EoI (Govt. photo ID with address)		
11	Minimum Financial Turnover For NGOs-10 lakhs/ Annum For CBOs- 1 Lakh/Annum		
If any of the above criteria is not fulfilled, the proposal will not be shortlisted.			

Table 17. Preliminary Screening/Desk Appraisal of Applications: (Negotiable Criteria)

S.No	Particular	NGOs	Less Than 3 Years CBOs
1	Copy of valid registration/certificate under section 12A or 80G of Income Tax Act/ Valid Tax exemption certificate	•	X
2	Organogram reflecting staff of similar nature/scope of work projects in last three financial years.	•	X
3	Experience of: A. HIV/AIDS Project experience in carrying out Targeted Interventions/Link Worker Schemes with Core/ Vulnerable groups, Community Care Centres, Community Support Centre, and Drop-In Centres (DIC) for PLHIV or any other activities as per guidance of NACO/SACS in last three financial year.	•	X
	B. Managing other health projects such as RCH, Sexual health projects, TB, and Family planning in the last three financial years.	•	X
	C. Managing community development projects in the last three financial years. (Health, Education, Skill Development, Rural Development, SHGs formation, etc.)	•	•
4	Experience in forming/establishing community-based networks	•	
5	Document showing any member of the target community in the advisory committee of the NGO/For CBO any professional in the advisory committee.	•	•
6	NGO/CBO have any document explaining their experience of involving different Stakeholders in their work? such as • Civil Society Organizations • Government Departments • Private Sector • Faith-Based Organizations (FBO) Cooperatives	•	•
7	NGO/CBO being a part of any consortium/network	•	•
8	NGO/CBO involved in any committees formed by SACS/government departments		•

Note: In continuance to the effort of NACO, to promote CBOs to implement the programme, an attempt has been made to relax the essential and desirable criteria. This will enable CBOs to take part in the selection process and the eligible organisations to take up the projects.

Other qualifying criteria:

- The agencies with experience in Health and HIV sector would be preferred. The agencies should submit the details of the project/s implemented and presently implementing (name of the donor agency, nature of projects, project period, contract value, continuing/ completed)" in prescribed application format. Format for information related to EoI format is at Annexure 14
- Applications of a maximum of three NGOs/CBOs for each CSC/project required in the State will be shortlisted for institutional/field appraisal. In a Particular District overlapping of CSC & any other NACP Project /Scheme to be avoided. However, PD-SACS has the prerogative to decide the number of NGOs/CBOs to be visited for Filed Appraisal based on the requirement.
- NGOs/CBOs implementing any NACP Projects discontinued during External Evaluation facilitated by SACS or withdrawn projects on their own should not be considered for a period of three years from the date of discontinuation by SACS in the same State/UT.
- NGOs/CBOs implementing any NACP Projects discontinued by SACS on financial misappropriation/fraud and gross irregularities will not be eligible to apply. If required SACS may check the details of applicants/EOIs submitted by NGOs/CBOs during the desk review /appraisal.

- NGOs/CBOs running an NACP project under the SACS, if they haven't completed at least one external evaluation, are not eligible to apply.
- NGOs/CBOs who have registered in different State / UT of India and have applied for a CSC Projects in other State and do not have any field experience in community development projects in the Applicant State may not be considered.
- However, NGOs/CBOs having field experience/ presence in the applicant State (other than the state where originally registered or implementing NACP projects in another State/UTs) may be considered if qualify the essential criteria. In this case, SACS may obtain the references from the respective SACS about the programme performance, evaluation result and association/ partnership with SACS.
- The NGOs/CBOs which are already implementing interventions/Projects under NACP in states/ UT and wishes to apply for a new CSC in other districts, the organization will undergo a fresh process of selection like any other NGOs/CBOs to ensure fair competition.
- One NGO/CBO may be awarded a maximum of three (03) projects CSC under each SACS or States/UT, however there is no limit to implement CSC interventions by one NGO/CBO at National level in different States/UTs. However, in a particular district overlapping of CSC and other NACP project is to be avoided.
- One NGO/CBO will submit only one application for the same project or for EoI or whatsoever stated in advertisement for selection.
- Agencies/organizations if legally registered under the above acts and having government affiliations, still have to undergo the process of selection like any other NGO/CBO.
- It is advised to SACS to send the request to NACO for concurrence before implementing CSC Projects through DAPCU, Zila-Parishad, Municipal Corporations and having government affiliations etc. under NACP.
- During the field appraisal assessment process, if an NGO and CBO have scored the same marks, in this context preference may be given to the CBO to implement the intervention/ program.
- However, if two or more CBOs have scored same marks, preference will be given to more experienced/old registered CBO.
- In case two or more NGOs score the same marks, preference will be given to more experienced/old registered NGO.
- While awarding the grant, preference may be given to the NGO/CBO which has a district presence in terms of implementation of the programme or infrastructure available.

All the NGO/CBO who fulfil the essential criteria will be further allocated a score to identify the top three shortlisted for JAT Visit (per CSC, three NGO/CBOs need to be shortlisted-1:3). In case more than three NGOs/CBOs, fulfil all essential criteria and scores equally, then organization having maximum relevant experience will be given priority/shortlisted.

Based on the desk review the TAC/SR may make any of the following recommendations:

- o Accept the application and recommend a JAT visit; or
- o Reject the application after recording specific reasons.

Table 18. Criteria for Grading (Maximum Score: 20):

S.No	Criteria	Score Allotted	Score Attained
1	Type of organization	For CBO (2)	
		For NGO (1)	
2	The organization has an existing presence at the district level and currently implementing programmes for the welfare of PLHIV.	For CBO (2)	
		For NGO (1)	
3	Minimum turnover (per Annum): For NGO	20 lakhs and Above (2) • 10-20 lakhs (1)	
	Minimum turnover (per Annum): For CBO	• 3 lakhs and Above (2) • 1-3 lakhs (1)	
4	Experience in providing any of the following services in the proposed district: Community Care Centres, Care and Support Centres, drop-in centres for PLHIV, HIV counselling and testing centres, HIV prevention, targeted intervention and treatment support programmes etc. (One organization can be awarded maximum three CSC including already functional CSC if any)	For NGOs: • ≥ 3 years (2) • <3 years (0)	For NGOs:
		For CBOs: • ≥ 1 year (2 • < 1 year (0)	For CBOs:
5	Agencies with experience working with projects supported by SACS under NACP (at least for 1 year and work order required for verification)	• Yes (2) • No (0)	
6	Experience in managing projects related to any of the following areas: RCH or TB (at least for 1 year and work order required for verification)	• Yes (2) • No (0)	
7	The organization is well aware and has documented experiences in linking PLHIV to Central/State-sponsored social protection schemes. (Proof linkages are required for verification)	• Yes (2) • No (0)	
8	The organization has conducted awareness programmes on the HIV/AIDS Prevention and Control Act 2017 and/or to reduce stigma discrimination. (Proof of organizing programme is required)	• Yes (2) • No (0)	
9	The organization provides psychosocial counselling to PLHIV & their families. (Records are required)	• Yes (2) • No (0)	
10	The organization has PLHIV as board members and actively involved in the decision-making process (at least 1/3 of the board members from PLHIV Community)	• Yes (2) • No (0)	

Intimation to the shortlisted Applicants for field appraisal by JAT:

SACS/SR will send a communication to all short-listed applicant organizations informing the proposed date of visit at least 07 days prior, along with a brief schedule of the activities that would be undertaken by the JAT. The details of applications received and their status will also be posted on the SACS/SR website. SACS/SR will send a regret letter citing reasons to all organizations whose applications have not been shortlisted for JAT visit.

Step 3: Field Appraisal of Shortlisted Organizations

A Joint Appraisal Team (JAT) is formed to undertake field visits for appraisal of the organizations & facilitate a transparent and quality selection process.

JAT will consist of following members:

- One Financial Consultant
- One external technical consultant (District/state level subject expert)
- One Observer (Zonal officer/DISHA/DAPCU Program Manager)

ToR of JAT

- Review of the short-listed applications before undertaking the field visit
- Physical review of records and registers during the field visit.
- Interaction with Board of Directors/Trustees and staff
- Visit the field or sites to interact with beneficiaries to assess their programme implementation strategies and their rapport with the community and stakeholders.
- Share the scoring of the organization at the end of the last day of field visit
- Prepare the visit report in the prescribed format and submit it to TAC/SR, along with supporting documents, within seven days of completion of the field visit.

Steps 4 & 5: Endorsement of JAT Report by Project Director SACS/PR and approval by the competent authority:

Upon receiving JAT recommendations, TAC/SR will do the scrutiny to ensure the correctness and completeness of the report. Further, TAC will submit the recommendations for the endorsement by the Project Director, to SACS, within 7 days of receipt of the JAT Report for approval. SR will submit the recommendations to PR for approval. PD SACS/ PR to endorse the JAT report within 7 days and hereafter, the JAT report will be submitted on file for approval of the competent authority. This process to be completed within 15 days of endorsement by PD SACS.

Step 6: Final Selection and Contract Signing

- Once the selection of the NGO/CBO is approved by the competent authority, SACS/PR will send a communication to the selected agency with a copy to NACO/SACS and SR. within one week after the receipt of the communication of approval.
- The selection letter issued to the successful CBO/ NGO will define the performance indicators for the selected organisation.
- Based on these indicators, NGO/CBO need to prepare the proposal and submit to SACS within 7 days of receiving the selection letter.
- The Contract should be signed within seven days of the submission of the proposal by the NGO/CBO. The contract letter would consist of the Agreement between the SACS and the NGO/CBO (Format placed at Annexure 15) and the Performance Bond (Format placed at Annexure 16)
- The final selection of CSC will remain core responsibility of SACS and Global Fund PR.

6.2 Conflict of Interest:

- Neither the NGO/CBO, their personnel, agent, network partner nor their service providers shall engage in any personal business/professional activities, either during or after the termination of the contract, which conflicts with or could potentially conflict with the objective of the services provided by CSC.
- The NGOs/CBOs shall notify the SACS/ SR immediately of any such activities or circumstances, which give rise to or could potentially give rise to a conflict of interest and shall inform the SACS/NACO/SR/PR how they intend to avoid such a conflict.
- NGOs/CBOs (including their personnel, agent, network partner or service providers) shall not have a close business or family relationship with a professional staff of the SACS/NACO/SR/ PR who are directly or indirectly involved in any part of the selection process or the supervision of services provided under this Contract/Project/ Intervention.
- In the event of a conflict of interest, as described above arising during the tenure of this Contract, the SACS/NACO and SR/PR reserves the right to terminate this Contract by giving written notice to the NGO/CBO.

6.3 Closure of a CSC/Termination of Contract*

A CSC may have to be closed due to an issue related to Programmatic performance/financial reasons/ management issues and the contract has to be terminated.

Table 19. Criteria for closure of CSC

Programmatic issues	Financial Issues	Management Issues
Constant poor performance on core indicators	Fund misappropriation	Voluntary handing over
Fudging of M&E data	Fraudulent practices	Conflict in the board affecting CSC work
Non-compliance of CSC guidelines	Non contractual compliance	Governance Issues

***Note: Refer to Section 3.3.5 of this document for details on "Termination of Contract"**

6.4 Governance

Good governance is a prerequisite for effective implementation of care and support project that requires the involvement of various stakeholders at different levels. 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 the local level is discussed below:

6.4.1 CSC Governance Structure

Table 20. Governance structure

National	State/ Regional	Local
• National Coordination Committee (NCC) • Project Management Team	• State Oversight Committee (SOC) • SACS Management Team	• ARTC Management Team • CSC team

A] National Coordination Committee: The National Coordination Committee (NCC) reviews the progress of the program periodically, ensures alignment with national priorities, and provides strategic direction for improved implementation. It serves as a platform for coordination, technical inputs, and policy guidance.

Profile of members of NCC:

- Head of CST Division, NACO (Chairperson)
- Officials from the CST Division, NACO
- Representatives from other NACO divisions
- SACS and SR representatives (on rotation)
- Development Agencies supporting NACO
- Technical Experts in Care Support and Treatment division
- Representatives of Principal Recipients of Global Fund implementing CSC

Meeting Frequency: The NCC will meet at least once

a year, chaired by NACO and coordinated by the SACS. The minutes of the meeting should be documented.

Terms of Reference (ToR) for NCC:

1. Provide strategic direction and technical inputs for CSC implementation.
2. Align CSC program strategies with NACP goals and priorities.
3. Facilitate coordination with other line ministries and departments to ensure holistic care.
4. Monitor CSC performance and identify areas for improvement.
5. Encourage knowledge-sharing and adoption of best practices and innovations across states.

B) State Oversight Committee (SOC): The State Oversight Committee (SOC) serves as a critical platform for reviewing the implementation of CSC within the state. It provides programmatic support tailored to the local context and addresses operational challenges. The SOC also ensures alignment with national priorities and facilitates coordination among stakeholders at the state level.

Key Functions of SOC:

1. Programme Review: Periodically review the implementation of the CSC program and provide necessary support to SACS and CSC.
2. Coordination: Facilitate regular coordination meetings between CSC and ART centres to enhance service delivery.
3. Referrals and Linkages: Address issues related to coordination with health and other line departments, ensuring active referrals and linkages to health and social welfare schemes.
4. Stigma Reduction: Provide actionable inputs to address stigma and discrimination at various levels.
5. Knowledge Sharing: Encourage the identification and dissemination of best practices across CSC.
6. Advocacy: Support the SR in implementing state- and district-level advocacy initiatives for policy and operational improvements.

Member Profile of SOC

1. Project Director of SACS or a senior officer, such as APD/JD (CST), nominated by the PD (Chairperson).
2. Joint Director (CST) or officer-in-charge of CST, SACS.
3. Regional Coordinator (CST) for the state, if in place.
4. GIPA Coordinator, SACS.
5. Representative from the Mainstreaming Unit, SACS.
6. State TB Officer.
7. SR representative.
8. PR representative.

Meeting Frequency: The SOC will convene biannually, with at least one meeting attended by a representative from NACO. Additional meetings may be called based on risk assessments or programmatic needs. The minutes of the meeting should be documented.

Quorum for SOC Meetings: To ensure decision-making capacity, SOC meetings must have:

1. At least two-thirds of the members present.
2. Mandatory attendance of at least one representative each from SACS and SR organizations.

Meeting Facilitation

1. The SR/CST nodal at SACS will facilitate the SOC meetings, including agenda preparation, meeting materials development, and documentation.
2. Minutes of the meeting will be prepared by the SR/CST nodal and shared with the PR/SACS and NACO within one week of the meeting.
3. In times of emergencies, three nominated members of the SOC must be available for consultation at short notice.

6.5 Policies and Procedure

Below are the policies which are recommended for smooth functioning of the CSC:

6.5.1 Financial Management Policy

- Establish financial controls to ensure transparency, accountability, and proper use of funds.
- Define budgeting, financial planning, and reporting procedures.
- Set protocols for the approval of expenses, including any project-specific or travel-related expenditures.
- Provide guidance on how to track and report financial status, including monitoring expenditures against the budget.
- Outline procedures for audits and financial reviews.

6.5.2 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 3 vendors.
- Comparative statement for quotations obtained is prepared and approved for selection of the vendor.
- A purchase order or work contract is issued to a 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.

6.5.3 HR Policy

It must contain processes for the following: -

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

6.5.4 Anti-Discrimination and Equal Opportunity Policy

- Ensure all staff of CSC, PLHIV, and stakeholders are treated fairly and equitably.
- Define the organization's commitment to non-discriminatory practices, including during recruitment, training, and service provision.
- Establish clear procedures for reporting and handling discrimination complaints. The details should be documented.

6.5.5 Complaints and Grievance Redressal Policy

- Establish procedures for reporting and resolving complaints or grievances from staff, PLHIV, or stakeholders.
- Ensure transparency and fairness in the handling of complaints.
- Define timelines for addressing grievances and providing resolutions and should be documented.

6.5.6 Data Protection Policy

This policy applies to all CSC staff, volunteers, and affiliated stakeholders involved in managing, accessing, or processing PLHIV data.

- Principles of Data Protection: beneficiary data should be treated as confidential, and being accessible to authorized users when needed and restricted from unauthorized access.
- Data Collection and Usage: Store data on secure, password-protected laptops/MIS/ tablets or encrypted databases approved by the organization. For physical/hard copy records, use locked cabinets with restricted access.
- Retain data only for the duration which is necessary for programmatic or legal requirements (Hard copies of patient records to be maintained by the CSC, as per NACP guidelines for ART centres). Establish a routine data deletion protocol for records no longer required, with secure deletion processes (e.g., shredding physical records, permanently erasing digital files).
- Share PLHIV data within CSC teams and affiliated organizations (e.g., ART Centres, DAPCU) only for legitimate program needs.
- Maintain clear documentation on who can access and share data, and under what circumstances.
- Do not share PLHIV data with third parties unless required for service provision through a proper approval process.
- For any required sharing with external stakeholders, such as research bodies, ensure due approvals from SACS and NACO are taken before sharing.
- Conduct regular security audits and data protection compliance reviews.
- Provide regular training for all CSC personnel on data protection, confidentiality, and security best practices.
- Include data protection training as part of on boarding for new hires and periodically for all staff to address emerging threats and changes in policy.
- Data Confidentiality agreement to be signed by CSC staff in place.
- Data needs to be handed over through soft copies to respective SACS and ARTC in case of closure.
- Hard copy records of patients to be handed over to the ARTC, at the time of closure of CSC.

6.5.7 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 requests 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

6.5.8 Staff Advances for Project Activities and Travel

- Each advance request will have support documents e.g., an approved activity budget in case of project advance and an 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.

6.5.9 Use of Private/Organizational Vehicle

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

6.5.10 Allocation of Common Costs

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

6.5.11 Conflict of Interest

The Organization 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 by the Grant, in which there is a conflict of interest.

If the Organization 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 SACS/SR/PR and seek guidance.

6.6 Role of Stakeholders

This section outlines the roles and responsibilities of key stakeholders involved in CSC implementation, emphasizing their collective commitment to achieving the program's goals and addressing the evolving needs of PLHIV. By fostering partnerships and leveraging each stakeholder's strengths, the CSC initiative aims to create a robust support system that promotes better health outcomes and improved quality of life for PLHIV.

The success of any public health program depends on the effective collaboration and coordination among diverse stakeholders. In the context of CSC, stakeholders play a pivotal role in ensuring comprehensive, PLHIV-centred services for PLHIV. Each stakeholder, from the national to the local level, brings unique expertise, resources, and perspectives, creating a synergistic framework that drives program success.

The involvement of stakeholders is crucial for several reasons:

1. Resource Optimization: Effective coordination among stakeholders minimizes duplication of efforts and ensures the efficient use of resources.
2. Holistic Support: By integrating health and social services, stakeholders ensure that PLHIV receive both clinical care and support for their psychosocial and economic well-being.
3. Accountability and Governance: Clearly defined roles and responsibilities enhance accountability and foster a governance system that supports transparency and informed decision-making.
4. Community Trust: Active involvement of local-level stakeholders, including NGOs, CBOs, and community leaders, builds trust and encourages the uptake of services by PLHIV.
5. Sustainability: Stakeholders help align the program with broader national and local health strategies, ensuring long-term sustainability and impact.

A) State AIDS Control Societies (SACS)

1. Facilitate smooth implementation of Care and support activities in the state, as per NACO guidance.
2. Ensure training & capacity building of the CSC staff.

3. Periodic financial and programmatic performance review & assessment of CSC.
4. Facilitate ARTC & CSC coordination and seamless data sharing.
5. Monitoring & Supervision to ensure quality of services provided and data submitted
6. Coordinate with various stakeholders involved in care and support activities.
7. Designate the JD/officer in charge of CST in SACS as the Nodal Officer for coordinating with SRs and ensuring program performance.
8. Ensure periodic SOC meetings and resolution of issues, challenges faced by field teams.
9. Ensuring adherence to programmatic goals.
10. Forward pertinent issues or information related to CSC operations to NACO/PR for resolution.
11. Participate in state-level training programs organized for CSC and SR staff, focusing on quality assurance and monitoring.
12. Support troubleshooting during operational challenges and in managing crises.
13. Facilitate state-level advocacy initiatives in coordination with CSC, SR/PR and other stakeholders.

B) District AIDS Prevention & Control Unit (DAPCU)/District Integrated Strategy for HIV/AIDS (DISHA) Unit

1. Facilitate capacity building activities in the district.
2. Support SACS in monitoring & supportive supervision of CSC.
3. Undertake/Support Advocacy on reducing stigma & discrimination.
4. Coordination with all stakeholders at district level.
5. Ensure CSC participation in the District AIDS Prevention Coordination Committee meeting organized by DAPCU.

C) Integrated Counselling & Testing Centres (ICTC)

1. Participate in the Monthly review meeting of ARTC-CSC to validate data & discuss the challenges & solutions.
2. Update the validated data in SOCH

D) ART Centres

1. Ensure that monthly ART-CSC coordination meetings are held regularly to discuss program performance and resolve challenges.
2. Share the monthly meeting report with DISHA unit/DAPCU and SACS.
3. Validate data on outcomes reported by the CSC during the monthly meeting, before updating it in SOCH.
4. Facilitate smooth coordination between ARTC and CSC.

E) Care and Support Centres (CSC)

1. Work in close coordination with ART centres, ICTC & district level stakeholders to ensure streamlined service delivery.
2. Ensure staff training & capacity building to perform their allocated work
3. Facilitate timely reporting of data in mobile application and other records/reports.
4. Share monthly report with the ART centre, SACS/SR.
5. Support the ARTC in conducting Monthly ARTC-CSC coordination meetings.
6. Attend district-level meetings convened by DAPCU/DISHA units.
7. Organize/participate/support Advocacy to reduce stigma & discrimination.
8. Facilitate linkage of PLHIV to social entitlements and social welfare schemes for which they are eligible (National/State specific).
9. Implement the Care and support project effectively, ensuring the achievement of programmatic targets and financial utilization as per the approved annual plan.

F) TI/LWS/OST centres

1. Coordinate with CSC to enhance community-level linkages & improve outreach services.
2. Support the CSC staff in tracking LFU cases, ensuring follow-up and reintegration into care.
3. Provide adherence and psychosocial support to PLHIV through established networks.
4. Collaborate on local-level advocacy to address stigma and discrimination within key populations.

G) Local Health System

1. Support CSC in linking PLHIV to health services available at district hospitals and PHC.
2. Collaborate with CSC teams to provide access to co-infection and Co-morbidities management services, including TB, Hepatitis and Non communicable diseases like hypertension, diabetes mellitus and cervical cancers.
3. Facilitate referral systems to ensure comprehensive care for PLHIV.
4. Participate in district-level health campaigns aimed at awareness generation and stigma reduction.

H) Other Partners (NGOs, CBOs, and Community Networks)

1. Collaborate with CSC to enhance service outreach and community mobilization efforts.
2. Participate in capacity-building initiatives to strengthen the quality of care and support provided to PLHIV.
3. Contribute to tracking LFU through community-driven approaches.
4. Advocate for policy changes and increased resource allocation for PLHIV welfare at local, state, and national levels.

I) Sub-Recipients (SR)

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

6.7 Coordination with Stakeholders

Each CSC will be coordinating with all the key stakeholders while undertaking activities to achieve their goal and objectives, including the following:

PLHIV Community: The CSC Coordinator/Project Coordinator and/or ORW/CLH will organize periodic SGM to provide support mechanisms for PLHIV. These meetings will offer a safe, confidential space for members to share their concerns and learn from each other. Additionally, the SGMs will help enhance their knowledge of HIV-related issues. The meetings will be held mainly at the CSC or another convenient location in the community that ensures audio-visual privacy. The minutes of the meeting should be documented by the Coordinator/Project Coordinator of the CSC and should be kept at the CSC. More details related to SGM such as guidance and modalities for conducting the SGM and topics to be covered during SGM is provided in chapter 2 of this document.

Government line departments offering social welfare schemes:

- The CSC staff should keep a list of all national/ state-specific social welfare schemes for which the PLHIV are eligible and should establish contact with nodal persons at the government offices offering these welfare schemes.
- A referral directory listing the schemes, the office addresses of the concerned government offices and contact details of the nodal officers may be maintained at the CSC to facilitate the submission of applications for social welfare schemes by the eligible PLHIV.
- Some of these officers may be invited for the stakeholder meetings conducted by CSC/DISHA unit/DAPCU/SACS.

GRIEVANCE REDRESSAL MECHANISM UNDER THE HIV AND AIDS (PREVENTION & CONTROL) ACT, 2017

CHAPTER - 7

The HIV and AIDS (Prevention & Control) Act, 2017[4]

The Act came into force on September 10, 2018, with the objective to prevent and control the spread of HIV and AIDS and reinforce the legal and human rights of individuals infected with and affected by HIV and AIDS. It also seeks to protect the rights of healthcare providers.

The Act addresses stigma & discrimination and strives to create an enabling environment for enhancing access to services. As per Section 14(1) of the Act, the Central and State Governments are required to take measures that include providing, as far as possible, diagnostic facilities relating to HIV or AIDS, Anti-Retroviral Therapy (ART), and Opportunistic Infection (OI) management to people living with HIV or AIDS.

The Act mandates the creation of a safe, non-discriminatory environment in various settings, including workplaces, educational institutions, and healthcare facilities etc, for people infected and affected with HIV and AIDS.

7.1 Grievance Redressal Mechanism under the Act

To ensure timely redressal of grievances, the Act also establishes a robust grievance redressal mechanism, comprising:

- Ombudsman appointed or designated by the State Government at the State level
  - o One or more Ombudsman shall be appointed or designated as the State desires. Ombudsman shall inquire into complaints of violations of provisions of the Act related to discrimination and providing of healthcare services.
- A Complaints Officer designated at the Establishment level.
  - o It is obligatory for the establishment, having one hundred or more persons to designate a person, as it deems fit, as the Complaints Officer who shall dispose of complaints of violations of the provisions of this Act in the establishment. Healthcare establishments shall designate a Complaints Officer in case of twenty or more persons. Here person could be an employee or officer or member or director or trustee or manager, as the case may be.

Note:
it must be noted that there is no hierarchy in terms of filing of complaint; if any establishment does not qualify to have a Complaints Officer, then the aggrieved person belonging to that establishment can file aa complaint to the Ombudsman. Also, if the establishment has a Complaints Officer, it is at the discretion of the aggrieved person to file the compliant to the Complaints Officer or Ombudsman.

7.1.1 Roles of the Ombudsman

Every State Government shall appoint one or more Ombudsman, -

(A) possessing such qualification and experience as may be prescribed, or

(B) designate any of its officers not below such rank, as may be prescribed, by that Government,

to exercise such powers and discharge such functions, as may be conferred on Ombudsman under this Act.

7.1.2 Power of the Ombudsman

The Ombudsman shall, upon a complaint made by any person, inquire into the violations of the provisions of this Act, in relation to acts of discrimination mentioned in section 3 of the HIV and AIDS (Prevention & Control) Act, 2017 and providing of healthcare services by any person, in such manner as may be prescribed by the State Government.

The Ombudsman may require any person to furnish information on such points or matters, as they consider necessary, for inquiring into the matter and any person so required shall be deemed to be legally bound to furnish such information and failure to do so shall be punishable under sections 176 and 177 of the Indian Penal Code.

The Ombudsman shall maintain records in such manner as may be prescribed by the State Government.

7.1.3 Orders of Ombudsman

The Ombudsman shall, within a period of thirty days of the receipt of the complaint under sub-section (I) of section 24 of the act, and after giving an opportunity of being heard to the parties, pass such order, as he deems fit, giving reasons therefor.

Provided that in cases of medical emergency of HIV positive persons, the Ombudsman shall pass such order as soon as possible, preferably within twenty-four hours of the receipt of the complaint.

[4]https://naco.gov.in/sites/default/files/HIV%20and%20AIDS%20Act-%20English.pdf

7.1.4 Procedure of complaints

The complaints may be made to the Ombudsman under sub-section (1) of section 24 of the act, in such manner, as may be prescribed, by the State Government.

7.1.5 Report to State government

The Ombudsman shall, after every six months, report to the State Government, the number and nature of complaints received, the action taken and orders passed in relation to such complaints and such report shall be published on the website of the Ombudsman and a copy thereof be forwarded to the Central Government.

7.1.6 Duty, Power and Responsibility of complaints officer:

Complaint Acceptance: The Complaints Officer must register complaints made within three months of the complainant becoming aware of the violation. An extension of up to three additional months may be granted if justified.

Assistance in Filing complaint: Complaints must be submitted in writing to the complaints officer. If the complainant cannot do so, the officer must provide all reasonable assistance.

Acknowledgement and Registration of complaints: Each complaint must be acknowledged, recorded electronically with time-stamp and action details, and assigned a sequential number. The officer must act objectively and independently.

Timeline for decision-making: Complaints must be decided within seven working days. In emergencies or healthcare-related discrimination cases, decisions should be made on the same day.

Decision making powers: Upon confirming a violation, the officer may:

- Direct corrective measures,
- Counsel and require training for the violator,
- Assign social service (e.g., with NGOs working on HIV/AIDS),
- Recommend disciplinary action for repeated violations.

Informing the Complainant: The officer must inform the complainant about the action taken and the right to approach the Ombudsman or other legal avenues if dissatisfied.

Reporting Mechanism: A report detailing the number, nature, and action on complaints must be submitted every six months to the appropriate authority at NACO. A 'nil report' is not mandatory.

Confidentiality: Upon request, the officer must protect the identity of the complainant by:

- Storing identifying documents in sealed custody,
- Using pseudonyms,
- Ensuring no unauthorized disclosure by anyone involved.

Data Management: The officer must comply with data protection norms under Section 11 of the HIV and AIDS (Prevention and Control) Act, 2017, and related guidelines.

7.2 Key features of the HIV and AIDS (Prevention and Control) Act, 2017

Key features of the Act are:

- Address stigma & discrimination
- Create an enabling environment for enhancing access to services.
- Safeguard the rights of PLHIV & those affected by HIV.
- Provide free diagnostic facilities and ART to PLHIV.
- Promote a safe workplace in healthcare settings to prevent occupational exposure.
- Strengthen the system of grievance redressal.

7.2.1 Informed Consent under the HIV and AIDS (Prevention and Control) Act, 2017

The Act lays down clear provisions regarding informed consent for HIV testing, treatment, and participation in research. According to the Act, no HIV test shall be undertaken or performed upon any person, or no positive person shall be subject to medical treatment, medical interventions, or research without their informed consent.

The Act defines informed consent as the voluntary agreement given by an individual or their representative, specific to a proposed intervention, and free from coercion, undue influence, fraud, mistake, or misrepresentation. Such consent must be obtained after providing information about the risks and benefits of, and alternatives to, the proposed intervention, in a language and manner comprehensible to the individual or their representative, as the case may be. It also includes pre-test and post-test counselling to the person being tested or to their representative as an integral part of the informed consent process.

However, the Act also provides specific circumstances under which informed consent for conducting an HIV test shall not be required:

A) Where a court determines, by an order, that the carrying out of the HIV test of any person, either as part of a medical examination or otherwise, is necessary for the determination of issues in the matter before it.

B) For procuring, processing, distribution, or use of a human body or any part thereof, including tissues, blood, semen, or other body fluids, for use in medical research or therapy: Provided that where the test results are requested by a donor prior to donation, the donor shall be referred to a counselling and testing centre, and such donor shall not be entitled to the results of the test unless they have received post-test counselling from such centre.

C) For epidemiological or surveillance purposes where the HIV test is anonymous and is not for the purpose of determining the HIV status of a person: Provided that persons who are subjects of such epidemiological or surveillance studies shall be informed of the purposes of such studies; and

D) For screening purposes in any licensed blood bank

7.2.2 Disclosure of HIV status

As per the Act, no person shall be compelled to disclose his HIV status, except by an order of the court that the disclosure of such information is necessary in the interest of justice for the determination of issues in the matter before it.

No person shall disclose or be compelled to disclose the HIV status or any other private information of other person imparted in confidence or in a relationship of a fiduciary nature, except with the informed consent of that other person or a representative of such another person obtained in the manner as specified in section 5 of the HIV and AIDS (Prevention and Control) Act, 2017, as the case may be, and the fact of such consent has been recorded in writing by the person making such disclosure:

Provided that, in case of a relationship of a fiduciary nature, info rmed consent shall be recorded in writing.

However, the Act also specifies a few situations where informed consent is not required for disclosing HIV-related information. These are:

A) by a healthcare provider to another healthcare provider who is involved in the care, treatment or counselling of such person, when such disclosure is necessary to provide care or treatment to that person;

B) by an order of a court that the disclosure of such information is necessary in the interest of justice for the determination of issues and in the matter before it;

C) in suits or legal proceedings between persons, where the disclosure of such information is necessary in filing suits or legal proceedings or for instructing their counsel;

D) as required under the provisions of section 9 of the Act.

E) if it relates to statistical or other information of a person that could not reasonably be expected to lead to the identification of that person; and
to the officers of the Central Government or the State Government or State AIDS Control Society of the concerned State Government, as the case may be, for the purposes of monitoring, evaluation or supervision.

7.2.3 Disclosure to a Partner under section 9 of the HIV and AIDS (Prevention & Control) Act, 2017

Section 9 of the Act deals with the disclosure of HIV status to a partner by a healthcare provider.

(1) No healthcare provider, except a physician or a counsellor, shall disclose the HIV-positive status of a person to his or her partner.

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

A) reasonably believes that the partner is at the significant risk of transmission of HIV from such person; and

B) such HIV-positive person has been counselled to inform such partner; and

C) is satisfied that the HIV-positive person will not inform such partner; and

D) has informed the HIV-positive person of the intention to disclose the HIV-positive status to such partner:

Important Safeguards under Section 9:

Disclosure to the partner shall be made in person after counselling:

Provided further that such healthcare provider shall have no obligation to identify or locate the partner of an HIV-positive person:

Provided also that such healthcare provider shall not inform the partner of a woman where there is a reasonable apprehension that such information may result in violence, abandonment or actions which may have a severe negative effect on the physical or mental health or safety of such woman, her children, her relatives or someone who is close to her.

The healthcare provider under section 9 of sub-section (1), of the HIV and AIDS (Prevention and Control) Act, 2017, shall not be liable for any criminal or civil action for any disclosure or non-disclosure of confidential HIV-related information made to a partner under this section.

7.2.4 Confidentiality of HIV-related Information

Every establishment that keeps the records of HIV-related information of protected persons shall adopt data protection measures. The measures shall include procedures for protecting information from disclosure, accessing information, security, accountability, and liability of persons in the establishment.

7.2.5 Safe Working Environment

Every establishment engaged in the healthcare services and every such other establishment, where there is a significant risk of occupational exposure to HIV, shall, for the purpose of ensuring a safe working environment,

Provide, in accordance with the guidelines,

- Universal Precautions to all persons working in such establishment who may be occupationally exposed to HIV; and
- Training for the use of such universal precautions;
- Post Exposure Prophylaxis (PEP) to all persons working in such establishment who may be occupationally exposed to HIV or AIDS;
- Inform and educate all persons working in the establishment of the availability of Universal Precautions and Post-Exposure Prophylaxis.

ANNEXURE

Annexure 1. Scenarios for Inter District/Inter-State tracking of PLHIV

Scenario 1:

Step 1: CSC ORW/CLH updates the migration status on the mobile app with address / contact details of the destination.

Step 2: The PC validates this outcome and submits the final status on mobile app.

Step 3: The data manager of ARTC (A) validates the outcomes submitted by PC (within 1 week of receiving feedback from CSC).

Step 4: Data Manager of ARTC (A) generate district specific line list for follow up. ARTC (A) to share this list with ARTC (B).

Step 5: On receipt of line list of PLHIV for interdistrict tracking from the ARTC (A), the data manager at the ART Centre (B), will cross check for duplication, different name enrolment, dispensation in transit and silent transfers in the records of own ART centre.

Step 6: ARTC (B) will update the data in SOCH of all those found in records. (Updated records will be visible to ARTC A)

Step 7: Share the list of remaining PLHIV with linked CSC of ARTC (B) for tracking (within 1 week of receiving list).

Step 8: The PC will segregate location wise PLHIV data received from ARTC (B) and share it with the ORW/CLH in the concerned locations for follow-up.

Step 9: Take the support of other NACP stakeholders, taking care to ensure confidentiality, to track cases in the districts that do not have ORW/ CLH (within 1 week of receiving list from ART Centre A).

Step 10: CSC will share the updated list with the ARTC (B).

Note: Both the ARTC (A) and ARTC (B) keep their SACS updated till the status of all the PLHIV is updated and shared back.

Scenario 2:

Step 1: CSC ORW/CLH updates the migration status on the mobile app with address / contact details of the destination.

Step 2: The PC validates this outcome and submits the final status on mobile app.

Step 3: The data manager of ARTC of State (A) validates the outcomes submitted by PC (within 1 week of receiving feedback from CSC) and generate State specific line list for follow up.

Step 4: ARTC of State (A) to share this list with SACS of State (A).

Step 5: SACS of State (A) compiles state specific line lists and shares with respective SACS of State (B) for follow up.

Step 6: On receipt of Line list of PLHIV for Interstate tracking, district specific line lists will be generated by SACS of State (B) and shared with the concerned ARTC of State (B).

Step 7: On receipt of line list of PLHIV for interstate tracking from the SACS of State (B), the data manager at the ART Centre of State (B) will cross check for duplication, different name enrolment, dispensation in transit and silent transfers in the records of own ART centre.

Step 8: Update the data in SOCH of all those found in records.

Step 9: Share list of remaining PLHIV with linked CSC of ARTC (B) for tracking (within 1 week of receiving list)

Step 10: The PC will segregate location wise PLHIV data received from ARTC of State (B) and share it with the ORW/CLH in the concerned locations for follow-up.

Step 11: CSC will share the updated list with the ARTC of State (B).

Note: SACS of State (A) coordinates with the SACS of State(B) till the status of all the PLHIV is updated and shared back with the concerned ARTC of State (A).

Annexure 2. Supportive Supervision Visit Form (SSVF) for CSC

1. Basic Information

Name of CSC		Type	Domestic Budget/GF supported
Linked Anti-Retroviral Therapy Centers (ARTCs)		Name and Designation of NACO/SACS/PR//SR Personnel	
District:		State:	
Visit Date		Date of previous SSV visit	
Name & Designation of the CSC staff interacted with			

2. Human Resource & Capacity Building

Designation	Sanctioned	In place	Vacant	Trained in CSC 2.0	Remark
Project Director/Project Manager					
Accountant cum M&E /Monitoring, Evaluation & Finance Officer (MEFO)					
CSC Coordinator/Project Coordinator (PC)					
Out Reach Worker (ORW)/ Community Liaison Health (CLH)					

3. Coordination and meetings:

Sr. No.	Component	Yes/No	Observations (Cross check staff responses with meeting minutes and comment on quality- issues identified, follow up and activities planned)		
1	Monthly Staff review meeting held with documented gaps and action point -	Yes/No			
2	Monthly Plans and Daily logs/plans maintained for all staff	Yes/No			
3	Monthly ARTC coordination meeting conducted with documented gaps and action point.	Yes/No			
4	Monthly DAPCU/DISHA/DTO/DHMO meeting conducted with participation of CSC staff	Yes/No			
5	Any Advocacy meeting conducted in the last 3 months	Yes/No			
6	Any Support Group Meeting (SGM) conducted in the last 3 months	Yes/No			

4. Strategic/programmatic assessment - CSC performance

Key Indicator		Target Reported	Achievement Reported	Target Verified	Achievement Verified	Variance in Target (reported vs verified)	Variance in Achievement (reported vs verified)	Performance Reported during reference period in % by SSR	Actual Performance Reported during reference period in %	Score on Performance (<50% =0,50% to 60%=1, 60% to 70%=2,70% to 80%=3, More than 80%=4)	Compliant (Yes=0/No=2)
Percentage of PLHIV who are Lost to Follow-up (LFU) to ART centre tracked back with definite outcome						0	0				
Percentage of people living with HIV and on ART with viral load test result- **General Clients**	Male					0	0				
	Female					0	0				
	Transgender					0	0				
	Total	0	0	0	0	0	0				
	Male Children (<15 Yrs.)					0	0				
	Female Children (<15 Yrs.)					0	0				
	Total	0	0	0	0	0	0				
Percentage of people living with HIV and on ART with viral load test result- **3rd line ART**	Male					0	0				
	Female					0	0				
	Transgender					0	0				
	Total	0	0	0	0	0	0				
	Male Children (<15 Yrs.)					0	0				
	Female Children (<15 Yrs.)					0	0				
	Total	0	0	0	0	0	0				
Percentage of people living with HIV and on ART with viral load test result **PPW (32-36 weeks)**						0	0				
Total for Viral Load Testing Indicator		0	0	0	0	0	0				
Percentage of HIV exposed infants tested for HIV at **2 months**	Male Children					0	0				
	Female Children					0	0				
Percentage of HIV exposed infants tested for	Male Children					0	0				
	Female Children					0	0				
Percentage of HIV exposed infants tested for HIV at **6 months**	Male Children					0	0				
	Female Children					0	0				
Total for EID Testing Indicator		0	0	0	0	0	0				

Percentage of other vulnerable populations that have received an HIV test during the reporting period and know their results	Male					0	0				
	Female					0	0				
	Transgender					0	0				
	Male Children (18m-<19 Yrs.)					0	0				
	Female Children (18m-<19 Yrs.)					0	0				
Total for Index Testing Indicator		**0**	**0**	**0**	**0**	**0**	**0**				
Newly registered/Initiated address verification						0	0				
Newly registered/Initiated 7th Month Retention and Viral load Testing						0	0				
ICTC-ARTC Linkage Loss						0	0				
EVTHS- EID 12 months and 18 Months						0	0				
HEI Positive linkage and initiation On-ART						0	0				
TB Referral/ HIV TB Co-infection						0	0				
Total Score										**0**	**0**

Data review (Reviewer to do desk review of CSC performance for previous quarter before visiting the CSC)- Identify Priority indicators on which CSC had underperformed in the last 3 months as per grading tool	
1. 2. 3. 4.	5. 6. 7. 8. 9.

Priority areas identified for improvement:	Recommendations:

5. CSC activity Checklist

Sr. No.	Review points (Documents to be verified)	Response	Observations
1	Referral Register	Yes/No	
2	Referral Slip	Yes/No	
3	Discrimination Response Tool	Yes/No	
4	CSC Operational guideline	Yes/No	
5	How many clients have availed benefits from the Social Protection schemes in the last 3 months? (list down the beneficiary count and schemes)	# clients: _____ Schemes: _____ _____	
6	Field visits by the PC/CSC Coordinator in last 1 month (Specify No.):	1. ICTC:_____ 2. ARTC:_____ 3. Home Visits (with CLH): ___	
7	Outreach by the ORW/CLH in last 1 month (Specify No.):	Client reached via field visit:____ Clients reached by phone:_____	

6. Infrastructure Status:

Infrastructure (Refer asset register and physical verification)	Yes (2)/No (0)	Comments
Computer		
Tablets		
Internet with WIFI		
Invertor/UPS		
Printer		

7. Innovation/Best practices:

Please describe any innovation or best practices implemented by CSC for expanding HIV prevention and care services

SUMMARY AND RECOMMENDATIONS

Observations-Issues/Gaps/Challenges	Action points suggested to SR/CSC
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.

Annexure 3. Opted Out form

Draft Written undertaking for PLHIV who "Opted out/Private Practitioner/Alternative Medicine" of services given at ART Centers

Section A: For Patient

I, _____ (name of the PLHIV), ...(SOCH ID) would like to state that I am aware of my HIV status and I have been counselled by the CSC and ART staff on the benefits of taking ART. However, I do not wish to take the ART from the NACP ARTC, even though I have been explained fully and, in a language, I understand, the harmful effects of not taking this treatment.

The reason I do not want to take the ART from the NACP ARTC is:

1. I prefer to take treatment from my allopathic /private doctor/Hospital
2. I prefer to take non-allopathic treatment/alternative medicine
3. Any Other reason: _____ _____ _____ _____ _____

I acknowledge that while opting out, I was given opportunity to ask questions to the ART centre staff / CSC staff pertaining to HIV services. Further, I was also guided on the steps for re-registering myself in future when I return again for availing services under NACP.

Patient's name: _____Name of CSC PC/ARTC counsellor_____

Signature: _____ Signature: _____

Date: _____ Place: _____

Section B: For ART Centre and CSC Staff

Record of contacts made:

S. No.	Contacted by	Date of Contact	Name of the staff	Signature
1	ORW/CLH			
2	CSC PC/Coordinator			
3	ARTC Counsellor/MO			

Annexure 4: Scorecard for Care and Support Centre

Score card for monitoring CSC performance						
S. No.	**Indicator**	**Denominator**	**Numerator**	**Indicator Score**		
1	Proportion of PLHIV linked to ARTC (ICTC to ARTC Linkage)	Number of PLHIV newly diagnosed with HIV at ICTC in the current financial year, not linked to an ART Centre within 7 days of diagnosis, and shared with the CSC for follow-up by the end of the reporting month.	"Number of PLHIV out of those in the denominator who have been contacted and assigned a definite outcome by the end of the reporting month (i.e., Died, Opted-out, Linked to ART, or taking ART from a private provider)."	0 to 59.9%	60% to 89.9%	90% & above
2	Proportion of PLHIV Newly Initiated on ART Retained at 6 Months.	Number of PLHIV, newly initiated on ART 6 months prior to the reporting month	Number of PLHIV out of those in the denominator who are alive on ART, by the end of the reporting month.	0 to 59.9%	60% to 79.9%	80% & above
3	Proportion of LFU PLHIV achieving a definite outcome after CSC follow-up	Number of PLHIV reported as LFU with their last due visit date within the last 6 months, Shared with the CSC for follow-up by the end of the reporting month.	Number of PLHIV out of those in the denominator who have been contacted and assigned a definite outcome by the end of the reporting month (i.e., Re-initiated on ART, Died, or Opted-out).	0 to 79.9%	80% to 94.9%	95% & above
4	Proportion of PLHIV with Unsuppressed Viral Load, Underwent Repeat VL Testing	Number of PLHIV reported with an unsuppressed viral load result (≥1,000 copies/ml) 6 months prior to the reporting month.	Number of PLHIV out of those in the denominator who underwent at least one repeat viral load test within 6 months of their unsuppressed result.	0 to 79.9%	80% to 89.9%	90% & above
5	Proportion of positive pregnant women tested for viral load at 32–36 weeks gestation in the current financial year	Number of positive pregnant women reported as reaching 32–36 weeks gestation and due for viral load testing in the current financial year, shared with the CSC for follow-up.	Number of positive pregnant women out of those in the denominator who underwent a viral load test at 32–36 weeks gestation by the end of the reporting month.	0 to 84.9%	85% to 94.9%	95% & above
6	Proportion of HIV-Exposed Infants (HEIs), who underwent EID-testing as per Algorithm in the current financial year	Number of EID test instances for which HIV-exposed infants were reported as eligible as per the EID algorithm (at 6 weeks, 6, 12, & 18 months, or 3 months post-breastfeeding cessation) in the current financial year, shared with the CSC for follow-up.	Number of EID test instances out of those in the denominator for which HIV-exposed infants were tested as per the EID algorithm by the end of the reporting month.	0 to 84.9%	85% to 94.9%	95% & above
7	Proportion of PLHIV initiated on 3rd Line ART tested for Viral Load	Number of PLHIV reported as initiated on 3rd line ART regimen 6 months prior to the reporting month, shared with the CSC for follow-up.	Number of PLHIV out of those in the denominator who underwent a viral load test in the reporting month.	0 to 79.9%	80% to 89.9%	90% & above
8	Proportion of Eligible Contacts under the Index Testing strategy screened for HIV.	"Number of eligible contacts of the index case, who are eligible for HIV screening at the end of the reporting month in the current financial year. (Family members, spouse, sexual/ injecting partners, biological children of PLHIV, and biological parents of CLHIV/ALHIV aged more than 18 months and less than 19 years)"	Number of eligible contacts screened for HIV at the end of the reporting month.	0 to 39.9%	40 % to 79.9%	80% & above
9	ARTC Coordination Meetings Conducted and Minutes Shared with SACS in the current financial year	Number of ARTC-CSC coordination meeting conducted in the current financial year	Out of the meetings conducted, number of meetings for which minutes (MoM) shared with State AIDS Control Societies (SACS) by the end of the reporting month.	0 to 49.9%	50% to 89.9%	90% to 100%
10	CSC mobile app usage - Login Activity under CSC	Total number of login IDs created for the CSC mobile application under the CSC during the reporting period.	Average number of login IDs used each day by the end of the reporting month.	0 to 49.9%	50 to 89.9%	90% to 100%
Total Score				0 to 59.9%	60% - 79.9 %	80% and above

Annexure 5. List of Indicators for External Evaluation of CSC

S. No.	Organizational Capacity	Financial Management	Programmatic Delivery
1	Project staff sanctioned positions filled within two months of contract signing	Expenditure is aligned with the approved budget or has documented prior approval from SACS for deviations.	Proportion of PLHIV linked to ARTC (ICTC to ARTC Linkage)
2	Replacement of all ORW sanctioned vacant position done within 2 months of vacancy	A separate bank account is maintained exclusively for the CSC	Proportion of PLHIV Newly Initiated on ART Retained at 6 Months
3	At least two-third of ORWs are from the PLHIV community.	Bills/vouchers, updated books of accounts and necessary approval documents available for all payments done	Proportion of LFU PLHIV achieving a definite outcome after CSC follow-up
4	Documents regarding job descriptions and activity plan are available at CSC.	All payments for staff and vendor are done through appropriate digital portal as per NACO/ SACS guideline.	Proportion of PLHIV with Unsuppressed Viral Load, Underwent Repeat VL Testing
5	Organization follows CSC HR policies (e.g., recruitment, termination, grievance redressal, code of conduct), and all staff are oriented on the same.	Statement of Expenditure (SOE) is submitted on time to SACS, in the prescribed format.	Proportion of pregnant women living with HIV, tested for Viral Load at 32-36 week of gestation in current financial year
6	Attendance and leave registers are maintained for all project staff.	All procurements done by CSC should be in compliance with appropriate guidelines.	Proportion of HIV-Exposed Infants (HEIs), who underwent EID-testing as per Algorithm
7	Performance appraisal system in place with at least one annual review of all staff, and documented feedback/ action plans.	Previous year's audited financial statements are available, and all audit recommendations have been acted upon with documented evidence.	Proportion of PLHIV initiated on 3rd Line ART tested for Viral Load,after 6 months
8	All newly recruited staff have undergone induction training.	If advances are issued, an Advance Register is maintained and regularly updated with timely settlements.	"Proportion of Eligible Contacts under the Index Testing strategy screened for HIV. (Family members, spouse, sexual/ injecting partners, biological children of PLHIV, and biological parents of CLHIV/ ALHIV aged >18 months and <19 years)"
9	At least one training/sensitization session annually on gender, inclusion, and working with marginalized groups (e.g., PLHIV, key populations).	At least one internal financial review/audit has been done by SACS and action taken has been documented in the last FY.	ARTC-CSC Coordination Meetings Conducted and Minutes Shared with SACS
10	All reported cases of Stigma & discrimination resolved / addressed and documented by CSC	Budget Utilization	CSC mobile app usage - Login Activity under CSC
11	Asset list maintained and all assets purchased for CSC are coded/marked for identification.		
12	Digital infrastructure available and training done for use of CSC mobile application.		
13	CSC staff attended 80% or more of project-related meetings (e.g., SOC, ARTC-CSC coordination), and appropriate follow-up actions have been taken as per meeting minutes.		
14	Updated documents such as signed contract, NGO/CBO registration certificate, and organizational chart are available.		
15	5% of untraceable and 5% of opted out cases validated by PC through home / field visit for which documentation is available.		

Annexure 6. Terms of Reference for the External Evaluation team

Eligibility criteria, qualification, and experience of CSC external evaluators:

1) Programme Consultant:

- PG in Social Work, other allied Social Sciences & Public Health (MPH), with seven years of experience in the development sector and at least five years in the HIV sector.
- For community members graduation with minimum of three years of experience in the HIV sector.

2) Finance Consultants: Graduation in Commerce with three years of experience or a Chartered Accountant.

Consultancy fee:

- The external evaluators will be engaged for two days in evaluating one CSC.
- The financial evaluator will be engaged for only one day in each CSC.
- The external evaluator and financial evaluator will be paid as per SACS/NACO norms.

Travel and accommodation:

- Expenditure for the travel, accommodation and other logistics related to evaluation will be met by SACS as per existing norms.

Activities to be conducted by the Evaluators:

- The evaluators must visit the CSCs as per schedule and are required to follow the guidance provided by NACO to carry out the evaluation of CSCs.
- The research ethics for focus group discussions, interviews and meetings must be adhered to, during the process of evaluation. Refer Annexures 3 and 4 for Focus Group Discussions and Interview format.
- The signed copy of the annexures, supporting documents, filled-in tool to be submitted as hard copy within 7 days of completion of each evaluation.
- The finance evaluator needs to verify the financial documents in detail, mention observations and fill in the finance tool. The detailed report, score sheet and supporting documents should be submitted before leaving the CSC. The soft copy of the same needs to be shared with Team Leader and SACS.

Annexure 7. Process of External Evaluation of CSC (Day wise)

Duration for Evaluation:

- Each CSC will be evaluated over a period of two consecutive days.
- The second day (second half) is exclusively reserved for report writing.

Day -1

A. Evaluators should initiate field assessment, interacting with staff and reviewing documentation.

B. At least 5 to 10 PLHIV should be randomly selected and contacted through one-on-one interactions or small group discussions at the CSC project office.

C. Evaluators must visit the ARTC linked to the CSC, located in the same district as the CSC.

D. It is strongly recommended that evaluators interact informally with the community during appropriate hours, as per the community's convenience.

Day-2

A. Continued assessment activities (as required).

B. Feedback session with CSC staff should be organized before the team departs.

C. The second half of the day must be dedicated to report writing.

Finance Evaluation: The Finance Evaluator is required only for one day, ideally on Day 1

Day wise activity for Evaluation.

The following are the day wise suggested evaluation activities to be carried out by the evaluation team. The activities mentioned are the bare minimum for the evaluation team to perform. If the evaluation team conducts additional activities, they are subject to approval of SACS.

Day wise Evaluation Activities by Evaluation team.

Day 1:
Place of interaction: CSC Project Office and ARTC Pre-requisites: • Presence of all the project staff is essential. SACS has to inform in advance to CSC that staff has to be available for entire two days of evaluation. • Availability of all project related reports and documents is essential. **Activities to be undertaken:** • Meeting with all the staff and briefing about the evaluation process. • Verification of Project proposal, ORW diaries, ORW registers, counselling registers and other relevant documents. • Verification of Data Validation exercises undertaken by CSC, ART-CSC Meeting register, Co-ordination b/w CSC-ART, monthly internal CSC meeting register, the review undertaken by SACS/SR/PR/NACO etc. • Review of the work done by Project Manager, ORW/CLH, M&E cum part-time Accountant. • Visit to ARTC linked to the CSC, located in the same district as the CSC. • ARTC visit and Interview with service providers (MO, staff Nurse, Counsellor, Data Manager and CCs), any SHG members, the Nodal Officer of ARTC, and other relevant stakeholders.

Day 1:

Role of Finance Consultant:

- The service of the finance evaluators can be limited to one day.
- The finance person in the evaluation team has to verify all the documents related to the project activities and review all the audited reports shared by SACS.
- All major findings or observations to be discussed with other evaluation team.
- Major financial discrepancies, if any, should be reported to the evaluation team leader in writing before the debriefing session on the second day.

This whole exercise needs to be conducted as a participatory process.

- For evaluating the CSC, various qualitative and quantitative tools and techniques will be used including key informant interviews and participatory observations.
- Relevant documents and registers will be verified by the evaluators.
- The feedback of the PLHIV / ARTC – Staff / Community members on the project shall be given priority for final recommendations.
- The evaluation tools and indicators have been developed based on the deliverables expected from the CSC, which broadly include the following:

(A) NGO/CBO Operational Guidelines

(B) Guidelines on Financial & Procurement Systems for NGOs/CBOs

(C) Scorecard/ Grading System

Day 2:

Activities to be undertaken

- Focused Group Discussions with the community members on Outreach, Services and Commodities, Enabling Environment.
- Interview with community members on linkages, interview with all CSC staff and ORWs
- Debriefing of the project staff along with the Project Director and feedback session.
- Collection of all required documents as the case may be, supporting the report.

Report Writing: The report writing should be completed preferably in the second half of the Day 2. The Evaluation report including the evaluation tool, executive summary and detailed report shall be submitted on the 3rd day after completion of the evaluation and will be submitted by email to SACS and copied to NACO.

- Signed hard copies of the reports and documents also to be submitted to SACS within 7 days of completion of the evaluation.

Note: The above schedule has been planned to smoothen the process of evaluation. However, the evaluators in consultation with the project staff and community members may develop required plans accordingly.

Annexure 8. (A) Guidance on Focussed Group Discussions (FGD), Conducting Interviews and Code of Ethics

Focus Group Discussion:

1. Participants should be made comfortable; they should sit in such a fashion that everyone including evaluators can see each other.
2. Introduce everyone and explain the purpose of the focus group, the duration of discussion, and the expected feedback.
3. Explain that what the participants say will remain confidential.
4. Identify and brief the moderators from respondents/observers and evaluators so that each respondent gets equal opportunity to participate in the discussion.
5. Use the sampling frame as mentioned above and, in the tool,
6. Use the key questions mentioned in the FGD tool to continue the discussion.
7. Start the discussion, with broad questions at the start, to get the feel of the group, and to contextualize later and get more specific responses.
8. Questions need to be open ended and relevant to the evaluation
9. Documentation-writing/recording

Guidance for conducting the interviews

A) Introduce and brief about the purpose of interview

B) Ask key questions.

C) Listen and learn, sensitively.

D) Avoid close-ended and leading questions.

E) Probe for more information and triangulate with documents, FGD information.

Code of Ethics:

The Code summarizes broad ethical principles that reflect the evaluator's core values and establishes a set of specific ethical standards that should be used to guide the assignment. The following set of guidelines shall be adhered to for proper completion of the assignment:

1) The evaluator should ensure that in no way he/she undermines the dignity of any person concerned with the project including the community members and other stakeholders.

2) The evaluator should refrain from making or implying any commitments to any organizational staff and/or any community member during the process of evaluation.

3) The evaluator should not reveal the final result of the evaluation to any of the CSC or any members of SACS or NACO under any circumstances, unless such request/order has been made through proper official procedure.

4) The evaluator should try to reflect the perspectives of different stakeholder in the project area and should give necessary recommendations based on the above.

5) The evaluator should also refrain from giving work time to other areas of need related/unrelated or relevant/irrelevant to the project concerned, even if requested by the partner organization.

6) The evaluator is expected to focus on priorities as expected in the job assigned.

7) The evaluator should try to apply fair means and follow pre-determined process and tools provided in carrying out the assignment.

8) While taking photographs or pictures the evaluator should always ask for permission/ consent wherever possible from the subject.

9) The evaluator is also expected to refrain from any sort of manipulation of reports out of personal relationship/dynamics with the organization or any of its members.

10) The evaluator should neither support nor initiate any sort of activities which shows disrespect to the community.

11) Evaluator should always try to maintain confidentiality regarding issues between the partner organizations, and SACS.

12) The evaluator should strive to remain fair and professional in dealing with matters related to payment of bills and memos out of the expenses made during the assignment given.

13) The evaluator should always avoid receiving any sort of favour from the organisation (NGO/CBO).

Annexure 8. (B)- Beneficiary (PLHIV)-FGD Format

Introductory Section

Place of Interview:		
Name of Facilitator:		
Names of Note Taker:		
FGD Date:		(dd/mm/yyyy)
FGD Time Began:		FGD Time Ended:
Digital Recording		Y ☐ N ☐

SECTION: BACKGROUND INFORMATION

(NOTE TO FACILITATOR: Please note that the sub-questions are only there to assist you in stimulating responses and inspiring discussion.)

1. Since when have you been associated with the CSC?

1.1. How did you come to know about this center?

1.2 How long after you started the treatment did you get associated with CSC?

1.3 What was the process?

2. What are the services provided through the CSCs?

2.1 Which of these services have you availed? (Workshops on different topics- including legal/ medical, linkages to social welfare schemes, bus pass, any other Specific activities for the CLHIV/ALHIV/ KPs Life-skills e.g., ailoring, Mahila bachat gat, outdoor camps for adolescents)

2.2 How has been the general experience of availing services from CSC?

SECTION: EXPERIENCES OF COUNSELLING SERVICES PROVIDED AT CSC

3. What is the process of counselling?

3.1 Is there different types of counselling provided (group /one on one)

3.2 Is one to one counselling for everyone? What are the general topics that are discussed? Are these topics /information different from what you receive at the ART / ICTC center?

3.3 Do you think the topics are useful? In what way?

3.4 What is discussed when you are alone and what are the topics discussed in a group? (Topics- importance of ART, positive prevention, partner testing, HIV-TB , any other)

3.5 Do you get adequate privacy during counseling? Has it helped you come to terms with your disease?

3.6 Do you think counselling has helped in adhering to treatment in a better way?

3.7 Do you think counselling has helped in disclosing disease status with partners/family members?

3.8 Have you faced any stigma from family or society? Has counselling from helped to overcome this in any way?

SECTION: TREATMENT ADHERENCE

4. Have any of you missed your doses or delayed initiation of ART? OR During the course of the treatment, have you ever felt like withdrawing the treatment? (also check If the patient was earlier LFU and what special actions were taken)

Reasons? Did you interrupt? How did you deal with it?

4.1 If yes, what was the response from the CSC?

4.2 Was there any phone call for follow-up or home visits?

4.3 How did the ORW/ CSC staff motivate you/remind you to take the medicines?

4.4 Do the CSC staff help in overcoming difficulties that you are having in continuing the treatment?

4.5 Is the CSC staff available whenever you need them?

4.6 Do they accompany you to the ART center if required/requested?

5. Have you been told about the importance of treatment continuity? (something that has helped the patient in treatment continuation)

5.1 What was told to you?

6. Were there any instances where the CSC staff helped you in continuation of treatment (changed timings of the center/ delivered medicines/any other) helped you financially)

6.1 Any other type of support- psychosocial support, family support

6.2 Do you feel emotional and mental support after talking to the CSC staff

6.3 Do they talk to your family /friends?

SECTION: REFERRAL AND LINKAGES

7. Viral load/CD4 Testing details

Reasons? Did you interrupt? How did you deal with it?

7.1 When did you last underwent the CD4 and Viral load testing?

7.2 Has the CSC staff accompanied you to the center for testing?

7.3 What information was given to you by the CSC staff before and after the test?

8. Are you a part of a support group?

8.1 Is there a support group in this center? Are you a part of it?

8.2 How many meetings have you attended? How often do you meet in a month?

8.3 What is the duration of the meeting? Where does it happen?

8.4 What is generally discussed in the group? How has it helped you?

8.5 Is there anyone from the CSC who facilitates the meetings?

9. Are you all linked to any social schemes through the CSC?

9.1 Which social schemes? Do you get benefits from the scheme? (Bus pass, widow pension, education for children, any specific schemes for TGs/KPs)

10 Early testing and linkages

Has your partner /spouse / children been tested for HIV and linked to the facility if positive?

11 What are the challenges in terms of accessing services from the CSC?

12. What are the needs of the PLHIVs that the CSCs will be able to address? What suggestions you would like to give for further improvement of treatment adherence of PLHIV?

Annexure 8. (C) CSC Staff-Interview Guide

Introductory Section

Venue:		
Name of Interviewer:		
Name of the participant:		
Age:		Gender:
Type of Participants:		Project coordinator ORW/CLH
Interview Date:		(dd/mm/yyyy)
Interview Time Began:		Interview Time Ended:
Digital Recording		Y/ N

SECTION: BACKGROUND INFORMATION

NOTE TO FACILITATOR: Please note that the sub-questions are only there to assist you in stimulating responses and inspiring discussion.

Present section is applicable only to the Project Co-Ordinator

1. About the organization and its evolution over the years

1.1 What major projects are handled in the past and present? Various themes of work?

1.2 Since when it was associated with NACO as CSC? What was the selection process?

SECTION : SERVICE PROVISIONING

NOTE TO FACILITATOR: Please note that the sub-questions are only there to assist you in stimulating responses and inspiring discussion.

2. Understanding Role of Staff under CSC

2.1 Since when you have been associated with the CSC? total years of experience, the experience of working with CSC

2.2 What is your role in CSC?

3. Awareness about the functioning of CSC Center

3.1 What are the objectives of CSC?

3.2 Are you aware of the key deliverables? What are they?

4. How are PLHIVs registered in the center?

4.1 Do you contact ART center for any data? What type of data (look for the mention of PLHIVs to be initiated for ART, LFU, etc)

4.2 Once you get the list /updated in Mobile Application from ART center what do you do?

5. What is the purpose of the home visits?

5.1 Who conducts home visits? How often home visits are conducted?

5.2 Apart from home visits what other outreach activities are conducted by the CSC staff?

6 How do you prioritize/categorize the PLHIVs for contacting them?

6.1 What are the criteria for prioritization?

7 Do you categorize the clients based on their needs? How is it done? Is there any guideline to do the categorisation?

7.1 Do you know what is a differentiated care model? What has been your experience with this differentiated care model?

7.2. Do you feel that the patient-centric approach is helping patients? How?

7.3 Any difficulties in implementing the model?

7.4 Is it helping in treatment adherence and retention? If yes how?

7.5 How it can be improved?

7.6 Do you have any other suggestions for such new models which will cater to PLHIVs needs?

8. What is the process of tracking LFU patients and the experience, and what is your role in the process

8.1 LFU- what additional efforts do you take? What issues do you face? LFU? How many LFU patients do you follow up with every month?

8.2 Amongst the CSC staff, who has an important role to play in tracing LFU patients?

8.3 What are your achievements in the past year regarding bringing back LFU patients on treatment?

9 How do you ensure the follow-up of the older patients?

9.1 How important is Follow-up? What are the different types of groups you follow up with, and for what duration? (Youth, KP, adolescents)

10. Are you aware of the HIV 1097 helpline? do the beneficiaries use it? Yes/ no what is the reason? How do you disseminate the information about the helpline available among staff and their registered clients?

10.1 Do they have any data/information on number of clients using the helpline?

11. Group Sessions:

11.1 What is discussed during the group session? What is the frequency?

11.2 Do you provide counselling on various subjects?

11.3 What kind of information given to PLHIVs? (HIV knowledge, safe sex practices, ART medication, nutrition, importance of others)

11.4 Is counselling provided whenever the PLHIV needs it?

11.5 Do peer counsellors visit the PLHIVs at the ART centers? What information is given ?

11.6 How do you ensure the privacy and confidentiality of the PLHIVs during counselling?

11.7 Special steps are taken in making sure treatment adherence/retention.

11.8 HIV-related stigma is still prevalent in our society, Do you talk to patients about stigma/their experiences?

11.9 Do the patients have self-stigma? How do you help patients to overcome that? How does counselling help in this regard?

11.10 Do you have a discrimination response system? Is it functional?

11.11 What kind of IEC activities are conducted to reduce stigma amongst the community?

12.1 Support Groups: Who takes the initiative to organise the meetings between patients or staff? What is generally discussed in the meeting? Advocacy activities, Community events, any other)

13. Referral and linkages

13.1 How do you help the patients with accessing social welfare schemes? How many PLHIVs are currently attached to social protection schemes? How many are taking benefits of the scheme?

13.2 What are the benefits of linking patients to social protection services? What is your role in ensuring that it is a successful linkage? Do you think providing social protection help the patients in any way?

13.3 Does CSC also refer to Social welfare schemes, legal services,

What can be additional ways in which patients can be provided support and type of support? What services are provided to the CLHIVs?

14 Does your CSC conduct CBS screening?

14.1 What is the frequency of CBS screening in a month? Is there any target?

14.2 Place – how is it decided? Who does the screening? Is the staff trained? How do you procure the testing kits?

14.3 How many people are screened at a time? is there any target set? How many PLHIVs have been identified through CBS till now? Generally who are the people that get tested?(profile)

15 What are the barriers and facilitators you face while implementing a particular programmatic element?

15.1 Barriers- Budget-related restrictions, Restrictions due to unavailability of resources Some Processes in CSC- (linkages, co-ordination activities, processes at ART center, Engagement with government bodies, Hospitals CoE, SACS- Co-ordintion with different stakeholder) Staff retention.

15.2 Patient related barriers -Managing patients, follow up, Other

15.3 what are the Facilitators that help in better implementation of the program staff support, Support from Stakeholders, Community response, PLHIV response

16. Has there been any Capacity Building of the staff in past 1-2 years?

If yes, when was it done?

Do you think it was helpful?

Who conducted it? Which aspects do you think staff needs capacity building?

17. Have you adopted any new work ways employed in this program?

17.1 Have you incorporated any innovative methods/ strategies on your own to bring patients back on ART? Can you tell any of your success stories?

18 Association with stakeholders

18.1 How do you make sure there is smooth co-ordination with all stakeholders, including ICTC, ART center, NACO, SACs, SRs

18.2 What is the frequency of meetings with SACS/ DAPCU/ ART centered? and what is discussed?

Annexure 9: (C) Evaluation Tool for External Evaluation of CSC

The CSC Evaluation Tool is a structured framework for assessing Community-Based Organizations (CBOs) or Non-Governmental Organizations (NGOs) implementing Care and Support Centres (CSCs) under the National AIDS & STD Control Programme (NACP). The tool evaluates organizational capacity, financial management and programmatic performance, with results summarized in an evaluation matrix to ensure alignment with NACP objectives of enhancing retention, adherence, and quality of life for People Living with HIV (PLHIV). This note outlines the tool's components and provides instructions for its use.

Components of the Evaluation Tool & how to score each indicator:

1. **Organizational Capacity Assessment (15 Indicators)** This component evaluates the CSC's operational framework through 15 binary-scored indicators (0 or 1)

- Project staff sanctioned positions filled within two months of contract signing (verified via appointment letters, attendance sheets).
- Replacement of all ORW sanctioned vacant position done within 2 months of vacancy (checked via attendance sheets, appointment letters).
- At least two-third of ORWs are from the PLHIV community. (assessed via selection records).
- Documents regarding job descriptions and activity plan are available at CSC.(verified via documents available).
- Organization follows CSC HR policies (e.g., recruitment, termination, grievance redressal, code of conduct), and all staff are oriented on the same. (check documents/records available)
- Attendance and leave registers are maintained for all project staff (examined for usage).
- Induction training completed for Counsellor, ORWs, and staff post-recruitment (confirmed via training registers/reports).
- Performance appraisal system in place with at least one annual review of all staff, and documented feedback/action plans. (assessed via interviews with 2/3 staff members and check available records).
- All newly recruited staff have undergone induction training. (verified via staff interviews and training records)
- At least one training/sensitization session annually on gender, inclusion, and working with marginalized groups (e.g., PLHIV, key populations).
- All reported cases of Stigma & discrimination resolved / addressed and documented by CSC (review documents available)
- Asset list maintained and all assets purchased for CSC are coded/marked for identification.
- Digital infrastructure available and training done for use of CSC mobile application. (Interview staff to see if any challenges faced)
- CSC staff attended 80% or more of project-related meetings (e.g., SOC, ARTC-CSC coordination), and appropriate follow-up actions have been taken as per meeting minutes. (verified via registers, action reports).
- Updated documents such as signed contract, NGO/CBO registration certificate, and organizational chart are available.
- 5% of untraceable and 5% of opted out cases validated by PC through home / field visit for which documentation is available.

2. **Financial Management Assessment (10 Indicators)** This section ensures NACP financial compliance through 10 binary-scored indicators (0 or 1)

- Expenditure is aligned with the approved budget or has documented prior approval from SACS for deviations. (checked via vouchers, budget, SOEs).
- A separate bank account is maintained exclusively for the CSC(verified via bank book).
- Bills/vouchers, updated books of accounts and necessary approval documents available for all payments done (examined for compliance).

- All payments for staff and vendor are done through appropriate digital portal as per NACO/ SACS guideline.
- Statement of Expenditure (SOE) is submitted on time to SACS, in the prescribed format.
- All procurements done by CSC should be in compliance with appropriate guidelines.
- Previous year's audited financial statements are available, and all audit recommendations have been acted upon with documented evidence. (confirmed via audit documents).
- If advances are issued, an Advance Register is maintained and regularly updated with timely settlements.
- At least one internal financial review/audit has been done by SACS and action taken has been documented in the last FY.
- Budget Utilization

3. **Programmatic Delivery Assessment (10 Indicators):** There are 10 indicators to be scored as 1, 2 or 3. The score has to be graded as "1" for poor "2" for average and "3" for good depending on the performance of each of indicator as mentioned in the CSC Score card. The scoring for each indicator should be given after validating the data reported by the CSC, for the last quarter (the quarter completed before the date of external evaluation visit).

- Proportion of PLHIV linked to ARTC (ICTC to ARTC Linkage)
- Proportion of PLHIV Newly Initiated on ART Retained at 6 Months
- Proportion of LFU PLHIV achieving a definite outcome after CSC follow-up
- Proportion of PLHIV with Unsuppressed Viral Load, Underwent Repeat VL Testing
- Proportion of pregnant women living with HIV tested for viral load at 32–36 weeks of gestation in current financial year
- Proportion of HIV-Exposed Infants (HEIs), who underwent EID-testing as per Algorithm
- Proportion of PLHIV initiated on 3rd Line ART tested for Viral Load after 6 months
- Proportion of eligible contacts under the Index Testing strategy screened for HIV. (Family members, spouse, sexual/injecting partners, biological children of PLHIV, and biological parents of CLHIV/ALHIV aged >18 months and <19 years)
- ARTC-CSC Coordination Meetings Conducted and Minutes Shared with SACS
- CSC mobile app usage - Login Activity under CSC

Note: If CSC does not even fulfill minimum criteria as mentioned for each indicator (i.e. not even eligible for score "1"), then need to give "zero" mark for that particular indicator and specify in the explanation column the reasons for giving zero. No partial achievement will be considered to give a score of "1" – the decision has to be taken in consensus with the team members

Arriving at final scoring for overall performance:

- When the individual sheets for the indicators are filled, scores are automatically calculated in the CSC evaluation matrix sheet.
- CSC Evaluation Matrix summarizes scores for Organizational Capacity, Financial Management and programmatic delivery and calculates the final performance score of the external evaluation.
- The recommendations of the evaluation team are based on the final overall performance grading attained by the CSC, as follows:

Scoring	Grade	Performance	Recommendation
Below 40 %	D	Poor	Recommended for Discontinuation*
41% to 60 %	C	Average	Conditional Extension for six months with Mandatory Criteria to be fulfilled in a specified extension period.
61% to 80 %	B	Good	Recommended for Continuation for one year
>80%	A	Very Good	Recommended for Continuation for one year

*Note: CSC with scores less than 90% individually in either Organizational capacity or Financial Management assessment are also to be recommended for Discontinuation

Annexure 10. Format A for External Evaluation Report

(Score on each component for each CSC)

(Submitted by SACS to NACO)

Confidential

Name of SACS: Date of Reporting

Sl.No	Name of NGO/ CBO	Location (Name City / Town, State)	Name of ARTC linked to CSC	Date of Evaluation	Marks Obtained by each NGO / CBO				
					Programme Delivery	Finance	Organi-zational Capacity	Total Marks	Recommendation

Signature of JD- CST

Signature of PD-SACS

Annexure 11. Format-B for External Evaluation Report

Structure of the Detailed Reporting format

(To be submitted by Evaluators to SACS for each CSC evaluated with a copy NACO)

Introduction

- Name and address of the Organization
- Background of Project (year of starting. ever registered PLHIV, currently under active HIV care, Number of approved staff vs. no. of staff on board etc.)
- Year of establishment
- Year and month of project initiation
- Evaluation team; Names and designations
- Evaluation Timeframe (Start and end dates)

Profile of CSC

(Information to be captured)

- PLHIV on active care, Key activities undertaken by CSC, Geographical coverage
- Name of ARTC linked to CSC, PLHIV on Active care,
- Key activities undertaken by CSC , Target Area etc.

Key Findings and recommendations on Various Project Components

1. Organizational support to the program

- Interaction with key office bearers, 2-3 of the implementing NGO/CBO to see their vision about the project. support to the community, initiative of advocacy activities, monitoring the project etc.
- Evidence of community ownership and involvement

2. Organizational Capacity

- Human resources: Staffing pattern, reporting and supervision structure and adherence to the staff structure of NACP & supervision structure, staff role and commitment to the project, perspective of the office bearers towards the community and staff turnover
- Capacity building: Impact assessment of capacity-building initiatives, nature of training conducted, contents and quality of training materials used, documentation of training, impact assessment if any.
- Infrastructure of the organization: Office setup, accessibility, and basic facilities
- Documentation and Reporting: Mechanism and adherence to SACS protocols, availability of documents, mechanism of review and action taken if any, timeliness of reporting and feedback mechanism, dissemination and sharing of the reports and documents for technical inputs if any.

3. Program Deliverable

- PLHIV Line list by category.
- Micro planning in place and the same is translated in field and documented.
- Differentiated Service Delivery planning in place and the same is reflected in documentation.
- Outreach planning - Reaching out to PLHIV who are treatment interrupted with services including CBS, Index testing and health camp etc.
- Regular contacts the no. of PLHIV contacted as per the Differentiated Service Delivery Model The frequency of visit and the medicine distribution, should be referred with SACS.
- Quality of peer education- messages, skills and reflection in the community
- Supervision- mechanism, process, follow-up in action taken, etc.
- Supervisor Mechanism, process, follow-up action taken etc.

4. Services Deliverable

- List of services provided by the CSC (tracking back, counselling, treatment literacy, referrals, health camps, etc
- Service uptake data and quality review
- Client feedback, if available

5. Linkages

- Assess the linkages established with the various services providers like VL testing, Adherence monitoring, CD4 test, TB clinics, HEI (DNA PCR test), PPW etc.
- Percentages of discordant couple tested in ICTC and gap between referred and tested.
- Support system developed with various stakeholders and involvement of various stakeholders in the project.

6. Financial Systems and procedures

- Systems of planning: Existence and adherence to NGO-CBO guidelines or any approved accounting principles endorsed by SACS/NACO, supporting official communication form NACO/SACS for any deviance needs to be presented.
- Systems of payments- Existence and adherence of system of payment endorsed by SACS/NACO, adherence to CPFMS, availability and practice of using printed and numbered vouchers, approval systems and norms, verification of all documents related to payments, quotations, bills, vouchers, stock and issue registers, practice of settling of advances before making further payments and adherence to other general accounting principles.
- System of procurement- Existence and adherence of systems and mechanism of procurement as endorsed by SACS/NACO.
- Systems of documentation: Availability of bank accounts (maintained jointly. reconciliation made monthly basis), audit reports

7. Competency of the project staff

A) Project Manager

- Educational qualification & Experience as per norm, knowledge about the proposal, Quarterly and monthly plan in place, financial management, computerization and management of data, knowledge about CSC programme including Key indicators, knowledge about program performance indicators, conduct review meetings and action taken based on the minutes, mentoring and field visit & advocacy initiatives etc.

B) M&E cum Accounts Assistant

- Whether the M&E cum Accounts Assistant is able to provide analytical information about the gaps in outreach, service uptake to the project staff. Whether able to provide key information about various indicators reported under CSC and able to plan their outreach activities.

C) ORW

- Knowledge about target on various indicators for their PC/ Counsellors, outreach plan, Geographical distribution, distance of block & villages, importance of KPI indicators, ICTC to ARTC Linkage lose, support to PCs, field level action based on review meetings, knowledge about CSC programme etc.

8. Outreach activity under Project

- Interact with all CLH/ORW to understand whether the number of outreach sessions conducted by the team is reflecting in service uptake, that is whether enough Counselling and ARTC footfalls are happening. Whether the stake holders are aware of the outreach sessions. Whether the timings of the outreach sessions are convenient / appropriate for the PLHIV key population, PPW, HEI, daily workers, students, migrants key population, when they can be approached etc. Evidence based outreach plan, outreach monitoring, block wise micro plan and its clarity to staff.

9. Enabling environment

- Systematic plan for advocacy, involvement of stakeholders and community in the advocacy, clarity on advocacy, networks and linkages, community response of project level advocacy and linkages with other services, etc.

10. Social Protection

- Social protection schemes / innovation, availed welfare schemes, social entitlements etc.

11. Details of Best Practices if any

Annexure 12. Format C of External Evaluation Report

Confidential Report

EXECUTIVE SUMMARY OF THE EVALUATION

(Submitted to SACS for each CSC evaluated with a copy to NACO)

Profile of the evaluator(s)

Scoring	Name of the evaluators
Officials from SACS (as facilitator)	

Name of NGO/CBO	
Name of ARTC linked to CSC	
Date of Visit	
Place of Visit	

Overall rating based on Programme Delivery Score:

Total Score obtained (in %)	Category	Rating	Recommendation
Below 40%	D	Poor	Recommended for
41 % to 60%	C	Average	Recommended for
61% to 80%	B	Good	Recommended for
> 80%	A	Very Good	Recommended for continuation with specific focus for developing learning site.

Specific Recommendation

Name of Evaluators	Signature

Annexure 13. Format for Annual staff Appraisals

APPRAISAL FORMAT FOR STAFF OF CARE AND SUPPORT CENTER											
Name of the NGO/CBO implementing the CSC											
Name of the district in which CSC is located:											
Name & Designation of the staff:											
Project Coordinator											
Duration of Performance being reviewed:											
Date of performance Appraisal:											
Project Coordinator		A.1 Self Review					A.2 Supervisor's Assessment				
S. No.	Parameter	1	2	3	4	5	1	2	3	4	5
1	Validation of data before submitting outcomes on the CSC mobile application										
2	Timely submission of reports										
3	Undertaking field visits for data validation & supportive supervision										
4	Ensuring compliance with policies and procedures										
5	Sensitive & responsive to the challenges faced by ORW/CLH										
6	Ensuring minutes of meetings and actions taaken on recommendations of performance reviews by SACS/SR										
	Total Score										
(Discuss with staff member, if there is major discrepancy between the scores)											
ORW/CLH		A.1 Self Review					A.2 Supervisor's Assessment				
S. No.	Parameter	1	2	3	4	5	1	2	3	4	5
1	Performance of role as peer educator/peer counsellor										
2	Timely Follow up of allocated cases through outreach										
3	Assistance provided to PLHIV based on their needs										
4	Coordination with staff of Linked ARTC										
5	Keeping data updated on the CSC mobile application										
	Total Score										
(Discuss with staff member, if there is major discrepancy between the scores)											
	KEY TO PERFORMANCE GRADING										
	1-Poor 2- Needs Improvement 3- Satisfactory 4- Good 5- Excellent										
Overall Assessment by 1st level Supervisor											
	The overall performance of the staff (Tick the appropriate option)										
1	Exceeds Expectations										
2	Meets all Expectations										
3	Meets most expectations										
4	Falls below Expectations										
Recommendations of 1st level Supervisor											
1	Recommended for contract renewal for one year	Approval of 2nd level supervisor to be taken									
2	Recommended for contract renewal for 6 months	Reasons to be metioned & approval of 2nd level supervior to be taken									
3	Not Recommended for contract renewal										
	Date & Signature of staff being appraised:										
	Date & Signature of 1st level supervisor:										
	Date & Signature of 2nd level supervisor:										

Annexure 14. Expression of Interest

Format for information related to Expression of Interest

Section A: Basic Information

1. Name of the Organisation :_____
2. Postal Address :_____
   PIN: District:

3. Telephone : Telex Fax Email

4. Legal status : ( ) Society ( ) Company ( ) Others(specify)

5. Registration Details : Registered on(Date)

By _____
6. Registration Number of NITI Ayog : _____

7. Contact person : _____

8. Designation : _____

Section B: Organisational Background

9. Assets/Infrastructure of the organization

Category	Worth in rupees	(eg. Land, building)

10 a. Please provide details, regarding the annual budget of your organisation at least last 3 years (attach the detailed audited statement for 3 years)

Year	Source of funding	Amount (in Rs.)	List of activities	Activities similar to the TOR/Scope of Work	Geographical area o activities as mentioned in colum no. 5
1	2	3	4	5	6

10.b.: Whether blacklisted/debarred by any agency (both government, private or World Bank/ UN bodies) in the past? If yes, provide details in an Affidavit.

10. c.: Whether any staff or board member of your organization is part of any SACS/TSU staffs currently or in the past. Please provide the above information in the form of an Affidavit.

Section C: Current Programmes being run by the organization

10

Annexure 15. Format of Agreement to be signed between SACS and NGO/CBO implementing the Care and Support Centre.

AGREEMENT BETWEEN STATE AIDS CONTROL SOCIETY, AND CSC Name and Location.

AGREEMENT NUMBER – XXXX, Dated:.....

This AGREEMENT (hereinafter called this AGREEMENT) is made on ..... (Dated) between CSC Name, a society registered under Societies Act 1860 and having its office at CSC Address Registration No ..... valid up to .....hereinafter called the GRANTEE, which unless repugnant to the contrary shall include its successors, administrators, heirs, assigns and nominees of first part

And

State AIDS Control Society having its office at SACS Address, ...hereinafter called the GRANTOR, which expression shall unless repugnant to the context be deemed to include its successors in-interest.

WHEREAS

(a) National AIDS and STD Control Programme under the Annual Action Plan (AAP) funds have been earmarked for running Care and Support Centres in different States as per need. The GRANTOR intends to apply a part of the proceeds of the said credit and grant made available to it for the purpose of Care and Support Centres as defined in this AGREEMENT (hereinafter called the "SERVICES") on the terms and conditions set forth in this AGREEMENT;

(b) the GRANTEE has represented to the GRANTOR that it has the required professional skills, and personnel and technical resources, to provide the SERVICES on the terms and conditions set forth in this AGREEMENT;

NOW THEREFORE the parties hereto hereby agree as follows:

1. Documents: The following documents shall be deemed to form an integral part of this AGREEMENT:

(A) SECTION I - Terms and Conditions of this AGREEMENT;

(B) SECTION II - Approved Project Proposal and Detailed Implementation Plan describing the SERVICES to be performed;

(C) Section III - Schedule of Grant Disbursements

(D) Guidelines for selection/hiring of CBO/NGO to Implement Care and Support Centres under NACP.

2. Previous Communications

This AGREEMENT between the parties supersedes all previous communications, whether oral or written, in relation to the implementation of the SERVICES to be undertaken in accordance with this AGREEMENT.

3. Implementation of the SERVICES:

The GRANTEE shall in accordance with the terms and conditions as specified in Section I of this AGREEMENT implement the SERVICES as described in Section II of this AGREEMENT. The GRANTEE shall submit to the GRANTOR necessary documents and reports as specified in this AGREEMENT.

4. Financial Limit

The total financial grant for the SERVICES shall not exceed Rs. 17,16,000 (Rupees Seventeen lakh sixteen thousand only)

5. Disbursement

The GRANTOR shall disburse grants to the GRANTEE for the SERVICES in such manner as provided in Section III - Schedule of Grant Disbursements, within the financial limit specified in Clause 4 above. The disbursement shall be subject to receipt of grant funds by the GRANTOR from NACO.

6. Duration of this AGREEMENT:

This AGREEMENT shall remain in FORCE from 1st April, ... to 31st March, ... unless terminated earlier in accordance with the provision of this AGREEMENT or in the event the period is extended through a mutually agreed amendment to this AGREEMENT. The total duration of the AGREEMENT including extension, if any, shall not exceed a period of one year.

IN WITNESS WHEREOF, the parties hereto have caused this AGREEMENT to be signed in their respective names as the day and year first above written.

FOR AND ON BEHALF OF THE GRANTEE

Signed by (1) _____ Project Director – CSC, Address, Date .....

Signed by (2) _____ Treasurer – CSC, Address, Date .....

In the presence of Signature of Witness 1 ..... Name with Designation, Address and Date

In the presence of Signature of Witness 2 ..... Name with Designation, Address and Date

FOR AND ON BEHALF OF THE GRANTOR Project Director, State AIDS Control Society,

Signature..... Date.....

In the presence of Signature of Witness 1.....

Joint Director, CST., SACS (Date).....

In the presence of Signature of Witness 2.....

Deputy Director, Finance, SACS (Date)..... Location:

Annexure 16. Format of Performance Bond to be signed by the NGO/CBO selected to implement the CSC and the concerned SACS

Performance Bond

This bond made this day the.....202..... between CSC Name..... a Community Based Organization registered under The Societies Registration Act 1860 and having its registered office at CSC Address Society Registration No XXXXX valid up to Date Month, Year hereinafter called 'the obliger' (which expression shall, unless excluded by or repugnant to the context, be deemed to include its successor–in–interest) of the First Part and Name and Address of CSC authority of signing contract , hereinafter jointly called the sureties (which expression shall unless excluded by or repugnant to the context be deemed to include their respective heirs, executors, administrators and legal representatives) of the second part and State AIDS Control Society a registered society, a Joint Project of Government of State and the National AIDS Control Organisation (NACO) launched for HIV/AIDS Care and Support Centre in the state of Name.

Whereas at the request of the obliger, State AIDS Control Society has sanctioned a grant-in-aid of Rs 17,16,000.00 (Rupees Seventeen lakh sixteen thousand only). The total amount of the grant in aid is Rs 17,16,000.00 (Rupees Seventeen lakh sixteen thousand only)vide their Grant Award letter no: XXXXXXX/..... dated ..... hereinafter referred to as the said letter, which forms an integral part of these presents and a copy whereof is annexed hereto and marked with the letter 'A' for the purpose of and on condition of the obliger executing along with two sureties a bond in favour of State AIDS Control Society on the terms and conditions and in the manner hereinafter contained which the obliger has agreed to do.

Now this bond witnesseth and it is hereby agreed and declared as follows:

1. That the obliger shall utilize the said grant-in-aid of Rs 17,16,000.00 (Rupees Seventeen lakh sixteen thousand only)for the purpose specified in the said letter and for no other purpose whatsoever.

2. That the obliger shall abide by all the terms and conditions specified in the Grantee agreement and the General Financial rules, and any orders or instructions that be issued by State AIDS Control Society from time to time.

3. That in the event of any failure in the part of the obliger to abide by any of the terms and conditions of the grant-in-aid specified in the said letter or his committing any breach thereof State AIDS Control Society will be at liberty to order the obliger and to repay in full forthwith the State AIDS Control Grant amounting to Rs 17,16,000.00 (Rupees Seventeen lakh sixteen thousand only)or any part thereof with interest thereon at the rate of 6 % percent per annum and any order made by the State AIDS Control Society in this respect will be final and binding on the obliger and on receipt of the said order, the obliger shall forthwith and without any objection pay to State AIDS Control Society such sum not exceeding a sum of Rs 17,16,000.00 (Rupees Seventeen lakh sixteen thousand only)plus interest thereon as may be fixed by State AIDS Control Society and the amount so decided will be final and conclusive.

4. CSC Name..... agrees and undertakes to surrender/pay to State AIDS Control Society the monetary value of all such pecuniary or other benefits which it may receive or derive/ have received or derived through unauthorized use such as letting out the premises for adequate or less than adequate consideration or use of premises for any purpose other than that for which grant was intended of the property/building created/acquired constructed largely from out of the grant. The decision of the State AIDS Control Society as regards the monetary value aforementioned to be surrendered/paid to the State AIDS Control Society will be final and binding to CSC Name.....

5. Upon the obliger utilizing the grant-in-aid only for the purpose specified in the said letter and abiding by fulfilling and performing all the terms and conditions of the said letter the written obligation shall be void and of no effect but otherwise it shall be and remain in full force, effect and virtue.

Provided always and it is hereby agreed and declared that the decision of State AIDS Control Society as to whether the obliger had or has not performed and observed the obligations and conditions herein before received shall be and binding.

The stamp duty on the bond borne by CSC Name and Location.

IN WITNESS WHEREOF these presents have been signed by CSC Project Director and Address and on behalf of the obliger as witnesses

CSC Project Coordinator and address and on behalf of the obliger as witnesses

Dated .....Signed by (Project Director) for and on behalf of State AIDS Control Society in presence of 1. : JD/DD CST and 2: JD/DD Finance

GENERAL CONDITIONS FOR THE RELEASE GRANT-IN-AID TO ORGANISATIONS

1. In the event of any failure to comply with these conditions or committing any breach of the bond will be liable to refund to State AIDS Control Society the entire amount of the grant together with interest at such rate as is stipulated in the bond.

2. Utilization of the grant-in-aid must be started within the period of six months from the date of receipt of the money for the purpose for which it is sanctioned and to be completely utilized within the period of the Agreement.

If the grant or any part thereof is proposed to be utilized for a purpose other than that for which it is sanctioned, prior approval of State AIDS Control Society should be obtained by CSC Name.....

The payment of the grant-in-aid will be made by State AIDS Control Society through PFMS after all the requirements mentioned in this sanction letter have been fulfilled by the grantee. A separate account exclusively for this purpose should be opened in a bank if not done before, the name of which may kindly be intimated to State AIDS Control Society.

The payment of grant is subject to the following condition.

a) CSC Name..... should furnish a certificate that a person signing the understanding is duly authorized to operate upon and bind the funds of the grantee organization

b) CSC Name..... should furnish the certificate that CSC Name..... is not involved in any proceedings relating to the account or conduct of its office bearers. A certificate to the effect that the organization is not involved in corrupt practices should also be furnished.

c) CSC Name..... should furnish the certificate to the effect that CSC Name..... has not been sanctioned grant-in-aid for the same purpose by any other organization during the period to which the grant relates.

d) CSC Name..... will not, without the prior sanction of State AIDS Control Society, dispose of, or divert or use for any other purpose of permanent and semi-permanent assets that may be created or acquired of the grant. If and when such body is dissolved the assets are to be reverted to the government.

e) CSC Name..... should maintain a register in G.F.R. Form 19 of all assets acquired out of this grant. This register is required to be maintained separately in respect of each sanction and two copies of the same duly signed by CSC Name .....be furnished to State AIDS Control Society annually)

f) The register of assets maintained by CSC Name .....be available for scrutiny by audit or any other person authorized on this behalf by State AIDS Control Society.

g) CSC Name..... should forward to State AIDS Control Society a signed utilization certificate along with three copies of the Audited Statement of Accounts duly certified by a Chartered Accountant as mentioned in item nos. (i), (ii), & (iii) below as soon as possible after the close of the current financial year and in any case not later than six months of its closing.

i. The receipts and payments accounts of the body as a whole for the year in which the grant has been received

ii. The income and expenditure accounts of the body as a whole for the financial year in which the grant has been received.

iii. The balance sheet at the end of the current financial year for the body as a whole.

CSC Name .....would give an undertaking in writing that CSC Name ..... agrees to be governed by the condition of the grant mentioned in this annexure and the sanction letter.

Certificate / Undertaking to be given by CSC Name..... in terms of State AIDS Control Society's Grant Award letter No: XXXXXXXXXXXXXXXXXX/_____ dated _____

1. We undertake that our organization namely CSC Name..... agrees to the conditions of the grant as laid down in the above mentioned letter.
2. We certify that our organization is not involved in any proceedings relating to the account or conduct of any of its office bearers.
3. We certify that all the Rules and regulations are being followed and the prescribed documents are being maintained.
4. We certify that the office bearers signing/ Undertaking are duly authorized to operate upon and bind the funds of the organization.
5. We certify that our organization namely CSC Name .....is not engaged in any corrupt practice.
6. We certify that our organization namely, CSC Name..... has not received grants from any other Organisation for the same purpose during the period of the grant.
7. We, CSC Name..... undertake that the funds made available by State AIDS Control Society under the grant award for the Care and Support project with (location) for the period from 1st April 20XX to 31st March, 20XX shall not be used for any other purpose spelt out in the contract. Any violation of this shall be ground for unilateral termination of the grant award by State AIDS Control prior to the end of the grant period.

Signed & sealed for and on behalf of CSC Name.....

Name of the Official:

Designation: Project Director (CSC Name)

CSC Address

Scope of Document:

This document is a comprehensive resource for the successful implementation of the CSC services through outreach. It provides a structured approach to implement with clear and concise instructions, comprehensive indicators, and guidance on services of CSC, its implementation, human resource management, reporting, documentation, and stigma & discrimination. This document will support the staff at the CSC and other stakeholders for effectively implementing the services and improving adherence, retention and the quality of life of PLHIV through community driven approaches.
This document is inclusive and provides guidance on accessible healthcare environment to PLHIV and promote better health outcomes