National AIDS Control Organisation
India's voice against AIDS
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in

TARGETED INTERVENTION REVAMPED STRATEGIES

NATIONAL TRAINING OF TRAINERS

USAID FROM THE AMERICAN PEOPLE
PEPFAR
LINKAGES Across the Continuum of HIV Services for Key Populations
fhi360 THE SCIENCE OF IMPROVING LIVES

AUGUST 1, 2019

NATIONAL AIDS CONTROL ORGANIZATION

Ministry of Health and Family Welfare, Government of India, New Delhi

Contents

Summary

National AIDS Control Organization (NACO), based upon the recommendations from its Mid-Term Assessment (2016) and its understanding from the TI programs, was constantly discussing with its partners for innovative approaches. Based upon the consultative meeting by NACO, several new strategies were identified by NACO, from the partners and decided the revamp the existing TI strategies. This resulted in developing document on "Revamped TI Strategies" which was released by NACO in July 2019. The revamped TI Strategy document included, a series of activities, including, but not limited to, strengthening outreach, navigation as a concept for strengthening treatment linkage and various models of destigmatized and decentralized service delivery.

NACO with the support of FHI 360, as technical and financial partner organized two, 2-day Training of Trainers (ToT), one at Hyderabad and the other at Delhi in August 2019. The objective of the ToT is to, (a) Impart the purpose of the new strategies to the SACS and TSU TI staffs and (b) Develop a plan for integrating the new strategies at the field level for implementation.

Joint Secretary, Shri. Alok Saxena and Dr. Shobini Rajan, ADG (TI & SI), NACO felicitated the ToT at Delhi and communicated the importance of revamping TI strategies in the context of 90-90-90 and to achieve the last mile of the national program. Each batch of the ToT accommodated around 40 participants from SACS and TSUs. The resource persons for this ToT was primarily from NACO and FHI 360.

The key discussion points in this ToT are,

- As part of strengthening outreach, Delhi state team clarified that through web platform program access the HRGs on dating sites and connect them to diagnostic or treatments facilities. It is suggested that each state may interact with HRGs to identify the sites which are frequently accessed by MSM/FSW, for providing basic outreach or information.

- It has been informed that NACO would soon conduct a workshop on "Programmatic Mapping and Population Size Estimation (MPSE)" involving the SACS and TSU to have a revised and updated information on the key population spread and size of the population

in the geographical location. This information could be later used for all programmatic purposes.

- As per the strategy document, there is a need for differential service delivery for prevention, for optimizing the resources available in the country for the HIV prevention program. In addition, the model developed by LINKAGES project, experiences from other states, such as Delhi, Punjab and West Bengal had been discussed and acknowledged.

- The ToT oriented the attendees on "Index-testing" approach, to facilitate early detection and increase case finding. The requirements and the process of implementing index-testing was discussed thoroughly and even the kind of indicators that needs to be collected are also discussed.

- The ToT highlighted the importance of reaching Female Injecting Drug Users (FIDUs) in addition to the male injectors, considering the vulnerability and their issues accessing the existing TI services. A need for comprehensive service model for FIDU was discussed including de-addiction, OST, Hep-B screening and vaccination, Hep-C screening and treatment and other social entitlements.

- The ToT highlighted the navigation as one of the concept as part of the TI, to ensure 100% on ART and for ensuring adherence. In addition, it will also facilitate to ensure partner testing.

- More importantly, the revamped TI strategies also focus on community score card mechanism to receive feedback from the community, on the various services provided by the TI.

To further move ahead on implementing the Revamped TI Strategies, (a) operational guideline will be developed by NACO, (b) based on the feedback and comments the current slides and training material will be revised, (c) regional level training will be conducted to orient SACS and TSU personnel across on the country on revamped TI Strategy.

Background

National AIDS Control Organization (NACO) has been continuously evolving and strengthening its strategies across the HIV prevention, care, support and treatment continuum. HIV prevention strategies have been always been vigorously implemented, due to the dynamic nature of both the population at risk and the HIV epidemic. NACO through its mid-term assessment, understood the need for strengthening these strategies; hence there have been continuous discussions with the community, NGOs/CBOs and its partners on how to strengthen this model. Through its continuous interactions with a plethora of stakeholders, the leadership of NACO released the strategy document, "Targeted Intervention (TI) Revamped Strategies" in July 2019.

To move forward in implementing the Revamped Strategies, NACO conducted a series of trainings from the national level to the state level. As part of this planning, a two-day Training of Trainers (ToT), was planned in two batches, with each batch having approximately 40 participants, from State AIDS Control Societies (SACS) and Technical Support Units (TSU). It is expected that these SACS and TSU officials will be conducting the next level training for the Project officers in TSUs, who will train and mentor the implementing partners, NGOs/CBOs.

FHI 360 has been working with NACO as a technical and funding partner across various components of the national HIV program, including the TIs. As part of this technical assistance, the Linkages Across the Continuum of HIV Services for Key Populations (LINKAGES) project, funded by USAID, in coordination with NACO, worked on developing the training materials (primarily the slides) for the revamped strategies. The resource persons for these trainings are predominantly from NACO and FHI 360 (LINKAGES and Sunrise projects).

The objective of the ToT is to:

a. Impart the purpose of the new strategies to the SACS and TSU TI staffs
b. Develop a plan for integrating the new strategies at the field level for implementation

The details of the both the ToT are provided in the table presented below for quick reference:

Batches	**States Participated**	**Dates**	**Venue/ Place**	**No. of Participants**
Batch 1	Andhra Pradesh, Goa, Gujarat, Karnataka, Kerala, Maharashtra, North-East (NETSU), Odisha, Puducherry, Rajasthan, Tamil Nadu and Telangana.	20-21 August 2019	ITC Kakatiya, Hyderabad	53
Batch 2	Arunachal Pradesh, Assam, Bihar, Chandigarh, Chhattisgarh, Himachal Pradesh, Jharkhand, Madhya Pradesh, Manipur, Mizoram, Nagaland, Punjab, Sikkim, Tripura, Uttarakhand, Uttar Pradesh, and West Bengal,	22-23 August 2019	The Lalit Hotel, Delhi	53

A detailed agenda and the list of participants are attached as annexure for reference. Below are the details of each session, highlights and key points of discussion. For convenience of readers, both the batches key discussions points are presented together.

Welcome and Introductions

Batch 1 (Hyderabad): NACO, along with APSACS and FHI 360, welcomed the participants and provided the background for the revamped strategy for the TI along with the purpose of the ToT.

While welcoming the participants Dr. Bitra George, Country Director, FHI 360 shared that the TI revamped strategy has been piloted and that the ToT workshop would be an avenue to understand the strategies in detail and discuss the implementation plans at the state level. NACO/SACS has had about six to eight months to implement the strategy. Based on availability of budget and guidelines, the subsequent phase could be further strengthened.

A historical overview had been provided by Mr. Rajeenald T. Dhas, PO-TI, NACO indicating that the revamp exercise has been initiated and developed in consultation with all major stakeholders like NACO, SACS, communities, partner and support agencies, and technical experts. He explained that this ToT aimed to demonstrate what, when and how these strategies must be implemented at field level. The ToT team will take the exercise up to TI level. The ToT team will be supported by the representatives of FHI, NACO and other stakeholders during the roll-out process.

The entire two-day ToT has been facilitated by Mr. Kannan Mariyappan, Consultant FHI 360. As part of ice breaking participants were guided to self-introduce by sharing their name, organization they represent, and to share one strength and one limitation of the national TI program. Few of the selected strengths and limitations shared are provided below:

Strengths:

- TI program keeps motivating the team to identify and address field challenges,
- Community was recognised and brought to the forefront of the program
- Program is flexible allowing scope to implement newer strategies

- Directly working with high risk groups (HRG) and that it is largely a community driven program
- Revamp strategy guidelines is very useful
- Structured and well-planned program at all level
- Success model of partnership and community participation
- TI has demonstrated a successful national program up to district level.
- TI program has rich source of data and information

Limitations:

- Guidelines and policies sometimes are too rigid
- Reaching the unreached and loss of follow-up continues to be a challenge
- State level - change of senior leadership of government, often has impact on the program
- Financial issues - Salary structure is not very motivating and staff retention is a challenge
- Community ownership - Involving key population in planning, implementation and monitoring of TI program is a challenge
- Program focus is on identifying HRGs, conducting RMP, ICTC testing, but the efforts towards community behaviour change is not as rigours as needed. Limited focus on treatment monitoring and adherence.
- Too many reporting and documentation formats and requirements. Data and information available from field, however the data is not used effectively.
- Interstate coordination to follow up the bridge and migrant population if not effective
- The program is working with same population, and there is a need to identity the new HRGs unreached, virtual population. Size estimation needs to be very practical and as per current.
- Capacity building continues to be a challenge
- Outdated computers, and IEC materials

Batch 2: New Delhi

Inviting the participants to the ToT, Mr. Kannan Mariyappan, Consultant FHI 360 had welcomed the participants and provided an overview of the ToT agenda and encouraged participants to provide feedback on the TI revamped strategy as the operation guidelines are still in the process of finalization.

The ToT was graced by the presence of NACO dignitaries Shri. Alok Saxena, Joint Secretary, Dr. Shobini Rajan, ADG-TI&SI, Dr. Bhawani Singh, DD-TI, and Dr. Bitra George, Country Director, FHI 360. The dignitaries were welcomed by Dr. Saravanamurthy PS, Research and SI Specialist, FHI 360 felicitated the NACO dignitaries and provided a green welcome. He briefly talked about the process of revamped strategies and invited Mr. Rajeenald T. Dhas for a detailed discussion on the Revamped Strategies.

TI Revamped Strategies; the beginning, process, current status and the way forward has been shared by Mr. Rajeenald T. Dhas, PO-TI, NACO. He revisited the kind of continuous guidance and unconditional support received from JS, NACO and ADG-TI&SI, NACO during the process of development of TI Revamped strategy, besides their facilitation through critical decisions. He recalled the accompaniment, mentoring and motivation of Dr. Bhawani Singh, DD-TI-NACO throughout the journey of choosing and shaping appropriate TI strategies and leading the TI team to reach the stage of conducting ToT and thus ensuring that all the

personnel of TI programme to be trained on the TI Revamped Strategies. It is planned that the entire cascade training is scheduled to be completed by end of October '19, he reiterated.

Dr. Shobini Rajan, ADG-TI&SI, NACO appreciated that the training on the TI revamped strategies has already began in field, and she stated that this ToT is also an effort to strengthen these strategies. She appreciated the FHI 360 team involvement in developing the revamped strategy from start to finish.

Dr. Bitra George, Country Director, FHI 360 briefly explained that this workshop is culmination of joint efforts from various organization working towards revitalization of TI. He said that it has been observed that the pattern of sex work, drug use has been dynamic, so the program must address this changing scenario. He further explained that a core group in March 2018 initiated the process of developing the revamped strategy. Best practices from different programs like VHS, TAI and different program were brought together for this exercise. He encouraged the state team (during the ToT) to give feedback on its implication at the field level and that the team should develop an implementation plan for roll-out. He also assured that FHI 360 will continue to provide support as needed, even after closure of LINKAGES project.

Shri. Alok Saxena, Joint Secretary, NACO provided encouragement by informing that most of the work towards revamping the TI strategy at NACO has already been planned. He stated that the administrative and financial approval is awaited. He also states that the dynamics of sex work and MSM population has changed throughout country and it very different from state to state, hence each state can pick up a strategy or idea tailored to them. He states that the World Bank has been very supportive for this process and he informed that NACO has put in significant efforts to strengthen the TI division, while the IEC division team was strengthened with additional human resources. He concluded that the team worked on

strengthening the strategy for DAPCU to actively engage them in service delivery at the field level. The TI level work has been actively addressing the changing dynamic of sex work.

While thanking the dignitaries Dr. Govind Bansal, NC-DNRT, NACO highlighted that support from the JS has been a continuation motivation for the all the NACO officers by continuously challenging them at work. He also thanked ADG-TI & SI and DD-TI for their continuous inputs to the program and keeping the momentum get going in the team. He also thanked FHI 360 leadership and the team, for their continuous support to national HIV program.

Session 1: Strengthen Outreach Activities (SOA)

Key session highlights:

1. Strengthen Outreach Activities (SOA) will focus on hard-to-reach and hidden HRGs who are outside the TI areas. To saturate the coverage, efforts will be made to reach out to new populations and newer areas. Eligibility criteria for HRGs registration is individuals who are 18 years & above, who have never registered in TI and those who are engaged in high risk behaviour.

2. Process of implementation – identify new hotspots, with necessary approvals and coordination with other divisions to organize community-based screening camps to provide counselling, TI registration, initiate ART registration and treatment.

3. Approach will be 'Respondent Driven Sampling' (RDS), virtual outreach, event-based camps, *Dera* based approach. Role of SACS, TSU and DAPCU was detailed out.

4. Monitoring indicators include number of uncovered areas, number of HRGs & spouses, sexual or injecting partners, number of HRGs, spouses or partners screened or tested for HIV testing, number found positive, numbers linked to ART registration and treatment. Separate reporting formats for this SOA were explained. A few challenges in implementing the SOA were also briefly discussed.

Key discussion points

- The participants enquired on the minimum number of participants for the community based testing camps, and it was clarified that SACS and state teams to decide based on geographical areas and local TI.
- It was decided that outreach workers (ORWs) should take responsibility for HRGs who are constantly migrating/highly mobile as the ORW is best placed to follow-up with these clients.
- There was apprehension of not being able to provide quality counselling or care for HIV testing. CBS can be stigmatizing and can discourage HRGs attending these camps. State teams need to plan adequately to address this challenge.

- There are hotspots and HRGs operates in areas that are not TI catchment area. TIs are aware of it and have an understanding about the same and these HRGs will be able covered through SOA.
- In camp approach, we identify population from non-TI area, how do we reach out to these.
- There is no specific criteria for age of HRGs at hotspots, it is purely based on availability of HRGs at the hotspot for SOA.
- Delhi state team clarified that through web platform program access the HRGs on dating sites and connect them to diagnostic or treatments facilities. It is suggested that each state may interact with HRGs to identify the sites which are frequently accessed by MSM/FSW and need to provide basic outreach or information on these. We preferably might select non-payment sites unless we have budget under IEC to access paid sites.
- Mizoram – should we register these sites for outreach? Not necessary, in SOA we identify uncovered sites or population, conduct CBS camps, screen HIV positive and link them to ART. We are not planning to continue aggressive outreach at these sites; however, we encourage the HRG who attended these camps to register in the nearby TI.
- Does it mean we should go beyond our project area; do we have additional budgets? Not needed as it is just conducting CBS which is already planned budgeted activity.
- If we have general population access the CBS, and do we have target to link number of camps attendees to linking to HIV testing? No, the only indicator the project is expected to report is HRG who are reported positive and linked to ART, but many general population attending the camp TI may reflect on this based on field situation.

Session 2: Programmatic Mapping and Population Size Estimation (MPSE)

Key session highlights:

Strategy to be adopted for mapping was explained in detail under the following three sections:

1. Working estimated based on existing mapping data.
2. Community led mapping & size estimates through community network.
3. Mid-course correction will be TSU driven, like peer led mapping.

Key discussion points:

- Should we get the data, compile the information and submit the report? Clarification provided that first there will be national ToT, followed by state level and district level by then we could have more clarity on this process.
- For districts where TI discontinued due to different reasons like TI NGO closure, the known HRGs are not being reached out whereas we are identifying new HRGs and new areas? Clarification was new TIs should be identified to reach these already identified population or these populations should be linked to exiting TIs.

Session 3: Differentiated Prevention Service Delivery (DPSD)

Key session highlights:

1. This objective of this model is to prioritize HRGs using the risk segmentation model, and the differential service delivery strategies.
2. There was significant variance in understanding or interpreting the high-risk behaviour indicators – for e.g. alcoholism, violence which made HRGs vulnerable for HIV, hence the "risk and vulnerability assessment checklist" was revised to provide more clarity.
3. New indicators were added to include anal sex, lubricant use, group sex, alcohol use (before and during sex), sexual violence and/or violence which led to sex.
4. Most responses on sharing of needle was reported as zero, hence a proxy indicator like 'do you share drugs or inject drugs in a group' was added.
5. Tool include an excel sheet, and as they fill in the sheet, the back sheet will automatically calculate the risk of the HRGs. Each possibility of risk behaviour of the HRGs is linked and analysed using a dominant analysis method.
6. The strategy must be created once the risk analysis categorization is done and the service must be planned and provided accordingly.
7. Differentiated service model was divided into new HRGs, high priority, medium priority, stable and HRG-PLHIV, accordingly the frequency of outreach visit, services or commodity provision would be planned.
8. A service matrix provides the details on contact, clinics visit, HIV testing, condom & needle syringes, presumptive treatment and behaviour change communication (BCC) to all priority I, II III and HRG PLHIV.

9. The program must closely monitor this to help high HRGs to move to low risk category.
10. A dynamic categorization chart provides details on hotspot of details for planning. Performance indicators include eight critical indicators.
11. For reporting and documents, all of the forms will remain the same except form A, which have had small modification.

Key discussion points:

- State teams were encouraged to share the current experience in implementing the differentiated prevention approach. Karnataka and Gujarat presented their experience of implementing differentiated prevention approach to reach HRGs. They differentiate the HRGs based on budgeted and non-budgeted population. Whereas in the North east, they categorize priority and non-priority clients. Prioritized clients are given more and frequent outreach service, which has resulted in more HRGs accessing the testing services.
- Andhra Pradesh/Telangana has a specific micro-plan for reaching newly identified key populations, which resulted in the identification of key challenges.
- Delhi team shared their experience based on risk vulnerability assessment tool, HRG divided into 3 categories and outreach activities are planned accordingly.
- West Bengal team divided HRG based on scores given on risk and vulnerability assessment indicators. For low priority Regular Medical Check-up (RMC) was not provided, but syphilis screening once a year had been ensured.
- Punjab team prioritized the first group as new HRG which has a high number of positives and their data is analysed on monthly basis, while the second group included active HRG in line list, and third are the HRG who are weaning out and low risk. Accordingly outreach activities are provided to them.
- North-east team explained based on 7 variables for IDU, vulnerability may be low, but risk is high. HRG are categorised based on risk exposure, and the number of years associated in the TI project. It has to be noted, that the newly registered HRGs are more at risk in case of FSWs and MSM but not in case in IDU, as IDU risk behaviour is different even if he is injecting 2 or 3 times a week.
- NACO is planning to streamline the online reporting systems through the Strengthening Overall Care for HIV patients (SOCH) project. Through this it is being decided to gradually include the indicators of differentiated prevention model as part of this effort.

Session 4: Community Based Screening (CBS)

Key session highlights:

1. CBS is improving early diagnosis. The rationale of the strategy is to improve performance, reach the 90-90-90 target by 2020, reach the un-reached high risk population, and to saturate 100% HIV testing of all HRGs.
2. Preparatory work for CBS includes training, details of untested population, cold chain maintenance, establishing quality assurance mechanism at sites and ensuring confidentiality.
3. Overall responsibility of this screening camp lies with the ICTC team as the TI team is only responsible for facilitating the camp implementation.
4. Annual target for TI includes total 5 lakh which include 1.5 lakh spouses, 2 lakh new HRGs, 1.5 lakh HRG.

Key discussion points:

- The importance of supply chain management, indent, waste disposable plan to be included into the preparatory work part of presentation.
- CBS at prisons is a challenge as there were incidents of prisoners escaping when they were allowed to access ART centre. There is lot of stigma as they stay in a common prison and there are clients on special diet where there is concern of confidentiality.
- There are challenges to follow NACO guidelines as jail too has guidelines for the prisoners.
- CBS yearly target is a challenge for TI as the dynamics of sex work is getting more challenging, especially young age group. Other participants too raised some concerns on field issues in achieving the targets.

Session 5: Service Delivery: Index testing

Key session highlights:

1. Index clients in our project consists of HRG who HIV positive and index cases are may also include spouses, sexual partner, injecting partner and social partner.
2. The program strategy involves first stabilizing the index client and the identifying the partners (sexual, social and injecting) and providing them counselling testing services.
3. Steps for scale-up include training TI team, peer educator (PE) role to facilitate spouse/partner to access testing and treatment services.

Key discussion points:

- There was lot of discussion on social partners in the index testing. It was clarified that it is not expected to screen all the social network partner, but only those who are more at risk or vulnerable and it must be voluntary and not forced.
- Sexual partners of PLHIV would be a challenge as it raises issues on confidentiality. In such cases, PLHIV are encouraged to reach out to their sexual partners for HIV screening.
- Project is not expected to maintain a line list of index testing partners, however we need to have basic information for further follow-up, as the purpose is not to increase our line list but, to control the spread of HIV infection.

Session 6: Female Injecting Drug Users (FIDU)

Key session highlights:

1. There are many more issues for Female IDU in comparison to male IDU. Gender based stigma, violence, sex work or vulnerable to sexual exploitation are some of the issues.
2. Enhanced service packages provided to FIDU include access and referral for self-help groups, social protection schemes, income generation programs, safe night shelter/drop in centres, access to legal services.
3. De-addiction services for FIDU may be considered for inclusion in NACO comprehensive services for women.
4. Hepatis services may also be provided along with the HIV services to FIDU.

Key discussion points:

- Clarification was provided that for children below 18 years, whose biological mother is positive, they must be screened for HIV.
- NACO is very supportive for spouses and wives of IDU, new IEC materials like flip books are in the process of being finalized and rolled out.

- NETSU and North East partners may be contacted to access more information and support on this area.
- SUNRISE project under FHI 360, is also planning to bring out a note on experiences of network model with spouses and wives of IDU.

Session 7: Spouses and Partners of IDUs

Key session highlights

1. Index-testing of spouses and/or sexual partners had been reiterated
2. Navigating HIV positive spouses/ sexual partners was discussed and emphasized
3. Spouse/ sexual partners could be considered as one of the SDNS point
4. Inclusion of monitoring indicators for spouse/ sexual partner testing, treatment adherence and viral suppression was discussed in detail

Key discussion points

- Concerns were raised by the Nagaland team that the IDU TIs, have not employed the female outreach workers, who are supposed to reach the spouses of IDUs and even if they are employed, they were not being utilized appropriately. As a conclusion, one of the immediate measure agreed was to ensure employing the female outreach worker across all the TIs.
- NACO is very supportive for spouses and wives of IDU, new IEC materials like flip books are in the process of being finalized and rolled out.
- SUNRISE project under FHI 360, is also planning to bring out a note on experiences of network model with spouses and wives of IDU

Session 8: Service Delivery: Discussion on Community Mobilization

Key session highlights:

1. The session discussed on the purpose and benefit of community-based ART and it has been a proven approach for increasing access and adherence by the community. To this facility, only stable clients would be referred for accessing the medicines. In these centres, nurse will be responsible for drug dispense and supply chain management.
2. As part of the clinical services, STI screening and treatment, TB screening and TB treatment and the status of referral to Revised National TB Control Program (RNTCP) and Reproductive Maternal New born and Child Health (RMNCH).
3. The clinical services sessions also discussed on the abscess management for IDUs, including FIDUs.
4. The session also discussed about various models of interventions among Transgender/ Hijra (TG/H), including, dera/gharana based approach.
5. The session also discussed on the event-based approaches and the process involved in the event-based approaches.

Key group presentations:

- ***Community based ART:*** Advantages include: shorter commute and it brings the centre to the community, increases client retention, provides friendly environment, leading to OST and ART improved adherence. Challenges include definition of stable clients is not clear, issues on confidentiality, initiation of ART within 10-15 days. Technology based adherence needs first 6 months to ensure adherence.
- ***Clinical services:*** Current practices include working with government facilities, TI based static clinics for IDU and camp-based approach. Challenges include ensuring quality, only verbal screening at many facilities, no physical examination and routine medical check-up, capacity building, sensitization and honorarium for health care providers (HCP). Areas of improvement include capacity building and sensitization of HCP. Supply of syphilis screening kits, single prick dual testing institutionalization, coordination meeting with government HCPs once in six months. Coordination treatment at static clinics of IDUs and integration of TI STI management into HMIS.
- ***Enabling Environment:*** Stakeholder analysis presented the below diagram:

Low Influence Low Importance	High influence Low importance
Low Influence High importance	High influence High importance

- Good practices included formation of community committees, capacity building of committee members, advocacy with stakeholders and addressing crisis (CRS).
- ***Dera based approach:*** Experience of Dera based intervention has been good in Surat and Thane, while it was challenging in Ahmedabad and other big cities. Cooperation from leaders (Gurus) has been good and many of TI have Gurus working as PE, which is important to gain access to Dera. Challenges include both MSM and TGs as there is often conflict among these groups.
- Event based: Events support HIV service delivery, mostly package of services is given, helps in establishing new contacts, IEC and BCC approach can be used, sometime funds are also mobilized due to these events. Few examples of big events for FSW and MSM population in state of Tamilnadu and Kerala were shared. As package of services are provided in an event follow up is challenges, sometime entertainment dominates the program objective in an event

Day 2:

Recap:

Participants recalled some of the major learnings and discussions from the previous day. The recall included community-based screening strengthened outreach activities, procurement, indent cold chain management, Index testing – testing of partners through CBS for enhanced case detection, and importance of having ORWs to encourage spouses for testing, especially female IDU.

Challenges were further discussed especially for individuals below 18 years. Most projects shared their experience, where they provided services by registering TI documents and they maintain a different register for this purpose. As per the HIV act there were many concerns, for example, one participant shared if they give consent services can be provided or if the parents of client are HIV service can be provided. We need to review the HIV act clearly, especially the clause on testing for below 18 years, and then we need to implement in the program accordingly.

Dynamic list – we need to continue the line list in the project and provide them services, however based on the risk assessment, the service package may differ. We have HRG line list, however in project period we continue to identify new HRGs. In Delhi, the HRGs who are not active for last 2 years and at low risk may be considered for deletion from the list and include new HRGs, but it was discussed that it is not recommended to delete HRGs from the list. If there is provision of budget, new HRGs with need of services may be provided the same.

Session 9: Community System Strengthening

Key session highlights:

1. A community score board was developed to understand the community perception of the program being implemented in the field.
2. The committee was formed by community members and provides detailed feedback on all the program services like testing centres, prevention commodities, ART centres, timings and support provided to HRGs.
3. The primary purpose of this activity to reduce and address stigma and discrimination.

Key discussion points:

- The score card initially was to assess the TI services, but now the focus is on facility-based services like ICTC, ART centre etc, where TI may have limited influence.
- Institutionalization of the approach needs to be planned more effectively with TSU and SACS, and it is recommended to include this into scope of work for the TSU PO and DAPCU.
- We also may explore the option of integrating this into the "Mera Hospital" software-based feedback system developed by SAATHI for National Health Mission (NHM).
- Participants debated on the question related to the timings of ICTCs, as the timing cannot be changed, and the consensus was the question can be reframed to understand if the timing is suitable so that program is informed on this issue too.
- A suggestion was provided to include few feedback questions on outreach session, peer education, IEC etc. Another suggestion was to change the members on rotation.
- Madhya Pradesh (MP) team shared their experience where HRGs scored services based on some indicators, and later TSU team had a meeting involving the community to understand the challenges in accessing services, periodicity etc. and it was decided that this will be conducted on a quarterly basis with 15 members representing the community.

- Timings of ICTC was discussed and states will review these based on their respective state situation and in consultation with all relevant stakeholders. Few participants were not aware of the score card hence requested for a copy to conduct a detailed review.

- It was also discussed that the frequency of implementing the score card should be defined. A suggestion was to include the outreach activities and few other questions based on these ToT workshops.
- A suggestion was also that these community score cards will be analysed at frequent intervals and a community committee will be formed to facilitate the action to be taken on the feedback. At regular interval these feedback and action points will be shared with SACS.

Session 10: Commodity Distribution: Secondary distribution of needle syringe

Key session highlights:

1. This approach was implemented by FHI 360 in the Orchid project under the Avahan program and one of the key lessons from the earlier project was that it is important for proper accounting and documentation at the outlet level.
2. Another lesson from this program is that the secondary distribution sites are dynamic; they keep changing based on community needs.
3. It was also discussed that it is also important to review the sites identified and have discussion with stakeholder on appropriateness of these sites.
4. Preparatory work is critical to identify the hard to reach areas, non-registered HRGs sites, and to identify the secondary outlets, which are easily accessed by the community.
5. A supply chain mechanism also should be thought of, while identifying the secondary outlet as TI will be the main supply point for them.
6. This model has been reviewed by NACO, and the respective state teams have to ensure the state government leadership supports this.
7. Teams may consider using different methodologies, one option is central procurement, or the state can decide to procure locally through TI. For e.g. in West Bengal, the TI are encouraged to procure from the medical department which provides huge subsidy.

Key discussion points:

- As this program has been implemented in earlier projects too, it is essential to document the success and challenges as it helps new states in initiating implementation of this program.
- TSU PO may be involved in the monitoring this program and on a day to day basis the TI program manager must monitor this activity closely.

- PE and outreach workers have mechanisms for disposition of needles and syringes

- Peer educators and ORW are responsible and they do counselling on the issues associated with sharing of needle/syringes and once in week ANM/counsellor further visits the sites to reinforce the message.
- Accountability is not an issue for government facilities, as it is simple to register the distribution and return of syringes

Session 11: Satellite OST centres

Key session highlights

1. The session highlighted the importance of increasing the accessibility of OST to IDUs, which would increase their enrolment and reducing the HIV transmission rate among IDUs in the country.
2. It would help is decongesting the existing OST centres and increase the accessibility for IDUs remotely located and away from the existing OST centres.
3. There have been different models discussed in the context of rationalizing the resources such as NGO model, collaborative model, Integrated OST centre and OST in prison setting.
4. The challenges of this S-OST is availability of skilled personnel, facility assessment, transportation of drugs and storage and mobilization and maintaining of IDUs.

Key discussions points

- Primary documentation of client will be done at satellite OST centre. Delhi team shared the experience that transfer is done once a client is stable because it is possible to lose a client if we wait for 1 year, as per guidelines. NACO responded that national guidelines cannot be revised as it made for all states, however states depending on field situation can transfer the clients in one or two months.
- Monthly meeting, frequent monitoring may not be feasible in northeast as the distance is large, but we need to develop a basic reporting mechanism for these satellite centres, for them to monitor their work.
- Manpower and furniture (just a basic chair) may be minimal at satellite centres especially in hilly/mountain based on location and demand for OST.
- Availability of OST centres on Sundays and holidays may be considered based on demand at field.
- Draft detailed guidelines on satellite OST will be shared with group, suggested to refer the operational guidelines on OST of NACO

Session 11: Reporting formats

All of the reporting formats were reviewed in detail and the following are some of the suggestions from the participants:

Key session highlights:

1. The session highlighted the importance of various forms in the TI and the frequency of utilization of these forms.
2. Further, the session highlighted the indicators already available in the existing formats for capturing the implementation of revised TI strategy. In addition, it also indicated which existing formats can accommodate new and/or refined indicators to monitor and track revised TI strategies.
3. The session also highlighted it is not all 17 formats used on a daily basis, it is only 5-6 formats being utilized on a daily basis for monitoring and tracking the program activities.

Key discussion points:

- Form A – HRG registration - One of the suggestions is include the date of birth instead of age, group discussed and the consensus was to continue the current format.
- Form A – 16 or 18 state/area/hotspot code can be made to give uniformity.
- Form A1 – network operator registration form is optional as it more relevant to those TI intervention who have Spa and massage parlour form of sex work operation.
- Whether to exclude Panthi or not, need to be taken call later as the project is not actively reaching out to Panthi (Indicator 23)
- Indicator 32 may be changed to ever tested/screened.
- Use of social media to be included all HRGs groups as it is now currently for MSM/TG.
- Suggestion was to include bar based HRGs, and it was agreed any other column this may be included as it won't affect the coding.
- The recent TISS study identified new additional FSW soliciting areas, which may be included.
- Instruction on filling all the formats to added.
- CBS format – Insert a column on confirmative test and refer to ICTC centre, link to ART format may be changed.
- Peer navigation dairy – age to replace by date of birth.

- ART status to be segregated into 4 on ART, pre-ART, LFW and miss cases. Cross verification to be added on stability of cases in the format.
- Index testing -Name column to be added and age may be deleted.
- Last two columns on linkages may be deleted.
- Secondary distribution of needle syringe - referral register and doctors register need to be combined.

Session 13: Bio medical waste management

Key session highlights

1. All the activities in the TI project should follow the bio medical waste management procedures and processes.
2. The processes should be documented appropriately as there are many legal liabilities pertaining to HIV, bio medical waste management etc.

Key discussion points:

- If there is accidental needle prick, PrEP can be accessed at ART, ICTC and other public health facilities. But there was some discussion of it being not available at ICTC and other facilities in few states. It was suggested that ART centre should be visited within 72 hrs of exposure.

Session 14: TI Evaluation

Key session highlights

1. In this session, alternative approaches for evaluation of TI was discussed along with the challenges within the existing system and/or mechanism.
2. Similar to the HIV program, NACO also keen to evolve in its way of approaching the TI evaluation, but there were other administrative and financial difficulties, because of which the current existing system of evaluation is said to be continued along with well-known challenges.

Key discussion points

- Evaluation tool to be revised, especially the essential indicators.
- Evaluators must review the earlier program review reports.
- Clear code of conduct for the evaluators. Community involvement in the evaluation/ evaluation team, review the community evaluation scorecards.
- Consultant honorarium may be reived to ensure quality evaluators are available.
- Hiring of consultant/evaluators by NACO. NACO may provide the list of consultant and state will coordinate based on timelines and consultant availability.
- Evaluation process to include indicators like number of years NGO experience, typology of TI etc need be analysed.
- Any additional inputs or technical assistance provided by donor.
- Evaluation period time period may be adjusted so that the evaluation can completed as per consultant availability.
- List of empanelled consultants, TOR for consultant a committee is formed, and this is being reviewed.
- Prior experience in TI evaluation may be recommended.
- The revised TI evaluation has been shared with the Ministry for review and approval. There was discussion on the fact that ranking from external consultants is different from internal TSU scoring. This difference could be due to the fact that external evaluation has a set of indictors for overall organization capacity and TI performance, whereas TSU evaluation is often focused on target and plan on HRG reach out.

Way Forward

- Training of TSU and SACS officials through a regional level workshops was planned
- The feedback, comments and suggestions made during the ToT, will be used for refining the slides prior to the regional training.
- Training duration, training manual, PPTs, hand-outs to be provided to the ToT team in advance time before rolling out the trainings
- State level training duration can be for two days followed by TI level training
- Operational guidelines for the revamped TI strategies are yet to be finalized, once finalized will be made available for reference.
- All components/activities must be reviewed and revised state specific.
- Implementation or training plan – within a month all five regional training can be completed between Sep-Oct'19
- Timelines suggested by states are
    - Gujarat – within a week by Aug end, will submit a implementation plan
    - Andhra Pradesh, Telangana and Karnataka – 29th Aug
    - Tamilnadu and Kerala – 31st Aug '19
    - Odisha and Maharashtra – 31st Aug '19

Workshop Wrap up

Best Practice shared by Karnataka: The state team shared their experience of pooling all the lab technicians both contracted and full time and made them available at all the facilities 24/7. This was jointly discussed with the Director of Medical Services and other stakeholders involved.

Participants' feedback at ToT workshop Delhi

- Very good learning and sharing experience. FIDU and night shelter discussion was a very practical experience and was very beneficial. We also need to now focus on Hepatitis-B among IDU.
- Team expressed they feel re-energised.
- Revamping of TI strategy is very useful as it addresses most of field challenges.
- Revamping is very useful, especially in resource poor setting of north east, and the workshop of brought the team together and also provided assurance from NACO to support the field level staff in addressing the implementation challenges.

Closing remarks by the workshop organizers included:

- Ensure revamped strategies are developed and adopt them to local condition. We find challenges as we implement, but we will also learn to work around these challenges. Key population TIs need to change as per changing dynamics of sex work network and behaviours.
- Listen to community needs and change/adopt the program to effective reach.
- Please document success and challenges of the revised strategy which will support in finalizing the Operational Guidelines for TI program.
- The final PPT of this workshop will be shared with all stakeholders.


019 | ITC Kakatiya, Hyderabad
LINKAGES


NACO
ToT on Targeted Intervention's Revamped Strategies
22-23 August 2019 | The Lalit, New Delhi
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Annexure 1: Agenda of National ToT on Targeted Intervention's Revamped Strategies – Batch 1

Objectives of the Training Programme:

1. To orient the newer strategies of targeted intervention programme and its additional monitoring indicators under NACP.
2. To build the capacities and skills to implement the revamped strategies of targeted intervention programme under NACP.
3. To familiarize the participants on the additional responsibilities and the provision of costing guidelines based on the revamped strategies.

Date & Time	Title of the session	Duration	Facilitator
DAY 1: 20 August 2019			
08.30 – 09.00	Registration	30 Minutes	FHI360
09.00 – 09.30	Inauguration of the training programme	30 Minutes	NACO/SACS/USAID/FHI360
09.30 – 10.00	Ice-breaker and Introduction of participants	30 Minutes	Mr. Kannan, FHI360
Community Outreach			
10.00 – 10.45	Strengthen Outreach Activities	45 Minutes	Mr. Dew Stanley, NACO Mr. G S Shreenivas, FHI360
10.45 – 11.30	Mapping & Population Size Estimation (MPSE)	45 Minutes	Mr. Rajeenald, NACO Dr. Saravanamurthy, FHI360
11.30 – 11.45	Tea Break		
Service Delivery			
11.45 – 12.45	Differentiated Prevention Service Delivery (DPSD)	60 Minutes	Mr. Jimreeves K, FHI360 & Mr. Maninder Setia, FHI360
12.45 – 01.45	Lunch		
01.45 – 02.45	• Community Based Screening	60 Minutes	Ms. Sophia, NACO

Date & Time	Title of the session	Duration	Facilitator
	• Index Testing		
02.45 – 03.15	Navigation	30 Minutes	Dr. M.R. Parthasarthy, FHI360
03.15 – 03.30	Tea Break		
03.30 – 04.00	Female Injecting Drug Users	30 Minutes	Dr. Bitra George, FHI360 Mr. Mung, NACO
04.00 – 04.30	Spouses and Female Partners of IDUs	30 Minutes	Ms. Sophia, NACO Dr. Bitra George, FHI360
04.30– 05.30	**Discussion on Community Mobilization** • Clinical Services • Enabling Environment • Dera Based approach • Event Based approach • Community based ART dispensation	60 Minutes	Mr. Rajeenald, NACO Mr. G S Shreenivas, FHI360
DAY 2: 21 August 2019			
09.00 – 09.30	Recap of Day 1	30 Minutes	Mr. Mung, NACO
Community System Strengthening			
09.30 – 10.00	Community Scorecard	30 Minutes	Mr. Dew Stanley, NACO
Commodity Distribution			
10.00 – 10.45	Secondary Distribution of Needle and Syringes	45 Minutes	Ms. Sophia, NACO Dr. Bitra George, FHI360 Mr. Mung, NACO
10.45 – 11.15	Satellite Opioid Substitution Therapy Centres	30 Minutes	Ms. Sophia, NACO Mr. Mung, NACO NETSU Representative
11.15 – 11.30	Tea Break		

Date & Time	Title of the session	Duration	Facilitator
11.30 – 01.00	Review of reporting formats aligning with TI Revamped Strategies - • TI MIS formats • MITR • SIMS • Performance indicators of TI Revamped Strategies	90 Minutes	Mr. Rajeenald, NACO Mr. Kannan, FHI360 All participants
01.00 – 02.00	Lunch		
02.00 – 02.30	Biomedical Waste Management	30 Minutes	Mr. Mung, NACO
2.30 – 03.15	Revised TI Evaluation Manual and Evaluation Tools	45 minutes	Mr. Rajeenald, NACO
03.15 – 03.30	Tea Break		
03.30 – 04.15	Discussion on implementation plan	30 Minutes	Mr. Dew Stanley, NACO
04.15 – 04.45	Feedback from Participants	30 Minutes	NACO& FHI360
04.45 – 05.00	Valediction / Closing Remarks	15 Minutes	NACO/SACS/FHI360

Annexure 2: Agenda of National ToT on Targeted Intervention's Revamped Strategies – Batch 2

Date & Time	Title of the session	Duration	Facilitator
DAY 1			
08.30 – 09.00	Registration	30 Minutes	FHI 360°
09.00 – 09.30	Inauguration of the training programme	30 Minutes	NACO/SACS/USAID/FHI 360°
09.30 – 10.00	Ice-breaker and Introduction of participants	30 Minutes	Mr. Kannan, FHI 360° Mr. Karthikeyan, NACO
Community Outreach			
10.00 – 10.45	Strengthen Outreach Activities	45 Minutes	Mr. Samresh Kumar, NACO Mr. G S Shreenivas, FHI360°
10.45 – 11.30	Mapping & Population Size Estimates (MPSE)	45 Minutes	Mr. Lalit S.K., NACO Mr. Karthikeyan, NACO
11.30 – 11.45	Tea Break		
Service Delivery			
11.45 – 01.15	Differentiated Prevention Service Delivery (DPSD)	60 Minutes	Mr. Jimreeves K, FHI & Mr. Maninder Sethia, FHI360°
01.15 – 02.00	Lunch		
02.00 – 03.00	• Community Based Screening • Index Testing	60 Minutes	Dr. Sarvanamurthy, FHI360°
03.00 – 03.30	Navigation	30 Minutes	Dr. Parthasarthy, FHI 360°
03.30 – 04.00	Female Injecting Drug Users	30 Minutes	Mr. Aditya Singh, FHI360° Mr. Vijay, NACO

Date & Time	Title of the session	Duration	Facilitator
04.00 – 04.15	Tea Break		
04.15 – 04.45	Spouses and Female Partners of IDUs	30 Minutes	Mr. Aditya Singh, FHI360° Mr. Vijay, NACO
04.45 – 05.45	**Discussion on Community Mobilization** • Clinical Services • Enabling Environment • Dera Based approach • Event Based approach • Community based ART dispensation	60 Minutes	Mr. Kannan Mariyappan, Consultant, FHI 360
DAY 2			
09.00 – 09.30	Recap of Day 1	30 Minutes	Mr. Vijay, NACO Mr. Karthikeyan, NACO Representatives from Participants
Community System Strengthening			
09.30 – 10.00	Community Scorecard	30 Minutes	Mr. Samresh Kumar, NACO
Commodity Distribution			
10.00 – 10.45	Secondary Distribution of Needle and Syringes	45 Minutes	Mr. Aditya Singh, FHI360° Mr. Vijay, NACO
10.45 – 11.15	Satellite Opioid Substitution Therapy Centres	30 Minutes	Mr. Vijay, NACO NETSU Representative
11.15 – 11.30	Tea Break		
Other components			
11.30 – 01.00	Review of reporting formats aligning with TI Revamped Strategies - • TI MIS formats	90 Minutes	Mr. Lalit S.K., NACO Mr. Kannan, FHI 360° All participants

Date & Time	Title of the session	Duration	Facilitator
	• MITR • SIMS • Performance indicators of TI Revamped Strategies		
01.00 – 02.00	Lunch		
02.00 – 02.30	Biomedical Waste Management	30 Minutes	Dr. Bhavna Rao, NACO Mr. Mung, NACO
2.30-3.15	Revised TI Evaluation Manual and Evaluation Tools	45 minutes	Mr. Lalit S.K., NACO
03.15 – 04.05	Discussion on implementation plan	30 Minutes	Mr. Samresh Kumar, NACO
04.00 – 04.15	Tea Break		
04.15 – 04.45	Feedback from Participants	30 Minutes	NACO & FHI360°
04.45 – 05.00	Valediction / Closing Remarks	30 Minutes	NACO/SACS/FHI360°

Annexure 3: List of Participants: Batch 1 – Hyderabad

Sl. No	Name	Organization/State
1.	Dr. Anna Prasana	Telangana State AIDS Control Society
2.	Mr. M. Chandrashekar	Andhra Pradesh State AIDS Control Society
3.	Mr. Y D Prakash	Andhra Pradesh State AIDS Control Society
4.	Mr. P. Venkateshwara Rao	Andhra Pradesh/Telangana TSU
5.	Mr. Vinay Kumar	Andhra Pradesh/Telangana TSU
6.	Ms. Nain Kumari	Andhra Pradesh/Telangana TSU
7.	Mr. Nagarjuna	Andhra Pradesh /Telangana TSU
8.	Mr. Dennis Joseph	Kerala State AIDS Control Society
9.	Dr. S.K. Harikumar	Kerala TSU
10.	Mr. Sachendra Katkar	Mumbai District AIDS Control Society
11.	Mr. Lokesh Gabhane	Maharashtra State AIDS Control Society
12.	Ms. Karuna Borkar	Maharashtra State AIDS Control Society
13.	Mr. Jagadish Patil	Maharashtra/Mumbai/Goa TSU
14.	Mr. Rupak Mohanty	Maharashtra/Mumbai/Goa TSU
15.	Mr. Ramesh Rathod	Goa State AIDS Control Society
16.	Mr. Sunil Kumar	Rajasthan State AIDS Control Society
17.	Ms. Pinky Shekhawat	Rajasthan State AIDS Control Society
18.	Mr. Umesh Chandra Routray	Rajasthan TSU
19.	Dr. V. Manimaran	Tamil Nadu State AIDS Control Society
20.	Mr. V. Velaiah	Tamil Nadu State AIDS Control Society
21.	Mr. K. Nagarajan	Tamil Nadu State AIDS Control Society
22.	Mr. S. Arivalagan	Tamil Nadu State AIDS Control Society
23.	Mr. S. Swaminathan	Tamil Nadu TSU
24.	Dr. Jayaraju D	Karnataka State AIDS Control Society
25.	Mr. Shashidharan Katteri	Karnataka TSU
26.	Mr. K N Meswaniya	Gujarat State AIDS Control Society
27.	Mr. Chaitanya Bhatt	Gujarat TSU
28.	Dr. Jayaraju D	Karnataka State AIDS Control Society
29.	Ms. V. Selvanayagy	Pondicherry State AIDS Control Society
30.	Mr. Yanchenthung Yanthan	NETSU
31.	Ms. RK Nishikanta Singh	NETSU
32.	Mr. Khyuchamo P Ezung	NETSU
33.	Mr. Deepak Kshetrimayum	NETSU
34.	Mr. Rezzaque Hussain	NETSU
35.	Mr. Pankaj Choudhury	NETSU
36.	Mr. Sanjib Chakraborty	NETSU
37.	Mr. Alan Lalmuanpuia	NETSU
38.	Mr. Mahesh Doddamane	FHI 360
39.	Dr. Maninder Singh Setia	FHI 360
40.	Mr. Kaveesher Krishnan	FHI 360
41.	Dr. P.S. Saravanamurthy	FHI 360

Sl. No	Name	Organization/State
42.	Mr. G.S. Shreenivas	FHI 360
43.	Dr. M. R. Parthasarathy	FHI 360
44.	Mr. Jimreeves Kirubakaran	FHI 360
45.	Ms. Thota Maheshwari	FHI 360
46.	Dr. Bitra George	FHI 360
47.	Mr. Kannan Mariyappan	FHI 360
48.	Dr. Anand Kumar Paulraj	FHI 360
49.	Mr. Anthony Reddy	FHI 360
50.	Mr. Rajeenald Tanes Dhas	NACO
51.	Ms. Sophia Khumukcham	NACO
52.	Mr. Dew Stanley Ephraim	NACO
53.	Mr. Ginlianimung Ngaihte	NACO

Annexure 4: List of Participants – Batch 2 – Delhi

Sl. No.	Name	Organization/State
1.	Dr. Vanita Gupta	Chandigarh AIDS Control Society
2.	Dr. Abhoy Prasad	Bihar State AIDS Control Society
3.	Dr. Sandeep Kumar Mittal	Chandigarh AIDS Control Society
4.	Mr. Sanjay Singh Bisht	Uttarakhand State AIDS Control Society
5.	Mr. Manoj Govil	Uttarakhand TSU
6.	Mr. Om Prakash Singh	Uttarakhand TSU
7.	Ms. Savita Thakur	Madhya Pradesh State AIDS Control Society
8.	Mr. Mahendra Pancholi	Madhya Pradesh TSU
9.	Mr. K.P. Sharma	Madhya Pradesh TSU
10.	Mr. Ramesh Chandra Srivastava	Uttar Pradesh State AIDS Control Society
11.	Dr. Abhishek Singh	Uttar Pradesh State AIDS Control Society
12.	Mr. Nabarun Panda	Uttar Pradesh TSU
13.	Dr. Meenu Singh	Punjab State AIDS Control Society
14.	Ms. Manu Lalia	Punjab State AIDS Control Society
15.	Ms. Mamta Gulati	Punjab State AIDS Control Society
16.	Mr. Manish Kumar	Punjab TSU
17.	Mr. Sewanand Vats	Punjab TSU
18.	Ms. Tina Mitra	West Bengal State AIDS Control Society
19.	Ms. Kiran Misra	West Bengal State AIDS Control Society
20.	Ms. Betty Lalthantluangi	Mizoram State AIDS Control Society
21.	Ms. Lalrinawmi Sailo	Mizoram State AIDS Control Society
22.	Mr. Masoom Ali	Uttarakhand TSU
23.	Mr. Arunangsu Aich	Uttarakhand TSU
24.	Ms. Dipshikha Talukdar Haloi	Assam State AIDS Control Society
25.	Dr. Marto Ette	Arunachal Pradesh State AIDS Control Society
26.	Mr. Vikrant Verma	Chhattisgarh State AIDS Control Society
27.	Mr. Subhajit Pakira	Chhattisgarh TSU
28.	Mr. Hitesh Maheshwari	State AIDS Control Society
29.	Ms. Meena Kumari	Himachal Pradesh State AIDS Control Society
30.	Mr. Rajeev Ranjan Kumar	Bihar State AIDS Control Society
31.	Mr. Deepak Kumar	Bihar TSU
32.	Ms. Berniced Thapru	Nagaland State AIDS Control Society
33.	Mr. Abhiram Mongjam	Manipur State AIDS Control Society
34.	Mr. Rabendra Sen	Tripura State AIDS Control Society
35.	Mr. Karthikeyan	NACO
36.	Mr. Samresh Kumar	NACO
37.	Mr. Lalit S. K	NACO
38.	Mr. Abraham Lincoln	NACO
39.	Mr. Vijay Singh	NACO

Sl. No.	Name	Organization/State
40.	Mr. Ginlianimung Ngaihte	NACO
41.	Mr. Sophia Khumukcham	NACO
42.	Mr. Dew Stanley Ephraim	NACO
43.	Mr. Rajeenald T.D	NACO
44.	Dr. Noorussabah	NACO
45.	Dr. Govind Bansal	NACO
46.	Mr. Kannan Mariyappan	FHI 360
47.	Mr. Maninder Singh Setia	FHI 360
48.	Dr. P.S. Saravanamurthy	FHI 360
49.	Mr. G.S. Shreenivas	FHI 360
50.	Dr. M. R. Parthasarathy	FHI 360
51.	Mr. Jimreeves Kirubakaran	FHI 360
52.	Ms. Thota Maheshwari	FHI 360
53.	Mr. Aditya Singh	FHI 360