The Link Worker Scheme in
National AIDS Control Programme-*Phase IV* (NACP-IV)

Report of the Technical Working Group

3—4 May 2011

Institute for Defence Studies and Analyses, New Delhi

DRAFT

National AIDS Control Organisation

Department of AIDS Control

Ministry of Health and Family Welfare

Government of India

Preamble

Over 57 per cent of HIV-positive individuals in India are estimated to be living in rural areas, emphasising the need for an intensive intervention focussed on the rural parts of the nation. The need to strengthen the fight against HIV/AIDS—particularly in rural areas—becomes more pronounced in view of the stigma and discrimination surrounding the disease. Poor access to healthcare, gender inequality and, above all, infections going undetected or being treated by unqualified practitioners are issues are just some of the pressing issues that resulted in the launch of the Link Worker Scheme (LWS) under the National AIDS Control Programme Phase-III (NACP-III).

An overview of the states and districts that the LWS is currently operational in (or will expand into during FY 2011-2012) is given below along with information about the donor partners that are supporting the Scheme:

State	Number of Districts				
	LWS projects supported by Development partner				Total
	GFATM (Round 7)	UNICEF	UNDP	USAID/CDC	
Andhra Pradesh	19	3			22
Bihar	8	3	4		15
Chattisgarh	4		1		5
Goa	1				1
Gujarat	8	3			11
Karnataka	8	4		16	28
Kerala	1				1
Jharkhand	3				3
Madhya Pradesh	12				12
Maharashtra	24	5			29
Manipur	9				9
Mizoram	3				3
Nagaland	10				10
Odisha	6	1	4		11
Punjab	2				2
Rajasthan	6	1	3		10
Tamil Nadu	21	1			22
Tripura	2				2
Uttar Pradesh	9	3	2		14

West Bengal	7	2			9
TOTAL	**163**	**26**	**14**	**16**	**219**

The LWS, an intensive rural-based intervention to reach marginalised groups not covered by expanding urban interventions, has functioned under NACP-III to achieve its primary objective of halting and reversing the HIV/AIDS epidemic in India. In addition to high-risk groups (female sex workers; men who have sex with men; and injecting drug users), the LWS specifically address other vulnerable sub-populations, including truckers, migrants, youth and women residing in rural areas. Its community-based model (epitomised by the setting-up of youth-driven Red Ribbon Clubs in target villages, networking with PRI and existing health systems, and developing a cadre of community-level volunteers) ensures sustainability while at the same time making members of its target populations stakeholders in the programme.

In every identified LWS district being supported by GFATM, 100 villages with vulnerabilities are chosen as "core villages", whereas an additional 500 are designated "proximal villages". For every five core villages (a "cluster") there are two Link Workers (one male and one female). Link Workers are monitored by the Supervisor. Volunteers are identified by the Link Worker to support them in various activities in the village for HIV prevention. While selecting the Volunteers representation is ensured from different cultural, political, social and religious groups (such as local elected leaders, SHG members, youth leaders, representatives from women groups, farmers, schools or out-of-school youths). The population reached is at least 5,000 in each of 100 core villages, reaching approximately 5 lakh individuals in each district.

An overview of some of the major achievements of the LWS (as of March 2011) is given below:

#	Category	Description
1	Coverage of Target Populations	Over 1,50,000 HRGs (FSWs, MSMs and IDUs) are covered by the LWS in rural areas nationally. In addition, the Scheme also covers nearly 3,00,000 Bridge Population members (truckers and migrants) and 20,00,000 Vulnerable Population members (including, but not limited to, at-risk women, spouses of HRGs, and out-of-school youth). The programme has also identified and covers over 37,000 people living with HIV (PLHIV).
2	Service Delivery	Over 75,000 HRGs have been tested for HIV under the LWS, with approximately 6,000 being tested in March 2011 (either for the first time, or for a repeat test, which is expected to be conducted every six months). In addition, over 5,40,000 HRGs have sought treatment for STI symptoms under the LWS.
3	Community-Level Indicators	There are nearly 20,000 condom depots operating under the LWS, with almost 75,00,000. This number also includes Link Workers functioning as condom depots themselves, one of the Scheme's key achievement.In addition, there are over 8,000 Red Ribbon Clubs and Information Centres operating in villages around the nation.
4	Human Resources	In addition to state- and district-level staff, the Scheme has also capacitated nearly 8,700 Link Workers and 2,10,000 volunteers in the rural community

DRAFT

		against HIV.

The LWS, faced with its unique set of challenges, has also allowed its state- and district-level staff to foster a certain innovative streak that is evident in the unique strategies adopted by several programmes around the country. For example, one of the avenues of galvanising the village community is through village-level Information Centres. Avert Society (the Lead Agency for Maharashtra) operates its Information Centres under the moniker *Saiyukta* (Sanskrit for "integrated"). The term is appropriate as it represent an integration of all relevant government departments, a convergence of various local- and district-level bodies, as well the mainstreaming of HIV/AIDS issues with the general health-related concerns of the rural community. *Saiyukta* has allowed for enhancements in the uptake of HIV-related services, helped in reducing the stigma surrounding the disease and can, in the long term, create a sense of ownership of the rural intervention amongst the target populations.

Other states have tried different (but equally innovative) strategies to enhance the effectiveness of their respective rural interventions. In the LWS in Madhya Pradesh, for example, the list of Link Workers operating in each village is displayed prominently at the local Primary Health Centre (PHC) and Community Health Centre (CHC). In addition, all Link Workers in the state are a part of their respective Village Health and Sanitation Committee (VHSC).

In Kanchipuram district in Tamil Nadu, a Public-Private Partnership (PPP) model is being initiated, with private firms such as Hyundai and Saint Gobain making contributions in the form of HIV/AIDS banners and village-specific handbooks.

In Karnataka, village-level *Panchayats* have been actively involved in reviewing the implementation of LWS by interacting with Link Workers as well as organising a structured review of the programme during VHSC meeting. In many villages, the *Panchayat* has also borne the cost of certain IEC activities, such as wall paintings and writings. In one district, the *Panchayat* was able to leverage its position to organise and conduct health camps in villages where no proper health infrastructure existed by bearing the cost of travel for healthcare providers and counsellors.

The 2011 Census indicates that India has approximately 6,41,000 inhabited villages, in which over 72 percent of Indians live. In addition, with rural literacy rate often less than the national average (74 per cent), the need for continuing the LWS, a rural HIV-focussed outreach programme, is both evident and pressing.

The changing trends of the HIV/AIDS epidemic (including a spread from urban to rural areas) as well as the feminisation of the disease emphasise the importance of this rural HIV intervention. One example is the changing of methods of solicitation by FWS: whereas previous the vast majority solicited clients in "hot spots" (such as bus stands and railway stations), the rapid rise in mobile technology has allowed for alternate, "invisible" methods of solicitation. TI projects are unable to reach this rapidly growing group. Such rural FSWs (as well as their partners) can, however, be reached by the Link Worker Scheme, given the Scheme's unique, community-based structure.

This report by the Technical Working Group explores the role that the LWS should have under the National AIDS Control Programme Phase-IV (NACP-IV). It proposes important modifications in the implementation structure of the LWS with the aim of increasing the effectiveness and reach of the programme. The report bases its recommendations on available quantitative data, as well as evidence from and experiences of NACP-III.

DRAFT

Given that the LWS is the only intervention specifically targeted at the rural population, integrating the various aspects of prevention-to-care continuum lies at the heart of the Scheme's vision for NACP-IV. The stand-alone nature of the LWS, however, makes this integration challenging. It is already established that when services are not linked well, the target population may not be aware that the services they need even exist. Programmes with weak referral linkages often reach only a small percentage of those in need and make a minimal impact. It is therefore of prime importance that strong linkages be developed with other programmes within NACP-III in order to provide a comprehensive prevention, care, support package to the target population. Apart from the medical and psychological needs of the target population, it is important to address non-health issues as well. This would not only be a step in the direction towards improving the quality of life of the target population but also mainstreaming HIV at the village level. This document is an effort towards achieving the main proposed goal of NACP-IV -to accelerate the reversal of the HIV epidemic - by adopting a the strategy of effective coordination and integration within and outside NACP-III for an unified response against HIV.

DRAFT

Proposed Changes in LWS under NACP-IV

S.No.	Issue	Current Status	Challenge	Proposed under NACP-IV
LWS Operational Guideline				
1	Definition of Target Population Coverage	Coverage is defined as one time contact with the target population.	The "ever contacted" often operate outside the target villages hence cannot avail services provided within the Scheme	Coverage should be measured in terms of provision of services to the target population
2	Operation Definition of Vulnerable Population	Women headed households, spouses of migrants and IDUs, child headed households, Men and women having multiple sex partners, spouses of PLHIVs and youth	"Youth" is a larger term encompassing all categories of youth, regardless of their degrees of vulnerability to HIV	Youth to be defined as : • Out of School Youth • Youth with families living with HIV • Youth orphaned by HIV/AIDS
3	Criteria for selection of villages	100 most vulnerable	Not all Districts	Set a district-specific

	for LWS implementation	villages are selected	have a total of 100 villages	village target, resulting in a **need-based target**. Number of Link Workers and the supervisors may be changed accordingly
Service Delivery				
4	IDU and MSM specific services	No provision for specific services for MSMs and IDUs	ISDUs and MSMs not getting attracted to the Scheme in absence of customised services	Provision of MSM and IDU specific services (NSEP, Lubes etc)
5	Increase uptake of services (ICTC and STI)	Often times there is Low uptake of services	Distant location of service delivery points	--Direct and accompanied referrals (plains areas within 10 km; hilly areas within 5 km) --Mobile ICTC (Remote villages) --Link the Mobile ICTCs with the NRHM outreach camp. This will help to increase the number of testing at ICTCs and the number of people treated for STI. --Syphilis test can be

DRAFT

				done during camp approach and colour-coded drugs can be provided (at point of care). --DRP to formulate a monthly plan for camp and mobile approach requirement, in consultation with DAPCU. --Condom promotion campaign of social marketing organization can also be integrated with this outreach program
	Selection of Peer Volunteers	Peer Volunteers not selected	Optimal coverage of HRGs not achieved due to stigma attached to the group.	- Peer Volunteers to be selected where high no. of HRGs are present.
LWS Structure				
	Absence of value addition by majority of Lead Agency	LWS being implemented by a Lead Agency at the state-level where there are =>3		--Lead Agency tier may be avoided --Assistant Director (LWS) can be

DRAFT

		Districts in a state		appointed exclusively for the LWS in the State -- TSU to be entrusted with the responsibility of monitoring LWS at State Level
	District Level staff	1 DRP, 1Traning Coordinator and 1 M&E cum accounts Officer	Under-utilization of District level staff	- The position of Training Coordinator to be abolished - STRC to be entrusted with the capacity building under the LWS - DRP to take over the responsibility of M&E and the. role of M&E

				cum Accounts Officer may be limited as Accounts Assistant - DAPCU to be with the responsibility of monitoring LWS at District Level -
Integration with other Health and Non- Health Departments				
6	Verticality of LWS within NACP-IIII	A Stand alone rural intervention within NACP-III	Weaker coordination and convergence with other Programmes 5within NACP and with Line Departments has led to: --LWS has not been able to utilize the strengths of the	Coordination and convergence within NACP and with other Health and non-health departments. **NRHM:** --Convergence with ASHA would, therefore, necessarily involve an expansion

			other Programmes within --NACP-III Duplication of efforts --- HIV not perceived as a developmental issue at the village level.	of the ASHA mandate, and would need to be monitored. --Joint ASHA-LWS training modules need to be developed, to equip the ASHAs to work as Link Workers in the long run. --The focus to strengthen the LWS to **gradually integrate with NRHM** **--** By the end of NACP-IV, NRHM may absorb Link Workers and utilise them as mentors for facilitating the work of ASHAs and ANMs and assist the health

DRAFT

				service departments to prepare village-level health plans. **Non Health Departments:** --Department of Women and Child Development- for nutrition support for infected women and children, for women empowerment, prevention of child marriage. --Department of Social Justice and Empowerment- treatment and rehabilitation support to drug-addicts, organize campaigns against drug abuse. -- Juvenile Justice Board and Child Welfare Committee. To assure that the **OVC** concerns get properly attend to; --Department of Youth

				Affairs- for organizing youth-centred activities such as cultural events; youth exchange program, awareness programs and vocational training. --Department of Rural Development- for NREGA and other welfare schemes like housing and sanitation --Department of Panchayat Raj- for reducing stigma and discrimination, ensure the participation of link worker in VHSC. --Department of Education- for conducting adolescent health education classes, to form RRCs in schools/colleges.

DRAFT

Strategy for LWS Implementation under NACP-IV

The relevance and the need for continuation of the Link Worker Scheme has been amply mentioned in the preceding section. However, it is important that gaps and challenges currently faced by the LWS be adequately addressed in order to effectively respond to the HIV epidemic in the rural areas.

The under- mentioned gaps are observed in the implementation of LWS in NACP-III:

- **LWS a vertical programme within NACP- III**: LWS, under NACP-III is a standalone intervention for the rural areas having no integration with other programs like TI and IEC
- **Lack of additional services and customized service package for various segments of the target population:** LWS does not provide specific services for IDUs and MSMs. Since among the HRGs, FSWs are found in high concentration , activities for HRIs mainly focused on FSWs.

Limited Service Delivery Points: Major responsibility of the link worker is to link the needy people with various services centres like ICTC, STI clinic and ART Centers. However, in many districts, these service centers are far away from the link worker villages and hence people are not willing to access these services.

- **Cost Intensive Scheme:** Due to the involvement of many layers for the implementation of the LWS, a considerable amount is spent towards the HR and administrative cost.
- **Absence of value addition by majority of Lead Agency:** As per the assessment IMACS conducted in July, 2010, the implementation model involving the implementation of LWS through a Lead Agency is not providing any value addition vis a vis the models where the Scheme is being implemented directly through SACS.

In order to address the gap and for achieving the desired goal of NACP-IV, following strategies are proposed:

Proposed Changes in LWS under NACP-IV:

NACO's commitment to contain the spread of HIV in India by building an all-encompassing environment to respond to the epidemic and reaching out to diverse populations has resulted in the development of various structures at District, State and National levels together with a formidable workforce at each of these levels. Integration with and utilization of existing structures and services would not only help in rationalizing the cost and human resources that is required at the LWS level but would also address the rural epidemic effectively.

Three main areas of LWS which need to be focussed on in NACP-IV are:

I: Additional Strategy for Programme Implementation

II: Strategy for Sustainability of LWS

III: Structural Changes

I: ADDITIONAL STRATEGY FOR PROGRAMME IMPLEMENTATION

a. Provision for Youth Focused Services: Young people (15-24 yrs) are one of the fastest emerging “at- Risk” population in regards to the spread of HIV. They also form an important part of the target population under the LWS. The services and activities under LWS like VICs, Mid – Media should focus on youth and issues faced by them. The IEC messages should be customized to suit the needs of the young people covered under the Scheme. The activities of RRCs can also be strengthened by linking it with various schemes of other departments like Youth Affairs and Panchayati Raj. Apart from formation of RRCs, detailed work plan should be developed for each RRC.

b. Integrating IEC with SACS: In NACP-II, there is a budget of INR 3 Lakhs per LWS District for the Mid- Media activities. The budget is utilized for folk program, wall writing, street-plays, developing and printing of IEC materials etc. Keeping in mind the optimum utilization of existing programs at SACS, it is suggested that the IEC activities under the LWS be mainstreamed with the IEC programs of SACS, allocating only a minimum amount under LWS for specialized IEC activities.

Since the Mid- Media activities are utilized as the tool for mass awareness, it could be used as a platform to address other pertinent issues at the village levels. Expansion in the scope of the mid- media activities would create a room for coronation with the health and PRI functionaries at the village level for organizing such activities. To intensify the outcome of the mid- media activities and provide a cohesive structure to it, thematic Mid- Media activities could be conducted. Such a thematic approach would address both HIV and non-HIV issues pertinent to the villages.

c. Integrating the Training under LWS with STRC: State Training and Resource Center has the mandate for the capacity building of NGOs and CBOs implementing Targeted Intervention. The mandate of STRC can be widened by including the capacity building under the LWS.

d. Camp approach for HIV testing to be avoided: The Health camp approach has been widely adopted under the Scheme in order to deliver the ICTC services in the hard to reach areas. The quality of the health camps approach has been questioned due to issues associated with it like cold chain maintenance of blood samples, counselling, and confidentiality. Instead of conducting camps for HIV testing, the service of ICTC counsellors to be utilized for conducting counselling sessions at village (outreach by counsellor) and there by motivate the clients to access the services of ICTCs.

.e **Special services for IDUs and MSMs**: Under the current implementation model of the LWS, IDU and MSM specific services are not provided. Further Targeted Intervention model of NACO, being an urban model, leaves the rural HRGs from its ambit. This poses problems especially for the IDUs, who cannot avail the services of NSEP. Linkages with TI

DRAFT

for distributing Needles and Syringes to the rural IDUs would help contain the spread of HIV among the sub- population. The Link Workers could also be trained on NSEP. Developing linkages with the Oral Substitution Therapy program under TI would further lead to containing the HIV epidemic and destigmatization among the IDU community in the rural areas

.f **Integration with TI projects**: Apart from the service delivery component mentioned in the preceding section, integration with TI can also be done in other issues.

In some States, the thin urban rural divide or saturation of IDUs due to an IDU driven epidemic, there exist duplication in coverage of IDUs between the LWS and TI. Regular meetings between the two Divisions for sharing of line listing and hot- spots would go a long way in minimising duplication. There are many HRGs that migrate from rural to urban areas for purposes of work. This often leads them to be covered under TI once but not avail the services offered under TI once they are back to their village. Such “ever reached” HRG population can be covered under the LWS.

Also, in order to maintain the standardization of messages at all level, STRC should be given the responsibility to train the LWS staff.

g. Community Care Centers and Drop in Centers: Under NACP-III, NACO has an army of trained functionaries under various programmes (Community Care Centres and Drop- in Centers) to cater to the diverse requirements of the PLHIVs and their family members.

Having such a number of functionaries under various programmes at different levels often times lead to duplication of coverage of the target population. Sharing of line listing among the Link Workers and the staff of CCC and DICs would be a step towards minimization of duplication. Further, a monthly meeting of the LWS, CCC and DICs chaired by the DAPCU can be used as a platform to develop strong referral system at different levels.

h. Customised Service Delivery Package:

As on date, the service delivery component has adopted a homogeneous approach to cater to the diversity of the target group population. There are no additional services that are provided for MSMs and IDUs under the LWS. It is therefore suggested to have customised package of services for each segment of the population:

Typology	Package of Services
FSW	Condom, IPC, referrals to ICTC and STI Clinic and follow-up, linkages with TI NGOs/ CBOs, IEC Materials
MSM	Lubricants, condom, IPC, referrals and follow-up, IEC Material, linkages with TI NGOs/ CBOs
IDU	Condom, IPC, referrals and follow-up, linkages with TI NGOs/ CBOs, IEC Materials, Needle Syringe Exchange Programme *NSEP would be conducted with the support of TI*

Migrants	Safe Migration Training, providing migrant kit, condom, referrals and follow-up
Truckers	Condom, IPC, IEC Materials, referrals
Vulnerable Males and Females	Condom, IPC, IEC, referrals and follow-up
PLHIVs	Linkages with Social security Schemes and psycho- social, livelihood and nutrition support programmes, referral to ART and DIC.
Orphaned and Vulnerable Children (OVCs)	Linkages with psycho- social, educational and nutritional programmes and parents to be linked with livelihood support programmes,

I. Recruiting Peer Volunteers

Currently the each village covered under the LWS has 10 volunteers from the community. Since the HRGs form a very significant target population under the Scheme, having 1-2 peer volunteers would have a positive impact towards the access of services by the HRGs.

II: SUSTAINABILITY OF LWS

Under the NACP-IV, the LWS being looked through the prism of sustainability. This section is an attempt towards outlining the modifications that would augment the efforts and effectiveness of the LWS and make the Scheme sustainable

a. VIC and RRC: The main objective of the Red Ribbon Clubs (RRCs) is to create an enabling environment among the youth of the villages to address issues related to HIV and other related topics. RRCs also have a mandate to build the skills and capacity of the youth to effectively address the HIV epidemic.

Although currently there are more than 3000 RRCs under the LWS, measuring the outcome of the RRCs is a challenge due to its “non- institutional” nature. Sustainability of the RRCs beyond the life of the LWS can be achieved if the RRCs are integrated with the activities of the Youth Clubs registered with the NYKS.

The VICs are envisioned as common meeting place for the villagers cutting across the barriers of age, gender, religion etc. In its current form, the VICs main focus is on providing HIV related information. This has sometimes resulted in stigmatization of the VICs. Widening the scope of issues addressed in VIC, utilizing the existing Panchayat owned structure for VICs and involvement of PRIs, Health and District Administration in planning and implementation of the VIC activities to ensure accountability and sustainability. States like Maharashtra have launched brand “Sakunkta”, an effort towards de- stigmatizing VICs among the village community. Integrating the RRC and VIC services under one umbrella would maximise the output.

DRAFT

b. Integration with NRHM:

The strategy under NACP-IV should be to bring NRHM on board. Integration with ASHA would necessarily result in broadening the canvas of NRHM. Linkages with ASHA need to be strengthened in order to bring the pregnant women within the coverage of PPTCT. The feasibility of ASHA working as the Link Worker in the long run should also be explored.

Under NACP- IV, gradual integration of the LWS with NRHM is envisioned. The Scheme would continue as a separate intervention for the first three years of NACP-IV and would then be gradually integrated with NRHM in the last two years of Phase- IV. Link Workers after integration would act as mentors to ASHA so that the Link Workers can support both NACP and NRHM.

Link Worker should be an integral part of the Village Health and Sanitation Committee and regularly attend the Village Health and Nutrition Day. Link Workers participation in VHND would ensure the mainstreaming of HIV as a relevant issue at the village level and increase ownership and accountability of the PRIs.

c. Integration with Non- Health Departments:

- **Panchayati Raj Institutions:** PRI can ensure that the Link Workers are an integral part of the Village Health and Sanitation Committee. Further, with the help of the PRIs the woman can be encouraged to access the services. Further, the PRI can support in establishing and strengthening the VICs and RRCs.

- **Department of Education:** Linkages can be developed with the LW to act as resource persons in schools to talk about issues related to HIV and adolescents.

- **Department of Rural Development:** Linkages with DRD would help the target population to access the benefits of various employment schemes (MNREGA etc)

- **Department of Labour and Employment and Department of Social Welfare/ WCD:** Linkages with Department of Labour and Employment and Social Welfare would help the target population avail various welfare schemes and improve the quality of their life.

III: STRUCTURAL CHANGES IN LWS:

The current structure of the LWS is an expensive one with many layers to it and human resource that is not optimally utilized

a. LWS Point Person at SACS :

DRAFT

At present the Joint Director (TI) is the focal person for TI as well as the LWS. This has sometimes resulted in issues regarding ownership of the LWS by SACS. An Assistant Director (LWS) can be appointed exclusively for the LWS in the State. For effective coordination at SACS level the AD(LWS) is proposed to report to JD(TI)

b. TSU to be entrusted with the responsibility of monitoring LWS at State Level:

Every State has a Technical Support Unit with a mandate to extend technical assistance to TI projects in the State. There is one Project Officer for every 10 TI projects. These Project Officers can look after the LWS as well in that region. Depending upon the number of TI projects and LWS Districts extra Human Resource would be provided so that the Project Officers can look after both the Programmes efficiently and effectively. This would ensure the involvement of the TSU can be entrusted with the responsibility of monitoring the LWS at the State level instead of having a Lead Agency.

c. DAPCU to be with the responsibility of monitoring LWS at District Level:

DAPCU, like the TSU, can be made responsible for monitoring the LWS at District Level.

d. Removal of the Lead Agency:

If the above suggestions for rationalization of HR at staff level are implemented, there would be no role for Lead Agency. Therefore would as part of the restructuring of LWS, the concept of the Lead Agency can be abolished. This would result in minimising duplication of efforts by various programmes of NACO.

e. STRC to be entrusted with the responsibility of Capacity Building:

The mandate of coordinating and organizing LWS trainings could be given to the STRC, thereby abolish the post of Training Coordinator in the District Implementing Agency level.

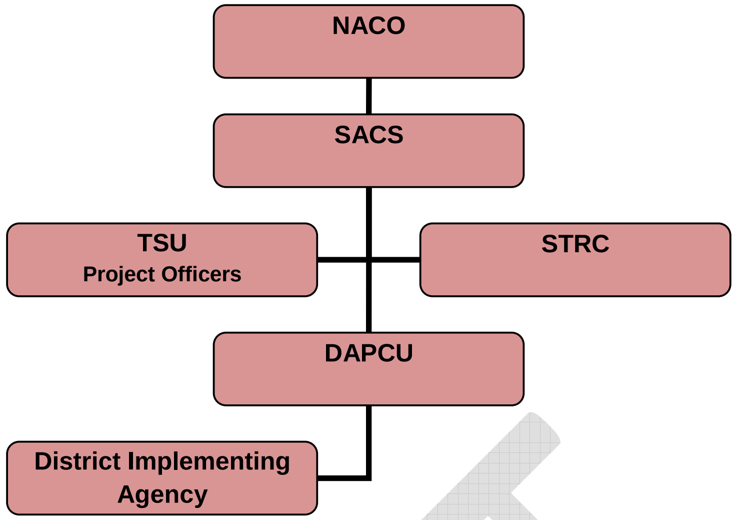
f. District Implementing Agency: The District Implementing Agency may be continued with the following modifications:

- Since STRC is proposed to be entrusted with the capacity building under the LWS, the post of Training Coordinator may be abolished.

- Since the DRP would be responsible for M&E at the District Level, the role of M&E cum Accounts Officer may be limited as Accounts Assistant only.

Following diagram represents the structure of LWS under NACO:

DRAFT



Recommendations

1. Due to the prevalence of HIV in rural areas and absence of other specified schemes for addressing the HIV-related needs of rural HRGs, vulnerable populations and PLHIVs, the **Link Worker Scheme may be continued in NACP-IV.** Link Workers are a specialised work force within the community working on the issues related to HIV/AIDS at the grassroots level. **Transition plan must be kept in mind** as the programme proceeds, and must retain the core of the Guidelines of NACO.

2. Link Worker Scheme may be implemented in '**A & B' category** districts as well as in other **highly vulnerable districts**.

3. One of the objectives of Link Worker Scheme is to cover members of the '**Vulnerable Population'**. This is a very broad term and hence there should be an **operational definition** for this. The LWS may cover the entire population in the village through awareness programmes and cover the 'people at risk' with specified services. It is also necessary to define the term '**coverage'** of *HRG and Vulnerable population* in the context of the LWS.

4. Criteria (eg: population of the village, No. of HRGs and No. of PLHIVs in the village) may be fixed for selecting the LWS villages. All villages satisfying these criteria may be selected for LWS implementation. The current practice of selecting 100 villages in each district may be changed. It may be possible to set a district-specific village target, resulting in a **need-based target**. Number of Link Workers and the supervisors may be changed accordingly.

5. In order to have functional convergence, there is a need to **bring NRHM on board**. However, Link Workers are currently working closely with the frontline workers such as ASHAs, ANMs and Anganwadi Workers. As far as ASHAs are concerned, the target group is mainly mothers and children. Convergence with ASHA would, therefore, necessarily involve an expansion of the ASHA mandate, and would need to be monitored. In addition, joint ASHA-LWS training modules need to be developed, to equip the ASHAs to work as Link Workers in the long run. The focus should be to strengthen the LWS to **gradually integrate with NRHM**. By the end of NACP-IV, NRHM may absorb Link Workers and utilise them as mentors for facilitating the work of ASHAs and ANMs and assist the health service departments to prepare village-level health plans. A feasibility study of this may be conducted in the remaining one year; the prospective time-frame of this absorption is three to five years, assuming that this is a feasible option. A mentor for ASHAs could be appointed under NRHM, who knows the NRHM as well as NACP.

6. In high-prevalence districts, there are **multiple outreach workers** under NACP-II. There is a need to utilise these Human Resources.

7. At present in LWS, ASHAs, AWWs, ANMs and SHG leaders are selected as volunteers. But in the villages where the numbers of high risk individuals are high, **'Peer Volunteers'** may also be selected and trained. This will help to increase coverage and improve the quality of service delivery. In addition, there needs to be a clear definition for the role of volunteers including peer volunteers from each category.

8. Convergence should perhaps **look beyond just the "health" sector**. This is particularly relevant when coverage of youths is concerned. Eg: A *health mela* that is being organised with non-health departments participating is likely to draw a higher audience, achieving its health-specific targets specifically. This can also apply to something as intrinsic as "RRC", which can very much integrate with the existing Youth Clubs in villages. The LWS planning should be such as to make the programme **Youth-friendly.**

9. In order to have better coordination and ownership, there is a need for a LWS-specific point-person at the SACS. A post of **Assistant Director (LWS)** may be created in SACs where there are more than 4 districts covered by LWS. The AD (LWS) may work under Joint Director (TI). Whereas the selection of District Implementing Agencies may be done as a concerted effort between SACS and the Lead Agency. Development of **linkages with the STRC can result in making training more efficient** and to help reducing the cost of HR. The position of Training Coordinator at the district level can be abolished as part of this integration. This will also help streamline the programme and make it effective.

10. In all the **A and B category** districts District AIDS Prevention and Control Units have been established. **DAPCU may be entrusted to do the regular monitoring of Link Worker Scheme**. The gaps in referrals from one service centre to the other may be analyzed by the DAPCU team and necessary inputs may be given to the district team of LWS to enhance effective service delivery to the people who need it.

11. In order to avoid duplication and ensure uniformity of messages, it is recommended that respective **SACs may include the IEC program for Link Worker Scheme in their state level IEC plan**. Only minimum amount may be provided to the district level agencies of LWS for district specific IEC activities. Resource pulling from other sources is feasible for the IEC component may also be looked into. Specific IEC programmes should be tailored to different stages in programme implementation (such as, programme rollout, after one year etc.)

12. The service delivery can be improved by adopting following strategies
    a. Direct and accompanied referrals (plains areas within 10 km; hilly areas within 5 km)
    b. Mobile ICTC (Remote villages)
    c. Link the Mobile ICTCs with the NRHM outreach camp. This will help to increase the number of testing at ICTCs and the number of people treated for STI. Syphilis test can be done during camp approach and colour-coded drugs can be provided (at point of care). DRP to formulate a monthly plan for camp and mobile approach requirement, in consultation with DAPCU.
    d. Condom promotion campaign of social marketing organization can also be integrated with this outreach program.

13. **Strong linkages to be established with various non-health department** and agencies to meet the social needs of the target population and to ensure the sustainability of the link

worker scheme. Possible linkages that can be established by the link worker scheme with various agencies are given below.

i. Department of Women and Child Development- for nutrition support for infected women and children, for women empowerment, prevention of child marriage.
ii. Department of Social Justice and Empowerment- treatment and rehabilitation support to drug-addicts, organize campaigns against drug abuse. To assure that the **OVC** concerns get properly attend to; they should be linked with Juvenile Justice Board and Child Welfare Committee.
iii. Department of Youth Affairs- for organizing youth-centred activities such as cultural events; youth exchange program, awareness programs and vocational training.
iv. Department of Rural Development- for NREGA and other welfare schemes like housing and sanitation.
v. Department of Panchayat Raj- for reducing stigma and discrimination, ensure the participation of link worker in VHSC.
vi. Department of Education- for conducting adolescent health education classes, to form RRCs in schools/colleges.

14. As part of care and support, following activities may be done by the Link Worker:

    a. Follow up for CD4 testing and to for ensuring usage of ART drugs.
    b. VIC can be utilised a village- level Drop- in Centre
    c. Help and support the PLHIVs to avail various welfare schemes to meet their health and non-health needs.

    Link Workers may be capacitated enough to provide care and support to the PLHIVs.

15. Inclusion of IDU- and MSM-specific commodities- The LWS in NACP-IV may have **needle and syringe exchange program (NSEP) for IDUs** and **lubricant condoms for MSMs.** The NSEP may be linked with the nearby IDU-TI projects. The number of IDUs in LW districts can be calculated and communicated to the nearest IDU -TI project, which can then procure the relevant number of items. Effective coordination will therefore be required between ORW and LW Supervisor. MSMs may also be linked with their CBOs working in district or sub-district level.

16. The **lead agency tier may be avoided** by providing Project Officers in TSU and one nodal person at SACS. The **Human Resources at District and State level should be modified** to make the system more streamlined (for example, removal and merging of overlapping roles). This will help to make the programme cost effective.

17. It may be ensured the Link Workers are included in the **Village Health and Sanitation Committee** and the untied funds allotted to VHSC is also effectively utilize for the HIV related programs. In addition, participation of Link Workers in ASHA-run **"Mother's day"** as well as participation in the **VHND meeting**, resulting in convergence with reproductive health needs of HRG groups for example.

18. **Conduct "forward-looking" feasibility studies** that explore the current institutional structure of the programme and gauge the degree to which the Scheme may be transitioned to the NRHM, or other programmes. Core competencies for Link Worker can be a topic of the feasibility study.

19. Condom promotion may be done through free distribution as well as through social marketing. However, **more emphasis may be given to social marketing** by considering the sustainability of condom promotion program.

20. Following are the suggestions for monitoring and evaluation

    a. CMIS enable individual tracking sheets.
    b. Data quality has to be inbuilt
    c. **E**valuation on regular basis
    d. ESRM to be implemented (Documentation of Best practices by District Level)

21. With regard to TB program, the link worker can help in identifying the TB patients by referring the people to nearest PHC or Designated Microscopy Center (refers the people having cough for more than two weeks, and refer the PLHIVs having cough in any duration). In the case of people infected with HIV and TB, the link worker may check whether he/she is taking DOT regularly and whether he/she is linked to ART and also taking CPT.
22. **Revision in Travelling Allowance**: Keeping in mind the long distances travelled by the Link Workers, the travel allowance needs to be revised. The T.A can be on actual basis with a maximum ceiling. The honorarium of the Link Workers may also be revised with parity being kept with the ORW remuneration in TI.
23. **Selection Criteria of Link Workers** : The age of the female Link Workers may be relaxed up to 35 years and preference may be given to the daughter-in-law of the village over the daughter-of- the village. This would result in lower attrition rates among the Link Workers and provide sustainability to the LWS. The qualification of the Supervisor and Link Worker may be revised. Minimum qualification for a Supervisor may be Graduation and for the Link Worker could be High School.

DRAFT