सत्यमेव जयते

Link Workers Scheme Operational Guidelines

TI Division

April 2015

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National AIDS Control Organisation

India's voice against AIDS

Ministry of Health & Family Welfare, Government of India

www.naco.gov.in

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FOREWORD

Under the fourth phase of the National AIDS Control Program (NACP-IV), the Link Worker Scheme (LWS) has been designed to intensify and consolidate the prevention services, focusing on the at-risk population in the rural areas. The Scheme aims to address complex needs of HIV prevention, care and support, in rural areas through identification and training of field level workforce of Zonal Supervisors, Cluster Link Workers and other stakeholders on issues of HIV/AIDS, gender, sexuality and Sexual Tract Infections (STI). Mobilizing difficult-to-reach, others at risk populations, such as High Risk Groups, to access the public health services for STI, HIV Counselling and Testing Centres (ICTC), Anti-Retroviral Therapy (ART) etc. is a component of the Scheme. Their follow up back to communities is also envisaged. It also seeks to address the issues of stigma and discrimination in rural areas of India.

The present guidelines describe the scientific methods of selecting the most vulnerable villages, and strategies to implement the Scheme by using rich epidemic data which hitherto has limited use for local level planning and implementation.

I take this opportunity to acknowledge the contribution made by the technical experts and Targeted Intervention team at NACO in preparing these guidelines. I would also like to acknowledge SACS, TSUs and District NGOs for their valuable inputs.

I hope that these guidelines will help the SACS, TSUs and Districts NGOs for rolling out the Link Worker Scheme more effectively.

(N.S. Kang)

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K B Agarwal, IAS
Joint Secretary

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PREFACE

The HIV epidemic in India continues to be heterogenic, especially in terms of its geographical spread. As per the Technical Brief of HIV Sentinel Surveillance (HSS) 2012-13, the declining trend among ANC clients, considered as a proxy for general population, is consistent with India's story of large scale implementation and high coverage during Third Phase of National AIDS Control Programme.

The Scheme envisages to "Reach out to High Risk Groups (HRGs) and other at risk population in rural areas with information, knowledge, skills on STI/HIV prevention and risk reduction".

The HIV response in rural areas requires a localised approach as it is influenced by the unique socio-culture structures present in these areas. For example, ensuring access to healthcare for PLHIVs and detecting and treating HIV infections become a greater challenge in rural areas because of differing perceptions surrounding issues of sex and sexuality, drug use, and HIV, as well as stigma and discrimination towards the PLHIVs.

Link Worker Scheme aims to meet these challenges by reaching out to rural communities and to saturate their coverage. The scheme is designed to build the competencies of rural communities to take the onus of responding to the epidemic in an informed and responsible manner. Recognising the reach and capacity of the local people, the Link Worker Scheme envisages identifying villages-level personnel to work as Block Level Link Workers. These Block Level Link Workers will play the roles of catalysts, identifying the at risk populations, linking them to appropriate services (such as prevention, testing, care and support) and following up with them on a regular basis.

I am confident that effective implementation of Link Worker Scheme will help us reach out the difficult -to-reach population in the rural area and address their risk and vulnerability to HIV/AIDS. NACO would like to acknowledge the support of Public Health Foundation of India (PHFI) for supporting the development of the operational guidelines.

(K.B. Agarwal)

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CONTENTS

ABBREVIATIONS

AAP	:	Annual Action Plan
ANC	:	Ante Natal Care
ANM	:	Auxiliary Nurse and Midwifery
ART	:	Anti Retro Viral Treatment
ARV	:	Anti Retro Viral
ASHA	:	Accredited Social Health Activist
AWW	:	Anganwadi worker
BCC	:	Behaviour Change Communication
BDO	:	Block Development Officer
CBO	:	Community Based Organisation
CDPO	:	Child Development Project Officer
CHC	:	Community Health Centre
CMIS	:	Computerised Management Information System
DAPCU	:	District AIDS Prevention and Control Unit
DHS	:	District Health Society
DOTS	:	Direct Observed Treatment and Short Term Chemotherapy
DSRC	:	Designated STI/RTI Treatment Centre
DTO	:	District Tuberculosis Officer
FGD	:	Focus Group Discussion
FICTC	:	Facility linked ICTC
FSW	:	Female Sex Workers
Health & FW	:	Health and Family Welfare
HRG	:	High Risk Group
HSS	:	HIV Sentinel Surveillance
ICDS	:	Integrated Child Development Scheme
ICTC	:	Integrated Counseling and Testing Centre
IDU	:	Injecting Drug User
IEC	:	Information, Education and Communication
IPC	:	Inter Personal Communication
KP	:	Key Population
LFU	:	Loss to Follow up
LWS	:	Link Worker Scheme
MIS	:	Management Information System
MNERGA	:	Mahatma Gandhi National Employment Guarantee Act
MSDS	:	Migrant Service Delivery System
MSM	:	Men who have Sex with Men
MSW	:	Male Sex Worker

NACO	:	National AIDS Control Organisation
NACP	:	National AIDS Control Programme
NACSP	:	National AIDS Control Support Project
NCR	:	National Capital Region
NERO	:	North East Regional Office
NGO	:	Non Government Organisation
NTSU	:	National Technical Support Unit
OI	:	Opportunistic Infections
ORS	:	Oral Rehydration Salt
OST	:	Opioid Substitution Therapy
OVC	:	Orphan and Vulnerable Children
PHC	:	Primary Health Centre
PLHA	:	People Living with AIDS
PLHIV	:	People Living with HIV
PPICTC	:	Public-Private partnership ICTC
PPTCT	:	Prevention of Parent to Child Transmission
PRI	:	Panchayati Raj Institution
RSBY	:	Rashtriya Swasthya Bima Yojana
RTI	:	Reproductive Tract Infections
SACS	:	State AIDS Control Societies
SHG	:	Self Help Group
SNA	:	Situation Need Assessment
SOP	:	Standard Operating Procedures
STD	:	Sexually Transmitted Diseases
STI	:	Sexually Transmitted Infections
STLS	:	Senior Tuberculosis Laboratory Supervisors
STRC	:	State Training and Resource Centres
TB	:	Tuberculosis Bacili
TG	:	Transgender
TI	:	Targeted Interventions
TSG	:	Technical Support Group
TSU	:	Technical Support Unit
UC	:	Utilisation Certificate
UNDP	:	United Nations Development Programme
UP	:	Uttar Pradesh
VHND	:	Village Health and Nutrition Day

INTRODUCTION

In this chapter, the following areas are covered:

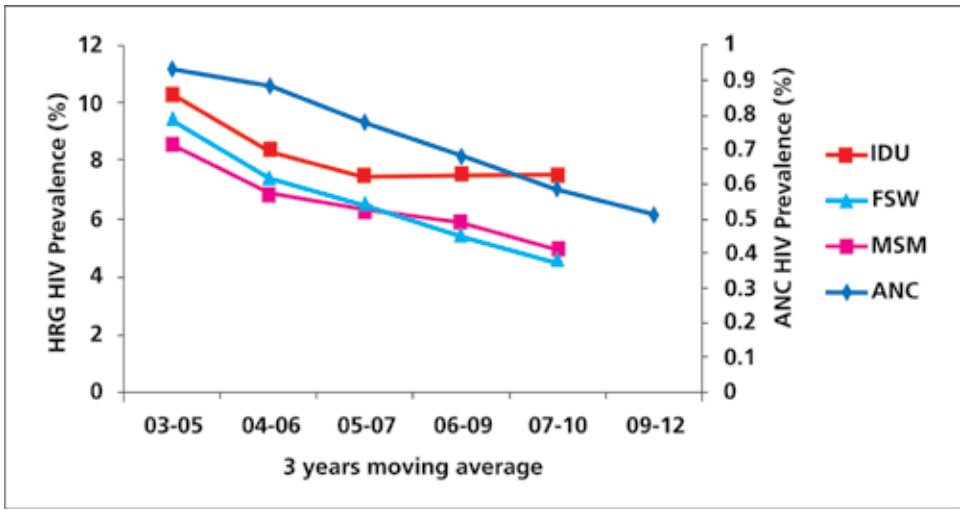
- The key strategies of NACP-IV and relevance of Link Workers Scheme
- Objectives, Purposes and Target audiences of the guidelines
- Salient features of the guidelines
- Services provided under link workers scheme
- Operational definitions used in the guidelines
- Organogram of implementation of the Link Workers Scheme

The key strategies of NACP-IV (part of NACSP) focuses on intensifying and consolidating prevention services with a focus on HRGs and vulnerable population as well as expanding IEC services for high risk groups with a focus on behavior change and demand generation and increasing access and promoting comprehensive care, support and treatment. These key strategies hold good in a way to consolidate the gains achieved during third phase as well as expand those learning to emerging pockets of epidemic.

The HIV epidemic in India continues to be heterogenic, especially in terms of its geographical spread. As per the Technical Brief of HIV Sentinel Surveillance (HSS) 2012-13, the declining trend among ANC clients, considered as a proxy for general population, is consistent with India's story of large scale implementation and high coverage during Third Phase of National AIDS Control Programme.

The HSS, 2012-13 also highlights that although the overall HIV prevalence continues to be low as 0.35%, there are about 80 sites which shows more than 1% prevalence and 12 sites with more than 2% prevalence. Some of these sites are in the moderate and low prevalence States of Bihar, Chhattisgarh, Gujarat, Madhya Pradesh, Jharkhand, Odisha, Rajasthan, Uttar Pradesh and West Bengal. Similarly, HSS 2010-11 highlights that there is significant decline in prevalence among High Risk Groups (i.e. Female Sex Workers, Men who have Sex with Men) except in case of IDUs the prevalence remains consistent.

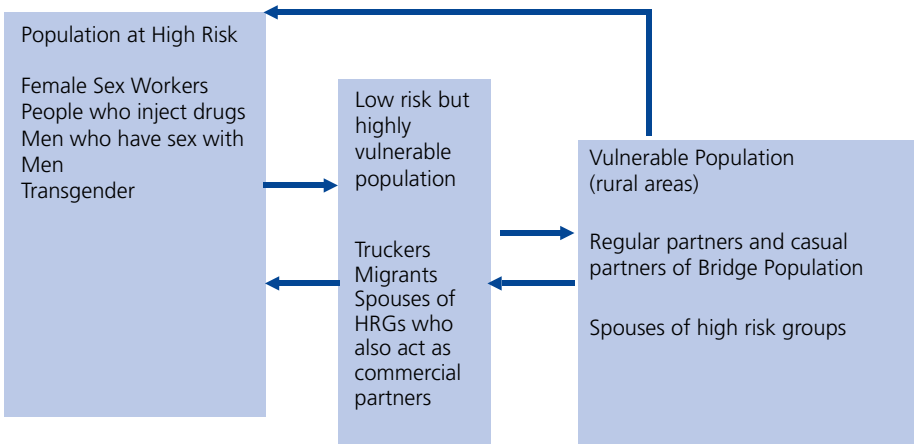
HSS 2010-11 highlights that some low prevalence States in west, north and east India have demonstrated a stable to rising trend. This rising trend in moderate and low prevalence States is interpreted by the growing understanding for need of high intensity interventions, saturation of coverage of high risk groups especially in rural areas, improving access to testing and treatment services. During NACP-III, NACO had invested significant resources and garnered political leadership to bring in these State's capacity and strengthen response.



Although, during NACP-III, the coverage of FSW (81%), MSM (67%) and IDU (81%) through a total of around 1821 targeted interventions (TIs) for high risk groups and bridge population was achieved mainly in urban and peri-urban areas, the coverage of rural HRGs and vulnerable population remained comparatively challenged. During NACP-III, the coverage and understanding of rural sex-work dynamics, impact of migration related transmission dynamics has evolved through implementation of Link Workers Scheme in selected districts in India. During NACP-III by the end of March 2012, the Scheme covered about 1,60,000 HRG, 18,70,000 Vulnerable Population and 37,000 PLHIV. Nearly 59% HRGs have been tested at ICTC and 58% HRGs have been referred to STI services under this intervention. This has been done by establishing linkages with existing services. In order to create a sense of ownership in the community and involve the youth in fighting against HIV, 13,296 Red Ribbon Clubs and 21,170 Information Centres had been established at the village level by March, 2012.

From these evidences it is clear that there is a need for comprehensive interventions focusing at community level to reach out rural HRGs and vulnerable population to achieve the accelerated response considering the emerging epidemic drivers in India especially that of rural ANC prevalence being higher than urban ANC prevalence in moderate and low prevalence States (HSS, 2010-11), spouses of migrants having four times higher risk than non-migrants (Male out-migration: a factor for the spread of HIV infection among married men and women in rural India, PLOS One, September 06, 2012).

The following figure shows the importance of rural HRGs and vulnerable population in the context of HIV transmission dynamics:



The above diagram highlights the fact that until now, the focus on population at high risk and bridge population has resulted significant decline, but the emerging epidemic drivers due to selected groups among general population in rural areas also need to be targeted adequately and comprehensively maintain the responses achieved. This is possible once the interventions are designed and implemented in a community environment by the community volunteers as is being carried out under Link Workers Scheme.

OBJECTIVES OF LINK WORKERS SCHEME

1. The scheme aims at building a rural community model to address the complex needs of rural HIV prevention, care and support requirements in selected geographies.
2. The scheme aims at reaching out to rural population who are vulnerable and are at risk of HIV/AIDS in a non-stigmatised enabling environment.
3. The scheme aims at improving access to information materials, commodities (condoms, needles/syringes) through collaborating with nearest TI or government health facilities, testing and treatment services ensuring there is no duplication of services or resources.
4. The scheme aims at improving linkage to other social and health benefits provided by other line departments in line with local norms, regulations suitable for vulnerable populations.

PURPOSE OF THE GUIDELINES

The purpose of these revised operational guidelines is to ensure delivery of quality HIV prevention interventions with strong linkage for access to testing and treatment under National Programme for rural HRGs and vulnerable population in selected districts of India. The guidelines outline standardized operating procedures for implementing comprehensive HIV prevention services on a scale. In summary the purposes of the Guidelines are:

1. Build in uniform understanding about the need, design and outcomes of prevention interventions among rural HRGs and vulnerable population across all stakeholders, users.
2. Bring in technical competence among implementers, managers and technical support persons.
3. Bring in performance benchmarks and quality interventions to contribute to the National Goal.

TARGET AUDIENCE OF THE GUIDELINES

These guidelines have been developed for the following audience:

- Policy Makers (Ministry of Health & FW through NACO, Ministry of Women and Child Development, Ministry of Rural Development, Ministry of Panchayati Raj and other line departments).
- Programme Team of State Level and NACO level
- Implementing partners (NGOs, CBOs and Collaborating partners; Staffs working in the TIs, ICTC and ART centres; Private Health Organisations / individual providers etc.)

It is recommended that all organisations using these guidelines consider each of the proposed elements in the context of the organization's current environment and other relevant guidelines published by NACO.

SALIENT FEATURES OF LINK WORKERS SCHEME

The salient features of this scheme are as follows:

1. The scheme uses evidence-based approach to identify rural areas having greater risk and vulnerabilities of contracting HIV through scientific tools such as broad mapping. Individuals/groups within the villages are identified for providing information and services based on detailed situation needs assessments.
2. The scheme envisages creation of demand for various HIV/AIDS related services and the linking of the target population to existing services. The scheme itself does not create any service delivery points.
3. The scheme involves highly motivated and trained community members – preferably a male or female cluster Link Worker for clusters of villages – who will establish linkages between the community on one hand and information, commodities and services on the other.
4. The scheme envisages creating an enabling and stigma free environment in the project area to ensure that the target population continue to access information, services in a sustained manner.
5. The scheme envisages creating linkages with services of other departments through ASHA volunteers, anganwadi workers, panchayat heads, MNREGA scheme officials etc. This is to ensure that the vulnerabilities are identified and addressed by building capacity of ground level stakeholders.

SERVICES PROVIDED UNDER LINK WORKER SCHEME

<table>
<tr><th>Target Groups</th><th>Common Services provided</th><th>Specific services</th></tr>
<tr><td colspan="3">High Risk Groups</td></tr>
<tr><td>Female Sex Workers
Men who have Sex with Men</td><td rowspan="2">• Information and counseling regarding risky behaviour and ways of preventing them.
• Condom negotiation skills
• Information accessing services for STIs, accessing testing services.
• Information and counseling related to safe sex practices
• Information regarding availability of condoms (both free and social marketing)
• Referrals and linkages with nearest ICTC/FICTC and follow up of referred cases.</td><td>Provision of condoms</td></tr>
<tr><td>People who inject drugs</td><td>• Provision of needles and syringes by linking to nearest TI.
• Collection of used needles and syringes and processing for bio-medical waste management through nearest ANM/PHC/TI/ ICTC centres
• Information on how to prevent abscess.
• Referral to nearest health centre for overdose management, OST (if available)
• Provision of condoms</td></tr>
</table>

Target Groups	Common Services provided	Specific services
Bridge Population highly vulnerable		
Truckers (local) Migrants (all categories)	• Information and counseling regarding the risk of unsafe sex, risk of STI and importance of syndromic case management • Information regarding condom availability • Information regarding importance of testing services to ensure early detection and access to services.	• Provision of condoms • Referrals and linkages to ICTC and follow up • Family counseling
Spouses of HRGs who also act as commercial partners	• Information and counseling regarding safe sex, condom negotiation skills • Referrals and linkages with ICTC and ART centres • Information and counseling regarding STI/RTI and importance of syndromic management • Information regarding availability of condom	• Provision of condoms • Follow up for STI treatment, referral and linkage for syndromic management
Bridge Population with low vulnerability		
Regular partners and casual partners of Bridge Population	• Information regarding condom use as triple protection • Importance of RTI /STI, partner management and syndromic management • Information regarding availability of materials, condoms	• Partner counseling and referral for STI check ups, voluntary counseling and testing. • Referrals and follow up for services of STI, HIV testing and ART • Periodic Health Camps in selected out migration villages

However, under this scheme youth with STI, with high risk practices, who are known to be clients of HRGs, who are HIV positive or TB patients, who are on ART are targeted more intensely. Otherwise in general youth are covered through mid/mass media activities.

OPERATIONAL DEFINITIONS USED IN THE GUIDELINES

High Risk Groups in rural context

a. Female sex workers (FSWs): Women who sell sex. Includes women who live and practice sex work in the village, women who live in the village but practice sex work outside the village, and women who practice sex work in the village but live outside the village. Excludes women who used to be sex workers in the past and are currently not entertaining clients since last three months. **Focus would be on FSWs who are high volume (more than 8 clients in 15 days) and medium volume (5 to 8 clients in 15 days), those who are highly mobile i.e. travelling at least 10 days a month outside the village. Also FSWs who are being covered by TI but they visit TI irregularly and there is evidence of services being discontinued.**

b. Men who have sex with men (MSM): Men who engage in anal sex with men. Includes men who live and engage in anal sex with other men in the village and with men outside the village and those who have anal sex with men in casual partnerships or in commercial relationships.

c. Transgenders (Hijras) who sell or buy sex with regular or commercial partners.

d. Injecting Drug Users (IDUs): IDUs are defined as those who used any drugs through injecting routes in the last three months. IDUs may live and inject drugs in the village, live in the village but inject drugs outside the village, and inject drugs in the village but do not live in the village. Some IDUs might be sex workers or MSM and some of them are also female. For Female IDUs standard definitions of NACO should be used including services.

Low Risk Bridge population

a. Partners/spouses of migrant/mobile men and women who are not into high risk activities

b. Partners/spouses of commercial drivers/ cleaners who are not into high risk activities

c. Spouses and partners of MSM, TG, IDU who are not into high risk activities

d. Men who have sex with men (not necessarily anal sex)

e. IDUs (not necessarily sharing needles)

f. Youth Population who have STI or HIV, who are TB patients, who are known to be clients of HRGs, who are on ART.

Pregnant Mothers from the point of vertical transmission and preventing them by ensuring early testing and necessary support during delivery.

TB patients from the point of reducing co-infection among TB patients who are currently on treatment or with suspected symptoms need to be targeted with information and services.

People Living with HIV

Persons infected by HIV are considered to be high risk in case they donot continue to maintain positive prevention practices. Suppose a positive man continues to have multi-partner sex without condoms.

This also includes children living with HIV and AIDS, they may be staying with their parents or not, should be provided with necessary services.

Male Population at Risk

Spouses of FSW: Spouses of FSW are at higher risk as their regular sexual partner carries the risk of contacting HIV from other multi-partner unprotected sex.

Migrants

As per the definitions of revised migrant strategy, these are men or women who migrate to high prevalence districts or towns/cities within or outside the State and have evidence of risk exposure (buying or selling sex; injecting habits based on information from the destination intervention or HSS). These migrants must be circular and of short duration, thus having the risk of carrying HIV from one place to another.

Mobile Population

Significant populations of the village move to nearby towns for work or business and they may come back on the same day or during the weekend. In case it was found that in the nearby town where they move also have HRGs and during discussion with these HRGs it was found that these groups also buy or sell sex during their stay in the town. Then it is important that these groups need to be covered.

Truckers: In India, these are male who primarily drive trucks. They may start from the originating station, they may board at any place in between the originating and destination points. They may be employed by the transport companies or are on contract basis, however no formal contract exists.

But for HIV programme point of view in rural areas the truckers (including helpers) are defined as those who are plying trucks in and around the area for various purposes, they may belong to the

same village or may be coming to the village for business purposes and having significant risk for HIV.

Female Migrants

The program should target female migrants who move with their family, as individual or in groups to other parts of the district or State or to other State are highly vulnerable. They need to be provided information about the risk and vulnerability of HIV and AIDS through group sessions and home visits.

Bridge Population who are highly vulnerable

a. At risk men including clients of FSWs or MSMs: Includes commercial drivers and cleaners who live in the village and work within or outside the village, migrant workers (single men or women) who come into the village or go outside the village for work/business for a short duration. Excludes long-term migrants who migrate for more than once a year. Includes spouses of female sex workers also.

b. At risk women: Women who have casual multiple partners including FSWs. Spouses of MSMs/MSWs and IDUs who are also HRGs.

Cluster Link Worker

Under this scheme, a person who has been trained and has been made responsible to carry out specific activities is called a Cluster Link Worker. The person can be male or female depending upon the requirements of the district. He/She is expected to reach out to the above groups, link them with services and follow up for continous uptake of services. Other activities as required are also expected to be carried out by the cluster link workers.

Target District

New districts are to be identified based on the risk and vulnerability parameters provided in the guidelines. These districts should have significant number of HRGs in rural areas (who are high or medium volume and are concentrated in pockets), high out migration with significant positivity among migrants or their spouses, high number of PLHIV concentrated in pockets would be considered on priority. In addition TB incidences and PPTCT coverage would add in deciding the selection of the district.

Target Blocks

New or Existing Blocks may be reconfigured based on the following criteria:

- At least 40% of the villages which are located at least 10 kms (5kms in hilly or districts with low population density) or more from the head quarter and having significant number of HRGs (who are high or medium volume and are concentrated in pockets), high out migration with significant positivity among migrants or their spouses, high number of PLHIV concentrated in pockets.
- One or more blocks can be clubbed together to make it one cluster for operation may be considered even if these blocks are from two different districts. However, the districts should have only one implementing agency. If separate agencies are available then this cannot be considered.

Target Area

The target area would be one village or a number of villages. The selection of village would be based on three basic assumptions. (refer the table on site assessment in Chapter 2)

1) Number of HRGs in the village and/or the HIV positivity at district level (ever in the district)
2) Number of PLHIV per 1000 population tested in the district (ever and alive)
3) Number of migrants from the village (% of total population in the village) and /or

HIV positivity among migrants (ever) in the district.

4) In addition, the number of pregnant mothers (including spouses of high risk men/women, spouses of migrants) to be covered and number of TB patients and PLHIV in the village or cluster of villages

Hotspots: These are solicitation sites of Female Sex Workers, Male Sex Workers, Transgender. These sites may be within a village, along the national highways or in dhabas near the village, at the weekly market place near the village, nearby town, nearby lodges/brothels or any other place which would be beneficial for the programme to reach out and provide information and condoms.

Hotspot for IDUs: These are places within a site where significant concentration of IDUs come together for various purposes including injecting of drugs, taking rest or during crisis events (abuse by family, public or police).

Sites: These are congregation points where congregation of above target population occurs for various purposes not necessarily for high risk activities. Every site cannot be a hotspot but each hotspot may also be a site as well.

Mid-media: These are forms of communication where the communicator (cluster link worker, ORW or a group) reaches to more than 8 people with contents relevant to the group. However, there is limited participation of the group with the communicator. These may be in the form of skits, plays, musical programmes, games etc.

Mass media: Mass media provides a means of expanding programme messages and creating demand beyond the boundaries of the intervention. It has the added advantage of reaching the population outside a formal intervention environment. However, there is no participation of the group with the communicator. These may be in the form of posters, pamphlets, hoardings, short films, short text message, social media etc. These include wall writings, posters, danglers with specific messages.

Social Marketing of condoms: In the process, condoms are marketed by outlets in an accessible place in the villages. This can be a paan shop, tea shop, grocery shop or can be an individual. By marketing these condoms the outlet holder makes some profit and this helps him/her motivated to be engaged for a social cause. In rural context, condoms can be marketed with sanitary pads, ORS pouches etc.

Health Camps: These are specific events organized at Panchayat Level especially during festivals when migrants return to their villages. This helps everybody to get their health checked up as well as undergo HIV counseling and testing. These should be organized with prior consultation with SACS and local District Health Society (DHS). So that there is no duplication and necessary support can be provided. Ideally the doctors, medicines and IEC materials, condoms are to be provided by DHS and SACS should provided testing and counseling support. A detailed guideline on conducting health camps may be referred from SACS/NACO.

Volunteers and Volunteerism: In the context of Link Worker Scheme, it is required that the target population get service from other available service points. Hence, the volunteers in this scheme would be ASHA, ANM, Anganwadi Worker, Livelihood mission staffs, Watershed project staffs etc. who work or live in the Panchayat. They need to be essentially sensitized and used as a volunteer to link up services. When they link up services and continue to do so, this can be one of the best example of volunteerism. Besides these SHG members, Youth club members can also be taken as volunteers.

Referral: When a client is sent to avail a service from a centre, the process is called referral. Usually in LWS, the process may be accompanied by the staff or may be by issuing a referral slip indicating the date and place of referral.

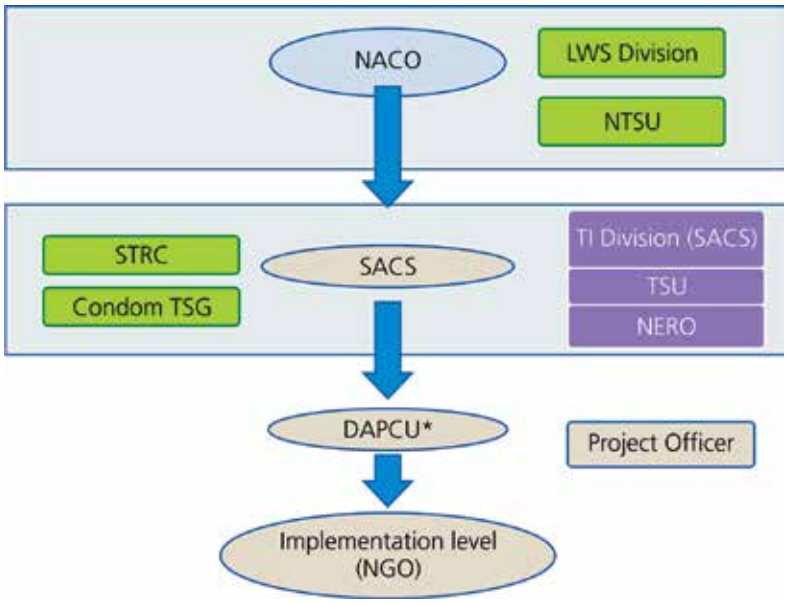
Linkage: When a client is linked to any service and is continuously followed up for adherence of services, then the process is called linkage. The linkage monitoring helps to understand the issues those need to be addressed for are improve adherence.

Contact: When any target population as defined in these guidelines is contacted either one to one or one to group for information or services such as provision of condom would be considered as contact. However, in case of contact of HRGs it is mandatory that the IPC tools are to be used for IPC sessions and the used copies of tools are kept in the office by block supervisor for verification.

Coverage: When any target population has accessed clinical services such as STI clinic visit or STI treatment, HIV testing or syphilis testing would be considered as coverage.

Drop out: If no services are provided as mentioned in the coverage for continuous of three months, then the name of the concerned individual to be dropped from the linelist and the total target is updated.

ORGANOGRAM OF IMPLEMENTATION AND MANAGEMENT OF LINK WORKER SCHEME



ORGANOGRAM OF IMPLEMENTATION OF LINK WORKER SCHEME AT NGO LEVEL

Entities	Major responsibilities
District level NGO	Management support
District Resource Person (1 per district)	Programme Management support
Zonal Supervisor (2 per district)	Supervision, Monitoring, Networking
Cluster Link Workers (maximum 20 per district for 100 villages)	Implementation, Advocacy, Monitoring
M&E cum Accounts Assistant	M&E, Accounting support

CHAPTER 1

RATIONALE FOR PREVENTION INTERVENTIONS AMONG RISK AND VULNERABLE POPULATION IN RURAL AREA

In this chapter, following areas are covered:

- The rationale for prevention interventions among risk and vulnerable population in rural area.
- HIV risk among rural population
- Factors which make rural population to vulnerable for HIV

1.1 RATIONALE FOR PREVENTION INTERVENTIONS AMONG RISK AND VULNERABLE POPULATION IN RURAL AREA

A central strategy of India's National AIDS and STD Control Programme has been to reduce sexual transmission of HIV within high-risk sexual networks, and from these high-risk networks into the general population. Accordingly, NACPIV (part of NACSP) had prioritised HIV prevention among at risk and vulnerable population as a key programme component. During this phase of NACP IV (part of NACSP) the priority to scale up and provide quality services among this population would be taken forefront both in rural and urban areas.

According to the HSS data there are about 80 districts with more than 1% prevalence and 12 districts with more than 2% prevalence have been identified along with about other 100 districts to improve the epidemic scenario especially among rural general population.

India's success in declining HIV prevalence need to address the inclining or stable trend of HIV in moderate or low prevalence States as well. In these States, the HRG urban mapping data highlights sparsely distributed low volume HRGs (with less number of clients or less than 2 sexual encounters in a week in case of FSW and MSM, TG). This urban HRG mapping data does not significantly probe into the possible epidemic drivers in these States.

According to a research conducted by NACO in association with UNDP in Odisha- Gujarat Corridor, UP-Mumbai, Bihar- Delhi NCR highlights migration being one of the epidemic drivers especially the study indicates that spouses of migrants are four times at risk than the non-migrant spouses.

Further the ICTC prevalence in these States especially among general population highlights the need for three levels of challenges:

- To identify, prioritise and implement interventions targeting at risk in an environment where HIV/AIDS is still considered a stigma as well as myth.
- To address between demand and supply gap. As long as the services are not available and accessible any degree of risk perception or awareness about early diagnosis, access to condoms would not result in practice.

- To address the need for improving TB-HIV and reproductive health and HIV related service delivery in an inclusive approach instead of seeing these services as separate entities.

Hence, reaching risky and vulnerable populations with an effective HIV prevention programmes and services is important for a number of reasons. The existing Link Workers Scheme during 2013-14 has reached 1,79,393 HRGs (against a mapped estimate of 1,68,082 HRGs) and 41,11,795 vulnerable population (against a mapped estimate of 45, 99,326 vulnerable population). (Source: Annual Report of NACO, 2013-14). This signifies that the presence of significant number of HRGs and vulnerable population in rural areas may be one of the important factors in driving the epidemic. Hence, there is a need for customized package of services tailor made for rural communities and tuned with their culture and practices, so that the risk and vulnerabilities can be addressed.

1.2 HIV RISK AMONG RURAL POPULATION

Among all rural population, from the epidemic transmission point of view, the at risk population are crucial because of following:

1. HRGs in rural areas have heightened risk because of their natural and casual sex partners and in most of the cases a closed sexual network within which they operate.
2. The bridge population have significant mobility pattern and hence, they are considered at high risk of transmitting HIV infections across different risk venues and risk partners.

Considering the above the prevention interventions will focus on approaches to reaching out to both rural high risk and vulnerable population with differentiated intensity of interventions. In additions, communication strategy, services would be provided to general population and youth in a project district.

1.3 FACTORS WHICH MAKE RURAL POPULATION VULNERABLE TO HIV

The factors affecting rural populations' risk-taking behaviour are varied, but are important in understanding the overall vulnerability to HIV.

- **Low level literacy and limited accessibility to information:** While the level of information among these population related to STIs and HIV/AIDS is relatively high, this information is rarely converted into action. Primarily due to improper understanding or interpretation of information about HIV/AIDS leads to risky behaviour.

Other factors which affect their vulnerability to HIV include:

- High TB incidence and co-infection:
- Closed sexual networks often lead to quick transmission among these people:
- Vulnerability associated with social position of women and often being considered as a commodity:
- Attraction for disposable income and often being pushed into sexual practices out of poverty:
- Prevailing myth about condom use, STI treatment makes them to seek treatment from quacks, lack of adherence to treatment.

1.3.1 Related Groups at Risk for HIV

- With pressure on improving road infra-structure, there is construction of new highways or upgrading the present highways, many migrant labourers have become involved in road construction, and female road workers often also sell sex to truckers. This is often a vulnerability factor for villages nearby.
- Staffs of eating points, Border and Police staffs, Transport Workers are also at risk because of their vulnerability and power structures in relation to the HRGs in rural areas.

Take home messages

- From HIV program point of view, the rural HRGs operating in a closed network or those who operate from nearby urban or peri-urban areas are important to be targeted with prevention intervention programmes.
- Rural HRGs already registered with existing TIs but have high degree of mobility between Ti site and nearby rural areas are important in terms of their contribution in spreading the HIV in a closed network.
- Rural MSMs especially those who operate in a social structure often do not open up about their identity and behavior, these group need to be tapped through the clients who are also accessing heterosexual regular or commercial partners.
- Their low self-worth, limited knowledge and access to services, peer pressure and peer behavior makes them vulnerable to various health problems including HIV.
- Availability of services which are non-stigmatised and acceptable to their norms would enhance access.

CHAPTER 2

GUIDELINES FOR SACS AND TSU

In this chapter, the following areas are covered:

- Role of SACS and TSU
- Role of TSU Project Officer
- Defining the target population at risk – WHOM to be targeted under Link Workers Scheme
  - Steps in defining target population at risk in a new or existing district
- Steps in defining the target area (WHERE) of the link workers scheme in a new district – Broad mapping, Site assessment
  - Steps in prioritizing the villages or blocks in an existing district of LWS – Site assessment
- Target settings for coverage of different target groups in a new and existing district
- Determining availability of services (WHAT SERVICES) are to be planned
- Capacity Building areas of implementing partners
- Monitoring and Evaluation in LWS

ROLE OF SACS AND TSU

State AIDS Control Society is the key player in providing management and technical support to the LWS programme. In addition TSU, STRC play their respective roles as outlined in this chapter. However in the absence of STRC and TSU, SACS has to carry out all the functionalities.

ROLE OF SACS

- Contract management and timely fund flow by ensuring that the attrition of link workers is not attributed due to poor fund flow mechanism.
- Conduct regular bimonthly/quarterly meetings with LWS NGOs, DAPCUs to review and understand field challenges and gaps and provide inputs for any mid course corrections to NACO.
- Conduct field visits to the implementing districts to review and provide technical inputs to the programme.
- Ensure coordination amongst all partners working in a particular district especially in terms of HRGs, bridge populations and vulnerable populations.
- Ensure free condoms, IEC materials as per requirement of the scheme is available from the districts or block Health Society under National Health Mission.
- Ensure that the folk troupe activities, condom social marketing campaigns and migrant health camps are conducted in 80% of the project area in a district each year.

- Consider the mainstreaming of programmes in all districts covered in the scheme in a synergetic manner so as to address the issue of vulnerability.
- Ensure that the staff conducting the scheme is trained and their skills are built to implement the activities effectively by the STRC or any other arrangement where STRC is not available.
- Select Implementing NGOs as per National Guidelines.
- IEC division to plan number of mid-media events, adequate supply of IEC materials, Link Workers Kit for use by the District level NGO staffs. All IEC related activities are to be carried out in coordination with IEC division of SACS/NACO. These activities should ideally be planned in the AAP to ensure that the District level NGOs are supplied with the materials as per requirements.

ROLE OF TSU

In order to ensure uniformity in approach (with local adaptation), quality intervention the role of management and technical teams would be to:

- In NEW Districts: Ensure identification of project districts and villages or cluster of villages and come up with an estimated size of at risk and vulnerable population within a given 1-3 months of initiation of projects in case of new districts.
- In EXISTING Districts: While in existing intervention districts there is a need to prioritise villages/cluster of villages and target population who need to be covered as per the revised norms of this guidelines.
- Facilitate SACS in determining the performance indicators and approaches to be followed for implementation. Establish quality assurance and quality improvement systems.
- Facilitate capacity building of staffs on the implementation approaches.
- Ongoing mentoring support to provide day to day support in implementation especially areas of improvement as the TSU staffs would be visiting to the TIs, ICTC, ART centres and may come across with issues related to service gap among rural HRG but registered with nearest TI, high positivity or high number of ART clients from rural areas etc.
- Provide support in identifying gaps, working out local solutions through regular reviews.
- Support in conducting bio-behavioral surveys.

Evidence Building	• Evidence collection about distribution of risk and vulnerability pattern • Identification of target villages and facilitate target setting • Assessment of sample villages or clusters in existing districts
Planning	• Working out individual proposals for each district with clarity on approaches, performance indicators and budget. • Determine approaches with clear cut monitoring indicators. • Facilitate capacity building of implementing agency
Monitoring	• Supportive supervision and review of the proposed approaches • Carry out mid-course correction. • Generate evidences on impact and outcomes

- Facilitate advocacy among allied ministries to bring in sustainability of the approaches suitable to the local conditions.

ROLE OF TSU PROJECT OFFICER

The role of TSU Project officer is to provide supervisory and mentoring support to the districts with LWS in his or her area. In the absence of TSU, the DAPCU and SACS officers have to perform the same functions as mentioned below. The TSU Project officer is expected carry out following duties and responsibilities as mentioned below:

- Ensure all staff are recruited by District level NGO according to the approved plan and guidelines
- Ensure the District level NGO provide the appointment letter to all staff with detailed TOR
- Facilitation for induction training of newly recruited staffs by the in house mechanism
- Ensuring that the District level NGO conduct site assessment on regular basis
- Ensure that the District level NGO conduct health camps as per the approved plan and in close coordination with SACS/DAPCU/ District Health Society
- Ensure DRP carries out monthly review the performance of the staffs and provides support in improving the same
- Ensure that the District level NGO staffs develop referral network for ICTC, Care & Support, TB management, STI complications, medical care, social and legal support, IDU services
- Ensure that the District level NGO staffs have a plan to setup free condom outlets and social marketing as per the guidelines
- Ensure that the District level NGO utilize the funds in time and as per budget guidelines
- Ensure that the District level NGO staffs have the correct understanding of all Monthly Reporting indicators
- Ensure that District level NGO timely submit UCs and Monthly Reports to SACS
- Ensure that each District level NGO receives analytical feedback on their monthly performance as per Monthly Reporting indicators
- Ensure that District level NGOs are adequate stock of IEC materials from SACS
- Facilitation of rapport building with all stakeholders, co-ordination with DAPCU and other Government agencies for program support
- Coordinating with TSU and STRC to ensure all staffs are trained
- Ensure the following supervisory plan is ensured in a LWS district: (first time visit to any district should be of five days, subsequent each visit should be 2-3 days, single day visits are not recommended). Ensure that all the blocks are visited atleast once in six months in case the number of blocks covered in the district is less than 10.
- During each district visit plan to visit atleast one block and 2 villages based on the review of the programme – during block visits meeting with key stakeholders like block medical officer, CDPO, BDO, Block Pramukh (Panchayati Raj head at block level) etc.

2.1 DEFINING THE TARGET POPULATION AT RISK AND SITE ASSESSMENT

There are no gold standards to the assessment approaches to define the target population at risk and sites where the prevention interventions would be most effective for populations which continue otherwise to remain anonymous in a closed sexual network. In several countries, the approaches have been evolved along with time. There is nothing that fits in for all. This is because of following:

- Risk behaviour of rural HRGs especially FSWs and their clients is generally drawn from that of the general population of same area from where they belong to. Hence, the socio-demographic features would not be different, but their risk taking pattern would depend upon the vulnerabilities and peer pressure, peer group behaviour.
- With the changing landscape of the rural areas, with more and more entertainment and business related options available in close by urban and peri-urban areas there is great degree of mobility of FSWs/MSMs to take part –time jobs and some of them also take up high risk activities as a part of disposable incomes.
- Similarly, the persons who abuse substances like ganja, alcohol often fall into prey to the local quacks or pharmacies to get habituated for injectable pharmaceuticals. There may be other examples as well. This transition often leads to self experimentation in groups and often leads to people habituated to inject pharmaceuticals or drugs on their own.
- Limited evidence about the profile of these rural HRGs who take risk, who are HIV positive and require ARV or those who are taking ARV and their drug adherence pattern. This is due to documentation gaps within the existing systems of reporting and evidence informing systems.

Hence, to overcome these challenges there is a need for continuous study at programmatic level to understand following:

- Defining the target population (whether all HRGs or vulnerable population in rural areas are at risk or only those who have more partners, are mobile between places, have high STI episodes, who are spouses of HRGs are at risk).
- Defining the relative risk among these target population (defining the risk taking pattern and peer group behavior (young or old ones), (new or old ones), (at one location or at different locations).
- Defining the relative risk taking pattern among the most at risk target population (type of sexual behaviour, condom use pattern, injecting pattern, health seeking behaviour, attitude towards less risky behaviour)

Therefore, it is important that the SACS and TSU need to understand some of these above important areas before stepping for developing local evidence based strategies based on the broad strategies discussed in the guidelines. These understanding are based on past experiences, these may be reviewed and mid-course correction can be brought in with enough evidence.

STEPS IN DEFINING THE TARGET POPULATION AT RISK

1. Collect PLHIV related data from nearest ICTC/PPTCT/ART/Link ART/FICTC/PPICTC to understand the burden of HIV in the district (whether the same is 10 per 1000 population tested in a specific geographical area).
2. Collect HRG related data from nearest TI (may be located in the neighbouring district or same district to understand what percentage of the HRGs line listed in the TI belong to the rural areas and their mobility pattern, client profile. Also collect information from the clients of HRGs to understand the presence of HRGs in rural pockets of the block/district.
3. Collect STI data from nearest DSRC/PHC/ CHC/Private practitioners or any other sources which indicate the STI burden, profile of STI patients and geographical distribution of these cases.
4. Collect migration related information from anganwadi workers/ANM/Panchayats or from other recent studies in the district – to highlight the volume of migration, pattern of migration (whether long term, short term),

seasonality pattern and HIV or STI burden from above information.

Based on these information, TSU/SACS is expected to come up with a definition of the target population which is at risk and need to be covered by linkworkers scheme, especially determining:

a) HRGs from rural area at risk

b) Migrants and their spouses are at risk

c) PLHIV burden is high or STI burden is high or both

2.2 DEFINING THE LOCATION WHERE THE SCHEME CAN BE IMPLEMENTED

Once we identify the risk groups, then comes the process of identifying the geographies or pockets which need to be targeted with services. Hence for new and existing districts following steps are to be followed as per table below.

In the HIV/AIDS programming, mapping has significance in terms of its importance in broad planning and resource allocation. But in case of rural prevention programming the house to house survey or preparing point estimates generated through mapping at a given point of time often may not be the best evidence for programming. The mapping estimates may vary with the social milieu of the area about HRGs and high risk behavior, about the social acceptance of multi-partner sex etc. as well as the place where mapping is being conducted, the purpose and timings during which the mapping is conducted, availability of the target population at risk are being mapped.

Hence, while designing these interventions it is highly recommended to carry out Broad Mapping across the district in sample pockets of the block with the secondary data sources which suggest presence of significant PLHIV load/ ANC HIV positivity/ presence of HRGs (atleast 20-30 in a cluster of 4-5 villages) to understand the possible target village or cluster of village for intervention. This Broad Mapping is to be followed by site assessment in a new district only. In existing districts only site assessment (NO BROAD MAPPING) is to be conducted by the implementing agency while working with the communities as a part of their ongoing activities by using specific tools.

Existing Districts to prioritise amongst existing villages	New Districts OR New Blocks in an existing district
Site assessment	Define the target population at risk
Service mapping	Broad Mapping
	Site Assessment
	Service Mapping

To summarise these terms, the following table can be referred:

Activities	Definition	Importance	Where to carry out
Broad Mapping (only in NEW Districts)	Broad mapping is defined as an activity which provides broad information in a map of limited or wide geographical area indicating concentration and availability of target population.	Gives broad information about the locations where concentration of HRGs or vulnerable population available as defined in this guideline.	Sample pockets of the block which the secondary data sources suggest presence of significant PLHIV load/ ANC HIV positivity/ presence of HRGs (at least 20-30 in a cluster of 4-5 villages).
Site Assessment (In both new and existing districts)	Site assessment is an activity which provides detailed information about the target population in terms of its needs, priorities; about the resources available and about the environment where intervention is proposed.	Gives detailed information about the risk pattern of groups, services available in the area, services to be planned, and resources required.	All villages or cluster of villages with sites which have at least 15-20 HRGs in 4-5 villages or there is seasonal and short term migration to high prevalence States of more than 200 migrants from 4-5 villages or 10 PLHIV per 1000 adult population tested in cluster of 4-5 villages.

EXCLUSION CRITERIA FOR BOTH BROAD MAPPING AND SITE ASSESSMENT

- Villages within 10 kms (in hilly regions or low population density areas 5 kms) from the block or district head quarter to which they belong to are to be considered for second priority.
- Villages (population of more than 5,000) with more vulnerable population but less than 10 high or medium volume HRGs should be considered as second priority.

Based on these following steps the village or cluster can be selected for prevention interventions.

The broad mapping and site assessment would result in following outputs:

1. Establish the expected volume of at risk and vulnerable population in villages or cluster of villages.
2. Establish the key factors influencing vulnerability of the above population.
3. Assess the risk associated in terms of client profile of HRGs in the area, STI burden, condom use pattern and barriers to condom use.

Steps in Conducting Broad Mapping

The Broad mapping should be carried out for new districts/blocks/villages and this has to be followed by site assessment. The broad mapping is carried out basically using secondary data and discussion with key informants like health care providers, ICDS staffs, ICTC and ART staffs, PRI members etc.

The SACS and TSU would constitute a task force represented by State level officers from SACS, DAPCU (if present) or District Health Society, civil society. This mechanism is suggested to bring in involvement of multiple stakeholders in decision making especially local representatives.

This task force would come out with a document which clearly informs the SACS and NACO about the possible target areas with significant concentration of at risk and vulnerable population.

Based on the deliberations of this task force, the document highlighting following areas would be worked out:

- Locations or sites with significant at risk and vulnerable population. The villages should be at least 10 kms or more in plain areas and 5 kms or more in hilly/ low population density areas from the nearest town/ head quarters. These villages or cluster of 4-5 villages should have 15-20 high or medium volume HRGs as reported by nearest TI or other key informants, atleast 200 outmigrants with comparatively high HIV positivity (as per nearest ICTC or ART data), 5-10 PLHIV per 1000 adult population tested as per information from nearest ICTC or ART.
- The task force also can use existing SNA or mapping data for the district but the same should not be more than two years old.
- The list of stakeholders or associates which control or influence the mobility of HRGs, their access to condoms, needles and syringes, and other services.
- The list of potential condom outlets for free and social marketing.
- The list of health care providers who need to be sensitized for syndromic case management and abscess management.
- The list of locations where information centre can be established.
- The list of SHGs, Youth Clubs or other institutions which can be tapped for reaching out the communities.
- Data related to STI pattern and prevalence among target population and health seeking pattern.
- Data related to HIV prevalence among HRGs, spouses of HRGs, vulnerable population from nearest ICTC/ FICTC at least for last one year by villages or cluster of villages.
- Data related to current number of PLHIV or people on ART from the nearest ART centre by villages or cluster of villages.
- Data related to migration pattern (seasonality), volume of migration, time of return and who facilitates the migration process.
- Information related to nearest TI (how many of the HRGs belonging to the rural area are under service), how many of them regularly serviced and how many of them serviced at certain intervals, client profile of these rural HRGs, sites where they solicit (lodge, weekly market, dhabas, market yards, local small industries, quarries etc.)
- Information related to ICTC referral and access by these rural HRG as documented by the TI – what are the challenges and opportunities.

Steps in Conducting Site Assessment in an existing district

The site assessment is carried out by the existing LWS district staffs for the following purpose:

Purpose 1:

To consider only 40% of the villages amongst current number of villages within 10 kms radius from nearest district or block headquarter (5 kms in hilly or low population density areas) for future LWS implementation. In case of villages closer to adjoining district or block headquarter would be considered as per its original distance from parent district or block. The SNA data or programme data used for this purpose should not be more than two years old.

For example, there are 12 villages within 10 kms or 5 kms radius of block or district head quarters – in future, as per the guidelines only 5 villages would continue to have the cluster link workers scheme based on the site assessment as per following process:

Step 1:

Take data of current LWS programme data, SNA data (should not be more than 2 years), data from PLHIV data base, PLHIV data from ICTC, ART centres, data from TB programme, data from existing TIs in the district about the rural HRGs (how many registered are from villages, how many are getting service from the TI but they reside in villages) etc. Migration data to be collected from anganwadi workers, programme data of LWS, any other village level migration data indicating migration to high prevalence districts. The following format may be used for collecting the data.

District type	FSW or MSM per 1000 population of the village	IDU per 1000 pop. of the village	HIV Positivity among HRGs (ever) in the district/ village	PLHIV per 1000 pop. tested in the village (ever and alive)	Migration to high prevalence districts (% of total pop. in the village)		HIV positivity among migrants (ever) in the district/ village	Whether to be considered for Step 2 if following is fulfilled
	1	2	3	4	5		6	
High prevalence	8 or more	4 or more	1-2%	1-3	>3%		>1-2%	Following options to be exercised: • 1/2 and 3/4 • 1/2 and 5/6 • 3/4 and 5/6 (must fulfill any of the one option out of three option above)
	6 or more	4 or more	2-3%	2-3	>3%		>1-2%	
	4 or more	4 or more	>3%	3-4	>5%		>2%	
Low prevalence	3 or more	3 or more	1-2% or more	0-1	Pop.size	% of migrants	>1-2%	
					< 800	5% or >5%	>1-2%	
					800-2000	3-5%		
					>2000	2-3%		
					less than 2% would not be considered			
	2-3 or more	2-3 or more	2% or more	0-1	Pop.size	% of migrants	>1%	
					< 800	5% or >5%		
					800-2000	3-5%		
					>2000	2-3%		
					Less than 2% would not be considered			
	0-2 or more	0-2 or more	2% or more	0-1	Pop.size	% of migrants	0-1%	
					< 800	5% or >5%		
					800-2000	3-5%		
					>2000	2-3%		
					Less than 2% would not be considered			

Step 2:

Based on the algorithm given in the previous page the team has to take a decision whether the village is to be continued of not. An excel sheet with formula is available with SACS and TSU which can be used to enter data and it will automatically calculate the eligibility of the village based on the algorithm.

The villages which were earlier covered and after site assessment are not considered for link workers scheme may be offered for intensive IEC activities and linkage with nearest ICTC for visit by counselor etc. Instead new villages which are more than 5 or 10 kms radius as applicable having higher risk and vulnerabilities to be selected and LWS may be implemented.

This is important, most of our programme activities are largely concentrated around the urban or pre-urban areas (towns, head quarters) whereas far off villages are always deprived of services including IEC activities and thus they have heightened risk and vulnerabilities. These far off villages face migration due to poverty and lack of employment opportunities and carry higher risk than villages which are close to economic centre of the districts where migration happens to grab better opportunities.

Purpose 2: (to be carried out for each block where the villages are more than 10 kms from the nearest head quarters (5kms in hilly or low population density areas).

The purpose of this exercise is to prioritise the villages which would be continued for future interventions. During analysis of performance of villages it has been found some villages although having larger population but lack the risk (no HRG or 1-2 HRGs only, HRGs which are very low volume and risk, quality of services being very poor during last 6 months), no PLHIV or PLHA, no migration or migration to nearby town etc.) and vulnerability. Hence, these villages need to be carefully assessed and based on which villages to be prioritized and new villages need to be selected. The same steps to be followed as highlighted in the above sections.

Village Visit to follow after selection of ineligible villages. At least 10% of the samples of villages to be visited by a team. During the visit following activities is to be carried out. A village level meeting to be organized. During these meetings specific issues to be discussed related to their experience of accessing services, challenges faced, how many times they have participated in group activities or what can be best method to reach out them in groups.

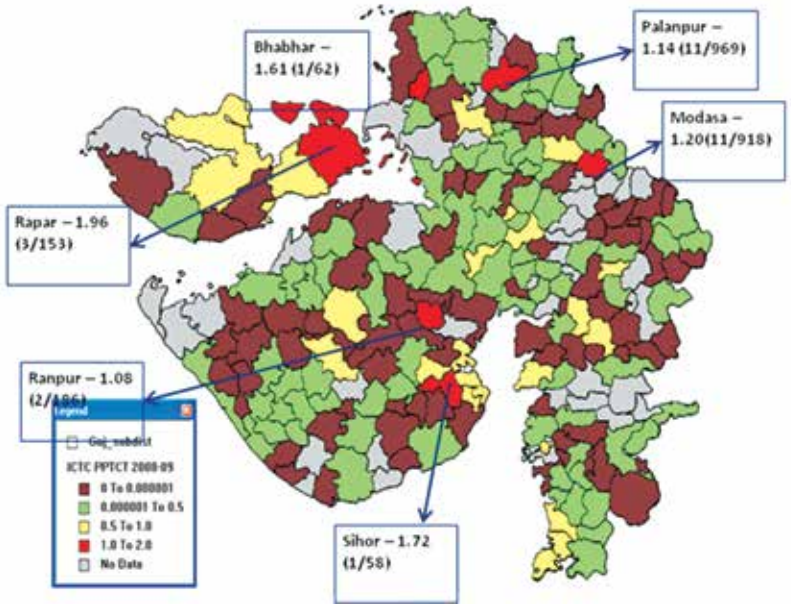
1. The groups would also be meeting the stakeholders in the village like the panchayat head, anganwadi workers, ANM, ASHA, Village level workers or MNERGA staffs to understand what support they have been providing for the programme and how this programme can reach more members with their support.
2. At the end of the visits as mentioned above, groups are expected to draw up a social map of the village highlighting the gaps they have found and recommend whether the village need exclusive services of cluster link workers or the support of other stakeholders can have similar results with minimum support of cluster link workers.
3. From these information calculate the broad estimates of target population in a village would be: (the calculation is based on the SNA reports of existing project districts not more than 2 years or programme data in case SNA is more than 2 years)

TARGET SETTING FOR LINK WORKER SCHEME DISTRICTS

	Target Group	Existing Districts	New Districts
1	ANC mothers	100% as per the information from the ANC register of the village	100% as per the information from the ANC register of the village
2	TB patients	100% as per the information from the DTO/STLS of the area	100% as per the information from the DTO/STLS of the area
3	HRGs (as per definition)	Reported by last SNA (within 2 yrs) or program data (last 6 months)	The target should be fixed within 6 months of implementation in the village (100%)
4	Male population at risk including spouses of FSWs	5% of adult male population (considering National STI prevalence of 5% among male)	5% of adult male population (considering National STI prevalence of 5% among male)
5	Bridge Population low risk but highly vulnerable including spouses of MSMs/IDUs	Spouses of migrants/truckers/ IDUs/ MSMs and migrants/ truckers as per last SNA (within 2 yrs) or number of households reported in the program data	Number of migrant/truckers households as informed by anganwadi workers/ANM/ Panchayat
6	PLHIV	Number as reported in the ICTC/ART facilities	Number as reported in the ICTC/ART facilities
	Total Target	Sum of 3,4,5,6	Sum of 3,4,5,6

An example of Broad Map is presented below:

The broad map is based on the ICTC and PPTCT data analysed from CMIS to prioritise pockets which require intervention. The next step would be to understand in each block, which are the panchayats or cluster of villages which represent higher trends of ICTC and PPTCT positivity as recorded in the nearest ICTC.



An example of site map of a village is presented below:

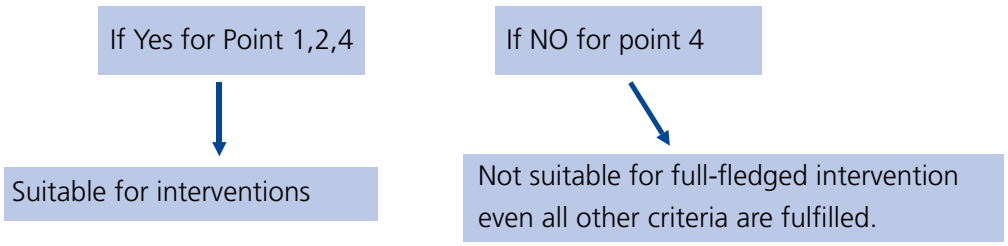
Steps in Conducting Site Assessment in a new district:

The site assessment is to be carried out by the newly recruited LWS district staffs with the support of SACS and TSU for the following purpose:

- To prioritise new villages in compliance with the location and target population as defined earlier.
    1. Take the map of District and identify the blocks with highest rural HRGs as reported by nearest TI line lists or high number of PLHIVs as reported by nearest ICTC/ART/positive network/TB clinics reporting presence of co-infected patients or high number of TB patients or with high outmigration.
    2. Review of secondary data of nearest TI or hotspots of TI (maximum within 20 kms radius of the village) female sex workers and male sex workers as well as FGD with these groups to understand what percentage of HRGs are from the village and what barriers to condom use are.
    3. Review of secondary data of ARV clinics and HIV testing centres in the nearby areas to understand what percentage of on ART/pre-ART clients belong to the villages.
    4. Review of secondary data of STI clinics and health care providers in the nearby areas to understand what percentage of clients, HRGs belong to the villages and are having STI infection and health seeking behaviour.
    5. Collect information regarding potential outlets for condom social marketing, any kind of health facilities catering to general population.
    6. Collect information regarding the existence of sex networks (both male and female sex workers) and the support structures for these networks, operational timings of KPs in the area, the concentration of HRGs.

Based on these information the Management and Technical Team would decide and inform about the suitability of the village for designing an intervention. While making such decision following algorithm may be used:

1. 60% of the FSWs are medium (more than 6 clients in last 15 days) volume FSWs and there is at least 3 STI/RTI infections reported for 40% of the FSWs for 2 quarters.
2. 50% of MSMs, MSWs, clients of FSWs or spouses of MSM/IDUs have reported at least one infection of STI during 2 quarters
3. IDUs with 4-5 injecting episodes per week
4. 60% of those are who are migrants or truckers are coming back to village at least more than 2 times a year and there is significant information about STI infections.
5. At least 5-10 per general population tested are PLHIV or are on ART



2.2 DETERMINING AVAILABILITY OF APPROPRIATE SERVICES

Availability of appropriate services at any location which has suitability for intervention would depend upon following:

1. The quality of engagement with target population.
2. The efficiency of coverage of target population with services.

This is important from the point of placing Link Worker Scheme in a village or cluster of villages:

- Efficiency of coverage: In order to optimize the utilisation of resources, it is necessary that these services are accessed. This will essentially depend upon the availability of services such as syndromic management, HIV testing and counseling services.
- Quality of engagement: From an intervention perspective, it is also important that the point of access provides an environment where the target population continue to access service with confidentiality and these services are stigma freegage in depth with the programme.

It is not expected that services available far off (more than 10-20 kms) would be accessible for HRGs and vulnerable population in rural settings considering issues with affordable transportation. Hence, it is important to understand different locations and its importance in designing services.

Different options for service delivery in rural settings:

- In case the existing government facilities have provision of syndromic case management and / or HIV testing and counseling within 10 kms (5kms in hilly or low population density areas) from the villages or cluster of villages the same may be considered for referrals. In such cases the target for those villages will be significantly higher considering availability of services may be of 80%.

- The proposed health camps with syndromic case management and / or HIV testing and counseling services can be tagged with the villages or cluster of villages and at least 60% of the HRGs should receive services at least once a year.
- The provision of mobile health clinics with syndromic case management should be utilized to provide services under National Health Mission.
- The provision of mobile ICTC vans along with other activities may be planned to provide HIV testing and counseling services at least twice a year and should ensure 80% of the HRGs are tested.

2.2.1 Types of Villages or Cluster of villages

They can generally be classified under three types.

2.2.1.1 Villages or Cluster of villages primarily of HRGs

These are villages with

- More than 10 HRGs mostly of medium volume (more than 6 clients in 15 days) or most of them are young and new.
- With less than 10 HRGs but are of high volume (more than 8 clients in last 15 days)
- High degree of mobility (atleast more than 3 days a week) FSWs/MSMs/IDUs move to the nearest highway, dhabas, market yard, railway station, construction sites, TI area etc. and solicit clients.
- TI line list highlights significant number of FSWs, MSMs or MSWs or IDUs belong to the village or its peripheral hamlets or cluster of villages.

2.2.1.2 Villages pre-dominantly out migration villages with more than 20% of the adult males migrate more than 3 months in a year.

- Households with more than 20% adult male out migration and significant of them are on ART or are on pre-ART.

2.2.1.3 Villages have low risk and vulnerable populations but have significant number of persons are from PLHIV community

- These villages are important from the point of halting the transmission by introducing timely treatment and ensuring adherence.

Hence, based on these considerations the design of interventions and services can be determined. The same is presented below:

Villages or Cluster of villages primarily of HRGs	Full- fledged interventions
Villages pre-dominantly out migration villages	
Villages have low risk and vulnerable populations but have significant number of persons are from PLHIV community	

2.3 CAPACITY BUILDING OF IMPLEMENTING PARTNERS

The role of SACS and TSU is important from the point of bringing common understanding among different stakeholders about the expected outcomes of the interventions, the implementation approaches and expected impact.

While the in-house training may be imparted through the project staffs so that they can be used for training of new staffs as well as can support the project ongoing basis.

The training activities would be carried out by State Training and Resource Centres (STRC) in States with STRC, in rest of the States the SACS would use trained resource persons to deliver the training for Link Workers Schemes. Therefore, it is important that the capacity of the implementing partners is built in and a system of local evidence building and feedback to the programme is built in within the prevention intervention.

The capacity building inputs should include:

- Training (induction, refresher, specialized theme based training)
- "Hand holding" or mentoring

Various themes for Capacity Building can be:

Areas	Participants
• National AIDS and STD Control Programme Basic information on HIV and STIs • BCC and development of IEC materials • Dealing with myths and misconceptions • Peer education and community outreach • Harm Reduction including OST • Condom programming • Safer sex negotiation • Sex and sexuality • HIV testing and counseling • Outreach planning, monitoring	Cluster Link workers Supervisors
• Stigma and discrimination • Community participation and empowerment • STI management • Advocacy	Supervisor District Resource Person
• Reporting systems • Project management • Resource mobilization	M&E cum Accounts Assistant District Resource Person

The "Hand Holding" or "Mentoring" visits carried out by the SACS and TSU teams or by external experts need to be outlined keeping in mind that the project staffs are able to understand the gaps and are able to find solution within their own settings. The objectives of these visits should be:

1. Brain storming and facilitating to identify gaps, opportunities
2. Facilitating in finding out solutions
3. Facilitating advocacy and networking
4. Bringing in scale for services with private sector, other referral services for TB, ART services
5. Monitoring of the performance benchmarks and grading the performance
6. Capacity building through onsite support

2.4 MONITORING AND EVALUATION

The implementation for link workers scheme will be monitored by the SACS and TSU teams using specific supervisory tools.

The basic purpose of the monitoring is to ensure:

1. That the intervention is aligned with the National Guidelines or aligned to the strategies worked out in the proposal in line of the National Guidelines.
2. That the interventions has put systems for peer education by cluster link workers (recruitment as per the guidelines), updated out-reach plan, appropriate service delivery system, networking and advocacy approaches, social marketing of condom programme, linking with HIV testing facilities and linking with ART facilities.
3. That the intervention has been reporting on National Guidelines.
4. That the intervention has been making efforts to engage with different stakeholders towards addressing programme management issues, stigma and discrimination as well as overall improvement of performance of the intervention.
5. Triangulation of data on STI incidence among HRGs with other sub-groups and key population groups in the area to understand the transmission dynamics and provide necessary inputs.

In addition to the routine monitoring there is need for monitoring of specific outcomes such as; condom use pattern among different clients and vulnerable population, behaviour change patterns among these groups, HIV testing and ART compliance rates among HRGs and other vulnerable populations.

These are important from the point of improving the outcomes of the intervention. While monitoring of these interventions are important from the point of investments, the process of evaluation is required to understand the systems in place and their effectiveness and efficiency, effectiveness of existing referral systems and delivery pattern.

The role of SACS and TSU teams in Evaluation would be:

1. Build capacity of the team, experts to implement evaluation tools.
2. Facilitate the process of evaluation. Provide critical feedback to the policy makers, stake holders and implementers in improving the quality of interventions.
3. Build in and manage the quality assurance and quality improve mechanisms within the project.
4. Carry out documentation of best practices, training needs and outcome assessments using various tools.

SPECIFIC STRATEGY FOR NORTH EASTERN STATES AND TRIBAL AREAS

While the implementation mechanism of Link Workers Scheme would be same for North Eastern States and Tribal areas in terms of target population, services for each target population and performance indicators. While the service delivery mechanism would be more based on reach out models such as health camps linked with Testing services, outreach models for needle/ syringe distribution, linkage with OST centres would be high priority in districts with IDU program requirements.

Similarly, the management model of implementing link workers scheme in North East States and tribal areas would include merger of neighbouring districts with less than 60 targeted villages in each district to optimize the management by one NGO. The villages are to be selected as per the guidelines and districts may be merged as one cluster to implement the scheme. The proposal has to be prepared by SACS and the same would require prior approval of NACO.

Take home messages

- The role of SACS and TSU team is to support the program in building evidence for planning, better implementation and building capacity of the partners.
- Broad mapping, site assessments are key steps in estimating the denominator and assessing the feasibility.
- Villages or cluster of villages with 60% of the FSWs are medium (more than 4 clients per week) volume FSWs and there is at least 3 STI/RTI infections reported for 40% of the FSWs for 2 quarters AND/OR 50% of MSMs, MSWs, clients of FSWs or spouses of MSM/IDUs have reported at least one infection of STI during 2 quarters AND/OR 60% of those are who are migrants or truckers are coming back to village at least more than 2 times a year and there is significant information about STI infections in addition to at least 10 per adult population tested are PLHIV or are on ART.
- IDUs with 5-6 injecting episodes per week to be considered for intervention
- Capacity building of partners and continuous monitoring are essential to maintain quality and ensure optimal investments.

CHAPTER 3

GUIDELINES FOR IMPLEMENTING PARTNERS

In this chapter, following areas are covered:

1. What are principles of service delivery among risky and vulnerable population in rural settings
2. Programme Strategies
3. Different service delivery models
4. Component of service delivery
   a) Behavioural Component – how to prepare microplan for outreach, what are the outreach components, what are the components of IPC and BCC
   b) Biomedical Component – what are the different services, how to link with services
   c) Structural Component
5. Programme Management
6. Human Resource Management

3.1 PRINCIPLES OF SERVICE DELIVERY AMONG RISKY AND VULNERABLE POPULATION IN A RURAL SETTING

Considering the nature of target population and the socio-cultural milieu it is important that the service delivery among these populations need to be guided by certain basic principles:

1. Alignment with National Guidelines

The intervention is required to align with all existing National Guidelines for its various components.

2. Differential Approaches

Different approaches are required for rural HRGs based on the dynamics of the sexual and social networks of each of the sub-category (from where they operate, who controls these networks etc.). The vulnerability pattern (outmigration volume and mobility pattern), sexual behavior of spouses of HRGs, availability of STI services and condoms would determine the approaches.

3. Community participation and ownership building

Ideally, the social and sexual network in rural settings is homogenous in nature and building affinity for mobilizing them as community for risk or vulnerability reduction is achievable. Their participation needs to be structured based on their perceived needs may be in the form of mobilsing through Self Help Groups, Small groups based on their profession/occupation etc.

4. Adoption of combination prevention approaches

Considering the different scenario in which the interventions would be designed it is important

that combination prevention approaches may be adopted targeting both HRGs and their regular sexual partners both for prevention and treatment. However, these approaches are to be confidential and stigma free.

5. Affordability, Acceptability and Accessibility of services

Considering the low literacy level, varying degree of health seeking behaviour owing largely due to limited access and prevailing myth, the services may be accessible, acceptable and affordable.

6. Confidentiality and Continuum of services

Rural HRGs and vulnerable clients prefer to be anonymous about their identity as well as behaviour, hence it is important to ensure confidentiality of services offered. Similarly it is important to ensure mechanisms for continuity of services across their mobility especially if the HRGs can be linked to nearest TI to ensure a full package of services.

3.2 PROGRAMME STRATEGIES

Link Workers Scheme is a prevention intervention programme targeting rural risky and vulnerable population. From epidemic response perspective, the scheme is expected to target both vertical transmission and lateral transmission of HIV among these target population. The following diagram describes the importance of these transmission dynamics and programme strategies of Link Workers Scheme:

Routes of Transmission	Vertical Transmission	Lateral Transmission	Transmission from Positive clients
At risk communities	Pregnant Mother	Sexually active men and women (HRGs and their clients) Migrants and their spouses	Spouses of positive clients and their sexual partners, children
Risk level	Very High	Moderate to High	Highest
Visibility in the community	High	Low	Low
Strategy	Outreach combined with service linkage with existing ASHA and ANM	Outreach combined with BCC, Enabling Environment Component strong linkage to services	Outreach combined with strong linkage to services and positive prevention components

High visibility High Risk Population		**Low visibility High Risk Population**		**High visibility moderate risk population**
• ANC Mothers • HRGs with TB • TB patients • PLHIVs/PLHAs	• Spouses of migrants • IDUs and their partners • Migrants	• FSWs • MSMs • TG/Hijra • MSWs	• Clients of HRGs • Spouses of HRGs	• Youth • Mobile population

Step 1. *Coverage to build Rapport* ***Step 2.*** *Rapport Building for High Risk Groups*
Step 3. *Identify High Risk Groups, Coverage and Services* ***Step 4.*** *Referrals*

The above framework shows that the cluster link workers should start covering High visibility High Risk Populations to link them with services provided by other workers in the area. This will help them to build rapport in the community and would help them to identify HRGs and other low visible high risk population. Once these group of high risk population is identified, snow balling need to happen to identify other members in the same village or in the area. Cluster Link workers are expected to link all these members with services, follow up them and ensure adherence and continuity. Whereas the moderate risk groups need to be sensitized and provided opportunity to access information centre and health camp services.

This guideline outline broad strategies under three components as described above:

Behavioural Component:

1) Outreach: Designed specific to the nature of target population Location, time specific micro plans to conduct outreach would be designed (details of micro plan available in Training Module Peer driven approach (SHG members, DOTS providers etc.)

2) Communication: Both IPC (one to one) and group level approaches Carried out by Cluster Link workers and volunteers Targeting risk perception, condom use, safer injecting practices, OST, service uptake, self worth

3) Condom Promotion: Primarily through social marketing Condom demo and free condom availability would be restricted to those who are medium and high risk FSWs, MSMs, IDUs, and MSWs. Free condoms for other target population need to be linked with nearest ASHA and ANM.

4) Provision and collection of needles and syringes by linking to nearest TI (distribution by cluster link workers based on the requirements of the IDUs preferably collected from TI on monthly basis)

Biological Component:

5) Services: Clinical services for treatment of STI/RTI, abscess by linking to nearest health facilities, camps organized in the area. Linked to HIV counseling and testing Referral and networking with other service providers

6) HIV testing and counseling: Primarily linked to ICTC/FICTC/ICTC vans, Health camps

Structural Component:

7) Community Systems Strengthening: Using village health and sanitation committee and District AIDS Coordination Committee as platform for sharing the progress and issues that needs to be addressed with support of District and Block level functionaries.

8) Creation of Enabling Environment: Cluster Link Workers are expected to work with other health staffs (ANM, ASHA), Anganwadi Workers to ensure that the target population are able to access information, services in a stigma free environment. Especially the village mothers meeting should be used to reach out to the females and their family members regarding myth and misconceptions on HIV/AIDS and ways to prevent.

DIFFERENT SERVICE DELIVERY MODELS

In summary, the different service delivery models that may be feasible for implementation in the locations which have been found feasible for LWS are as follows:

Type of location	Type of service component	Service delivery model
Villages predominantly concentrated with rural HRGs/outmigration villages (as defined earlier) within 10 kms or 5 kms in hilly / low population density areas (not less than 10 kms) from the nearest Govt. facility in ICTC/FICTC	Behavioural Component	Mid-media linked with SACS campaign Condom outlets Counseling by Cluster link workers
	Treatment of STI/RTI, Abscess management in IDUs	Linked to nearest PHC/CHC or trained private providers
	Provision of OST	Linkage with nearest OST Center
	HIV Counseling and testing	Linkage with ICTC/FICTC
Villages predominantly concentrated with rural HRGs/outmigration villages (as defined earlier) more than 10 kms or 5 kms in hilly /low population density areas from the nearest Govt. facility in ICTC/FICTC	Behavioural Component	Mid-media linked with SACS campaign Condom outlets Counseling by Cluster Link workers
	Provision of OST	Linkage with nearest OST Center
	Treatment of STI/RTI, Abscess management in IDUs	Linked to nearest Sub centre through PHC/CHC or trained private providers
	HIV Counseling and testing	Linkage with Mobile ICTC/Mobile Medical Unit with testing facility Linkage during health camps planned by SACS/LWS with testing facility
Villages significant concentration of PLHIV/ PLHAs and other risk groups (as defined earlier) within 10 kms or 5 kms in hilly / low population density areas from the nearest Govt. facility in ICTC/FICTC	Behavioural Component	Linkages with nearest PLHIV network Linkages with other social welfare schemes through Panchayat or Taluka office Condom outlets Counseling by Cluster Link workers
	ART provisioning	Linked to nearest Link ART or ART centres
	HIV Counseling and testing	Linkage with ICTC/FICTC

3.3 COMPONENTS OF SERVICE DELIVERY

The services under these interventions are primarily considered three components, they are:

1. Behavioural Component
2. Bio-medical Component
3. Structural Component

BEHAVIOURAL COMPONENT

In Link Workers Scheme, the behavioural component of the programme is implemented in principle of location time cluster approach to maximize the inputs provided. Considering the low visibility and anonymous nature of the population, the location time cluster approach is used to reach out the HRGs or their partners (regular or commercial) through one to one (by home visits), one to group session (through SHG meetings, mothers meeting, youth group meetings, gram sabha meetings) and mid-media activities. To delivery communication session the cluster link worker has to prepare a micro-plan.

The behavioural component essentially a mix of services which enables the client to perceive the risk associated with certain behavior and enables with services, condoms, needles and syringes to practice safer behavior and thus reducing the risk associated.

Accordingly the framework of implementing and monitoring of this component would be as per table below.

3.3.1 Preparation of Micro plan by Cluster Link Workers

The following steps are required to be undertaken.

3.3.1.1 Preparation of Site Map

Step 1: Preparation of Site Map:

Preparation of Site Map of the village or cluster of villages is required to prepare the micro-plan. A site map provides geographical and social overview of an area, including details regarding landmarks. It will help in planning to decide how many sessions required, who are to be targeted and where the services are to be linked.

This also provides to collect detailed information in a phased manner, starting with high visibility high risk population to low visibility high risk population and ensure their linkage with services. (as mentioned at the start of this chapter).

What	How	Responsibility	Expected outcome	Measurable indicators
Health education	Through IPC, Mid-media and Counseling	Cluster Link Workers and Supervisor	Increase in condom use, safer injecting practices, OST, and reduction in STI burden	• Increase in condom use in last sex • Decline in STI burden among HRGs and their clients • Increase in OST registration • Increase in using clean needles and syringes in every injecting episode
Increase in risk perception	Through IPC, Counseling	Cluster Link Workers	Increase walk-in clients to the ICTC/FICTC/ICTC van for counseling and testing	• Increase in walk-in clients versus referral clients

Site Mapping will focus on the following

- List out all households with high visible high risk populations and their current service uptake status especially related to accessing services for treatment of STI/RTI, HIV counseling and testing.
- Prioritise the households with migrants, PLHIV/PLHA and TB patients.
- Differentiate by volume and risk level of HRGs and injecting frequency of IDUs

Activities to be taken up before Site Mapping

- Introduce yourself to the Taluka Medical Officer preferably with zonal supervisor during weekly meeting of ANM and ASHA. Briefly describe the link worker scheme and expected support from Health Society and National Health Mission. (especially supports in terms of requirements for free condoms, participation in special activities, linkage of pregnant mothers to HIV testing, linkage of HRGs to STI treatment and HIV testing, support for conducting health camps, linkage for HIV TB programmes).
- Cluster Link workers should attend similar meeting at least once in 3 months preferably the zonal supervisor should present in these meetings to discuss progress and issues that needs to be addressed by Taluka/block level officers of various departments.
- Collect the list of pregnant mothers on three monthly basis from the ANM

The broad mapping is to be carried out at least for 5 different parts in a village with more than 500 households and consolidate into one map. In case of village with less than 500 households the map is to be carried out in 3 different parts and in village with less than 200 households one map is to be prepared.

Steps in Site mapping (is a continuous process at least to be done every 3 months)

- Start by asking general questions about the village. Spread chart paper on the ground, hand over the sketch pens, and request the participants to draw the geographical outline of the village and its adjoining 5 kms area. Participants can be youth groups, mothers.
- Request participants to mark the important landmarks. Whilst marking landmarks probe for land marks such as subcentres, house of ASHA, Anganwadi centres, doctors/medical facilities, existing and potential condom outlets, KP hotspots, congregation points of local migrants and truckers.
- Next, ask participants to mark the specific households with pregnant mothers (guide with your list), migrant families, TB patients.
- Whilst the participants draw the map, ask them probing questions to generate information on mobility of village population (both male and female), purpose of mobility and mark those households. Note down all the information collected in the map
- Additionally, after the exercise discuss this map and information with ANM, ASHA and mark households with PLHIV/PLHAs, HRGs (already known).

Step 2: Line listing of beneficiaries:

The following table shows the process and source of information for line listing:

Type of Population	Population	Source of information	When to collect and update
High visibility High Risk Population	ANC Mothers	ANM/ASHA register	Every quarter
	HRGs with TB	ANM	Every month
	TB patients	ANM/DOTS provider	Every month
	PLHIVs/PLHAs	Nearest ART/link ART/ICTC/ Positive Network	Every 3 months
	Spouses of migrants	Migrant households information through discussion and home visits	During home visits
	Migrants		During home visits
	IDUs and their partners	ANM/ASHA/during home visits	During home visits
Low visibility High Risk Population	FSWs	• From line list of existing LWS data or TI data • During home visits	Every month
	MSMs		Every month
	MSWs		Every month
	IDUs		Every month
	TG/Hijras		Every 3 months
	Clients of HRGs	Through discussion and home visits	During home visits
	Spouses of HRGs		During home visits

A simple format for line listing is annexed at Annexure -1 and 2. The objective of maintaining a line list is

- To identify households by risk category, update their service requirements and service accessed.
- To monitor the progress of cluster link workers scheme by villages and cluster of villages.
- To understand workload for a village or cluster of villages and help in optimizing the requirements of cluster link workers in a district irrespective of work load.
- To minimize duplication of services for HRGs who are also line listed in a nearby village or nearby TI.
- Helps in building rapport and ensuring adherence of services.

Step 3: Risk and Vulnerability Mapping

Social and Sexual Networks mapping: Identify the social networks and sexual networks especially in case of FSWs, MSMs, MSWs, TG/Hijras, Migrants, Spouses of migrants to understand the service requirements, factors which influence their health seeking behavior.

Understanding the risk exposure and risk pattern: Amongst the listed HRGs, initially provide condoms or needles/syringes without accurately estimating the requirements. While doing so over a period, the cluster link worker would be able to estimate the risk pattern (number of clients

per week) and risk exposure (whether regular or commercial clients). Then these information may be used to calculate condom requirements per week and how the condoms can be supplied.

COMPLETE THE SITE MAP by including the above information on a map i.e. households map, social and sexual network map and line listing.

Example of information from site maps consolidated at block level:

Name of the block	Name of the village	Total number of households	Number of segment maps prepared	Total number of households with different categories	Total number of target population	Source of information

3.3.1.2 Resource Mapping

In order for the cluster link workers to be able to link the target population to services, they first need to understand the exact location and services already available which can be linked or to be planned. This process is called resource mapping.

Steps to make a resource map:

1. Using the information collected regarding sub-centres, ASHA, Anganwadi centres, doctors/medical facilities, existing and potential condom outlets during preparation of site map as a template, the cluster link workers should mark out all the service centres in the project area.
2. These centres should also include HIV related service and include STI clinics, HIV counseling and testing centres, ARV facilities, TB sputum microscopy centres, Malaria blood testing facilities etc.
3. Collect information of timings of services, contact details of these services and sensitise them about the scheme.

These services may be individual providers, government facilities or existing wellness centres. This resource map helps in planning various services under the project.

3.3.1.3 Preparation of outreach plan

Why we prepare the outreach plan?

- The outreach plan is prepared to reach out to target population based on the timings, availability at any site within the villages or cluster of villages.
- The outreach plan is prepared to focus on sites which require additional efforts to provide services.
- The outreach plan helps in planning mid-media activities by SACS, condom depots, advocacy activities based on the issues in each site.

Who would prepare the outreach plan?

- The plan preferably is prepared by the supervisor with support of cluster link workers and data of previous services offered in the area.
- Collect information from the stakeholders during the stakeholder meetings besides through discussion with target population at each site.

How often the outreach plan would be prepared?

- The outreach plan preferably is prepared once in three months. This ensures stability in the programme. Frequent change unless required may affect the services and outputs.

When outreach should happen?

- The outreach should be conducted at the convenience of the target population especially when they are in a mental state to listen and interact. In case we plan our outreach when they are busy with household work, in a public place etc. they may not prefer to be interfered.
- Hence, preferably the outreach be conducted during the time when a group of target population is available for discussion or some activities.
- Unless prescribed by State or NACO team the outreach timings may adhere to the above norms.
- Such outreach timings may have impact on the office timings of the agency. However working time of cluster link workers preferably match with the outreach timings of the villages or cluster of villages.

Where the outreach sessions to be conducted?

- The outreach session (one to one) can be conducted in the house or agreed place.
- Preferably should be one to group in the information centre, during group meetings, SHG meetings, mothers meetings, near the worksite or weekly market, in the ANM/ Anganwadi centre or any other preferred place.

How often the outreach sessions to be conducted?

Based on the risk pattern and service requirements the frequency of outreach sessions need to be planned. Following table is suggestive to carry out number of sessions:

Settings	Population	Number of sessions per month	Number of follow up in a month
1 to 2 villages with at least 50 to 52 target population per month excluding migrants, youth, clients or spouses of HRGs, mobile population	ANC Mothers	Once till the mother gets tested If positive once a month till delivery Once a month if the baby is positive	During breast feeding period, once a month
	HRGs with TB	Once till the person is tested for HIV If positive, to be motivated for CD4 testing and ART accordingly	Every month
	TB patients		Every month
	PLHIVs/PLHAs	On ART/LFU/Missed cases once a month in coordination with CSC team in the area if available	Every 3 months
	Spouses of migrants	Twice a month during home visits or return season of migrants	During home visits
	Migrants		During home visits
	IDUs and their partners	Every alternate day in case the IDUs have high injecting frequency (4-5 times per week). In other cases, twice a month for providing Needles/Syringes	During home visits
	FSWs	Weekly at least once for providing condoms and referral for testing	Every month
	MSMs		Every month
	MSWs		Every 3 months
	TG/Hijras		Every 3 months

In case there is a cluster of villages to be serviced by the cluster link workers, then the weekly services are to be converted to fortnightly once, but it should be ensured that all line listed target population is reached at least once in a month.

In case the HRGs are not staying in the LWS village but they operate from the village (FSWs work from the village, IDU visits for injecting or picking up drugs, MSM visits for high risk activities) they need to be targeted during their availability in the village for service delivery and follow up. For follow up also the concerned ASHA, ANM may be sensitized to provide condoms in their village from where the HRGs belongs to, however they should not disclose the identity of the HRGs.

What are the components of outreach session:

- Information sharing about the risks associated with each target population and ways to prevent.
- Condom Demo by the staffs and Re demo by the HRGs, migrants or mobile population
- Sharing of information related to the HIV Testing and Counseling, ARV, Condom Depots
- Information collection from the group about the services they are accessing, any issue faced related to availability or accessibility.
- Information about preferred providers or locations where condoms can be made available.

How the outreach plan is prepared:

Suppose the site map of three different sites indicate following information, then how the outreach plan would be prepared:

Places		Mon	Tue	Wed	Thu	Fri	Sat	Sun
Household no. 12, 14, 16, 29, 38	No. of target popn.	0	6	8	0	6	0	0
	Timings		2-3 pm	3-4 pm		2-3 pm		
Mothers meeting in ANM centre	No. of target popn.			15 including 6 of the above				
	Timings			10-11 am				
Market day	No. of target popn.		18 including 3 of the above					
	Timings		12 to 3pm`					

Based on above information it is very clear that:

Monday: 2-3 pm – outreach need to be planned by home visits (one to one session)

Tuesday: 10-11 am outreach need to be planned at ANM centre (one to group session)

Similar plans can be worked out for other days looking at the timings and convenience of target population.

3.3.2 Behaviour Change Communication (BCC)

The communication strategy will have the following approaches:

- **Dialogue-based one to one or one to group Interpersonal Communication (IPC):** Peer-led IPC is critical to enhance the credibility of messaging in the field. The messaging should be dialogue-based as opposed to top- down flipbook style messaging. Dialogue-based communication promotes critical thinking and self- reflection by the participants. These are necessary steps towards behaviour change. Some of these tools are discussed at Annexure -3
- **Creative, synchronized and thematic skits and role plays:** Given the large numbers of youth available in the village, they can play significant role in disseminating message on stigma and discrimination related to HIV/AIDS. It is necessary to supplement IPC activities with street plays, exhibitions, games etc. These serve to widen the exposure base of the programme, increase awareness of services and generate demand. Synchronizing these activities with other events at Panchayat Level through SACS helps reinforce key messages and build sustained engagement with the target population.
- **Selective mass media:** Mass media, particularly outdoor signage, radio programmes in local language provide a mechanism to promote programme services and expand awareness on a large scale. Mass media alone is unlikely to change behaviour, but it can plant the seed of a demand for services and a desire to learn more about HIV. These are expected to be worked out by SACS only.

3.3.2.1 Peer-led dialogue-based IPC

Dialogue based IPC uses tools and methods that stimulate a discussion on an issue and enable the group to problem-solve and arrive at an agreed course of action. Peer-led IPC uses members of the population (amongst the mothers, amongst the HRGs, amongst the youth) as facilitators to manage the discussion.

All the IPC sessions with the HRGs should preferably be one to one and the tools used in these sessions are to be kept with the office of LWS for verification by SACS or TSU. The cluster link workers are expected to use various tools for discussion with the HRGs, they should indicate the village, date and the signature of the HRGs with whom the tool is used. These tools after signature should be handed over to the block supervisor and the same need to be kept in the office of LWS for verification.

The advantages of peer-led IPC are that it:

- Has greater credibility than other outreach-led communication strategies
- Uses familiar language and the experience of having "lived the life" to ensure better affinity building around the message, reduced stigma and an environment of sharing
- Facilitates a higher degree of acceptance and ownership of the programme goals amongst the population

3.3..2.1.1 Types of peers

Peers may be of two types:

- **Cluster Link Workers:** Cluster Link workers themselves representing from the same village can be best resources and can be the best motivators for others in the programme.
- **Volunteers:** These are among the mothers, HRGs or youth who have been sensitized and have seen the result of services they have accessed. They can

be supported with cluster link workers to volunteer for meetings with target population.

(the details of selection of cluster link workers is included in the section under human resources in this chapter)

3.3.2.1.2 IPC tools

The IPC tools placed in Annexure –3 are based on three thematic areas:

1. Body Mapping – which enables the participants to understand the risk and generate information on perceiving the risk level.
2. Service Mapping – which enables the participants to get information about various services and their location.
3. Vulnerability Mapping – which enables the participants to understand the measures which can reduce their vulnerability.

3.3.2.1.3 Contents of the BCC sessions:

The IPC and BCC sessions should focus on following areas:

1. How to trigger risk perception i.e. what they do in their profession or while engaging in a risky sexual act or injecting act carries risk.
2. How to enable target population to understand that what measures they can adopt and practice so that their risk level becomes minimum or nil.
3. Why is it important that they get medical checked up for other ailments including STI, because they need to be productive, earning money for their family. In case, they fall ill, their income may get affected.
4. To make them understand how STI can be problematic for themselves as well as for their partners. Everyone of us wants their partner to be healthy to support us. Hence, it is important to get the STI treatment done from a qualified practitioner, complete the treatment and seek partner treatment as well.
5. To make their skills enabled on how to use a condom in different conditions, conditions in a dark room, with a partner who is alcoholic, conditions with a male partners etc.
6. To make their skills how to tell these information to a friend and help him to reach the programme and seek health services whenever required.
7. Provide information about whole range of services, its need and the location of services available near to them.
8. Provide information on safer injecting practices, abscess treatment at the nearest PHC or CHC and advantage of OST.

3.3.2.2 Mid-media

Mid-media serves to widen exposure, increases programme awareness and recall of programme services and helps generate demand. Synchronising mid-media activities with other services like health camps helps reinforce key messages and build sustained engagement. These can be organized by SACS as a part of the folk media activities.

3.3.3 Condom Programme

Link Workers Scheme can have provision of male and female condoms (if only the female condom program is available in the district) at the sub centres, with the ASHA, ANM and cluster link worker in the area.

It is suggested that under Link Workers Scheme free condom should be made available for following purposes:

- Condom demo and re-demo purposes.
- Free condoms would be provided to the HRGs and clients through.
- Free condoms for other target population would be provided through ASHA and ANM.

The suggested formula for calculating the requirement of free condoms for each cluster link worker is as follows:

- For demo and redemo purposes: Number of outreach sessions per month x number of month + 10% wastage
- For distribution among HRGs and their clients: Number of total HRGs and their clients listed last 2 qrs multiplied by 72 per person + 10% wastage

The suggested modalities for Social marketing of condoms are as below:

a. Identification and preparation of potential outlets list.

b. Procurement of condoms as per the requirement of the outlets for at least 2 months from distributors or agency.

The outlets should be a mix of both traditional and non-traditional outlets. The training of outlet holders may be taken up for better rapport building with the clients, display of products etc.

BIO-MEDICAL COMPONENT

Under this component, the focus may be on increasing risk perception, provision of risk reduction measures through treatment, counseling and referrals and further augment activities to reduce the risk environment. These services include:

1. Prevention, Treatment and Management of STIs/RTIs
2. Syphilis Screening
3. Linkage with HIV related services:
   a. HIV screening
   b. HIV care and treatment
   c. Post exposure prophylaxis
4. Linkage with other health services:
   a. Prevention, Screening, treatment and management of TB
   b. Family planning services

However, all these services are linked to the existing service providers. Hence, a minimum package of service is suggested as below with clear roles and expected outcomes.

What	How	Responsibility	Expected outcome	Measurable indicators
STI screening and treatment	Through existing providers	Private or Govt. trained doctors	Increase in clinic footfalls and STI treatment	• Decline in STI burden among target group
Syphilis screening	Through existing facilities		Decline in syphilis burden	• Decline in syphilis burden
TB screening and treatment	Through TB screening facilities	TB microscopic centres	Increase in screening and treatment compliance	• Reduction in TB burden among target group
HIV testing	Through HIV testing facility	Nurse/ Counselor	Increase in HIV testing and decline in HIV burden among truckers over a period	• Increase in HIV testing among HRGs and their partners • Decline in HIV burden among target group

What	How	Responsibility	Expected outcome	Measurable indicators
HIV care and treatment	Through nearest Care and Support Centre	Care and Support tam	Increase in adherence to treatment among HIV positive clients	• Increase in adherence and increase in quality of life
Family Planning services	Through nearest SubCentre or PHC	ANM/ASHA	Increase in acceptance of FP services.	• Increase in triple protection deliverables (protection against child bearing, STI and HIV)

3.3.5 Linkages with other HIV Services

Since all services under Link Workers Scheme are expected to be linked with existing services. It is important that how the linkage with other HIV services would be planned and monitored by the project:

1) Planning of referrals to other HIV services:

- A list of HIV services (HIV testing, TB Screening, ARV, OI management) may be made available with the project along with contact details, service timings.
- The nature of services (whether free of cost or charged services).

2) Referrals:

- Referrals being made to government run HIV testing and ARV facilities may be done based on the existing NACO protocols.
- It is suggested that 2 sets of referral slips may be provided to the clients – so that one is retained with the facility for future verification.
- The list of referrals may be shared with the facilities at the end of the month so that the staffs in the facility can track the referrals and assign unique numbers in cases where the clients have accessed services with or without referral slips.

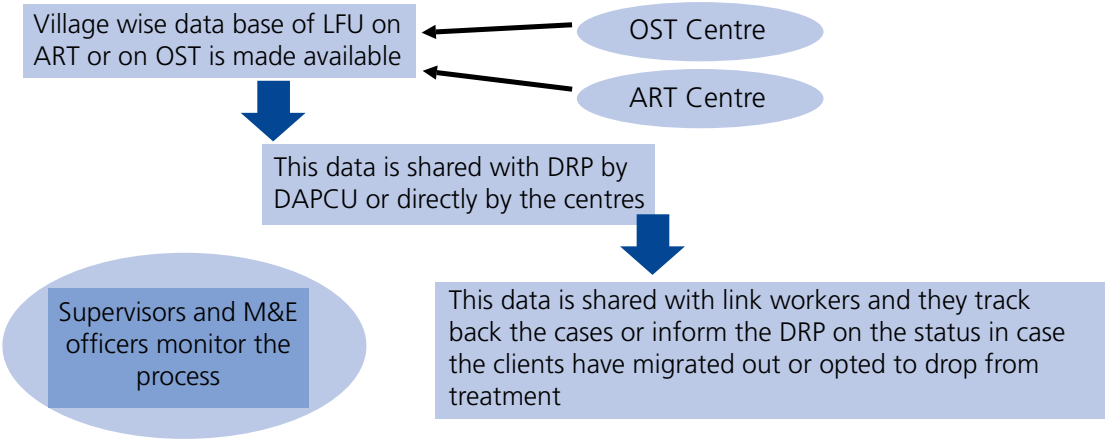
A sample format for referral and linkage register to be maintained at district level is provided at Annexure -4.

3) Referral monitoring:

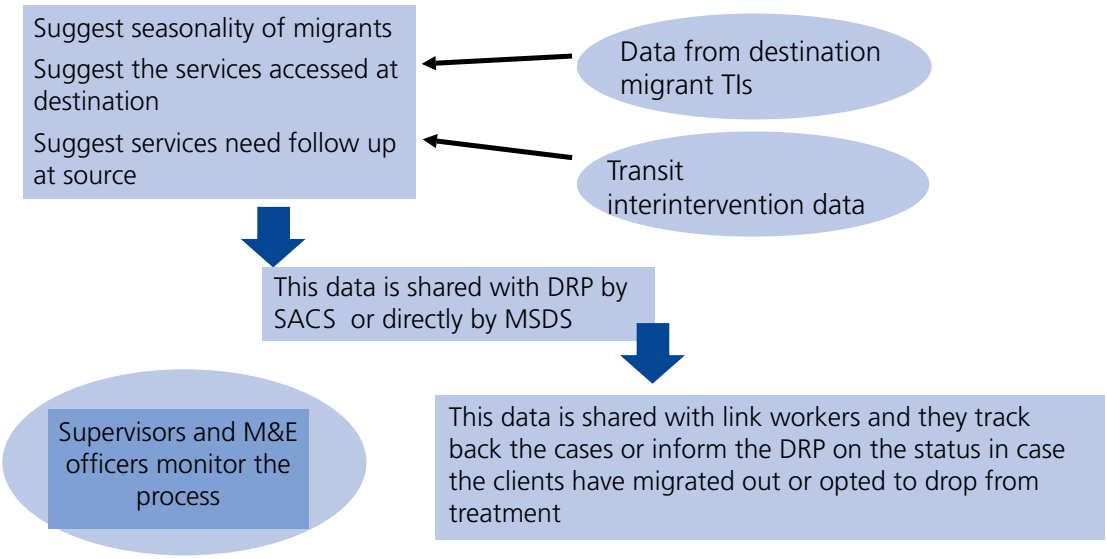
- In case of government run HIV testing and ARV facilities the line list with unique numbers may be collected from the facilities and the same is updated in the project MIS system.
- The summary of the figures among referred who availed services are reported in the monthly reports. A sample format for monitoring referral and linkages is provided at Annexure -5.

POSITIVE PREVENTION SERVICES

It may be more efficient to change behaviour among fewer HIV+ individuals than many HIV– individuals. The goal of positive prevention services to keep people living with HIV physically and mentally healthy and ensure prevent transmission of HIV to other people as well as increase their participation in societal purposes. These can be done by ensuring that they are receiving ART, psychosocial counseling regularly. Besides their engagement in the programme would motivate them and would increase their self esteem. Similarly, linkage to network and support groups would help them to share their thoughts better. For tracking of LFU especially those on OST and ART following mechanisms to be followed up:



For tracking of migrants who migrate to high prevalence States and are coming back once or more than once a year following mechanisms to be followed up:



3.3.6 Linkages with other Health Services

It is important to have strong linkage with existing public health system for following services:

- Syphilis screening – this may be provisioned along with HIV testing services or may be offered as a separate service to those who are being treated for STI.
- TB screening – this may be offered to clients with suspected or history of primary, secondary tuberculosis.
- Abscess management- this may be offered to IDUs clients with abscesses due to injecting drugs.
- Family Planning – this may be offered to all clients who are being referred to the sub centres or to the nearest public health facilities. Since male or female condom use for family planning reduces the risk of transmission of HIV and STIs.

It is very important that for linkages with other health services, the District level NGO need to take up following activities:

1. Sensitisation of District Administration, District Health Society, District level NGOs on the scheme especially the role expected from other institutions.
2. The DRP need to sensitise District Health Society, Block Medical Officers, CDPOs, District Social Welfare Officer etc. about the support expected from ASHA, ANM and Anganwadi Workers in ensuring service

linkage in all villages. But due to epidemic importance the LWS will work in selected 100 (maximum) in a district.

3. There is a need to train and sensitise the ASHA workers, Anganwadi Workers through regular meeting at block and district level especially through the ongoing platforms of review meeting, ASHA training or any other workshops.
4. Similarly, the DOTS providers, STLS need to be sensitise with support of TB programme staffs to ensure that the coordination is improved at village level for HIV-TB cross referrals.
5. Block supervisors should attend the monthly or weekly meeting of ASHA, ANM, Anganwadi Workers in their own blocks and neighbouring blocks to ensure that in a quarter at least all block level meetings are attended. During these meetings – the zonal supervisor is expected to share the performance of the block in terms of coverage of link workers scheme, the challenges faced and expected support from Health and Women & CD departments.
6. Similarly, the District Resource Person is expected to attend monthly meetings or any other meeting with District Administration – should share the progress of the scheme, role expected from various authorities.
7. The District Resource Person and Block supervisors during these meetings may concentrate on sensitizing and training the staffs so that they can work better with cluster link workers.

3.3.7 Implementing Health Camps

These are specific events organized at Panchayat Level especially during festivals when migrants return to their villages. This helps everybody to get their health checked up as well as undergo HIV counseling and testing. These should be organized with prior consultation with SACS and local District Health Society (DHS). So that there is no duplication and necessary support can be provided. Ideally the doctors, medicines and IEC materials, condoms are to be provided by DHS and SACS should provided testing and counseling support. Detailed guidelines on conducting health camps is available with SACS.

3.3.8 Stock Management

The stock and issue register for the free condoms, needles and syringes may be maintained by the supervisor for each taluka level. There would be a sub stock register for each cluster link worker. At the end of each month the supervisor need to make each sub stock register as NIL and get back all stocks available. This would make the central stock maintenance and monthly reporting easy. Accordingly inform the nearest TI from whom the needles and syringes are used for distribution and nearest Block PHC for free condoms.

There is a need to be maintain the list of items by their expiry dates. Free condoms with early expiry may be consumed first followed by late expiry ones. In case of expired condoms, the same may be submitted to nearest sub-centre for proper disposal and striking out from the stock register. A sample format for stock and issue maintenance by cluster link workers is attached at Annexure -6 and a format for maintenance at district level is attached at Annexure -6a.

3.3.9 Bio-Waste Management of used Needles and Syringes

The needles and syringes collected from the field or from the IDUs or their family members may be maintained in a separate register and should be kept in a puncture proof plastic container with medium size opening. This container may be carried with utmost care to the nearest TI which will carry out proper disposal as per Waste Disposal Guidelines.

3.3.10 Advocacy Activities

These activities are aimed at creating an enabling environment so that the stakeholders are sensitized about project activities, target population, vulnerabilities associated with the target population. These activities should be planned based on the stakeholders analysis and their role. This should be planned with aim at leveraging resources and support of district administration, other line departments so that the planned activities under this project are carried out. These meetings range from local body, block and district level meetings. These meetings are to be attended by Block Development Officer or District Collector and other senior officers of the block or district, NGO representatives working in the block or district so that they contribute meaningfully. TSU-Project officer or SACS officers may also attend this meeting and should provide an overview of the need of the project in the area.

3.3.11 Local Village level Meeting

The villages are to be selected based on the need for sensitization, preferably new villages, villages with high outmigration, villages planned to set up information centre etc. These meetings are to be planned with other activities of the project such as planning health camps, IEC folk activities, mothers meeting and SHG meetings. These meetings are to be attended by panchayat leaders, Village Health and Nutrition Sanitation Committee members, ANM, ASHA, Anganwadi Workers, SHG members and other members. The meetings are planned to mobilize support for different activities. Hence, before the meetings all the possible stakeholders are contacted and sensitized about the project so that during the meeting they participate and contribute meaningfully.

3.3.12 Stigma Reduction Activities

Each District with LWS should plan a district level sensitization activities in close association with SACS and District Health Society. Activities such as training of health care providers, ICDS staffs, Panchayati Raj and Labour department officials may be planned in coordination with Mainstreaming Division of SACS. The aim of this activity is to address stigma and discrimination associated with staffs of different service delivery points and sensitizing them about the need for their contribution in implementing various HIV/AIDS related activities including LWS. The LWS team should prepare a broad agenda and ensure participation from SACS in this event. Similar activities can either be planned at block or district level.

3.3.13 Coordination and Facilitation of PLHA/PLHIV Networks

The LWS team is expected to work closely with PLHA/PLHIV networks to involve in various activities so that there is an inclusive environment and they contribute in sensitizing the stakeholders about issues associated with HIV/AIDS prorgamme in the area. They may be involved as speakers in various forums and meetings. Any other activities may be planned in close coordination with SACS and local networks.

3.3.14 Cluster Link Worker Award

This is a motivational activity to promote cluster link workers in a district. The cluster link workers are expected to contribute effectively in the programme by strengthening liaison with other stakeholders, improve service access by target population. These awards are expected to be announced during the World AIDS Day functions planned for the district or any other important day in the district. A committee chaired by District Nodal Officer for HIV/AIDS should decide the five cluster link workers who would be felicitated. The other members of the committee should be representative/official from DAPCU, TI division SACS, TSU, local civil society organization, District Social Welfare Officer and as decided by the Chairman of the committee. The criteria for

selection of these cluster link workers should be displayed visibly in the notice board of the implementing agency, district administration and district health society offices.

The award will consist of an appreciation certificate along with Demand Draft (refer the budget for details) in the name of recipient. The minimum criteria for selection of five cluster link workers would be as follows:

1. Cluster link workers who were employed by the District NGO fulfilling basic eligibility criteria of education and experience as noted in this guidelines
2. The cluster link workers should have completed one year (12 months) of service is eligible for the award
3. The cluster link workers should have good conduct and punctuality over last 12 months
4. The cluster link workers should have excellence in performance against the targets for the program
5. New initiatives or efforts taken by the Cluster Link Worker to strengthen the programme or to achieve the project objectives.
6. The cluster link workers should not be involved in any other activities which are detrimental to the project such as in any conflict of interest to the organization or any members of the committee or indulged in any financial misappropriation.

The reports of the award function should be circulated widely in local newspapers and should be published in District NGO's annual report, SACS newsletter. A selected number of these reports will also be published at National level through NACO newsletter.

The decision to arrange the award ceremony of the five cluster link workers is sole responsibility of DAPCU and SACS. TSU is expected to provide necessary support.

Responsibilities of LWS NGO:

- NGO has to ensure that necessary documents and records of staff is available for the process.
- The NGO's responsibility is also to ensure the coordination, communication among all these stakeholders for appreciating the effort of LWS staff and the NGO has to complete this task before end of December in each financial year.
- The activity should not be carry forwarded to the next financial year.
- The case studies of all these recipients should be compiled appropriately. The case studies should be available at the LWS NGO and copy should be shared with SACS.

The final list of Cluster Link Worker Award recipient names to be displayed in SACS office and website for public information at the state level. SACS to send the few best case studies to NACO out of total case studies received from all LWS program in the state.

Structural Component

This component is important from the point of bringing a positive and enabling environment where various target groups can engage with the project services in a non-stigmatising and non-compelling environment everyone finds the service quality is better. To establish a structural component, following services may be considered:

1. Sensitisation of the local panchayat leaders and other stakeholders about the services being provided by the scheme. The pitch may start with importance of linking ANC mothers, TB patients with HIV services initially. Later on the vulnerability of migrants and HRGs may be used to sensitise.
2. Mobilising vulnerable groups in the form of Self Help Groups and Youth Clubs to demand and access services and participate in its delivery.

3. Involving other government service functionaries or programme staffs as volunteers so that they will fully register the vulnerable groups in their programme and delivery services even without active involvement of the cluster link workers.
4. Mobilising other NGOs or organizations who also target the same vulnerable and risk groups for various other services can be sensitized about the need of motivating these group of clients for better health seeking behavior even through their programme activities.
5. There should be efforts to transfer knowledge and skills by DRP, Zonal Supervisors to the other staffs at ground level so that the entire district is covered under the programme in spite of the presence of the scheme limited to a number of villages.

Group Formation by Cluster Link Workers:

There are enough evidence suggesting on peer group decisions influencing one's health seeking behaviour. Especially with respect to the HIV programming, the peer groups drive certain norms which also influence individual risk taking behaviour. Hence it is proposed that cluster link workers should form at least two groups in each year of the programme in a village. These groups may be formed among the spouses, adolescents, youths. The purpose of the group is to enable them to take decisions about their health and health seeking behaviours.

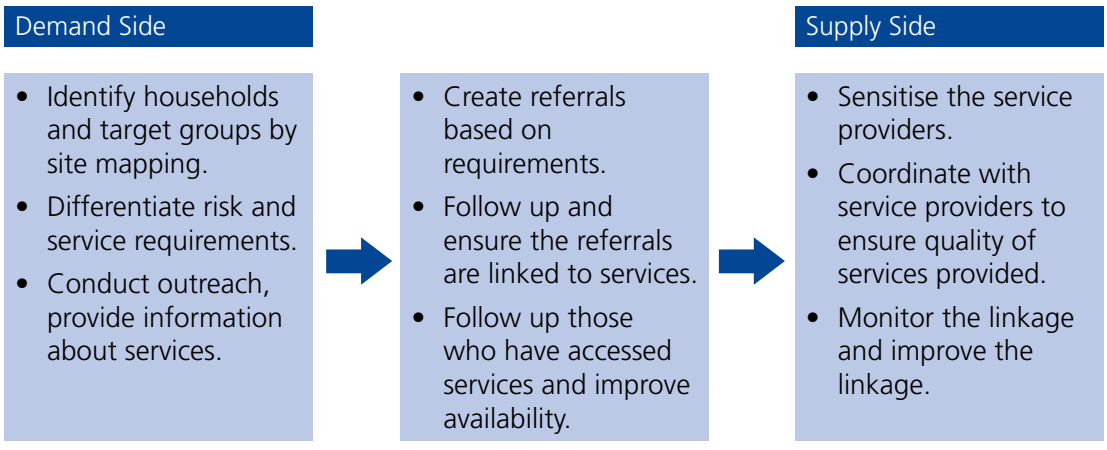
The following steps may be adopted:

- The existing platforms of Self Help Groups, VHND meetings, Adolescent meetings to be tapped to provide knowledge and skills for minimizing risk taking behaviour and improving health seeking behaviour.
- On regular interaction it would be found that there would be champions or volunteers who would be eager to participate in the programme for various purposes such as working as condom depot, person who refers clients for various services, person who helps during health camps.
- These champions or volunteers would be sensitized to further transfer similar skills to their friends, in this process a group can be formed and they can participate in various activities under the scheme.

3.4 PROGRAMME MANAGEMENT

The Link Workers Scheme is a district implementation model and is an important prevention intervention targeting various at risk and vulnerable groups. Since no service delivery points are created under this scheme it is essential that the outreach component of the scheme is strong enough to create demand for services and the services are made available.

The important elements of the effective programme management in Link Workers Scheme:



Demand Side:

- Target specific and differentiation of risk of population is required to design the intensity of outreach services by the cluster link workers.
- Ensure the services are provided in a manner which does not breach confidentiality of the client.

Supply Side:

- Ensure that the work done by ANM, ASHA or Anganwadi Workers is not taken over by the cluster link workers. The purpose of follow up of ANC mothers for HIV testing and other related services is to link up these mothers with HIV related services.
- Coordinate with service providers like Medical Officer of PHC to ensure routing of Mobile Medical Units for the village (if available), availability of doctors and medicines for organizing health camps, availability of condoms and IEC materials for distribution.
- Effective linkage and referral monitoring by maintaining referral slips by the PHC/ Subcentre staffs and ensure cross checking.

3.5 HUMAN RESOURCE MANAGEMENT

The human resources provisioned under the scheme at district level compromises following staffs and their roles in the programme. (detailed about process of recruitment is annexed at Annexure -9)

Position	Roles and Responsibility
District Resource Person (1 per District)	• Over all responsibility of the programme in the district. • Supervise works delegated to other member of the team and mentor them. • Facilitate recruitment of staffs as per the Guidelines in case of vacancies. • Development of district implementation plan ensure approval by competent authorities. • Monitor the implementation of district plan and submit progress reports as per requirement. • Ensure training of all staffs when they join and training by STRC. • Make field visits, meet and coordinate with stakeholders at district and block level to address issues related to implementation of the scheme. • Support SACS/DAPCU in implementing various activities such as Condom Programme, Folk Media Activities, Mass Media campaigns, Health camps etc. • Work with various government departments ensuring that the target groups are enrolled, receiving necessary services if they are eligible. • Play key role in advocacy at all levels against stigma and discrimination. • Compile reports and ensure analysis by M&E assistant for programmatic gaps. • Submit programme and financial reports on time to SACS/TSU/DAPCU or any other agency.

Position	Roles and Responsibility
M&E cum Accounts Assistant (1 per district)	• Timely collection of various reports from the field level staffs, financial documents analyse them and prepare monthly report indicating progress,gaps • Ensure timely submission of reports to SACS/TSU/DAPCU or any other agency • Ensure procurement process is followed as per directions of SACS • Ensure all financial norms, financial documents are maintained as per norms • Ensure orientation of staffs about different reports, financial transactions.
Zonal Supervisor (1 per 10-12 cluster link workers)	• Supervise works delegated to cluster link workers and mentor them. • Facilitate in site mapping, participate in taluka and panchayat level meetings to sensitise about the work being done under the link workers scheme. • Ensure regular supply of condoms and needles and syringes (wherever required) • Coordinate with other programme staffs in the field (TI, ANM, ASHA, Anaganwadi and other staffs including staffs of other NGOs who are working with the same target population) • Maintain rapport and coordinate with local govt. health facilities. • Reconcile the referral slips at least once a month and update referral register of the area and inform cluster link workers about the gaps. • Maintain Stock and issue register by reconciling the sub stock register. • Facilitate formation of condom depots, information centres and supervise their functioning. • Coordinate and facilitate with other govt. departments at panchayat and taluka level ensuring the eligible target groups are enrolled under various schemes and are accessing benefits.
Cluster Link Workers (maximum of 20 for 100 villages – 80 main villages as per the guidelines and 20 tagged villages)	• Conduct village-level site mapping (vulnerability mapping, health services/facility mapping, and household mapping). • Understand the migration patterns (both in and out migration) in the local community. • Reach out to the un-reached HRIs/groups and vulnerable young people with information and skills relevant to HIV prevention and risk reduction. • Provide relevant information regarding condom use, using innovative means that are contextually, locally and culturally appropriate. • Work towards reducing stigma and discrimination in the community by facilitating involvement of HIV positive people, community groups like SHGs, PRI and VHSC, and bringing into focus and addressing gender dimensions of stigma and discrimination. • Advocate with identified stakeholders for creating an enabling environment (and reducing stigma and discrimination). • Maintain rapport with local health units and facilitate access to services. • Have knowledge about the key health facilities in the vicinity, at FRU and the district level, and possess necessary information about the services available at the identified facilities. • Work towards reducing barriers to accessing services and promote STI management and partner notification. • Coordinate the linkage between communities and service institutions (especially ICTC, PHC/CHC, RTI /STI clinic and district hospital). • Identify and train volunteers. • Collect monthly data from condom depot holders. • Prepare monthly reports for his/her area according to a pre-defined format.

Take home messages

- From HIV program point of view, the at risk population require equal priority on behavioural, bio-medical and structural components of the project.
- Outreach and one to group BCC sessions are cornerstone of behavioural component. Outreach should be location and time specific, prepared by the link workers once in every quarter.
- Free condoms demo, re-demo and distribution in addition to social marketing of condoms is essential to ensure availability of condoms in the project area.
- Linkages and acess to services are important from the point of addressing risk environments
- Linkage with other HIV and health services further brings in inclusive approach for addressing risk

CHAPTER 4

REPORTING AND DOCUMENTATION AND QUALITY ASSURANCE MECHANISM

In this chapter, following areas are covered:

1. What are the various areas of documentation and reporting
2. What are the quality parameters and mechanisms of quality assurance
3. Monitoring and evaluation – role of SACS, TSU
4. Performance Indicators

4.1 DOCUMENTATION AND REPORTING

4.1.1 Documentation

- The project is expected to maintain daily records of all outreach activities, referrals for STI treatment, HIV counselling and testing, enabling activities, and condom social marketing.
- The project is expected to maintain profiles of all staff and minutes of planning and review meetings.
- All activities in the project is expected to be documented as per the standardized documentation formats.

4.1.2 Reporting

- A monthly report for as per requirement of NACO would require to be reported as per required dateline.

The following set of reporting formats would be used to document, report various activities under the scheme.

Name of the document	Who prepares	How frequently
Line listing of migrants and other categories	Cluster Link Workers supported by Supervisor	As and when a new contact is made (Annexure-1), For migrants (Annexure -2)
Referral and Linkage	Cluster Link Workers supported by Supervisor	As and when a person is referred (Annexure -4)
Referral and Linkage monitoring	Supervisor supported by DRP and M&E cum Accounts Assistant	On fortnightly basis (Annexure-5)
Stock and Issue	Cluster Link Workers supported by Supervisor	On a weekly basis (Annexure -6)
Stock and Issue at District	M&E cum Accounts Assistant	On a fortnightly basis (Annexure – 6a)

Name of the document	Who prepares	How frequently
Field visit	Supervisor, DRP	As per requirement (Annexure -7)
Meeting	Any level of staff	As per requirement (Annexure-8)
Human Resources	M&E cum Accounts Assistant	Monthly Once (Annexure -10)
Monthly report	M&E cum Accounts Assistant	As per requirements (Annexure-11)
Accounts and Finance	M&E cum Accounts Assistant	As per requirements
Monthly analysis report for each Supervisor	M&E cum Accounts Assistant supported by DRP	Weekly once for supervisors on rotation basis

4.2 QUALITY ASSURANCE MECHANISMS

As part of the project management, the National, State and Project Level staffs would manage certain key quality assurance mechanisms in terms of the inputs, processes and outputs of the Link Workers Scheme.

4.2.1 Defining quality parameters

The following quality parameters would be defined for input level:

Quality Parameter	Role and Responsibilities
Standardised training and field level inputs for intervention	NACO
Selection of staffs as per ToR	Implementing Partners
Training of staffs as per prescribed guidelines	Implementing partner in coordination with STRC
Supply of condoms, Needles and Syringes as per prescribed guidelines	SACS in coordination with local District Health Society
Number of visits made and addressed gaps in the programme	TSU/SACS/NACO

The following quality parameters would be defined for process level:

Quality Parameter	Role and Responsibilities
Average number of target population reached through outreach sessions	Cluster Link Workers
Number of target population referred by outreach team are attending clinic	Cluster Link Workers and Local health care providers including Govt. facilities
Number of target population amongst the clinic attendees were treated for STI	Govt. and private trained providers

The following quality parameters would be defined for output level:

Quality Parameter	Role and Responsibilities
Number of target population reached with services – clinic, counseling and HIV testing	Implementing Partners
Reduction in STI burden among target population at least measured after 2 years	Implementing Partners
Increase in condom sales through social marketing as per the target of outlets after 6 months	Implementing Partners
Increase in condom use during last sex as measured during IBBS	NACO
Decline in HIV burden among HRGs and their partners over a period	NACO
Improved ARV adherence among target population	NACO

4.2.2 How to measure quality parameters

It has been noted that measurement of quality parameters are seen as proxy of outcome or output indicators. But it is important to ensure that there is a system to measure the inputs and processes as well. Hence, it is important that the inputs and processes need to be continuously monitored in order to ensure better outputs.

For example, in a link workers scheme, if the village selected is not feasible, if the cluster link workers are not from the same area, if adequate number of outreach sessions is not being conducted, if in each quarter no new members are contacted, if there is less clinic footfall - then the output and outcome would be affected.

Hence, it is important that the measurement of quality should start with each activity, considering that each activity itself would impact the output. This sensitivity needs to be built in within each staffs and should not be a top-down approach. Measurement of quality parameters may be part of field visit checklists of project team, may be part of the technical and management team's review.

The TSU may come up with SOP for each of these above parameters with clear cut operational definition, operational mechanism and reporting norms. Thus there is uniform understanding across different teams and members within the team. Performance benchmarks may be developed taking into account local scenario to further measure outputs and inputs better.

5.1 MONITORING AND EVALUATION

The projects will be monitored regularly by the TSU. The robustness of data collection and the intervention level as well as at the national level (de-centralised and centralised levels) will aim to inform national intervention quality and design.

- The officers/team visiting the projects will have a clear agenda for the visit and will be based on the supervisory check list developed by TSU or NACO.
- All visits will be documented and the suggestions/recommendations shared in writing with the implementing organisation and NACO
- Suggestions/recommendations made by the monitoring officer/team will be implemented by the organisation
- All documents, reports and plans maintained by the project will be open for scrutiny during these monitoring visits

- Staff reviews will be part of the monitoring process
- The data must be used to correlate the progress made by the project
- Quarterly reviews are to be used to evaluate trends and improvements.
- The project preferably be evaluated by an external agency/evaluator. The evaluation tool and manual can be developed by technical team.

5.1.1 Performance Indicators

This set of indicators is suggested to monitor the performance of the link workers scheme.

- These indicators are based on the assumptions that the Interventions have appropriate facilities and staffs in place as required in the guidelines.
- The indicators in this section are broken out component-wise - e.g., outreach, condoms, STI/Clinical, enabling environment.
- The "denominator": The denominator represents the basis for assessing the performance. It captures the annual actual coverage target on the ground and has been established based on the estimates worked out for a particular cluster link worker.
  - In case of ongoing interventions it is the sum of the current coverage and the annual coverage targets established based on the revalidation.
  - In case of a new interventions, the denominator is the coverage targets based on the calculations in Chapter 3.

No.	Area	Indicator	Frequency of Reporting	Data Source	Definitions
1	Outreach	Estimated Number of Target population by each category in the district	One time	Site maps consolidate at district level	The total estimate of individual target group divided by each category in a district.
2		Denominator (i.e. proposed coverage as per calculation as above)	Annually		As defined above
3		% of HRGs covered/ contacted by the program through the outreach contacts in a year	Annually		There should be a minimum of two to four times contact per HRGs and their spouses, spouses of migrants, TB patients, PLHIV on ART in a quarter and one time contact for other target population. This ensures coverage of all target population in the district are covered at least once with information and referral once in a quarter.

No.	Area	Indicator	Frequency of Reporting	Data Source	Definitions
4	Condoms	Total no. of free male condoms distributed against he calculated demand	Monthly	Condom stock registers	Total No. of condoms distributed by the cluster link worker and does not include condoms stored in dispensing boxes.
5	Needles & Syringes	Total no of free needles and syringes distributed against the calculated demand	Monthly	Needles and syringes stock register	Total no of needles and syringes distributed by the cluster link worker and does not include needles and syringes stored in dispensing boxes or available with cluster link worker.
6	STI treatment	Proportion of STI treatments among the referrals made	Monthly	Referrals Register	Total no. of target population by various category treated for STI divided by total no. of referred (benchmarked earlier as above)
7	Linkages	% Target population by different categories who are tested at ICTC	Monthly	Referral register and ICTC register	Total no. of target population by various category divided by total referred plus walked –in.
8		% of target population by various category linked to ARV	Monthly	Referral register	Total no. of target population by various categories for provision of antiretroviral therapy (ARV) divided by the no. of tested positive and reported back to the project till date.
9	Linkages with OST services (wherever applicable)	Proportion of IDUs retained in OST	Quarterly	Referral register	Proportion of IDUs linked to nearest OST centre are continuously taking medicine versus number registered with the centre.
		Percentage of OST clients who completed treatment	Quarterly	Referral register	Percentage of IDUs linked with nearest OST centres completed treatment in the reporting quarter.

CHAPTER 5

ROLE OF STAKEHOLDERS

5.1 ROLE OF STAKEHOLDERS

The collaborative coordination of the HIV response and management of implementation by NACO and implementing partners ensures that the national programme is dynamically designed to maintain relevance; aligned to implementation principles of efficiency and effectiveness and closely monitored to ensure that opportunity gaps are addressed. These processes give rise to additional and complementary capacity building and mentorship initiatives aimed at strengthening and sustaining quality coverage of at risk and vulnerable populations in rural settings with prevention interventions. To facilitate National level implementation of the Link Workers Scheme following stakeholders would be involved as mentioned below:

- Policy Makers (Ministry of Health & FW through NACO, Ministry of Women & Child Development, Ministry of Rural Developments, State Governments through SACS).
- National Technical Working Group for Link Workers Scheme, Technical Support Unit
- Implementing partners (NGOs, CBOs, STRCs, Private Health Organisations etc.)

The detailed role for various stakeholders may be as follows:

National AIDS Control Organisation:

The NACO being the nodal agency for the Ministry may play important role in steering the Link Workers Scheme. The scheme would be managed by TI Division at NACO. These include:

- Evidence building around estimates, prevalence and behavioral parameters of at risk and vulnerable population in rural settings including their service utilization pattern such as ART uptake, TB and HIV co infection rates.
- Guide implementing partners for implementation of programme in consonance with National Guidelines.
- Guide implementing partners in impact and outcome assessment and support for mid-course corrections.
- Provide guidance in developing training curriculum, training resources, communication materials.
- Provide guidance in ensuring supply of condoms, needles and syringes for the programme and coordination among various services and programmes among key populations.

Other Ministries (Ministry of Women and Child Development, Ministry of Rural Development):

The Ministry of Women and Child Development, Ministry of Rural Development may play the role in creating enabling environment which addresses the vulnerability of women in sex work, children orphaned due to HIV/AIDS and other vulnerable male population, improves the working condition of cluster link workers by ensuring service linkages by sensitizing their departmental staffs.

State Governments through SACS:

The role of State governments may be to facilitate the smooth implementation of the programme as per National Guidelines. The scheme would be managed by TI division at SACS. The broad areas include:

- Contract management and timely fund flow by ensuring that the attrition of cluster link workers is not attributed due to poor fund flow mechanism.
- Conduct regular bimonthly/quarterly meetings with District level NGOs, DAPCUs to review and understand field challenges and gaps and provide inputs for any mid course corrections to NACO.
- Conduct field visits to the implementing districts to review and provide technical inputs to the programme.
- Ensure coordination amongst all partners working in a particular district especially in terms of HRGs, bridge populations and vulnerable populations.
- Ensure free condoms, IEC materials as per requirement of the scheme is available from the districts or block Health Society under National Health Mission.
- Ensure that the folk troupe activities, condom social marketing campaigns and migrant health camps are conducted in 80% of the project area in a district each year.
- Consider the mainstreaming of programmes in all districts covered in the scheme in a synergetic manner so as to address the issue of vulnerability.
- Ensure that the staff conducting the scheme is trained and their skills are built to implement the activities effectively by the STRC or any other arrangement where STRC is not available.
- Select Implementing NGOs as per National Guidelines.
- IEC division to plan number of mid-media events, adequate supply of IEC materials, Link Workers Kit for use by the District level NGO staffs. All IEC related activities are to be carried out in coordination with IEC division of SACS/NACO. These activities should ideally be planned in the AAP to ensure that the District level NGOs are supplied with the materials as per requirements.

Mainstreaming of services by SACS:

Since the scheme would focus in selected villages and blocks as well as selected districts, it is essential that efforts must be made to transfer similar skills and knowledge to ASHA, ANM and Anganwadi Workers through respective ministries as well as including similar activities in their annual plans in phases.

It is important that all divisions of SACS should work together to scale up services through mainstreaming especially through National Health Mission. Technical Support Unit may work out a mainstreaming plan in consultation with various divisions at SACS and NACO so that the same can be implemented by various divisions at SACS.

The Technical Support Unit (TSU):

This is a State level technical support structure that is responsible for providing technical support to TI programme and LWS. The TSU provides strategic and implementation support in 4 key areas:

i. Support in development of improving the evidence building and approaches in line with National Guidelines.

ii. Support in development of training curricula aligned to the guidelines.

iii. Support in development of communication materials.

iv. Support in building capacity of implementing partners in areas of programming, M&E.

DAPCUs:

DAPCUs being important coordinating body at selected districts would carry out following functions for strengthening the implementation of the link worker scheme:

i. Conduct monthly review meeting of district level NGOs ensuring that issues related to service availability, availability of condoms/ needles and syringes/IEC or BCC materials or support from Mobile ICTC/Mobile medical units or support of TB programme or support of ASHA/Anganwadi workers/ANM is facilitated by taking relevant issues with respective officers.

ii. Ensure district level coordination among various agencies directly or indirectly linked to smooth implementation of LWS.

iii. Data validation especially of referral services accessed by beneficiaries of LWS.

iv. Should not use cluster link workers for tracking of LFUs in non-LWS villages

v. Should not use cluster link workers to implement programmes which are not approved by SACS.

Implementing partners (NGOs, CBOs):

Implement and manage the interventions as per the requirement of National Guidelines and ensure there is no duplication of activities or funding resources for same activities.

STRCs:

The STRCs are expected to build capacity of the implementing partners, help in developing local level evidence for better programming, document best practices to improve quality of the programme.

Private Health Care Providers:

The Link Workers Scheme is expected to identify and collaborate with private health care providers that they are sensitized and trained on National Guidelines to provide necessary services for the target population. To establish, document and strengthen referral systems and quality of services.

ANNEXURE–1 (FORMAT FOR LINE LISTING CUM SERVICE TRACKING SHEET)

District _____ Block _____ Name of the link worker _____ Month: Year:

Village name	Household no. /Name of the hotspot	Name of the person	Age	Sex (M /F / T)	Marital status (M-married, UM-Unmarried, D-Divorced, S-Separated)	Category*	Date of registration as per the guidelines	Date when services provided or accessed (ICTC testing, STI clinic visit / treatment, Condoms provided)	Date when dropped out due to migration/ services are completed as per the guidelines			Services for which referral made	Referral Services accessed (yes/ no),if yes, write the name of the center	Whether the same person is receiving services from a TI or any other link worker village	Remarks(including dates for subsequent services)
									ICTC	STI	Condom				

* 1-FSW,2- MSM, 3-IDU,4- Truckers,5-TB patient,6- Pregnant mother,7- PLHIV,8- CLHIV,9- Spouses of FSW, 10-Spouse of IDU, 11- Spouse of MSM, 12-Spouse of TG, 13- Spouses of migrant, 14- Spouses of truckers, 15-TG/Hijra, 16- Other Vulnerable groups. In case of above target population is not met with services for 3 months, the same may be dropped out for next quarter. Separate format for migrant line-listing.

Note: Additional Columns may be added as per requirement without removing any from the above mentioned format.

ANNEXURE–2 (LINE LIST FORMAT FOR MIGRANTS)

Sl. No.	1			
State		2		
District			3	
Taluka / Thesil				4
Block				
Post Office				
Revenue Village				
Segment Code				
House street Colony code				
Name of the bread Winner/Guardian/Head of the Family				
Name of the Key Population				
Unique ID				
Sex				
Age				
Father's name				
Whether eligible for RSBY				
Does he/she have the required docs to be registered with RSBY				
Whether registered with RSBY				
Spouse Name				
Whether eligible for JBSY				
Whether linked with JBSY				
Husband's name (for female migrants)				
Destination details: Category Code				
Destination details: Mob No.				
Destination details: State				
Destination details: District				
Destination details: Town				
Destination details: Post Office				
Destination details: Major Landmark (if any)				
Destination details: Occupation				
Services Delivery Status of migrant: Referred (HIV) Date				
Services Delivery Status of migrant: Tested (HIV) Date				
Services Delivery Status of migrant: HIV Status				
Services Delivery Status of migrant: Referred (STI) Date				
Services Delivery Status of migrant: Treated (STI) Date				
Services Delivery Status of migrant: STI Treatment for (Type)				
Services Delivery Status of migrant: ART Linkage				
Services Delivery Status of migrant: DLN Linkage				
Services Delivery Status of migrant: Referred for T.B.				
Mobility: T.B. status				
Mobility: Duration of stay in source : No of Days				
Mobility: Planning to go back to destination (Tentative date)				

Note: Additional Columns may be added as per requirement without removing any from the above mentioned format.

ANNEXURE–3: IPC TOOLS

Name of the Tool: Body Mapping

Objective of the tool: To enable the participants to understand the risk and generate information on perceiving the risk level.

User: Cluster link workers

What skills required by the facilitating team: Knowledge about transmission modes, knowledge about risky behaviours, difference between risk and vulnerability, knowledge about risks associated with HRGs, their partners and whether this has any impact on their risk perception levels.

Materials required: At least 2 chart paper and 3-4 colour markers for each session

Additional materials can be in the form of a flip chart with a story about the clients they come across, these clients being non-committal to any body in using condoms can carry HIV virus from one HRG to another. Thus once the HRG gets infected with STI/HIV it limits their ability to earn better and lead a quality of life.

Degree of privacy: Moderate

Time required: 30-45 minutes per session

Method:

- Collect at least 8-10 participants majority of them should be from the target population.
- Ask one group to draw the outline of human body and ask other group to indicate what risk do they carry in each part of the body which is harmful to their life e.g. taking unhealthy food or water may affect their stomach, smoking can have cancer, unprotected sex can lead to STI/HIV etc.
- While one group starts calling out the risk behaviours, the other group should write down them on another paper.
- Pick three risk behaviours (one must include risk behaviour associated with STI/HIV). Ask participants to build consensus on these.
- Ask one group to write each of these risk behaviour and circle them. Ask now both groups to tell why these are risk behaviour and if so how can be prevented.
- Ask both groups to highlight the reasons in another chart paper, which can be controlled by individuals and which require support from peers, family and others.
- Conclude highlighting that better understanding of reasons and application of efforts can reduce any sort of risk include risk for STI/HIV.

Additionally, both groups can work out messages for their own groups which can be used for replication and messaging on various risk behaviours among the target population.

Name of the Tool: Service Mapping

Objective of the tool: To enable the participants to get information about various services and their location.

User: Cluster link workers

What skills required by the facilitating team: Knowledge about different formal and informal services used by the target population in the project area which may include services for daily life (grocery, government paper work) or services for health care. How different providers behave and how the target population perceive and react to these.

Materials required: At least 2 chart paper and 3-4 colour markers for each session

Additional materials can be in the form list, service hours, cost of services and contact details of various health and HIV related services may be printed out in the form of small hand outs or in the form of posters.

Degree of privacy: Low

Time required: 30-45 minutes per session

Method:

- Collect at least 8-10 participants majority of them should be from the target population.
- Divide the participants into 2 groups and keep 2 persons to be facilitator and time keeper.
- Ask one group to draw the map of the village and nearby localities – start marking the services they seek on a day to day basis including health care and HIV related services.
- Ask other group to highlight the services provided by the health care providers in the form of following:
  - What services they seek ?
  - How much it costs ?
  - Whether they get benefit out of these services ?
  - What is the source of information about these services ?
- Pick three service providers which attract lots of the target population. Ask participants to build consensus on these.
- Ask one group to write which are the factors that make services attractive:
  - The cost/distance/benefits/behaviour of the provider/less waiting time/confidentiality and so on.
- Ask both groups to rank these three services indicating if the services needs to be better especially in the case of providing HIV/STI related services.
- Conclude asking both the groups saying that the services can only be improved if one there is participation of the target population in providing these useful suggestions to the NGOs, to the staffs of these centres.
- The same chart papers can be used time and again to assess the feedback on the services, participation level as well as what additional services required.

Name of the Tool: Vulnerability Mapping

Objective of the tool: To enable the participants to understand the measures which can reduce their vulnerability.

User: Cluster link workers

What skills required by the facilitating team: Knowledge about different situations and factors that increases risk of the target population and what can be done to reduce their risks.

Materials required: At least 2 chart paper and 3-4 colour markers for each session

Additional materials can be in the form a flip book having 2 stories one about a youth who survives by staying with his family in the village and the friend of the youth who travels to distances comes across many friends but have habits of consuming alcohol, gambling and often visiting sex workers.

Degree of privacy: Low

Time required: 30-45 minutes per session

Method:

- Collect at least 8-10 participants majority of them should be from the target population.
- Divide the participants into 2 groups and keep 2 persons to be facilitator and time keeper.
- Ask one group to write down if whether the youth who stays in village have the risk of having STI/HIV, if so why and how can be prevented.
- Same question can be put to the other group who is a family member of migrants/truckers.
- Ask both groups to discuss what if can be done so that the migrants or truckers and his friend can make difference preventing both of them from STI/HIV.
- It does not necessarily that either of them leaves their occupation or exchange their occupation – it is that the person have to make informed choice for better life.
- Conclude asking both the groups saying that the being responsible to their life can bring changes both within the individual as well as among their peers.

New stories can be built up or the participants can be asked to tell stories about their life and different challenges they face.

ANNEXURE–4 (REFERRAL AND LINKAGE REGISTER FOR CLUSTER LINK WORKERS)

Name of the Cluster link worker:

Name of the Block: **Name of the District:**

Month of reporting:

Category of persons	No. of persons reached ICTC / PPTCT or testing done during health camps		No. of persons visited/ treated with STI (both govt. and private)		No. of persons tested for syphilis		No. of persons received ART services		No. of persons linked with PLHIV network		No. of persons linked with social benefits schemes		Any other services linked		Total
1	2		3		4		5		6		7		8		9
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
AN mothers															
Spouses of FSW															
Spouses of MSM															
Spouses of TG															
Spouses of IDU															
Spouses of migrants															
Spouses of truckers															
FSW															
MSM															
IDU															
TG/Hijra															
Migrants															
Truckers															
Youth with STI/ HIV/AIDS															
Children with HIV/AIDS															
TB patients															
PLHIV															

ANNEXURE–5 (REFERRAL AND LINKAGE MONITORING FORMATS FOR ZONAL SUPERVISOR)

Name of the Zonal Supervisor: **Name of the village:**

Name of the Block: **Name of the District:**

Reporting Quarter: **Year:**

Category of persons	No. of persons reached ICTC / PPTCT or testing done during health camps		No. of persons visited/ treated with STI (both govt. and private)		No. of persons tested for syphilis		No. of persons received ART services		No. of persons linked with PLHIV network		No. of persons linked with social benefits schemes		Any other services linked	
	T	A	T	A	T	A	T	A	T	A	T	A	T	A
AN mothers														
Spouses of FSW														
Spouses of MSM														
Spouses of TG														
Spouses of IDU														
Spouses of migrants														
Spouses of truckers														
FSW														
MSM														
IDU														
TG/Hijra														
Migrants														
Truckers														
Youth with STI/ HIV/AIDS														
Children with HIV/ AIDS														
TB patients														
PLHIV														

T = Target for the quarter, A = Achievement during the quarter

ANNEXURE–6 (STOCK AND ISSUE REGISTER FOR CLUSTER LINK WORKERS)

Name of the Cluster link worker:

Name of the Block: **Name of the District:**

Month of reporting: **Year:**

Sl. No.	Name of the item	Source from where received	Opening balance of the item	Total numbers received during the month	Total number of items available at the start of the month	Total numbers distributed/ socially marketed during the month	Closing balance of the item
1	2	3	4	5	6=(4+5)	7	8=(6-7)
	Free Condoms						
	Needles						
	Syringes						
	Socially marketed condoms						
	IEC materials						
	BCC materials						

ANNEXURE–6A (STOCK AND ISSUE REGISTER FOR DISTRICT LEVEL)

Name of the reporting person with designation:

Name of the Block: **Name of the District:**

Month of reporting: **Year:**

Sl. No.	Name of the item	Source from where received	Opening balance of the item	Total numbers received during the month	Total number of items available at the start of the month	Total numbers issued during the month (mention date of issue)	Person to whom issued on the date mentioned in the earlier column	Signature of the person received or place the voucher number in case the item was sent through post/courrier	Closing balance of the item
1	2	3	4	5	6=(4+5)	7			8=(6-7)
	Free Condoms								
	Needles								
	Syringes								
	Socially marketed condoms								
	IEC materials								
	BCC materials								

Indenting Format (to be signed by the DRP only, should be on the letter head of the organization along with copy of the sanction letter or office order of SACS indicating that the agency is expected to receive items from the concerned authority)

Designation of the officer to whom addressed (Medical Officer/ANM/JD of SACS)

Number of Items for which indent placed	Number of Items earmarked for the program at the start of the year	Total items received till date	Remarks about last supply received

Purpose for which items received has been fulfilled: (Yes/No)

I certify that the items have been used for the purpose for which it was supplied for during the period from _____ to _____ by _____organisation.

(Signature)

(Please retain a copy with the organization and share a copy with SACS in case the intended supply is to be done by Block/District/State level organization other than SACS)

ANNEXURE–7: (VISIT REPORT)

for DRP, senior staffs of Implementing agency

Date of visit: DD/MM/YYYY **Name of the reporting person:**

Places of visit:

Designation of the reporting person:

Purpose of the visit:

1.

2.

3.

Persons met during the visit:

Summary of discussions or observations:

Action taken and future action plan:

Observations	Action taken	Future action plan	Responsibilities	Timeline

(The report should not be more than 2 pages and should be signed by all concerned as well as the reporting officer)

ANNEXURE–8 (MEETING ACTIVITIES REGISTER)

for various meetings such as Stakeholders, Meeting with health department/women and child development department, district officers, Internal meetings

Name of the Block: **Name of the District:**

Month of reporting: **Year:** **Date of the meeting held:**

Purpose of the meeting:

Name of the persons who attended the meeting	Designation of the persons	Decisions taken	Next plan of action	Responsibilities	Expected timeline by which the discussed activities is expected to commence	Expected timeline by which the discussed activities is expected to complete	Any other
1	2	3	4	5	6	7	8

ANNEXURE–9: RECRUITMENT PROCESS:

Position	Qualification and Experience	Recruitment Process	Agencies required
District Resource Person	Masters in Social Sciences with at least 3 years experience in working with programmes related to livelihood promotion, adult literacy, microfinance, health sector programmes not merely awareness activities. Should be based in the district for which applied. Should be willing to travel in the district extensively. Should have knowledge of MS-Word, Excel.	Open advertisement followed by written test and interview. Written test questions to be provided by the JD/ DD/AD TI or LWS. The interview panel should have representation from SACS/TSU, district officers from DAPCU/ District nodal officer on HIV/AIDS.	District Implementing Agency SACS TSU DAPCU District Nodal officer on HIV/AIDS
Zonal Supervisor	Bachelors in Social Sciences with at least 2 years experience in working with programmes related to livelihood promotion, adult literacy, microfinance, health sector programmes not merely awareness activities. Should be based in the district for which applied. Should be willing to travel in the district extensively. Should have a vehicle for travel. Should have knowledge of MS-Word, Excel.	Open advertisement followed by interview The interview panel should have representation from district officers from DAPCU/District nodal officer on HIV/AIDS.	District Implementing Agency DAPCU District Nodal officer on HIV/AIDS
Cluster Link Workers	10+2 or above with at least 1 year experience in working with programmes related to HIV/ Health/Livelihood promotion, adult literacy, microfinance, health sector programmes not merely awareness activities. Existing link workers who fulfill above criteria will be considered as priority Should be based in the district for which applied. Should be willing to travel in the district extensively. Preference should be given to candidates having a vehicle for travel.	Open advertisement followed by interview The interview panel should have representation from district officers from DAPCU/District nodal officer on HIV/AIDS or Block level Program manager	District Implementing Agency DAPCU District Nodal officer on HIV/AIDS

Position	Qualification and Experience	Recruitment Process	Agencies required
M&E officer cum Accounts Assistant	Bachelor in Commerce/Computer Application with at least 1 year experience in managing data, data entry, creating analysis sheets from excel, preparing power point presentations. Experience of managing accounts for any NGO would be preferred.	Open advertisement followed by interview The interview panel should have representation from district officers from DAPCU/District nodal officer on HIV/AIDS or Block level Program manager	District Implementing Agency DAPCU District Nodal officer on HIV/AIDS

ANNEXURE–10 (HUMAN RESOURCES)

to be filled by DRP

Name of the District:

Reporting Month: **Year:**

Category of staffs	Total number of staffs during last month		Total number of staffs joined during reporting month		Total number of staffs available at the end of reporting month		No. of staffs completed training by NGO		No. of staffs completed training by STRC/SACS/ any other agencies		Write down the topics/ areas trained so far			
	S	A	S	A	S	A	S	A	S	A	1	2	3	4
DRP														
Zonal Supervisor														
Zonal Supervisor														
M&E cum Accounts Assistant														
Cluster Link Workers														

S = Sanctioned, A = Available

ANNEXURE–11 (MONTHLY REPORTING FORMAT)

The soft copies of these formats would be available with SACS

National AIDS Control Organisation (NACO)																	
DISTRICT MONTHLY CONSOLIDATED REPORTING FORMAT FOR LINK WORKERS SCHEME UNDER TI DIVISION																	
Name of the District:						**State**			**Name of the NGO**								
Name & Designation of the Reporting Officer:						**Contact No.**			**Month:**			**Year:**		**No. of blocks reporting**			
No. of villages under implementation in each block (write the name of the blocks and number of villages)	Total	Block 1	Month:	Block 3	Block 4	Block 5	Block 6	Block 7	Block 8	Block 9	Block 10	Block 11	Block 12	Block 13	Block 14	Block 15	Block 16
	0																
	Total	**Write below the numbers covered in each block against quarterly estimates during the month**															
No. of estimated HRGs targeted during the start of the quarter as per site assessment reports	0																
Total number of new HRGs (head counts) identified during the reporting month	0																
Total number of HRGs dropouts during the month (head counts)	0																
Number of different activities conducted in the reporting month	Total	**Write below the numbers activities carried out in each block during the reporting month**															
No. of one to one sessions conducted	0																
No. of One to group sessions conducted	0																
No. of mid-media campaigns held	0																
No. of health camps organised	0																

National AIDS Control Organisation (NACO)													
DISTRICT MONTHLY CONSOLIDATED REPORTING FORMAT FOR LINK WORKERS SCHEME UNDER TI DIVISION													
No. of VHND meetings attended by LWS implementation team	0												
Number of beneficiaries (old and new) received various services	Linelisted numbers till the reporting month	Only contacted through one to one or one to group (BCC or IPC) session	Only contacted through Mid-media session	No. of persons tested in the near-east ICTC/ PPTCT centres	No. of persons found positive among the tested ones during the reporting month	No. of persons treated at the nearest STI providers	No. of persons tested for syphilis	Total no. of persons are tested positive during the year (starting April) till the end of reporting month (cumulative)	Total no. of persons are on ART till the end of reporting month (cumulative)	No. of persons who are put on TB treatment duing the reporting month	No. of persons linked with PLHIV network during the reporting month	No. of new persons linked to social protection	No. of condoms provided during the reporting month (both free & Socially marketed)
FSW													
MSM													
IDU													
TG/Hijras													
Total HRG	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**	**0**
Spouses/Partners of MSM													
Spouses/Partners of TG													
Spouses of IDU													
Spouses of migrants													
Spouses of Truckers													
Total low risk Bridge Population	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**	**0**
Antenatal Mothers													
TB Patients													

National AIDS Control Organisation (NACO)													
DISTRICT MONTHLY CONSOLIDATED REPORTING FORMAT FOR LINK WORKERS SCHEME UNDER TI DIVISION													
Children with HIV/AIDS													
PLHIV													
Total (PLHIV+CLHIV)	**0**	**0**	**0**			**0**	**0**		**0**	**0**	**0**	**0**	**0**
Spouses of FSW													
Migrants													
Truckers													
Total Male population at risk	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**	**0**
Female migrants													
Any other Vul. Pop													
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

A. Human Resource:									
Category of the staff (as applicable in the budget)		Number of man power approved	Number of manpower in place	Trained during the month	Cumulative Trained during the year	Number of days of visits made during the month	No. of meetings with other stake holder s held		
District Resource Person		1							
Zonal Supervisor		2							
M&E cum Accounts Officer		1							
Cluster Link Workers		20							
Involvement of Volunteers									
		Trained during the month	Trained Cumulative Trained	Number in Place					
Number of volunteers									
Service Delivery:									
B. Commodities and Materials									
	a. No. of new social marketing condom depots established in the reporting month	b. No. of social marketing condom depots established till the reporting month	c. Total no. of social marketing condom depots functional till end of reporting month	d. Uptake of condoms by social marketing	e. Total free condoms distributed	f. No. of needles/ syringes distributed	g. No. of needles/ syringes collected and sent for safe disposal	h. No. of IEC materials distributed	i. No. of BCC materials distributed

A. Human Resource:						
C. Outreach activites:	Total Number planned for the reporting month	Total Number conducted in the reporting month	No. of person participated	Cumulative no. till the reporting month	Total Number planned for the next month	Remarks, if any
a. Advocacy meeting with district level stakeholders (detailed reports to be maintained at NGO level)						
b. Meetings with village level stakeholders(Panchayat/NYK etc)						
c. Community events and meetings organised with SHG/Youth clubs (detailed reports to be maintained at NGO level)						
d. Review meeting under supervision of SACS/TSU/ DAPCU (Signed meeting minutes to be maintained at NGO level)						
e. Others (Specify)						

D.Financial Management:			
Financial Status	Budget Approved for the FY	Expenditure made till reporting month	SOE submitted till date

E. Major Highlights (if any)- Share the detail reports of the events via email

F. Activities planned for next month:

ANNEXURE–12

DISTRICT WISE DATA (HEAD-COUNT/UNIQUE INDIVIDUAL) UNDER LINK WORKER SCHEME (LWS) from APRIL till end of reporting month												
		HRG										
Sl. No.	District	Total line-listed HRGs	Unique individuals (head-counts) HRG contacted (through one-to-one or group sessions or condom only) during the period 1st April till end of reporting month	%	Unique individuals (head-counts) HRG covered (through services) during the period 1st April till end of reporting month	%	Unique individuals HRG tested for HIV only once during the period 1st April till end of reporting month	%	Unique individuals HRG tested for HIV twice during the period 1st April till end of reporting month	%	Number of positive HRG detected under LWS during the period 1st April till end of reporting month	Number of HRGs referred for STI treatment during the period 1st April till end of reporting month
Self-explanatory	*Write name of the district*	*Write the total line-listed HRGs in the district after including newly identified HRGs*	*Write the number of unique individual (head-count) HRGs reached through one-to-one, one-to-group or condom distribution from April till end of reporting month. Irrespective of the number of contacts through one-to-one, one-to-group or condom distributed, the individual will be counted as one in the reporting financial year.*	*Auto-generated*	*Write the number of unique individual (head-count) HRGs covered through any clinical services (including HIV testing) from April till end of reporting month. Irrespective of the number of clinical services, the individual will be counted as one in the reporting financial year.*	*Auto-generated*	*Write the number of unique individual (head-count) HRGs tested for HIV only once (1 time) from April till end of reporting month.*	*Auto-generated*	*Write the number of unique individual (head-count) HRGs tested for HIV twice (2 times) from April till end of reporting month. Irrespective of the number of tests, the individual will be counted as one in the reporting financial year.*	*Auto-generated*	*Write the number of unique individuals dectected HIV positive during the period April till end of reporting month*	*Write the number of unique individual (head-count) HRGs referred for STI from April till end of reporting month. Irrespective of the STI referrel, the individual will be counted as one in the reporting financial year.*

DISTRICT WISE DATA (HEAD-COUNT/UNIQUE INDIVIDUAL) UNDER LINK WORKER SCHEME (LWS) from APRIL till end of reporting month									
		Migrants							
Sl. No.	District	Total line-listed Migrants (Male& female)	Unique individuals (head-count) Migrants contacted (through one-to-one or group sessions) during the period 1st April till end of reporting month	%	Unique individuals (head-count) Migrants covered (through services)during the period 1st April till end of reporting month	%	Unique individuals (head-count) migrant tested for HIV during the period 1st April till end of reporting month	%	Number of migrant positive detected under LWS during the period 1st April till end of reporting month
Self-explanatory	*Write name of the district*	*Write the total line-listed Migrants in the district after including newly identified.*	*Write the number of unique individual (head-count) migrants reached through one-to-one, one-to-group or condom distribution from April till end of reporting month. Irrespective of the number of contacts through one-to-one, one-to-group or condom distributed, the individual will be counted as one in the reporting financial year.*	*Auto-generated*	*Write the number of unique individual (head-count) migrants covered through any clinical services (including HIV testing) from April till end of reporting month. Irrespective of the number of clinical services, the individual will be counted as one in the reporting financial year.*	*Auto-generated*	*Write the number of unique individual (head-count) migrants tested for HIV from April till end of reporting month. Irrespective of the number of HIV testing, the individual will be counted as one in the reporting financial year.*	*Auto-generated*	*Write the number of unique individuals dectected HIV positive during the period April till end of reporting month*

DISTRICT WISE DATA (HEAD-COUNT/UNIQUE INDIVIDUAL) UNDER LINK WORKER SCHEME (LWS) from APRIL till end of reporting month						
		PLHIV				
Sl. No.	District	Total line-listed PLHIVs	Unique individuals (head-counts) PLHIV contacted (through one-to-one or group sessions or condom only) during the period 1st April till end of reporting month	%	Unique individuals (head-counts) PLHIV covered (through services) during the period 1st April till end of reporting month	%
Self-explanatory	*Write name of the district*	*Write the total line-listed PLHIVs in the district after including newly identified.*	*Write the number of unique individual (head-count) PLHIVs reached through one-to-one, one-to-group or condom distribution from April till end of reporting month. Irrespective of the number of contacts through one-to-one, one-to-group or condom distributed, the individual will be counted as one in the reporting financial year.*	*Auto-generated*	*Write the number of unique individual (head-count) PLHIVs covered through any clinical services (such as OIs, ART visit, CD4 testing visit,TB-DOTS linkage) from April till end of reporting month. Irrespective of the number of clinical services, the individual will be counted as one in the reporting financial year.*	*Auto-generated*

DISTRICT WISE DATA (HEAD-COUNT/UNIQUE INDIVIDUAL) UNDER LINK WORKER SCHEME (LWS) from APRIL till end of reporting month									
		All other groups/categories							
Sl. No.	District	Total line-listed population excluding HRGs, Migrants & PLHIV	Unique individuals (head-count) excluding HRGs, Migrants & PLHIV contacted (through one-to-one ot group sessions) during the period 1st April till end of reporting month	%	Unique individuals (head-count) excluding HRGs, Migrants & PLHIV covered (through services) during the period 1st April till end of reporting month	%	Unique individuals (head-count) tested for HIV (excluding HRGs, migrant & PLHIV) during the period 1st April till end of reporting month	%	Number of positive detected under LWS (excluding HRGs, Migrant & PLHIV) during the period 1st April till end of reporting month
Self-explainatory	*Write name of the district*	*Write the total line-listed in the district after including newly identified.*	*Write the number of unique individual (head-count) reached through one-to-one, one-to-group or condom distribution from April till end of reporting month. Irrespective of the number of contacts through one-to-one, one-to-group or condom distributed, the individual will be counted as one in the reporting financial year.*	*Auto-generated*	*Write the number of unique individual (head-count) covered through any clinical services (including HIV testing) from April till end of reporting month. Irrespective of the number of clinical services, the individual will be counted as one in the reporting financial year.*	*Auto-generated*	*Write the number of unique individual (head-count) tested for HIV from April till end of reporting month. Irrespective of the number of HIV testing, the individual will be counted as one in the reporting financial year.*	*Auto-generated*	*Write the number of unique individuals dectected HIV positive during the period April till end of reporting month*

DISTRICT WISE DATA (HEAD-COUNT/UNIQUE INDIVIDUAL) UNDER LINK WORKER SCHEME (LWS) from APRIL till end of reporting month								
Sl. No.	District	Total no. of persons are on ART till the end of reporting month (cumulative)	No. of persons who are put on TB treatment during the period 1st April till end of reporting month	No. of Cluster Link Workers on-board till end of reporting month	No. of volunteers on-board till end of reporting month	No. of new persons linked to social protection during the period 1st April till end of reporting month	Uptake of condoms through Social Marketing	Total free condom distribution
Self-explanatory	*Write name of the district*	*Write total number of persons (alive) on ART till end of reporting month. This data pertains to existing/ current numbers only and no start time required (all categories).*	*Write the number of unique individual (head-count) who are put on TB treatment from April till end of reporting month (all categories).*	*Write the number of Cluster Link Worker on-board till end of reporting month*	*Write the number of Volunteers on-board till end of reporting month*	*Write the number of unique individual (head-count) linked to social protection/ benefit schemes during the period 1st April till end of reporting month*	*Write the number of uptake of condoms through Social Marketing during the period April till end of reporting month.*	*Write the number of free condoms distribution during the period April till end of reporting month.*

REPORTING REQUIREMENTS:

As per the requirement of the LWS, the following reporting requirements are mandatory. The back up of various information below will follow NACO's and Government of India's Intellectual Property Rights. Nome of these information can be used for purposes otherwise agreed in the contract. Upon requirement, all these information should be shared with SACS.

Name of the report	Soft Copy and Back up	Hard Copy
Line listing cum service tracking format except for migrants	Yes	Yes
Line listing of migrants	Yes	Yes
Referral and Linkage register	No	Yes
Referral and linkage monitoring format	No	Yes
Stock and Issue	Yes	Yes
Stock and Issue at District level	Yes	Yes
Field visit report	No	Yes
Meeting register	No	Yes
Recruitment Process	No	Yes
Human Resources	Yes	Yes
Accounts and Finance	Yes	Yes
Monthly report	Yes	Yes
Monthly analysis report for each Supervisor	Yes	Yes

Data definitions:

Item: Monthly Reporting format Who fills: M&E cum Accounts Frequency: Monthly

Purpose of the report:

- To report the key indicators of the programme implemented by the district during the last reporting month.

Explanations:

Name	Explanation	Source of collection
Name of the District	Where the program is being implemented	
State	State in which the programme is being implemented	
Name of the NGO/Implementing agency	NGO/Implementing agency reporting	
Name and designation of the reporting officer	Person reporting on behalf of the implementing NGO	Self explanatory
Contact number		Self explanatory
Designation	Person reporting	Self explanatory
Month	Last month of implementation	
Year	Current year of implementation	
Number of villages under implementation in each block during the reporting month		
No. of blocks reporting	Number of blocks reporting during the last reporting month	
No. of villages under implementation during the month	Write the name of the block against the block number and number of villages implemented the programme in each block during reporting month	Cluster Link workers and supervisor daily report In case number of blocks are more than 16, group them and report
No. of estimated HRGs targeted during the start of the quarter	Write the number of estimated HRGs targeted in the villages during start of the quarter – this may be the SNA information (as per last SNA reported in March 2015 for those villages which are continued after site assessment), may be the line listed figures available with each cluster link worker (this should include new HRGs identified during last 3 months). The number of HRG dropped out during last 3 months to be deducted from the final number.	SNA information (as per last SNA reported in March 2015 for those villages which are continued after site assessment) or Line listed minus drop outs for each cluster link worker For example in December there were 400 HRGs in the district. During January – 20 new were found and 10 were dropped out, In February – no new found but 3 dropped out, in March, 6 new were found and 4 were dropped out. So for April reporting – the total estimated HRG targeted during the quarter would be = 400 + (20+6)= 426 – (10+3+4)=409.

Name	Explanation	Source of collection
Total number of new HRGs (head counts) identified during the month	Write the number of individual HRGs that is the head counts identified and registered during the month. This may include someone who was dropped out and again getting registered.	Cluster Link worker's IPC contact information and the number of IPC sheets submitted by cluster link workers
Total number of HRGs dropouts during the month (Head counts)	Write the number of individual HRGs that is the head counts who did not receive any service or condoms during last 3 months	Cluster Link Workers IPC contact information would provide the drop outs.
Number of different activities conducted during the reporting month		
Number of different activities conducted in each block in the reporting month	Write different activities carried out by LWS based on the approved plan in each block during the reporting month	Activities report and Supervisors report
No. of one to one sessions conducted	Number of sessions conducted by the cluster link workers in each block during reporting month	Cluster link workers information
No. of one to group sessions conducted	Number of sessions conducted by the cluster link workers in each block during reporting month	Cluster Link workers information
No. of mid-media campaigns held	Number of sessions conducted by the project in each block during reporting month	Cluster Link workers information
No. of health camps organized	Number of health camps organized by the project in each block during reporting month.	Activities report and health camp report as prescribed by SACS
Number of VHND meetings attended by implementation team	Number of sessions conducted by the cluster link workers in each block during reporting month	Cluster Link workers information
Number of beneficiaries (old and new) received various services in each block during the last reporting month	Number of both old and new beneficiaries from different target population group received services directly or through referrals in each block during last reporting month	Line listing , referral and linkage register, stock and issue register
Line listed numbers till the reporting month	Number of different categories of beneficiaries line listed during the reporting month (this should include both old and new registered ones)	Cluster Link Workers line listing information
Only contacted through one to one or one to group (BCC or IPC session)	Write the number of different categories of beneficiaries only reached out with messages during one to one or one to group sessions. This may be using IPC or BCC materials or without any such materials	Cluster link workers linelisting information

Name	Explanation	Source of collection
Only contacted through mid-media sessions	Write the number of different categories of beneficiaries who attended mid-media sessions during reporting month. Often it is very difficult to categorise the attendees of a mid-media session except for male or female. However, in case the link workers have the information of different categories they must mention these figures by categories.	Mid-media event report
No. of persons tested in the nearest ICTC/ PPTCT centres	Write the number of referral slips matched (both referred during the previous months or reporting month) in ICTC/PPTCT or the information provided in ICTC/PPTCT register matches with the project villages. These number includes walk-in from implementing villages, preferably PID numbers may be maintained if available.	Linkage and referral register, referral slips validated by ICTC and PPTCT
No. of persons found positive among the tested one during the month	Write the number of positives found among those tested as mentioned above. This may include people tested twice even not referred, they have walked in and got tested.	Referral and linkage register
No. of persons treated with STI at the nearest STI providers	The STI providers may include OPD of the nearest PHC/CHC, Govt, STI clinics, OPD information from the private practitioners. This may include persons referred earlier as well as during reporting month. Write the numbers treated in these facilities.	Referral and linkage register
No. of persons tested for syphilis	As a practice, those undergoing HIV testing are also expected to undergo syphilis testing. The may include persons who have not been treated with STI as well.	Referral and Linkage register
Total no. of persons are tested positive during the year (starting April) till the end of reporting month (cumulative)	Write the number of total positives detected and reported since April of current Financial year by the project till the reporting month.	Referral and linkage register
Total no. of persons are on ART till the end of reporting month (cumulative)	Write the number of total persons on ART (alive) since start of the project till the reporting month (cumulative since the beginning of LWS programme).	Referral and linkage register

Name	Explanation	Source of collection
No. of persons who are put on TB treatment during the reporting month	Write the total number of TB patients (new or relapsed) on treatment by the project during the reporting month	Referral and linkage register
No. of persons linked with PLHIV network during the reporting month	Write among all the PLHIVs in the project area – number of PLHIV linked to network during reporting month	Referral and linkage register
No. of new persons linked to social protection	Write the number of persons linked to social protection schemes (this can be number of persons who applied or number of persons who received the benefits for the first time during the reporting month)	Referral and linkage register
No. of condoms provided during the reporting month	Write the number of free and socially marketed male and female condoms provided to different categories of beneficiaries during the reporting month	Stock and Issue register
HRGs provided various services as applicable from the list in the monthly reporting format	Write the number of FSW,MSM, TG/ Hijra, IDU provided various services as applicable during reporting month	Line listing information
Low risk population provided various services as applicable from the list in the monthly reporting month	Write the number of spouses/ partners whether registered or not registered but have provided services or have taken services from referral centres	Referral and linkage register Line listing information
Ante natal mothers received any services	The unique individual ANC mothers receiving any of the services – if one ANC mother may receive three services, then mention against each service. For example if one ANC mother receives condoms, HIV testing – then mention against both the condom and HIV testing columns.	Line listing cum service record of cluster link workers
Total no. of TB patients received any services	The unique individual TB patients receiving any of the services – if one client may receive three services in addition to TB treatment then mention against each service. For example if one TB patient receives TB testing, HIV testing – then mention against both the TB testing and HIV testing columns.	Line listing cum service record of cluster link workers

Name	Explanation	Source of collection
Total number of PLHIV and CLHIV accessing different services	Write the unique number of individual CLHIV and PLHIV received services (even if they have received multiple services) – then mention against each service during the reporting month.	Line listing cum service record of cluster link workers
Total male population at risk who received different services	Write the number of spouses of FSWs, migrants and truckers who have accessed different services – mention against each service during the reporting month	Line listing cum service record of cluster link workers
Female migrants receiving different services	Write the number of self reported female migrants receiving different services – mention against each service during the reporting month	Line listing cum service record of cluster link workers
Any other category of the target population receiving different services	Write the number of target population or general population receiving services during the last reporting month. Mention the category as well.	Line listing cum service record of cluster link workers
Total persons reached in the reporting month	The report will automatically calculate total persons reached with different services in the reporting month	Self explanatory
Human Resources		
Number of man power approved	Number of staffs approved in the budget or contract	
Number of manpower in place	Number of staffs in place during last month	
Number trained during the month	Number of available staffs who are trained during last month	
Cumulative trained during the year	Number of staffs trained till the reporting month	
Number of days visit made during the month by each staff	Number of days visit made by each staff during the reporting month	Field visit reports and field diaries to be cross checked
No. of meetings with other stakeholders held	Number of meetings held by the staffs during the reporting month	Meeting reports to be cross checked
Volunteers in place, trained and cumulative trained	Number of volunteers contacted, trained during the reporting month	
Commodities and Materials		
No. of new social marketing condom depots established in the reporting month	Write the number of new depots established in the reporting month – this may include depots which has been reopened.	Stock and Issue register

Name	Explanation	Source of collection
No. of social marketing condom depots established till the reporting month	Number of depots established till the reporting month since the April	
Total no. of social marketing condom depots functional till end of reporting month	Number of depots which reported sales during the reporting month	Stock and Issue register
Uptake of condoms by social marketing	Number of condoms socially marketed by the available condom outlets during the reporting month	Stock and Issue register
Free condoms distributed	Number of condoms distributed free by the staffs	Line listing and service tracking format, stock and issue registers
No. of needles/syringes distributed	Number of needles/syringes distributed by the staffs during the reporting month	Cluster Link workers diary, line listing and service record of cluster link workers, stock and issue registers
No. of needles/syringes collected and sent for safe disposal	Number of needles/syringes collected from field by cluster link workers or supervisors and sent for disposal	Bio medical waste management register
No. of IEC materials distributed	Number of IEC materials distributed by the staffs	Stock and issue registers and cluster link workers daily diaries
No. of BCC materials distributed	Number of BCC materials distributed by the staffs	Stock and issue registers and cluster link workers daily diaries
Outreach Activities		
Advocacy meeting with district level stakeholders	Meeting with stakeholders	Meeting register (signed by participants)
Meeting with other village functionaries (Panchayat/NYK etc.)	Meeting with these functionaries	Meeting register (signed by participants)
Community events and meeting s with SHG/Youth clubs	Self explanatory (community events with any group of target population during BCC sessions or health camps). Meetings with SHG/Youth clubs self explanatory	Meeting register
Review meeting under the supervision of SACS/TSU/DAPCU	Self explanatory (review meetings conducted either in SACS/TSU/DAPCU office or meetings conducted in LWS project office)	Signed copy of the meeting minutes to be made available
Others	Mention the specific activities that are carried out by the LWS team during the reporting month	Details of the reports to be available at project office.
Total number planned for the reporting month	Mention number of activities planned as per the monthly plan	Monthly plan

Name	Explanation	Source of collection
Total number conducted in the reporting month	Mention the number of activities conducted during the reporting month as against the monthly plan	Activity reports
No. of person participated	Mention number of persons participated in various activities conducted during the reporting month	Activity reports and their signature
Cumulative number till the reporting month	Mention the cumulative number of particular activities except for others (in case of others combine all sorts of activities carried out under others categories) since April of the current financial year till the reporting month	Activity reports
Total number planned for next month	Mention total number of activities planned for next month including others categories	Monthly plan
Remarks	Mention comments or observations on short fall or achievements under different categories	
Financial Management		
Financial Status (Budget approved for the FY)	Budget approved for the FY in the project proposal	Contract document and budget sheet
Financial Status (Expenditure made till the reporting month)	Cumulative figure from the Statement of Expenditure till the reporting month during the FY	Statement of Expenditure
Statement of Expenditure submitted till the date	Statement of Expenditure figure submitted till the date	Statement of Expenditure
Major Highlights	Describe major achievements in bulleted points. In case of activities which require to be highlighted a separate one pager may be shared detailing the activities.	
Activities planned for next month	Describe major activities for next month	

Item: Format for line listing **Who fills: Cluster Link Worker** **Frequency: As and when**

Purpose of the line listing:

- To identify households by risk category, update their service requirements and service accessed.
- To monitor the progress of cluster link workers scheme by villages and cluster of villages.
- To understand workload for a village or cluster of villages and help in optimizing the requirements of cluster link workers in a district irrespective of work load.
- To minimize duplication of services for HRGs who are also line listed in a nearby village or nearby TI.

Explanations:

Name	Explanation	Source of collection
District	The name of the district for which the particular format is being filled	Project Proposal of the LWS
Block	The name of the block for which the particular format is being filled	Project Proposal of the LWS
Name of the cluster link worker	The name of the person who is responsible for filling the format	Self Explanatory
Village Name	The name of the village for which the particular format is being filled	Project proposal of the LWS
Household number	Household number as per the village records for which the format is filled	Self explanatory
Name of the person	The name of the person who is line listed	Self explanatory
Age	The age of the person	Self explanatory
Marital Status	The marital status of the person	Self explanatory
Category (FSW, MSM, IDU, Migrants, Truckers, TB patient, Pregnant mother, PLHIV, CLHIV, Spouses of high risk groups or bridge population, youth, any other)	The category for which the person belongs to	As per the definition in the guidelines
Date of registration as per the guidelines	Date when the person is first time registered with the programme, also in case registered after dropping out	As per the definition in the guidelines
Date when dropped out due to migration/ services are completed as per the guidelines	Date when the person could not be traced for services or was confirmed to have migrated or does not require services as per the guidelines	As per the definition in the guidelines
Services for which referral made	Report services for which referral was made with the service centres	As per the definition in the guidelines
Referral Services accessed (yes/no)	Report services have been accessed for which referral was made	As per the definition in the guidelines
Whether the same person is receiving services from a TI or any other cluster link worker village	Report only cases where the same person has been recorded and receiving services from a nearest TI or cluster link worker village	As per the definition in the guidelines

Item: Format for outreach planning Who fills: Cluster Link Worker Frequency: As and when

Purpose of outreach planning:

- To use field level data related to availability of target population by their location and convenient timing for outreach activities.

Explanations:

Name	Explanation	Source of collection
Location	The place where an individual or a group of individuals from the target population can be met as per their convenience to provide information and/or services	Individuals or group of individuals as per their discussion during last meeting
Number of target population	The number of target population who have expressed their convenience for next meeting	Individuals or group of individuals
Timings	The time noted by individual or group of individuals for meeting or sharing information or providing services	Individuals or group of individuals
Day	The day when meeting is planned as per the convenience	Individuals or group of individuals

Item: Format for stock and issue Who fills: Cluster Link Worker Frequency: Once a month

Purpose of documenting stock and issue of various items:

- To use data from stock and issue of various items handled by the cluster link worker for improving the distribution of various commodities as per the need of target population

Explanations:

Name	Explanation	Source of collection
Name of the item	These items can be free/socially marketed condoms, needles, syringes, IEC/BCC materials	Self explanatory
Source from where received	Mention from where the item has been received – it may be from ANM, from District or Block Medical officer, Cluster Link supervisor or DRP	Self explanatory
Opening balance of the item	The number of items available at the start of every month or as per the date decided by SACS or NGO	Based on calculation of items available at the start of the month and sum of items distributed during the month
Total numbers received during the month	The number of items received from various sources during the month	Self explanatory
Total number of items available at the start of the month	Sum of various items available at the start of the month plus the items received during the month	Calculation of items available at the start of the month and items received during the month

Name	Explanation	Source of collection
Total numbers distributed/socially marketed during the month	Sum of items distributed for various target population as mentioned in the line list. Sum of items socially marketed.	Information about distribution as per the line listing format and information on social marketing from the social marketing register
Closing balance of the item	The number of items available on the last day of the month or as per the date decided by SACS or NGO	The calculation of total items available at the start of the month minus the sum of total items distributed or socially marketed during the month

Item: Format for referral and linkage Who fills: Cluster Link Worker Frequency: As and when

Purpose of documenting referral and linkage activities:

- To use data monitoring of referrals and services accessed by various target population

Explanations:

Name	Explanation	Source of collection
Category of persons	Various target population Total number of persons as mentioned in the line list format who have accessed services at different referral centres	Self explanatory
No. of persons reached ICTC or testing done during health camps		Number of persons who got tested for HIV amongst number of persons who were referred for HIV testing
No. of persons treated with STI (both govt. and private)		Number of persons who were treated for STI among those referred
No. of persons received PPTCT services		Number of persons who were receiving PPTCT services among those referred
No. of persons received ART services		Number of persons who were receiving ART services among those referred
No. of persons linked with PLHIV network		Number of persons who were linked to PLHIV network among those referred
No. of persons linked with social benefits schemes		Number of persons who were linked to social benefit schemes among those referred
Any other services linked	Any other services which were provided by the NGO/SACS or any other institutions and the target population were linked with services.	Self explanatory

Item: Format for documenting meetings

Who fills: Member of LWS Frequency: As and when

Purpose of documenting meeting activities:

- To document and use the proceedings of the meetings for improving the outcomes

Explanations: The items mentioned in this format are self explanatory and the information are to be collected from the respective meetings.

Item: Format for referral and linkage monitoring Who fills: Zonal Supervisor

Frequency: Quarterly Once

Purpose of documenting referral and linkage monitoring activities:

- To use data monitoring of referrals and services accessed by various target population in each village in a quarter and understanding the barriers so that these issues can be addressed during stakeholder meetings.

Explanations: Self explanatory as mentioned in the format related to referral and linkage activities

Item: Format for Human Resources Who fills: DRP Frequency: Monthly Once

Purpose of documenting HR related activities:

- To document and use the data for understanding staff availability, trainings undergone and areas of training by various agencies including by the NGO.

Explanations: Self explanatory as mentioned in the format related to Human Resources related activities

Item: Format for Visit Report Who fills: DRP/Zonal Supervisor Frequency: As and when

Purpose of documenting field visit related activities:

- To document and use the information for monitoring of purpose of visit, action taken during the visit and future plans worked out – followed up following the visit

Explanations: Self explanatory as mentioned in the format related to field visit related activities

Item: Format for Stock and Issue register at District level Who fills: DRP

Frequency: As and when

Purpose of documenting stock and issue register at district level:

- To document and use the information stock and issue of various items for monitoring the inflow and out flow at district level.
- Ensure indenting at least when the stock level is less than 3 months for items
- Indenting format has been included to ensure smooth handling of supplies and maintain official records of indenting

Explanations: Self explanatory as mentioned in the format related to field visit related activities

Notes:

Notes:

Notes:

National AIDS Control Organisation

India's voice against AIDS

Ministry of Health & Family Welfare, Government of India

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