

**National AIDS Control Programme
Phase IV**

**RURAL INTERVENTIONS/
LINK WORKER SCHEME**

Report of the Technical Working Group



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

July 2011

Abbreviations

AIDS	:	Acquired Immuno Deficiency Syndrome
ART	:	Anti Retroviral Therapy
AWW	:	Anganwadi Worker
BSS	:	Behavior Sentinel Surveillance
DAPCU	:	District AIDS Prevention and Control Unit
DPM	:	District Program Manager
DRP-P	:	District Resource Person – Program
DRP-T	:	District Resource Person – Training
FSW	:	Female Sex Worker
HIV	:	Human Immunodeficiency Virus
HRG	:	High Risk Group
HSS	:	HIV Sentinel Surveillance
ICTC	:	Integrated Counseling and Testing Centre
IDU	:	Intravenous Drug Users
IEC	:	Information Education and Communication
IMR	:	Infant Mortality Rate
IPC	:	Interpersonal Communication
LW	:	Link Worker
LWS	:	Link Worker Scheme
M&E	:	Monitoring and Evaluation
MSM	:	Men who have sex with men
NACO	:	National AIDS Control Organization
NGO	:	Non Government Organization

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1. Introduction

As National AIDS Control Programme is entering phase IV of its implementation in India, evidence shows a stabilizing trend in the progression of the epidemic in the country. In several of the high prevalence states the latest surveillance data that is available is showing a decline in the prevalence indicating impact of sustained programme interventions in the country¹.

1 (a) Rural HIV Epidemic

About 69% of India's 1.21 billion people live in rural India and despite the country's growth in the last decade; there remains a rural-urban disparity. Within the context of HIV, evidence of a rural HIV epidemic is emerging. Overall, HIV prevalence was higher among urban than rural populations. However, some states had a slightly higher HIV prevalence among rural populations than urban populations, namely, Punjab, Tamil Nadu and Uttar Pradesh. Within a state there are also variations across districts. Districts in northern Karnataka, southern Maharashtra, and coastal Andhra Pradesh are more severely affected by HIV than other districts in the states. Some of the other vulnerabilities of rural areas to HIV are high number of rural based sex workers, high in and out migration, low literacy, higher poverty, high stigma attached to HIV, relative paucity of health and social infrastructure and high gender disparity.

1 (b) National Response

The seemingly escalating HIV infection in the rural sector indicating a visible shift in the HIV epidemic from urban to rural as well as the existing trends suggesting feminization of the epidemic are some of the underlying factors that led to the genesis of a rural intensive programme – **Link Worker Scheme** in 2006. The scheme was then scaled up with GFATM round 7 funding and today the scheme is being implemented in 219 districts in the country. (Annex:1)

¹ Note on Rural Epidemic Response for NACP IV, Swasti Health Resource Centre, 2011

Objectives of the Link Worker Scheme

The specific objective of the scheme includes:

1. Reach out to HRGs and vulnerable men and women in rural areas with information, knowledge, skills on STI/HIV prevention and risk reduction. This entails:
2. Increasing the availability and use of condoms among HRGs and other vulnerable men and women.
3. Establishing referral and follow-up linkages for various services including treatment for STIs, testing and treatment for TB, ICTC/PPTCT services, HIV care and support services including ART.
4. Creating an enabling environment for PLHA and their families, reducing stigma and discrimination against them through interactions with existing community structures/ groups, e.g. Village Health Committees (VHC), Self Help Groups (SHG) and Panchayati Raj Institutes (PRI).

Achievements of the Scheme

The key achievements of the scheme have been establishment of comprehensive HIV rural intervention programmes in 219 districts. Through the over 1,50,000 HRGs (FSWs, MSMs and IDUs) are reached in rural areas nationally. In addition, the Scheme also covers nearly 3,00,000 Bridge Population members (truckers and migrants) and 20,00,000 Vulnerable Population members (including, but not limited to, at-risk women, spouses of HRGs, and out-of-school youth). The programme has also identified and covers over 37,000 people living with HIV (PLHIV). Over 75,000 HRGs have been tested for HIV under the LWS, with approximately 6,000 being tested in March 2011 (either and over 5,40,000 HRGs have sought treatment for STI symptoms under the LWS. This has been done by establishing linkages with existing services. 20000 condom depots have reportedly been established in the LWS villages. The uptake of condoms from these depots and direct distribution as reported is as high as 75 lakhs. 8910 RRCs and 9517 VICs have been formed in the LWS till date.

Learnings

The concurrent assessment of LWS in 44 districts undertaken by IMACS in 2010 and experiences of implementers of LWS throw up the following learnings:

Availability of services in the rural areas: Rural areas are faced with poor infrastructure in addition to the geographic distance proving to be a hindrance.

Integration and coordination with other departments within NACO/ SACS and outside: The LWS has not been able to utilize the strengths of other programs under NACP. Since the Scheme focuses on creating demand generation of existing services, stronger linkages with TI NGOs is imperative.

Considering the fact that Link Worker Scheme is the only intervention that addresses at risk and vulnerable rural population in the context of HIV, strong coordination needs to be developed with the PRIs and other departments offering social protection schemes.

Need for trained volunteers: For sustainability of the programme and to reach out to the HRGs Volunteers under LWS are envisaged to play an important role. It is therefore important to build the capacities of this cadre on relevant issues. Peer volunteers need to be also identified to reach the HRG population who are hidden.

Capacities of Link workers: Investment on building capacity of link workers on a continuous basis is very important.

Stigma and discrimination attached to the HRG population

Improve planning and monitoring

Low ownership of SACS: The involvement of SACS in the implementation of LWS has been limited. Currently the role of SACS is limited to handling of funds and supervision of Lead agencies.

II Strategic approach in Rural Interventions

There is compelling evidence to show that the rural epidemic is a reality. In fact in some districts the rural sexual networks are fuelling the epidemic in the districts. Burden of care is also increasing in many rural areas with increase numbers of people becoming positive. With increasing risk, burden of care and unmatched/ limited response the rural HIV epidemic needs attention.

The **vision** of the rural intervention (RI) under NACP IV is to halt and stabilize the rural HIV epidemic and improve quality of life of people living with HIV in the rural areas.

II a. Emerging Issues

Some of the emerging issues in the context of rural interventions are:

- To develop and sustain intervention models to address the rural intervention keeping in mind the diversity in the epidemic

- To increase convergence of the rural interventions within NACO and with other line departments
- Role of men in the epidemic is very well known and researched. Men become bridge population and hence need to be reached through information, behavior change counseling and services. Currently in the rural areas there are limited schemes which reach men addressing their health related issues. Hence a cadre of focused male staff who can counsel and reach the men who engage in risk and take decisions on sexual health issues is a must.
- While large populations of PLHIV live in rural areas, there are limited outreach staffs that reach them and address their needs beyond treatment. Low adherence and high LFU warrants a focused outreach to PLHIV in the rural areas

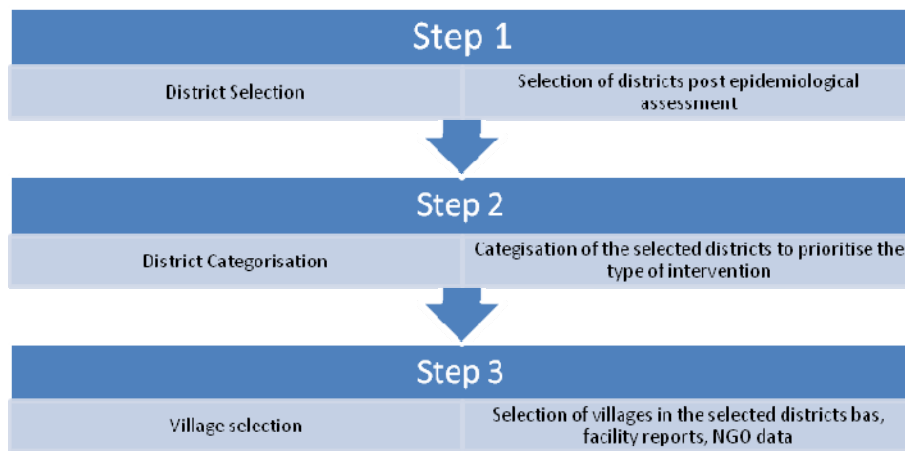
II (b) Priorities

Keeping all the priorities and emerging issues in mind the rural interventions have prioritized the following issues in the context of NACP IV:

- Saturation in terms of geographies : priority districts and villages and population: target population within the selected villages
- Increase uptake of both HIV prevention and care related services in the rural areas specially in selected districts
- Improved adherence to ART and reduced Loss to follow up among PLHIV in the rural areas
- Reduction in stigma and discrimination against HRGs and PLHIV and improvement in the quality of their lives in the rural areas
- Address issues related to gender inequity and its influence on increase in risk and vulnerability in the rural context
- Need to involve the rural community in planning , implementation and monitoring thus creating ownership and sustainability of the response
- Convergence with other programmes and schemes operational in the rural areas to ensure that the rural interventions are comprehensive and address the needs of rural populations

II (c) Changes Suggested Intensifying Rural Interventions under NACP- IV

Interventions in the rural areas need to be designed keeping in mind the evidence, needs and diversity of the epidemic. Hence district and village selection is fundamental. A three step process is proposed to select the districts and the villages for interventions:

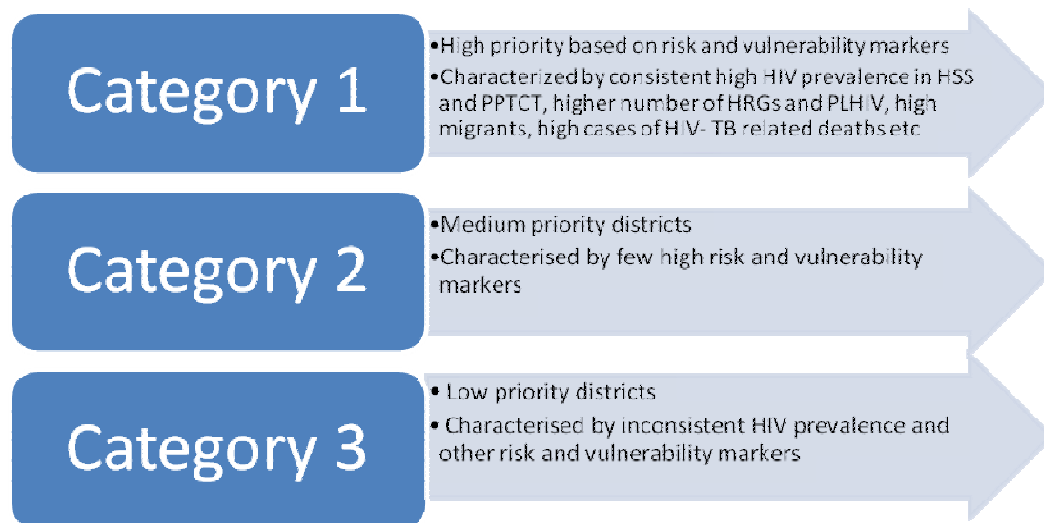


Understanding the following in the rural context is important to undertake an evidence-based planning:

- Overall burden of HIV
- Sub-population distribution of HIV
- Basic HIV transmission dynamics
- Assessing gaps in responses to HIV situation

Categorization of districts

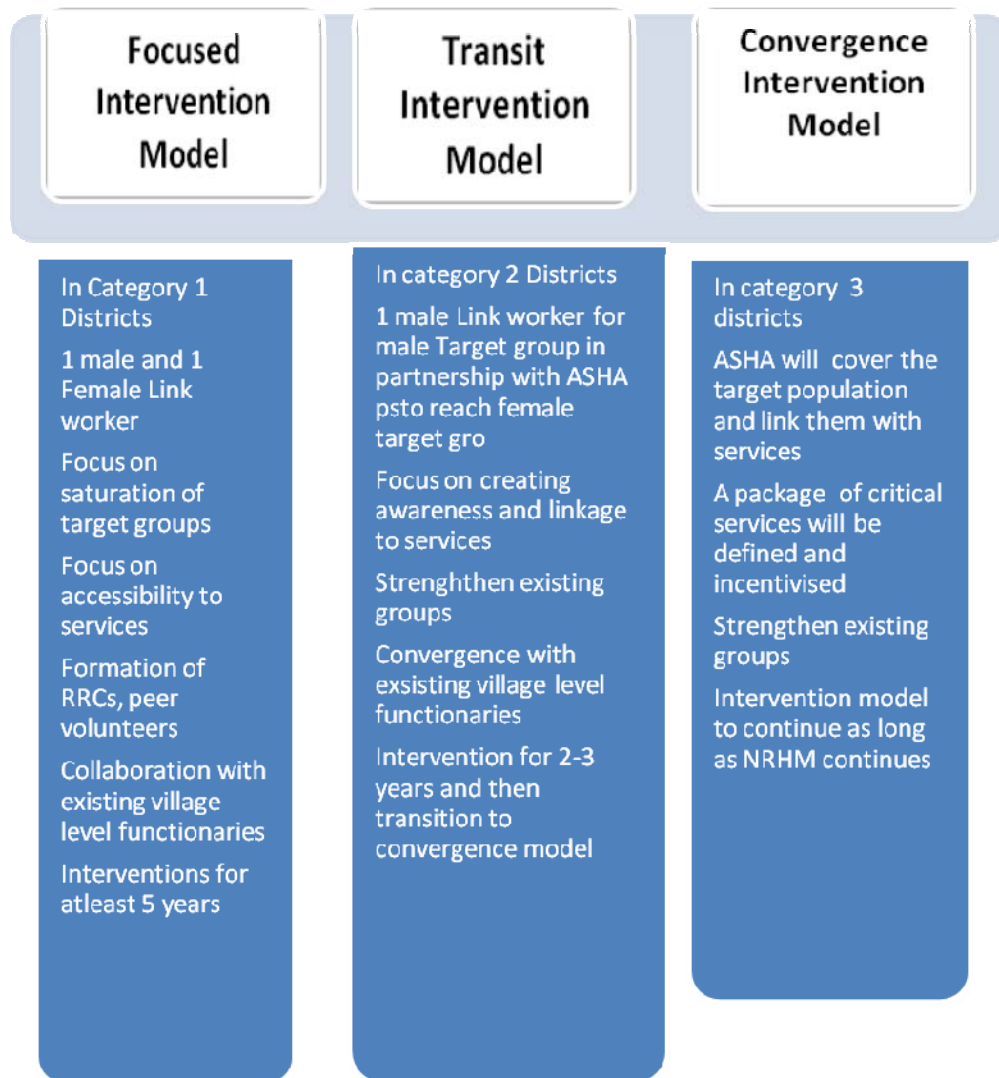
Based on these markers, districts can be prioritized and rural intervention models can be selected. The categories of districts are as follows:



II (d): Intervention Models

The working group very strongly recommended that there should be a variety of rural intervention models keeping in mind the intensity of the epidemic in the districts based on data triangulation. Three models have emerged based on assessment of various rural intervention models (in the area of health and HIV). The three intervention models are explained below:

Intervention models in the rural context need to be designed keeping the epidemic in mind. 3 intervention models are suggested to make the interventions contextual and need based:



Presently ASHA is catering only to the female population on issues related to reproductive and child health. The issue of covering male population (particularly HRG) is of critical importance under the Convergence Model. The Multi Purpose Health Worker can be trained and given this responsibility in districts where there is a substantial no. of male HRGs. Simultaneously, the volunteers and

the RRC members under the LWS can be capacitated to assist the MPW and to shoulder the responsibility where the percentage of male HRG is low.

II (e) Target Population

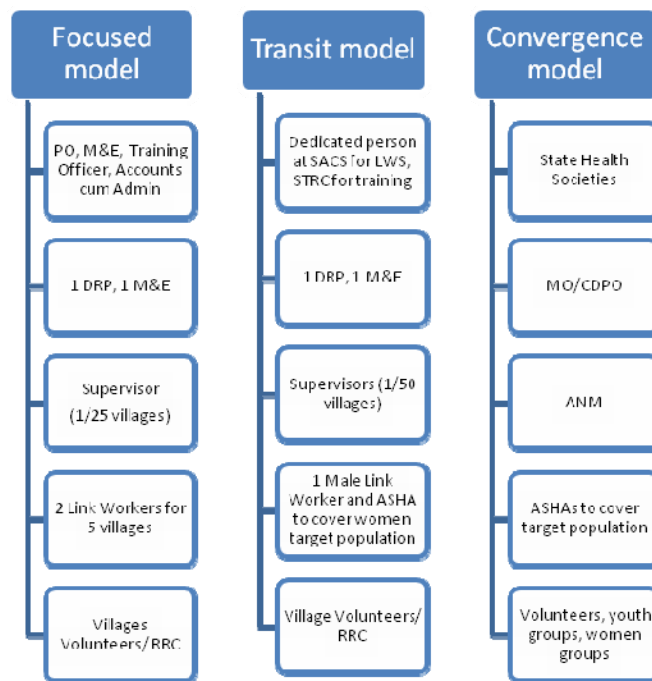
Primary focus in this kind of models will be to address both high risk groups and vulnerable population. Saturation of high risk population coverage is a priority. Following target populations have been identified for coverage under intensive intervention:

- High Risk Groups (FSW,MSM, IDU) and their partners
- People Living with HIV (PLHIV) and their spouses specially discordant couples
- Most at risk adolescence (MARA)
- Most at risk youth
- Migrants and their spouses
- Truckers and their spouses
- Woman/Child headed households
- Children affected by AIDS (CABA)

II (f) Implementation Structure

The Rural Interventions seek to address the need for HIV prevention, support and care services at the rural level. This intervention will be implemented with a strong management and technical support structure from village to national level. The implementation of interventions will have institutional structures at the following levels:

1. Technical guidance and support for the programme: TRG
2. Overall policy direction and supportive supervision: NACO and SACS
3. Management of the programme: SACS/Lead NGO
4. Continuous Handholding, Monitoring and Supervision: SACS/DAPCU or Lead NGO
5. Capacity building : Lead agency/ STRC
6. Evaluation and Quality Assessment: NACO/SACS
7. Implementation at District level: District level Implementing NGOs or DAPCUs through a cadre of skilled staff and trained volunteers.



III Monitoring and Evaluation

A robust monitoring system is critical for measuring progress and the performance of the rural interventions. It will also help in consolidating learning, taking corrective actions and ensuring accountability while implementing the project.

The indicators for rural interventions in NACP III will continue with additional indicators on convergence and mainstreaming as NACP IV will focus on that aspect. Additionally the focus on output level monitoring will be strengthened by institutionalising systems and processes within the interventions.

III (a) Areas of Monitoring and Key Indicators

Under the Rural Interventions, the following key areas will be monitored:

a. **Inputs:** Resources invested in the scheme for the recruitment, training of team at various levels, outreach and referral by team of the project staff at various levels. These are monitored through a set of recording and reporting formats. Following are the key input indicators:

- Recruitment of staff and volunteers
- Training of staff and volunteers
- Advocacy and convergence meetings conducted
- One time contact of estimated target population

- Regular contact of estimated target population (HRG specific)
- Condom and lubes distribution
- Referral to services
- Address of crisis/ violence/ stigma and discrimination among target groups

b. Outputs: Immediate achievements of the programme in terms of the deliverables, such as coverage of districts and target population, number of condoms/ lubes distributed, number of individuals effectively linked to the services and social protection schemes etc. These will be monitored through a set of recording and reporting formats. Below mentioned indicators need to be taken into account:

- Proportion of districts covered under rural intervention (state and national level)
- Proportion of villages covered under rural intervention (state)
- Proportion of target population covered (specific target groups)
- Number of condoms distributed to target population
- Proportion of target population referred to services
- Proportion of target population referred to social entitlement/ protection schemes
- Number of programmes and schemes/ departments the intervention has linked with.

c. Outcomes: Changes observed in the communities covered by the scheme including the trends in the percentage of different target groups using condoms, accessing services, experiencing reduced stigma and discrimination etc. The outcomes will be monitored through a series of outcome studies including polling booth surveys and focus group discussions at regular intervals during the implementation. The key indicators that will be considered during the monitoring include:

- Increased knowledge of HIV among target population in intervention districts
- Increased consistent and correct condom use in intervention sites among target population
- Increased utilisation of services (STI, ICTC, PPTCT, ART) in intervention districts
- Decreased experience of stigma and discrimination among HRGs and PLHIV
- Increased access to schemes and programmes
- Increased participation of volunteers/ RRCs in village level HIV related activities

d. Impacts: The long term impact that occurs in the larger community as a result of implementing a programme, including changes in the prevalence of HIV and incidence of STIs in districts covered by the scheme. This will be carried out through special analysis of the secondary data.

- Prevalence of HIV in the rural areas
- Incidence of STIs in the rural areas

III (b). Mechanisms for Monitoring

Key monitoring mechanisms under the LWS will include the following:

- Recording and Reporting Systems
- Review Meetings
- Supportive Supervision Field Visits
- Research Studies and Reports

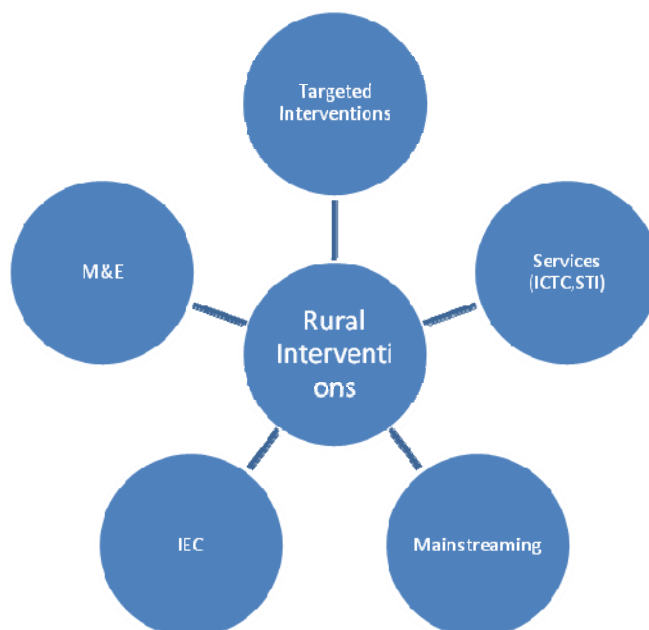
The indicators will be same for all categories of districts. However input level indicators will be decreased in convergence model keeping in mind the time and capacity of ASHAs.

IV: Integration and convergence

As HIV/AIDS touches on many facets of life and is continually influenced by a convergence of factors, it requires a multifaceted approach particularly at two levels:

- Within the different strategies of NACP IV
- Between NACP IV and other programmes and initiatives.

The linkages within NACP and with other departments would result in making the rural intervention more comprehensive in nature. For rural interventions convergence will have to be developed at national, state, district and village level



IV (a) Convergence within NACP:

Convergence and linkages with various units of NACO is very important. The rural interventions will have to develop strong linkages with TI division to ensure HRG related commodities (especially lubes for MSM and clean needles for IDUs) are available for rural HRGs. Coordination with IEC division of NACO and SACS is also important to ensure uniformity of messages and availability of IEC materials. Linkage with STI division is needed to ensure budgeting of condoms and STI drugs for rural HRGs and VP in the national plan. (Annex:3)

- Convergence with Health Department

Convergence and linkage with NRHM would be important in the context of rural interventions. Though the Link Workers are currently working closely with the frontline workers such as ASHAs, ANMs and Anganwadi Workers, the suggested intervention models in certain districts may require better convergence with ASHA, necessarily expanding the mandate of ASHA. This will ensure gradually integration of rural interventions with NRHM in certain geographies where the epidemic is moderate or low. This will ensure effective utilization of existing human resources in the rural areas and sustainability of interventions. Following steps need to be taken into account to address the convergence effectively:

- Incentive of ASHA to be mutually decided between Department of AIDS Control and NRHM
- NRHM to designate State Health Societies the nodal agency at State level

- ASHA's to be capacitated on HIV/ AIDS related issues
- ANM to be designated as the reporting officer for HIV related activities

- **Convergence with non- Health and Social protection Departments:**

There is a need to establish strong linkages with various non-health departments and agencies, to meet the social needs of the target groups and to ensure the sustainability of the link worker scheme. Possible linkages that can be established with Department of Women and Child Development, Department of Social Justice and Empowerment- treatment and rehabilitation support to drug-addicts, organize campaigns against drug abuse. To assure that the OVC concerns get properly attend to; they should be linked with Juvenile Justice Board and Child Welfare Committee, Department of Youth Affairs, Department of Rural Development, Department of Panchayat Raj, Department of Education etc. education classes, to form RRCs in schools/colleges.

V NACP IV Focal Areas

Following are the focal areas of this strategy with NACP IV:

Va. Quality

A robust monitoring and evaluation system will be put in place for rural interventions in NACP IV, which will include indicators at Input, Output, and Outcome and Impact level. These indicators will be quantitative as well as qualitative. Frequency for generating data at all level will be set. Apart from that periodic review meetings will be organized. Supportive supervision will be given to field staff to ensure the quality of the program at grassroots level. To ensure the quality at all level special studies will be done like data audit, client satisfaction survey etc.

Vb. Innovation

Three new implementation models have been designed for the implementation of the program at state and districts level keeping in mind diversity in the epidemic. These are Focused model, Transit model and Convergence model.

- Focused model continues to be vertical in structure and is applicable in districts where epidemic is defined as high.

- Transit model is about part convergence with existing interventions and structures. In this model at village level ASHA will cater to female population while male population will be covered through Link Workers. One Link Worker will reach 5 villages. This model will be implemented in districts where the epidemic is termed as medium.
- Under Convergence model the entire program at all level will be handed over to NRHM. HIV will be a part and parcel of ASHA and ANM activities. This model will be applicable for low epidemic districts.

V c. Integration

Efforts have been made to integrate rural intervention at all level; within NACO and with other line departments. Within NACO integration will be done with ICTC, Blood Safety, TI, IEC, M&E, STD, ART, DIC, and Capacity Building. Under Transit model capacity part of LWS will be integrated with STRC and monitoring with TSUs. Integration with NRHM will be very important for both transit and convergence model.

V d. Sustainability

Sustainability is part and parcel of rural interventions. In all the three models of interventions, this is an important component. Integration with NRHM, strengthening VHSC, developing a volunteer base, establishing RRCs and VICs are all key strategies to ensure sustainability.

State	Number of Districts				
	LWS projects supported by Development partner				Total
	GFATM (Round 7)	UNICEF	UNDP	USAID/CDC	
Andhra Pradesh	19	3			22
Bihar	8	3	4		15
Chattisgarh	4		1		5
Goa	1				1
Gujarat	8	3			11
Karnataka	8	4		16	28
Kerala	1				1
Jharkhand	3				3
Madhya Pradesh	12				12
Maharashtra	24	5			29

Manipur	9				9
Mizoram	3				3
Nagaland	10				10
Odisha	6	1	4		11
Punjab	2				2
Rajasthan	6	1	3		10
Tamil Nadu	21	1			22
Tripura	2				2
Uttar Pradesh	9	3	2		14
West Bengal	7	2			9
TOTAL	163	26	14	16	219

Annex: 1

Annex: 2

NACP IV Round II TWG Consultations			
Registration Form			
Link Workers Group - 26th July, 2011			
S. No	Name	Organisation	Signature
1	Dr. Neeraj Dhingra	DDG(TI), NACO	
2	Dr. Sunil D. Khrparde	DDG(LWS), NACO	
3	Dr. Rajan Khobradgde	TL(NTSU)	
4	Dr. Mohmmad Shaukat	ADG(CST), NACO	
5	Ms. Sita	INPW+, UP	
6	Dr. Brijendra Singh	TL(Mainstreaming), NACO	
7	Ms. Smrity Kumar	PO(LWS)	
8	Ms. Nidhi Dubey	TO(LWS)	
9	Ms. Pragya Mishra	TO(LWS)	
10	Dr. Indira Kapoor	Ex-Reg. Director, IPPF	
11	Dr. Sunil Mehra	CEO, MAMTA	
12	Dr. Anjana Palve	Director (CST), Avert	
13	Dr. S K Satpathy	Director AIPH	
14	Dr. P. Nuli (Nqully)	Director, Kripa Foundation	
15	Dr. Sudha Balakrishnan	UNICEF	
16	Neha Chauhan	UNAIDS	
17	Dr. Reynold Washington	KHPT	
18	Parineeta Bhattacharjee	KHPT	
19	Susan Caritas India, Gujarat new	Caritas India	
20	DRP, Binar, Preeti Sharma	Narayani Seva	
21	Gautam Salam	DAPCU Coordinator NERO	
22	Dr. B. Kishore, Assistant Commissioner	Training, MOHFW	
23	Dr. Sumita Ghosh, FWTRC	Sr. EMO (SAG) CMO (NESC), FWTRC, MUMBAI	
24	Shravan Kumar	NACO	
25	Mr. Deepesh Gupta	PHFI	
26	Mr. Rambabu K.	PHFI	
27	Mr. Krishnan H.	PHFI	
28	Mr. Philip	Consultant	
29	Aika Nawang	UNDP	
30	Joseph Julia	Swasth	

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Convergence

Targetted Interventions

- Coordination with TIs to ensure that there is no duplication of efforts. This coordination will also help in village selected based on evidence.
- Linkages with TIs to ensure that HRGs in the rural areas have access to services and commodities including condoms, lubes and needle/ syringes. Linkage with TIs can also be done to ensure that the rural HRGs get included in other mobilisation related activities initiated by TIs.

IEC unit

- The IEC unit in NACO and SACs should provide relevant IEC materials addressing the rural epidemic. These materials are needed for display in Village Information Centres which is a key strategy in rural interventions.
- Besides IEC unit should also prioritise the districts/ villages selected for rural interventions of all IEC related activities (street plays, mobile IEC vans etc) as they are the high priority districts/ villages.

Services

ICTC: Outreach ICTC camps in special pockets of rural areas where testing services are not accessible. These camps will keep in mind basic principles of confidentiality and provide time for counseling. This can be done by using mobile vans too.

ART: The list of LFUs in the intervention villages can be shared with the Link workers for follow up and adherence. Basic principles of informed consent and confidentiality should be followed

Mainstreaming

- Various activities undertaken by mainstreaming unit including capacity building of out of school youth, sensitisation of SHGs etc can be conducted in the intervention villages through the rural intervention team. This will not only be cost effective but will also benefit the rural intervention teams to build rapport and credulity in the villages.
- The rural intervention team can be used as a resource to reach the groups in rural areas with HIV related information and build linkages to services for those who need.