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RE-IMAGINING FUTURES

REVISITING THE LINK WORKERS SCHEME IN INDIA- AN EVALUATION STUDY

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EXECUTIVE SUMMARY

The Link Worker Scheme (LWS) started in 2009 to provide HIV prevention services focusing on at-risk populations in rural areas considering 57% of the HIV positives at the time were estimated to be living in rural India (LWS Operational Guidelines, 2009).

Over the period of last decade, given the evolution and strengthening of NACP, it was important to evaluate the Link Worker Scheme with an objective to understand the coverage, implementation strategies, effectiveness, and scalability of the programme.

LWS has been the only HIV prevention intervention for the rural areas, explicates the need for the programme. The study identified programmatic issues such as limited coverage of states in Northern bigger states although having higher load of new PLHIV cases but relatively poor coverage with LWS. Within the existing LWS projects, the performance targets for coverage are being met with. The testing of at-risk populations has improved over time and meets the programme's expectations. However, the contribution to case detection is limited to only about 10 cases per project per year. Redefining target population for optimal utilisation of resources, exploring need-based service-delivery model in addition to current linkage model, developing models for continuum of prevention through ASHA, peer-led model (with possible convergence with RKSK and mobile messaging), improving coverage based upon programme data and judicious use of CBS are some of the possible strategic options.

THE ISSUE

Link Worker Scheme aims to address the complex needs of rural HIV prevention, care and support through Cluster Link Workers (CLW) and other stakeholders on issues of HIV/AIDS, gender, sexuality and Sexually Transmitted Infections (STI). The scheme envisages creating demand for various HIV/AIDS related services, linking the target population to existing services, creating an enabling and stigma free environment, ensuring the target population continues to access information, services in a sustained manner, creating linkages with services of other departments through ASHA volunteers, Anganwadi workers, Panchayat heads etc.

A Link Worker Scheme being an important programme, an evaluation study was envisioned to revisit the programme. LWS has been in operation for almost 14 years. Operational guidelines were developed in the beginning and were revised once during the course of its implementation. NACP has witnessed many changes during this period including improved testing facilities especially for high-risk groups, pregnant women and TB patients; improved access to treatment with expansion of ART services clinically to cover all PLHIV and administratively with effective decentralisation. Given this context, it was important to 'revisit' LWS to examine strategies employed for covering the population under the LWS. The study attempted to understand the implementation of linkage model, programme strategies, its integration into multiple programmes, its effectiveness, success and challenges.

THE STUDY

A qualitative study was conducted to evaluate the Link Workers Scheme to understand the program strategies, its integration into multiple programs, its effectiveness, and the scope for its scalability.

THE METHODOLOGY

STATE	DISTRICTS
Maharashtra	Sangli
	Nagpur
Tamil Nadu	Vellore
	Salem
Uttar Pradesh	Basti
	Gorakhpur
Manipur	Imphal West
	Ukhrul
West Bengal	Bardhhaman
	Jalpaiguri

The selection of states and districts was based on the following criteria:

- HIV prevalence in the state
- Presence of LWS in the district for more than 5 years
- Representation of geographic regions (North, East, South, West and Central parts of India).

DATA COLLECTION

- 121 qualitative interviews
- Secondary data on LWS programme indicators

Study Participants

NACP Managers	Programme Implementors	Other Stakeholders	Beneficiaries
NACO	District Resource Persons	ASHA	PLHIV
SACS	Cluster Link Workers	Anganwadi Teachers	HRGs
DAPCU and TSU		Graam panchayat members	Bridge Population Other vulnerable population
			Youths

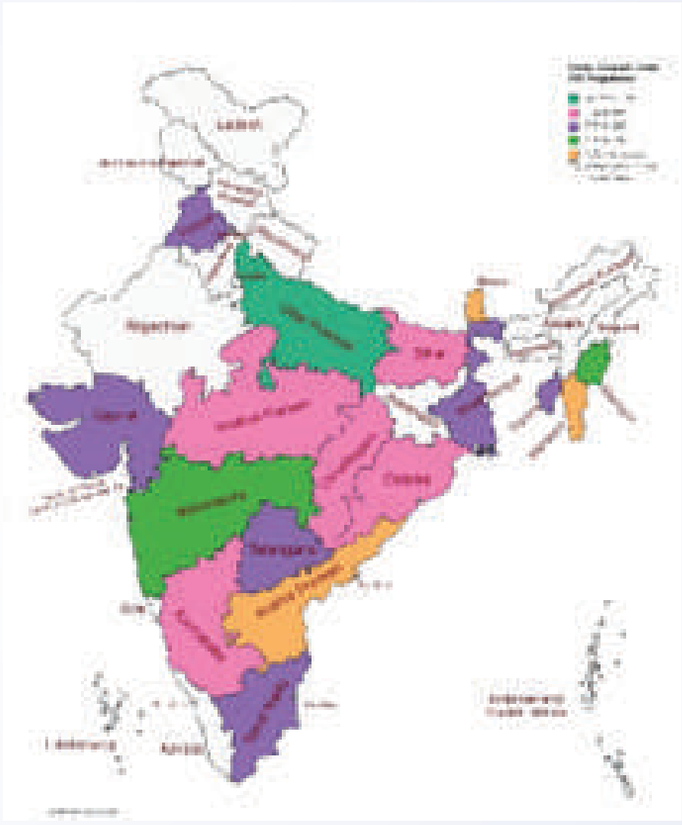
FINDINGS

Coverage of LWS across India:

18 states in India didn't have LWS (Sankalak 2021). A larger state with more than 30 districts like Rajasthan, and Assam didn't have a single LWS, whereas Uttar Pradesh being the largest states in India with 75 districts, had only 7 LWS. Whereas Madhya Pradesh another large state had only 9 LWS project districts (total 52 districts).

16 states and **138 districts**
covered LWS programme

16,93,345
vulnerable populations covered



Findings on the Population Coverage:

At the national level, data shows that LWS had testing rates for HRG ranging from 67.8% for TG to 82.5% for FSW. In comparison only half of the registered bridge population underwent HIV testing. The seropositivity was 2.7% among IDU and 1.6% among TG and that for other risk groups varied from 0.1% to 0.5%.

A total of 42,091 PLHIVs are catered to by LWS nationally, which is less than 3% of the total PLHIVs currently on ART at national level.

Table 1. Coverage of population under LWS

Typology	Coverage of Population	% of people tested under LWS	Seropositivity among tested under LWS	% of PLHIV Linked to ART
FSW	69411	82.5	0.2	96.5
IDU	5770	79.8	2.7	91.9
MSM	9850	74.1	0.5	94.6
H/TG	642	67.8	1.6	100.0
Migrant	520985	53.2	0.1	93.3
Trucker	105600	57.5	0.1	89.9
OVP	726303	50.1	0.2	92.8
TB cases	61132	67.6	0.02	91.7
ANC	151561	88.3	0.06	94.4

Source 1 - National Data from Sankalak Report 2021

Findings from five states:

The next table shows that bridge population (truckers, migrants and their spouses) and to certain extent FSW were reached by all projects and the qualitative data also indicates that these groups were easy to identify and register. However, HRGs especially TG, MSM, and IDUs (in some parts) were difficult to identify and some LWS schemes have no registrations which was also substantiated through the qualitative inquiry. The fear of stigma and discrimination hinders the HRGs from accepting their status and therefore stops them from availing services particularly in rural areas. Identification of MSM was expressed to be difficult with the conventional methods of identification, which is still being followed. With regard to TG, though the identification is easier, but in some places, TGs are linked to the nearby TI. This results in lesser number of identified HRGs in rural areas. TG being an important typology in HIV intervention programme and, not covered in rural areas brings a point of required critical examination of this target population in the selected 10 districts.

Table 2. Coverage of population under LWS programme in the selected study areas

Typology of population	Maharashtra		Uttar Pradesh		Tamil Nadu		West Bengal		Manipur	
	Nagpur	Sangli	Basti	Gorakhpur	Vellore	Salem	Jalpaiguri	Bardhman	Ukrul	Imphal (W)
FSWs	456	472	138	232	269	354	109	309	99	227
MSM	64	33	22	12	49	50	3	7	0	108
IDUs	0	0	29	6	0	0	0	0	280	312
TGs	5	58	0	0	0	1	13	42	0	0
Bridge Population	18184	5416	10235	12523	5142	3713	5282	9757	665	802
OVP	5934	3660	7413	9456	4015	3560	4676	7324	507	634
Youths	88	17093	592	0	1000	936	0	1097	509	337
PLHIV	203	1537	84	74	78	201	197	328	126	71

Other findings on population coverage:

- Newly identified PLHIV under the LWS was 1.6% (out of 129308) in 2022 and was 1.4% a year before (out of 100,918). However, in absolute terms, the numbers are larger than all FSW TI or MSM TI or IDU TI projects.
- 64958 are estimated PLHIV in the 10 districts, out of whom 2899 (<5%) were being covered by LWS projects.
- Number of PLHIV identified per project annually was 10.3 in 21-22 and 14.3 in 22-23, the number of PLHIV covered by each cluster link worker is also less. In 6 districts less than 1 PLHIV was covered by each of the CLWs.
- During the FGD it was found that not all the PLHIV are identified by the programme, many of them were already linked to NACP programme

Observations on the adherence to LWS operational guidelines

Guideline's adherence

Status

District and village selection

Yes. As per the guidelines HIV prevalence and priority districts are selected. A decentralised mechanism has helped SACS to take a decision on selecting the districts based on need and changing local context. Local knowledge was crucial and programme data was more useful than HSS at times. Village selection was determined at district level by discussion with stakeholders (District Nodal person, ICTC, ART, TSU)

Change of Villages

There is a variance in the % of change of villages.

States	% of change of villages
Maharashtra, Uttar Pradesh and West Bengal	Between 20-40% of the villages are changed
Tamil Nadu	99% of the villages are changed
Manipur	2% of the villages are changed

Coverage of population

As per the guidelines all the eligible at-risk groups were covered. However, there was ambiguity for other vulnerable populations with wide variations in coverage of youth and spouses of bridge population.

Activities and services provided

Activities such as awareness, condom promotion, stigma and discrimination reduction efforts were conducted by all the NGOs; services on HIV testing, community-based screening (CBS) and health camps are conducted at the field level. Wide variation was observed in condom depot numbers and reported numbers of condom demonstration.

Community Based screening has been used for HIV testing with seropositivity of less than 1% in the 10 districts (Nationally, seropositivity in LWS is 0.18% and overall seropositivity among all tested at ICTC is 0.52%)

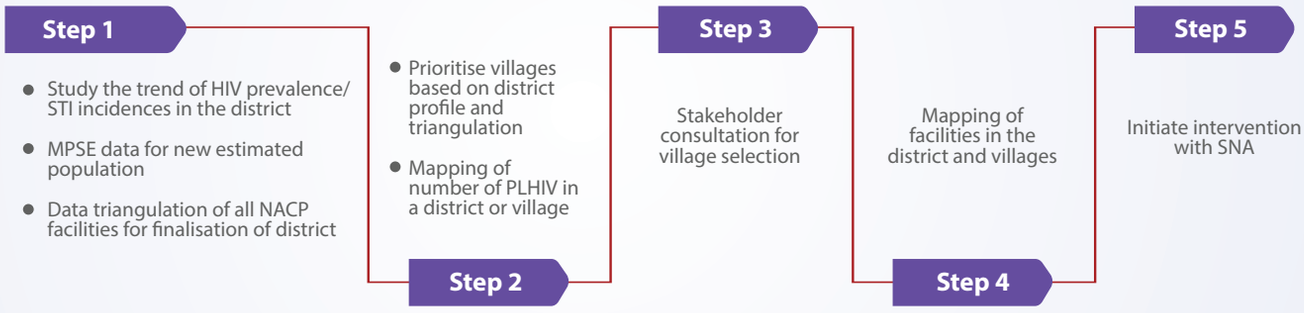
Services provided underLWS	Maharashtra		Uttar Pradesh		Tamil Nadu		West Bengal		Manipur	
	Nagpur	Sangli	Basti	Gorakhpur	Vellore	Salem	Jalpaiguri	Bardhman	Ukrul	Imphal (W)
Seropositivity from CBS	0.00	0.46	0.14	0.20	0.09	0.13	0.13	0.00	0.00	0.49

RECOMMENDATIONS

- **Redefining and prioritising the target population:** Coverage of ANC and TB patients through better convergence with other programmes may be explored. Focus to continue with the core and bridge populations including other vulnerable populations, truckers and migrants.

- **Scaling up of Coverage:** Presently the coverage of LWS is in only 16 states, therefore consider focusing more on rural districts with higher mobility of population, significant number of HRGs, and large number of new PLHIV detection. The state/district/village selection should be based on programme data along with HSS.

- **Selection of districts and villages/area**



- **Development of implementation models:** LWS has demonstrated efficacy as a linkage model. In addition, services such as Community Based Screening (CBS), ART home delivery, provision of commodities may also be considered. The need for continuation of prevention services in the phase out villages, incentive models for ASHA and/or RKSK peer educators can be piloted.
  There is potential of mobile messaging within peer model to effectively deliver health messages with the given human and time resources. However, these models need to be piloted.
  As the identification of MSM, TG and IDUs are lesser under LWS (as observed in the study area) the peer educators model of Targeted Intervention (TI) can be tried out as a pilot study and observe the improvement in the coverage of core population.

- **Strengthening yield of CBS:** Risk-assessment should be considered for offering CBS, HIV testing services including linkages to SSK in the district for HIV-negative high risk individuals.

- **Revised BCC and IEC and Mainstreaming pacakages:** A standard and effectve IEC tools must be developed, that could be effectively used by Cluster Link Workers (CLWs) while conducting awareness programme. Along with IEC materials, all the other related materials must be made available to CLWs. To optimise the coverage of outreach activities, congregations points such as mela, bazaar, religious events need to be tapped. Based on the local context, the mapping of such spots/ events needs to be made by the programme, so that outreach activities can be organised.

- Role of DISHA to be redefined for Monitoring and Evaluation

- Strengthened engagement of Youth and Community Champions

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