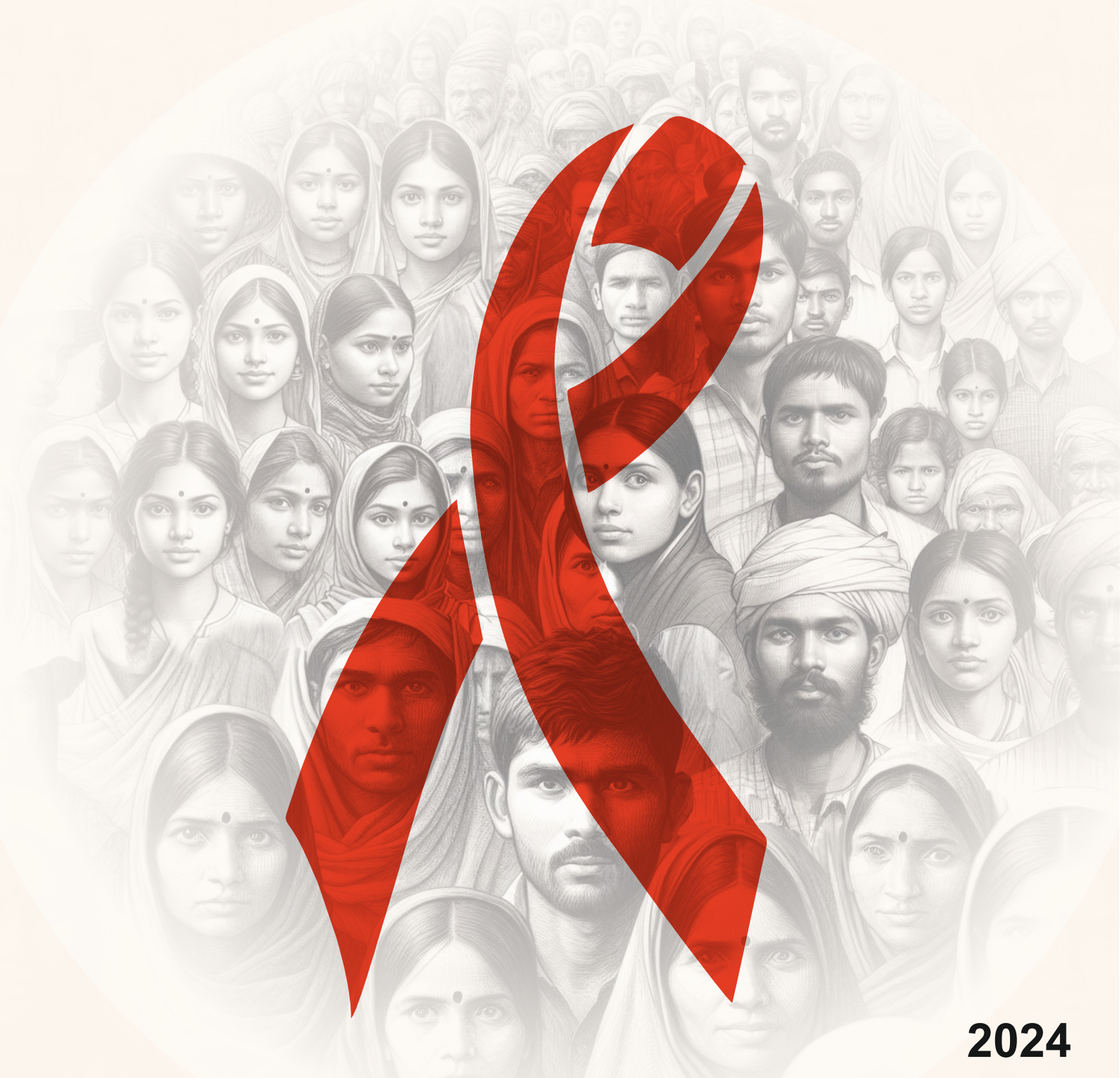
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India's response to HIV & Sexually Transmitted Infections
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in

Ministry of Health & Family Welfare
Government of India

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

# Guidelines for Intervention among Rural HRGs and Vulnerable Population (Link Worker Scheme 2.0)



2024

## NACO, MoHFW, GoI, 2024

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# Guidelines for Intervention among Rural HRGs and Vulnerable Population (Link Worker Scheme 2.0)

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## FOREWARD

The National AIDS and STD Control Programme Phase V aims to accelerate the reduction in new annual HIV infections among the high risk groups and other at risk population residing in urban and rural areas. The Link Worker Scheme (LWS) has been designed to intensify and consolidate the provisioning of prevention care and support services, focusing on the rural population who are at risk of acquiring HIV/STI infections. The newer evidences suggest the HIV response in rural areas to adopt a localised approach as it is often influenced by the unique socio-cultural structures present in these settings. Ensuring access to healthcare for rural HRGs including PLHIVs, linking their spouses and partners to care and treatment is essential to the prevailing perceptions surrounding HIV/AIDS, sex work or drug use, and the resultant stigma and discrimination.

With the changing dynamics and the potential exposure of rural population to HIV/AIDS and STI, National AIDS Control Organisation (NACO) has revised the Guidelines for intervention among Rural HRGs and Vulnerable Population as Link Worker Scheme 2.0. The revised guideline envisaged evidence based approaches and strategies for the prevention programme which involves reaching out to unreached rural population including spouse and partners of rural HRGs, PLHIV, including HRGs who are active in virtual platforms, Spa and massage parlours, with a focus on promoting comprehensive prevention packages tailored to the specific needs and population groups. It also involves provisioning of health camp based approaches to ensure service delivery and prevention commodities with mechanisms for linkage and referrals to health facilities.

I would like to congratulate NACO for the development of this revised operational guideline through a robust consultative process while ensuring all required inputs are incorporated. I believe this revised guideline will provide the necessary guidance and direction to the SACS, DISHA/DAPCU and the LWS units to address any gaps and barriers to strengthen the HIV response for reaching out to the last mile under NACP.

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## PREFACE

Aligning with the Global target of ending AIDS as a public health threat by 2030 in India, the National AIDS Control Organisation aims to ensure increase in access to comprehensive preventive services to the high-risks and other vulnerable population groups. The prevention of new infections among the high risk groups such as Female Sex Workers (FSW), Men who have sex with men (MSM), Hijra/ Transgender (H/TG), People who Use Drugs (PWID), Prisons inmates and bridge population like Migrants and Truckers, has been the major thrust of the HIV response in India.

The HIV epidemic continues to be heterogeneous in terms of locations, population size and route of transmission. Further, the changing dynamics of solicitation of clients, use of online platforms to find sexual partners, substance use among HRGs is not only observed in urban areas but is also seen in rural areas. These risks and vulnerabilities augment the need for revision of LWS guidelines to intensify the prevention efforts to cover the uncovered population living in rural areas of the country.

The operational guidelines for the Link Workers Scheme was first developed in 2007 and gradually updated in 2009 and 2015. With the changing dynamics of risks and vulnerability of population due to extensive use of technology, mobile phones, social network sites for solicitation, mobility, drug use in the rural areas, the guideline for intervention among rural HRGs and vulnerable population has been revised in 2024 as Link Worker Scheme 2.0.

The revision process involved extensive consultations with Program experts, National Technical Resource Group (NTRG) and National Technical Working Group (NTWG) constituted by NACO, with participation of representatives from communities, civil society, government officials and other stakeholders for providing technical inputs.

It is envisaged that the revised LWS 2.0 guideline will significantly support the Link Worker Scheme to reach out to the vulnerable population in rural settings in a strategic manner, while also build uniform understanding on the need, strategy and expected outcomes of the prevention interventions among rural HRGs and vulnerable population amongst all the stakeholders.

I believe this document will support the National HIV and STD response in bridging the gaps of the 95-95-95 targets with the provision of prevention and continuum of care services for the rural based vulnerable population.

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## MESSAGE

As we advance in our efforts to combat the AIDS epidemic, it is imperative that our strategies and interventions are grounded in the evidence and best practices. The Link Worker Scheme (LWS) has been one of the cornerstones of the National HIV response, significantly contributing to augment the reach and efficacy of our programs among the rural vulnerable populations.

This comprehensive document "Guideline for Intervention among Rural HRGs and Vulnerable Population (Link Worker Scheme 2.0) 2024" represents the culmination of extensive research, stakeholder consultations, and learnings from field experiences. It encapsulates the latest advancements in HIV prevention, treatment and care, tailored specifically to address the needs of high-risk populations, including the marginalized and underserved communities in the rural settings.

The revision of the LWS guideline reflects the program's commitment to adapting and improving strategies based on evolving data and emerging trends. Since the launch of the previous LWS guidelines in 2015 under NACP Phase IV, there have been significant developments in the approaches to address HIV and in the effectiveness of various interventions. These updated guideline incorporates new evidences and field intelligence to enhance the approach and ensure that the interventions remain relevant and impactful.

The updated guideline is also designed to enhance the operational efficiency and impact of the intervention strategies. The guideline integrates evidence-based methodologies to ensure that interventions are both effective and adaptable to local contexts. This approach provides a structured framework to address the diverse needs of target populations, including female, sex workers (FSW), people who inject drugs (PWID), men who have sex with men (MSM), transgender persons, and bridge population. This inclusive strategy aims to bridge the gaps in service delivery and ensure equitable access to HIV prevention and care services among the rural population.

The revised "Guideline for Intervention among Rural HRGs and Vulnerable Population (Link Worker Scheme 2.0) 2024" is expected to support the program to reach the unreached population towards provision of services based on specific needs. This will further support the State AIDS Control Societies, DISHA/DAPCU units and LWS Projects to strengthen and enhance the scale and coverage of high-risks and vulnerable population groups towards achievement of the 95:95:95 targets.

Shobini

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The "Guideline for Intervention among Rural HRGs and Vulnerable Population (Link Worker Scheme 2.0) 2024" has been developed while adopting the of extensive consultative approach. This ensured that the Program experts, National Technical Resource Group (NTRG) and the National Technical Working Group (NTWG) constituted by NACO, representatives from communities, civil society, government officials and other important stakeholders are the part of development process of this guideline. This document is an outcome of a series of National level Consultations and based upon the "National AIDS and STD control programme phase-V" Strategy document.

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**(Dr. Saiprasad V. Bhavsar)**

अपनी एचआईवी अवस्था जाने, निकटतम सरकारी अस्पताल में अपनी मुफ्त सलाह व जाँच पाएँ
**Know your HIV status, go the nearest Government Hospital for free Voluntary Counselling and Testing**

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# ABBREVIATIONS

| | |
|---|---|
| **ABHA** | Ayushman Bharat Health Account |
| **ABHWC** | Ayushman Bharat Health and Wellness Centres |
| **AEP** | Adolescent Education Programme |
| **AFHC** | Adolescent Friendly Health Clinics |
| **AIDS** | Acquired Immuno Deficiency Syndrome |
| **ANM** | Auxiliary Nursing and Mid- Wifery |
| **ANC** | Ante Natal Clinic |
| **ART** | Anti-Retroviral Treatment |
| **ARTC** | Antiretroviral Therapy Center |
| **ASHA** | Accredited Social Health Activist |
| **AWC** | Anganwadi Center |
| **AWW** | Anganwadi Worker |
| **BCC** | Behaviour Change Communication |
| **CBO** | Community-Based Organization |
| **CBS** | Community-Based Screening |
| **CDC** | Centers for Disease Control and Prevention |
| **CHC** | Community Health Center |
| **CLW** | Cluster Link Worker |
| **CMHO** | Chief Medical and Health Officer |
| **CSM** | Condom Social Marketing |

| | |
|---|---|
| **CST** | Care, Support & Treatment |
| **DAPCU** | District AIDS Prevention and Control Unit |
| **DDAP** | Drug De-addiction Programme |
| **DH** | District Hospital |
| **DHO** | District Health Officer |
| **DISHA** | District Integrated Strategy for HIV/AIDS |
| **DRP** | District Resource Person |
| **DSRC** | Designated Sexually Transmitted Infections Clinics |
| **EID** | Early Infant Diagnosis |
| **EVTHS** | Elimination of Vertical Transmission of HIV and Syphilis |
| **FGD** | Focused Group Discussion |
| **FHI** | Family Health International |
| **FICTC** | Facility Integrated Counselling and Testing Centre |
| **FRU** | First Referral Units |
| **FSW** | Female Sex Workers |
| **GFATM** | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| **HBV** | Hepatitis B Virus |
| **HCV** | Hepatitis C Virus |
| **HCTS** | HIV Counselling and Testing Services |

| | |
|---|---|
| **HIV** | Human Immuno Deficiency Virus |
| **HMIS** | Health Management Information System |
| **HRG** | High Risk Groups |
| **HSS** | HIV Sentinel Sero-surveillance |
| **HWC** | Health and Wellness Center |
| **IBBS** | Integrated Biological and Behavioural Surveillance |
| **ICDS** | Integrated Child Development Scheme |
| **ICTC** | Integrated Counseling and Testing Centres |
| **IEC** | Information, Education and Communication |
| **IHC** | Integrative Health Care |
| **KP** | Key Population |
| **LAC** | Link ART Centre |
| **LFU** | Lost to Follow Up |
| **LWS** | Link Worker Scheme |
| **MNREGA** | Mahatma Gandhi National Rural Employment Guarantee Act |
| **MSM** | Men Having Sex with Men |
| **NACO** | National AIDS Control Organization |
| **NCD** | Noncommunicable Diseases |
| **NFHS** | National Family Health Survey |
| **NGO** | Non-Government Organization |

| | |
|---|---|
| **NHM** | National Health Mission |
| **NPCDCS** | National Programme for Prevention & Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke |
| **NSEP** | Needle Syringe Exchange Program |
| **NTEP** | National Tuberculosis Elimination Program |
| **NVHCP** | National Viral Hepatitis Control Program |
| **OI** | Opportunistic Infections |
| **OSC** | One Stop Center |
| **OST** | Oral Substitution Therapy |
| **OVP** | Other Vulnerable Population |
| **PEPFAR** | U.S. President's Emergency Plan for AIDS Relief |
| **PHC** | Primary Health Care Center |
| **PLHIV** | People Living with HIV |
| **PMJAY** | Pradhan Mantri Jan Arogya Yojana |
| **PMPSE** | Programmatic Mapping and Population Size Estimation |
| **PRI** | Panchayati Raj Institutions |
| **PWID** | People Who Inject Drugs |
| **RCH** | Reproductive Child Health |
| **RRC** | Red Ribbon Club |
| **RTI** | Respiratory Tract Infection |

| | |
|---|---|
| **SACS** | State AIDS Control Society |
| **SBCC** | Social and Behavior Change Communication |
| **SDH** | Social Determinants of Health |
| **SHG** | Self Help Group |
| **SNA** | Situation Need Analysis |
| **SOCH** | Strengthening Overall Care for HIV Beneficiaries |
| **SSK** | Sampoorna Suraksha Kendra |
| **STD** | Sexually Transmitted Disease |
| **STI** | Sexually Transmitted Infection |
| **TB** | Tuberculosis |
| **TG** | Transgender |
| **TI** | Targeted Intervention |
| **TISS** | Tata Institute of Social Sciences |
| **TSU** | Technical Support Unit |
| **VHND** | Village Health and Nutrition Day |
| **VHSNC** | Village Health, Sanitation and Nutrition Committee |
| **VL** | Viral Load |

# CHAPTER 1: INTRODUCTION

Link Worker Scheme (LWS) covers the rural High-Risk Groups and Vulnerable Populations with provisions for prevention, testing and treatment services for HIV/AIDS and STI under the National AIDS and STD Control Programme. The NACP phase V (2021-26) envisages to continue and develop the Link Worker Scheme to reduce the new HIV infections. The programme is committed towards ending AIDS as a public health threat by 2030 with a focus on High Risk Groups and Other Vulnerable Populations in rural India.

HIV epidemic in India is concentrated in nature. The HIV prevalence continues to be low with an adult HIV prevalence of 0.22% (95% CI: 0.21–0.24).The prevalence among the HRG population such as Female Sex Workers (FSW), Prison Inmates, Men who have Sex with Men (MSM), Hijra/Transgender (H/TG), People Who Inject Drugs (PWID) is 7-28 times of adult population. [1] Around 90% of HIV infections are through the sexual route at national level. However, in some States like Manipur, Mizoram, Tripura, and Punjab, more than 25% of HIV infections are found to be through infected needles and syringes. [2] Higher prevalence of Hepatitis, especially of Hepatitis C virus among PWIDs, has been noted. HIV prevalence of 1% or more was noted at 44 sentinel surveillance sites spread across 41 districts of the country. [3] The annual new HIV infections in India have declined by 48% against the global average of 31% (the baseline year of 2010). The annual AIDS-related mortalities have declined by 82% against the global average of 47% (the baseline year of 2010). [4]

The HIV epidemic continues to be heterogeneous in terms of location, population, and route of transmission. The district prioritisation conducted in 2019 reveals that around 299 districts out of a total of 735 districts cater to 84% of the total estimated PLHIV in the country [5]. Another important epidemiological indicator is the size of HRG population. The recent programmatic Mapping and Population Size Estimation (p-MPSE) conducted under NACP to update the HRG size estimates in the country (2022-23) suggests that there is a much bigger size of HRGs than being currently covered under the programme. Further, the changing dynamics of solicitation of clients, use of online platforms to find sexual partners, substance use among HRGs is not only observed in urban areas but is also seen in rural areas. These risks and vulnerabilities augment the need for revision of LWS guidelines to intensify the prevention efforts to cover uncovered populations living in rural areas of the country.

India's HIV program has become a global exemplar to reach the vulnerable populations. [6] The initial phase of sero-surveillance, followed by a focused targeted intervention for HIV prevention among high-risk groups coupled with scale-up of treatment has shown a steady decline in the HIV prevalence over the years. Phase III of NACP focussed at the district level and aimed at “halting and reversing the epidemic” before the end of the defined period. During this phase, the rural intervention of NACP, the Link Worker Scheme (LWS) was introduced. The introduction of LWS cemented NACO's commitment of tackling the AIDS epidemic in all the facets. The Operational Guidelines for the Link Worker Scheme were revised in the NACP phase IV and has been operational during the extension period, wherein partnerships with communities and civil society were strengthened to improve coverage of the High Risk Groups under NACP IV.

**The NACP phase V (2021-2026)** takes into account the global contexts, targets and strategies in order to meet its ambitious goal of reducing annual new HIV infections and AIDS-related mortalities by 80% by 2025-26 from the baseline value of 2010. NACP phase V introduces a hybrid model to cater to HRGs and bridge populations (Migrant & Transport Workers) with plans to cover other vulnerable populations as well. NACP phase V is centred around eight guiding principles that form the foundation for achieving the targets. The guiding principles under NACP Phase V are presented in the figure below:

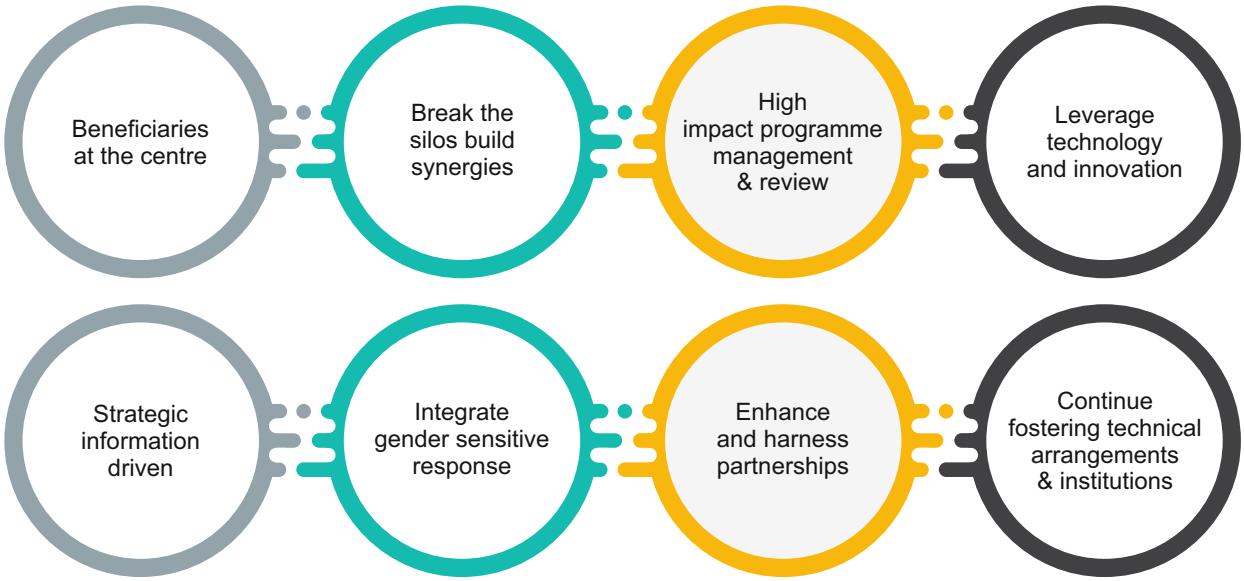



**Figure 1: Eight guiding principles of NACP-V**

In accordance with the guiding principles of NACP Phase V, the goal is to expedite the decline in new annual HIV infections through a range of strategies designed for high-risk, low-risk, and at-risk population groups. The strategy proposes to continue and develop existing peer-led targeted intervention projects and Link Worker Scheme strategies for integrated service delivery. Additionally, it emphasises the promotion of evidence-based comprehensive prevention packages tailored to specific locations and populations.

## 1.1 Current Status of HIV Intervention in Rural areas under NACP

Under the programme, the focus of the HIV interventions has also been to improve the health outcomes of rural HRGs including PLHIVs. Of the 121 crore Indians, 83.3 crore live in rural areas (68.8%) [7] marking it as a total of two-third of the total population. The Technical Report HSS Plus 2021 reported that around 65.6% of the respondents reside in the rural areas. Evidence suggests that the higher HIV prevalence rate among the bridge population (Migrants & Transport Workers) could be one of the significant contributor to the spread of HIV in rural women due to their mobility and low HIV risk perception. Research on male migrants in India suggests that HIV is being spread from high HIV prevalence areas to populations in areas with low prevalence by HIV infected male migrants [8]. HSS Plus 2021 also reports higher HIV prevalence among pregnant women with migrant spouses vis-à-vis pregnant women with non-migrant spouses. In 2022-23, 13.62 lakh people from rural areas were tested for HIV under the LWS program, with 0.26% testing seropositive (Sankalak, 2023).

NACP implements various interventions within its fold to address HIV prevention and control in rural India.

- Link Worker Scheme: LWS as an intervention was initiated under the Global Fund Round - IV under NACP III. The LWS aims to address complex needs of rural HIV prevention, care and support. It provides HIV prevention, referral and follow-up services to HRGs, PLHIVs, bridge population and other vulnerable groups. Implementation of LWS has led to an understanding of rural sex-work dynamics and the impact of migration related transmission. In 2022-23, LWS was implemented in 168 districts across the country covering around 18.88 lakh people including 1.56 lakh pregnant women and 0.42 lakh PLHIV [9]. High out-migration from certain districts results in pockets of moderate and high HIV prevalence in otherwise low-prevalence districts. This is also corroborated by various studies that indicate that partners and spouses of migrants are at an elevated risk of HIV. The LWS provides a minimum package of services to the target population. Wherein, the package consists of outreach, diagnosis and testing for STI, HIVand linkages to the nearest health facility. This will be in addition to referral for TB services. In line with the key guiding principle of NACP phase V- “break the silos and build synergy”, the revised guidelines make the service package a more comprehensive one covering the entire spectrum of outreach to care by developing linkages both within and outside NACP.
- Health Camps: Key festival seasons across the country witnesses the migrants returning home to meet their families. Health camps are organized during this time for returnee migrants and their spouses including partners under the programme. Services such as general health check-ups, along with HIV, STI, TB related services are provided to the attendees in coordination with the local health machinery. The health camp model positions health services at the doorstep of the target population thereby addressing the limitations of access to services caused due to the frequency of mobility.

- Facility Integrated Counselling and Testing Centres (FICTC): In order to reach the last mile and cover the hard- to reach population, FICTCs were expanded in accordance to the National HIV Counselling and Testing Services (HCTS) Guidelines- 2016. FICTCs are established within the government health facilities like Primary Health Centres (PHC)/ Community Health Centres (CHC)/ Sub Divisional Hospital (SDH), MobileICTCs and within TIs. FICTCs offer pre-test HIV counselling, HIV screening, screening of STI/RTI/TB and linkages to Stand Alone -ICTC/ TB Units for confirmation of diagnosis and for care and treatment.
- Care and Support Centres (CSC): CSC is the focal point of all activities related to the care and support services for PLHIVs. The centres not only provide a safe space to PLHIVs but also serves as a link between the community and other allied services required for PLHIV. A CSC is located within 2.5 to 3 kms of an ART centre [10].
- Integrated Health Campaign (IHC): The recent evidences have shown that the sites and districts which were hitherto considered low prevalence and less vulnerable have become highly vulnerable due to lack of awareness, changing dynamics surrounding sexual exposure, drug use, absence of prevention facilities and service delivery points etc [11]. The strategy of the Integrated Health Camps (IHC) has been adopted keeping in mind the emerging evidence of rural vulnerabilities coupled with uncovered areas. The objective of the IHC is to reach out to the 'at risk populations' in priority districts across the high burden states with a Comprehensive Service Package. The IHC is based on a hybrid approach of identification of target beneficiaries i.e. at risk population and screening them for HIV, STI, TB, HBV, HCV and other morbidities prevalent in the geographies through fixed site-static camps and extended outreach activity involving key community groups and informants. The IHC has witnessed a footfall of 54,776 across the eight north eastern districts between Feb 2023 to October 2023. The IHC approach has helped bridge the gap of the first 96.

## 1.2 Risk and Vulnerability of Rural Population to HIV and STI

Evidences suggest vulnerability of rural population to HIV and STIs in India. [12] Various factors contributing to their vulnerability are highlighted below:

- **Co-location of hotspots:** The learnings of various interventions and recent findings of p-MPSE (FY 2022-23) points towards the presence of hotspots/congregation areas in the rural areas where rural HRGs operate. As per IBBS 2014 overall 15% of FSW reported practicing sex work in rural areas, while 55% reported in urban areas and another 30% reported both rural and urban areas. Rural sex workers solicit clients mostly from home (around 54%), followed by rented homes (14.4%) and public places (13.9%). In addition, higher mobility of population (intra/inter states), opening of business sites, emergence of different congregational points has led to emergence of new hotspots of risk activities which could be for solicitation for sex, drugs peddling, etc. For instance, a focus on improving rural-urban connectivity has led to a proliferation of highway upgradation/construction projects wherein individuals living in rural areas, male and female labourers including migrants are engaged in road construction. This increases the exposure of the local population as well as the migrant labourers to multiple or a combination of high-risk activities/hotspots.
- **High traffic economic corridor linking urban to rural areas:** A higher proportion of men than women travel daily or seasonally between rural and urban areas increasing the chances of exposure to high risk activities with availability of sexual and injecting networks. Intersectionality of risk , the relative freedom at the new place, peer pressure, substance use, increases the risk and vulnerability of persons to HIV and STI moving from rural and urban areas [13].
- **Knowledge gap of HIV among women:** The NFHS-V data reveals a significant knowledge gap of HIV among urban and rural women. Only 18.2% rural women had comprehensive knowledge about HIV as opposed to 28.6% in the urban area. This low level of knowledge on HIV results in a corresponding low level of risk -perception to sexually transmitted infections and knowledge of prevention methods. While condom use awareness has improved, rural women (64.7%) lag behind urban women (76.1%), and rural men (79.6%) trail urban men (86.4%).
- **Limited access to health care facilities:** Barriers of accessibility have hindered many HRGs benefiting from prevention services. It has been observed that around 14 Indian states have less than minimum density of doctors and nurses/midwives [14]. Poor healthcare infrastructure in the public domain coupled with distance and transportation cost acts as a deterrent in accessing the public health care system [15]. NACP has sought to reduce new HIV infections in India by promoting widespread HIV testing, linkage to care and ultimately higher rates of viral suppression to prevent onward transmission. However, as per Sankalak 2023, only 79% of people with HIV in India know their sero-status as of March 2022.

- **Risk of PLHIV developing TB:** TB is the most common Opportunistic Infection (OI) among PLHIV. According to the 2020 Global TB Report, PLHIV are 18 (15–21) times more likely to develop active TB disease than people without HIV. Even when on Antiretroviral Therapy(ART), PLHIV are 3 times more likely to die during TB treatment [16]. In India, there were 54,000 HIV-positive TB incidences in 2021 and 11,000 HIV-positive TB mortality. [17] Further, the annual risk of TB infection is around 1.3% in rural in India [18]. The NFHS-4 indicates that TB was common among males and in rural areas. As per the design, the LWS is implemented in the High HIV burden districts.
- **Limited access to educational and economic opportunities:** Although the literacy rates of the country have shown a consistent upward trend since the 1st census conducted in 1901, there exists a notable gap between the literacy rates in urban and rural settings. [19] The male literacy rate is 82.14% and the female literacy rate is 65.46%, signifying a gap of 16.68% in the male-female literacy rate. In the rural context, the overall literacy rate is 67.77% (Male: 76.62%; Female: 65.74%) [20]. A low level of literacy leads to limited opportunities and access to the right kind of information leading to increased vulnerability towards HIV. While the level of information among these populations related to STIs and HIV/AIDS is relatively high [21], this information is rarely converted into action. Improper understanding or interpretation of information about HIV/AIDS leads to risky behaviour. According to Niti Aayog's Multi-dimensional Poverty Index (MPI) report released in July 2023, the poverty rate [22] of rural India stands at 19.28% vis- a-vis 5.27% in urban areas [23]. Poverty is one of the main push factors for out-migration. Sex work becomes a source of earning quick money in the absence of employment opportunities in rural areas and the socio-cultural factors that highly restrict a woman's access to resources [24]. Further, long periods of separation from the sexual partners and availability of greater disposable income among the bridge population combined with closed sexual networks often lead to quick transmission among the spouses and partners of the bridge population.
- **Cultural and social norms:** As in many other countries, in India too, cultural and social norms are intrinsically linked to power relation among the genders. Unequal power relations and the low status of women, as expressed by limited access to human, financial, and economic assets, weaken the ability of women to protect themselves and negotiate safer sex both within and outside of marriage, thereby increasing their vulnerability. Moreover, due to cultural expectations of homemaking, child rearing, and caregiving, women are hardly left with time to focus on their health. This has also been observed in a study [25] conducted in Heggadadevanakote (HD) Kote and Saragur located in Karnataka where 17% of women cited lack of time to participate in a health intervention.
- **Stigma and discrimination:** Studies suggests that stigma related to HIV/AIDS continues to exist in rural communities despite increased awareness. Stigma is found to be higher towards rural HRGs and PLHIV [26, 27, 28]. This stigma becomes a significant barrier that

prevents rural HRGs from accessing treatment and health care services and also keeps them hidden, making it difficult to identify them for providing services in rural areas. Many TG and MSM migrate to urban locales to escape stigmatisation because metros provide them anonymity and more earning opportunities. However, they also maintain links with their home towns thereby bridging the urban to rural communities. Stigma against commercial sex work also makes many rural women practice sex work in towns and cities.

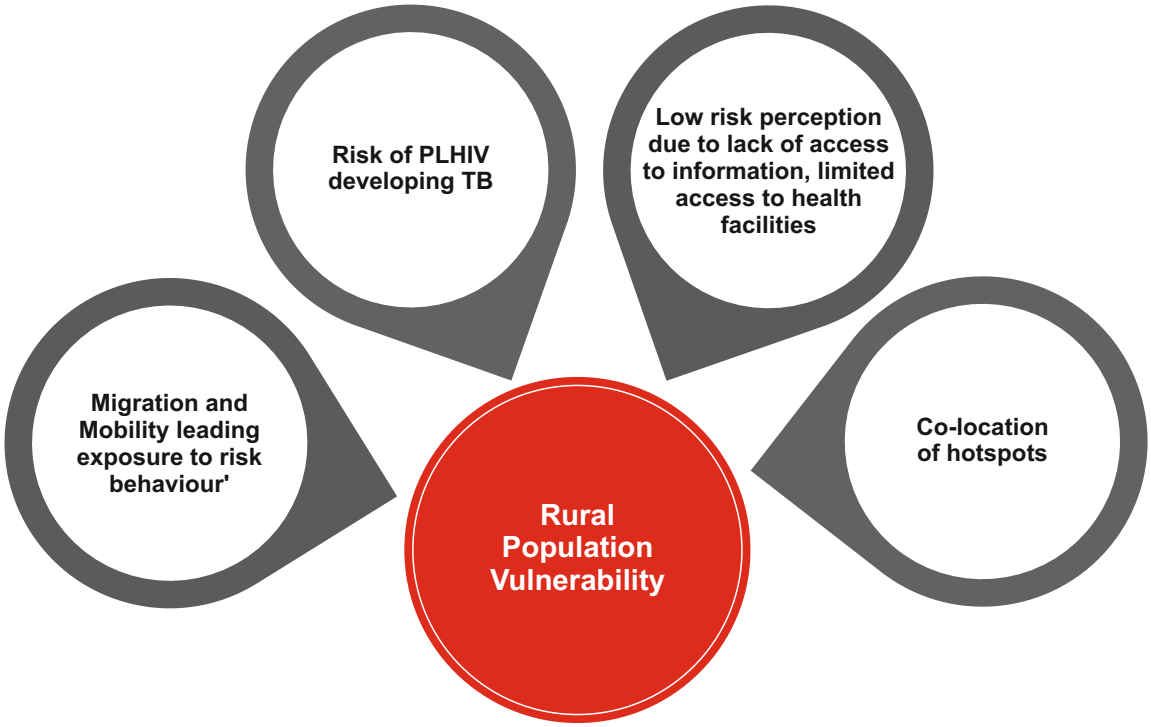



**Figure 5: Factors that make rural population vulnerable to HIV[29,30]**

## 1.3 Rationale for Prevention Interventions among Rural HRGs and Vulnerable Population

The NACP Phase-V calls for the attainment of ambitious targets of 95-95-95 by 2025, where 95% of all people living with HIV to know their HIV status, 95% of all people diagnosed with HIV infection receive sustained antiretroviral therapy (ART), and 95% of all people receiving antiretroviral therapy achieve viral suppression by 2025. Although significant strides have been made by India in achieving the 95-95-95 targets, however, if the targets have to be achieved in the stipulated timeframe, the current strategies need to be viewed in accordance with the emerging programmatic evidence and recalibrated suitably. The recent programmatic analysis and the evidence from studies conducted in the field put forth a strong rationale for revamping of the LWS guidelines [31].

- **Gap in achieving the 1st 95 despite all efforts:** The challenges related to accessibility have impeded the ability of HRGs to access HIV and STI prevention services. NACP has sought to address these challenges by facilitating extensive HIV testing, and access to healthcare with an aim to increase viral suppression rates and prevention of onward transmission of HIV. However, only 79% of individuals living with HIV in India were aware of their HIV status. [32]
- **Higher at-risk sexual behaviour in rural areas:** NFHS-V data highlights a higher propensity among men to indulge in at- risk sexual behaviour vis-a vis women (Male: 3.8%; Female: 0.5%). It also revealed that non-use of condoms among the higher-risk respondents were more among rural areas for both men and women. Even though the percentage of people having sex with non- regular partners is higher in urban areas (Male : 4.8% ; Female: 0.6%) than rural areas, the percentage in rural area in significant among rural male respondents (3.7%). Analysis of paid sex in the past 12 months preceding NFHS-V indicate a significant percentage in both urban and rural geographies. A study conducted in the southern states of India of male migrants at their place of destination found that more than 30 percent had sex with women, who were not their married partner, in the place of origin [33].
- **Knowledge Gap on HIV in rural areas:** Analysis of NFHS IV & V indicate a persistent gender disparity in the comprehensive knowledge on HIV/ AIDS. Men's comprehensive knowledge improves from 30.7% (NFHS-IV) to 32.5% (NFHS-V), yet the rural-urban gap persists, with urban men at 37.5% compared to rural men at 27.1%. The comprehensive exploration underscores higher awareness and knowledge among men in urban areas, emphasizing the necessity of targeted interventions in rural geographies. A study conducted among rural women PLHIVs in Prakasham district of Andhra Pradesh concluded that the respondent faced both public and private stigma including challenges related to accessing and adhering to ART , food insecurity, and health care access. [34]
- **New vulnerable pockets in the low prevalence states:** The rural- urban migration plays a pivotal role in HIV transmission in rural areas creating pockets of high HIV prevalence in

otherwise moderate to low prevalence Districts. Studies suggest that men who migrate or spend long periods away from home may engage in risky sexual behaviour due to separation from their families. [35] In a Mumbai-based study (N = 5130), data revealed that married men with wives in close proximity to area of origin and who were able to be mobile due to occupation had the highest sexual risk behaviors. [36] A cross-sectional study conducted in Jharkhand highlighted the vulnerability of HIV transmission among rural migrants, citing a lack of comprehensive knowledge and engagement in high-risk behaviours. [37] While another study conducted by CDC/PEPFAR in the context of HIV transmission across the state borders as a result of migration in the North East region and looking into the "Spaces of Vulnerability" suggests a high risk of HIV transmission due to engagement in high-risk activities with availability of sexual and injecting networks in identified uni/bi-directional migration corridors.

- **Low coverage of target population:** A study conducted by TISS on the Link Worker Scheme reveals that reaching out to hard-to-reach HRGs in a rural setting is challenging. In some of the districts in the study, gaps were observed in terms of identification and service coverage of HRGs like TG/H, PWID and MSMs. Higher coverage is seen among the more visible population like spouse of Migrants / Trucker (come under other vulnerable groups), Migrants, Truckers, ANC etc. This is corroborated by Sankalak (2023) which states that the total coverage across all population groups was around 22.83 Lakhs. Among all the groups, Other Vulnerable Population that includes spouse and partners of HRGs, bridge population, youth and PLHIV etc. had the highest coverage (42.7%) followed by migrants (30.57%), ANC (8.73%), truckers (7.91%), FSW (3.53%) and TB cases (3.62%). Coverage of MSM, H/TG persons and PWIDs were at 0.53%, 0.04% and 0.69% respectively. The absolute numbers of vulnerable populations covered under LWS are yet to translate into meeting the ambitious goal of 95-95-95. Youth comprise 25% of the total population in India and account for 31% of the total HIV burden [39]. However, mobilisation of 'at-risk' youth has not been found equal to their coverage in LWS (Revisiting Link Worker Scheme, TISS, 2023). Out-migration plays a significant role in the high prevalence of many of these pockets. Bihar and Uttar Pradesh are characterized by the highest out-migrations in the country. [40] Women left behind by migration represent a unique and growing population. Spouses of migrants are four times at risk than non-migrant spouses. Therefore, it is crucial to prioritize high and moderate prevalence pockets in low prevalence Districts in order to address and control HIV in a comprehensive manner.
- **High number of HRGs still outside the fold of Intervention Projects:** Findings from the Integrated Health Camp (IHC) state that despite substantial progress achieved during NACP phase V, a significant number of HRGs still remain outside the purview of TI projects which continue to focus in urban and peri-urban areas. One of the factors attributed to this gap is the population residing in rural and hard-to-reach geographies. This situation is

exacerbated by the scattered distribution of these populations. Another study titled "Presenting Pattern and Psychiatric Comorbidities in Rural versus Urban Substance Dependent Patients: A Hospital-Based Cross-Sectional Study" [42] conducted on 500 newly registered outpatients in District Hospital, Bhatinda, Punjab highlights that the opioid dependence exhibited in rural patients was slightly higher than the urban patients (86.6% and 85.5% respectively) and around 22 % rural patients were PWIDs.

- **Low geographical coverage in rural areas:** As on March 2023, the LWS was implemented in 168 priority districts spread over 16 states. The LWS in large states like UP (adult HIV prevalence, 0.11%; estimated number of PLHIV -1.95 lakh) and Bihar (adult HIV prevalence, 0.17%; estimated number of PLHIV -1.56 lakh) have notably the higher out-migration in the country, covers only 7% districts under LWS. State like Rajasthan with a total of 75.1% rural population and a total literacy rate of 66.11% has only one LWS district. [43] As per district prioritization with epidemic burden, 2019, a total of 299 districts (out of a total of 735 districts) fall under high and moderate category [44]. Out of which 168 districts (56% of the total high and moderate category districts) are currently covered under LWS.
- **Overlapping of Population under different health Programme:** ANC and TB populations covered under the LWS are also simultaneously covered under other national programmes, thus resulting in duplication of efforts. Therefore, to optimise prevention initiatives and increase service delivery more focussed approach is envisaged by prioritising at-risk populations over these population groups under the ambit of LWS. Capacities of grassroot-level health functionaries like ASHA and AWW can be strengthened to adequately respond to the HIV-specific needs of these groups.
- **Use of technology in rural areas:** With the rationalisation of cost and easy availability, internet penetration has increased in India. India has seen a significant rise in internet usage [45]. The number of internet users in India has surged to an estimated 624 million, marking an increase in internet penetration from 4% in 2007 to 50% in 2020. [46] For the first time, internet in rural India surpasses urban India [47]. Concurrently, there has been a growth in the number of websites and applications used for finding sexual partners [48]. Furthermore, a study conducted jointly by NACO, FHI 360 and TISS in both rural and urban districts in seven states of India – reported an emergence of non-traditional forms of solicitation including technology-based solicitation such as solicitation through basic keypad phones, smartphones, WhatsApp, Facebook, LinkedIn, Instagram, and video calls. [49] The study also revealed that 20.9 % FSWs used technology as their primary mode of solicitation.

## Scope of the document:

- The purpose of the revised guidelines is to ensure delivery of quality HIV and STI prevention interventions with strong linkages for access to testing and treatment under

NACP for HRGs and vulnerable population in rural India.

- The Guidelines outline standardized operating procedures for implementing comprehensive HIV and STI prevention services at scale. In summary, the purpose of the Guidelines is to:
- Build uniform understanding on the need, design and outcomes of prevention interventions among rural HRGs and vulnerable population across all stakeholders.
- Bring in technical competence among implementers, managers and technical support persons.
- Bring in performance benchmarks and quality interventions to contribute to the national goal (NACP phase V).
- Ensure exclusion of duplication of activities and coverage at the rural level with the focus on strengthening HIV and AIDS related IEC activities and referral linkages.



# CHAPTER 2: STRATEGIES UNDER NACP PHASE-V FOR RURAL POPULATION

## 2.1: Context

LWS aims to address complex needs of rural population for HIV prevention, care and support. The scheme offers HIV prevention, referral, and follow-up services for HRGs and other vulnerable populations. The introduction of LWS has enhanced comprehension of the dynamics of sex work in rural areas and the repercussions of migration-related transmission dynamics. In 2022-23, LWS was implemented in 168 districts across the country covering around 26.04 lakh people including 1.9 lakh pregnant women and 0.43 lakh PLHIV [50].

LWS provides a basic set of services to its intended population, encompassing outreach, diagnosis, and testing for STIs, HIV, and TB, along with referrals and linkages to the nearest health facility. Aligned with the fundamental principle of NACP phase V - breaking silos and building synergy - the revised Guidelines convert the service package into a more comprehensive one, spanning the entire spectrum from outreach to care. This is envisioned to be achieved by fostering linkages both within and outside the NACP framework.

### 2.1.1: Objectives of LWS

- The scheme aims at building a rural community model to reach out to HRGs, bridge population and other vulnerable population to address the prevention, testing, treatment and care requirements for HIV and STI in select geographies.
- The scheme aims at improving access to information materials, and commodities (condoms, needles/syringes, OST, lube) through a multi-prong approach.
- The scheme aims at creation of an enabling environment for PLHIVs, HRGs and Other Vulnerable Population towards reduction of stigma and discrimination by strengthening community structures and systems.
- The scheme aims at improving linkage to other social and health benefits provided by other line departments in line with local norms and regulations suitable for vulnerable populations.

### 2.1.2: Salient Features of LWS

The salient features of LWS are as follows:

- The scheme uses evidence-based approach to identify rural areas with greater risk and vulnerabilities of contracting HIV through scientific tools such as broad mapping. Individuals/groups within the villages are prioritised for providing information and services based on detailed situation needs assessments.
- The scheme envisages creation of demand and provision of various HIV and STI related services and linking of the target population to existing services points under the revised Guidelines.

- The scheme involves highly motivated and trained community members 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.
- The scheme envisages creating an enabling and stigma free environment in the project area to ensure continued access to information and services in a sustained manner.
- The scheme envisages creating linkages with services of other health departments through ASHA, Anganwadi Workers, panchayat heads, MNREGA scheme officials, Red Ribbon Clubs etc.

## 2.2: Defining Population for Coverage under the Scheme

The current LWS covers ten different groups of high-risk and vulnerable population such as FSW, MSM, PWID Hijra/TG, bridge populations (Migrants, Truckers), PLHIV, TB cases, Antenatal mother and other vulnerable populations in the selected villages. However, the study conducted by TISS [51] across 10 States recommends a re-visit of the population covered under the LWS. The study suggests that since groups like ANC and People with TB (PwTB) are successfully covered under other National intervention programmes like Elimination of Vertical Transmission of HIV & Syphilis (EVTHS) and National TB Elimination Programme ( NTEP), the coverage of these group may be de-prioritised under LWS. However, pregnant women who remain virally suppressed and whose new-born infants need 18 month EID services can be part of the follow-up services under LWS. This would enable CLWs to focus on more 'at-risk' and vulnerable population. Further, the study observed discrepancies in the manner in which youth were covered. Although identification and coverage of PLHIV is an important objective of the LWS, eight out of 10 study districts account for less than 1% of PLHIVs under the LWS.

Based on the prevalence rates of various categories and the evidence from studies and programmatic analysis, the revised Guidelines for the LWS focuses on the HRGs including their spouses, partners; bridge population (migrants and transport workers) including their spouses and partners; PLHIVs including their spouses, partners and Other Vulnerable Population.

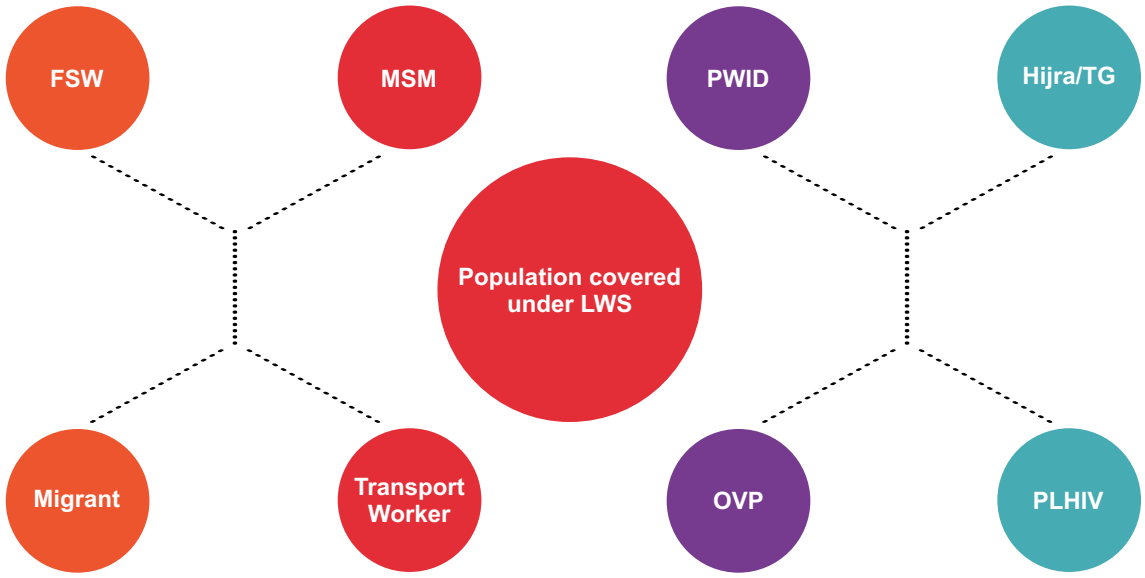



**Figure 6: The target population covered under the LWS**

**Female Sex Workers (FSWs):** FSW is defined as ”an adult woman who engages in consensual sex for money or payment in kind, as her principal means of livelihood.” [52] In the rural settings, women who sell sexincludes 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. Under LWS this definition 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 (LWS Guidelines,2015). Also FSWs who are being covered by TI but they visit TI irregularly and there is evidence of services being discontinued as per TI guidelines. [53]

**Men who have Sex with Men (MSM):** The term “Men who have sex with Men” (MSM) is used to denote all men who have sex with other men as a matter of preference or practice, regardless of their sexual identity or sexual orientation and irrespective of whether they have sex with women or not. Coined by public health experts for the purpose of HIV/STI prevention, this epidemiological term focuses exclusively on sexual practice. This term does not refer to those men who might have had sex with other men as part of sexual experimentation or very occasionally depending on special circumstances. It should be noted that not all of those who engage in male-to-male sex necessarily identify themselves as homosexuals or even men. [54] In the rural settings, 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. [55]

**PWIDs: People who Inject Drugs (PWIDs):** are those who used any drugs through injecting routes in the last three months [56]. PWIDs may inject drugs in their own village or outside in secluded hotspots adjacent to their village to protect their privacy or there might be some PWID from the neighbouring village who come and inject in the village of intervention. Some PWIDs might be engaged in high risk sexual activities under the influence of drugs as well. For Female PWIDs comprehensive services addressing both injecting and sexual risk and the reproductive health risks needs to be covered.

**Hijra/Transgender (H/TG):** A person whose self-identity does not conform unambiguously to conventional notions of male or female gender roles but combines or moves between these. [57]

**Migrants:** Any person moving from one place to another and has the likelihood of exposure to HIV /STI risk irrespective of distance, time/ duration or occupation. [58]

**Transport Worker:** Any person associated with transport industry and has the likelihood of exposure to HIV /STI. This may include commercial drivers, truckers, motorized vehicle and population serving them like mechanic, helper etc. They may belong to the same village or may be coming to the village for business purposes and having significant risk for HIV. [59]

**Other Vulnerable Population (OVP):** Any person other than the HRGs, PLHIVs and bridge population who is a part of their sexual and/or injecting network including post- release inmates.

**People Living with HIV (PLHIV):** Persons infected by HIV are considered to be high risk in case they do not 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. [60]

# CHAPTER 3: OPERATIONAL STRATEGY

Operational strategy under LWS is designed specifically to the nature of target population and location. Efficiencies at scale can be achieved only if an intervention reaches out to the appropriate and optimal number of the target population, while also taking cognizance that not all individuals under the target population are at the same level of risk and vulnerability to HIV.

LWS intervention to initiate a six- step process for site selection prior to the implementation of the intervention.




**Figure 7: Six- step process for site selection under the LWS**

## 3.1: Defining Area of Intervention in District and Villages

### 3.1.1: Selection of District and Village for intervention

Considering the risks and vulnerability of HRGs and Other Vulnerable population under the scheme, district selection will be done based on the following evidence/ information;

- High and moderate districts identified based on the latest District Epidemiological Profile and Estimation
- Presence of HRG
- High out- Migration **(Census/ Study/ Reports etc.)**

Based on the above information, SACS and DAPCU/DISHA will identify districts to be prioritised for the intervention. One LWS project (executed by one NGO/CBO) will be implemented in one district. However, considering the geographical proximity of vulnerable blocks and villages, one LWS project may cover the nearby district(s). After the district(s) selection, the second step will be to select the priority blocks and villages for implementation of the intervention. Block and villages for implementation would be selected based on the evidences generated and triangulated at district level as defined below.

### 3.1.2: Block/Taluka and Village Selection

Block and village selection is a critical step towards reaching out to the right target population for any rural intervention. A total of 100 villages per district are to be selected for the intervention. In North Eastern States and hilly terrain atotal of 60 villages to be selected based on risk and vulnerability. The guideline lays down the following criteria for block and village selection:

- Presence of People Living with HIV (PLHIV) in the villages: To be collected from nearest ICTC /ART, FICTC, Link ART (LAC) Centre, Link ART Centre Plus (LAC +) etc. to understand the burden of HIV in the district.
- Presence of HRGs in the village: The findings from p-MPSE to be analysed to identify or locate the presence of HRGs in the villages coupled with the information from nearest TI (may be located in the neighbouring district or same district) to understand the percentage of HRGs line listed in the TI belonging to the rural areas as well as gain information on their mobility pattern, client profile, etc. Also collect information from the clients of HRGs to understand the presence of HRGs in rural pockets of the block/district.
- High out-migration: Number of potential and active migrants migrated during last three years to a destination which reported high HIV prevalence. Collect migration related information from Anganwadi Worker (AWW)/ ASHA /Auxiliary Nurse and Midwife (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 the above information.

The village selection will be done through a triangulation of data from HMIS, ICTC, ARTC, p-MPSE, de-addiction and rehabilitation centres, field intelligence from the law enforcement agencies, civil society organizations and the community members at large. This will primarily involve analysis and triangulation of the village-wise positivity data from Prevention Unit (like TI NGOs, OST Centre, LWS, Prison, One-Stop-Centre (OSC), etc. along with district-wise STI data, district-wise ICTC data and district-wise ARTC data) for last 3-5 years preceding to the intervention. CSOs working in the villages, community members may also be consulted while selecting the villages in the selected districts. After selection of villages, the next task will be to cluster the villages for placement of Cluster Link Worker (CLW). Villages clusters will be defined according to the target population size and the geographic proximity. Each cluster will consist of 4-6 villages which will become the operational area for the Cluster Link Worker.

## 3.2: Situational Need Assessment (SNA)

Situational Need Assessment (SNA): SNA would be conducted to understand the needs and priorities of communities, target population to be reached out to, and availability of resources in the villages for planning and monitoring.

The Link Worker Team with the support of DISHA/DAPCU will conduct SNA in the selected block and villages for intervention through the Participatory Rural Appraisal (PRA) process. The following activities would be conducted while conducting SNA by the outreach team in the villages.

- Stakeholders Identification and analysis: The list of stakeholders or associates which control or influence the mobility of HRGs, their access to condoms, needles and syringes, and other services.
- Resource and Social Mapping - Resource Mapping of existing health facilities/ CSOs working in the blocks/villages area etc.
- Existing Community Systems: The list of Self Help Groups (SHGs), youth clubs or other institutions which can be tapped for reaching out the communities, Community Champions, Community Meeting (Gram Sabha- Periodicity of meeting), PLHIV networks, Beneficiaries of NACP facilities etc.
- Identification of Sexual and injecting networks: Information collection regarding the existence of sexual/ Injecting networks (both male and female sex workers) and the support structures for these networks, operational timings of HRGs in the area, concentration of HRGs through ASHA/ AWW/ youth.
- Listing of big events in the villages (Haat , Bazzar, Fair, Mela etc.)
- Identification of sites (Constructions, Brick Kiln, Factories, Industrial Sites etc.
- HRGs and Other Vulnerable Population mapping – Listing of HRGs and OVPs in the villages
- Migration data: Data related to migration pattern (seasonality), volume of migration, time of return and the point person responsible for facilitating the migration process.
- Number of HRGs belonging to the rural area who are under service, number of HRGs regularly serviced and how many of them serviced at certain intervals, client profile of these rural HRGs, sites where they solicit or congregate (lodge, weekly market, dhabas, market yards, local small industries, quarries, nearby lodges/brothels, along the highways, old desolated buildings, bus stands, near landmark buildings like temples, open spaces in public areas like public parks etc.) [p1]

- Identification of possible avenues/areas of convergence- Integration of HIV/AIDS into other activities of health systems/ programmes to be made. LWS will work closely with the basic health functionaries, PRIs, local NGOs on social mobilisation of HIV preventions/ Management in their functions.

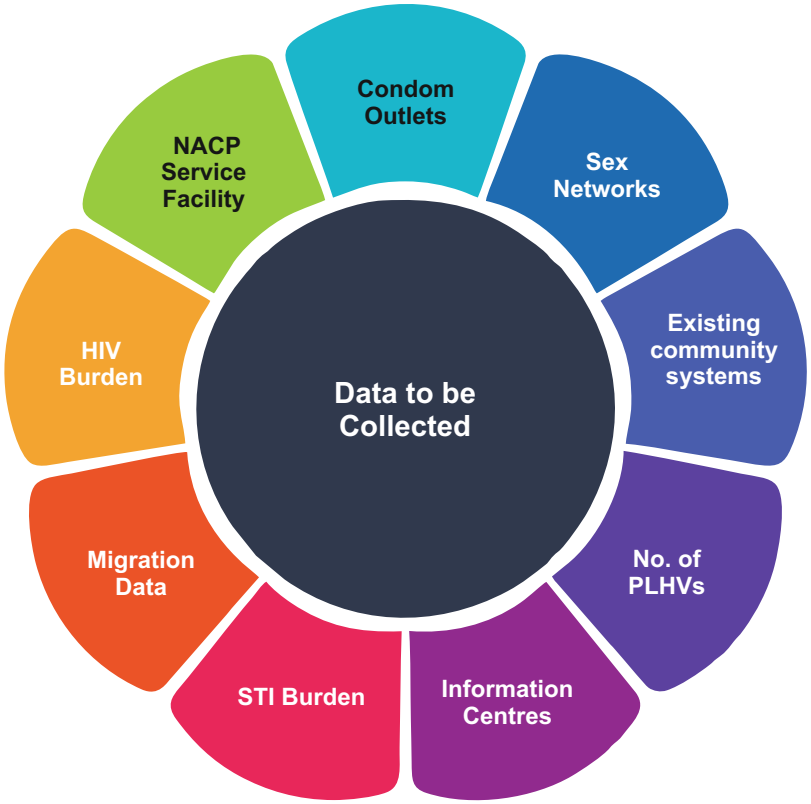



**Figure 9: Information to be collected during SNA**

SNA has to be conducted every time a new project is initiated as well as every two year of the project period or whenever new villages/geographies are added in the project. After SNA, Cluster Link Worker will develop an action plan / outreach plan to conduct different activities in the villages. While developing the action plan, community/ stakeholder consultation to be conducted to gain insight regarding the community needs, mapping of resources and high risk sites, and understanding the knowledge gap, etc.

### 3.2.2: Village Rotation and Strategies for Sustainability

LWS implements the approach of village rotation in order to maximize the coverage of rural areas. Saturation of the population and achievement of LWS objective in the villages indicate the intervention for shifting from the existing villages to new villages. Need based rotation of villages to be done every year after assessing the risks and vulnerability of existing villages and depending upon the undermentioned factors:

- Number of PLHIVs
- Number of HRGs
- Number of out-migration
- HIV new case detection in the existing village

The rotation of villages need to be planned by the SACS and DACPU/DISHA in consultation with the TI and LWS Implementing NGOs.

The previously covered villages will be covered under an intensified IEC campaign, Integrated Health Camps (IHC) and with the support of ABHWC (Now - Ayushman Bharat Arogya Mandir) under NHM to ensure continuum of prevention services including NCDs, Hep B & C. Linkages would also be developed with drug- de-addiction centre under Ministry of Social Justice and Empowerment for refers of the target population.

## 3.3: Activity Framework for Service Delivery

The activity framework broadly covers planning, population mobilisation, and service delivery in a step-by-step approach. Some of the activities will overlap depending on the need of the community and working pace of the implementation team. The suggested activities are placed below:

**Step 1**

Planning: It is the initial phase that lays the groundwork for service delivery. It encompasses the following activities;

- Risk and Vulnerability Assessment of population: Assessment of the typology of HRGs, bridge and other vulnerable populations present /operates in the villages to be done. This includes exploration of social, sexual and injecting network of target groups under the scheme. The findings of the SNA to be used and updated.
- Identification of vulnerable sites /pockets: Sites witnessing the presence of HRGs, Bridge and other vulnerable populations; including local hotspots, congregation sites etc., will be identified to reach out to the HRGs. These sites are to be validated with the feedbacks of communities or key informants/stakeholders in the villages.

**Step 2**

Mobilisation of target population: Various approaches such as mid-media, multi-media, interpersonal communication (IPC), and social and behaviour change communication (SBCC) will be used to mobilise the target population. The CLW will make use of communication materials and dialogue based communication skills to discuss issues like HIV, Sexuality, injecting behaviour and substance use in the groups. This also includes various demand generation activities, followed by line listing of beneficiaries by CLW for service provisioning.

**Step 3**

**Service Delivery**

- Conducting health camps
- Referrals and Linkages

The flow of activities would ensure that every component of the comprehensive service delivery package is delivered at the appropriate stage.

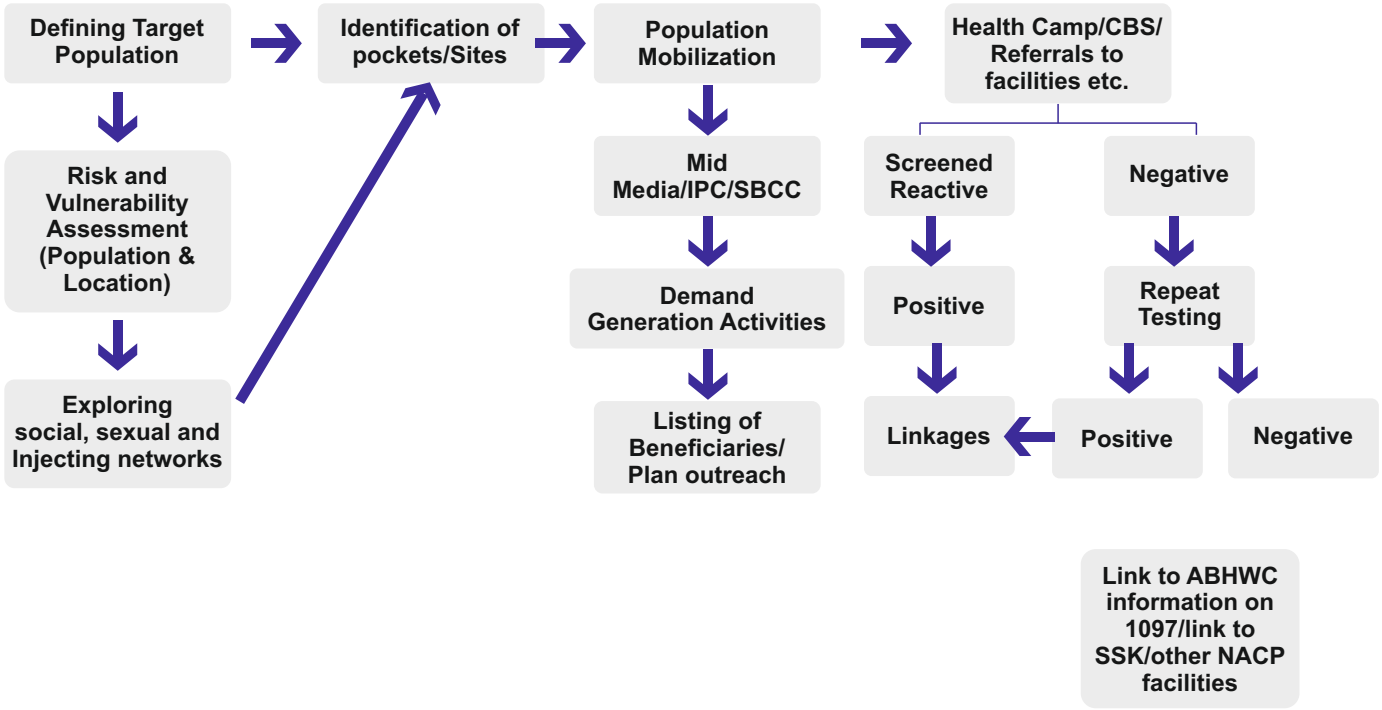



**Figure 10: Activity flow chart**

# CHAPTER 4: SERVICE PACKAGE

Aligning with the first guiding principle of NACP Phase V of keeping communities at the centre of the response LWS covers the entire spectrum of prevention, testing, treatment, and care. This ensures that all aspects of the intervention are addressed in a comprehensive manner.

## 4.1: Components of Service Delivery Package

Under the revised Guidelines, the packages of services to be provided to the target population as per their requirements is placed below:

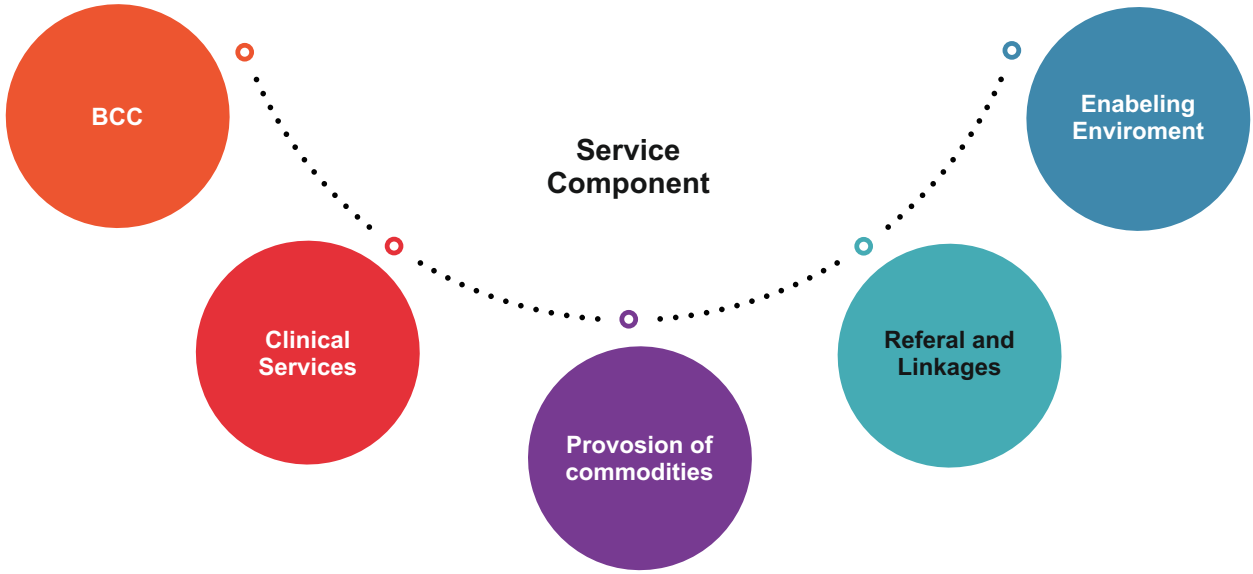



**Figure 11: Components of package of services under the LWS**

## 4.2: Service Delivery Approches

A comprehensive package of services for the target population with appropriate approaches is envisaged to ensure increased access and optimise utilisation of services. Component wise comprehensive service package, approaches, and activities for service delivery are as below.

| Components | Comprehensive Package of Services | Approaches | Target Population | Proposed Activities |
|---|---|---|---|---|
| Behavior Change Communication (BCC) | • Information and counselling regarding risky behaviour and ways of preventing them.<br>• Safer sex practices<br>• Safer injecting practices, abscess prevention and overdose management<br>• Importance of HIV testing/Syphilis screening/ STI treatment<br>• Access to HIV testing and STI services.<br>• Condom negotiation skills<br>• Information regarding availability of condoms (both free and social marketing)<br>• Counselling on treatment adherence and positive prevention on VL suppression ( U=U) | • Dialogue based IPC<br>• One to one discussion and One to group/FGD<br>• Community outreach by CLW / Help of Community Volunteers/ Champions<br>• Use of Multi-pronged IPC/ SBCC material and tools<br>• Mid- media activities<br>• Differential outreach strategy in the congregation sites or the places selected by the community<br>• Use of village platforms (Mela, Fair, Festivals, Sports events, SHGs meetings, PRI meetings etc.)<br>• NACO helpline -1097<br>• Use of NACO / Ministries social media platform ( Youtube channel, Facebook, AIDS App etc.)<br>• Demand generation activities | FSW, PWID, MSM, TG/H, Migrants, Transport Workers, PLHIV, OVP. Including their spouses and partners | • Provide key messages related to information on HIV/STIs, risk perception focusing on consequence of risky behaviour, condom, treatment behaviour etc.<br>• Use of social media messaging platforms for SBCC intervention<br>• Conduct polling booth survey to assess the behaviour of the target population.<br>• Exploring sexual and injecting networks - CLW to reach out to the sexual and injecting partners of HRGs and PLHIV<br>• Mobile outreach to be undertaken in hard to reach and hilly terrains<br>• Coordination with District level government functionaries, health camps/ IHC<br>• Leveraging support of villages SHGs Groups, PRIs, CSOs |

| Components | Comprehensive Package of Services | Approaches | Target Population | Proposed Activities |
|---|---|---|---|---|
| Clinical Service | • HIV Screening & Testing<br>• STI Diagnosis and treatment (including syphilis)<br>• TB- 4-S screening<br>• Screening for Hep B and C<br>• OST Dispensation<br>• Capacity Building of Service provider | • Health camps in the strategic locations<br>• Mobile Outreach / Deployment of mobile vans for HIV/ STI screening<br>• Community Based Screening for HIV<br>• STI diagnosis and treatment facilities (including syphilis)<br>• Spouse/ partner testing of Positive index cases<br>• 4S-TB screening and Referrals<br>• Establishment of satellite OST centres/ Sensitization of community support groups | FSW, PWID, MSM, TG/H, Migrants, Transport Workers, PLHIV, OVP including their spouses and partners | • Develop Micro plan for the cluster villages to organise health camps with the help of line departments.<br>• Plan the timing of health camp in consultation with the stakeholder and the returnee migrant season.<br>• Combined with SBCC exhibition, counselling facilities<br>• Provide STI/RTI drugs free of cost.<br>• Wherever possible medicines may be procured from the govt. health systems as per the direction of SACS.<br>• Hold CBS during health camps<br>• Use sexual and injecting network for HIV screening<br>• Referrals for Hep B/C cases<br>• Help the PLHIVs to mobilise their contacts (spouse, regular male/female partners, sexual/injecting partners) to access HIV and STI services<br>• Application of Syndromic Approach for screening for STI in health camps / / ABHWC (Now - Ayushman Bharat Arogya Mandir)<br>• HIV testing of spouses' / sexual/injecting partners and biological children of <19 years of all confirmed HIV positive index cases<br>• Conduct follow up visits (for Ensuring service continuum)<br>• Build capacity of service providers in the public health facilities, CSOs to address the health care needs of communities |

| Components | Comprehensive Package of Services | Approaches | Target Population | Proposed Activities |
|---|---|---|---|---|
| Referral and Linkages | • Referrals and Linkages to the nearest ICTC /ART / DSRC, Hep B & C treatment facility and follow up of the referral cases.<br>• PWID: Referrals and Linkages to the nearest OST/Satellite OST centres and follow up of the referred cases<br>• Referrals/ Linkages to increase access to the social security /benefits of HRGs/Vulnerable population | • Referral to ICTC and ART<br>• Referrals to DSRC<br>• Referral for Hep B and C services and OST<br>• Linkage with other health clinics of Govt., or Private sectors<br>• Referral to nearest ICTC<br>• Referral to ART centre<br>• Post release / family follow up with inmates/ family linkage to prevention/ treatment and social protection services | FSW, PWID, MSM, TG/H, Migrants, Transport Workers, PLHIVs, OVP including their spouses and partners. Post – release- PLHIV inmates and their spouses | • Coordinate with local private or govt. hospitals, NGOs/CBOs run clinics, mobile clinics to link the population.<br>• Conduct HIV screening & counselling at health camp<br>• Coordinate with ICTC and ARTC for offering Index testing to the missed cases<br>• Link with the ART centre as per the NACO CST guidelines.<br>• CLW to follow through with the post release inmates / families to ensure that they availing the services that the prison authorities have linked them with.<br>• Referrals and linkages to increase access to different social security/benefits/ livelihood support for HRGs/ Vulnerable population |
| Commodity Distribution | • Condoms<br>• Needle /Syringes(N/S)<br>• Lubes<br>• OST Medicines | • Creation of condom outlets, Secondary Distribution of Needles / Syringes (SDNS) sites<br>• Provision for free distribution condoms, Socially Marketed condoms etc.<br>• Free distribution of N/S<br>• Linkages with nearest TG/ MSM TI for lubes<br>• Linkages with nearest satellite OST/ community | FSW, PWID, MSM, TG/H, Migrants, Transport Workers, PLHIVs and OVP including their spouses and partners | • Focus on condom demand generation activities<br>• Prioritise spots for initiating condom outlets<br>• Focus on family planning services through ASHA, ANM, ABHWC (now: Ayushman Bharat Arogya Mandir)<br>• As required N/S and bio medical waste management for SDNS to be used.<br>• Cater to the population who require OST primarily to be referred to nearest TI to increase access to services. Support in creating secondary distribution of needles and syringes.<br>• Ensure linkage of newly diagnosed with the nearest ART centre<br>• Referral to nearest Satellite OST.<br>• Collection of used needles and syringes and processing for biomedical waste management through nearest Sub Centre/PHC/TI/ ICTC centres<br>• Information on how to prevent abscess. |

| Components | Comprehensive Package of Services | Approaches | Target Population | Proposed Activities |
|---|---|---|---|---|
| Enabling Environment | • Awareness generation on HIV/AIDS Control Act. 2017<br>• Community Event- based activities<br>• Establishing linkages to meet demands beyond HIV/AIDS /STI services<br>• Referral and linkage to appropriate social entitlements<br>• Advocacy towards addressing issues of stigma and discrimination.<br>• Trained professionals of all types (medical staff, counsellors, outreach workers, peer educators etc) | • Advocacy with key stakeholders<br>• Congregational events<br>• Levering support of community champions | FSW, PWID, MSM, TG/H, Migrants, Transport Workers, PLHIVs and OVP | • Advocacy with PRI Members, Sensitization of SHGs, Village Health, Sanitation and Nutrition committee (VHSNC) on HIV and AIDS related stigma.<br>• Use of VHND and as platforms to address HIV/ AIDS-related stigma<br>• Use of U=U messages to dismantle stigma and discrimination related to HIV testing<br>• Develop linkages with AWC and SHGs to talk about various risks and vulnerabilities (poor economic conditions, poor condom negotiation skills, high-risk sexual behaviour of the migrant spouse etc.) with the target population<br>• Develop linkages with Community Health Officers in ABHWC (Now - Ayushman Bharat Arogya Mandir) and sensitize them on HIV/ AIDS and STI.<br>• Referral and linkage for appropriate social entitlements.<br>• Awareness generation on HIV/AIDS Control Act. 2017.<br>• Awards and recognition for Villages and CLW staffs to sustain motivation |

## 4.3: Outreach Strategy

Outreach is the essential element under the LWS to create a demand, increase coverage and provide services in the rural areas to the target populations.

### 4.3.1: Components of Outreach

The outreach by CLWs consists of five components that will ensure that outreach is implemented in a comprehensive manner.

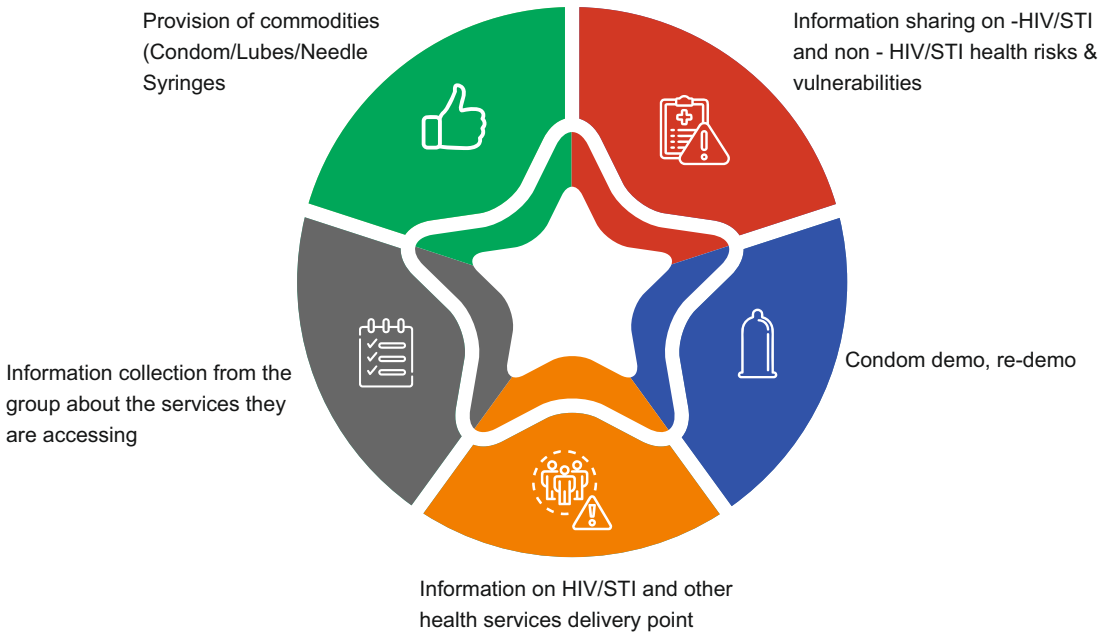



**Figure 12: Components of outreach activities in the LWS**

1. Information sharing on risks and vulnerabilities and on HIV/ STI along with other health issues of the target population in the rural context.

2. Condom usage and demonstration by the staff and re-demo by the HRGs, migrants or mobile population.

3. Sharing of information related to HIV/STI prevention, testing and counselling, importance of HIV testing spouse and injecting/sexual partners, ART, Condom delivery points, SDNS sites, ABHWCs etc.

4. Information collection from the target population on services they are accessing, and on issues related to availability or accessibility.

5. Provision of condoms is made through multiple sources under LWS that include linkages with ANM, Condom Social Marketing and free distribution.

### 4.3.2 : Outreach Plan under LWS

The outreach plan would be prepared by the supervisor on a quarterly basis with the support of Cluster Link Workers (CLW) and based on the data of pervious or existing services offered in the area. Based on the plan, outreach activity to be conducted at the convenience of the target population so as to increase the yield in the programme in terms of testing and treatment of beneficiaries, improving access to ART medicines and VL suppression including LFU follow-up, behavior change, and reduction of stigma and discrimination etc. in the rural context.

- One on one sessions: One-to-one outreach session can be conducted in the homes of the target population, or at an agreed place.
- One -to- group sessions: For one-to-group sessions, the preferred location could be the information centre, during group meetings at the youth clubs, SHG meetings, mothers' meetings, near the worksite or weekly market, in the ANM/ Anganwadi centre or any other preferred place.

The frequency for the development of the outreach plan needs to be based on the risk pattern and service requirements of the target population. Unreached HRGs or 'At Risk' population, who are operating through virtual platform (including in the dating platforms), through Network Operators or who are engaged in the Spa/ Massage parlours in the rural areas to be reached out to as per the strategy envisaged under the "Standard Operating Procedure for Reaching Out to the Unreached HRGs Operating at Spa/Massage Parlours, through Network Operator and at Web-Based Platforms under NACP" [61].

The outreach activity will be carried out by CLW or though Mobile/Bike outreach through home visits or in the sites convenient to HRGs/Bridge and Vulnerable Populations. Follow up of the services provided would be made via in-person visits or telephonic contact to ensure service continuum. The frequency of outreach to different category of target population under LWS would be as follows;

| Population | Frequency of Outreach |
|---|---|
| FSW | Monthly at least once for providing condoms, BCC and referral for testing. |
| MSM | |
| TG/ Hijra | |
| PWIDs | Weekly, in case the PWIDs have high injecting frequency (4-5 times per week). In other cases, twice a month for providing Needles/Syringes, BCC and referral for testing |
| Bridge Population | Monthly during home visits or return season of migrants |
| Other Vulnerable Population | Monthly at least once |
| PLHIVs | Monthly at least once for treatment literacy follow up on treatment adherence and for providing condoms<br><br>LFU follow-up, improving access to ART medicines if needed arrangements for home delivery of ART medicines |

Exception to the outreach activity frequency;

- In case HRGs are not staying in the LWS village but operate from the village (FSWs work from the village, PWIDs visit for injecting or picking up drugs, MSMs visit for high-risk activities) they need to be targeted during their availability in the village for service delivery and follow up. For follow-up, the concerned ASHA, AWW and ANM may be sensitized to provide condoms in the villages that the HRGs belongs to, however, they should not disclose the identity of the HRGs to their family or the general community. In case of PLHIVs residing in the villages, based on their convenience and consent, outreach can be done to understand (1) their risk pattern and use of condoms, Needles/syringes (2) ART adherence (3) Side effects and opportunistic infections management (4) issues faced with ART medicine pick-up (5) support for HIV testing of their spouses and partners. The frequency of the visit is at least once in two months or based on the need.

The suggestive format for development of an outreach plan is placed below;

| Places | | Mon | Tue | Wed | Thur | Fri | Sat | Sun |
|---|---|---|---|---|---|---|---|---|
| Household no 1,2,3,44 | No. of Target population | 0 | | | | | | |
| | Timings | | | | | | | |
| Weekly Vegetable Market | No. of Target population | | 18 | | | | | |
| | Timings | | 3pm-9pm | | | | | |
| Congregation points example “Pan Shop” | No. of Target population | | 25 including 5 from the above | | | | | |
| | Timings | | 12pm-3pm | | | | | |

### 4.3.3: Differentiated Outreach

Mobile ICTC van and Bikes for HIV counselling and testing services (HCTS) to be provisioned to augment the reach to far-flung and difficult to reach geographic terrain as well as hard to reach areas to provide testing and treatment facility tailored to the needs of the communities. Apart from the above, specific hotspots/sites/locations in the villages would be covered with the support of community volunteers along with their sexual /injecting networks to address the risk and vulnerability of HRGs.

The micro plans for mobile service delivery have to be prepared in consultation with DAPCU/DISHA and local health functionaries. The SACS will ensure Mobile Van and Bikes usage for provision of services for campaign, prevention, testing and treatment services, etc.

### 4.3.4: Demand Generation through Outreach

Establishing and ensuring strong linkages to the existing services under NACP are the cornerstone of the LWS. It is therefore, essential for the outreach component of LWS to create demand for services while also ensuring the availability and accessibility of those services. The LWS conducts several activities to ensure demand generation of services under the intervention. LWS employs the following key activities for SBCC and demand generation:

- IPC/ Group Session/Community Outreach: The CLWs contact the target population at hotspots or during home visits and provide information on HIV/ AIDS including information on behaviour change (condom use, HIV/ STI / Hep B&C referrals, safer injecting practices etc). The OVPs are contacted during community outreach.
- Mid-Media: Mid-media engages the audience in their own cultural context to deliver the messages. Mid- media activity includes street plays, IEC exhibitions, popular folk forms, musical programmes, games etc. [62] These activities are conducted by the CLWs and reach out to more than 8 people with content relevant to the group. NACO has developed typology specific SBCC package to be translated in local language by the SACS and provide to the interventions in the state for further dissemination to the relevant target groups.
- 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. These may be in the form of posters, pamphlets, hoardings, short films, short text messages, social media wall writings, posters, and danglers with specific messages. [63] SACS is responsible for implementing mass – media activities in their states.
- Outdoor activities: LWS effectively uses outdoor activities to disseminate information on HIV prevention and related services. [64] Activities include hoardings, bus panels, wall writing pole kiosks, information panels, and panels in railways and metro trains implemented by the State AIDS Control Societies, condom social marketing organisations of NACO. These

activities are conducted through respective SACS under the IEC activities.

- Condom promotion activities: Condom promotion activities for demand generation are an integral part of IPC/ group sessions, health camps, mid- media / mass media messaging. In the context of the LWS, the objective of condom promotion is to protect all sexual acts that can put someone at the risk of HIV and/or STI. LWS follows a three-prong approach of condom promotion: Free distribution of condoms in conjunction with Condom Social Marketing and access to condoms through ANM, ASHA under the family planning programme.
- N/S demand generation: The Guidelines of the LWS has a provision of commodity distribution including N/S. The CLWs talk about safer injecting practices and N/S during IPC/ group sessions with the PWIDs and inform them about the availability of N/S

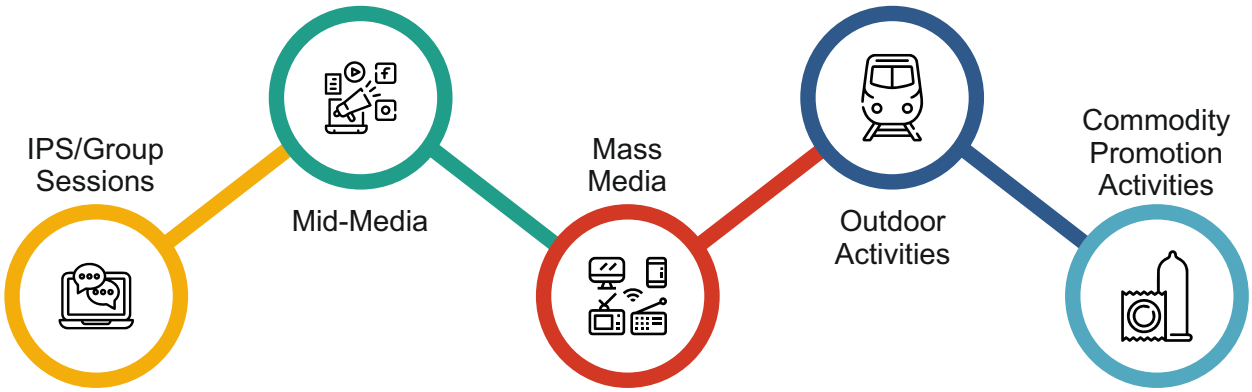



**Figure 13: Activities Conducted for Demand Generation under the LWS**

**Demand Side**

- Identify households and target groups by site mapping.
- Differentiate risk and service requirements.
- Conduct outreach, and provide information about services.

**Referral and Follow Up**

- Create referrals based on requirements.
- Follow up and ensure the referrals are linked to services

**Supply Side**

- Sensitise the service providers.
- Coordinate with service providers to ensure quality of services provided.
- Monitor the linkage

**Figure 14: Three- Step Demand Generation Strategy**

- **Demand Side:** Demand generation for HIV/STI services is created through the following steps:
    - 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.
- Referrals and follow ups: Once the demand for specific services is created, referrals are made for the target population to access those services. CLWs conduct follow-ups to verify that the referred target group has utilized the services.
- **Supply Side:**
    - Coordinate with relevant service providers including ABHWC (now Ayushman Bharat Arogya Mandir), PHC / CHC, nearest NACP facilities to ensure availability of services
    - Effective linkage and referral monitoring by maintaining referral slips by the ABHWC PHC/ Sub-centre and ensuring cross-checking.

## 4.4: Line Listing of Target Population

Activities under LWS Intervention encompass both outreach and service delivery. While outreach activities target a large segment of the populations at identified locations. The service provision is tailored for those individuals who are identified as high-risk within the populations.

For the purpose of the LWS intervention, the identified target population will be line listed based on their consent. This line list will then be used to ensure provision of comprehensive services, tailored-made to their specific needs.

## 4.5: Clinical Services

The service delivery model of the LWS embodies one of the core guiding principles of NACP V, i.e to break the silos and building synergy. Synergies are created through it's linkage model which leverages the existing public health infrastructure to provide various HIV and non-HIV health related services. The revised guidelines endeavour to augment the model by contextualizing the linkages in the current public health eco-system.

Under the revised Guidelines, the delivery of health-related service for HIV & STI treatment and management, condom distribution, OST and referral for Hepatitis B & C would be augmented through leveraging support of rural health infrastructure and establishing linkages with existing public health systems.

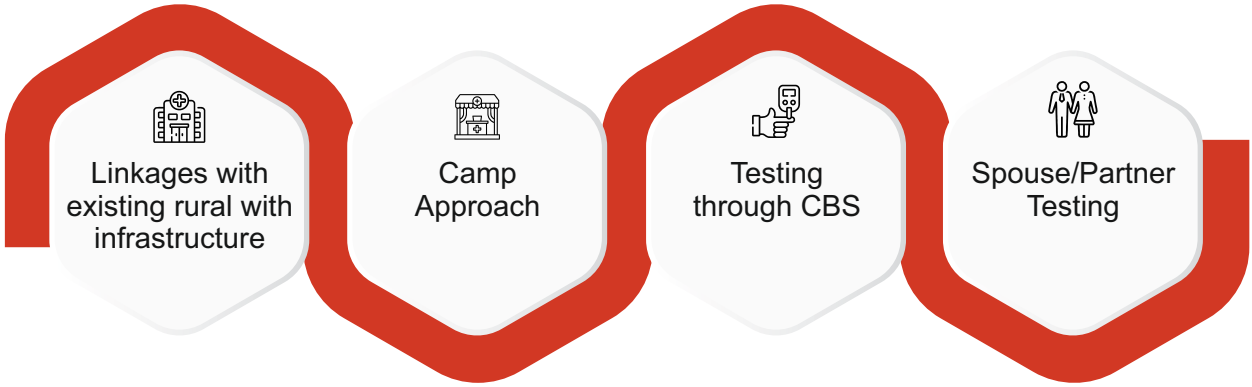



**Figure 15: Clinical Service Model under the LWS**

### 4.5.1: Leveraging Support of Rural Health Infrastructure (Health and Wellness Centre, PHC, CHC and Sub Divisional Hospitals)

Creating synergy with existing health interventions to amplify impact underlines the core concept of the revised LWS Guidelines. Synergies would be created by establishing linkages with health interventions, de-addiction centres, Ayushman Bharat Health and Wellness Centres (ABHWC) / Ayushman Arogya Mandir , Community Health Centres ( CHC), Primary Health Centres ( PHC) and Sub-Divisional Hospitals (SDH).

- Linkages with Health and Wellness Centre(HWCs): Health & Wellness Centres (HWCs) are created to deliver Comprehensive Primary Health Care, that is universal and free to users, with a focus on wellness and the delivery of an expanded range of services closer to the community. HWC are envisaged to deliver expanded range of services that go beyond maternal and child health care services to include care for non -communicable diseases, palliative and rehabilitative care, oral, eye and ENT care, mental health and first level care for emergencies and trauma, including free essential drugs and diagnostic services.

The expanded range of services provided under ABHWC/ Ayushman Arogya Mandir include [65]:

1. Care in pregnancy and childbirth
2. Neo-natal infant health care services
3. Childhood and adolescent health care services
4. Family planning, contraception services and other reproductive health care services
5. Management of communicable diseases, National Health Programmes
6. Screening, prevention and management of NCDS and chronic communicable diseases like leprosy.
7. Basic oral healthcare
8. Care of common ophthalmic and ENT problems.

9. Screening and basic management of mental health ailments.

10. Elderly and palliative health care services

11. Emergency medical services including burns and trauma

12. Screening and Basic management of Mental health ailment

The services envisaged at the HWC level will include early identification of HIV, basic management, counselling, ensuring treatment adherence, follow up care, ensuing continuity of care by appropriate referrals, optimal home and community follow up, and health promotion and prevention for the expanded range of services.

The outreach team under LWS would coordinate with HWC team to provide services to the beneficiaries and organise health camps.




**Figure 16: Service Package Offered under ABHWC / Ayushman Bharat Arogya Mandir** [66]

- **Community Health Centres:** Community Health Centres (CHCs) in India are a vital part of the country's healthcare system. These centres play a crucial role in providing primary healthcare services to rural and underserved communities. CHCs constitutes the First Referral Units(FRUs), and the Sub-district and District Hospitals. CHCs provide the following services:
  - Provision of medical care (diagnosis and treatment of common illnesses)
  - Speciality clinical services including hospitalisation
  - Maternal & child health including family planning
  - Prevention and control of locally endemic diseases
  - Implementation of relevant health programmes
- **Primary Health Centre:** Primary Health Centres (PHCs) are the cornerstone of India's healthcare system, with a primary focus on serving rural communities. These centres serve as essential hubs for delivering fundamental healthcare services, making them the initial touchpoint for medical care within the population. PHCs provide the following services.

- Immunization
- Ante natal/ post-natal care
- Family planning services
- Child health services
- Preventive services of communicable diseases (TB, malaria etc.)
- Health, education and awareness

- **Linkages with ANM and ASHA:** Sub- centres are at the base of the three-tier rural health infrastructure system. It is the most peripheral and first contact point between the primary health care system and the target population. Each sub-centre is required to be manned by at least one ANM. ASHAs are at the core of the National Health Mission (NHM) to address the healthcare needs of the people, with a particular focus on the rural population. ASHA serves as a link between the community and the public health system.
- **Linkages with AWW:** Rural infrastructure is bolstered by various interventions under the Ministry of Women and Child Development. Anganwadi is a child and health care system in India, initiated by the government to promote nutrition, education and health care to pregnant mothers, lactating mothers, children below 6 years of age and adolescent girls, particularly in rural areas. Anganwadi workers in India are the first point of contact between organized health care and the households in rural India. The responsibilities of these workers include caring for the health and well-being of nursing women, children and socio-economically deprived groups [67]. This will help in supporting Child Living with HIV for nutrition and continue support the families.

Apart from the three-tier health care system, LWS would strengthen linkages with Adolescent Friendly Health Clinics (AFHC) and drug de-addiction centres implemented by the Government of India:

- **AFHC:** AFHCs serve as the primary care services for adolescent issues. AFHCs are established at the levels of CHC/SDH/DH and Medical College where services are provided on daily basis. A dedicated counsellor is available on all days at higher facilities – CHC and above. AFHC covers a broad spectrum of services including RTI/ STI management, HIV testing and counselling, NCD treatment, counselling on sexual & non- sexual issues etc [68]. AFHC is an integral part of service delivery at the AWCs.
- Drug- De-addiction Centres: Ministry of Social Justice and Empowerment ( MoSJE) runs 'Nasha Mukt Bharat Abhiyaan '(NMBA) in 341 identified vulnerable districts [69]. MoHFW also runs National 'Drug De-Addiction Programme (DDAP) in 64 hospitals across the country [70].
- **Linkages with relevant line departments:** Linkages would be developed with non- health departments for accessing services pertaining to livelihood, education, housing, migrant

information etc. For more details, please refer to section 5.9.

To ensure better coordination and integration of health services, it is envisaged to conduct monthly meetings in the district with Community Health Officer.

### 4.5.2: Camp Approach

- **Health Camp:** The health camps are largely aimed at returning migrants, their spouses/partners, as well as incoming and future migrants. Festivals act as gateways for the bridge population to return home. The introduction of an extensive package of health and communication initiatives would reach the greatest number of migrants and their spouses during the festival time. Providing health services at the doorstep would remove the hurdles to receiving these services. During the health camp, the following services will be accessible:
    - General Health check-up facilities and provision of medicines
    - Antenatal check-ups and immunization can also be provisioned
    - Condom Promotion Activities
    - HIV & STI Information, Education and Communication Activities
    - HIV & STI counselling
    - Inter- Personal Communication/ Behaviour Change Communication
    - HIV Screening facilities
    - Linkages to TU and ICTC
    - Health Exhibitions
    - Access to condoms
- **Integrated Health Campaign (IHC):** Integrated Health Campaign is a multi-sectoral approach which is conducted in collaboration with the key programmes under NHM- National TB Elimination Programme ( NTEP), National Viral Hepatitis Control Programme ( NVHCP) for providing screening/ testing and linkages to treatment for STIs, HIV, TB, Hep B & C and other non- communicable diseases. IHC is a combination of fixed/ static health camps and extended outreach activities to provide a comprehensive package of services beyond HIV detection and treatment to attract all the hidden and unreached population.

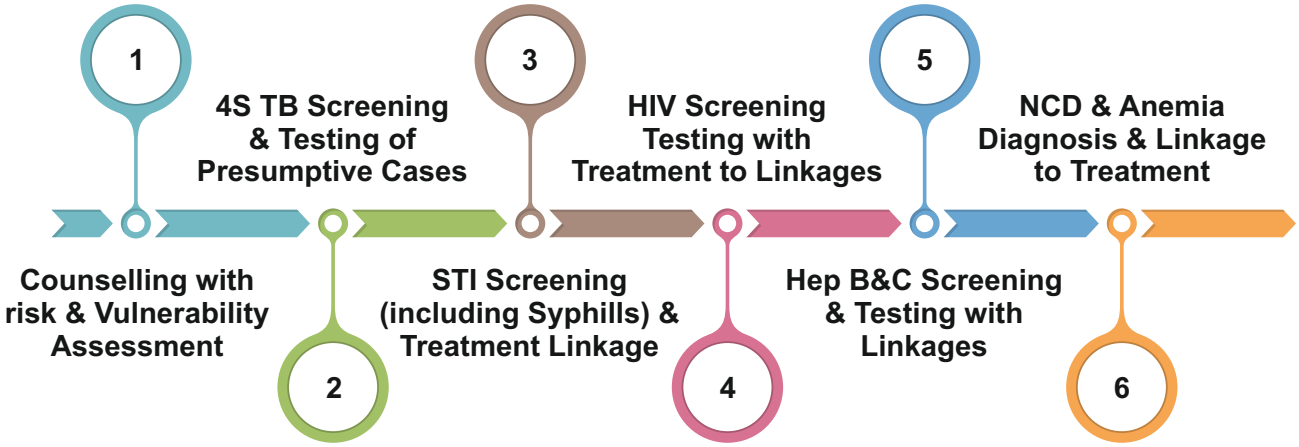



**Figure 17: Comprehensive Package of Services under IHC**

NACO has developed a Standard Operating Procedure (SoP) to conduct integrated health campaigns in selected geographies in the state. The document titled "Standard Operating Procedure for reaching out to At-Risk Population for Screening /Testing and Linkages to Treatment of (STI, HIV, TB & Hepatitis B & C) through Hybrid Outreach Approach, May 2023)" details out the modalities of conducting health campaigns, service packages, referrals and linkages and leveraging the support of various stakeholders.

### 4.5.3: Community-Based Screening (CBS)

CBS is an important approach for improving early diagnosis, reaching first-time testers and people who seldom use clinical services, including men and adolescents in high-prevalence settings and HRG populations. It provides an opportunity to meet the target group in their preferred setting and cover the un reached target population. CBS is a significant technique for improving early detection by targeting first-time testers and persons who rarely use clinical facilities, such as men and adolescents in high-prevalence areas. CBS would adhere to the procedures described in NACO's National HIV Counselling and Testing Services (HCTS) Guidelines71.

The LWS would leverage facilities under the other existing programmes of NACP to strengthen the component of clinical services.

Mobile ICTC vans: The provision of mobile ICTC vans along with other activities may be planned to provide HIV testing and counselling services at least twice a year and should ensure 80% of the HRGs are tested.

CBS kits by DISHA/SACS: The LWS Project shall be supplied with CBS kits by the DISHA / SACS, and this can be used for screening the target population (at least 50% of the target population can be screened once in a year using CBS kits). Tracking mechanism for migrants who migrate to high prevalent States and are back home more than once a year.

### 4.5.4: HIV testing of Spouses/ Partners of Index Cases

HIV testing of spouse/ partner of the index cases would be made to break the cycle of transmission. Spouse and Partner testing is a highly recommended approach for increasing community reach and testing coverage of unreached HRGs and their sexual and social partners. Tracing the sexual partners of PLHIV is feasible and beneficial in finding people with undiagnosed HIV infection. HIV testing among index HRGs's sexual partners, spouses, and social networks is done using either voluntary or facilitated partner notification, wherein the target population will be assisted/counselled in referring their partner for HIV testing. CLWs would ensure that voluntary testing is encouraged and confidentiality is maintained. For more details, please refer to the index testing guidelines of NACO (October 2023).

### 4.5.4: Follow up with post–release incarcerated populations (Prison and Other closed settings)

Follow-up with the post-release inmates by CLWs is a new element introduced under the revised guidelines. The Strategy document on Prison Intervention and Other Closed Settings – 2023 provides for the linkage of post-release inmates and their families with the services of NACP and its follow-up. The revised Guidelines bolsters this effort by making the provision of follow up by CLW with the post- release inmates and their families to ensure their access and that they are availing the relevant services under NACP.

## 4.6: Referral and Linkages

Strong referral and linkage for both health and non-health aspects of the target population forms the foundation of LWS. The revised Guidelines expand the scope of referral and linkages under the scheme beyond the scope of HIV services. Referral and linkages under the scheme would be made on the following services /areas;

- **Referral and Linkage for STI, HIV and co-morbidities:** This would entail referral and linkage of target population for HIV/ AIDS, STI services, Tuberculosis (TB), and co-morbidities Hep B & C.
    - **HIV referrals:** All target population attending the health camp would be screened for HIV and the ones who screened reactive would be referred to ICTC.
    - **STI referrals:** All target population attending the health camp would be screened for STI symptoms. Any person who has experienced STI symptoms in the last three years would be referred to Designated STI/RTI Clinics (DSRC).
    - **Referral to OST centres:** PWIDs would be referred to the nearest satellite OST/ TI to be linked to one of the three models of OST dispensation. [72]
    - **Referral for hepatitis screening, diagnosis and treatment:** PLHIVs are at a higher risk of hepatitis. MoHFW has designated hepatitis screening and testing centres. All newly diagnosed PLHIVs would be referred to the nearest centre. [73]
    - **Referral for NCDs:** Target population would be referred to ABHWC (Now - Ayushman Bharat Arogya Mandir) for NCDs like hypertension and diabetes mellitus.
- **Linkages and coordination between LWS, TI , DISHA/ DAPCU and the respective SACS (source and destination)** between which population moves.
- **Ayushman Bharat Health Account ( ABHA):** ABHA ID is a tool designed to facilitate seamless service delivery and ensure treatment continuity for the intended beneficiaries. It allows for the digital sharing and evaluation of health records. For more details please visit PMJAY - Beneficiary Portal (nha.gov.in)

Comprehensive package of services under the LWS will be provided through the active engagement of the existing healthcare services as mentioned in the table below:

| Services | Referral Point |
|---|---|
| HIV Counselling and Testing | ICTC |
| STI diagnosis and treatment | DSRC |
| Condoms | Sampoorna Suraksha Kendras<br>One Stop Centres ( OSC)<br>ANM and ASHA to act as condom access points |

| Services | Referral Point |
|---|---|
| N/S | Free distribution under LWS |
| Lubes | Nearest MSM/ TG TI |
| Hep B & C | Designated Viral Hepatitis Screening and Testing Centres under National Viral Hepatitis Programme |
| Welfare Schemes | Portals of relevant departments |
| Non Communicable Disease | ABHWC (Now - Ayushman Bharat Arogya Mandir |
| Family planning and contraception | ANM |
| Care in pregnancy and child birth | AWC |
| Ante-Natal/ Post Natal services | AWC, PHC |
| Adolescent and child health | AWC |
| Mental Health ailments | ABHWC |
| Substance abuse | Designated de- addiction centres under MoSJE |
| Smoking/ tobacco consumption | District Hospitals |
| Non- formal education and nutrition | Anganwadi Centre |

## 4.7: Availability of Commodities

The revise Guidelines augment the clinical services by expanding the scope of commodity distribution by furthering condom promotion through free distribution of condoms alongside CSM and access to condoms through ANM and ASHA.




**Figure 18: Provision of Commodities under the LWS**

- Condom: SACS will distribute free condoms in addition to leveraging them from SSK, with ASHA and ANM serving as condom access points.
- N/S distribution: PWIDs are at a greater risk of contracting HIV if they use and share needles, syringes, or other drug-injecting equipment. As part of the overall Harm Reduction strategy, to prevent HIV amongst PWIDs, NACP promotes safer injecting practices through its Needle Syringe Exchange Programme. Provision is made for SACS to provide free N/S to PWID as per the requirement by developing linkages with the nearest PWID TI. In such cases the PWID would be registered under the TI and provided services by LWS.
- Existing guidelines under the National Programme for the collection of needles /syringes and biomedical waste management for Secondary Distribution of Needle and Syringes (SDNS) to be used.
- **OST:** The revised Guidelines provides for easy access of OST to rural PWIDs through a two- fold approach:
    - **Creation of Satellite OST Centres:** OST is provided to PWIDs who want to transition from injecting. Under the revised Guidelines Satellite OST Centres would be established in PHC/ ABHWC (Now- Ayushman Bharat Arogya Mandir) guided by the Standard Operating Procedure for Buprenorphine-based Opioid Substitution Therapy under NACO for easy access to OST under LWS.
    - **Community Support Group:** In areas where there are PWIDs on OST, a community support group to be formed and take home OST can be given to the stable clients.
- Lube: MSM, TG/H will be connected to the nearest TI.

## 4.8: Enabling Environment

A crucial focal strategy for successful implementation of a healthcare programme is to create an enabling environment. The actions listed below will be conducted to create an enabling environment.

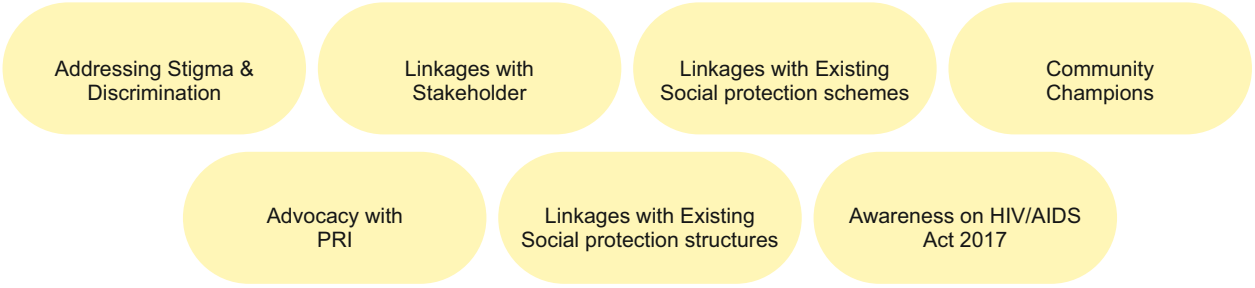



**Figure 19: Activities under the enabling environment**

- **Addressing stigma and Discrimination:** PLHIVs frequently encounter stigma and discrimination. This is further extended families of PLHIVs and marginalized groups including HRGs and KPs. Stigma often leads to negative consequences including loss of income and livelihood, loss of marriage and childbearing options, poor care within the health sector, withdrawal of caregiving in the home, loss of hope and feelings of worthlessness, loss of reputation. Fear of these consequences keep people away from seeking HIV information, adopting preventive behaviour, getting tested, disclosing their sero-status and accessing treatment. As a result, addressing stigma and discrimination is a cross cutting strategy under NACP. Under LWS , stigma and discrimination is addressed in multiple ways :
    - Working with front line staff of NHM: 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.
    - Utilizing existing community platforms to sensitize of stigma and discrimination. The various rural community structures and mechanisms like VHNC, Anganwadi Centres, RRC, 'gram' and 'aam sabhas' can be utilized to sensitize the public on HIV.
- **Linkages with stakeholders:** Stakeholder mapping would be done to identify important organizations / influential persons who could facilitate smooth service delivery under the intervention. Connections with community and opinion leaders, panchayat members, and frontline health functionaries would be developed for the smooth execution of the LWS. Advocacy meetings with Medical Officers to sensitize Community Health Officers in ABHWC ( Now - Ayushman Bharat Arogya Mandir) on HIV/ AIDS .
- **Advocacy with the PRI:** Advocacy with the PRI will ensure the highest level of commitment for HIV at the panchayat level, increase community ownership and participation and enhance effective coverage of the population.
- **Linkages with existing community structures:** Linkages with the existing platforms of SHG, Village Health and Nutrition Day (VHND), youth clubs, and Red Ribbon Clubs would be developed and strengthened to provide knowledge and skills for minimizing risk-taking behaviour and improving health-seeking behaviour. These would be also used as platforms to address HIV/ AIDS related stigma.
- **Linkages with welfare and social protection and other facilities:** Linkage with existing social protection schemes and programmes contribute to enhancing individuals' quality of life. They are also a successful means of responding to the broader demands of the target groups. Apart from the fundamental HIV-related services, the LWS programme has the provision of linking PLHIV or beneficiaries to various social services and welfare schemes. The intervention facilitates easier access to the government's social security and welfare programmes. This will enable access to relevant information related to migration. The outreach worker will ensure linkages of the target group to eligible schemes.

- **Awareness on HIV/AIDS ACT-2017:** The HIV and AIDS (Prevention & Control) Act, 2017 is a central legislation protecting and promoting the rights of persons infected with and affected by HIV and AIDS. Awareness on HIV/AIDS Act would be an integral part o creating an enabling environment.
- **Community Champions:** Communities have always been at the centre of the NACP. The concept of community champions is an acknowledgement of a more meaningful role of the communities in achieving the goals of the programme. Community voices, create opportunities across different typologies of key populations, vulnerable groups and PLHIVs to engage as per their strengths and create structured engagement processes within the NACP. Currently, the Community Champion is a voluntary position where Community Champions are individuals from the Community (key population, PLHIV and vulnerable groups) who are willing to play an active role in the National Programme and actively support or defend the cause of their community. LWS implementing organization should take active part in submitting the nominations in line with the Standard Operating Procedures on Identification of Community Champions under Community System Strengthening- 2022. Priority may be provided to the nomination of village-level Community Champions from hard-to-reach and challenging geographies in the rural context that have high vulnerability and prevalence. Community Champions under LWS would primarily be engaged in the following activities:
    - Exploration of sexual and injecting network of the target groups
    - Awareness on the HIV/ AIDS Act, 2017 in the community.

## 4.9: LWS Implimentation in the North East

The implementation strategy and mechanism of the Link Workers Scheme in the North-Eastern states would be informed by the geographical realities, drivers of the epidemic and the HIV prevalence rate.

The guidelines adopt a multiprong strategy to reach out to the rural population in north-eastern states:

- Link Worker Scheme: The priority districts in every north- eastern state would be reached out through the LWS.
- Intensive and integrated health camp approach: For the geographies untouched by the LWS, intensive and integrated health camp approach linked with referral for testing and treatment services. Would be organized. The health camps will be organized in partnership and close coordination with the local government authorities at the district level.
- N/S exchange and linkages to OST: Needle/ syringe distribution and linkage with OST centres would be a high priority in districts with IDU programme requirements.

### 4.9.1: Mobile Outreach in Challenging Geographies

Mobile outreach is suggested to increase access to services under the National AIDS Control Program (NACP) and other related health services for the at-risk /vulnerable/high-risk or unreached populations in underserved areas. The focus is shifted from facility-centric to community/client-centric HIV prevention and treatment services. Under NACP, mobile ICTC van and Bikes for HIV Counselling and Testing Services (HCTS) is provisioned to support reaching out to far-flung and difficult to reach geographic terrain as well as hard to reach areas to provide testing and treatment facility tailored to the local need.

The micro plans for mobile service delivery to be prepared in consultation with DAPCU/DISHA. Further, an approved monthly plan with coverage report to be reviewed regularly. State to ensure Mobile Van and Bikes usage for provision of services for campaign, prevention, Testing and Treatment services etc. The following services would be provided through the mobile outreach;

- Comprehensive Prevention Services
- Differential HIV Screening/Testing
- HIV and STI treatment services
- Other health services as deemed feasible and appropriate

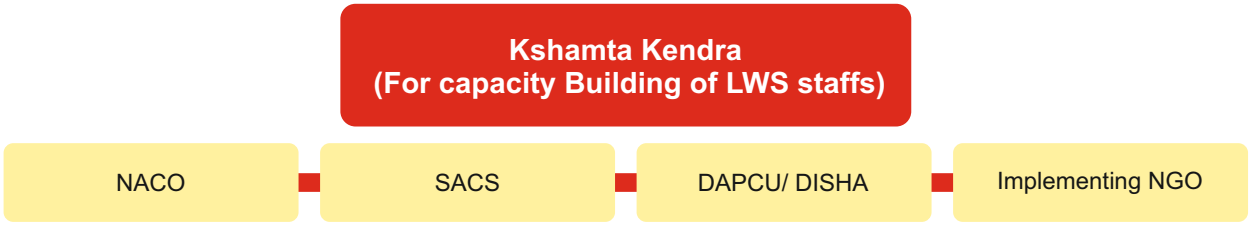
For more details, please refer to the Mobile Outreach Service Guideline issued in October 2023.



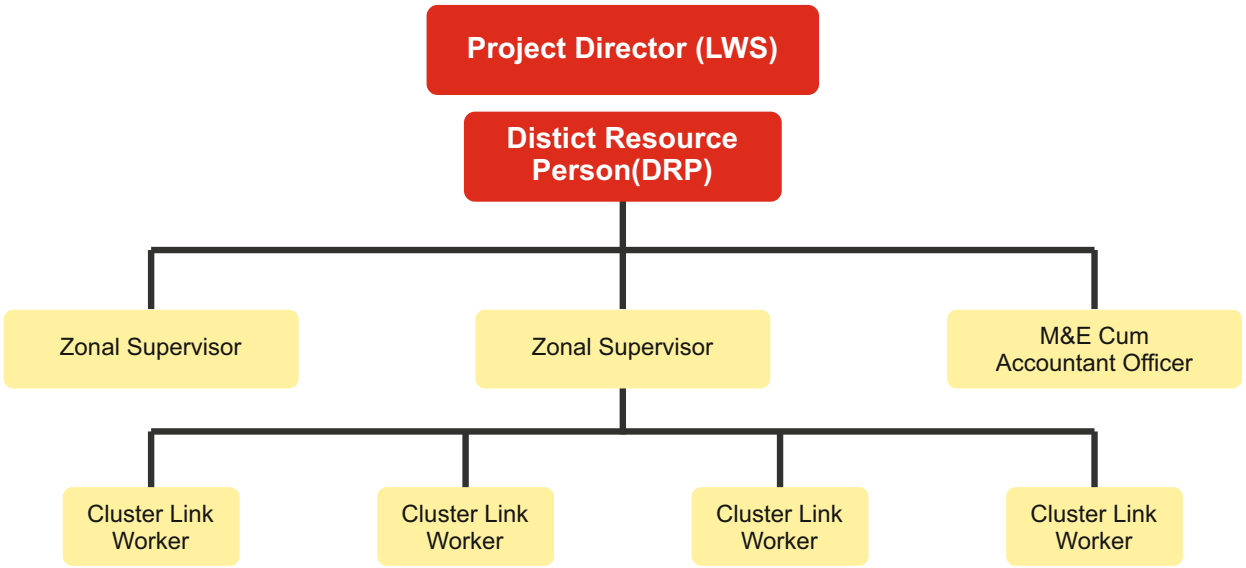
# CHAPTER 5: ROLE OF KEY IMPLEMENTING PARTNERS

## 5.1: Organogram of the LWS

### 5.1.1: Organogram of Programme Management under LWS




### 5.1.2: Organogram of the Implementing NGO /CBO




The collaborative coordination of the HIV response and management of implementation by NACO and implementing partners ensure 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.

## 5.2: Role of NACO

NACO being the nodal agency would be responsible for policy guidance and overall supervision for effective implementation. Specific responsibilities include:

- Provide policy level support and an enabling environment for the implementation of the programme, through liasoning with various other line ministries and facilitating their cooperation in implementing the project on the ground.

- Provide guidance to implementing partners for the implementation of the programme in consonance with the revised Guidelines
- Coordination with SACS and DAPCU/DISHA to ensure adequate technical support to the programme as well as ensure quality implementation across the states.
- Conducting regular review meeting at the national level to assess performance of the intervention at the ground. This will be done during the Project Directors, SACS meetings.
- Evidence building around estimates, prevalence and behavioural parameters of at-risk and vulnerable populations in rural settings including their service utilization pattern such as ART uptake, TB and HIV co-infection rates.
- Guide implementing partners in impact and outcome assessment and support for mid-course corrections.
- Provide guidance in developing a training curriculum, training resources, and communication materials.
- Develop a pool of resource persons for capacity building
- Provide guidance in ensuring the supply of condoms, needles and syringes for the LWS and coordination among various services and programmes for the target groups.
- Ensuring regular fund flow to SACS that will facilitate uninterrupted funds availability for implementation.

## 5.3: Role Of SACS

The role of SACS will be to facilitate the smooth implementation of the programme as per National Guidelines. The scheme would be managed by Prevention Division at SACS and at the district level by DAPCU/DISHA. The broad areas include:

- Selection of NGO/CBO partners as per the guidelines.
- Ensure timely implementation of the various activities as per the agreed timelines.
- Facilitate coordination between district functionaries (ICTC/ DSRC, TI etc.) and the implementing NGOs/CBOs.
- Conducting regular monitoring/review meetings with implementing partners with the help of DAPCU/DISHA.
- Technical guidance to DAPCU/DISHA for SNA, Stakeholder mapping, rotation and sustainability strategy.
- Coordination with Kshamta Kendra for capacity building of implementing partners.

- Liaison and advocacy with various line departments connected to varied aspects of the target population and mainstreaming HIV/STI activities to increase easy access to HIV services.
- SACS to facilitate coordination with NHM, RCH, NPCDCS, NVHCP for integrated activities and monitoring of LWS activities
- Ensure the availability of commodities under the LWS.

## 5.4: Role of Mentoring and Technical Support by DAPCU/DISHA

DAPCU /DISHA will be responsible for providing Technical Support to the LWS. They will provide strategic and implementation support in 4 key areas:

- Ensure handholding and mentoring support in coordination with SACS to the LWS for SNA and mapping exercise before the initiation of the intervention.
- Ensure capacity building of LWS staff engaged in offering ITS.
- Ensure handholding and mentoring support to the LWS for service delivery and outreach planning of the intervention.
- Ensure district-level coordination among various agencies directly or indirectly linked to the smooth implementation of LWS and update on the progress of the activities in the District AIDS Prevention and Control Committee(DAPCC)
- Build coordination mechanism at district level with DHO/CMHO for integrated health campaign involving NHM, NTEP, RCH etc.
- Conduct monthly review meetings of the implementing NGOs at the district- level.
- Conducting regular monitoring visits to NGO/CBO sites and HRG hotspots.
- Offering technical support to intervention staff during field visits

## 5.5: Role of Implementing NGO

The implementing partner will play a crucial role in the direct delivery of quality services at the field. Following are the critical roles that will be played by the implementing partner.

- Selection and appointment of staff.
- Conducting situation needs assessment and planning.
- Implementation of LWS as per the implementation plan.
- Regular capacity building of staff members.
- Regular capacity building of community stakeholders including contractors, agents, self-help

groups, panchayats, etc.

- Establish linkages with community systems and other local service providers
- Ensure the coordination with other implementing agencies along the corridor of migration
- Timely submission of programme and financial reports to SACS through DAPCU/ DISHA
- Network with allied line departments to ensure access to various welfare schemes and entitlements for the target population.

## 5.6: Role of TI Training Institute (Kshamta Kendra)

Training to LWS staff would be provided through TI training institutes (Kshamta Kendras) established under the support of GFATM. The Kshamta Kendras will play the following roles:

- In coordination with SACS, develop the training load matrix for each States
- Develop down training calendar and budget based on the training load matrix
- Build and update the capacity of the master trainers for LWS
- Roll out the down-training for LWS staffs as per the training load (Refresher and Thematic Training)

# CHAPTER 6: DOCUMENTATION, MONITORING AND EVALUATION

NACP phase- V has a strong system for documenting information at every stage. This is crucial for overseeing all procedures and maintaining high standards of quality control.

## 6.1: Documentation by the Cluster Link Worker

The CLW would maintain the following documents under the LWS:

- Daily Diary: The CLW should keep detailed records of the activities carried out in the field in their daily diary. Record of the number of target population members met vis- a vis the planned activity for each day should be documented. The daily diary should also have the list of target population individuals who need to be followed up.
- Line listing and service tracking sheet: Details of target population individuals who are referred for various services.
- Referral and linkage register: CLWs should fill the reference and linkage register on a monthly basis. This register provides category-wise information on linkages to services and social protection schemes.

## 6.2: Documentation Under the LWS

An indicative list of the documents to be maintained are listed below. As the program has many activities the details of the register to be maintained will be highlighted in the capacity-building modules.

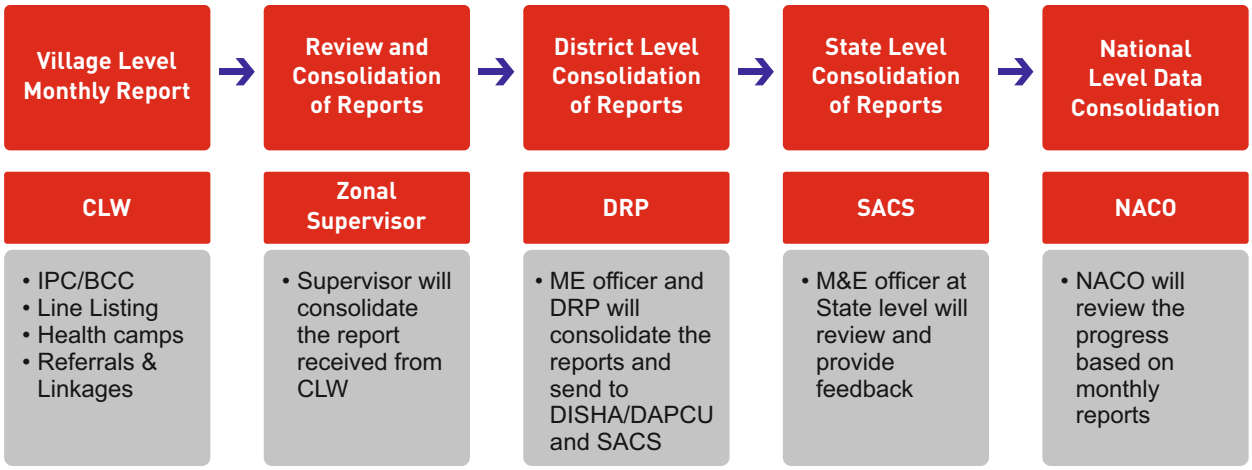
| Sr. No. | Types of Report | Responsibility | Frequency |
|---|---|---|---|
| 1 | Daily Diary | Cluster Link Worker | Daily |
| 2 | Monthly Plan | Cluster Link Worker | Monthly |
| 3 | Line List of FSWs, IDUs, MSM, TGs, Transport Workers Migrants, PLHIVs, OVP | Cluster Link Workers supported by Zonal Supervisor | As and when a new contact is made. |
| 4 | Resource mapping | Cluster Link Workers supported by Zonal Supervisor | Annual |
| 5 | Stakeholder mapping & analysis | Cluster Link Workers supported by Zonal Supervisor | Annual |
| 6 | Advocacy Meeting Register | Cluster Link Workers supported by Zonal Supervisor | Annual |

| Sr. No. | Types of Report | Responsibility | Frequency |
|---|---|---|---|
| 7 | Mid Media Register | Cluster Link Workers supported by Zonal Supervisor | Monthly |
| 8 | Referral and Linkage monitoring | Supervisor supported by DRP and M&E cum Accounts Officer | Fortnightly |
| 9 | Stock and Issue | Cluster Link Workers supported by Zonal Supervisor | Weekly |
| 10 | Stock and Issue at District | M&E cum Accounts Officer | Fortnightly |
| 11 | Field visit | Supervisor, DRP | As per requirement |
| 12 | Meetings | Any staff member | As per requirement |
| 13 | Human Resources | M&E cum Accounts Officer | Monthly |
| 14 | Monthly reporting in SOCH | M&E cum Accounts Officer | Monthly |
| 15 | Accounts and Finance | M&E cum Accounts Officer | As per requirements |
| 16 | Monthly analysis report for each Supervisor | M&E cum Accounts Officer supported by DRP | Weekly once for supervisors on a rotation basis |

## 6.3: Data Flow

The data flow process in LWS follows a bottom-up approach. This means that the data is consolidated at each level to provide both micro and macro-level depiction. This approach ensures that the data is analysed in detail and then combined to provide a comprehensive view of the situation. The process is designed to provide a clear understanding of the data at all levels, from individual data points to the overall picture.

Strengthening Overall Care for HIV beneficiaries (SOCH) would be used for data entry under the revised operational guidelines of the LWS. Requisite formats would be developed under the LWS for various carder of project staff.




## 6.4: Monitoring & Evaluation

A robust monitoring system is critical for measuring progress and performance of the Link Worker Scheme. It will help in consolidating learning, taking corrective actions and ensuring accountability while implementing the project. The monitoring indicators used for LWS are largely process-oriented.

The major process indicators for monitoring are presented below;

| Sr. No. | Areas | Process Indicator | Frequency of Reporting | Source / Means of Verification |
|---|---|---|---|---|
| 1 | Outreach | No. of Villages Covered in the district | Monthly | Reporting Format |
| | | No. of Health camp conducted | Monthly | Reporting Format |
| | | No. of HRG contacted | Monthly | Reporting Format |
| | | No. of Bridge and Other Vulnerable Population Contacted | Monthly | Reporting Format |
| | | No. of PLHIV contacted | Monthly | Reporting Format |
| 2 | HIV Screening and Testing | No. of Beneficiary* screened for HIV | Monthly | Reporting Format |
| | | No. of contacts of PLHIV including biological children were tested for HIV | Monthly | Reporting Format |
| 3 | Linkages | No. of STI cases treated | Monthly | Reporting Format |
| | | No. of beneficiaries detected with HIV linked to ART | Monthly | Reporting Format |
| | | No. of PWID put on OST | Monthly | Reporting Format |
| 4 | Commodity Distribution | No.of condom distributed to beneficiary | Monthly | Reporting Format |
| | | No.of free Needles and Syringes distributed | Monthly | Reporting Format |

**Beneficiary means HRG, Bridge and Other Vulnerable Population and PLHIV covered under the Scheme. In case of PLHIV, number of contacts of PLHIV include biological Children were tested for HIV.*

The indicators above will be regularly monitored by SACS and DISHA/ DAPCU. During the monthly review meetings and supervisory visits by SACS/ DISHA/ DAPCU, the above indicators would be reviewed and reported to NACO. In addition, monitoring of the scheme includes;

- That LWS is implemented in alignment with the operational guidelines.
- That LWS has put systems in villages with an updated out-reach plan of CLW, service delivery mechanism including STI/ RTI/ HIV testing and linkages with DSRCs/ ART/ICTC, nearest TI for NSEP, OST and lubes are in place, networking and advocacy with stakeholders, commodity distribution (condoms, N/S, Lubes etc.) etc.
- That LWS has been making efforts to engage with different stakeholders towards addressing programme management issues, stigma and discrimination as well as overall improvement of the performance of the intervention.

The outcome of the scheme will be measured based on the consistent and correct use of condom andupdate of services by beneficiaries (testing, treatment and access to social security schemes, reduction of stigma and discrimination).

Besides above, every NGO/CBO implementing the LWS in the district will undergo a third party evaluation every two year with the prescribed tools and manuals of NACO to decide further continuation and discontinuation of the project. A new project will be evaluated in the third year.

# CHAPTER 7: CAPACITY BUILDING

The revised Guidelines aims to create a continuous process of capacity building and strengthening at all levels, which extends beyond training programs. The primary responsibility for staff capacity building will be with the implementing NGOs/CBOs, who will be chosen based on their extensive experience in the field. Training will be conducted in the local language and adapted to fit the cultural practices and ethos of the area. The training activities would be carried out by SACS and Kshamta Kendhra in coordination with the DAPCU/ DISHA and SACS officials.

The capacity-building inputs should include:

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

| | | | | |
|---|---|---|---|---|
| SBCC and BCC | Myths & Misconception | Sex and Sexuality | Community Outreach | HIV prevention, testing and treatment Counselling including of STIs and U=U |
| Stigma & Discrimination | Advocacy | Resource Mobilization | STI Management | Project Management |

**Figure 20: Various themes for capacity building under the LWS**

The "Hand Holding" or "Mentoring" visits carried out by the SACS 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:

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



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# ANNEXURES

## Annexure -1: Project Norms and Terms of Reference of the Link Worker Scheme

### District Resource Person

| Recruitment Criteria | |
|---|---|
| Education and Experience | S/he should be a Post graduate in any discipline of Social Sciences preferably with 1 year experience at district level programmes related to health, livelihood programmes, rural development, microfinance and HIV/AIDS programmes.<br>Graduate in any discipline of Social Sciences subject with minimum three years' experience in development / health sector at district level programmes related to health, livelihood programmes, rural development, microfinance and HIV/AIDS programmes. |
| Knowledge and Skills | • Familiarity with government health policies and programmes, Strong communication skills<br>• Ability to work in small teams, and flexible ways of working<br>• Proficiency in data analysis, reporting writing, case study compilation.<br>• At least 10 days in the field visit required.<br>• Overall management capacity to monitor, report and guide the team under him/her. |

**Functions / Key Results Expected**

- Over all responsibility of the programme in the district.
- Prepare SNA, risk and vulnerability profile of the district population with migration pattern, geo-mapping of HRGs.
- 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 and 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 SACS.
- 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/DISHA 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/DAPCU/DISHA or any other agency.

## M&E cum Accounts Assistant

| Recruitment Criteria | |
|---|---|
| Education and Experience | Graduation in Mathematics, Economics, Statistics and Commerce.<br>Trained in basic computer software applications.<br>Minimum of 2 years of work experience which includes:<br>• Experience in data management, monitoring and evaluations tools, data quality checks, analysis and interpretation of data on program performance.<br>• Maintaining financial records / accounts, knowledge and experience in health and social development sector will be an added advantage |
| Knowledge and Skills | • Proficient in computer data management and analysis using computer software<br>• Familiarity with government health policies and programmes Strong communication skills<br>• Ability to work in small teams, and flexible ways of working |

**Functions / Key Results Expected**

- 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/SETU/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.
- Preparation and submission of SOEs
- Support and maintain data capturing in such as SIMS, MITRA, SOCH, p-MPSE or any reporting format assigned by SACS/TSU/SETU.

## Zonal Supervisor (1 per 10-12 link workers)

| Recruitment Criteria | |
|---|---|
| Education and Experience | The Supervisor should be a Post-graduate in preferably Social Science. In case, a person with above qualification is not available, candidate with following qualification and experience may be considered:<br>Graduate in Social Science (only with regular course) with minimum two years' work experience in development / health sector at district level programmes related to health, livelihood programmes, rural development, microfinance and HIV/AIDS programmes. |
| Knowledge and Skills | • Familiarity with issues related to marginalized and vulnerability communities especially with HRGs and their families.<br>• Strong communication and mobilisation skills.<br>• Ability to work in small teams, and flexible ways of working.<br>• Proficiency in report writing, case study compilation.<br>• At least 10 days in the field visit required.<br>• Overall management capacity to monitor, report and guide the team under him/her in absence of DRP or any other task provided by the team. |

**Functions / Key Results Expected**

- Supervise works delegated to 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.
- To plan and conduct integrated health campaign for target population in the select villages
- 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 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)

| Recruitment Criteria | |
|---|---|
| Criteria | • The Cluster Link Worker selection should be done through a process of peer progression among the volunteers who are associated with the project by way of helping in community/Vulnerable population.<br>• The Cluster Link Worker should be from the respective or nearby block or villages. |
| Knowledge and Skills | • Should have strong communication skills and knowledge about community structures, community dynamics, power structures within and outside the community which controls the community.<br>• Ability to work in small teams, and flexible ways of working<br>• Ability to maintain simple field records and have attitude to work in a team to complete pending works.<br>• Should be a good community motivator and should have rapport building skills. |

**Functions / Key Results Expected**

- 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.
- Coordinate with Ayushman Arogya mandir staff for integrated health camps for target population including referrals to the nearest health facilities.
- 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

## Annexure- 2 (Format for line listing cum service tracking register)

**Line Listing of Link Workers Scheme**

Name of the district: Name of the CLW:

| Sl. No | Name | Name of the Village | Age | Sex( M/F/ TG) | Marital Status | Mobile No | Education | Occupation /Other alterate livilihood options | Category * | Types of Risk /Vulnerability | | | | | | | | | | Area of Operation/ Available hotspots | | | Whether he/she receives services from a TI or any other link Worker Villages or NACP facilities (If yes, write the Name of TI, Village and NACP facilities) | Uptake history | | Types of Service provided | | | | | | Mode of Service | | Referal Services | | | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | Types of Substance Use if any | Habit of using/sharing Injecting Drugs | No of injecting episode in a week | Have sexual relationship beyond Spouse and Partner | Have bought Sex in the past from a man, women or TG | Provided sex in the past in exchange of money, goods, favors or benefits | Experinced any STI symptoms in the past | Spouse or Pamter is PLHIV | No of Sexual Encounter in a week | Name of Hotspot/ Congregation site | Virtual Platform | | | HIV screening -1st | HIV Screening 2nd | STI services | Condom | Lubes | Needle & syringe | OST | Mode of service delivery ( Health camps/ CBS/ Referral to Facilities etc.) | ICTC referal | STI referal | Referal to OST Centres | Referal for Hepatitis screening diagnosed and treatment | Referal for NCDs- Ayushman Bharat Arogya Mandir) | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

* 1-FSW,2- MSM, 3-PWID,4-H/TG,5- Migrants,6- Transport Workers,7- PLHIV, 8-Other Vulnerable Population, 9- Spouses or Pamter of high risk groups and Bridge Population etc.). In case of above target population is not met with services for 3 months, the same may be dropped out for next quarter.

## Annexure- 3 ( Daily diary cum Outreach Register)

| Annexure-3 (Daily Dairy cum Outreach Register) | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name of the CLW | | | | | | Month: | | | | Year | | | | | |
| Name of the villages Assigned | | | | | | | | | | | | | | | |
| Activity Details | | | | Day wise activities and Service details provided | | | | | | | | | | | Remarks |
| | | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | |
| Name of the village(s) covered: | | | | For ex. Sasan , Kampla | | | | | | | | | | | |
| Activities Conducted (For Ex.IPC/Stakeholder meeting/ Mid media activity/Health camp /Risk assessment etc.) | | | | | | | | | | | | | | | |
| Sl. No | Name | Category | Place of Outreach | Service Provisions; Code: 1- contact/outreach,2-commodities Provided,3-Refer for HIV testing/Syphilis screening/TB/Hep B/Hep C/OST/ ART etc. 4-Index Testing of spouse /partner,5 -Social Security,7-Health Camps etc. | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Day wise Total population reached | | | | | | | | | | | | | | | |

## Annexure -4 (Referral and Linkage Register for CLW)

| Annexure - 4 (Referral and Linkage monitoring formats for CLW) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Name of the Cluster Link Worker: | | | | | | | |
| Name of the Block: | | | Name of the District: | | | | |
| Reporting Month: | | | Year: | | | | |
| Category of persons | No. of persons reached the confirmation sites/ICTC 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 OST | No. of persons received ART services | No .of Persons Screened /treated for Hepatitis | No. of persons linked with social benefits schemes |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| FSW | | | | | | | |
| MSM | | | | | | | |
| PWID | | | | | | | |
| TG/Hijra | | | | | | | |
| Migrants | | | | | | | |
| Transport Worker | | | | | | | |
| PLHIV | | | | | | | |
| Spouses of HRGs | | | | | | | |
| Spouses of Bridge Population | | | | | | | |

## Annexure- 5 (Referral and Linkages Register for Zonal Supervisor)

| 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 Month: | | | | | Year: | | | | | | | | | |
| Category of persons | No. of persons reached the confirmation sites/ICTC | | No. of persons visited/treated with STI (both Govt. and private) | | No. of persons tested for syphilis | | No. of Persons received OST | | No. of persons received ART services | | No .of Persons received treated for Hepatitis | | No. of persons linked with social benefits schemes | |
| | T | A | T | A | T | A | T | A | T | A | T | A | T | A |
| FSW | | | | | | | | | | | | | | |
| MSM | | | | | | | | | | | | | | |
| IDU | | | | | | | | | | | | | | |
| TG/Hijra | | | | | | | | | | | | | | |
| Migrants | | | | | | | | | | | | | | |
| Transport Worker | | | | | | | | | | | | | | |
| PLHIV | | | | | | | | | | | | | | |
| Spouses/ Partner of HRGs | | | | | | | | | | | | | | |

# Annexure- 6 (Health camp Register)

## Annexure 6 (Health Camp Register)

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name of the Zonal Supervisor: | | | | | Name of the village/Camp Site: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of the CLW(S): | | | | | Name of the District: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reporting Month: | | | | | Year: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sr. No. | Date (DD/MM/YYYY) | Name | Village | Gender | Age (In years) | HIV Screening | | STI/ RTI SYNDROMIC (DIAGONOSIS) (1-Yes, 0-No) | | | | | | | Others (specify) | Treatment (KIT PRESCRIBED) | | | | | | | Syphilis Screening | | Distribution of Condom | Others (if other treatment given-write the name of the | | | | | | |
| | | | | | | Reactive/Non Reactive | Referred to ICTC for Confirmation | 1-UD/2-ARD/3-CERVICITIS | Vaginal Discharge | GUD-Non Herpetic | GUD-Non Herpetic(Allergic to Pencillin) | GUD-Herpetic | Lower Abdominal Pain | Inguinal Bubo | | Kit-1 (Gray) | Kit-2 (Green) | Kit-3 (White) | Kit-4 (Blue) | Kit-5 (Red) | Kit-6 (Yellow) | Kit-7 (Black) | Reactive/ Non Reactive | Treatment Given | | | | | | |
| 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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## Annexure- 7 (Stock and Issue Register for CLW)

| Annexure -7 (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 and Syringes | | | | | | |
| | Socially marketed condoms | | | | | | |
| | IEC materials | | | | | | |
| | BCC materials | | | | | | |

## Annexure- 8 (Stock and Issues register at district level)

| Annexure-8_ (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 | 9 | 8=(6-7) |
| | Free Condoms | | | | | | | | |
| | Needles | | | | | | | | |
| | Syringes | | | | | | | | |
| | STI Colour coded kits | | | | | | | | |
| | Socially marketed condoms | | | | | | | | |
| | IEC materials | | | | | | | | |

## Annexure- 9 (Meeting activities register)

**Annexure - 9(Meetings register)***

(for various meetings including Village level meeting with Stakeholders, Meeting with Health department/Women and Child Development department, PRIs, District officers, Internal meetings etc.

| 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 |
| | | | | | | | |
| | | | | | | | |
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*For each meeting a new format to be used for reporting




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