LINK WORKER SCHEME OPERATIONAL GUIDELINES

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

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अपनी एचआईवी अवस्था जानें; निकटतम सरकारी अस्पताल में मुफ्त सलाह व जाँच पाएँ।
Know your HIV status; go to the nearest Government Hospital for free Voluntary Counselling and Testing.

INTRODUCTION

The Link Worker Scheme proposed under National AIDS Control Programme III has been designed specifically to address populations with high-risk behaviours (including High Risk Groups and Bridge Populations) with the premise that there are significant numbers in rural areas and we needs to be reach out to them in order to saturate the coverage of these groups. In addition the Scheme will cover young people.

The Operational Guidelines for the Link Worker Scheme have been designed to help the key functionaries of SACS, DAPCU and NGO in implementing the Scheme. The Guidelines present the framework for *what* to implement and *how* to implement. In preparing these Guidelines, thought has been given to State-specific variations in capacities and needs that may influence the roll-out of the Scheme. Implementers are urged to conceptualise the 'how' part to best respond to the risks and vulnerability patterns specific to their State and Districts.

These operational guidelines are supplemented by the Training Manual, Handbook and Job Aids, which are intended to strengthen the roll-out of the Scheme at different levels.

List of Acronyms

AIDS	:	Acquired Immuno Deficiency Syndrome
ANM	:	Auxiliary Nurse Midwife
ART	:	Anti Retroviral Therapy
ASHA	:	Accredited Social Health Activist
AWW	:	Anganwadi WorkerWorkers
BCC	:	Behavioural Change Communication
CBO	:	Community Based Organisation
CHC	:	Community Health Centre
CSO	:	Civil Society Organisations
DAPCU	:	District AIDS Prevention and Control Unit
DHM	:	District Health Mission
DOT	:	Directly Observed Treatment
DRP	:	District Resource Person
EAG	:	Empowered Action Group
EOI	:	Expression of Interest
GP	:	Gram Panchayat
HIV	:	Human Immunodeficiency Virus
HRGs	:	High Risk Groups
HRIs	:	High Risk Individuals
ICDS	:	Integrated Child Development Scheme
ICTC	:	Integrated Counselling and Testing Centres
LW	:	Link Workers
MoHFW	:	Ministry of Health and Family Welfare
MoHRD	:	Ministry of Human Resource Development
Monogamy	:	Monogamy is the custom or condition of having only one mate.
MoYAS	:	Ministry of Youth Affairs and Sports
MPW	:	Multi-Purpose Health Worker
NACO	:	National AIDS Control Organisation

NACP	:	National AIDS Control Programme
NFHS	:	National Family and Health Survey
NGO	:	Non- Governmental Organisation
NIPCCD	:	National Institute for Public Cooperation and Child Development
NRHM	:	National Rural Health Mission
PHC	:	Primary Health Centre
PLHAs	:	People Living with HIV/AIDS
PPTCT	:	Prevention of Parent to Child Transmission
PRI	:	Panchayati Raj Institution
RCH	:	Reproductive and Child Health
RHS	:	Rapid Household Survey
RRC	:	Red Ribbon Clubs
SACS	:	State AIDS Control Society
SC	:	Scheduled Caste
SC	:	Sub-Centre
ST	:	Scheduled Tribe
STI	:	Sexually Transmitted Infections
TI	:	Targeted Interventions
TRI	:	Technical Resource Institutions
VCTC	:	Voluntary Counselling and Testing Centre
VHSC	:	Village Health and Sanitation Committee

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INTRODUCTION TO NACP III

1

1. Background

The HIV epidemic in India is heterogeneous, with diverse modes of infection, particularly in southern and north-eastern states, namely, Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra, Nagaland and Manipur. There is increasing evidence to suggest that India's epidemic is being driven by sex worker-client interactions, except in the North-East where injecting drug use is clearly the major mode of spread infection (although there too sexual transmission is increasing). There is evidence of increasing drug use in some other regions too.

The Indian epidemic continues to be concentrated in populations with high-risk behaviour characterized by unprotected sex, anal sex and injecting drug use with shared injecting equipment. Several high-risk groups have high HIV prevalence, and sexual networks are wide and interlinked. However, these groups are not isolated communities but often mixed up with other sub- populations. 57% of the total HIV infections are in rural areas.

In the general population, women and young people are becoming increasingly vulnerable to the infection. According to 2005 sentinel surveillance findings, 38.4% of those living with HIV are women. In many states, more and more monogamous women are getting infected by their husbands. The male- to- female ratio of infected persons indicates an increasing feminisation of the epidemic. As in many other countries, unequal power relations and the low status of women, as expressed by limited access to human, financial, and economic assets, weakens the ability of women to protect themselves and negotiate safer sex, thereby increasing their vulnerability.

Similarly, HIV and AIDS disproportionately affect young people. Young people comprise almost 50 percent of the new HIV infections, and nearly 32 per cent of reported AIDS cases till 31 August 2006 were in the 15 to 29 years age group[1]. Their risks vary with culture, age, sex and individual circumstances. It is increasingly apparent that the key to turning back the pandemic is to enable young people to protect themselves against its transmission

However, the low rate of multiple partners and concurrent sexual relationships in the wider community seems so far to have, protected the wider population with 99% percent of the adult Indian population being HIV negative. To reduce the overall level of the epidemic, it will be important to saturate the coverage of the HRGs as well as expand the coverage of the bridge populations and populations at varying levels of risk.

NACP – III envisages expanding the coverage of high risk groups (HRGs) to 80% during the programme period.

1.2 Goal of NACP III

The goal of NACP III is to reverse the epidemic in India over the next 5 years through integration of prevention and treatment programmes. This will be achieved through:

1. Prevention of new infections in high risk groups and vulnerable populations through:
    a) Saturation of coverage of high risk groups with Targeted Interventions (TIs)
    b) Scaled- up interventions among other vulnerable populations

2. Increasing the proportion of persons living with HIV/AIDS receiving care and treatment
3. Strengthening the infrastructure, systems and human resources in prevention and treatment programmes at the district, state and national levels
4. Establishing nation wide strategic planning, programme management, monitoring and evaluation system.

The vision of NACP III for vulnerable populations is to scale up interventions among these groups, with the presumption that increased awareness, skills building, changes in attitude and behaviour, and predominantly social change through communication, community mobilisation and advocacy, will result in the adoption and maintenance of sustaining safe behaviours and reduction of risk.

1.3 Programme Priorities and Thrust areas

NACP- III places the highest priority on preventive efforts while, at the same time, seeking to integrate prevention with care, support and treatment.

Sub-populations that have the highest risk of exposure to HIV will receive the highest priority for intervention. These include sex workerworkers, men who have sex with men and injecting drug users. Other groups which are highly vulnerable to HIV infection are long distance truckers, migrants (including refugees), prisoners and street children.

The HRG[1] in the rural areas (based on district mapping) will be addressed through the Link Worker Scheme. These groups are:

- Sex worker (FSWs) and clients of the sex worker
- Men who have sex with men (MSM)
- Injecting drug users (IDUs)

The following bridge populations will also be addressed:

- Truck drivers/cleaners and
- Migrant worker

Vulnerable young people may belong to the above groups and could also be partners/spouses of migrants, mobile populations and IDUs. Young girls/women in women- headed households, persons infected and affected by HIV, particularly in the context of stigma and discrimination and their linkage to care , support and treatment may also be vulnerable. These sub- populations too will also be addressed by the Link Worker Scheme.

[1] Finding women and men with risk behaviours in clusters/groups may not be possible in a village setting. For this reason the guidelines will refer to them as High- risk Risk Individuals (HRIs) or High- Risk groups Groups (HRGs) as found appropriate.

RATIONALE FOR LINK WORKERS IN NACP III

2

2.1 Prevention and Treatment Needs in Rural Areas

Unlike in sub-Saharan Africa, India's HIV epidemic is still concentrated among high- risk population groups, requiring a focused approach. Mapping data suggests that the sex work population is not brothel based and is increasingly becoming street based and home based, with a larger number coming from the rural hinterland to the urban areas. Migration is yet another important source of infection transmission in rural areas. Evidence suggests that single male migrants are an important bridge population in carrying the infection from urban to rural areas. Common to the sex worker or the male migrants going to the urban areas is the poverty and lack of economic opportunity in the rural hinterland. Rural mapping done in Karnataka (2005) also shows that these highly vulnerable and mobile groups are not reached by any interventions, as most Targeted interventions implemented by NGOs' are urban- centric.

> Therefore, in order to saturate all high- risk and highly vulnerable groups with prevention and essential services, there is a felt need to establish an appropriate low- cost structure that could provide prevention, care and support services to them.

There is equally robust evidence that more than one third of new infections are happening in young people. Their lack of knowledge and poor access to youth- friendly services predisposes them to sexually transmitted infections and HIV. Stigma and discrimination surrounding HIV continues to be a major challenge, more so in the rural context. This results in poor access and, gender inequality, and above all in infection going undetected or treated by unqualified practitioners.

> There is an urgent need to de-stigmatise HIV infection through effective community dialogue. With increased risk perception and diminished stigma, utilisation of the health infrastructure is expected to be strengthened under NACP -III. Link worker scheme hopes to address this competent in rural areas.

Over 57% of the HIV infected persons in India live in the rural areas. A Rural Situational Needs Assessment study that was carried out by Karnataka Health Promotion Trust and Swasti Health Resource Centre in seven Districts of Karnataka, observed villages having a higher margianalisized population groups, entering into sex worker to earn income and thereby increasing their risk to HIV. The study also showed that about 20% of sex workerworkers lived in half the villages. The scattered nature of the key population and its inaccessibility due to poor communication and transport network pose a great challenge for reaching out to all HRG populations.

> An outreach strategy through Link Worker Scheme has been carefully crafted based on District- specific needs optimising local resources.

2.2 Definition of Link Workers

The Link Worker Scheme envisions a new cadre of worker, the Link Worker, to be introduced at the village level. Link Workers will be motivated, community-level, paid female and male youth workers with a minimum level of education. A Link Worker is someone who is not "alien" to the neighbourhood, is accepted by the village community, and who can discuss intimate human relations and practices of sex and sexuality and help equip high-risk individuals and vulnerable young people with information and skills to combat the pandemic.

The Link Workers will cover highly vulnerable villages in Districts selected through mapping exercises, using criteria such as size of the population, number of sex Workers residing and practising sex work in the village and number of PLWHA in the village (see Annexure 1, Community Outreach through the Link Worker Scheme - The Bagalkot Experience, and Annexure 2, Rapid Mapping of HIV Risk in Rural Areas). They will work in each cluster of villages around a 5,000+ population village which will serve as the node for this sub-group intervention. They will be supported in their work by village-level volunteers selected from the available groups in the community.

Tools

Annexure 1, *Community Outreach through the Link Worker Scheme – The Bagalkot Experience*

Annexure 2, *Rapid Mapping of HIV Risk in Rural Areas*

2.3 Existing Health Functionaries in the Public Health System

The Government health systems are distributed on a population norm throughout the country. The Sub-centre is the most peripheral level of contact with the community, catering to a population norm of 5,000, but it effectively serves a much larger population. The available basic workers with direct contact with the rural population are ANM, MPW, ASHA and AWW.

Rural health care in most States is marked by absenteeism of doctors/health providers, low levels of skills, shortage of supplies, inadequate supervision/monitoring, multi-tasking and too high expectations of ANM and ASHA. HRGs are not really the focus of these functionaries and mostly get left out of the gamut of activities and programmes coordinated by the existing basic health and nutrition functionaries. This is also true for vulnerable populations, especially unmarried youth who are at varying levels of risk. Issues like relationships, safe sexual practices and condoms, which are pivotal for addressing the HIV epidemic, are not adequately tackled. This is both because of limited skills to address these issues and the fact that reaching out to HRGs and other highly vulnerable populations is not the overarching objective of the available basic health workers.

It has also been seen that increasing the responsibilities of the ANM reduces the amount of time for community and outreach interventions. Only 4% of the ever-married women in NFHS II report that they received information about AIDS from a health Worker other than a doctor. 31% received information from a friend or relative. According to RHS-RCH II, 6.9% of women received information about HIV/AIDS from a health Worker. The percentage varied by age group among women, from a low of 5.9% among 15-19 years to 7.9% among 25-29 years. Overall, among males, 7.8% learned about HIV from the same source, but the percentage went down to 6.4% in the <25 years group.

The very nature of the AWW's job responsibilities (with an emphasis on supplementary feeding

and pre school education) does not allow her to take up issues of sexuality, HIV/AIDS and condoms aggressively.

The Reproductive and Child Health Programme remain women centric & women focused while male involvement is only being sought. Most of the front line health personnel are female with a starkly low presence of male counterparts. In the HIV/AIDS epidemic, males involved in various high-risk behaviours are shaping the "feminisation" of the epidemic. It is unrealistic to expect a female front-line workforce to counsel the males of rural India in HIV prevention, given the traditional Indian social structures where discussion of aspects of sexuality and sexual relations is taboo.

A closer analysis of the current responsibilities and target groups being served by various health Workers (see Annexure 3, Available Frontline Village-Level Workers) shows that HIV/AIDS is not being adequately addressed. The HRGs that are key to the epidemic in India are left out of the gamut of existing programmes. The Link Worker Scheme has been envisaged in order to reach out to the scattered (and often invisible) high-risk populations in rural areas with a comprehensive package of preventive services.

Lessons learnt from NACP II indicate that TIs so far are not linked to care, support and treatment services. This gap has to be addressed in order to enhance adoption of safe practices by groups with high-risk behaviours. The Link Worker will aim at bringing in this much needed linkage and synergy with existing health services, many of which are under the NRHM (RCH II) domain.

Building on existing evidence and moving towards saturating the high-risk population in all A and B Districts, the Link Worker Scheme will be implemented in a phased manner across the country.

Tool

Annexure 3, Available Frontline Village-Level Workers

2.4 Objectives of the Link Worker Scheme

The Scheme will generate a cadre of trained local personnel as Link Workers and volunteers to work with HRGs and vulnerable young people and women in A and B Districts of India (see Annexure 4, Number of A and B Districts in each State) towards the following:

1. Create an enabling environment for PLHAs and their families by reducing stigma and discrimination through work with existing community structures/groups, e.g. Village Health Committees, SHG, PRI, etc.
2. Reach out to HRGs and vulnerable young people (men and women) in rural areas (as defined in Section 1.3 above) with information, knowledge and skills on STI/HIV prevention and risk reduction.
3. Establish inter-linkages between gender, sexuality and HIV and bring into focus factors that enhance vulnerability of young people and women, both in HRGs and the general population.
4. Promote increased and consistent use of condoms to protect against STIs and unwanted pregnancy.

5. Generate awareness and enhance utilisation of prevention, care and support programmes and services (especially STI, ICTC, PPTCT, ART, DOT and other health services).
6. Facilitate the delivery of youth-friendly health and counselling services through existing public health services/service delivery points.
7. Facilitate the re-integration of HRGs into the community and work with families against trafficking of women and children.

Tool

Annexure 4, Number of A and B Districts in each State

2.5 Expected Outcomes of the Link Worker Scheme

- A cadre of trained local people - the Link Workers and Volunteers
- Increase in knowledge about HIV transmission, risk behaviours, HIV prevention and available health services among HRGs and vulnerable young people and women
- Increase in knowledge about HIV transmission, risk behaviours, HIV prevention and available health services among community members/significant others (SHGs, PRI, VHC, etc.)
- Increased use of condoms by HRGs, their partners and clients
- Increased utilisation of STI management, ICTC, PPTCT and ART services by HRIs/HRGs, their partners and clients
- Increased access for young men and women to health services (e.g. STI management, VCTC, ICTC, PPTCT)
- Reduced stigma and discrimination against PLHA and their families

MANAGEMENT STRUCTURE AT THE DISTRICT LEVEL 3

It is important to emphasise that the Link Worker Scheme is a process of social mobilisation to reach peripheral communities, particularly where formal systems of communication such as TV and radio have limited reach. Such social mobilisation is essential to ensure that these villages/communities are protected from HIV infection. The underlying spirit therefore is volunteerism. Yet previous efforts to mobilise communities have failed for want of an appropriate structure to engineer and guide such enthusiasm. The Link Worker Scheme is an attempt to provide a platform and an instrument to guide the community's response to the HIV/AIDS epidemic.

To channel this effort a four-tier structure is proposed:

District Resource Person (DRP) - Supervisor - Link Worker - Volunteers

The following sections provide details of the implementation mechanism, the different functionaries and their mode of selection, roles and functions expected to be performed, capacity building plan and the outcomes (indicators) proposed to be achieved.

3.1 The Implementation Agency

SACS may implement the Link Worker Scheme through DAPCU or consider engaging an NGO in the implementation of the Scheme in A and B Districts where there is an NGO presence. The NGOs should have considerable experience of SRH and HIV/AIDS with the capacity to take on District-level work. Existing partners of SACS may be considered.

The SACs should advertise EOIs from NGOs in two leading local dailies, one in English and the other a vernacular newspaper. The EOIs should be short-listed and the organisations contacted for discussion, after which the interested organisations should be asked to submit a detailed proposal with action plan. The operational guidelines for the scheme can be shared with them. A committee should be constituted to review the proposals. This could constitute of SACs, TRIs and State-level experts on HIV/AIDS. Involvement of NRHM officials will be extremely helpful at this stage.

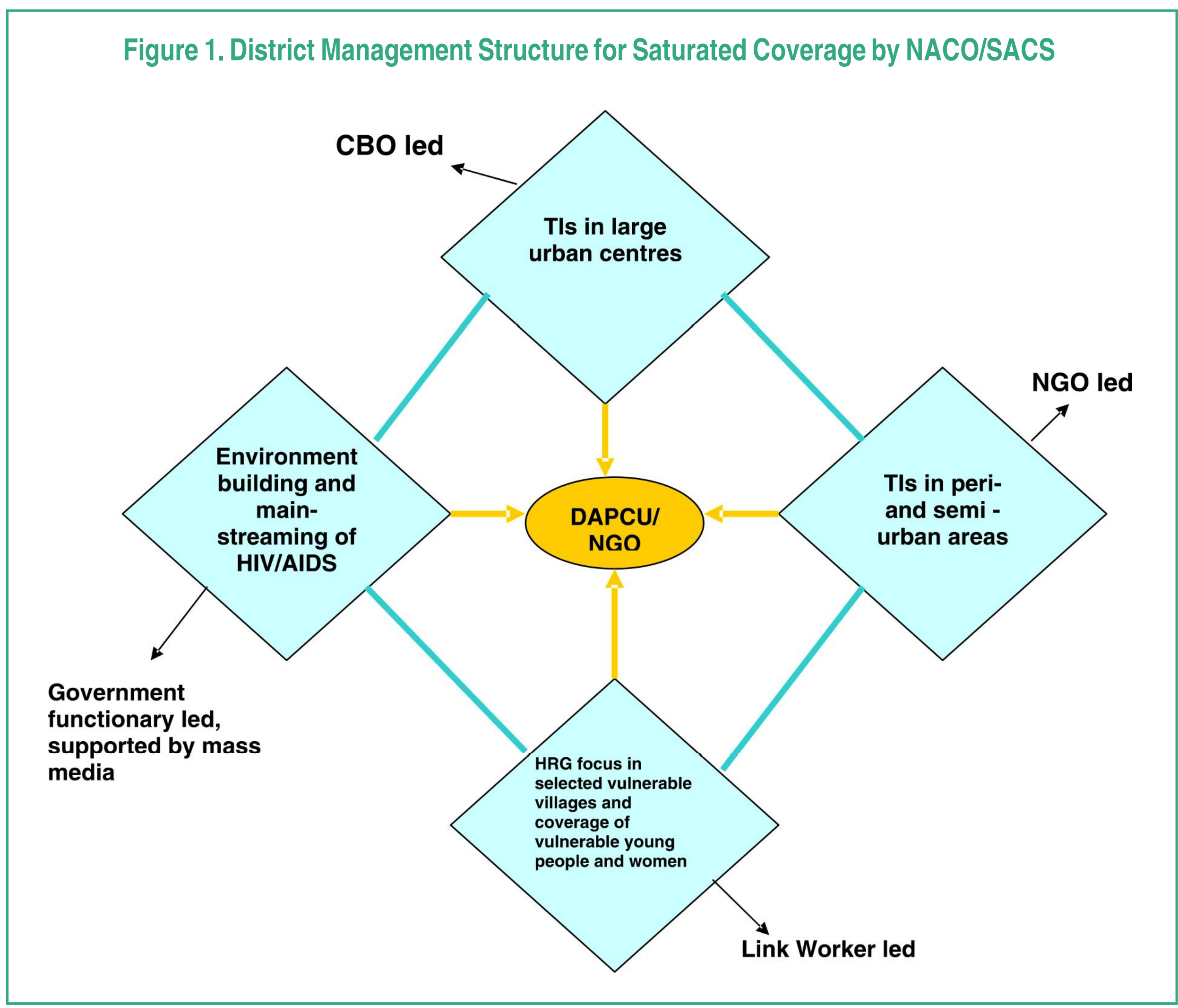
In the event of an NGO being the preferred implementing agency, its selection should be in accordance with the **NGO Selection Guidelines of NACO.**

After selection, the head and other key members of the selected NGOs should be invited for a two-day orientation workshop by SACS. The TRIs in partnership with SACS will be required to conduct the orientation, during which the Link Worker Scheme and operational guidelines should be fully explained. The NGOs should prepare the District action plan for implementation of the Link Worker Scheme and timeline in this workshop. The members of DAPCUs/District Health Committees wherever established should also be part of this workshop. The DAPCU/ District NGO will roll out the project in their respective Districts **(see Annexure 5, Roll-Out Plan¸ and Figure 1).**

Tool

Annexure 5, Roll-Out Plan

Figure 1. District Management Structure for Saturated Coverage by NACO/SACS



3.2 Institutional Structure

Census 2001 show that there are about 18,000 villages (termed as census towns) with a population of 5,000 or more. These cover about 20% of the country's population. The total number of personnel in the Scheme in the District will depend on the villages selected on basis of the District vulnerability mapping.

The Link Worker will be the key personnel in the Scheme. The main responsibilities of outreach to vulnerable populations/at-risk populations lie with him/her. S/he will be supported by the District Resource Person (DRP), supervisor and volunteers. The volunteers will support the field-level activities of the Link Worker at village level. The DRPs, supervisors and Link Workers will undergo intensive training to help them acquire knowledge and understanding of the issues and their roles.

The Link Worker reports to the supervisor who will further report to DRP. The Monitoring and Evaluation officer at the District AIDS Prevention and Control Unit (DAPCU) will work in close coordination with the DRP and Supervisor. If an NGO takes on the implementation of the Link Worker Scheme in the District, the DRP will report to the NGO.

The DRP, Supervisor & Linkworker would undergo intensive training & handholding to help them acquire knowledge & understanding of the issue and their roles respectively.

See Figure 2 for a diagrammatic representation of personnel and their reporting responsibilities.

Figure 2. District Management Structure for the Link Worker Programme

State AIDS Control Society

Management Structures

State Technical Resource Institutions

23 States

District AIDS Prevention and Control Unit (DAPCU)/NGO

District Resource Persons

1-DRP

Supervisors

1 Supervisor for 10 LW

TECHNICAL RESOURCE INSTITUTIONS

Implementation Structures

Link Worker

2 LW (M&F) per 5 Core Villages and 25 Proximal village

Volunteers

Volunteers from different Segments

Community Groups

Community Groups in each village

SERVICE PROVISION

BCC and condom promotion

Mainstreaming HIV Response

Linkages with Local health service

Advocacy and Networking with PRI

Referral Linkages with C&S Services

3.3 Technical Resource Institutes (TRIs)

In order to provide technical support at the State level, it is proposed to identify National Technical Resource Institutions (TRI) preferably with a regional presence, i.e. one each from north and south India.

3.3.1 Criteria for a National TRI

Organisations/Institutions with a vast experience of working on reproductive and sexual health and HIV/AIDS with communities and high-risk populations and conducting trainings will be considered for appointment as TRI. Understanding of SRH issues related to vulnerable young people and women in communities would be important. It is crucial for the TRIs to have an in-house resource team with experience of training related to high-risk groups and sexual and reproductive health (including HIV) and a fair understanding of how to mainstream gender and rights based approaches into activities at different levels of intervention.

3.3.2 Criteria for a State TRI

Organisations/Institutions should have vast experience (at least five years) of working in rural development in the particular State. The institute/NGO should have worked in any of the issues related to community health, reproductive and sexual health, HIV/AIDS, rural development and other various development related issues. Preference will be given to those organisations having prior experience in training panchayati raj and/or youth/women. Institutes with a strong working relationship with State government functionaries will be encouraged. Technical skills in providing training/capacity building and research documentation will be preferred.

For the initial year the two national level TRIs will carry out the trainings at the State level. It is envisaged that within the period of one year, State TRIs will be identified in States where the LWS will be implemented and the two National TRIs will build capacities of the state TRIs. The first round of training will be intensive and will include DAPCU, NGO, DRPs and supervisors. The National TRI will also conduct joint training with State TRIs and NGOs.

These TRIs will work in close coordination with SACS and NACO (with proposed National Programme Officer - Youth). They will partner with them to conduct trainings of DRPs and lend support for building capacities of Link Workers and supporting in implementation of the Link Worker Scheme at District level. The modules and Job Aids designed under the scheme and approved by NACO will be used by the TRIs to impart trainings, with the possibility of adapting them at the regional level.

To ensure standardized quality of the training among the State TRIs, a third-party evaluation will be carried out.

3.4 Selection and Responsibilities of (DRP) District Resource Person

3.4.1 Selection Criteria

- One DRP should be selected in each District
- Should possess Masters degree in Social Work or an equivalent degree from a recognised university

- Should have minimum of 3-5yrs of experience in rural development work
- The rating will be as follows:
  - Merit: 20%. Qualifications, the university from where the course/degree has been acquired, marks, any other professional courses or training related to the job.
  - Interview: 20%. This will assess knowledge of HIV/AIDS, sexuality and gender; understanding of community mobilisation; knowledge of organisational skills; communication skills and comfort level in discussing issues of sexuality and HIV. Should be familiar with team management and monitoring and evaluation.
  - Written test: 20%. In the written test a candidate can be asked to write a page on topics such as *Feminisation of HIV/AIDS or HIV/AIDS and Young people*, etc. This is to assess skills in analysis and documentation.
  - Any previous experience of work and training: 20% (work with HRGs and vulnerable young people and women).
  - Good understanding (written and spoken) of local language: 20%.
- HIV positive people, especially positive women, with the required qualifications and experience should be given preference.

3.4.2 Selection Process

- Advertisement should be placed in leading dailies, one English and one vernacular.
- Selection of DRP will be performed by DAPCU/NGO/SACS.
- Final list is to be drawn up on the basis of merit after screening, short-listing and interview. The final selection should be done by a committee constituted by SACS in partnership with District Health Committees constituted under NRHM.
- In event of an NGO implementing the scheme, a minimum of two persons must be co-opted in the selection committee from the District Health Committee /DAPCU.

The SACS in the States where this scheme is being implemented should evolve a monitoring and coordination mechanism wherein they meet with DRPs at regular intervals to assess their work and support them wherever needed. Efforts should be made to integrate the DRPs in the ongoing work of SACS and DAPCU at the District level especially with the ongoing TIs. This involvement will give the DRP the larger picture of the SACS work under NACP III and will prevent the Link Worker Scheme from becoming a vertical scheme in the District.

3.4.3 Roles and Responsibilities

- Train and induct newly recruited supervisors/Link Workers or their replacements. Assess the knowledge of supervisors and Link Workers and identify needs for refresher and follow-up training.
- Review, monitor and provide supportive supervision to supervisors and Link Workers
- Support development of communication campaigns at the district level and their effective implementation with a focus on creating an empathetic and non-abusive environment. SACS will develop, collate and adapt materials facilitated and supported by TRIs and help develop a communication plan.

- Establish linkages with Department of WCD, Rural Development, Social Justice and Empowerment, Education, etc. Promote convergence with ongoing programmes of different ministries, such as Adolescent Friendly Health Services being envisaged under the RCH-II. This will help to create a better environment for networking care and support of HRIs and vulnerable young men and women.
- Promote availability of condoms at PHC
- Bring connectivity with Red Ribbon Clubs', wherever established
- Keep the Supervisors and Link Workers motivated
- Compile supervisors' reports and provide necessary data to DAPCU/NGO
- Facilitate other training organised by SACS at the District level
- Play a strong role in advocacy and creating an enabling environment at District level

Apart from his/her role in Link Worker Scheme, the DRP will also be involved in training of service providers and basic health functionaries under NRHM. Issues of HRIs and young people can thus be integrated in other ongoing programmes.

3.4.4 Suggested Work Schedule

The morning half day can be spent monitoring visits and linkages. In the latter half of the day s/he should take care of administrative responsibilities; documentation; development of materials such as communication tools, materials for dissemination, etc.

Week One	
Day	**Action**
Monday	Visit to DAPCU/NGO - reporting organisation.
Tuesday	Monitoring visit to the village/block. This visit should be utilised to meet with key stakeholders, local functionaries and volunteers.
Wednesday	There should be two one-to-one meetings every month with key District health functionaries from departments mentioned earlier.
Thursday	Monitoring visit to the village/block.
Friday (there should be four to six visits to ICTC, STI clinic, PHC-youth corner. Each of these should be covered at least once every month)	■ Visit to ICTC, STI Clinic, ART, CCC, youth corners at PHC ■ Any follow up visits needed to the field areas
Saturday	Meeting with supervisors and preparing the weekly action plans
DRP should on a regular basis attend meetings of District Health Committee, ICDS supervisors etc after developing the desired linkages.	

[1] This is a scheme under NACP III to open clubs for young people in campus and community. It aims to converge with Dept. of Youth Affairs and Sports, MoYAS, and Dept. of Higher education, MoHRD. The RRCs in question are perceived as clubs for young people at the village level and will be a source of edutainment.

The same schedule can be repeated in the remaining three weeks. The last two or three days of each month should be devoted to conducting meetings with Link Workers and supervisors and reviewing their progress. The first two or three days should be used to compile a combined report for the District. Once every three months, the DRPs should provide an indicator based report to DAPCU/NGO. By the 5th of every month, the compiled report should be forwarded to DAPCU/NGO for further reporting to SACS.

3.5 Selection and Responsibilities of Supervisor

3.5.1 Selection Criteria

The Supervisor is to be selected using the following criteria:

- Be a resident preferably of the same District or neighbouring District, who can understand the realities in the District
- Must possess at minimum a graduate degree
- Must possess the following skills:
  - Communication and Documentation skills
  - Analytical and comprehension skills
  - Motivation and team spirit
- Previous experience in rural development work will be an added advantage

3.5.2 Selection Process

The process of identification of the supervisor needs to be initiated before the training of Link Workers. The supervisor shall be a person from the District who is professionally qualified to guide and supervise the link Workers. One supervisor will be responsible for 10 Linkworkers. S/he shall be selected at District level by NGO/DAPCU.

3.5.3 Roles and Responsibilities

- Support responsibilities of Link Worker in a smaller geographical area
- Guide the Link Workers in the village-level household mapping
- Ensure regular supply/availability of condoms at the Primary Health Centre and youth corners
- Orient ANMs, MPWs, AWWs and ASHA about HIV/AIDS.
- Facilitate and strengthen the STI related work being undertaken by other Basic Health functionaries.
- Facilitate formation of condom depots. Ensure timely supply of condoms in intervention areas.
- Support the functioning of youth corners in PHC
- Establish linkages for services. Work towards convergence at the block level with Health, Education and Pancahyati Raj Institutions.

- Receive and compile reports of work done by Link Workers
- Monitor and assure a minimum standard of output expected of Link Workers

3.5.4 Suggested Work Schedule

Week One	
Day	**Action**
Monday	Visit to the village for strengthening of Link Workers for intervention/mapping exercises
Tuesday	Meeting with DRP/District-level meeting for programme update.
Wednesday	Visit to the village for direct intervention for intervention/mapping exercise
Thursday	Work on available reporting formats and prepare feedback to District level
Friday	▪ Visit ICTC, STI Clinic, and youth corners at PHC or any other services where the Link Workers need support for strengthening linkages. ▪ Weekly report
Saturday	Meet all Link Workers under his/her supervision for technical support, addressing concerns, strengthening documentation through reporting formats.

The same schedule can be repeated in the remaining three weeks. The 25th/26th of every month (if a holiday, then a day before or after) should be devoted to conduct meetings with Link Workers. Following this they should prepare field reports for their own intervention area, compile Link Workers report and attend the meeting organised by DRP.

3.6 Selection and Responsibilities of Link Worker

3.6.1 Selection Criteria

- Women/men in the age group of 20-29 yrs. This age group is recommended as many HRIs, especially in sex work and drug abuse, are young women and men.
- Should have completed 10-12th grade. It is not advisable to take highly qualified people as their retention and job satisfaction may be a challenge.
- The rating will be based on a written test and interview:
  - Written test: 30%. This will assess knowledge on HIV/AIDS and sexuality issues.
  - Interview: 30%. This will assess understanding of community mobilisation, knowledge of organisational skills, communication skills and comfort level in discussing issues of sexuality and HIV.

- Any previous experience: 20%. Antecedents such as experience as Peer Educator, prior experience of working with other health/HIV related programmes or other development programmes.
- Merit: 20%. Educational qualification and marks obtained by the candidate. No extra merit will be given to people who are more qualified.

- Should be a resident of the same 5,000 population cluster for which s/he is selected.
- Preference to be given to Self Help Group members of youth clubs, farmers club, weaker sections.
- PLHA, especially HIV positive women, with the required qualifications and experience should be given preference.

3.6.2 Selection Process

- The supervisor will be involved in the District mapping to identify vulnerable villages at the District level. During the course of the mapping exercise the supervisor should endeavour to identify potential Link Workers from the pool of persons engaged in mapping. Those persons short-listed by the supervisor will be graded and subsequently interviewed by a District-level committee for the post of Link Worker.
- The screening committee for Link Workers should comprise members of the Village Health and Sanitation Committee and members of Self Help Groups. *(This is a suggested list. A quorum of three people should suffice for the screening and short-listing process.)*
- Proof of birth date and residence is required for all Link Worker applicants.
- Final list is to be drawn up on the basis of merit after screening, short-listing and interview. The final selection should be done by the DRP, and wherever possible either the medical officer of the PHC or the Panchayat Samiti Adhyaksh at the block level should be involved.

Contracting of Link Workers will be ratified by DAPCU/NGO implementing the Link Worker Scheme in the district, on the basis of recommendations made by the screening committee and verification of documents attached: educational qualifications and proof of residence. Due consideration must be given to caste/class/sex in finalising the appointments.

3.6.3 Roles and Responsibilities

The main responsibilities of the Link Worker include enhancing access to information and services related to HIV prevention and relevant sexual and reproductive health issues (such as STIs), through a gender-sensitive approach among HRGs and vulnerable young people in the community (e.g. partners/spouses of migrants, mobile populations, IDUs, girls/women in women-headed households, etc.). This should involve participatory learning processes rather than mere information delivery. Besides dissemination of information, Link Workers will establish linkages between these populations and the continuum of services. Link Workers will report to Supervisors.

It is expected that the Link Worker will undertake activities to facilitate interventions with HRIs who are part of the general population. S/he will also work with vulnerable young people in the community. Although HRIs are the prime target for the Link Workers, the Link Worker is expected to establish rapport with the communities and understand the specific vulnerabilities in that particular location (villages) in order to reach HRIs. In addition, it is

equally important to recognise and address the concerns of vulnerable populations like young people and women, so that they develop a perception of self-risk and can take appropriate steps to reduce individual risks.

It is also crucial that the Link Worker is seen as a functionary working with different sub-populations in the community; otherwise there is a risk of perpetuating stigma against the small number of so far hidden or invisible HRIs.

Key responsibilities for Link Workers have been identified based on the understanding of the roles of different basic health functionaries (see Annexure 3). They include:

- Conduct village-level household mapping (vulnerability mapping, community resource mapping, health services/facility mapping, household mapping (see Annexure 6, 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
- Provide youth-friendly counselling/advice (maintaining confidentiality, privacy and non-judgmental attitude) to young people and women in the community
- Work towards reducing stigma and discrimination in the community by facilitating involvement of HIV positive people, community groups like SHGs, PRI and VHC, and bringing into focus and addressing gender dimensions of stigma and discrimination. Tools like stepping stones can be used.
- Advocacy with identified stakeholders for creating an enabling environment (and reducing stigma and discrimination)
- Recognise the rights of HIV positive people and HRIs and create more awareness regarding these rights in the community and among the concerned groups
- Be knowledgeable about 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, utilisation of VCTC/ICTC, PPTCT services by HRIs and other vulnerable groups
- Coordinate the linkage between communities and service institutions (especially VCTC/ ICTC, PHC/CHC, RTI /STI clinic and District hospital)
- Identify and train volunteers
- Facilitate formation of Red Ribbon clubs (RRC)
- Supervise volunteers, Red Ribbon Clubs and establish condom depots
- Develop functional linkages with CBOs/networks, organisations working with HRI populations
- Collection of monthly data from RRC and condom depot holders
- Prepare monthly reports for his/her area according to a pre-defined format

3.6.4 Suggested Work Schedule

Link Workers initiate field-level work after training. A team of two Link Workers, one male and one female, will work together. The few initial visits to the village will involve village-level mapping, understanding local vulnerabilities and risks, and identifying and meeting with the key stakeholders in the village. These visits will also help them identify active young men and women as volunteers.

After this, the Link Worker, with support of the DRP and supervisor, will devise his/her schedule in such a manner that at least four visits are made to the village/clusters of villages in a week, amounting to 16 visits in a month. During their visit to the village they will devote a major part of their time to high-risk populations and vulnerable section of the community. The male Link Worker will work with men belonging to HRGs and the male clients and partners of HRG members. Similarly, the Female Link Worker will work with women belonging to HRGs and their clients and partners. The remaining time should be spent working with vulnerable young people and women. Volunteers can be involved while the sessions or work with young people and women are undertaken. The visit should also be utilised to form condom depots and Red Ribbon Clubs initially, and later to supervise the functioning of these centres.

Week One	
Day	**Action**
Monday	Visit to the village
Tuesday	Visit to the village
Wednesday (there should be two visits to the Sub-centre in a month)	▪ Visit to the Sub-centre (convergence with ANM and ASHA for RH services to women of HRGs and their partners/spouses and other vulnerable women) ▪ Any follow up visits needed with HRIs, young people and women ▪ Weekly report
Thursday	Visit to the village
Friday (there should be four to six visits to ICTC, STI Clinic, PHC-youth corner. Each of these should be covered at least once every month)	▪ Visit to ICTC, STI Clinic, youth corners at PHC ▪ Any follow up visits needed with HRIs, young people and women ▪ Weekly report
Saturday	Visit to the village

The same schedule can be repeated in the remaining three weeks. The last two or three days of each month should be devoted to conducting meeting with volunteers, preparing field reports and meeting the supervisor and DRPs. The Links Workers should also compile a list of contacts established with different stakeholders, HRIs, young people and services. This should be reported each month to the supervisor.

On a quarterly basis during visits to the village, the Link Workers should update records on HRIs, vulnerable households, migration patterns, households with young men and women, etc.

The two Link Workers - female and male - can either work together as a team and adopt the same monthly schedule of visits or can make their schedules independent of each other - whatever is most acceptable in their socio-cultural context.

Tools

Annexure 3, Available Frontline Village-Level Workers

Annexure 6, Mapping

3.7 Selection and Responsibilities of Volunteers

3.7.1 Selection Criteria and Process

Each Link Worker should identify 2 - 4 volunteers in each village under his/her jurisdiction, preferably with an equal distribution of men and women and in the age group of 15 to 29 yrs. It is helpful to have volunteers who represent both the general and weaker populations. HIV positive people are an excellent resource for voluntary work provided they are willing to come forward. Good communication, understanding of certain key issues and being a respected member of the community make for a good volunteer.

3.7.2 Roles and Responsibilities

- Act as information post for services, linkages and referrals
- Coordinate the day to day functioning of RRC
- Can be a condom depot holder
- Establish rapport with local groups in order to gather more information about the possible HRIs
- Mobilise people for events and/or services
- Provide care to PLWHA
- Provide crisis support

The personnel in the Link Worker Scheme must coordinate closely with each other and at the same time with other basic health functionaries in the District for effective implementation of the Scheme. Working towards convergence with other programmes at District and block level is an integral role of DRPs, supervisors, Link Workers and volunteers.

3.8 Areas of Convergence

As HIV/AIDS touches on many facets of life and is continually influenced by a convergence of factors, it requires a multifaceted approach. The multifaceted or multi-dimensional approach calls for convergence at two levels:

- Within the different strategies under NACP III
- Between NACP III and other programmes and initiatives

This will not only make the response to HIV/AIDS more comprehensive but will also bring together the infrastructure, human resources and capacities of different programmes which are critical to ensure scale-up and effective service delivery.

The Strategy and Implementation Plan Document of NACP III clearly lays out mainstreaming issues and convergence areas with different Ministries and their programmes. It also talks about partnerships with the private sector. But under the Link Worker Scheme the emphasis is more on local-level (District to village) convergence.

The DAPCU and District NGOs (including DRP) have a crucial role to play in the convergence. The roles envisaged under NACP III are as follows:

- Within the different strategies under NACP III:
    - Closely work with TIs
    - Have coordination, regular meetings and experience sharing with programmes addressing HRIs and bridge populations in the districts.
    - Work with the communication campaigns and initiatives undertaken to address HIV and AIDS issues
- Between NACP III and other programmes and initiatives:
    - Work with District-level departments for prevention, treatment and impact mitigation
    - Manage the integration of services with the general health system and other non-health interventions
    - Work with PRI institutions and local CSOs for social mobilisation for HIV prevention and management
    - Work with officers of RCH, TB, MOHFW, NRHM to effectively integrate HIV/AIDS in their functions
    - Facilitate and monitor integration of support and treatment with prevention in the District
    - Promote synergy between HIV/AIDS initiatives supported by SACS and other donor organisations being implemented in the District
    - Facilitate social support to PLHAs and families through District-level programmes of Government and NGOs

The framework for convergence under[1] NRHM should also be followed, wherein the effort of DAPCU and DRP should be to integrate HIV/AIDS into NRHM activities. One of the core strategies of the NRHM is to empower local governments to manage, control and be accountable for public health services at various levels. Link Workers and supervisors can work with the PRIs and the basic health functionaries to support this.

[1] Framework includes formation of the Village Health and Sanitation Committee (VHSC). VHSC, along with the standing committee of the Gram Panchayat (GP), will provide oversight of all NRHM activities at the village level and be responsible for developing the Village Health Plan with the support of the ANM, ASHA, AWW and Self Help Groups. Block-level Panchayat Samitis will co-ordinate the work of the GP in their jurisdiction and will serve as a link to the District Health Mission (DHM). The DHM will be led by the Zila Parishad and will control, guide and manage all public health institutions in the District. States will be encouraged to devolve greater powers and funds to Panchayati Raj institutions.

Convergence and linkages will be needed between Link Workers and other services, programmes and institutions in the areas as depicted in Figure 1.

The Link Worker Scheme is temporary in nature (for a period of 3 years from the date of implementation). In order to ensure sustainability of the scheme the VHC will be involved from the beginning. The VHC will be strengthened to take responsibility of HIV prevention and care in their villages. The VHC will gradually assess the Link Workers work, ensure all marginalised groups and at-risk groups get access to services, ensure building of community norms around prevention and care, and prevent stigma and discrimination.

3.9 Work Stations

The Link Workers and supervisors will largely be in the field and will require a physical structure for their meetings and when formulating reports. The following places can be used by the Link Worker and other functionaries in the scheme:

- Link Workers could conduct their meetings with other basic health functionaries at the Sub-centre. They could also have their weekly schedule displayed at the Sub-centre, so that the supervisor, DRP or any other functionary knows about their availability. The Anganwadi centres and the Red Ribbon Clubs are other places in the villages where Link Workers can conduct their meetings with volunteers or do their work.
- Supervisors can meet Link Workers at PHC/Block PHC. This place could be taken as their workstation.
- The DRPs can be attached to the DAPCU or NGO.

4 CAPACITY BUILDING

In view of the objective of establishing a national-level workforce of around 200 middle- to senior-level trainers (District Resource Persons) and around 30,000 - 35,000 trained/skilled youth working as Link Workers and supervisors, the quality and adequacy of training is most important.

Capacity building will take place through a cascade mechanism. The District Resource Persons and Supervisors will be trained by the identified **Technical Resource Institutions**. The capacities of Link Workers to carry out their assigned roles will be built through District Resource Persons and supervisors in partnership with State Technical Resource Institutes. The Link Workers will further orient the volunteers over a period of 5 days, as part of "on-the-job" training. See Figure 3.

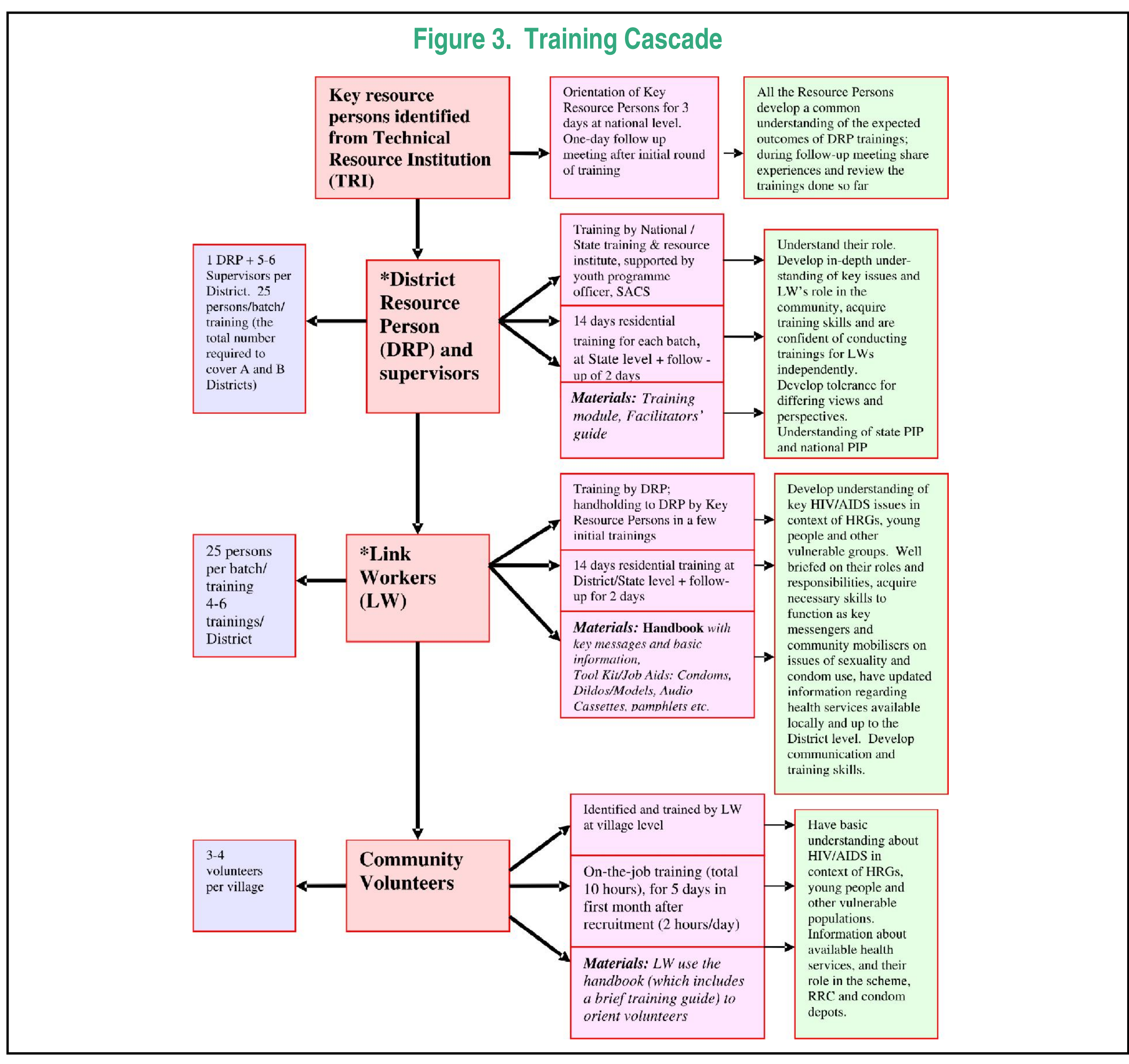


Figure 3. Training Cascade

*DRPs and Supervisors when established at the District level will be expected to conduct training of Link Workers. The number of Link Workers will vary from District to District depending on HRI population and the number of villages with 5,000+ population identified through district mapping. There will be between 4-6 trainings. Each of these trainings will be of two weeks' duration.

4.1 Training for DRPs and Supervisors

The training for DRPs and supervisors will be organised as a two-week residential training programme at the State level. During this training the participants will cover **six modules** over a period of approximately **80 hours**. This will include extensive field exposure as well as practical and participatory teaching. A detailed plan outlining the structure of the modules, their key objectives and suggestive training plan is provided in the training manual.

4.2 Training for Link Workers

The training for Link Workers will be organised as a two-week residential training programme at the District level. During this training the participants will cover **seven modules** over a period of approximately **80 hours**. This will include sufficient time for practising skills required for mapping, condom demonstration and communicating effectively. The training will also include field visits to TIs and health facilities. Experience sharing with TIs/CBOs and counsellors/ health care providers will be integrated within the training. The focus will be on contextualising all the information (to the rural context of the LW) and providing first-hand experience in working with HRIs and vulnerable populations. A detailed plan outlining the structure of the modules, their key objectives and suggested schedule is provided in the training manual.

The training will include issue-based knowledge; information on existing government programmes and schemes in the District, expected roles of Link Workers in the community and orientation on reporting formats. Participants will also be oriented to the handbook and the Job Aids during the training. As these are residential trainings, the evenings can be utilised for practising the use of Job Aids to impart information and convey key messages around HIV/ AIDS (behaviour change communication).

The DRPs and TRIs will also train the Link Workers to identify important stakeholders, and to understand and address risk behaviours.

4.2.1 Follow-Up Training

A two-day follow-up training for the Link Workers and Supervisors is envisaged at a gap of six months to one year after the initial training. It is expected that during this period, the DRPs will monitor the progress of the Link Workers and will be able to assess the areas that need to be strengthened. The DRPs should report these identified training needs in their regular field assessment reports and this should form the basis for planning the follow-up trainings. The DRPs, supported by the TRIs, will conduct the training.

4.3 Keeping the Workforce Motivated

The major workforce in the Link Worker Scheme is from rural areas. They will address issues of sexuality and HIV/AIDS which are at times very challenging. It is extremely important to maintain the motivation levels of the Supervisors, Link Workers and volunteers. This will promote feelings of personal commitment towards the Scheme and enhance the personnel's output.

> The basic spirit of volunteerism that this scheme aims to promote will be maintained if the workforce remains motivated.

This involves interventions with little or no financial resources. Some recommendations (largely based on lessons from the corporate sector and international agencies) for keeping the Link

Workers and Supervisors motivated are as follows:

- The strategic imperatives and vision of NACP III and the Link Worker Scheme must be conveyed to staff at all levels
- Create opportunities for empowerment among the staff and link them explicitly to achieving the goals of the Scheme
- Increase frontline autonomy by allowing key implementation decisions to be made by Link Workers and Supervisors under the supportive supervision of DRPs. Reward rather than punish frontline creativity and willingness to take implementation chances.
- Encourage grassroots innovation and provide incentives to explore the potential for improvement in their day-to-day activities
- Encourage them to identify "failures" in achieving their objectives and to communicate those failures up through management. This will prevent them from hiding their shortfalls and prevent misreporting.
- Develop **esprit de corps** among them. Encourage camaraderie with respect to their everyday work. Create opportunities for Link Workers and supervisors or other basic health functionaries doing similar work to develop trust and cohesiveness.

Rewards or incentives need not be financial: appreciation in front of co-workers or a citation may work just as well. Opportunities for capacity building, exposure to similar programmes elsewhere in the state or country, or opportunities for presenting one's work in front of seniors from SACS or NACO can serve as good incentives.

The volunteers, who are not paid staff under the Scheme, should be rewarded through these mechanisms. They can also be connected to existing employment and rural development schemes of the Government.

> The branding of the Link Worker Scheme may also add to the eagerness of young women and men to be associated with it, either as Link Workers or as volunteers.

In Government programmes, very little growth has traditionally been seen for frontline workers or basic health functionaries. Providing opportunities for growth - which may not always mean promotion but could be learning opportunities or job expansion (adding responsibilities, which is an indication of the faith of seniors in a worker) - is a good way to retain the motivation of staff.

Similarly, wherever possible the first choice for filling vacant positions in the Scheme should be an existing worker at a lower rank. For example, if there is a vacancy for a Link Worker, the volunteers in his/her area should get the first consideration for the position. This also saves time and money as the Scheme has already invested in their capacity building.

4.4 Dealing with Attrition

The need to appoint new DRPs/Supervisors/Link Workers may arise under two situations:

- Non-performance
- Attrition

It is assumed that there will be some attrition in the workforce in the ranks of DRPs, Supervisors and Link Workers.

The DAPCU/NGO should have the responsibility to report to SACS the vacancy of a DRP, and along with SACS they should take necessary steps to fill this vacancy within a period of two months.The supervisor in the monthly reporting format should report the status of personnel, both Link Workers and volunteers. For any Link Worker vacancy, the DRPs should consult the Gram Panchayat/VHSC and do the recruitment. This too should happen within two months. Volunteers who have developed considerable understanding of HIV/AIDS and have actively participated in the programme should be considered preferentially for the vacancy of a Link Worker. This will serve as an incentive for other volunteers. Whenever a volunteer discontinues working, the Link Worker should have the responsibility of selecting active people to fill the vacancy.

Assuming some attrition in the workforce at the field level ,the available workforce should be assessed periodically (preferably every 6 months) by the State Youth Coordinators (SACS) and DRPs, taking stock of the emerging training needs for the District. The State Youth Coordinators will coordinate with their counterparts in other States and recommend that the newly appointed DRPs be included into the ongoing state level trainings at that point of time.

Training of newly recruited replacement personnel is essential for effective implementation of the scheme. The TRIs, District NGOs and DAPCU should be responsible for the training of the newly recruited DRPs and Link Workers. Either training can be organised in the District itself, or, if there is training scheduled in other Districts of the State, the newly recruited staff can be sent to participate in it. Funds must be allocated for training at the beginning of the roll-out of Scheme.

4.5 Training Resources

Resource material for conducting the trainings includes a **Training Manual** supported by a **Facilitator's Guide**. This Training manual has been developed to standardise the training component in the Link Worker Scheme. The training manual will be used by National- and State-level Technical Resource Institution as a resource for developing the facilitation skills and knowledge base of DRPs about HIV and AIDS, and to establish the DRPs as a cadre of certified Master trainers at District level.

Once the DRPs are trained and positioned in the Districts, the key messages, contents and basic skills will be passed on to Link Workers in a more comprehensive and synthesized form. The Training Manual will serve as the basic training resource for the DRPs to conduct training programmes for the Link Workers in the District.

The Training manual will be supplemented by a **Handbook** for Link Workers. The Handbook will be the key resource for Link Workers and will summarise the important messages and information from the training manual in a simplified version. This Handbook will act as a ready reckoner for the Link Workers during and after the training. The Handbook will also provide brief guidelines on how to approach on-the-job training for the volunteers, which is envisaged as a 10-hour package to be delivered over 5 days in the first month after recruitment.

The Handbook will be part of the **Job Aids/Tool Kit**. The tool kit will include a set of "Edutainment materials" that will support the Link Workers and volunteers in communicating key messages more effectively in the community, and in a participatory manner.

Thus the three key resources - **Training Manual, Handbook for Link Workers, and Job Aids** - developed for the Scheme are connected, each one facilitating the transfer of information from one level of the training cascade to the next. In addition, the Job Aids will also be a useful resource for conducting specified activities and conveying key messages at the field level. **(For a list of Job Aids, see Annexure 7, Job Aids.)**

Tool

Annexure 7, Job Aids

5 MONITORING AND EVALUATION

Monitoring is a continuous/periodic review of the implementation of a programme to ensure that input, work schedules, outputs and other required actions are proceeding according to plan. Another way of describing monitoring is that it is a process of measuring, recording, collecting, processing and communicating information to assist project management decision making. Evaluation aims to assess the impact made by the programme, the contributory factors and the role of various partners.

The indicators presented here are both monitoring and evaluation indicators and are quantitative and qualitative in nature. Monitoring indicators are largely process-oriented and form part of the reporting formats of the Link Worker and the DRP. Some output/outcome indicators are also proposed that will be captured at the end of five years. Certain indicators around behaviour change that are already being covered by BSS are not included here. Simple reporting formats have been designed for the different personnel under the Link Worker Scheme **(see Annexure 8, Reporting Formats).**

It is proposed that a baseline be conducted by an independent research organisation (to be hired by SACs) to establish the benchmarks against which the progress of the Scheme can be measured. The research organisation can decide on the sample that is considered robust and representative for the total Districts in each State. The framework for the research should be prepared centrally by NACO so as to maintain uniformity in the research. An endline should be conducted after 5 years to understand the impact of the scheme on HRGs and vulnerable young people.

Tool

Annexure 8, Reporting Formats

5.1 Programme Roll-Out Indicators

- Number of DRP and supervisors selected, (by sex, age distribution, educational qualification) - quarterly
- Number of DRP and Supervisors trained (Basic Training) - quarterly
- Number of Link Workers (male and female) selected in each District, (District, Block and village-wise coverage) - monthly in the first year and then quarterly
- Number of Link Workers trained (Basic Training) - monthly in the first year and then quarterly
- Numberof Link Workers completed follow-up training - quarterly
- Number of village-level volunteers (male and female) selected and trained by Link Workers - monthly in the first year and then quarterly
- Number of replaced/newly recruited DRPs/supervisors/Link Workers trained - this will be part of the reporting formats

5.2 Programme Objective Indicators

Objective 1: To reach out to High Risk Groups and vulnerable young people in rural areas with information, knowledge and skills on STI/HIV prevention and risk reduction.

Process Indicators	Frequency	Responsibility	Source
Village vulnerability and resource mapping completed	One time	LW	Reporting format
Village vulnerability and resource information updated	Quarterly	LW	Reporting format
No. of HRIs (male and female) contacted village-wise	Monthly	LW	Reporting format
No. of vulnerable young people and women contacted village/ cluster-wise	Monthly	LW	Reporting format
No. of total awareness campaigns	Quarterly	LW	Reporting format
No. of awareness campaigns in highly vulnerable/risk group localities/pockets	Quarterly	LW	Reporting format

Output Indicator

- % of targeted population (HRIs/young people and women) with increased knowledge about the modes of transmission of STIs, HIV/AIDS; HIV/AIDS prevention; care and treatment

Objective 2: To promote increased and consistent use of condoms with casual and regular partners.

Process Indicators	Frequency	Responsibility	Source
No. of Condom Depots established and functioning* *(depot receive stock; and sale of condom)*	Monthly	LW	Reporting format
No. of individual males and females informed about the correct use of condom	Monthly	LW	Reporting format
No. of HRIs (FSWs, MSM, IDUs) and bridge population members informed about the correct use of condoms	Monthly	LW	Reporting Format
No. of vulnerable young people informed about the correct use of condom	Monthly	LW	Reporting Format
Uptake of condom from the depots (mean active collection by individuals - male and female)	Monthly	LW	Reporting format

Output Indicators

- % of women and men from HRGs and vulnerable young people aware of dual benefits of Condom use
- % of women and men from HRGs and vulnerable young people reporting easy availability of condoms
- % of women and men from HRGs and vulnerable young people aware of correct use of condoms
- % of women and men from HRGs surveyed informing of consistent use of condoms
- % of sexually active young people surveyed informing of consistent use of condoms

Objective 3: To generate awareness and enhance utilisation of prevention, care and support programmes and services (especially STI, ICTC, PPTCT, ART and DOT).

Process Indicators	Frequency	Responsibility	Source
No. of groups informed about services (STI clinics, ICTC, PPTCT, ART, DOTS) - male and female	Monthly	LW	Reporting format
No. of meetings attended (e.g. VHSC, panchayat) with grassroots level functionaries such as ANM, LHV, MO, AWW, PRI, functionaries of rural development, etc. for enhancing linkages	Monthly	LW	Reporting format
No. of visits made to service providers (e.g. ANM, AWW. ASHA, Doctors/ Paramedical) by Link Workers for enhancing linkages	Monthly	LW	Reporting format
No. of HRIs and vulnerable young people referred by Link Workers/ volunteers to services	Monthly	LW	Reporting format

Output Indicators

- Percentage increase of Full ANC (at least 3 ANC during pregnancy), from the HRGs and bridge populations.
- Percentage increase in ICTC service utilisation (e.g. number of women and men from HRGs and bridge populations tested for HIV)
- Percentage of women and men who returned to collect reports
- Percentage of couple with STIs/RTIs, who have sought full treatment and/or completed one cycle of treatment
- % of vulnerable young people utilising services

Objective 4: To create an enabling environment through involvement of PLHAs and reducing stigma and discrimination that facilitates the re-integration of HRGs into the community and recognition of their rights.

Process Indicators	Frequency	Responsibility	Source
No. of PLHA (male and female) contacted through one-to-one or group meetings	Monthly	LW	Reporting format
No. of PLHA reporting instances of stigma and discrimination	Quarterly	LW	Reporting format
No. of PLHA who attended meetings conducted by Link Workers	Monthly	LW	Reporting format

Output Indicators

- Number of PLHA reporting instances of stigma and discrimination
- Percentage of HRIs with better understanding of stigma and discrimination and how to prevent them
- Percentage of HRG members with positive attitude towards PLHAs
- Percentage increase of HIV positive people participating in awareness generation activities in comparison to baseline
- Percentage of men and women from HRGs who are accepted as part of the community

Objective 5: To provide information and enhance utilisation of care and support programmes and services by individual living with HIV.

Process Indicators	Frequency	Responsibility	Source
No. of care and support services identified and contacted	Monthly	LW	Reporting format
No. of PLHA referred to ART clinics	Monthly	LW	Reporting format
No. of positive pregnant women referred for PPTCT	Monthly	LW	Reporting format

Output Indicators

- Percentage of HIV positive women and men aware of ART and treatment of opportunistic infections
- Percentage of HIV positive women and men on ART
- Percentage of HIV positive pregnant women availing PPTCT services

5.3 Reporting Channels

Reporting is a major activity during project monitoring. It is the way in which information about the process and output of activities, and not just the activities themselves, is shared between the different functionaries of the project. There are reporting formats for DRPs, Supervisors and Link Workers which must be completed on a monthly basis. Volunteers will do verbal reporting.

- Volunteers report to Link Worker (informal mechanism)
- Link Workers report to DRP through Supervisor
- Supervisor reports to District Resource Person
- District Resource Person reports to DAPCU/NGO and SACS

COSTING AT DISTRICT LEVEL

6

6.1 Costing for One District

6.1.1 PERSONNEL COSTS

	Salary	Travel	No. of Persons	Total Cost per Month (Rs)
Link Workers	1,500	500	40	80000
Supervisors	6,000	1,000	4	28000
DRP	20,000	2,000	1	22000
M&E	12,000	1,500	1	13500
Office Assistant	5,000		1	5000
TOTAL (Rs)			**47**	**1,48,500**

6.1.2 TRAINING COSTS

6.1.2 (a) ORIENTATION TRAINING- 14 DAYS

	No. of Persons	One Time Cost		Accommoda tion	Food	No. of Training Days	Cost of Orientation Training
		Travel	Materials				
Link Workers	40	500	60	250	150	14	246,400
Supervisors	4	500	60	250	150	14	24,640
DRP	1	500	60	250	150	14	6,160
M&E	1	500	60	250	150	14	6,160
Total Cost for Orientation Training (Rs)							**2,83,360**

6.1.2(b) FOLLOW UP TRAINING -2 DAYS

	No. of Persons	One Time Cost		Accommoda tion	Food	No. of Training Days	Cost of Follow up Training
		Travel	Materials				
Link Workers	40	500	60	250	150	2	54,400
Supervisors	4	500	60	250	150	2	5,440
DRP	1	500	60	250	150	2	1,360
M&E	1	500	60	250	150	2	1,360
Total Cost for Refreshers Training (Rs)							**62,560**
GRAND TOTAL FOR TRAINING							**3,45,920**

6.1.3 ONE-TIME COSTS

Item	Cost	Total
Mobilisation events	10,000	10,000
Recruitment costs	3,000	3,000
Computer, Printer & furniture*	72,500	72,500
TOTAL (RS)		**85,500**

*Note: Insurance of office equipment, including computer, to be borne by Implementing agency.

6.1.4 RECURRING COSTS FOR OFFICE SET UP

Item	Total Cost per month Rs
Rent	2,500
Office maintenance	250
Electricity & Utilities	300
Postage	150
Communication	1,500
Xerox	300
Printing & Stationery	1,000
Computer maintenance	300
Programme expenses	2,500
Contingencies	500
TOTAL (Rs)	**9,300**

6.2 Costing For One District Per Year

6.2.1 TOTAL FOR ONE DISTRICT PER YEAR

	Months	Cost	Total cost for a year
Personnel	12	1,48,500	17,82,000
Training**	1	345920	3,45,920
Recurring costs	12	9,300	1,11,600
One-time costs	1	85,500	85,500
TOTAL (Rs)			**23,25,020**

**Note : The training cost mentioned in the table will change after the period of one year .In the second year the cost of the orientation training (14 days) will not have to be planned for all the personnel .Only the newly inducted personnel will undergo this training .

The cost of the follow up training (2 days) will however be the recurring cost for all the personnel.

LIST OF ANNEXURES

Annexure	Title	Referenced in Guidelines
Annexure 1	Note on Community Outreach through the Link Worker Scheme - The Bagalkot Experience	Section 2.2
Annexure 2	Rapid Mapping of HIV Risk in Rural Areas	Section 2.2
Annexure 3	Available Frontline Village-Level Workers	Section 2.3
Annexure 4	List of A and B Districts in India	Section 2.4
Annexure 5	Roll-Out Plan	Section 3.1
Annexure 6	Mapping	Section 3.6.3
Annexure 7	Job Aids	Section 4.5
Annexure 8	Reporting Formats	Section 5
NACO Guidelines referenced in these Guidelines		
NGO Selection Guidelines of NACO		Section 3.1

ANNEXURE 1

Tool:

Community Outreach through the Link Worker Scheme – The Bagalkot Experience

Source: Karnataka Health Promotion Trust

Tool Type: Narrative with tabular information

Who can benefit from this resource

DAPCU or NGO implementing Link Worker Scheme

Introduction

This is a brief note on the experience of implementing the community outreach programme for prevention of HIV in the rural areas of Bagalkot, one of the Districts of Karnataka, through the Link Worker Scheme.

Bagalkot district is spread over 6,593 square kilometers. It is surrounded by the Districts of Bijapur in the north, Belgaum in the west, Koppal and Gadag in the south and Gulbarga in the east. Bagalkot has six blocks (Taluks), namely Badami, Bagalkot, Bilagi, Hungund, Jamkhandi and Mudhol. As per the 2001 census, the District has a total population of 16,52,232 of which 8,35,684 is male and 8,16,548 are women.

Population Data for Bagalkot by Taluk				
Sl. No.	**Taluk**	**Male**	**Female**	**Total**
1	Bagalkot	1,25,737	1,22,133	2,47,870
2	Badami	1,46,627	1,45,292	2,91,919
3	Bilagi	71,295	70,548	1,41,843
4	Hungund	1,44,677	1,42,396	2,87,073
5	Jamkhandi	2,08,134	2,00,302	4,08,436
6	Mudhol	1,39,214	1,35,877	2,75,091
Total		**8,35,684**	**8,16,548**	**16,52,232**

The Bagalkot District has 163 Gram Panchayaths with only 12 declared towns. This District was earlier a part of Bijapur and was created as separate District only in 1997. The District has many tourist spots, which attract a large number of visitors from within and outside the District. The mobility serves to increase risk behaviors and vulnerability to HIV.

The economy is primarily agrarian with a higher concentration of migrant agricultural laborers. In-migration and out-migration – both across Districts and within the District – due to the seasonal nature of agriculture are a common feature in Bagalkot District. In-migration occurs primarily during the sugarcane-cutting season. Out-migration is mainly to Mumbai, Goa, Mangalore, Ratnagiri and Pune. The high level of mobility and migration results in higher levels of risk behaviors and vulnerability to HIV.

A socio-cultural entrenchment of female sex work due to the Devadasi tradition heightens vulnerability to HIV. Bagalkot has an estimated 7,300 FSWs who are primarily concentrated in several taluks. One of the striking features of sex work in Bagalkot, which it shares with much of Northern Karnataka, is the large numbers of FSWs in rural areas. This, along with complex sexual networks, high levels of migration and mobility, and a lack of services in rural areas have all contributed to rising rates of HIV infection in Bagalkot.

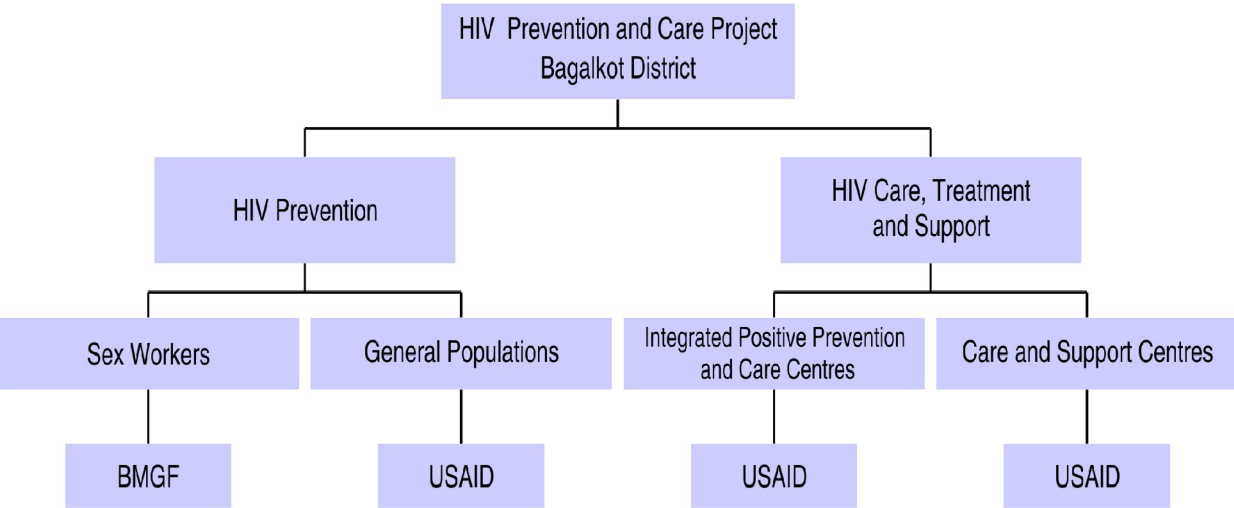
FSW Data for Bagalkot by Village and Rural Sites							
Sl. No.	**Taluka**	**Village Sites**	**Urban Sites**	**Total Village/ Urban Sites**	**Rural FSW**	**Urban FSW**	**Total FSW**
1	Jamakandi	67	3	70	1172	579	1751
2	Mudhol	77	2	79	1848	260	2083

3	Bagalkot	99	1	100	830	7	847
4	Bilagi	61	1	62	984	39	1023
5	Hungund	163	2	165	658	65	723
6	Badami	158	3	161	808	50	873
Total District		**625**	**12**	**637**	**6300**	**1000**	**7300**

A census survey of households conducted in Bagalkot District in the year 2003 found that AIDS was the leading cause of death among those aged 15-49 during the previous two years (17% of all deaths). Importantly, HIV prevalence has been higher than 1% for the last 4 years in the District. The ANC sentinel surveillance shows that prevalence in Bagalkot has been above 3%. The prevalence in rural areas is higher than in the urban areas. The situation assessment in Bagalkot District has highlighted several important issues like rural vulnerability to HIV and growing care and support needs.

In many rural areas, there are limited information, preventive health and social services, resulting in both a lack of knowledge about how to prevent HIV infection, and lack of access to key preventive services including condoms and RTI/STI services.

The Bagalkot Project



A rural HIV prevention and care project has been implemented in Bagalkot for last 4 years. The project, initially funded by the Canadian International Development Agency (CIDA) and known as ICHAP had by March 2006 been implement in 6 taluks of Bagalkot. Since April 2006, the project is being funded and implemented by Karnataka Health Promotion Trust with partial funding (for a sex work project under the project name Corridors) from BMGF. Since October 2006, USAID is also funding care and support programmes in the District. Currently this is the funding structure:

- The *e* funded by USAID aims to reduce the transmission and impact of HIV in Karnataka and selected Districts of Andhra Pradesh. Besides Bagalkot, the project is being implemented in 11 other District of Karnataka and 4 Coastal Districts of AP.
- The *e* funded by BMGF aims to reduce transmission of STIs and HIV among female FSWs in 3 Districts of Karnataka and 3 Districts of Maharashtra.

This 4-year project, which has now become a model project for rural HIV prevention and care, has the following components:

- Outreach
- Mobilisation

Outreach and Mobilisation

Outreach to the general population is done through a cadre of male and female Link Workers. The project has a pair of Link Workers for 3-5 villages covering a population of 10,000 people. The task of Link Workers is to provide information to people, motivate them to access services and then follow up to provide support and further care if needed. Up to May 2007:

- 4,82,705 men and 4,53,449 women were given one-on-one information
- 55,30,483 condoms were distributed

Mobilisation of the general population, especially village leaders, is important to provide a stigma-free environment for at-risk and HIV positive populations. Hence in the villages the project has formed/ activated Village Health Committees to take ownership and responsibility of HIV prevention work and the care of PLWHA. 198 Village Health Committees have been formed/activated for ownership and sustainability up to May 2007.

Outreach with sex workers is done through peers. The peers provide information, distribute and demonstrate condoms and also refer and counsel sex workers to go to the STI clinics. Peers also facilitate formation of groups of sex workers for empowerment, lead literacy classes for sex workers, respond to crisis and violence that the community faces and advocate on behalf of the community for social entitlements. Up to May 2007, 5,400 sex workers have been contacted by the project.

Community mobilisation in the context of sex work in Bagalkot has two facets, one sensitising the general community and village leaders to create a positive image of sex workers in the community, and the other doing advocacy with the sex work community (mothers, gharwalis, community leaders) to support HIV prevention and care work among sex workers. A sex worker CBO that was formed in 2000 aimed to take up the role to advocate for sex workers and their rights. The project supported the CBO by partnering with it in implementation of the project and by facilitating a process of democratic institution building. The CBO is now acknowledged by the community as the voice of sex workers. 3,050 FSWs have chosen to be members of the CBO.

HIV positive outreach workers besides Link Workers also do outreach with PLWHA. The positive outreach workers provide home based counselling and palliative care to PLWHA. PLWHA are linked with IPPCC/ out-patient care centres run by the Positive Network of Bagalkot. The positive outreach workers also link up PLWHA with TB care, ART and even institutional care where necessary.

Mobilising PLWHA to organize and collectivise has been a project objective. PLWHA have been encouraged to form their own group and this gave birth to Jeevan Jyothi, the first District-level positive network in Karnataka. The project is now strengthening the network and has initiated an institution-building process.

Prevention and Care Services

The project has been providing prevention and care services. STI services have been provided through programme-linked clinics and referral clinics for last 4 years. Capacity building of service providers (private and public) in Syndromic Case Management has been a key feature. Drug packs based on SCM have been provided to these providers. Up to May 2007, 14,973 men and 39,580 women were provided STI treatment and follow-up.

Care and Support services have been provided since 2005 through Integrated Positive Prevention

and Care center run by the District Positive Network, Jeevan Jyothi. The center provides outpatient services for PLWHA, conducts group meetings, provides counselling support to those infected and affected and also builds capacities of PLWHA and their family members. 2,036 men and 1,987 women living with HIV were supported through this IPPCC in Bagalkot up to May 2007. A Care and Support Centre has also been recently identified to provide inpatient care for PLWHA in the District.

Referral to existing services (VCTC/ PPTCT/ ART) is also being done in the District. Bagalkot was the first District to start taluk-level VCTC services. Up to May 2007, the project has referred 9,195 men and 5,539 women for counselling and testing support

Partnership with the Government

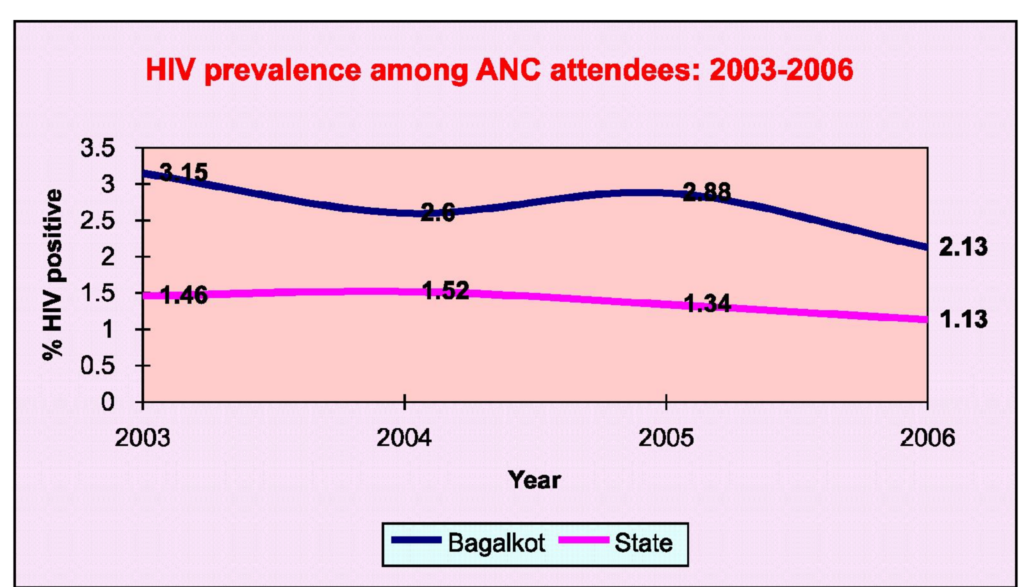
The Bagalkot project partners with the government in implementing HIV prevention and care programmes in the District. Bagalkot was the first District in the State to develop a joint action plan with the government for HIV prevention and care in the District. The project has a project steering committee, which is chaired by the District Commissioner (and now renamed the District AIDS Committee). The project also partners with the District health system in training doctors, health care providers, anganwadi workers and school teachers. Health camps and STI camps are conducted in collaboration with the District Health officials and PHC/ CHC. The project office, located in the District hospital, further facilitates collaboration with the government.

Coverage

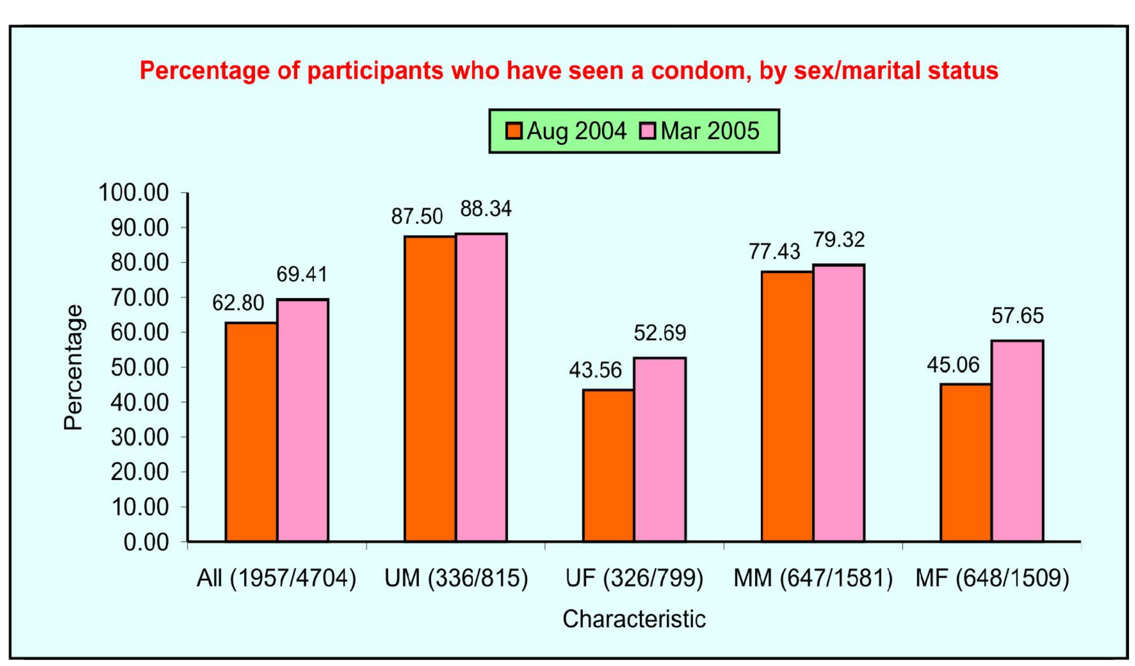
Currently the project is working in 250 villages for general population prevention and 158 villages for prevention with sex workers. Care and support (inpatient and outpatient) services have been set up with will cater to the whole District.

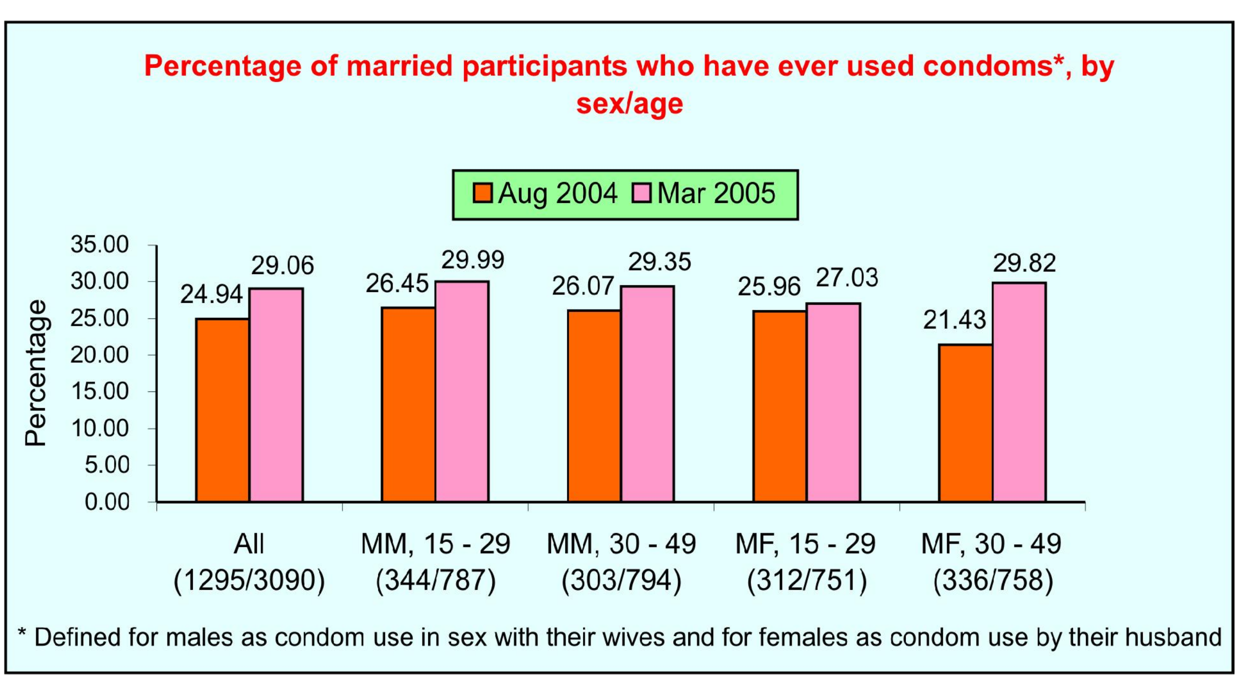
Achievement

Sentinel Surveillance data for Karnataka has shown an overall decline in HIV prevalence among the ANC attendees from 1.46% in 2003 to 1.13% in 2006. A similar decline was observed in Bagalkot District (from 3.15% in 2003 to 2.13% in 2006). However, the decline in HIV prevalence in Bagalkot cannot entirely be attributed to the project.



The two rounds of polling booth surveys carried out in the project areas of the District among the general population indicated a positive change in some of the project outcomes measured in terms of the percentage who have seen a condom and the percentage of married person who have ever used a condom. The change has been sharper among the females than the males.





Key Accomplishments and Learnings from the Project

Bagalkot site is currently being developed as a learning site for rural HIV prevention and care intervention. Our accomplishments learnings in the last 4 years have been:

- Planning and implementing a District-wide prevention and care project with focus on the rural areas.

- Planning and implementing a rural prevention programme, which is evidence-based and targets those at risk in relation to geography and population.
- Involving and building capacity of local community members (Link Workers, peers, village leaders, Government officials) to become change agents in their communities.
- Designing and implementing a differential package of outreach and services for rural villages and populations based on differentials in the risk

Our learnings in the past 4 years have been:

- The importance and the mechanics of building an enabling environment through advocacy with villages leaders to facilitate ownership and sustainability of the change process
- Collaboration with the government in designing and implementing a District HIV prevention and care programme
- Designing and implementing different strategies for provision of regular clinical services
- Being flexible and evolving the programme based on the needs of the community
- Strengthening local community based organizations to take leadership and ownership of programmes
- Need for regular monitoring and assessments of the programme to measure progress and make changes to keep the programme effective

ANNEXURE 2

Tool:

Rapid Mapping of

HIV Risk in Rural Areas

Source: Karnataka Health Promotion Trust

Tool Type: Description and Questionnaire

Who can benefit from this resource

DRPs and supervisors training Link Workers, and the Link Workers themselves

Introduction

One of the major components of the USAID Project in Karnataka is to implement an HIV prevention programme in high risk groups as well as vulnerable populations including youth in the selected 900 villages of the 9 programme Districts: Gulbarga, Raichur, Koppal, Dharwad, Bellary, Kolar, Bangalore Rural, Davanagere and Tumkur.

The selection of villages will be based on a rapid mapping of all villages in these Districts on a number of parameters, including:

- Size of the village (from the Census 2001)
- Estimated number of FSWs in the village
- Migration of village population
- Estimated size of the population infected with HIV
- Estimated proportion of deaths due to AIDS/TB in the past two years
- Major population congregation events
- Proximity to an urban centre, to a highway, to industrial hubs/workplaces

There will be 15 – 20 teams in each District (depending on the number of villages to be covered), each team consisting of **a researcher** and **a member of the district SW collective**. There will be one designated person from KHPT who will be the overall in-charge for this rapid assessment. In order to plan the field operations and to ensure quality, one **Regional Resource Person (RRP)** and **technical consultants from the Population Research Center (PRC)** will work closely with the District in-charge.

Methodology

For this rapid assessment, all villages with population above 500 are selected and the study team will visit each of these villages. Upon reaching the village, the team should first contact the **Village Mukhyasta** and inform him about the rapid assessment and the need for this assessment. Build rapport with the Mukhyasta and identify all the possible Key Informants available in the village for the study. The following are possible Key Informants in the villages:

- Office-bearer of the Gram Panchayat
- Anganwadi teacher
- ANM
- School teacher
- Owners of petty shops/grocery stores/fair price shops/hotels/tea stalls
- Members of Mahila Mandals, Sthree Shakti groups
- Members of Yuvak Mandals
- Local STD/Telephone booth operators
- People Living with HIV

Among the list of probable Key Informants, the study team will carry out a minimum of 5 in-depth interviews as per the guidelines.

During the initial or Key Informant discussions, if it is confirmed that there are FSWs living in the village, the team should try to meet at least 3 of these FSWs. The community member in the team should focus on getting more information about FSWs staying in the village and the FSWs from the village who practice sex work outside the village. This information can be explored by visiting the most vulnerable parts of the village such as Janata Plots, Tandas, Harijan Keris, etc.

Roles and Responsibilities

Each field team consists of one researcher and a community member. Every three teams will be under the supervision of a supervisor, who will plan the day-to-day activities of the teams. The teams will report their daily progress to the supervisor, while the supervisor reports the progress of his/her teams' field-work to the District in-charge on a daily basis.

Teams

- Visit the villages assigned to them on a daily basis
- Contact the village Mukhyasta
- Identify Key Informants
- Select the Key Informants for the interview
- Complete the key informant interviews
- Identify whether any sex worker lives in the village
- Triangulate the information from the key informant interviews and complete the Village Form
- Complete the villages assigned to the team daily
- Complete the Field Control Form and submit to the supervisor
- Report any issues in the field to the team supervisor immediately

Supervisor

- Take charge of the transportation of the teams assigned to him/her
- Daily field plans of his/her teams
- Check for the selection of Key Informants
- Examine the Key Informants interviews
- Verification of completeness of information
- Verification of triangulation of information
- Complete the control form and submit to the District in-charge
- Report the progress to the District in-charge
- Report any issues in the field to the District in-charge
- Conduct daily team meeting and discuss the progress and issues of the day

District In-charge

- Overall responsibility for the District
- Recruitment of teams and supervisors
- Train the teams
- Finalise the field work time schedule for the team. Although a tentative fieldwork schedule is prepared at the beginning of the fieldwork, modifications in this initial planning may be required on a daily basis. It is important to document these changes in the schedule on a daily basis and follow up the progress.
- Take charge of the vehicle for the transportation of the field teams, and the materials required for the teams
- Ensure the correct identification and selection of Key Informants
- Check the triangulation of information
- Ensure the quality of the information gathered from villages. Accompany the teams in the initial stages of the fieldwork and sort out any issues that may arise. Subsequently back-check for the completeness of information.
- Ensure that all the teams understand the consolidation of information and recording correctly
- Ensure that the teams are not running out of forms
- Troubleshoot whenever there is a community backlash
- Daily fieldwork review: Fix a time for daily review based on the fieldwork schedule, and (1) discuss the completion, (2) review the observations made by the team supervisor on the completed village forms, and (3) plan for the next day
- Verify the Field Control Form daily to ensure the completion
- Arrange dispatch of Village Forms to KHPT, Bangalore every 5 days

Field Procedures

Do not arrive at consolidating any information from only one in-depth interview. All issues must be addressed with all the Key Informants.

1. **Approximate distance to the nearest town (in kilometres).** Record the approximate distance to the nearest town from the village, in kilometres.
2. **Approximate distance to the nearest National Highway (in kilometres).** Record the approximate distance to the nearest National Highway from the village, in kilometres.
3. **Does this village have a Santhe or a weekly market** A Santhe means selling and buying of agricultural products and other commodities organised within the village, with the participation of people from outside. This usually happens on a weekly basis.
4. **Are there any big events (apart from Santhe) in the village such as Jatre, fair, Mela, etc., which attract a large number of people from other places** These events may be for a day or for several days.
5. **How many such events occur in a year** This is the number of big events such as Jatre, fair, Mela, etc. occurring in the village.
6. **Are there any major factories/construction sites close to the village (including within the village** This is a place where many people from the village and surrounding areas

are employed. This also could be a place where many migrants from outside the area are employed.

7. **Approximately how many persons from this village go out to work temporarily (for a period of one week or longer)** Does a large number of people (single or with families) move out of the village seeking employment during any part of the year Is there seasonal unemployment in the village which pushes people out to seek temporary work outside

8. **Approximately how many persons come to this village for work on a temporary basis (for a period of one week or longer)** Does a large number of people (single or with families) come to the village seeking employment during any part of the year Are there any pull factors for the people from outside come to the village

9. **Approximately how many individuals are currently infected with HIV** The main focus is to understand whether HIV is visible in the village. Do people in the village identify HIV as a problem

10. **Approximately how many individuals have died due to AIDS/TB in the past 2 years** We need to understand whether people think that many of the recent deaths are due to AIDS or TB. Do people consider AIDS/TB as a major cause of death in the village

11. **Are there any female sex workers staying in the village** A female sex worker (FSW) is defined as a woman who has sold sex during the past one month. The following persons should not be considered as FSWs:
    - Those who were sex workers but now have stopped sex work
    - The Devadasis who do not practice sex work
    - Those who have "casual" multiple partners

12. **How many female sex workers stay in the village** After all the Key Informant interviews, record the number of FSWs who **stay in** the village. This is not the average of the number reported by each Key Informant, but a number you arrive at after triangulating the information obtained from the Key Informants. This has two components:
    a. Those who practice sex work in the village.
    b. Those who live in the village but do sex work outside the village (for instance, a woman who does not practice sex work in the village but goes to the nearest town/ village daily/occasionally and practices sex work there should be included here).

13. **Among all the sex workers live in the village, how many of them belong to Devadasis** Some Devadasis may not currently be engaged in sex work, which should not be considered.

14. **How many FSWs from this village live and practice sex work outside the village** After all the Key Informant interviews, record the number of FSWs from the village who **live and practice sex work outside** the village. This is not the average of the number reported by each Key Informant, but a number you arrive at after triangulating the information obtained from all Key Informants. For instance, a woman who has migrated out of the village to a nearby or distant town, stays there and practices sex work should be included here. The reference period for this information is 6 months. This number is the sum of the following three categories:
    a. Those who have migrated to do sex work within the District

b. Those who have migrated to do sex work outside the District but within the State

c. Those who have migrated to do sex work outside the State

15. **Where do most of the clients come from** After discussing with the Key Informants, determine if most of the clients of FSWs come from:

    - The nearby villages/towns within the District
    - Distant villages/towns within the District
    - Outside the district within the State
    - Outside the State
    - Cannot determine (if the key informants are not clear about this)

16. **Total number of Key Informants interviewed (including FSWs if any).** Record the total number of Key Informants you interviewed to arrive at the information. If any FSWs are interviewed, include them also in this number.

17. **Total number of FSWs interviewed.** Record the total number of FSWs you interviewed in the village.

18. **Date of visit to the village.** Record the date on which you visited the village.

19. **Names of Assessment Team Members.** Record the names of both team members here.

20 **Verified by:** All forms need to be verified by the supervisor and his/her name recorded

DISTRICT NAME:		VILLAGE NAME
DISTRICT CODE: ☐☐		VILLAGE CODE: ☐☐☐☐

Item	Item Description	Consoli-dation
1	Approximate distance to the nearest town (in kilometres).	
2	Approximate distance to the highway (In Kilometer)	
3	Does this village have a Santhe or a weekly market	YES/NO
4	Are there any big events (apart from Santhe) in the village such as Jatre, fair, Mela, etc., which a large number of people from other places **IF NO SKIP TO 6**	YES/NO
5	How may such events occur in a year	
6	Are there any major factories/construction sites close to the village (including within the village)	
7	Approximately how many persons from this village go out to work temporarily (for a period of one week or longer)	
8	Approximately how many persons come to this village for work on a temporary basis (for a period of one week or longer)	
9	Approximately how many individuals are currently infected with HIV	
10	Approximately how many individuals have died due to AIDS/TB in the past 2 years	
11	Are there any female sex workers staying in the village	YES/NO
12	How many female sex workers stay in the village **THIS NUMBER IS THE SUM OF THE NUMBER IN 12a and 12b**	
12a	How many of these female sex workers do sex work in the village	
12b	How many of these female sex workers live in the village, but do sex work outside the village	
13	Among all the sex workers live in the village, how many of them belong to Devadasis **THIS NUMBER SHOULD BE LESS THAN OR E UAL TO THE NUMBER IN ITEM 12.**	
14	How many female sex workers from this village live and practice sex work outside the village **THIS NUMBER IS THE SUM OF THE NUMBER IN UESTIONS 14a,14b and 14c**	
14a	How many female sex workers from this village live and practice sex work outside the village but within the District	
14b	How many female sex workers from this village live and practice sex work outside the district, but within this State	
14c	How many female sex workers from this village live and practice sex work outside this State	
15	Where do most of the clients come from	

	RECORD ANY ONE CODE 1. From nearby villages/towns within District 2. From other villages/towns within District 3. Outside the District but within the State 4. Outside the State 5. Cannot determine	
16	Total number of Key Informants interviewed (including FSWs if any)	
17	Total number of FSWs interviewed	
18	Date of visit to the village	
19	Names of Assessment Team Members	1. 2.
20	Verified by:	

Number of Field Teams and Duration of Fieldwork in each District

District	**Number**			**Fieldwork Duration**		
	Field teams	**Supervisor**	**RRP**	**Start Date**	**End Date**	**Number of Days**
Davanagere	15	5	1	8 Dec	22 Dec	15
Dharwad	12	4	1	10 Dec	22 Dec	13
Tumkur	30	10	1	6 Dec	20 Dec	15
Bellary	12	4	1	9 Dec	24 Dec	16
Kolar	30	10	2	13 Dec	27 Dec	15
Gulbarga	27	9	1	11 Dec	24 Dec	14
Koppal	12	4	1	8 Dec	20 Dec	13
Raichur	30	10	1	24 Dec	1 Jan	9
Bangalore Rural	35	12	1	9 Dec	20 Dec	12
Total	**203**	**68**	**10**	**6 Dec**	**1 Jan**	**26**

ANNEXURE 3

Tool:

Available Front-Line

Village-Level Workers

Source: MAMTA

Tool Type: Table

Who can benefit from this resource

SACS, DAPCU/NGO

Criteria	ANM	MPHW	ASHA	AWW
Job Responsi-bilities	■ Providing services, giving medicines, tendering advice ■ Safe pregnancy and delivery, contraception (FP) and immunization ■ Screening and reporting of diseases, e.g. leprosy, TB, malaria, filarial ■ Weekly mobile schedule visiting villages and houses	■ Malaria prevention and sanitation ■ As far as the implementation of the RCH programme is concerned, male health workers have a role in popularising the male methods of family planning among men and educating as well as counselling men on RTI/STI and HIV (AIDS) and service ■ Provide primary services medical care for minor ilments such as diarrhoea, fevers, and first aid for minor injuries ■ Counsel women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including RTIs/STIs and care of the young child ■ Keeping and updating eligible couple register of the village concerned	■ Create awareness and provide information to he community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health and family welfare families in work area once a year ■ Undertake home visits	■ Supplementary nutrition feeding; record weight organise non-formal pre-school activities in the Anganwadi ■ Health nutrition education and counseling on breastfeeding/ Infant and young feeding practices ■ Carry out a survey of all the
Focus Group	■ Men, women and children	■ Men	■ Village communities	■ Pregnant and lactating women,and children under 6 yrs
Interface	■ ANM under the NRHM is now entrusted with the following responsibilities to strengthen and 'mainstream' ASHA and the health care facilities	■ Expected to help female health workers in immunisation sessions	■ Work with the Village Health and Sanitation Committee of the Gram Panchayat to develop a comprehensive village health plan	■ Assist PHC staff immunisation, health check-up, ante-natal and post- natal check, distribution of IFA and Vitamin A, etc. ■ Motivate married women to adopt family planning measures

Criteria	ANM	MPHW	ASHA	AWW
Other responsi-bilities Adolescent	■ Maintaining contact with PHC/CHC and District hospital for attending meetings, procuring essential supplies ■ Part of implementation of various schemes-Balika Samridhi Yojana, Janani Suraksha Yojana, etc. ■ Data Collection-part of many surveys ■ Under the community needs assessment approach (CNAA) is expected to prepare plans for her area (bottom-up approach) ■ Act as a resource person for the training of ASHA		■ Escort pregnant women and children requiring treatment/ admission ■ Provider of DOTS and primary health care ■ Depot holder for ORS, IFA, chloroquine, Disposable Delivery Kits, Oral Pills & condoms ■ Inform about the births and deaths in her village and any unusual health problems/ disease outbreaks in the community to the Sub-Centres/Primary Health Centre ■ Promote construction of household toilets under Total Sanitation Campaign	■ Assist in implementation of Kishori Shakti Yojana - Nutrition Program for Girls ■ Identify disabilities among children during her home visits and refer cases immediately to the nearest PHC or District Disability Rehabilitation Centre ■ Act as a resource person for the training of ASHA
Identified problems	■ ANM are exposed to community politics and it is at this juncture that their gender, age, marital status, social image, caste and political affiliations (if any) are crucial. ■ Sub-centres are set in isolation at varying distances from primary health centers and ANMs posted in these centers work in an unassisted fashion with only transient professional guidance from the Medical Officer or lady health visitor			■ Anganwari workers (AWW) are inadequately trained, supervised and supported

Criteria	ANM	MPHW	ASHA	AWW
Coverage	■ 75% of the PHCs have Female Health Worker/ANM. ■ As of 2004 there is a short fall of 11,191 ANMs against the sanctioned post in India.	■ 41% of the SCs at the all-India level do not have a sanctioned post of male health worker. Only 68% of sanctioned posts for SCs have been filled. ■ As of 2004 there is a short fall of 67,261 Health Workers (Male), Multipurpose Workers (Male) against the sanctioned post in India.		Number of beneficiaries per Anganwadi worker has gone up from 70 in March, 2001 to 83 in March 2003 can hardly been said as significant, looking at the number of targeted beneficiaries.

ANNEXURE 4

Tool:

Number of A and B Districts

in each State

Source: NACO

Tool Type: Table

Who can benefit from this resource

SACS, DAPCU, NGO

Sl. No.	States	Type A	Type B
1	Andhra Pradesh	22	0
2	Andamans & Nicobar	0	1
3	Arunachal	0	0
4	Assam	0	1
5	Bihar	0	3
6	Chandigarh	0	1
7	Chattisgarh	4	0
8	D&N Haveli	0	0
9	Daman and Diu	0	1
10	Delhi	1	4
11	Goa	1	1
12	Gujarat	2	4
13	Haryana	0	0
14	Himachal	1	0
15	Jammu & Kashmir	0	1
16	Jharkhand	0	0
17	Karnataka	27	0
18	Kerala	0	4
19	Lakshyadeep	0	0
20	MP	3	1
21	Maharashtra	29	1
22	Manipur	9	0
23	Meghalya	0	0
24	Mizoram	3	1
25	Nagaland	11	0
26	Orissa	1	2
27	Pondicherry	0	1
28	Punjab	2	0
29	Rajasthan	2	5
30	Sikkim	1	0
31	Tamil Nadu	16	7
32	Tripura	0	1
33	Uttar Pradesh	3	2
34	Uttaranchal	0	0
35	West Bengal	2	5
	Total	**140**	**47**

(List revised 8 February 2007)

ANNEXURE 5

Tool:

Roll-Out Plan

Tool Type: Table

Who can benefit from this resource

DAPCU/District NGO

The Link worker scheme requires establishing Technical Resource Institutes (TRIs) before the roll-out of the Scheme. The roll-out will initially take place in about 50 A and B districts of the country. The first 50 districts must be identified by NACO. Suggested criteria for selection of districts are:

- High prevalence of HIV in general population
- High percentage of high-risk groups
- High migration
- District Health Mission (under NRHM) constituted and functioning

NACO will finalise the TRIs. This will be followed by orientation of the key resource persons from the TRI on the Scheme and the tools (Manual, Handbook and Job Aids) developed to support the training and operationalise the Link Worker Scheme.

The first two months should be used by TRIs/SACS for adapting and translating the materials (Modules, Handbook and Job Aids) prepared under the scheme and approved by NACO.

Some preparatory work is required at the District level to roll out the Scheme:

Activities	Implementation Agency	Timeline from Date of Roll-Out of Scheme
District ulnera ilit mapping - apping o s and ulnera le groups su -populations	D PC C	2 months earlier reports on this are alread a aila le, this step can e omitted
daptation and translation o the operational guidelines and other materials manual, hand ook and Jo ids	s	2months
election o D Ps	District N D PC C	1 month
raining o D Ps		1 month
denti ication o illages with 5,000 population or clusters o illages with 5,000 population with presence o s	C D PC District N	1 month
Programme Planning: num er o clusters illages to e co ered, ke strategies, num er o ink workers and super isors needed in the district	D PC District N	1 month
election o ink orkers	D PC District N	1 month
raining o ink orkers	D P uper isor	2-3 months
mplementation o illage-le el acti ities ink orker	ink orker and uper isor	

The percentage of HRGs in the District should be based on identification of HRGs in a District through a mapping exercise that may have been undertaken in the previous 1-2 yrs. If no such research has been undertaken during this time, the SACS/DAPCU should undertake this mapping, which will form the basis for designing the implementation of the Scheme in the District. The number of Link Workers and volunteers will largely depend on the number of HRIs in the districts and how scattered they are.

The SACS/TRI must also initiate the selection process for District NGOs where the implementation of the Scheme is to be done by NGOs. The intensive training of DRPs and supervisors will precede the selection and training of Link Workers.

ANNEXURE 6

Tool:

Mapping

Source: MAMTA

Tool Type: Description with maps and tables

Who can benefit from this resource

Supervisors and Link workers to know the resources available in the village.

Introduction

Various contextual and structural factors prevailing in India are generally favourable to an increased incidence of HIV/STIs across the country. Documented risk factors include: the increasing pace of urbanisation, high internal population mobility, the unbalanced male-female ratio (leading to an excess of men in cities), geographical and economic disparities, illiteracy, lack of preventive knowledge and skills, rural-urban differentials in knowledge, poverty, gender roles and a spectrum of high-risk sexual behaviour (initiation of sexual activity at younger ages, engaging in sexual intercourse without using a condom).

HIV has moved to the general population in many parts of the country, while awareness and adoption of safe behaviours remain below desired levels. The specific objective of NACP III is to reduce new infections as estimated in year 1 of the programme. The objective is further divided into two segments - one dealing with High-Risk Groups (HRGs) and the other with general ("vulnerable") populations. NACP III will focus on young persons, women and workers while continuing with communication and service provision strategies for the general population.

Why is it Important to Know a Village (in the context of the Link Worker Scheme)?

Vulnerability

In the context of NACP III vulnerability is defined as the degree to which an individual or a section of population has control over their risk of acquiring HIV, or the degree to which those people who are infected and affected by HIV are able to access appropriate care and support.

> Women, youth and children in special settings, e.g. out of school (especially girls), children of sex workers, orphans of HIV/AIDS and infected and affected children, IDUs and migrants are the most vulnerable. For NACP III they shall be targeted through specific Link Worker interventions.

Youth

Operational definition and nuances of the term "youth" often vary from country to country, depending on the specific socio-cultural, institutional, economic and political factors. WHO defines young people as between 10-24 years. Consistent with the earlier policy of NACO youth will be defined as persons in the age group of 15-29 years.

Out-of-school people

All those young people in the official school-age group who are not enrolled in school.

Why should we target youth?

Nearly 33% of reported AIDS cases up to June 2005 are in the 15-29 year age group. Physiologically, young people are more vulnerable to STIs than adults, and girls are more vulnerable than boys. Gender power imbalances, societal norms, poverty and economic dependence all contribute to young people's risk of STIs. Many young people lack control over the choice of their marital and sexual partners, how many partners they have, the circumstances

and nature of sexual activity and the extent to which sex is consensual or protected. Many lack information and access to condoms or are unaware of the risk. The pandemic also has an impact on young people who live with an HIV-infected parent.

Almost 73% of young people surveyed in 2001 carried misconceptions related to modes of transmission of HIV/AIDS. Few know where to go to access contraceptive supplies or other services. Evidently, consistent use of condoms is much lower. Some young people, such as street children, adolescent sex workers, orphans and migrants, are marginalised from mainstream services and society and hence are even more vulnerable. Their poverty forces them to endure situations that put them at risk of unprotected sex and substance use.

Women

All women in the reproductive age group of 15-49 are the target group or stakeholders.

Why should we target women?

Women have about a two-fold higher incidence of HIV than men, due to female sex work, as well as a higher biological susceptibility of high- and low-risk women to HIV-1 infection. The higher incidence among women is likely to be maintained until 2015, and more of the women infected will be low-risk women (mainly wives of men who visit sex workers sometimes or often).

Children

The Convention on the Rights of the Child defines children as persons up to the age of 18 years.

Why should we target children?

In 2002, an estimated 4 million children lived on the street in India. As of 2003, approximately 35 million children in India under the age of 18 had lost one or both parents due to all causes, which is approximately 9% of all children. It has been estimated that 170,000 children below the age of 15 years are infected with HIV/AIDS in India. Children born to women in the sex trade are at high risk of HIV/AIDS and vulnerable to exploitation and abuse. 57,000 children are infected every year through mother to child transmission. The cumulative number of HIV infected children (0-15 years) reached 220,000 by 2004.

What is Mapping For?

Mapping is commissioned to provide an assessment of the locations and typology of vulnerable populations which NACP III is planning to reach through the Link Workers Scheme. Women, youth and children in special settings (out of school especially girls , children of sex workers, orphans of HIV/AIDS and infected and affected children, IDUs and wives of migrants) are to be identified and documented. The objective of mapping is to find clusters or locations where a vulnerable population (but not High-Risk Groups) is located in any village. The exact number is not important to note, but at the village level the locations are to be identified.

The mapping operation should include identification of the boundaries of the village, preparation of sketch maps and identification on the map of areas in the village where these vulnerable populations reside. (Households are found in dwellings, dwellings in structures and structures in the village.) In this way the target audience gets an unbiased chance of being exposed to awareness generation campaigns, and Link Workers and volunteers will be able to focus on these clusters.

Session 1: Knowing my Village

Time: 5-6 hours

Materials: Maps, tracing paper, pens, pencils

Preparation: Make advance preparation for going out to the village and interacting with key stakeholders

Location Mapping Process

1. Draw a Location Map (see Figure 1) showing the location of the village and how to get there.
2. Do not forget to place the ORIENTATION TO THE NORTH sign. Mark on the boundaries the name of the immediate neighbouring villages and include all useful information to find the village.
3. This rough sketch will serve as guide for the Link Worker or the DRP when they begin the monitoring work.

Lay-Out (Detailed) Mapping Process

1. Draw a lay-out map (see Figure 2) showing all roads, streets, paths, important landmarks and all structures in the village (see Figure 3 for standardised symbols to be used in the maps). It is useful to make a rough sketch map of the relative location of landmarks, public buildings (such as schools, temples and markets) and main roads. The mapping of the village should be done in a systematic manner so that there are no omissions or duplications.
2. On the sketch map, mark the starting point with a large X.
3. Follow either a clockwise or anti-clockwise direction from the starting point.
4. Place a small square at the spot where each structure in the village is located. In some areas, structures have been built so that they can easily be missed. If there is a pathway leading from the structure, check to see if the pathway goes to another structure. People living in the area may help in identifying any hidden structures.
5. For any non-residential structure, identify its use (for example, a store, school or factory).
6. In the rural area where structures may be grouped in small villages or hamlets, cover the entire area hamlet by hamlet. Whenever there is a break in the numbering of structures (for example, when moving from one hamlet to another), use an arrow to indicate how the numbers proceed from one set of structures to another.
7. In a village with scattered households, cover the village by dividing it into imaginary segments radiating from the centre to the village boundary, i.e. each segment covering some area from the centre to the village boundary. It is important to mark the segments on the location map as well.

Identification of Vulnerable Pockets

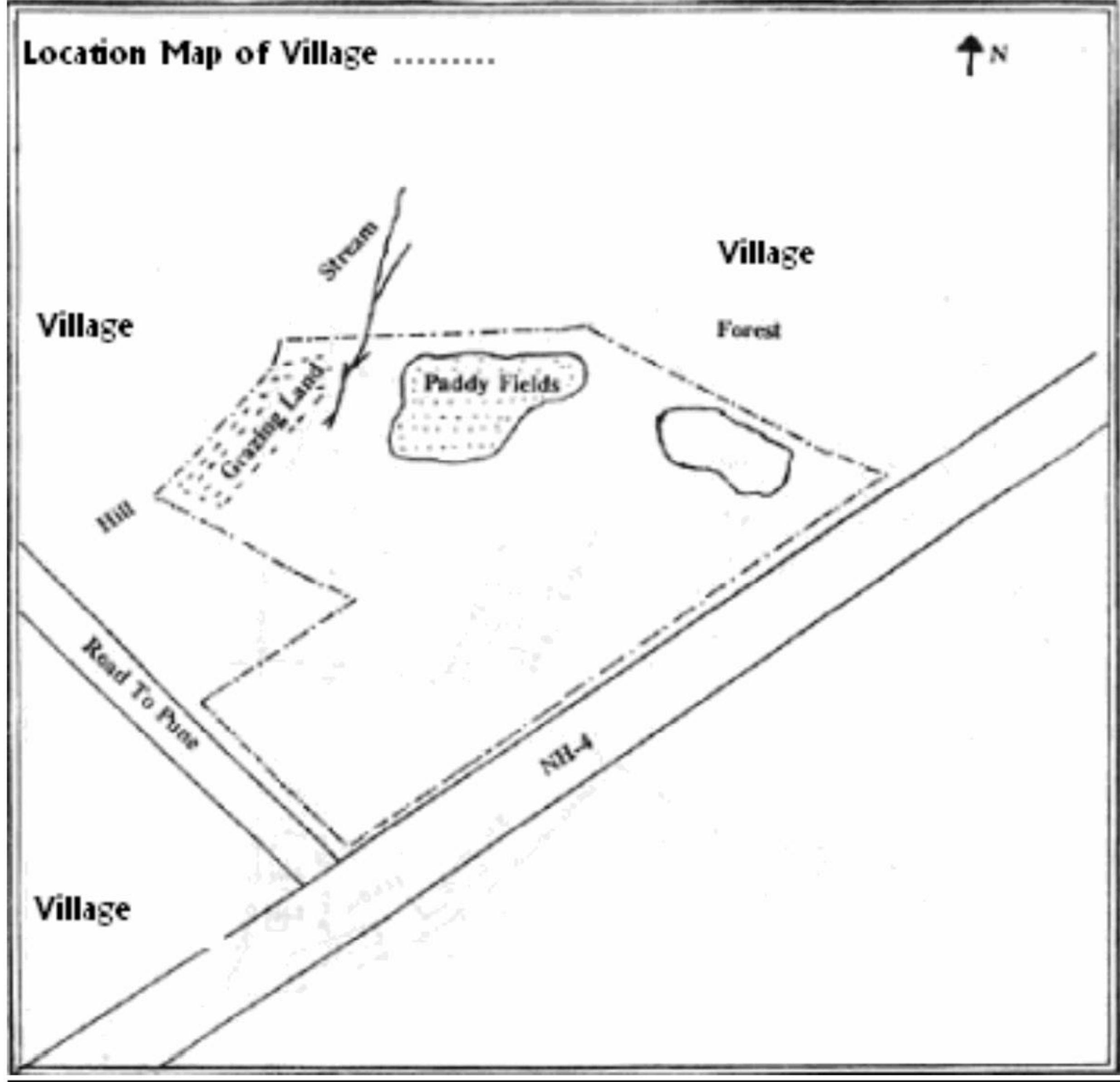
Once the physical lay-out map of the village is ready, follow the following steps. The process of data collection is through Key Informant interactions. In the first step, places where vulnerable populations reside are identified through PRA technique by involving key stakeholders, and in the second step these locations are validated through the Key Informant interactions.

1. Make copies (photocopies) of the map and preserve the original for further reference.
2. Call separately upon different stakeholders, i.e. school teachers, village panchyat member, youth (male and female) of 15-29 years, to identify the cluster or area where most of the vulnerable population reside.
3. Temporarily attach (do not paste) a sheet of tracing paper over the lay-out map so that the tracing paper can be removed without destroying the map, which can then be reused with the next stakeholders. Check that you and the stakeholder can see the map below clearly. Mark the orientation of the tracing paper on the map by marking the map with 1,2,3,4 on the four corners beforehand and marking the same numbers at the same locations on the tracing paper when it is placed on the map.
4. Use colour codes (see Figure 4) on the tracing paper with reference to the map below it. These colour codes do not bear any weight or priority, but to maintain uniformity follow the same colour scheme through out the Link Worker Scheme. Ask the stakeholder where a specific group of vulnerable population resides, and on the tracing paper mark the respective colour code on the identified spot.
5. Meet the next stakeholder and follow step 4 on a new sheet of tracing paper placed over the map.
6. Do not influence stakeholders' perceptions, and do not share information among the stakeholders. The purpose is to validate information from different sources, so as to minimise the influence of individual perceptions and knowledge.
7. When data from all stakeholders has been collected superimpose all the sheets of tracing paper, keeping the 1,2,3,4 marks on all the sheets aligned with each other. Now the set of marked papers superimposed on the map will give a picture of the vulnerable clusters in the village, identifying locations/pockets that the Link Workers and volunteers are to reach with focused interventions. Inclusion of more than one stakeholder's opinion will help reduce any omission and/or bias in identification by any specific stakeholder.
8. Mark the cluster/areas with colour codes on a fresh copy of the map to prepare the final vulnerable pocket map of the village. (See Figure 5.) Repeat the same process to make more copies and preserve the original.
9. Identification of a cluster or a group of families does not in any way indicate that these individuals are more prone to infections; thinking that way could make them the target of stigmatisation. As fellow villagers who have supported each other over the years, we must continue to do so through this Scheme.

Updating the Maps

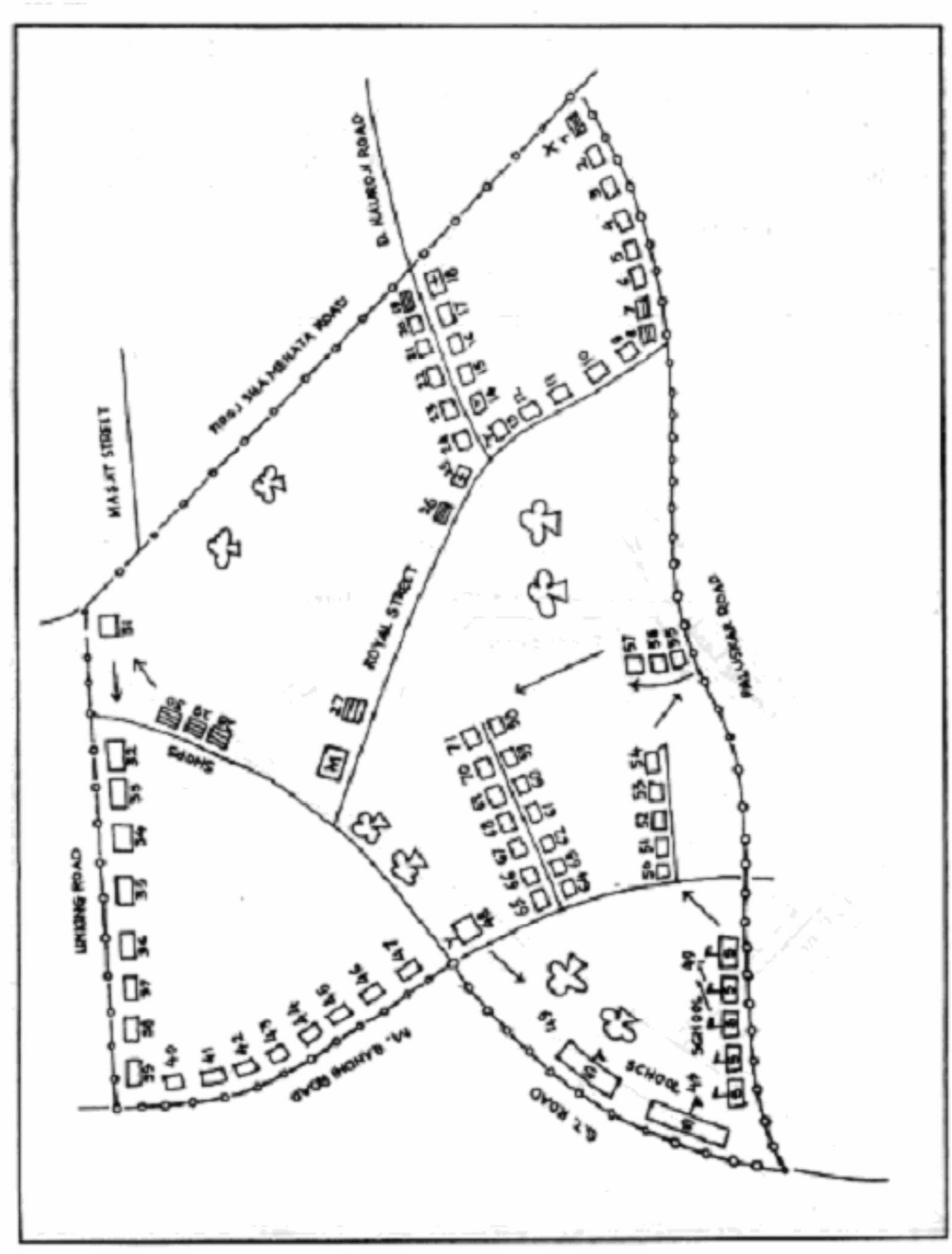
It is important to update the maps regularly in order to enhance the Scheme's ability to reach the target population. Although there might not be any physical changes in the village's structures, the character of any particular household may change over time. Even at the very beginning, the mapping exercise may have missed a particular vulnerable section in the village. It is also possible that in the course of their work, a volunteer or Link Worker may come across a new dimension of vulnerability which must be added to the original map. The number of additions to the map may also be indicate the constant interactions between the community and volunteers/Link Workers.

Figure 1. Location Map of Village



Adapted from NFHS III India Manual for Household Listing, January 2006, IIPS, Mumbai

Figure 2. Layout Map of Village



dapted rom NF ndia anual or ousehold isting, Januar 2006, P , um ai

Figure 3. Symbols to be used for mapping

Sl. No.	Descriptions	Symbols
1	Orientation to North	N
2	Village boundary	
3	Residential house	
4	Non-residential house	
5	Vacant dwelling unit	
6	Pukka road	
7	Kachcha road	
8	Footpath	
9	Broad gauge railway line	
10	Meter gauge railway line	
11	River	
12	Dry river bed	
13	Mountain/Hill	
14	Canal	
15	Pond	
16	Well, tubewell, water tap	
17	Market	M
18	Temple	
19	Mosque	
20	Church	

Sl. No.	Descriptions	Symbols
21	School	S
22	Dispensary	+
23	Sub-centre	
24	Primary Health Centre	+GS
25	Community Health Centre	+GP
26	Government Hospital	+GC
27	Private dispensary including RMP	+GH
28	Private hospital	+PH
29	Panchyat/Administrative Building	AB
30	Post Office	PO
31	Bridge	
32	Railway station	R
33	Electric pole	
34	Tree/Bush	
35	Where youth meets	Y
36	Youth Club	YC
37	NGO	NGO
38	Residence of volunteers	vol

Figure 4. Colour Coding list of vulnerable population

Sl. No.	Description	Colour	Colour Sample
1	Out-of-school Girls	Blue	
2	Out-of-school Boys	Green	
3	Alcohol user	Yellow	
4	IDUs	Black	
5	Houses from where male members migrated	Orange	
6	Orphans of HIV/AIDS and infected and affected children	Violet	
7	Street Children	Red	

Note: This list is not exhaustive. Further vulnerable populations within the ambit of the Link Worker Scheme may be identified and included beyond the existing list of colour codes.

Figure 5. Layout Map of Village with Vulnerable Population Mark-up

Lay Out Map of Village ....

Session 2: Identification and Recruitment of Link Workers (for DRP)

Time: 180 minutes

Materials: Maps, tracing paper, pens, pencils

Preparation: District and tehsil maps as described in this session should be procured well in advance

Process

Link Workers are supposed to be responsible for 5 villages while the village will be served by village-level volunteers. Recruitment of Link Workers in a State and at national context can be daunting. To streamline this task, micro-level planning at the District level through DAPCU is required; this is to be spearheaded by the District Resource Person (DRP). The Census of India in its District census handbooks publishes maps of each District along with detailed tehsil maps. These can be put in use to identify, regulate and monitor the selection process.

Use of District Map

In any District map the location of all the tehsils is displayed (see Figure 6). Detailed maps of the concerned tehsil can be used for micro-planning of the selection process. More than one tehsil is to be targeted to meet the selection process deadline.

Use of Tehsil Map

In the tehsil map (see Figure 7) the boundary of every naya panchayat is demarcated (look carefully in the legend and compare with the map to identify the demarcation). Mark the outline of the naya panchayat (see Figure 8). These naya panchayat are the smallest administrative units, comprised of a number of villages. On the tehsil map marked with the boundary of all naya panchyat, mark the starting point with a large X. The selection process is to begin at the naya panchayat level until the selected Link Worker number reaches thirty, so that a batch from one side of the administrative division is identified. Once the Link Workers are selected, mark the villages from where the Link Workers have been selected (see Figure 9). The jurisdiction list (JL) may be necessary to identify the village, as the Census uses JL Numbers instead of names to represent villages on the maps, to increase legibility. These JL numbers are available in the Census handbook. The eighteen-digit location code of the village can be used as this also bears the number of the naya panchayat.

The completed maps can be used to monitor the progress of the Scheme on the ground. At any given time, the total number of recruited Link Workers is to be expressed as a proportion of the total naya panchyats (e.g. 50% of Link Workers in tehsil X have been selected in the first month). The subsequent month's record should indicate the proportion in the current month and the cumulative over previous month as well. This data can be helpful in organising the orientation of Link Workers, training and subsequent follow-up trainings. These completed maps can also be a reference for the District Resource Persons to schedule monitoring visits and identify sub-

optimisation of the Link Worker capacities. Any changes among Link Workers should immediately be marked on the map to keep an updated record, as the new Workers will require training and more supportive supervision to maintain quality of programme delivery.

Description of Rural Code Directory

Sl.No.	Description	Character	Indicates
1.	STCD	2	State/UT Code
2.	Location CODE	18	Location Code
Description of Location Code			
Total length of the Location Code is 18 digits. Starting from left the code represents: 4 digits		2 digits 4 digits Block Code 4 digits 4 digits	District Code Tehsil Code Naya Panchayat Code Village Code
3.	NAME	30	Name of the Location

Example of the Village Location Codes used in the Census

If a location CODE (LOC CODE) is 01 0040 0060 0001 0002

this means

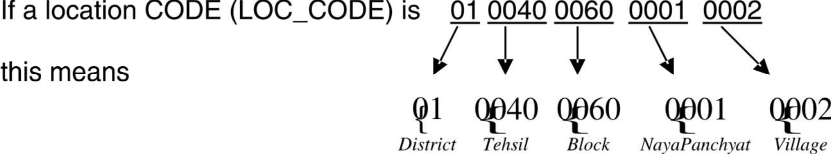


Figure 6. District Map

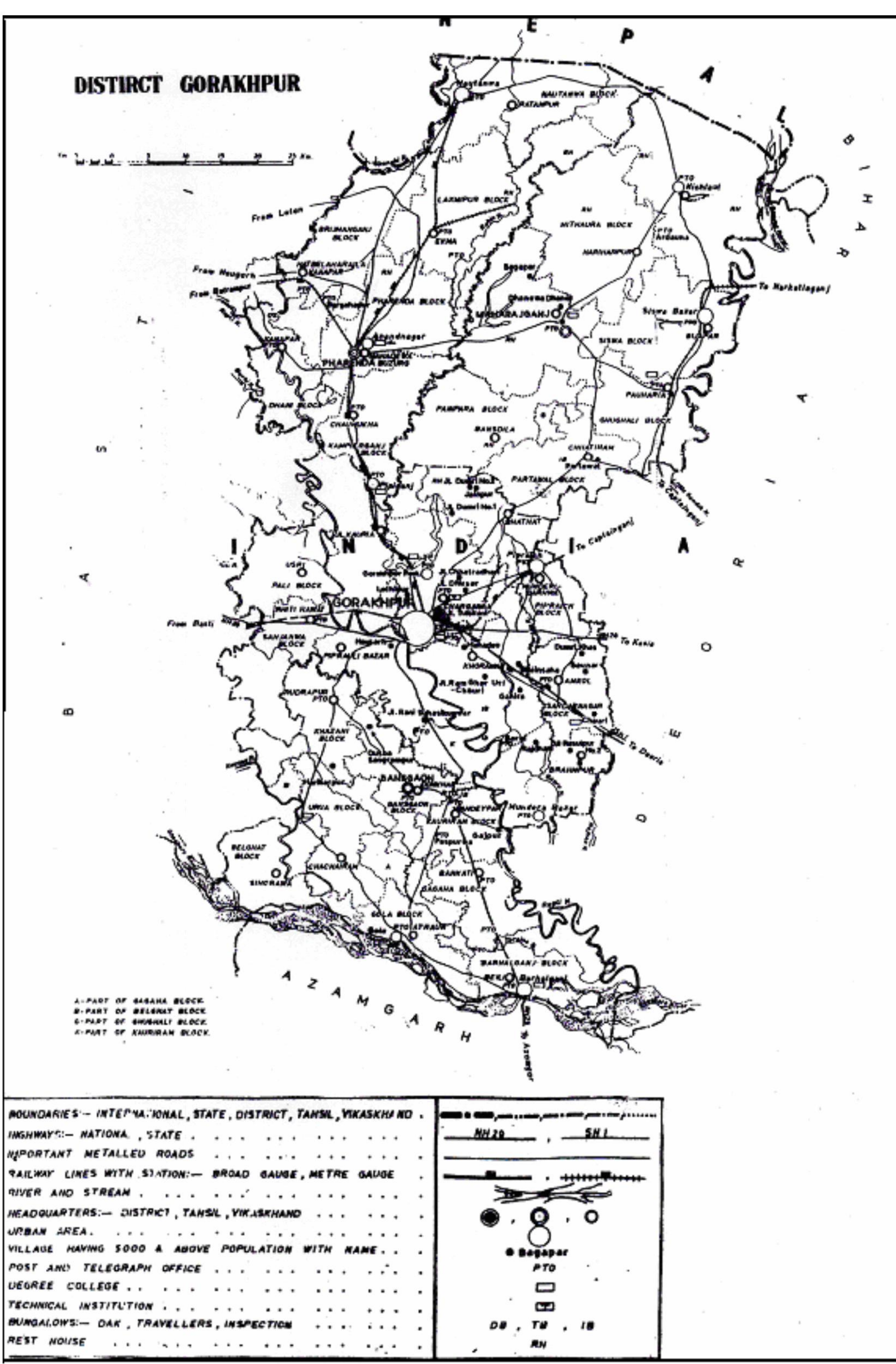


Figure 7. Tehsil Map

SHEET NO. II

TAHSIL PHARENDA

DISTRICT GORAKHPUR

BOUNDARY; DISTRICT; TAHSIL
" VIKAS KHAND; NYAYA PANCHAYAT
" VILLAGE FOREST WITH CODE NUMBER
URBAN AREA WITH LOCATION CODE
HEADQUARTERS: VIKAS KHAND
VILLAGE WITH POPULATION SIZE : BELOW 200; 200–499;
500–999; 1000–4999; UNINHABITED
HIGHWAY STATE
IMPORTANT METALLED ROAD
RAILWAY LINE WITH STATION METRE GAUGE
RIVER AND STREAM
POST OFFICE; TELEGRAPH OFFICE EXCLUDING RMS — PO/TO/
HIGH SCHOOL; INTER COLLEGE — S; IC
POLICE STATION EXCLUDING RLY. POLICE STATION — PS
HOSPITAL. PRIMARY HEALTH CENTRE; DISPENSARY
MATERNITY AND CHILD WELFARE CENTRE
IMPORTANT VILLAGE MARKET

Figure 8. Tehsil Map marked with boundary of Naya Panchyat

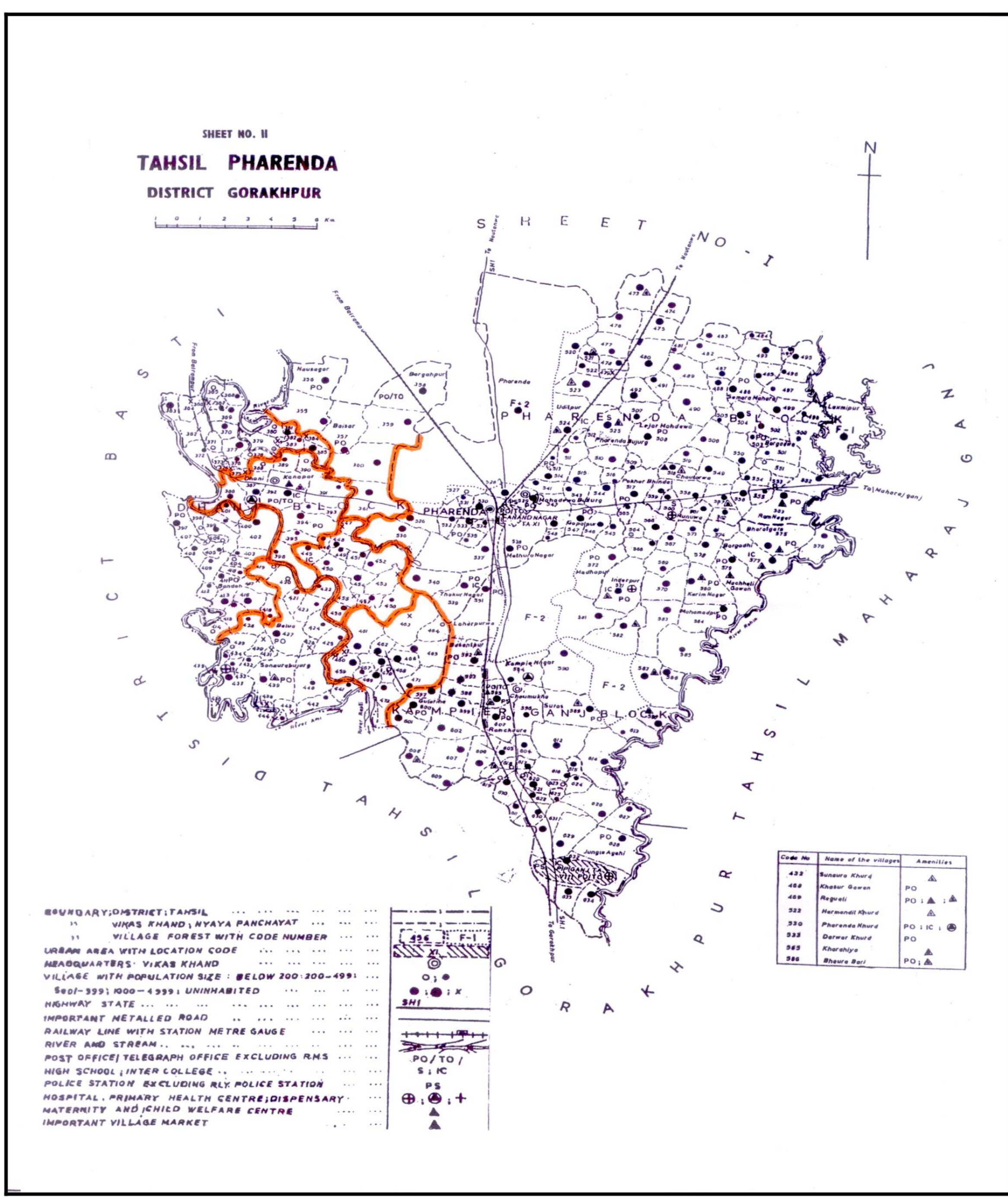


Figure 9. Tehsil Map marked with Locations of Link Workers markings

SHEET NO. II

TAHSIL PHARENDA

DISTRICT GORAKHPUR

Link workers

Code No	Name of the villages	Amenities
432	Sunaura Khurd	
458	Khatur Gawan	PO
469	Reguali	PO
522	Harmandil Khurd	
530	Pharenda Khurd	PO ; IC
533	Darwar Khurd	PO
565	Kharahiya	
586	Bhaura Bari	PO

BOUNDARY; DISTRICT; TAHSIL

VIKAS KHAND; NYAYA PANCHAYAT

VILLAGE FOREST WITH CODE NUMBER

URBAN AREA WITH LOCATION CODE

HEADQUARTERS: VIKAS KHAND

VILLAGE WITH POPULATION SIZE: BELOW 200; 200-499; 500-999; 1000-4999; UNINHABITED

HIGHWAY STATE

IMPORTANT METALLED ROAD

RAILWAY LINE WITH STATION METRE GAUGE

RIVER AND STREAM

POST OFFICE/ TELEGRAPH OFFICE EXCLUDING RMS

HIGH SCHOOL; INTER COLLEGE

POLICE STATION EXCLUDING RLY. POLICE STATION

HOSPITAL, PRIMARY HEALTH CENTRE; DISPENSARY

MATERNITY AND CHILD WELFARE CENTRE

IMPORTANT VILLAGE MARKET

ANNEXURE 7

Tool:
Job Aids

Tool Type: Table

Who can benefit from this resource

DRPs and supervisors training Link Workers, and the Link Workers

This is a suggested list to be finalised in consultation with SACS based on a review of available material that has potential for use in the field. In addition, States are encouraged to use locally developed communication material as well as to work closely with Jan Shikshan Sansthan-JSS adult literacy centres for developing low-cost materials for working with communities.

	Name of the Tool	Issues Addressed	Target group
1.	**Slide and Ladder Board Game** Board Game with counters and dice	Risk behaviour, myths and misconceptions, HIV transmission	■ Unmarried, young boys and girls ■ For community-level activities
2.	**Phad** Stories on flex	Monogamy/faithfulness; condom use; supporting partner for HIV testing	■ Married young couples and those in committed partnerships ■ Vulnerable populations
3.	**Colour TV** Picture Game	Stigma, discrimination	
4.	**Jaankari ki minar** 15" tall tower made of playing cards	ICTC High-risk behaviours	■ All sub-groups of young people ■ For community awareness and creating an enabling environment ■ Enhancing access to services among HRGs and highly vulnerable populations
5.	**Transmission Game** Sunboard on acrylic with different colour threads	HIV transmission and how it is not transmitted	
6.	**Flip book** (under production)	Key messages covering transmission, testing, stigma and discrimination. Gender aspects are also covered.	

Other materials that can be included in the Job Aids

Penis model, model of female reproductive organs. Condoms Golmal (Unifem-Charca) Song books (JHUCCP) Jasoos Vijay (BBC)	Masculinity, gender, HIV/AIDS Key messages covering a range of issues Key messages covering a range of issues	■ For condom demonstration and to build skills of HRIs and in the community ■ For all sub-groups of young people ■ For community awareness and creating an enabling environment

Instruction sheets will be provided for each of the above.

ANNEXURE 8

Tool:

Reporting Formats

Tool Type: Description and Templates

Who can benefit from this resource

Supervisors, Link Workers and volunteers

Reporting Formats

The formats developed will be machine-readable so that the data collected every month by the Link Workers can be compiled and be part of the MIS at the District level to be developed by DAPCU. These will gather information on the process indicators at the frequency indicated in the formats. The information generated by reports will be as follows:

Volunteers

Daily diary of activities giving information on the number of HRIs and young people reached, BCC activities carried out, number of referrals made and linkages developed. The volunteer will report this verbally immediately after any major activity and also in the monthly meetings with the Link Worker.

The Link Workers will review this diary during their visit to the villages and collect relevant information for further reporting.

Link Workers

Monthly report on HRIs contacted, number of young people mobilised, number of people provided with information, number of volunteers trained, activities carried out to reduce stigma and to assist the affected and infected people with psychosocial support, number of school going and out of school, children imparted life skills, BCC activities carried out to help the community to fight alcoholism and substance abuse, number of people provided access to STD treatment and testing facilities, number of linkages developed with CBOs and NGOs as well as other government schemes and programmes going on in the area, advocacy done at the cluster level, and the number of Red Ribbon Clubs and condom depots established.

The report of Link workers must be maintained in such a way as not to mention the names of HRIs and vulnerable groups. Since the population of HRIs may not be very big, a coding system can be developed for the same.

Every Link Worker will maintain the following records for the purpose of reporting:

(i) A Map showing all households along with High Risk Individuals and bridge population members

(ii) Household-level information on young people in the village

(iii) A register with details of activities of the Link Worker and information received from volunteers. The register should have details of meetings attended/organised, trainings conducted /undergone, referrals made and their follow up.

(iv) A logbook of visits made to areas of operation and to other health functionaries. The same logbook will also include all logistics handled by Link Workers/volunteers, e.g. condoms received, distributed, etc.

(v) A logbook of phone calls received as well as made to DRP.

The following information is to be reported on a monthly basis, village-wise.

Name of Link Worker

Area **Month**

Section	Topic	Females	Males	Cumulative	Source
1.	Number of people contacted a. HRIs b. Young people				
1.i	Through group meetings (with Job Aids)				LW Register
1.ii	Through one-on-one contacts				
2.	**Condom usage**				Log book register
2.i	No. of condom depots established				
2.ii	Uptake of condoms				
2.iii	Frequency of supply of condoms				
3.	**Linkages and Utilisation of services** *(to e given separately for HRIs and Young people)*				Service provider register
3.i	ICTC services used				
3.i.A	STI clinic(s) visited				
3.i.B	No. of collected reports				
3.ii	PPTCT services				
3.ii.A	Undergone HIV testing				
3.ii.B	Test result collected				
3.ii.C	Partners counselled for testing				
3.iv	ART Centre				
3.iv.A	No. receiving ART regularly (following treatment adherence as per guidelines)				

The following information is to be reported on a quarterly basis, village-wise.

Section	Topic	Females	Males	Cumulative	Source
1.	Total Volunteers				LW Register
1.i	Drop-outs during the month				
1.ii	Volunteers identified				
1.iii	Volunteers trained				Log book register
2.	No. of vulnerable locations identified (HRGs and bridge population) register and Vulnerability map				
2.i	Nature of vulnerability				
2.ii	Size and composition of vulnerable population				
2.iii	Location				
3.	Linkages developed				
3.i	Number of contacts with				LW Register
	■ ANM				
	■ AWW				
	■ ASHA				
	■ PRI functionaries				
3.ii	Number of contacts with				Log book
	■ PHC				
	■ STI clinics				
	■ ICTC				
	■ PPTCT				
	■ ART Centres				
	■ DOT Centres				
	■ Any other Pvt. Practitioners, NGOs				
4.	Number of individuals from high-risk groups and/or bridge population availing services				Service provider register
	■ PHC				
	■ STI clinics				
	■ ICTC				
	■ PPTCT				
	■ ART Centres				
	■ DOT Centres				

The following information is to be reported on a quarterly basis, village-wise. contd...

Section	Topic	Females	Males	Cumulative	Source
5.	Addressing stigma and discrimination Describe in descriptive for all these episodes.				LW Register
5.i	No. of PLHA (male and female) contacted				
5.ii	Number and nature of instances of stigma reported by PLHA				
5.iii	Number of PLHA invited to community functions				

Additional Information to be submitted by supervisor as consolidated reports

1. Timely receipt of reports form Link Workers

   No. received on time .. No. received late .. No. not received

   Received by the end of first week of next month on time;

   received before end of first fortnight late; not received by the end of fortnight not received.

2. Names of villages visited and how often:

   .

3. No. of activities undertaken by Link Workers facilitated ....

4. Activity undertaken by supervisor at community level ......

   .

5. Visit of High-Risk populations ....

   .
   .

Additional Information in addition to above consolidated reports by DRP

1. Training of Link Workers:

   No. of batches undergone training this month .

   No. of Link Workers trained in each batch

2. No. of Follow-Up trainings conducted

3. No. of locations/populations identified by LW and found acceptable as per laid guidelines

4. No of reports received from supervisors
   On time .. Late ..... Not received

5. No. of feedbacks given to supervisors .

6. Follow-up of linkages:
   No. of visits to concerned department .
   Name of department visited
   No. and place of records examined for referrals

7. No. of instances of stigma and discrimination in your District ..

8. No. of Link Workers in place Male .. Female

9. No. of Link Workers Resigned (if any) Male Female .

10. No of Link Workers recruited: Male ..Female

11. No. of volunteers given reorganisation: Male Female

    Monthly consolidated data feed to the District and State units

    In Time (if delayed please give reason)