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The MYRADA-CDC Experience

Rural HIV Programs with High Risk Groups in India

Towards a comprehensive & integrated strategy for effective &

Sustained impact

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PART 1

1. **Background:**

The Link Worker Scheme (LWS) was designed by the National Aids Control Organisation and incorporated in the National Aids Control program (NACP) Phase 111 (2007-2012). Its objective was to provide appropriate support to enhance prevention, referrals and follow-up for the core high risk groups(HRGs) like rural sex workers and People Living with HIV (PLHIVs) as well as for vulnerable groups (VGs) like the mobile population.

The strategy adopted in the NACO designed Link Worker Scheme (LWS) focused on the core HRGs and VGs; it did not truly encompass other sectors of civil society in which the HRGs and VGs were embedded. The delivery mechanism put in place was a cadre of Link Workers to provide outreach and referral services to these two-targeted groups. The LWS also included interventions to enhance prevention among youth and women and basic support services (besides referrals) for PLHIVs and orphaned and vulnerable children(OVCs). Considering the diverse risk and vulnerability patterns in the various States and Districts, NACO gave flexibility to each State to adopt the "how to implement" part of the LWS.

The LWS guidelines clearly state that it is a time bound program (2007-2012) to address the issues related to HIV prevention and care of HRGs and VGs. Further, one of the key objectives of the National AIDS Control Program (NACP-III) is the need to integrate (converge) the LWS with the National Rural Health Mission (NRHM) by the end of 2012. The NRHM includes in its

delivery strategy the Health Department and the Village Health and Sanitation Committee (VHSC), which has one member from the Panchayat and the Accredited Social Health Activist (ASHA) as members. Myrada assumed that this objective of integration focuses on building the organizational basis to raise and manage the resources required for continuity of the interventions (with HRGs and VGs) and sustainability of the impact; Myrada decided to test this assumption through the CDC PEPFAR supported program.

2. **Initial Findings:** Experience over the past five years.

A. COVERAGE

NACO's strategy for the Link worker scheme (LWS) intervention is to map the entire district using indicators such as village population, , the number of sex workers and the number of PLHIVs; and finally select 100 villages for implanting the scheme. A pair of Link Workers is expected to cover a rural population of 10000. Myrada's experience in the districts where it had taken up the program indicated that as far as sex workers were concerned, they tended to cluster in some Districts like Belgaum, Bagalkot, Bijapur, Gulbarga and Bellary, but not in other Districts like Kolar, Mandya, and Bidar, where they operate from the home and on the street. The mapping exercise should also take this diversity into account. In Districts where sex workers are scattered, it is difficult for the LWS to cover all of them.

The PLHIVs present an even more difficult challenge since Myrada's findings indicate that they are scattered and hesitate to meet in their village since they anticipate negative reactions from the local population. This makes it even more difficult for the Link Worker to contact these PLHIVs regularly and to follow up with each one. Further while the NACO program envisages providing ART treatment only to these PLHIVs, Myrada's interaction with them showed that they also needed other support services like care of children and nutrition.

B. CONVERGENCE

As regards the objective of convergence, NACO and NRHM jointly brought out a convergence document in 2010, which included instructions for the State Level SACs (State Aids Control Societies) and NRHM team to promote convergence. In practice, HIV services have been converged to some extent within the health department and NRHM program. Examples include counseling and testing at PHCs, PPTCT services and STI services in a few areas. However, outreach and community mobilization has not yet been converged with the ASHAs and the VHSCs. Myrada's findings indicate that since the Link Worker program is time bound, the ASHAs who will take over the Link Workers functions should work closely with the LW for at least a year during the transition period to the NRHM delivery system. There is no sign that this convergence during transition is being operationalised currently.

Convergence needs support from a local institution. The Village Health and Sanitation Committees (VHSCs promoted under the NRHM) are expected to provide this institutional support, which will bring all the interveners together so that a certain level of synergy is achieved. However, Myrada's findings indicate that the VHSCs need much more handholding to improve their organisational capacity. For example they need to meet regularly, set an agenda for each meeting, keep minutes of their meetings which will provide evidence of issues raised, decisions to resolve problems and evidence of follow up action; they need to maintain accounts and ensure that they are audited. Myada's findings indicate that initiatives to build the institutional capacity of the VHSCs are scattered and not consistent; building institutions takes time and consistent effort.

PART -2

Myrada - CDC Rural Link worker program (4 districts of Karnataka)

Over the past 6 years,(since 2006) Myrada, with the support of CDC-GAP (under PEPFAR-President's Emergency Plan for AIDS Relief), has been implementing rural HIV programs (similar to the link worker program by NACO) in Karnataka, For the first three years, Myrada implemented activities in Belgaum and Gulbarga taluks. Since late 2008, to honor the NACO strategy of "one district -one partner", Myrada shifted operations to 4 other districts of Karnataka, namely – Bidar, Mandya, Chamrajnagar and Kodagu to implement the rural intervention programs on similar lines as LWS. These locations were selected because they fell in the NACO 'A" category districts with high HIV prevalence. **Myrada first approached the District health authorities and mobilized their support.**

The first 3 years (2006- 2008) gave Myrada an opportunity to try out different strategies of working with rural populations. This experience enabled Myrada to develop in 2008 a strategy and activity document[1] to implement the Link worker scheme in the identified districts. **The key objectives of the intervention were to identify i) which strategies are workable and appropriate to cope with the diversity of ground situations and which would also promote sustainability of the intervention/impact and ii) what level of institutional support and training is required to promote and sustain convergence between the NACO program and the local health and governance system supported by the NRHM to build the basis for sustainability after NACO withdraws..**

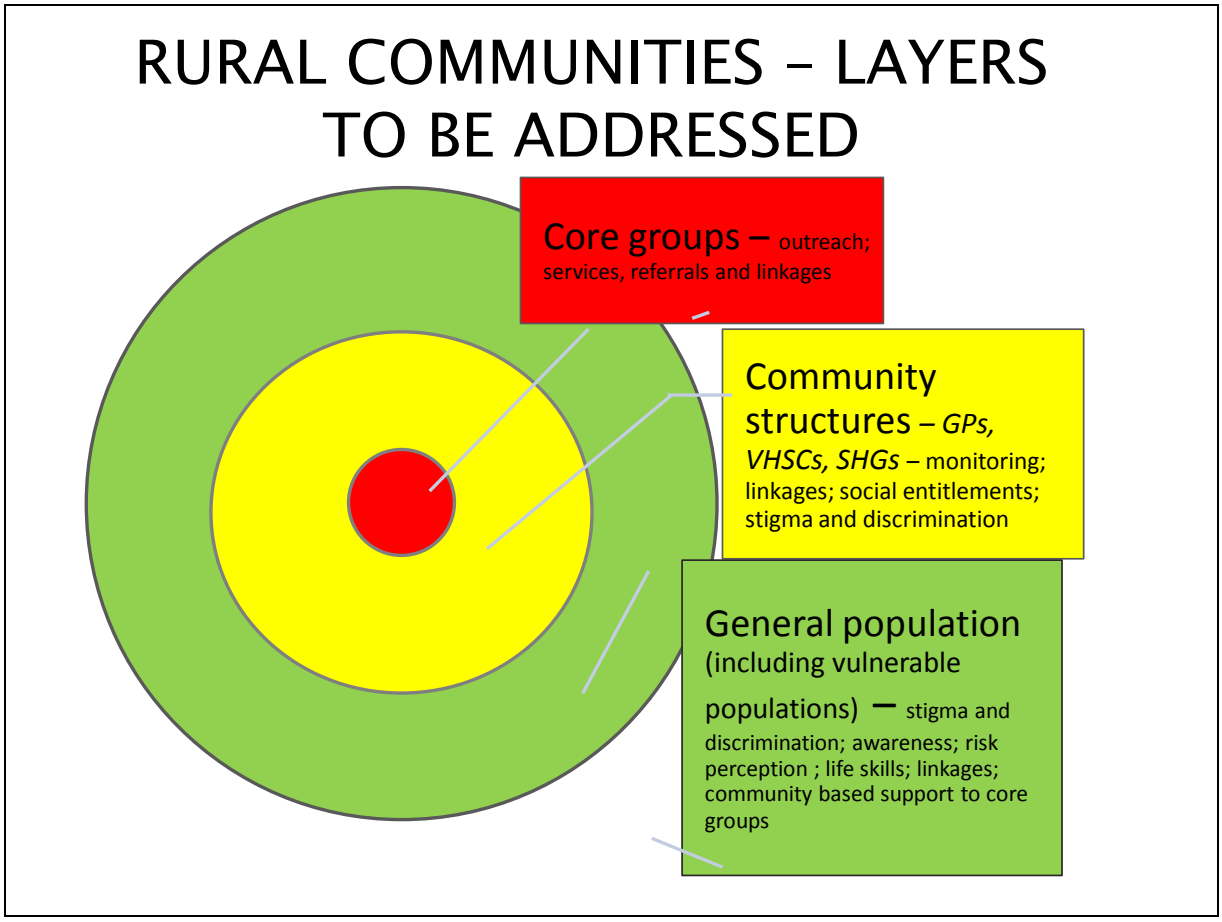
[1] Implementing the link worker program: strategy document for a sustainable and cost effective link worker program: Myrada internal document ; available on request

Myrada covered 364 high risk villages across 4 districts (a sufficiently large program to gain experience and learning)which had the following profiles:

	Bidar	**Mandya**	**Chamrajnagar**	**Kodagu**	**TOTAL**
Taluks	5	7	4	3	19
High risk villages	100	100	100	64	364
HIV prevalence (2008 HSS)	0.125	0.125	0.5	2.63	-
Registered FSWs	721	801	627	484	2633
Registered PLHIVs	393	517	500	90	1500
Registered OVC	326	375	297	55	1053
GPs in working area	88	88	79	50	305
PHCs in working area	34	60	44	18	156
ICTCs in working area	11	15	7	9	42

Though Myrada followed the operational guidelines (of the Link Worker program)of NACO, it added two features which were not part of these operational guidelines . These two features were included as a result of feedback from discussions with high risk groups during the first year, from the situation analysis and from interaction with Myrada project staff. The feedback indicated that the sex workers and high risk groups could not be isolated from the general population as they were part of society. The impression that society had of them was an important consideration. These groups identified "discrimination" by society as a major obstacle to their self esteem and progress. Further the Myrada staff had learnt that community based organizations were critical not only to make targeting of interventions more effective but also to play a major role in building the basis of sustainability of impact by influencing opinions in society and promoting convergence with the Gram Panchayats and main line health services ;they felt that a similar approach could be tested with the high risk groups. Hence the following two features were added in addition to those listed in the operational guidelines of the NACO Link Worker scheme.

1. **A focused as well as a Comprehensive approach** – the rural program was not seen as a targeted (focused) intervention for rural sex workers. Based on findings from the situational analysis and focus group discussions held in the first year (October 2008), the team realized that rural HIV interventions required both a comprehensive and well as focused approach. The comprehensive approach included interventions with the community based organizations (SHGs,VHSCs etc) as well as with the general population. The figure below shows the three sections in which interventions are required



Further, what emerged from experience in the first few months was that interventions were more easily accepted when we started with the community and the community based organization and made them aware of the problem and issue related to high risk groups , instead of intervening directly (in a focused way)with the high risk groups. This approach helped to gain the confidence of the community. The table below gives the activities promoted by the interveners in each group.

	Includes the following	**Focus of activities**
Core High Risk group	Female sex workers, MSMs, high risk migrants; PLHIV, OVC, Pregnant women, STI cases, TB clients	Regular outreach and linkages for services – medical and non medical
Community based organizations	Gram Panchayat, VHSC, SHGs, Soukhya groups	Training and mentoring using a standard curriculum; Support in monitoring service uptake, providing support for nutrition, education and social entitlements and promoting

		a zero tolerance for stigma and discrimination issues. GP, VHSC SHGs, Soukhya Groups were supported to develop a **detailed action plan from a basket of options**
General population	Gram sabhas, youth (male and female),informal groups , other service providers	Increase awareness to dispel myths; reduce stigma and discrimination. Provide support to community structures. Acquire life skills to reduce vulnerabilities to HIV

2. **Convergence/ integration with NRHM** :

The initiative to promote integration with NRHM started from the first year itself. The process went through several stages/phases. These stages are described in detail in the strategy document through a phase wise approach where each phase was detailed in terms of activities, indicators, staffing and budget. [2] Some of the key steps towards integration are described below:

Step 1: Phases

The link worker program was **divided into 3 phases** with different strategies and activities in each phase – the phases are:

a) Entry phase: (1 year) preparation of the community; contact and follow up of high risk groups, infected and affected persons and community based institutions. This was done by LW (ratio of 30 LW for 100 villages) and supervisory staff of Myrada.

b) Consolidation phase: (1 year) Strengthening the community and service/care providers through training of CBOs (GP/ VHSC/ SHGs) and care providers(ASHAs/ ANMs/ PHC medical officers) to understand and take over HIV related services for rural communities in a systematic manner.

All PHC medical officers were trained by faculty from St. John's Medical College in syndromic management of **STIs** and basic management of opportunistic infections **(OI)**.

c) Withdrawal phase: (1 year) Substituting link workers with ASHAs and ANMs; definite roles identified for GP/ VHSC and SHGs in monitoring providers and encouraging community to access services and reduce stigma and discrimination.

Step 2: Staff restructuring

By the third year of the program, **the number of link workers were reduced** from an original 30 in the district to 10 . They were substituted by ASHAs who were involved in all the outreach and referral activities for all core groups; follow up of general population activities and regular

[2] lmplementing the link worker program: strategy document for a sustainable and cost effective link worker program: Myrada internal document ; available on request

reporting of their progress. The ASHAs were trained and supported by the link workers, as well as by the trained VHSCs and GPs.

Community institutions such as the GP, VHSC and SHGs were supported to develop detailed a **action plan from a basket of options** given to them[3]. These action plans were followed up once a quarter and incorporated into the agenda of their review meetings.

PART 3

Issues in the Link worker scheme which emerged in the Myrada CDC program

1. **Coverage of high risk groups**

   A question often asked is "Does the link worker program address the majority of the rural HIV infected and affected individuals?" The answer, unfortunately, is NO. Even though there was a mapping exercise conducted to identify high risk villages, at best, the link worker program covers an average of 50% of the rural FSWs and 15% PLHIVs in a district. A small percentage of the remaining FSWs are covered by the urban TI when the rural FSWs regularly visit the towns to solicit clients. This was experienced in Chamrajnagar and Mandya districts when the initial mapping showed 1300 and 1700 sex workers respectively in the 100 selected villages. However, during revalidation, it was found that around 185 of them were also receiving services from the urban TI program. This was clearly visible in the Chamrajnagar program where Myrada was also implementing the urban TI program. In Mandya, the team found out that some of the sex workers who were residents of the high risk village actually practiced sex work in the urban towns close by. **Majority of the rural female sex workers have a low client volume (less than 5 clients per week) and medium client volume (between 5 – 10 clients per week). The low client volume covered 63% and the medium client volume covered 30% in the Myrada CDC coverage area**. **These can be covered by the regular staff and frontline workers of the health department if integration and convergence has taken place (see model suggested later in the paper)**

	Bidar	**Mandya**	**Chamrajnagar**	**Kodagu**
Total HRGs regd in urban TI (acc to KSAPS TI programs)	FSW-1354 MSM-401	FSW- 1573 MSMs-239	MSM-400, FSW-570=970	MSM-93, FSW- 591
Total PLHIV regd in ART centre	2137	3076	1982	431
Total PLHIV in LW villages	393 **(18.4%)**	517 (**16.8%)**	500 **(25.2%)**	90 **(21%)**

[3] SHG option basket document, GP action plan chart and VHSC action plan chart developed by Myrada.

Some of the PLHIVs who are on ART but not in the link worker villages, may have undergone pre ART registration directly by the ART centre.- this is about 70% of those not covered by link worker program. The ones who are put on ART are followed up regularly, but the same may not be true for those who are not eligible for ART, as there is no dedicated person follow up with this group at the field level.

These large numbers of PLHIVs and OVCs may not have regular contact with any health worker or access to services. This issue needs to be factored in and perhaps an "integration model" may offer a solution (see model described later in the paper).

2. **Regular availability of health care services**

In most districts, the link workers have successfully contacted the majority of the **identified** FSWs in the high risk villages. They **were** able to give them information on HIV and distribute condoms to most of them. However, even though they refer them for health checks up to the nearby PHCs or STI clinics, they **find that either the doctors are not trained on** syndromic management, or more commonly, equipment (speculums and focus lights) and STI drugs are not available at the PHCs on a regular basis.

3. **Stigma and discrimination**

This is the most significant challenge in the link worker program – as identified by the health providers as well as by the community. A key reason is because the program has been designed as a targeted intervention program for rural sex workers. **Hence** the link workers focus on working only with the high risk groups and little effort is spent in dispelling myths and misconceptions and reducing stigma in the community. A more comprehensive approach such as the one attempted by the Myrada CDC program will help to reduce stigma and discrimination especially if the National program follows through on integrating the link worker with the NRHM program.

In Mandya district, following the 2 day training given to all Gram Panchayat members, the GPs developed an action plan to provide support to PLHIVs and OVCs. They agreed to respect the need for confidentiality of the status of the PLHIVs, while mobilizing support for housing and education for some of them. . They also encouraged the PLHIV groups to meet regularly and attended some of the support group meetings. At one such meeting, the GP members donated books, food grains and offered other support to the PLHIV and their families. These gestures helped to reduce the feeling of discrimination or "self stigma" within the PLHIV community; many came forward to allow their OVC children to get the "benefit" of the financial and nutrition support scheme of the Women and Child Development department. In Bidar and Chamrajnagar, most of the trained GPs are providing financial assistance for travel of PLHIVs to ART centres. In Moornadu village of Coorg, the local Gram Panchayat was instrumental in convincing one male PLHIV person to practice positive prevention with his wife and prevent any further high risk behaviour. They also convinced him to get his wife and children tested. The wife was also found to be positive The GP gave financial assistance for her to go for registration at the ART centre and continues to give the couple regular support.

The KEY LEARNINGS from the experience of the program in 4 districts of Karnataka over the past 3 years are:

1. **Dividing the program into different phases** and **including the objectives of sustainability and networking with local institutions from the beginning** as part of an overall strategy. This approach resulted from regular feedback from people involved in the program in 4 Districts as well as from the broader experience of Myrada. This helped the team understand and design appropriate interventions at each phase, as well as to absorb learnings from interventions at each phase to improve the activities in the next Myrada's broader experience indicated that if the program is to be sustainable, this objective must influence the scope of interventions from the beginning of the program. If on the other hand the intervention invests in activities that require large grants which the program can provide as long as it lasts, then once it ends, the local community will not be able to sustain this activity. The Drop in Centres developed initially under the Targeted Intervention program are a good example. Similarly, Myrada's broader experience indicated that if other community institutions are to

be involved, they must be included in the process of planning itself. Hence community based organizations like the Gram Panchayats, VHSCs and SHGs were involved from the very beginning

2. The material and modules for **trainings of the CBOs (***VHSC and SHG) and the Gram Panchayats* **were prepared , implemented and** followed up by **developing specific action plans** (see Annexure 1). Myrada staff attended meetings of these organizations at least once a quarter to monitor progress. Feedback indicated that the CBOs were keen to support HIV prevention and care activities in the village and leveraged several opportunities to link the HRGs (high risk groups) and PLHIVs and OVCS to social entitlements, nutrition and education support schemes (see Annexure - 2).

3. **Convergence** between NACO and NRHM can be promoted successfully **UNDER THE FOLLOWING CONDITIONS**

   a. The ASHAs and ANMS need <u>extensive training</u> and mentoring for at least 6 months by the link worker and team before they can manage on their own. Issues related to sexuality, stigma and discrimination need to be handled from day one itself. The current ASHA **training** manual does have a chapter on HIV AIDS; but it is restricted to providing information on HIV and their roles. The training given to them by Myrada includes not only their roles in managing rural HIV interventions but also on inter personal communication, reporting and documentation, networking, importance of maintaining records of meetings etc. The PHC medical officer is also approached to participate in these trainings both as resource person and participant so that he/she can then meaning fully review the progress of activities. *The ANMs, and Anganwadi workers (AWW) in the district need to be trained* to provide basic services to PLHIVs and their families.

   Briefly, all the front line workers need to be trained on how to be sensitive to the needs of HRGs/PLHIVs and to maintain confidentiality and trust. In particular they need to be fully conversant with how to refer and follow up HRGs/PLHIVs for specific services at the PHC, ART centre and how to address special linkages and other care and support needs. They also need to know how to address stigma and discrimination issues related to PLHIVs, CLHIVs and HRGs; and to .work with the VHSCs to promote linkages for education, housing and other need based social entitlement support for those infected and affected with HIV.

   b. The ASHAs and ANMS and AWW need to be oriented to <u>fill up and update registers</u> since every high risk individual and PLHIVs and OVCs need to be followed up individually. These reports need to be simple, and to focus on key activities. Since there are only a few (2-3 FSWs and perhaps 1-2 PLHIVs and OVCs) per ASHA, this will not be a load on them. They have enough time to spend with each individual and maintain basic records. These <u>records</u> will then need to be reviewed and analyzed by the PHC medical officer during the monthly meetings, and copies sent to the DAPCU team. Analysis is critical as it indicates whether there is progress or not in each case and the reasons for either progress or otherwise.

c. Our experience indicates that, PHC medical officers, once trained, can manage all STIs and basic OIs. This will enable better access and enable the PLHIVs to access care earlier and closer to their home. In the long run, this also will help reduce stigma and discrimination both at the provider level and in the community.

d. There is a need to identify a "coordinator" at the district level who will take overall responsibility for all the rural based HIV/AIDS prevention and care programs. Whether this is through the DAPCU or an NRHM officer, it will require someone who will have time to attend coordination meetings, address problems, visit the field and be the point person to enable linkages with other departments and mainstreaming issues. It preferably should be someone from the health department since the ASHAs and ANMs are already reporting to them.

4. Is there **a role for NGOs**? Yes, for at least the first 2-3 years, an NGO can assist the department in the following areas:
    a. Training – of front line workers, CBOs / GPs/ VHSCs
    b. Mentoring - front line workers and follow up of CBO/ GPs/ VHSCs action plans.
    c. Initial outreach with HRGs and vulnerable populations, while the health staff are trained and then inducted into management and co-ordination of interventions.

5. The **focus of the intervention should NOT be limited to rural sex workers and vulnerable populations only. While it is important to identify the HRGs, who form the core group in the program, equal efforts are required to build trust in the general community and the supporting local institutions. This will lead to** reduced stigma and discrimination, allowing the high risk group to feel comfortable enough to access services and disclose their status when required to get support. This intervention in the broader community requires almost as much effort as outreach and referrals for HRGs, and must be factored into the program. It provides the basis for sustainability.

6. **Empowering the PLHIVs to address their own need**s by forming *small groups of PLHIVs* in each GP.

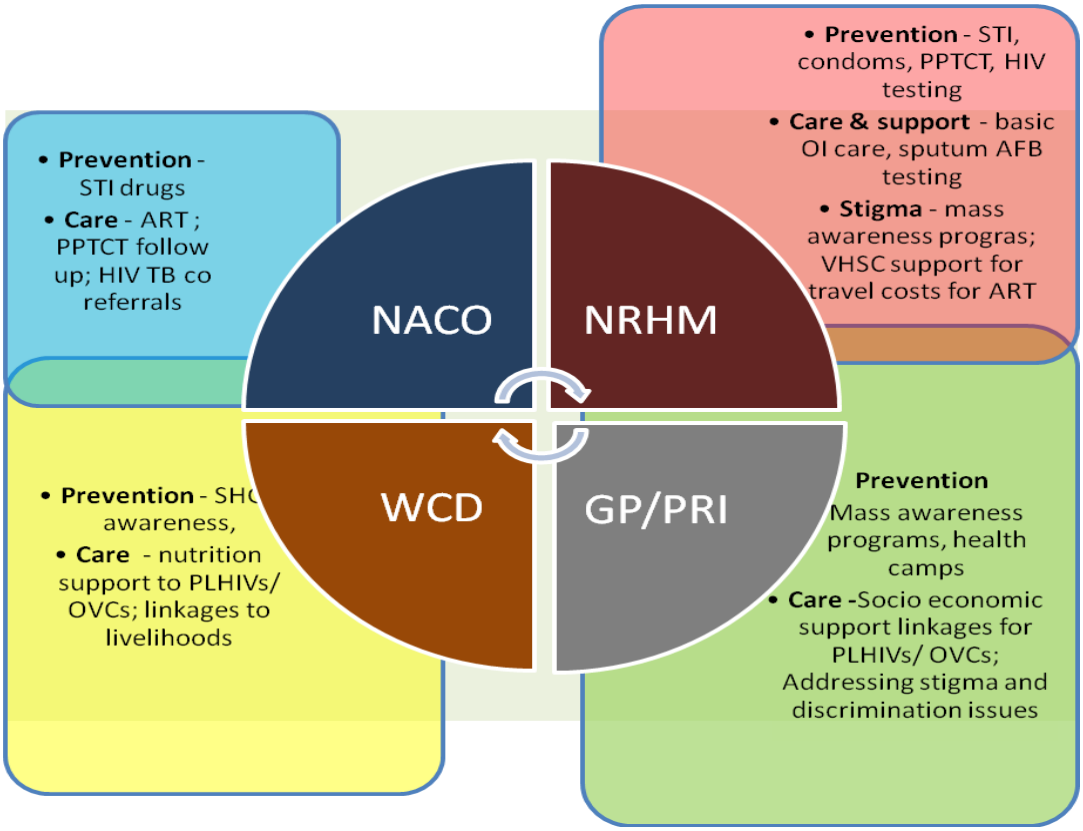
    Myrada piloted the formation of small groups of PLHIVs (called **Nemmadi groups** consisting of 8-15 mixed gender members) who meet twice a month at a location of their choice. They have participated in 9 modules of institutional capacity building to enable them to function as a group. Their agenda includes focus on their health as well as on livelihood issues,. While this is experiment is only 1 and a half year old, the initial feedback is positive. This approach is also able to cover PLHIVs outside of the link worker villages. Since the link worker program works closely with both the GP and the PHC, it will be possible for this program to train and mentor the groups formed.

PART 4

SUGGESTED INTEGRATION MODEL FOR RURAL HIV PROGRAMS WITH NRHM

The experience over the past 3 years indicates that integration is a process which takes around 2 years of intervention support and handholding to materialize. During the first 2 years, there is a focus on training and mentoring as well as an attempt to converge responses from allied departments (Women and Child, Panchayati Raj and the like). The model below describes the expected roles from the key partners involved in an integrated rural HIV program model.

While NACO and the SACS will still have to support the program in terms of ensuring that all PHCs have colour coded STI drugs and trained doctors, that they manage the ART centres, coordinate the ICTCs and provide appropriate IEC material to the health department, the health system will have the major role of outreach and service referral through its ANMs and ASHAs. The VHSCs also will be involved in supporting the PLHIVs and OVCs where required.



Suggested functionaries from these departments at each level

1. **Village level:** ASHA, ANM, AWW; VHSC members; GP members

2. **PHC level:** PHC medical officer, lab technician, ANM counselor, ICDS supervisor; GP leaders
3. **Taluk/block level**: ICTC staff, health officer, Block Health Education Officer, Taluk panchayat, CDPO (from WCD dept.)
4. **District level**: DAPCU, DHO, NRHM officer, DAPCC, Deputy Director, WCD, CEO of ZIlla Panchayat; ZP representatives, DC; staff of Housing schemes

Myrada has worked out a strategy for convergence with the Health department in the 4 districts where its program in being implemented. All the frontline workers have undergone a specific training to enable them to undertake several HIV related outreach activities in the field. They have been given specific tasks and reporting formats which are to be submitted on a monthly basis.

Experience with working with ASHAs in the rural link worker program during the period

April 2011 – September 2011

As part of the transition strategy described earlier, Myrada has, over 12 months (October 2010 – September 2011), substituted link workers with ASHAs in a phased manner. Bidar district initiated the concept in October 2010 itself with 25 ASHAs spread over the district. In villages with more than 1 ASHA, only one of them was selected to work, based on her interest and time availability. The other districts initiated this strategy in January 2011. Currently there are 308 ASHAs working across 4 districts.

From October 2010 to April 2011, the number of link workers was reduced from 30 in a district to 20. This was further reduced to only 10 after April 2011. The assumption was that, without the link worker around, the trained ASHA would take up the responsibilities of outreach and linkages on her own without the link worker duplicating her work. The 10 link workers who were retained supported the ASHAs in the areas of documentation; follow up of STI and ART cases etc.

Performance of the ASHAs from April 2011 to Sept 2011 :

Out of 364 villages with a total of 969 AHSAs, 823 were trained in HIV prevention and care and support interventions. From April 2011, 308 AHSAs were implementing all outreach and service referrals in 283 of the high risk villages. A rapid analysis of their performance during April to September 2011 shows that 97% of the ASHAs worked regularly and submitted reports on a monthly basis. 90% of them followed up on the registered FSWs and distributed condoms and

referred them for health checkups. A total of 83.6% of the HRGs were followed regularly and had their health check up through referrals made by the ASHAs.

In addition, around 68 % of the working ASHAs have followed up SHG, VHSC and GP action plans. Almost all of them have submitted regular reports monthly in the last 3 months. A detailed analysis is being done to analyze the differences and their causes.

ASHA performance April – September 2011

Parameters	**Bidar**	**Chamrajnagar**	**Kodagu**	**Mandya**	**Total**
ASHAs trained	246	232	117	228	823
ASHAs working	100	84	15	109	308
Submitted monthly reports regularly	100	84	15	102	301
Total villages covered by ASHAs	100	68	15	100	283
Total HRG target in these villages	721	430	57	835	2043
No. of ASHAs foll. Up HRG	100	55	15	109	279
No. of HRGs received outreach and services through ASHAs	721	191	35	762	1709
No. of ASHAs following up GP/ VHSC action plan	100	65	0	0	165
Max incentive paid in a month	450	585	500	1225	1225
Minimum incentive paid per month	130	70	111	60	60

Myrada worked out an incentive scheme for paying the ASHAs based on activities carried out (Annex – 3). An analysis of the payments reveal that the average incentive paid to the ASHAs for implementing HIV related services was Rs. 240/- per month (maximum was Rs. 450/- and minimum was Rs. 111/-) This is equivalent to paying around 19 link workers their monthly honorarium. The most common activities carried out by the ASHAs included maintenance of the condom outlets in the village, regular contact and referral of FSWs for health check up, monthly visit to PLHIV for home counseling, linkages of PLHIVs and OVC for nutrition support and referral of cases for HIV testing.

The WAY FORWARD: Key activities in the Integration model

1. Increased **awareness** of the whole rural community on HIV and AIDS through regular mass programs to dispel any myths and misconceptions in order to reduce existing stigma and discrimination
2. Identification and establishing **regular outreach** with **high risk individuals** in the community. These high risk individuals include:
    a. Core group – female sex workers, MSMs, IDUs
    b. Pregnant women
    c. Individuals with STI complaints
    d. Tuberculosis cases
    e. Migrant families
    f. Outreach will include regular contact at least once a month, condom promotion and referral for STI/ TB treatment and HIV testing and follow up.

3. Consolidation of **linkages with HIV** related **services** and non health related services
    a. Stakeholder analysis to identify local stakeholders
    b. Capacity building of all key stakeholders – individuals and institutions
    c. Mapping of all HVI and health related services
    d. Establishing systematic linkages and referral mechanisms.
    e. Setting up required infrastructure and mechanisms for regular stocks of equipment and drugs.
    f. Linkages with condom social marketing agencies to promote CSM in rural areas.

4. Strengthening and mentoring **community based institutions** – Gram Panchayats, VHSCs, SHGs, and youth groups to understand the problem of HRGs, their roles and responsibilities; and to develop appropriate action plans to respond to the local situation

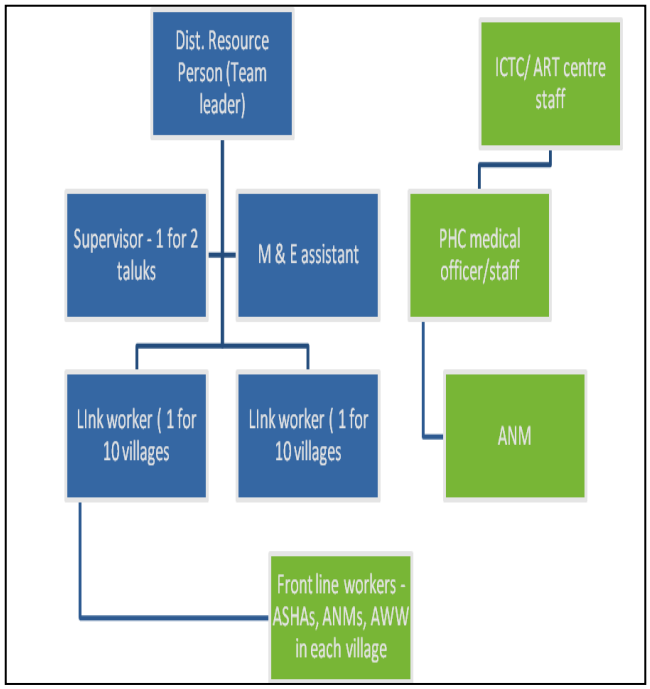
5. **Training of front line workers** (ASHAs, ANMs, AWW, school teachers etc.) to assist the link worker team in outreach and referrals, as well as to promote and enabling environment for reduced stigma.
6. Setting up a **convergence system** with key departments such as WCD, education , PRI to strengthen mainstreaming and provide quality care and support to affected families and individuals.

Recently, special meetings were held in each district under the chairmanship of the District Health Officer to discuss the convergence process. **A key barrier identified by the health department is the inability for them to pay incentives to the ASHAs under the current funding from NRHM.** They were very supportive of the idea that outreach and referral for

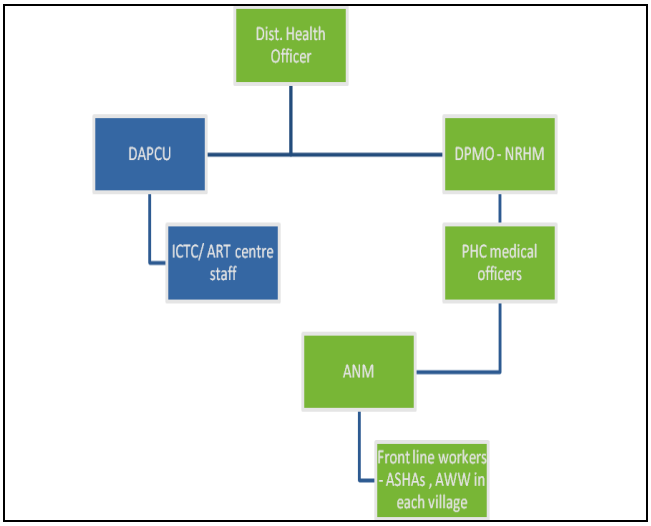
services could be managed by the ANM, while other departments could support them in the non medical interventions. The key components of the integration model with specific roles of each department are depicted below. However, from field experience, the ASHA will be more appropriate for outreach activities in comparison to the ANM.

Suggested organogram at district level for a modified - "Integrated link worker program" – convergence model

Year 1 of the Integration model



Year 2 onwards of the Integration model



Blue: LWS staff/ SACS

Green: Health dept staff

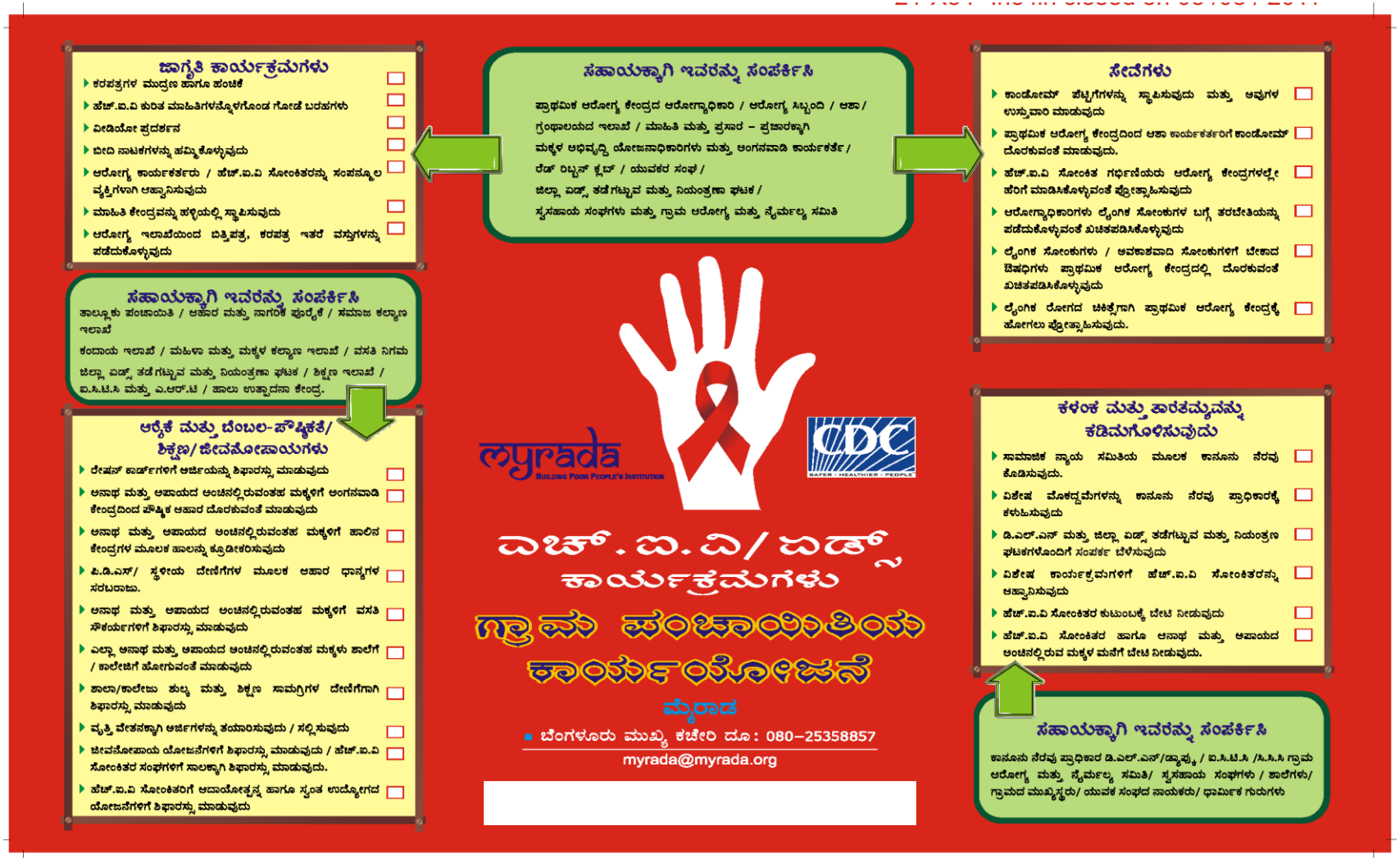
For the first year, the link worker program can be modified to have a few staff who can strengthen and mentor the health department to take over the key activities in the program. By the end of the first year, or halfway through the second year, the Health department can be the key player in the program.

Annexure – 1 – GP action plan chart

Annexure 2 – Consolidated leverages over a one year period

Annexure 3 – Suggested incentives for ASHA workers

ANNEXURE 1 – GRAM PANCHAYAT ACTION PLAN CHART



ANNEXURE – 2 LEVARAGES OVER ONE YEAR – MYRADA LINK WOREKR PROGRAM – 4 DISTRCITS

MYRADA CDC LINK WORKER PROGRAM
LEVERAGES REPORT - COORG

Who	Activity	What	Amount
	GP training	Venue, refreshments	39414
	ICTC camp	Space	10800
	Youth training	Space	338578
GP members	Mass events (along with local donors)		137128
	Health camp	Space & Medical supplies	34000
	PHC training	Space	7000
	Health camp	Doctor time	13500
	ASHA /ANM training		46240
PHC	Support group meeting		6050
SHGs	SHG trainings	Space	89775
	Condom distribution	Condoms	337949
DAPCU	ICTC camp	kits	25800
VHSC	VHSC training	Space, refreshments	78930
AWW	Nutrition support	Nutritious food	31100
	PLHA support	Donations	13200
Local Donors	Travel cost		6000
Total			**1215464**

MYRADA CDC LINK WORKER PROGRAM
LEVERAGES REPORT - MANDYA

Whom	Activity	What	Amount
Gram Panchayat	GP training	Venue, refreshments	70,690
	Nutrition-along with AWC, schools	Food grains and lunch	2000
	Awareness	Street play	13110
PHCs	Health camps	Drugs & Space	5900
	ICTC camp	space	5000
	Spport group meeting	Space, counsellor	24400
	staff mtg/ trg	Space	6100
KSAPS	ICTC camps	Kits	12960
		condoms	291242
	Staff training on TB	Food & travel	3000
Department	ASHA/ANM/AWW trg	Venue	6500
SHG members	Education	Note books	12500
	SHG training	Venue, refreshments	77720
Local Donors	Support group meeting	Food, space	9000
Total			**540,122**

LEVERAGES REPORT - CHAMRAJNAGAR

Whom	Activity	What	Amount
Gram Panchayat	GP training	Place, arrangements & refreshments	42663
	Health Camps	Doctor fee, travel, refreshments, arrangements	14400
	Nutrition support-along with AWC	Food grains, Multivitamin tablets	1125107
	Mass events	Refreshments, shamiyana, chairs etc	103715
	Education support	Not books	12738
	Resource Chat	Flex printing	2000
PHC	Health camps	Drugs	32700
	ASHA training	Venue	143975
	Support group meetings	Venue	37500
	Condom promotion	Condoms	430000
	ICTC camp	Venue	3200
SHGs	SHG Training	Place	183000
	PLHA support	Travel	391
Departments (DHO, DAPCU, KSAPS)	Department Training	Venue, refreshments	228220
	Education	Note books	3350
	ICTC camp	Kits	30640
Balakiyara Balamandira	Education	Note books	23,000
Care home	Education	Note books	2,800
Network	Education	Note books	3,500
Local Donors	Education	Note books, Scholarship	6,350
Total			2429249

MYRADA CDC LINK WORKER PROGRAM

LEVERAGES REPORT - BIDAR

Who	Activity	What	Amount
Gram Panchayat	GP training	Place, arrangements	7000
GP along with local Donors	Community events	Place, refreshments, stage arrangements	10200
PHC	Health Camp	Drugs, Place	6000
	ICTC camp	Space	5400
KSAPS	ICTC camp	Kits	29400
AWC	Nutrition support	Nutritious food for PLHIV and OVC	313600

ANNEXURE 3 – SUGGESTED INCENTIVE PAYMENTS TO ASHA WORKERS

SUGGESTED PAYMENT TO ASHA FOR LINK WORKER RELATED ACTIVITIES

MYRADA CDC PROGRAM

Sl.no	Name of the Activity	Description/ Units rate	Proposed incentives to ASHA	Record proof	Frequency	Load per ASHA/ Per year	Average annual costs	Monthly costs average
1	Men's group discussion	Per group	20	training register as proof	1 per 6 months	2	40	3.33
2	Women group discussion on reproductive health, personal hygiene and HIV	Per group	20	training register as proof	1 per 6 months	2	40	3.33
3	Youth group discussions - life skills; adolescent health			training register as proof			0	0
4	Male youth group	Per Work	15	training register as proof	1 per 6 months	1	15	1.25
5	Female youth group	Per Work	15	training register as proof	1 per 6 months	1	15	1.25
6	Referral of men for HIV testing & tested	per person	15	proof of testing - report	2	25	375	31.25
7	Referral of women for HIV testing		15	proof of testing - report	2	25	375	31.25
8	Referral of men for STI treatment & treated	Per Work	10	proof of treatment - health record		25	250	20.83
9	Referral of women for STI treatment & treated	Per Work	10	proof of treatment - health record		25	250	20.83
10	Maintenance of condom outlet	per month	20	condom stock register	Once a month	12	240	20.00

11	Registration of SW	per person	25	registered in her diary and linked to link worker program/ CBO	once per year	2	50	4.17
12	Health education of FSW - STI, condom. HIV etc	per person	15	daily log	once a month	24	360	30.00
13	Referral of FSW for health check - completed health check up	per person	10	health record	once per quarter	8	80	6.67
14	Direct condom distribution to FSW	per person	0.25	acc to volume check in book	4 times a month (30 condoms)	30	7.5	0.63
15	PLHIV/ OVC Registration	per person	50	registered in her diary and linked to link worker program	1 per year	4	200	16.67
16	Counselling of PLHIV/ ovc/ family care giver	per session	15	record to be maintained; countersigned by PLHIV	once a month	36	540	45.00
17	Reffered to ART centre & got services - registration, CD4 count, OI management , follow up, others	per person	25	pre ART no, CD4 count results, follow up records	once in 6 months	6	150	12.50
							2987.5	**249**