TARGETED INTERVENTIONS FOR MIGRANTS

OPERATIONAL GUIDELINES
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INTRODUCTION

The purpose of these guidelines is to ensure the delivery of quality HIV prevention interventions to high-risk migrant populations in India. The guidelines outline standardized operating procedures for implementing comprehensive HIV prevention services for migrant populations.

These guidelines have been developed with the following audience in mind:
- State AIDS Control Societies (SACS)
- Technical Support Units (TSU)
- Implementing partners (NGOs/CBOs)

It is recommended that all organisations using these guidelines consider each of the proposed elements in the context of the organisation’s current environment and other relevant guidelines such as NGO/CBO Guidelines, NACO, March 2007 and Guidelines on Financial and Procurement Systems for NGOs/CBOs, NACO, March 2007.
CHAPTER 1

Introduction to
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1.1 RATIONALE FOR TARGETED INTERVENTIONS (TIs) WITH MIGRANTS

1.1.1 Role of Migration in HIV Transmission

An important source of HIV-related vulnerability is mobility and migration, mobility being defined as a change of location and migration being defined as a change of residence. Migrant populations have higher levels of HIV infection than those who do not move – independent of the HIV prevalence at the site of departure or the site of destination. An attempt to understand the vulnerability of mobile populations to HIV must begin with an understanding of human mobility.

Human migration, people changing their place of residence permanently or temporarily, is a complex phenomenon with many different faces. Across the world, more and more people are on the move – from villages to towns, from towns to cities and across national borders. India, home to the second highest number of HIV positive people in the world, is characterized by widespread and fluid migration and mobility. More than 2 million Indians do not live in the place of their birth, and additional hundreds of thousands of uncounted Indians live mobile and uncharted lives. While mobility in other parts of the world is inhibited by national boundaries, there are few land masses the size of India with such a good transport infrastructure as this country. Male migrants in India often migrate alone, leaving their wives and families behind, usually to work in the informal sector, which is unorganised, unprotected and unregulated and accounts for 93 per cent of the total workforce in India. This amounts to 392 million people or almost 40 per cent of the population of the country.

Once migrants reach their destination, language and other difficulties lead to feelings of discontinuity and transition that enhance loneliness and/or sexual risk-taking. Such risk-taking may be reinforced by a lack of HIV/AIDS awareness, information and social support networks at both source and destination points, which cumulatively contribute to a migrant's vulnerability. Back home, spouses of migrants are also vulnerable to HIV if their husbands return on a regular basis and have become infected with HIV. Some wives also have their own sexual networks during their husbands’ absences.

Female migrants are also vulnerable to HIV. They are often forced into transactional sex – either through coercion or to supplement their income. For women who are part of high-risk sex networks, lack of knowledge, negotiation skills and decision-making power, together with reticence about seeking STI treatment, inhibit the adoption of safer sexual practices with both their husbands and other sexual partners/sex clients and facilitates the spread of HIV.

However, it is important to note that not all migrants are at equal risk of HIV. It is those men who are part of sexual networks at their destinations - either with female sex workers (FSWs) or with other men (MSM) or transgenders – who are more prone to HIV infection. Similarly, only those female migrants who take up transactional sex at destination locations are at greatest risk of HIV.
**1.1.2 Definition of Migrants for Targeted Intervention Purposes**

Migrants fall under NACO’s definition of “risk groups”, i.e. those warranting targeted interventions. Along with truckers, they are bridge populations requiring a specific HIV response. Migrants have two major routes of mobility: from rural to urban areas and between rural areas. The definition of migrants varies widely, hence this document defines migrants and provide guidelines for working with them from the perspective of HIV prevention interventions under NACP III.

Classification of migrants from an HIV vulnerability perspective is based on the following key criteria:

- Pattern, degree and duration of mobility and migration
- Age
- Whether moving singly or with family
- Route of migration
- Destination of migration

Based on these criteria, the definition of migrants is "single men and all women in the age group of 15-49 years who move between source and destination within the country once or more in a year". Those who return to their source location at regular intervals are called “circular migrants”.

The broader transmission of HIV beyond high-risk groups (FSWs, MSM and transgenders, IDUs) often occurs through their sexual partners, who also have lower-risk sexual partners in the “general” population. For example, a client of a sex worker might also have a wife or other partner who is at risk of acquiring HIV from her higher-risk partner. And a migrant woman who engages in sex work at her destination point may return to her spouse/partner at home, putting him at risk of HIV infection. Individuals who have sexual partners in the highest-risk groups and other partners are called a “bridge population”, because they form a transmission bridge from the key population to the general population.

From an HIV programming perspective under NACP III, migrant TIs are “destination interventions” for “in-migrants” (i.e. at the point of destination) and are to focus on high-risk migrant men and women, i.e. those who are part of high-risk sexual networks, either as clients of sex workers and high-risk MSM, or as sex workers themselves.

Note: Interventions at the “source” villages/towns/states – i.e. for “out migrants” – do not fall under TIs for migrants: if at all, they are covered under other schemes (e.g. link workers).
1.1.3 Significance of the Bridge Population in HIV Epidemics

Men are important as a bridge population in HIV epidemics for several reasons:

- Men are more likely to have multiple partners than women
- Men influence the “demand” side of sex work which determines the size and distribution of sex worker populations at destinations
- Higher levels of mobility can link HIV epidemics in different locations

This is illustrated in the following Figure 1, which shows how HRG members have many sexual partnerships with different bridge population members, who in turn have at least one partner in the general population. In this pattern of epidemic transmission, it is most effective and efficient to target prevention to the key population and bridge population members to keep their HIV prevalence as low as possible.

Figure 1. Illustration of an HIV transmission network

1.1.4 Sources of Risk and Vulnerability for Male Migrants

The sources of risk and the factors affecting male migrants' vulnerability with regard to HIV and AIDS are complex and influenced by the “3D” (dirty, dangerous and difficult) conditions in which they live and work. Apart from the factors already mentioned in Section 1.1.1. above, these include:

- Relative freedom in the new setting as well as peer pressure to experiment with new norms
- Distress migration driven by seasonal drought/disasters
- Loneliness, drudgery and long periods of separation from spouse/sexual partner
Having disposable income, clubbed with limited choices for affordable entertainment and recreation. This usually means drinking and, sometimes, drugs as well as sex with FSWs and when the opportunity arises, other casual sex relationships.

### 1.1.5 Sources of Risk and Vulnerability for Female Migrants

Migrant interventions should cover issues around female migrants, who are also vulnerable to HIV as they too are part of a circular migratory population working in difficult environments, often in the informal sector, which is unorganised, unprotected and unregulated. Their vulnerability is based on the following factors:

- Since most of them are migrating due to poverty, once at their destination place, they are more vulnerable to being pushed in to sex work to supplement their earnings
- This is reinforced by a lack of HIV and AIDS awareness, information and social support networks at both source and destination points
- Distress migration driven by seasonal drought/disasters, often routed through and controlled by organised network operators (sexual network operators/employers or workforce contractors)
- Loneliness, drudgery and long periods of separation from family/spouse/sexual partner
- Limited or no skills to cope with the overall pressures and environment at destination places. This may lead to behaviours associated with risk for HIV infection, i.e. drinking and sometimes drugs as well as sex with male colleagues, casual sex relationships or sex work.
- Additional vulnerabilities include the risk of being trafficked along the way and the risk of sexual exploitation, violence or harassment by sexual network operators/local power structures or by colleagues/supervisors/contractors in the workplace
- Lack of knowledge and negotiation skills make it difficult for women to negotiate condom use with both their husbands and other sexual partners
- Women’s lack of decision-making power and reticence about seeking STI treatment often leads to a suppressed demand for health services even when the need is obvious. This results in prolonged untreated STIs and increases the risk of HIV infection.
- Women’s unawareness of the existence of policies and laws which promote women’s rights to reproductive and sexual health, equal access to education and information on health care, and the elimination of harmful social norms and traditions that constrict women’s human and legal rights. These rights apply to all women, including those involved in sex work.

### 1.1.6 Targeting High-Risk Migrant Men

India’s male migrant population is very large and diverse, and since only a small proportion can be reached with HIV programmes the focus should be on those at highest risk.

Figure 2 illustrates two main strategic issues:

- First, **only a proportion of all sex worker clients are migrants.** In some locations, migrant men will comprise a large proportion, whereas in other locations they are a small section of the male clients.
- Second, **most migrants are not clients of sex workers (either FSWs or high-risk MSMs).**

Therefore, the emphasis of the TI strategy for male migrants should be on the subset of men who are both migrants and part of high-risk sexual networks, usually as clients of FSWs or of high-risk MSM.

Since many men who have sex with FSWs, high-risk MSM and transgender individuals also have other partners, both male and female, focused interventions for these bridge populations are strategically critical to controlling the HIV epidemic.

This focused intervention approach is illustrated in Figure 2. This approach ensures that the intervention is cost-effective, since resources will be directed to where HIV prevention is most critical.
This approach requires the gathering of strategic information on both the location of large concentrations of male migrants and their interaction with local FSWs/high-risk MSM as clients, or in the case of female migrants, their participation in transactional sex.

**Figure 2. Population approach to targeted interventions for migrant men**

1.1.7 Targeting High-Risk Migrant Women

As discussed above, female migrants are largely at risk due to the possibility of engaging in transactional sex, either through coercion or to supplement their income. To that extent, high-risk migrant women are entitled to receive the same package of services as female sex workers. The needs assessment conducted at the start of the project should share information on known high-risk female migrants with the closest NGO implementing TIs for female sex workers so the NGO can plan to include them in services.
1.2 CONSIDERATIONS FOR MIGRANT PROGRAMMING

1.2.1 Focus on High-Risk Men

It is important to invest available resources most strategically by focusing interventions on high-risk migrant men who are partners of high-risk group (HRG) members (FSW, MSM-T). Mapping exercises (see Chapter 2 below) can identify the confluence of migrant men with HRG networks to keep interventions focused on those migrant men who are actually at risk and at the locations where risk occurs.

1.2.2 Work with Women

Women in general have a high degree of sexual health vulnerability for the following reasons:

- Because of the high-risk behaviour of their husbands and sexual partners
- Many wives of migrant men are illiterate, and because they remain largely within the confines of their homes they are mostly uninformed about STIs and HIV/AIDS.
- Caring for their health is generally not a priority for them or for their male family members.
- They are often unaware of condoms, and even if they are aware, it is generally the decision of their husband/male partner whether to use them or not during sex.
- In the absence of their husbands, they are dependent on the men in the households or on neighbours for help in managing household affairs. This may lead to sexual relationships with other family members or men in the community.
- Women are not supposed to go out alone and hence are unable to seek health services.

The success of migrant programmes at destination will be greatly influenced by whether or not migrant spouses/sexual partners are educated about HIV risks and related issues.

In the source state, based on the mapping data from the destination states (shared between the source and destination SACS), the SACS should take responsibility to cover migrant wives/sexual partners, through link workers and as part of broader SACS-supported HIV/AIDS initiatives in the major pockets of high outward migration.

At the destinations, women migrants who are part of transactional sex networks and at risk of HIV are envisaged to be part of the female sex worker intervention.

1.2.3 Link Migrants at Source and Destination Points – not covered by SACS under TIs under NACP III – to be covered by other schemes (e.g. link workers)

While the migration continuum is often linked in international migrant programmes, this rarely occurs at the national level. In spite of the fact that migration is a continuum with different stages – source, transit, and destination point – the bulk of HIV related migration programming in India is directed as TIs towards migrants in their urban-based destinations.
As a result, where migrants come from, how they travel and the situation of their families left behind remain largely unaddressed by stand-alone destination-based interventions. This means that migrants' emotional, social and support needs before departure, during travel, and in the destination state/s are difficult to meet. Destination-based programmes often have outreach workers who speak different languages and have different cultural backgrounds. There is therefore a strong need and rationale for establishing effective linkages between source and destination programmes. Furthermore, an engaged source state can motivate and support the destination state/s to address specific migrant sub-populations under their HIV prevention and care programmes, e.g. Rajasthani / Bihari / Gujarati / Kannada migrants.

Such links between source and destination programmes are most efficiently established through a Memorandum of Understanding (MoU) between the SACS of the destination and source state/s (an MoU may be signed between two SACS or a group of SACS). An MoU provides a constructive framework for HIV prevention intervention by developing a coordination mechanism assuring the required support for the interventions.
1.3 INTERVENTION PACKAGE FOR HIGH-RISK MIGRANTS COVERED UNDER TIs

The intervention package for high risk migrants is outlined below and detailed further in the operational guidelines.

1.3.1 Outreach and Communication

Peer-led, NGO-supported outreach and behaviour change communication (BCC).
- Differentiated outreach based on risk and typology
- Large-group format activities (e.g. street theatre, games, etc.)
- Interpersonal behaviour change communication (IPC)

1.3.2 Services

- Promotion of condoms
- Linkages to STI (sexually transmitted infection) services and other health services (e.g., ICTC, ART, drug/alcohol de-addiction)
- Strong referral and follow-up system

1.3.3 Enabling Environment

- Advocacy with key stakeholders/power structures
- Linkages with other programmes and entitlements

1.3.4 Community Mobilisation

- Building capacity of migrant groups to assume ownership of the programme
- Project centres
CHAPTER 2

Operationalising Targeted Interventions for Migrants:

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- Risk assessment study
- Supplemental mapping

- Contracting NGOs / other implementing agencies
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Estimating the extent and nature of HIV risks and vulnerabilities among migrants through mapping

Recruitment and capacity building
2.1 MAPPING MIGRANT COMMUNITIES – GEOGRAPHIC MAPPING, SIZE ESTIMATION AND SITE ASSESSMENT

2.1.1 Identifying Intervention Areas

2.1.1.1 Step 1: Review and analysis of existing data sources
This is done through a state-level analysis to locate large pockets of migrants, and a risk assessment study to ascertain if there are significant numbers who are at risk for HIV.

2.1.1.1.1 Data analysis
Analyse data from National Sample Survey (NSS), Census and National Commission of Rural Labour to map major pockets of migrants in the state, where there are 5,000-10,000 single-male circular migrants (as defined in Section 1.1.2 above) living within a radius of 5-10 kilometres. This process should be undertaken by the SACS of the destination states. The review and analysis should be shared with the potential partner agencies to facilitate their understanding and enable them to move on to the next stage.

2.1.1.2 Risk assessment study
Contract an agency (preferably a local one and backed by TSU) to conduct a risk assessment study to decide if these migrants are at risk based on the following criteria (see also Annexure 1, Tool for Risk Assessment):

1. Had sex with a non-regular partner in the last 12 months
2. Different types of sexual partners for the risk population
3. Profile of risk population
4. Condom-related indicators
5. Proportion who suffered from STIs in the last 12 months
6. Proportion who sought treatment from a qualified practitioner for STIs
7. Proportion who feel it is important to know HIV status
8. Proportion who intend to get themselves tested
9. Proportion who feel at high risk with a female partner if they have sex in exchange for money or in kind
10. Proportion who have correct knowledge about the modes of HIV transmission

This exercise will provide details as to which "slums" or "migrant areas" require intervention, if any.

Unless the risk assessment study finds that the population in a given area is at GREATER risk than the average male population (defined in terms of the criteria above), there is no need for a TI there.

For example, the National Behavioural Surveillance Survey (BSS) 2001 indicates that ~10% of Indian men have had sex with a non-regular partner in the last 12 months. For migrant interventions to be necessary for a given population, this percentage must be much higher – e.g. in Dharavi this figure was >40% (according to a survey by Population Services International).
2.1.1.2 Step 2: Supplemental mapping

When no information exists, or it is not available through the state-level analysis of large pockets of migrants, a mapping and situation assessment should be conducted with the following considerations in mind:

- **Geographic approach to mapping and situation assessments** – High-risk sexual networking is often geographically clustered and is frequently linked directly to a range of vulnerable populations including migrants. Mapping should therefore identify priority locations for initiating and scaling up TIs for all vulnerable populations. Moreover, this information should be augmented by a comprehensive situation and needs assessment for the local planning of supportive services such as condom promotion, voluntary counselling and testing (VCT), STI services and care, treatment and support. By prioritising locations, the full range of prevention, care and support services can be clustered more appropriately to enhance efficiencies and integration of programme components needed for any migrant intervention.

- **Need to focus on large “catchment” areas for efficient programming** – Migrant programmes at destination should cover geographic areas which contain concentrations of migrant populations in conjunction with sex work concentration. It is therefore important to map pockets/villages/slums which have a high concentration of circular migrants (as opposed to relocated migrants) and overlay this mapping on sex worker concentration data from TIs with FSWs.

Mapping will find variable proportions of migrant men who are male clients or migrant women who are FSWs. Not all male migrants are clients of sex workers (FSWs or high-risk MSM and transgenders), and similarly, not all female migrants are part of sexual networks. Therefore, the emphasis of the mapping exercise for migrant TIs should be on identifying the high-risk migrant men and women who form a part of high-risk sexual networks, usually as clients of sex workers/high-risk MSM–T or as practicing sex workers themselves.

Mapping focuses on **three kinds of intervention sites**:
- Hotspots (points of sex solicitation)
- Prioritised industry/workplace centres
- Large residential centres

A dual-layer location mapping (**preliminary and detailed**) is required to identify sub-pockets of risk within larger locations and to gather information for intervention purposes. This is explained in the following paragraphs.

2.1.1.2.1 Preliminary mapping (Identifying sub-pockets of risk)

Preliminary mapping provides a general overview of the entire geographic area and is the basis for the refined methods and tools necessary for a detailed mapping study. Mapping is to be done by ORWs who are given training in the methodology, preferably by TSU and/or by an agency hired by SACS. Preliminary mapping will include a **geographic area overview** and **interviews with key informants** to help identify:

- Congregation points of high-risk men
- Presence of sex workers
- Presence of elements such as video parlours, youth clubs/mandals, NGOs, temples, hotels, lodges, bars and movie theatres that could be vantage points for target-efficient field communication

The key informants in each area include shopkeepers, cinema hall employees, slum residents, housing colony residents, slum development officers, municipal corporation officers, private doctors, government hospital doctors, NGOs, industry employers and employees, labour contractors, bar owners and clientele, railway station masters and bus depot in-charges.

**See Annexure 2, Methodology for Mapping, and Annexure 3, Tool for Preliminary Mapping.**
2.1.1.2.2 Detailed mapping (Identifying locations and populations for intervention)

Detailed mapping is needed in order to ensure a target-efficient, streamlined intervention among migrant workers. This study will:

- Assess the target group size of high-risk migrant men and women
- Identify target-efficient hotspots/strategic locations
- Determine possible range of communication activities to be conducted at the identified hotspots
- Assess the presence of sex workers in the area along with the type of sex work and the typology of the sex workers

The detailed mapping study will be done by ORWs, preferably trained by the TSU or an agency hired by the SACS, using three primary components:

1. A detailed mapping tool that provides information on target group size as well as congregation points of high-risk men and women (see Annexure 4, Tool for Detailed Mapping).
2. An FSW assessment that provides information on sites of sex work as hotspots for field communication activities and services (see Annexure 5, Tool for FSW Assessment).
3. A screening of mandals/youth clubs and video parlours/other sites that provides information on high-risk men and women who are part of sexual networks. Also the potential types and frequency of field communication activities (see Annexure 6, Tool for Hotspot Screening (Owners) and Annexure 7, Tool for Hotspot Screening (Patrons)).

2.1.1.2.3 Understanding source areas for migrants

While conducting mapping at the destination sites, an attempt should be made to identify source states, including the details of village/town/district clusters. This information should be communicated to the SACS of the source state to facilitate outreach to the migrant spouses/sexual partners back home and to returning migrants. See Section 1.2.3 of Chapter 1 for more information.
2.2 RECRUITMENT AND CAPACITY BUILDING

2.2.1 Contracting NGOs for TIs

NGOs and other implementing agencies (e.g. unions, registered youth groups) will be contracted to implement TIs for a population of at minimum 5,000 migrants.

NGOs/other implementing agencies should be selected and contracted based on the mapping and situation assessment findings and NACO’s NGO/CBO Guidelines. Preference may be given to NGOs/organisations that are already working with migrant communities in urban slum areas on other issues (such as water and sanitation, other basic urban services health, literacy/education, etc.), since they have familiarity and access to migrants and have gained their trust.

The NGO is to hire staff as per the following ratios:

- Volunteer peer leaders (VPLs) at a ratio of 1 VPL to 100 migrants.
- Outreach workers (ORWs) at the ratio of 1 ORW to 10 VPLs.
- Communication team(s) (street theatre/play teams)
- Coordinator at a ratio of 1 coordinator to 5 ORWs
- One part-time doctor for clinic
- One counsellor
- One Part-time accountant

The ORWs and VPLs will receive proper induction training covering all aspects and components of migrant programming, including the social marketing of condoms. The details of capacity building needs and planning for the same are described in Section 3.1.2.6 of Chapter 3 (refer also to Section 8 of the NGO/CBO Guidelines, NACO, March 2007).

The following table summarises the coverage and personnel/volunteers ratio under a migrant TI:

<table>
<thead>
<tr>
<th>Migrant Coverage</th>
<th>VPLs : Migrants</th>
<th>ORWs : VPLs</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,000 Migrants (minimum unit for the migrant TI)</td>
<td>1:100</td>
<td>1:10</td>
</tr>
<tr>
<td>50 VPLs for coverage of 5,000 Migrants</td>
<td>5 ORW for coverage of 5,000 Migrants</td>
<td></td>
</tr>
</tbody>
</table>
2.2.2 Roles of Partner Agencies

2.2.2.1 NACO
- Advocate with key funding sources to ensure that all infrastructure development projects incorporate a clause for construction and other contractors to provide HIV/AIDS prevention and referral services (as was done in the case of certain projects implemented by the World Bank or Asian Development Bank)
- Dialogue with Labour Department/Ministry for systematic data collection on migration (as part of the larger mainstreaming agenda with the Labour Department/Ministry)
- Through Panchayati Raj Institutions, facilitate the active maintenance of the “migration register” at village level. This can be done at all Panchayats.
- Coordinate information sharing between SACS to enable coverage of known source locations through link workers

2.2.2.2 SACS

2.2.2.2.1 Advocacy with Government departments
Government departments play a critical role in both service provision as well as addressing the underlying causes of distress migration. Safe migration is a factor of informed choice. Much is being done for provision of information on HIV/AIDS, safe sex, available services, etc., but very little on improving choices for migrants, especially in the source areas. Based on mapping of high out-migration areas, SACS must advocate with concerned government departments to implement programmes for livelihoods, self-employment, micro-credit, vocational training, etc. in line with their comparative strengths. This could include government departments such as PRI, Rural Development, Horticulture, Khadi & Gramodyog, DWCD, Education (vocational and skill based), etc.

2.2.2.2.2 Advocacy for workplace policies and programmes
As per NACO’s letter issued to all SACS in April 2006, SACS should link with small- and large-scale employers of migrants to advocate for workplace policies and programmes (see Annexure 8, Model HIV/AIDS Workplace Policies). A large number of industries/workplaces engage migrant workers as regular and part-time workers. These may include clusters of small industries/workplaces (eg. Pimpri Chinchwad near Pune, Wazirpur and Bhwari near Delhi) or large industrial houses such as Jindals, Reliance, Jubilant Organosys which are located in remote areas and require workers to migrate to those locations on a short-term basis.

While the large industries/workplaces have a Corporate Social Responsibility (CSR) strategy, few of them include HIV/AIDS in this. Possible actions with medium and large industries/workplaces include:
- Development and implementation of workplace policies to protect their workforce from HIV/AIDS and provide care and support to those infected.
- Best-practice examples of HIV/AIDS policy for the workplace from Gujarat Ambuja and TCIL are included in Annexure 8.
- Advocacy to include HIV/AIDS services into their CSR strategy, including provision of outreach, prevention and care services in their catchment areas

For smaller industries/workplaces, activities will include:
- Mapping of industry/workplace clusters (with initial cues from business organisations such as Rotary and Lions Clubs which have membership from smaller industries/workplaces)
- Advocating with senior management of these workplaces to undertake sensitisation of workers.
- Since most of the workers in smaller industries/workplaces are temporary, there is much less commitment towards workers’ welfare. An alternative plan is to contract NGOs to run awareness programmes for the workers (e.g. HIV&YOU model of UNDP).
- Establish referral linkages with public and private sector providers for STI, ICTC, care, and treatment services.
2.2.2.2.3 Linking migrants at source and destination points
An MoU between SACS provides a perfect structure to maximize beneficial links. For example, when migrants are returning home for visits, advance notice can be given to the source state through the SACS and outreach planned accordingly. In addition, outreach workers who speak the migrants’ own language and dialects may be provided to the destination states from the source state (through SACS/NGOs).

2.2.2.2.4 Linking programmes in destination and source SACS
Pooling information and resources is beneficial to both states and helps reach those at most risk at both source and destination, for example, in-migrants and their sexual partners in the destination state, and returning migrants and their sexual partners in the source state. The data of migrant mapping at the destinations will also provide information on the migrants’ source states/regions/districts/blocks. This information should be shared with the source state to facilitate outreach to returning migrants and to their spouses/sexual partners back home. The advantages of this strategy include:

- **A linked programme enables a holistic approach** that includes both migrant and spouse/sexual partner and the extra-marital relationships of both. Outreach to migrant spouses can be done through the ongoing HIV prevention and care programmes in the source state by engaging link workers and community-based structures.
- **Linked programming provides a framework for understanding the complete context within which migration operates:** the push factors of out-migration, the cycle of leaving and returning, the flow of funds, sexual networking at destination and source, and the living and working environment of migrants at destination. Linked programming provides vital and powerful information with regard to the nature of HIV risk and vulnerabilities in both destination and source states.
- **Facilitating assessment of impact of migrant interventions:** Since migrant interventions under NACP III are designed and executed at destination locations, source states can collect and provide information to monitor and evaluate the degree of success of these interventions (particularly on health-seeking behaviours, condom use by returning migrants with spouses/sexual partners at home and some of the proxy indicators of reduced vulnerability of migrants going out). Again, this will be done through the ongoing HIV prevention and care programmes in the source state by engaging link workers and community-based structures.
- **Integrate HIV into ongoing work of NGOs:** Integrating HIV interventions into the ongoing work of NGOs rather than having stand-alone initiatives can be an effective strategy to address issues of basic human rights, including the rights of migrants/workers at destination and issues of stigma and discrimination. In addition, establishing links with other government programmes that benefit migrants in both source and destination states can facilitate the realisation of their rights and entitlements, reduce their vulnerabilities and improve their overall quality of life.
- **Communication material sharing:** A linked programme provides the cultural affinity that is necessary for providing support to “strangers in a strange land”. For example, IEC/BCC materials in the migrant’s home language can easily be obtained from the source state/s.

2.2.2.2.5 Engage industry/workplace institutions, employers’ associations, other allied organisations and structures
These stakeholders should be engaged to develop and implement policies that reduce the vulnerability of migrants and promote accessibility of services. Key responsibilities at this level include:

- Development of healthy workplace policies for migrants that reduce their vulnerability to HIV
- Incorporation of education programmes for migrant labourers at an early stage of induction into the industry to provide them with perspectives, information and skills to reduce their HIV-related vulnerability and risk
2.2.2.3 NGOs and other implementers (including workplace NGOs)

- Identification of migrant pockets
- Being part of SACS programme
- Hiring of project staff
- Mainstreaming activities
- Monitoring of projects
- Community development and empowerment
- Local advocacy programme

2.2.2.4 Other government departments

- Sharing information and knowledge on migrant population
- Integration of HIV/AIDS programme in ongoing interventions

2.2.2.5 Core group TI partners

- Working with sexual partners of migrant population
- Coordination with NGO implementing programme and SMO

2.2.2.6 Social marketing organisations (SMOs)

- Coordination with migrant TI implementing partners
- Provision of condom supply and chain management for TI
- Capacity building of NGO project staff and VPLs in condom promotion

2.2.2.7 Other development agencies

- Mainstreaming HIV/AIDS through network based approach
- Meeting other needs of migrant population through resource provision
- Coordination with NGO implementing TI project
- Sharing knowledge, resources and skills for community development
### 2.2.2.8 Summary Table

The following table summarises the overall role of each agency in setting up migrant TIs:

<table>
<thead>
<tr>
<th>Steps in Intervention</th>
<th>NACO</th>
<th>SACS/TSU</th>
<th>NGOs and other implementers</th>
<th>Other govt departments</th>
<th>Core group TI partners</th>
<th>Social Marketing agencies</th>
<th>Other development agencies/ SACS at source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk review of existing information</td>
<td>Hire consultants/ agency</td>
<td>Provide available information</td>
<td>Provide available information</td>
<td>Provide available information</td>
<td>Provide available information</td>
<td>Provide experts</td>
<td></td>
</tr>
<tr>
<td>Supplemental Mapping if required</td>
<td>Develop standardised protocol</td>
<td>Hire consultants/ agency</td>
<td>Facilitate mapping in respective geographic area</td>
<td>Provide available information</td>
<td>Provide available information</td>
<td>Share experience of similar exercises in other programmes</td>
<td></td>
</tr>
<tr>
<td>Selection of partners (NGO, Corporate houses, SMOs)</td>
<td>Advertise for project allocation</td>
<td>Develop guidelines and appraisal system</td>
<td>Implement projects</td>
<td>Provide information on good agencies</td>
<td>Implement projects</td>
<td>Coordin -ate with NGOs</td>
<td></td>
</tr>
<tr>
<td>Contracting NGO</td>
<td>Develop protocol for contracting</td>
<td>Develop contracts</td>
<td>Monitor contracts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orientation of project team by SACS or TSU</td>
<td>Provide technical support and expertise</td>
<td>Participate in capacity building exercises</td>
<td>Provide resource persons and material</td>
<td>Share experience and information on migrants clients and networks</td>
<td>Provide resource persons and material</td>
<td>Provide information on different approach of community participation, resource mobilisation</td>
<td></td>
</tr>
<tr>
<td>Steps in Intervention</td>
<td>Actions and Agency Responsible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stakeholder advocacy</strong></td>
<td>NACO</td>
<td>SACS/TSU</td>
<td>NGOs</td>
<td>Other govt departments</td>
<td>Core group TI partners</td>
<td>Social Marketing agencies</td>
<td>Other development agencies/ SACS at source</td>
</tr>
<tr>
<td>Advocacy with central government department</td>
<td>Advocacy for developing framework</td>
<td>Identify stakeholders</td>
<td>Advocacy programme implementation</td>
<td>Facilitate linkages and mainstreaming</td>
<td>Allocate resources</td>
<td>Implement programme</td>
<td>Facilitate linkages</td>
</tr>
<tr>
<td><strong>Provision of services</strong></td>
<td>Guidelines for service provision</td>
<td>Resources allocation</td>
<td>Channel programme services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing capacity building</strong></td>
<td>Document and share experiences at national level</td>
<td>Develop plan, resource mobilisation and monitoring, networking</td>
<td>Participate in programmes and feedback on usefulness of programmes</td>
<td>Suggest non-conventional ways of capacity building</td>
<td>Mentor new organisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting</strong></td>
<td>Uniform reporting system development</td>
<td>Establish and develop system</td>
<td>Monitor the system</td>
<td>Follow formal system of reporting of activities implemented for HIV/AIDS</td>
<td>Establish programme based on system</td>
<td>Follow system</td>
<td>Monitor programmes undertaken</td>
</tr>
</tbody>
</table>
### Steps in Intervention

<table>
<thead>
<tr>
<th>Steps in Intervention</th>
<th>Actions and Agency Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring</td>
<td>NACO</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td>Mid-term evaluation of programme</td>
</tr>
</tbody>
</table>

Refer also to Section 11 ("Who will do what?") of NGO/CBO Guidelines, NACO, March 2007.

#### Tool

**Annexure 8  Model HIV/AIDS Workplace Policies**

### 2.2.3 Capacity Building

Capacity building inputs at all levels of implementation, i.e. SACS, NGOs and industrial centres/workplaces, other government departments, service providers, project staff and VPLs should be planned for effective TIs for migrant population. The capacity building inputs should include:

- Training
- Exposure visits
- "Hand holding" or mentoring
- Knowledge- and experience-sharing workshops

#### Themes for Capacity Building

<table>
<thead>
<tr>
<th>Themes for Capacity Building</th>
<th>Agencies Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SACS</td>
</tr>
<tr>
<td>Basic information on HIV and STIs</td>
<td>X</td>
</tr>
<tr>
<td>Community development and strategies for personal development and empowerment of communities</td>
<td></td>
</tr>
<tr>
<td>Stigma and discrimination</td>
<td>X</td>
</tr>
<tr>
<td>Human rights and violence</td>
<td>X</td>
</tr>
<tr>
<td>Community participation and empowerment</td>
<td>X</td>
</tr>
<tr>
<td>HIV testing and counselling</td>
<td>X</td>
</tr>
<tr>
<td>BCC and development of IEC materials</td>
<td>X</td>
</tr>
<tr>
<td>Peer education and community outreach</td>
<td>X</td>
</tr>
<tr>
<td>STI management</td>
<td>X</td>
</tr>
<tr>
<td>Condom programming</td>
<td>X</td>
</tr>
<tr>
<td>Safer sex negotiation</td>
<td>X</td>
</tr>
<tr>
<td>Sex and sexuality</td>
<td>X</td>
</tr>
<tr>
<td>Advocacy</td>
<td>X</td>
</tr>
<tr>
<td>Themes for Capacity Building</td>
<td>Agencies Responsible</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td>SACS</td>
</tr>
<tr>
<td>Dealing with myths and misconceptions</td>
<td>X</td>
</tr>
<tr>
<td>National AIDS Control Programme III &amp; Targeted</td>
<td>X</td>
</tr>
<tr>
<td>Intervention Programme</td>
<td></td>
</tr>
<tr>
<td>Reporting systems (CMIS)</td>
<td>X</td>
</tr>
<tr>
<td>Project management</td>
<td>X</td>
</tr>
<tr>
<td>Resource mobilisation</td>
<td>X</td>
</tr>
<tr>
<td>Counselling</td>
<td></td>
</tr>
<tr>
<td>Syndromic management of STIs</td>
<td>X</td>
</tr>
</tbody>
</table>

2.2.3.1 Linkages with other HIV programmes
In addition to HIV-specific technical areas, project staff should acquire more general skills enabling them to implement and manage interventions, such as conducting assessments, project planning, budgeting, monitoring and evaluation.

Different departments within SACS should work in coordination with each other. In the rapidly changing environment of HIV, their training requirements may vary. These may include the following issues:

- Structures, policies and procedures
- Good governance, management and decision-making
- Management information systems and institutional learning
- Critical analysis and strategic thinking
- Human and financial management systems
- External relations and partnership-building
- Resource mobilisation

2.2.3.2 Capacity building approaches
Conventional and non-conventional capacity building approaches should be encouraged at all levels.

2.2.3.2.1 At SACS level
- Capacity building needs assessment for the state
- Generation of capacity building resource pool of institutions and individuals
- Development of training modules
- Establishment of a regular capacity building input monitoring system
- Interstate MoUs and sharing of knowledge and resources

2.2.3.2.2 At implementing agency level
- Regular training programmes for mainstreaming HIV/AIDS intervention in other developmental programmes
- Community development training programmes and activities
CHAPTER 3

Implementing Targeted Interventions for High-Risk Migrants:

Guidelines for NGOs
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    3.1.1.2.2 Secondary stakeholders
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3.1 STEPS IN IMPLEMENTATION

3.1.1 Step 1: Stakeholder Analysis (SHA)

Stakeholder analysis (SHA) is the identification of a project's stakeholders and the assessment of their interests and the ways in which these interests affect the programme's risk and viability. It is conducted as part of an overall needs assessment (and the overall process is hence often referred to by the acronym NASHA). The SHA:

- Identifies ways of harnessing the support of those in favour of the intervention
- Manages the risks posed by stakeholders who oppose the intervention
- Identifies the specific role that a particular stakeholder can play to achieve the intervention’s objectives.

3.1.1.1 Objectives

The overall objective of SHA is to ensure the participation of stakeholders at various levels of the intervention for reaching the desired project impact and sustaining the desired changes. SHA has the dual benefit of interaction and rapport-building with the community when collecting information, while at the same time contributing to partnership in programme implementation.

More specifically, an SHA will help to:

- Identify and draw out the interests of stakeholders in relation to the issues the programme is seeking to address
- Capture local behaviours and perceptions within the intervention site that will allow more accurate and effective communication activities to be designed
- Identify conflicts of interests between stakeholders which will influence the impact of the project and manage these in such a way that maximum positive involvement is achieved from various stakeholders
- Identify relations between stakeholders which can be built upon, and enable strategic alliances of sponsorship, ownership and cooperation
- Help to assess the appropriate type and role of participation by different stakeholders at successive stages of the project cycle
- Identify the underlying causes of poor health among the target group and develop strategies in a participatory way to address them
- Develop an enabling environment to sustain the desired positive behaviour changes introduced by the programme
- Identify and promote the formation of community stakeholder groups and potential VPLs
The place of SHA within the context of mapping and planning is seen in Figure 3.

Figure 3. Relationship between Needs Assessment/SHA and TI

**NEEDS ASSESSMENT**
- AREA PROFILE
- SOCIAL ANALYSIS/ECONOMIC ANALYSIS/DEMOGRAPHIC ANALYSIS
- BEHAVIOUR ANALYSIS
- CONDOM DATA ANALYSIS
- STI DATA ANALYSIS
- BEHAVIOUR DETERMINANTS
- STAKEHOLDER ANALYSIS

**TARGETED INTERVENTION**
- AREA
- GROUPS WITH HIGH-RISK BEHAVIOUR
- BEHAVIOUR CHANGE COMMUNICATION
- SAFER SEX & CONDOM USAGE
- STI TREATMENT
- ENABLING ENVIRONMENT
3.1.1.2 Defining stakeholders in migrant interventions

3.1.1.2.1 Primary stakeholders (target population)
- High-risk migrant men and women who are interact with or are part of high-risk sexual networks (FSW, MSM-T)
- Spouses/sexual partners of migrants
- Migrants living with and affected by HIV and AIDS.

3.1.1.2.2 Secondary stakeholders
- Placement agencies, brokers and others
- Families of high-risk migrant men and women
- Families of migrants living with and affected by HIV and AIDS
- Sexual network operators (FSW, MSM-T) and power structures
- Health care providers (government and private, qualified, unqualified)
- NGOs, CBOs and other agencies implementing TIs
- Workers' associations, employees' unions, trade unions
- Infected and affected migrants, PLHA networks

3.1.1.2.3 Tertiary stakeholders
- Industrial centres, informal workplace institutions, employers' associations, other allied organisations and structures
- Community-level voluntary structures, e.g. migrants and youth forums/clubs, mandals, safe spaces/drop-in centres for migrants (spaces for migrants – SFM)
- Decision makers in the community, i.e. social and political leaders, police, elected representatives (PRIs), development functionaries
- NGOs, CBOs, CSOs
- SACS in both source and destination states
- NACO and the donor agencies

3.1.1.3 Location of Stakeholders
A separate needs assessment and stakeholder analysis has been envisaged for each type of intervention area (hot spot, prioritised industrial/workplace locations and large residential locations) for undertaking TIs with high-risk migrants. This exercise will yield relevant stakeholders, and depending upon the role they might play, an appropriate strategy for their involvement may be designed.

3.1.1.3.1 Prioritised industrial/workplace centres
Working with the owners and social welfare officers of industrial/workplace is essential to create an enabling environment for successful implementation of the project. Many such industrial/workplace engage various contractors for labour and raw material supply, and these also form an important category of stakeholder as they have greater influence on the migrant population. There may be canteens and Dhabas in and around the workplaces, and their owners can be targeted to reach out to the target population. Similarly, security agencies employed by the workplaces could emerge as another stakeholder.

3.1.1.3.2 Residential areas of migrants
Some areas in the place of destination are obvious and well known living places for migrants, e.g. slums and temporary shelters. A transect walk in these areas and conducting the NASHA will help to locate influential stakeholders such as Kabadi shops, tea stalls and cigarette shops that can be involved in reaching out to the target population. Often, unqualified private practitioners whom residents of slums and temporary settlements visit for their day-to-day medical needs will be identified as key stakeholders.

3.1.1.3.3 Hotspots
Sometimes there are known hotspots where migrants congregate (e.g. sex worker hotspots, cinema halls). These can be useful areas to identify possible methods of intervention (e.g. mid-media activities).
3.1.1.3.4 Cross-cutting stakeholders
Apart from separate stakeholders specific to each intervention site, there may be some “cross-cutting” stakeholders whose interests are not bound to a specific location. These include unions to which migrant populations are attached and without whose help and support they often do not get jobs at the place of destination. Examples include riksha pullers unions, auto drivers associations and traders’ associations (particularly in vegetable and grain mandis, etc.).

3.1.1.4 When to do it?
SHA is a part of the needs assessment exercise. Once the area of intervention has been finalised the needs assessment and SHA will be conducted in turn. “Social sanction activities” are helpful to establish an initial rapport with the community before SHA is conducted, for example by organising mid-media activities in the intervention areas.

SHA involves participatory techniques such as social mapping, focus group discussion, in-depth interviews/key informant interviews. See Annexure 9, Tool for Information Collection in Stakeholder Analysis.

3.1.1.5 Who will do it?
ORWs and senior staff of the NGO along with some key stakeholders carry out the SHA.

It is important to note that the information/data collected by various needs assessment exercises like focus group discussions, in-depth interviews, key informant interviews, transect walks will form the basis of the SHA.

Since it is impossible to gather all stakeholders together, these groups should be met with separately in the initial stage of the project. Through the SHA, clarity about the various stakeholders’ roles in the project cycle will help to ensure support based on mutually agreed expectations. Conflicting parties must know that the project objectives are the binding force for meeting and interaction among stakeholders. A clear and transparent process will ensure that a heterogeneous group of stakeholders gradually coalesces towards a common goal.

3.1.1.6 Steps in SHA
- Draw up a “stakeholders table”
- Identify stakeholders’ interests in the project and rank them according to their importance to the project’s success
- Assess stakeholders’ relative influence over the beneficiaries
- Conduct a comparative analysis between stakeholders’ importance and influence
- Plan their involvement in project cycle accordingly
- Share the analysis with key stakeholders
3.1.1.6.1 Importance vs. Influence

Importance is distinct from influence. For example, there will be stakeholders, especially unorganised primary stakeholders, upon whom the project places great importance. However, these stakeholders may have limited capacity to influence key decisions. By considering influence and importance, stakeholders can be classified into different groups, which will help identify the assumptions and risks which need to be managed through project design.

Box A: Stakeholders of high importance to the intervention, but with low influence. They require special initiatives if their interests are to be protected.

Box B: Stakeholders of high importance to the intervention who can also significantly influence its success. Managers and donors will need to develop good working relationships with these stakeholders to ensure an effective coalition of support for the intervention.

Box C: Stakeholders with high influence, who can affect outcome of the intervention, but whose interests are not the target of the intervention. These stakeholders may be able to block the intervention and therefore require careful management.

Box D: Stakeholders who are of low priority but may need limited monitoring. They are unlikely to be the focus of the intervention.

Those included in Boxes A, B and C are the key stakeholders in the intervention: they can significantly influence it or are most important to the intervention's objectives.
3.1.1.6.2 Participation Matrix

The next step is to plan the extent and nature of the participation of stakeholders in different stages of the intervention (from being informed about the intervention to being an active participant or a partner). A discussion with stakeholders based on the findings of the influence-importance matrix leads to a “participation matrix” to identify appropriate stakeholder participation.

An example of a participation matrix is provided below to illustrate this point. In this matrix, certain stakeholders have been ranked on importance and influence on a scale of 1-5, with 1 being the least important/influential and 5 being the most.

<table>
<thead>
<tr>
<th>Stakeholder No.</th>
<th>Stakeholders [examples]</th>
<th>Ranking according to importance</th>
<th>Influence in the community as well as on the migrants</th>
<th>Category of Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Workplace owners</td>
<td>4</td>
<td>5</td>
<td>X X X X</td>
</tr>
<tr>
<td>2.</td>
<td>Placement agencies</td>
<td>5</td>
<td>5</td>
<td>X X X X</td>
</tr>
<tr>
<td>3.</td>
<td>Private Medical Practitioners</td>
<td>5</td>
<td>4</td>
<td>X X X X</td>
</tr>
<tr>
<td>4.</td>
<td>Riksha Puller</td>
<td>5</td>
<td>2</td>
<td>X</td>
</tr>
<tr>
<td>5.</td>
<td>Riksha Garage Owner</td>
<td>3</td>
<td>4</td>
<td>X</td>
</tr>
<tr>
<td>6.</td>
<td>Money Lenders</td>
<td>3</td>
<td>1</td>
<td>X</td>
</tr>
<tr>
<td>7.</td>
<td>Dhaba owner</td>
<td>1</td>
<td>4</td>
<td>X X</td>
</tr>
</tbody>
</table>

Tool
Annexure 9 Tool for Information Collection in Stakeholder Analysis
3.1.2 Step 2: Peer Education

Approach: The peer education approach for migrants differs in two critical ways from the model for other TIs under NACP III.

1. **Volunteerism:** Peers are volunteers who engage in the project and are NOT paid honorariums or salaries by the TI, unlike in the case of other TIs. Volunteer Peer Leaders (VPLs) are thus the basis of peer education for migrants.

2. **Mid-media plays the central role in communications, not IPC:** While TIs for other high-risk groups focus on IPC as the main mode of communication, mid-media is the core method of peer education for migrants (as also with truckers).

Peer education is one of the most widely used strategies to address the HIV/AIDS pandemic. A peer is one of equal standing with another, one belonging to the same societal group especially based on age, grade or status. The purpose of volunteer peer leaders (VPLs) is to ensure that HRGs are reached and information on STIs and HIV/AIDS is shared with them to bring out a positive behaviour change. For TIs to migrants, VPLs are envisaged as volunteers from the migrant community.

Peer involvement is an effective way of reaching communities and affecting change in community norms. VPLs are knowledgeable “insiders” in migrant settings, and their involvement enhances trust and communication. VPLs are consequently a credible source of advice. They can be powerful role models and can help to change social norms. VPLs also act as a link between migrant workers and TIs, facilitating local participation. Peer networking and the sharing of information often leads to community mobilisation around issues of concern.

3.1.2.1 Objectives of peer education

- To contact and educate/sensitise a maximum number of the target group through Interpersonal Communication (IPC)
- To increase the knowledge of the target group on STIs, HIV/AIDS and condom use
- To motivate the target group to practice safer sex behaviour and access health services through a credible and acceptable channel of communication

3.1.2.2 Advantages of Volunteer Peer Leaders (VPLs)

- Based at the project's working area
- Have good rapport with the target audience
- Belong to the same professional segment as the HRG
- Are easily accessible to the primary stakeholders round the clock
- Can give sustainability to the project as they will remain in the area even after the project graduates out
3.1.2.3 Role of the VPL

VPLs are a link between project and migrant workers. Their main responsibilities are:

- **Operational elements**
  - Undertake risk assessment of migrant population in their area of operation based on criteria of multi-partner sex and history of STI status, and identify at-risk individuals for the purposes of the TI. This can be done through one-to-one contacts. VPLs also need to identify those migrants who overlap with high-risk sex networks (either as sex workers or clients of sex workers).
  - Link migrant workers with project services such as condoms, counselling and referral services, e.g., testing, care and support, etc.
  - Collect data related to the project for planning.
  - Support condom promotion activities undertaken by NGO staff and/or other organisations engaged for mid-media campaign for condom promotion.
  - Mobilise the target group to participate in mid-media campaign activities, e.g., street plays, video shows, slide shows, infotainment, health camps, mobile exhibition, World AIDS Day programmes, etc. conducted by NGO staff.

- **Behaviour change communication (BCC)**
  - Sharing information related to HIV/AIDS and safer sex practices with those migrants who are at risk of HIV.
  - Use of BCC materials for effective interpersonal communication to address myths and misconception regarding HIV/AIDS.
  - Motivate and dialogue with migrants who are at risk to adopt safer sexual practices.
  - Education on condom usage: buying, storing, opening, using, and disposing.
  - Encourage migrants to maintain cleanliness and personal hygiene.

- **STIs**
  - Create awareness among the migrant population of common symptoms of STIs and the need to seek appropriate treatment from qualified practitioners.
  - Support migrant workers in accessing STI treatment services (project-run or referral services).
  - Remove myths and misconceptions related to STI.
  - Follow up STI patients and their partners wherever possible for treatment compliance.
  - Mobilise migrants for health camps and related events in the areas.
  - Provide referral slips/cards.

- **Care and support**
  - Identify and support PLHA in the migrant workers area.
  - Help them to access to treatment.
  - Link to other departments to provide psycho-social support.

- **Advocacy**
  - Meet with community leaders identified through the SHA and stakeholders for sensitisation on HIV/AIDS and project activities.
  - Facilitate community resources for the project.

- **Linkages with HIV and other services**
  - Linkages with ART centre.
  - Identification of early symptoms of TB and referral to DOTS.
  - Help them to access testing and ICTCs.
3.1.2.4 Selection criteria for VPLs
Following are key considerations for PE selection:

- Must be of the same ethnic group as the migrant population
- Willing to work for the community on a volunteer basis
- Demonstrate self-confidence and show potential for leadership
- Good listening, communication, and interpersonal skills
- Understanding of the cause and committed to the goals of the project
- Knowledge of problems and difficulties of the community
- Should be acceptable among the target audience with whom they will work

3.1.2.5 Identifying potential VPLs
Based on some of the considerations above, the identification of context-specific VPLs for migrant TIs may proceed using the following list of examples:

- Petty shop owners in and around the area where migrants work, congregate or reside, e.g. mechanic shop owner, owners of small hotels which provide lunch and dinner for the target population, owners of popular tea shops, paan and cigarette shopkeepers, etc.
- Members of various associations of migrant workers, e.g. riksha puller association, auto drivers association, supervisors of those working as labourers at various mandis
- Contractors who supply labourers for skilled or unskilled work, including construction
- Social welfare officers of workplaces which employ migrant workers on a causal basis

The identification of VPLs should be initiated as part of project activities such as the Needs Assessment and Stakeholder Analysis (NASHA) and determining individual migrants who are at most risk.

3.1.2.6 Capacity building strategy for VPLs
Working as a PE requires special skills, and it is important to build capacity on technical as well as operational aspects of the project activities.

### Capacity Building Structure

| Initial structured sessions |
| Periodic refresher sessions |
| Supervision |
| Ongoing interaction and support for problem-solving |

A cascade training approach is envisaged for building capacity of VPLs. A cadre of “Master Trainers” will be developed by SACS for overall support of migrant TIs in the State and districts. The main responsibility of these Master Trainers is to train the NGO staff on:

- The basics of HIV/AIDS
- Conducting needs assessment and stakeholder analysis
- Project operational plans
- Approaches and methods of selection of VPLs
- Organising capacity building sessions for VPLs

The trained staff of the NGO, supported by the Master Trainers, will conduct a two-day structured training programme for the VPLs. Once the VPLs are trained on technical and operational aspects of the project elements, NGO staff will be in touch with them during regular field visits. A monthly capacity building cum review meeting can be organised with VPLs by the NGO staff to help solve any operational problems, discuss field activities and provide necessary support.

To maintain the motivation level of the VPLs, the NGO should organise quarterly one-day structured refresher programmes. The operational support and handholding of VPLs will help sustain their...
motivational level, facilitate field-level problem solving and encourage their participation in project activities.

The capacity building strategy should follow the following framework:

<table>
<thead>
<tr>
<th>Training Components</th>
<th>Methodology</th>
<th>Duration</th>
<th>Potential Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS and STIs</td>
<td>Lectures</td>
<td>Two days for initial training</td>
<td></td>
</tr>
<tr>
<td>Sex and sexuality</td>
<td>Games</td>
<td>One-day refreshers every quarter</td>
<td></td>
</tr>
<tr>
<td>Drug abuse</td>
<td>Screening of video films</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholism</td>
<td>Quizzes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community counselling</td>
<td>Sharing of experiences by a PE who has worked in HIV/AIDS outreach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health service linkages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom promotion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reproductive health Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skills building on mobilisation, advocacy and communications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lectures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Games</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening of video films</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quizzes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing of experiences by a PE who has worked in HIV/AIDS outreach</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

VPLs may initially face hostility from the community they seek to serve. Working in groups provides support and strength in numbers. In order to be effective, VPLs need to be seen and heard regularly.

3.1.2.6.1 Materials required by VPLs

- Flip book
- Hand bills
- Penis model
- Condoms
- STI Flip book
- Referral Cards
- Daily Diary
- Bag/Cap/Badges

3.1.2.7 Sustainability of the Peer Education Programme

Intentional strategies must be followed to make the peer education programme viable throughout the time of the TI and beyond. These include:

- Develop a cadre of motivated VPLs and encourage them throughout the project period
- Initiate federation/networking/group formation of VPLs at local level at the later stages of the project implementation. After establishing the TI and “hand holding” for some time, an attempt should be made to form a community based organisation of VPLs, in order to sustain project activities into the future. Other approaches to organising VPLs in formal or informal groups may be attempted depending upon the context and with active participation from the VPLs
- Institutionalise recognition systems and establish mechanism for regular interactions among VPLs as well as between VPLs and key stakeholders, including government counterparts.

3.1.2.8 Recognition for VPLs

VPLs are expected to work with the project on a voluntary basis, and to continue as a volunteer with the same activities beyond the project life span. To maintain their motivation to carry out stipulated tasks on a voluntary basis even with the project's time frame, a recognition and reward system should be devised by the project. While this system may vary in different contexts, it is essential in order to keep VPLs engaged in project activities. The recognition and reward system should accomplish two objectives:
- Reward superior performers and recognize outstanding accomplishments based on specific, measurable and transparent criteria
- Make the status of a peer with the programme aspirational for the target group

Examples of recognition and reward activities include:
- Monthly meetings for VPLs to learn from one another
- Follow-up refresher training
- Maintaining continued periodic interactions in the field
- Providing extra or enhanced materials to facilitate VPLs’ work, e.g. diary, reference materials, flip books, posters, handbills, stickers, etc.
- Exposure visits to various similar TI s
- Developing a healthy competitive attitude among VPLs
- “Peer of the Month” award
- Certificates/badges for good performance
- Gifts and recognition awarded by celebrities

### 3.1.3 Step 3: Behaviour Change Communication (BCC)

The aim of Behaviour Change Communication (BCC) is to make individuals perceive, understand and accept their self-risk due to specific behaviours and to create a desire for preventive action.

A BCC plan for migrants should be based on the following considerations:
- What are the barriers to adoption of safe behaviours or factors that encourage adoption of unsafe behaviours?
- What are the factors that can be used to motivate change in behaviour?
- What are the most appropriate timings and venues for BCC (mid-media and IPC)?
- What types of IEC and BCC material are most appropriate as communication tool?
- What is the mix of languages within the community?

BCC for migrant TI s has two primary components: mid-media and interpersonal communication (IPC)

### 3.1.3.1 Mid-media

Mid-media is a creative and efficient way of generating awareness on certain key issues among large numbers of people. It includes a range of large-group format communications such as street theatre, games, etc. Interactive mid-media techniques, such as street theatre in which the audience is invited to comment on a dramatic situation, can be used to provoke a discussion on community norms. Specific examples of mid-media include:
- Street theatre
- Games
- Traditional local media (interactive street theatre, e.g. Bhavai, Ramlila, etc.)
- Exhibitions
- IEC campaigns
- Debates and discussions
- Audio/video/film shows
- Special observances and commemorations (e.g. World AIDS Day)
- Information kiosks (displays of poster and relevant materials with provision of one-to-one counselling)

A professional agency may be engaged to conduct many of the mid-media events (e.g. street theatre performances), but some activities can be conducted by NGO staff on a regular basis (e.g. film shows, information kiosks).
3.1.3.2 Interpersonal communication (IPC)
Mid-media can be supplemented by one-to-one IPC focused on those individuals who are in need of greater information. One-to-one IPC can be delivered immediately after thought-provoking mid-media to that sub-set of the audience that stays back to obtain more information or seek services. In the interest of maximizing efficiency, it is important to identify that sub-group of migrants with high risk behaviour (primarily single migrant workers) who need to be provided additional information through one-to-one interaction. One-to-one interaction can focus on:

- Information on HIV/AIDS, means of transmission, prevention, STIs, etc.
- Risk perception of individual
- Understanding of high-risk behaviour and its consequences
- Options for safe behaviours
- Information on access to condoms and services available in the area for STI treatment, HIV testing and counselling

3.1.3.2.1 Contact strategy for IPC
The ratio of VPLs to migrants is 1:100. Within this population of migrants, the PE should identify high-risk individuals with the help of outreach workers from the NGO. High-risk migrants should be met with once a week in the initial stages of the project, though the frequency may be modified depending upon the behaviour of the individual migrants (see Annexure 1).

The NGO should prepare a detailed BCC strategy with a conversation plan for VPLs identifying a series of topics for discussion, e.g. safe sex methods, correct method of condom use, myths around condom use, partner notification for STIs, etc. It is important to note that while a minimum package should be designed to ensure a basic level of information and services for entire community, peer communication in the field should not be limited to these topics. Peers should be skilled enough to draw on their knowledge and tailor a discussion to the needs and concerns of specific individuals.

3.1.3.2.2 Development of BCC and Information Education and Communication (IEC) materials
IEC and BCC material should be developed based on the needs of the community. Existing job aids or migrant-specific BCC materials in the form of flip charts, case studies and story-based flashcards can be adapted for use by VPLs. It is important to use images and situations with which the migrant population can identify. Often there will be a need for material in more than one language within one project. The language mix should be based on the profile of the migrant community (as indicated by the initial mapping and NASHA exercises).

The BCC material should be developed and adapted in a participatory way by conducting pre-testing protocols after considering regional, cultural and target group characteristics.

3.1.4 Step 4: STI Management
TIs for migrants will focus on four aspects of STI prevention and management:

- Activities to generate awareness of STI symptoms while emphasising the long-term consequences of such infections, the need for correct and complete treatment, and the means of prevention
- Establishment of a referral network for treatment by interacting with existing health care providers, both public as well as private health facilities as mapped in and around the project site, including training on syndromic case management for providers
- Follow-up and tracking to improve treatment-seeking and compliance with treatment. VPLs and ORWs may use referral slips to monitor whether clients have followed up on referrals (see Annexure 10, Referral Slip)
- Ensuring condom availability
The STI services to be provided are:

- Health promotion and STI prevention activities, such as promoting correct and consistent use of condoms
- Provision of condoms
- Immediate diagnosis and clinical management of STIs using syndromic case management
- Health education and counselling for treatment compliance, correct and consistent use of condoms and regular partner treatment
- Partner management programmes (i.e., contact referral)
- Follow-up services
- Counselling for HIV positive persons
- Referral links to ICTC, HIV care and support and other relevant services

As per the NACO STI drug procurement guidelines, all STI drugs are to be procured by SACS/NACO. No drugs for STIs are to be purchased by NGOs.

### 3.1.4.1 Planning for STI services

The needs assessment undertaken at the start of the project should generate data on the following:

- Information on current barriers to accessing STI services
- Ways in which STI services can be made accessible and acceptable to the community in terms of location, operating hours, etc.
- Context-specific preferred list of physicians

Once this information has been gathered, the NGO must network with the identified service delivery providers to establish dependable services and to orient staff on syndromic case management and treatment of STIs.

<table>
<thead>
<tr>
<th></th>
<th>Referral to Public Sector</th>
<th>Referral to Qualified Private Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td>Free services</td>
<td>Ensures confidentiality</td>
</tr>
<tr>
<td><strong>Disadvantages</strong></td>
<td>May lack confidentiality</td>
<td>Sustainable services</td>
</tr>
<tr>
<td></td>
<td>Unpredictable quality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Possible stigmatisation of STI patients by staff</td>
<td>Cost</td>
</tr>
</tbody>
</table>

In addition to these technical/medical considerations, special attention should be paid to ensuring that STI service delivery options are community-friendly. This means:

- Clinicians with a supportive attitude towards the community
- Availability of services as per the needs of the community, e.g. late-night access
- Access to services at optimal location (e.g. not too far from major sex work sites, not requiring outlay for public transport)
- Basic infrastructure of facility as per NACO STI guidelines
- Confidentiality between the clinic team and the community

### 3.1.4.2 Referral services for other illnesses

The project should actively create referral linkages for other health concerns of migrants. Again, such linkages can draw on both government facilities as well as qualified private practitioners.
3.1.4.3 Social marketing of STI services
Health services and drugs for migrants should be socially marketed, as opposed to free of cost, for the following reasons:

- Migrants have disposable income and therefore can afford to pay socially marketed rates for such services
- Such services are valued more by the community when they are provided at a nominal fee
- Services are perceived to be of higher quality when provided at a nominal charge
- This is more sustainable than providing services free of cost. Private practitioners can more easily be engaged by the programme on a social marketing model

Tool
Annexure 10  Referral Slip

3.1.5 Step 5: Condom Programming

Condom promotion in migrant TIs entails:

1. Regular demand-generation activities to increase visibility, perception of accessibility and demand for condoms
2. Ensuring availability of an adequate supply of socially marketed condoms at traditional and non-traditional condom outlets in and around the project sites
3. Condom demonstrations by VPLs and ORWs to ensure correct usage of condoms

A social marketing organisation (SMO) should be contracted for activities (1) and (2) above. The project should undertake training and capacity-building of VPLs and ORWs to build their knowledge of the benefits of condom use and to impart skills in conducting condom demonstrations and addressing common misconceptions surrounding condoms (reduced pleasure, breakage, etc.).

3.1.5.1 Monitoring condom availability
VPLs and ORWs should also be encouraged to solicit feedback on the availability of condoms, preferred brands, etc. This information should be provided to the SMO to improve distribution. Condom availability at the intervention location should be assessed according to the following:

- **Number of outlets carrying condoms:** Focus should be on those outlets that are convenient for migrants, e.g. those open at night. It is necessary to monitor distribution in traditional and non-traditional outlets. Non-traditional outlets are those that are not retail outlets (e.g., bars, dhabas, barbers, etc.). Such outlets are often more convenient and accessible for migrants.
- **Visibility of condoms at these outlets:** Merchandising at outlets (i.e. prominent display of condoms, posters, banners, etc.) helps increase demand for condoms. Often merchandising material triggers recall of a message and prompts a purchase.

3.1.5.2 Condom boxes
In corporate-sponsored workplace interventions, condom boxes may be provided at the site. Condom boxes enable workers to access condoms anonymously and free of cost. They should be installed at accessible and relatively private locations (e.g. toilets). VPLs can be charged with ensuring that adequate supplies are available through condom boxes.
3.1.6 Step 6: Community Mobilisation

Community mobilisation entails creating a platform for the community to come together to discuss common issues and social norms and to build a collective desire for preventive action. In order to create such a platform, the project should:

- Identify existing congregation points for migrant workers. These may include places of entertainment like video parlours, bars, etc. In case of a workplace intervention, a congregation point may be a common resting area or lunch room.
- Explore the option of using such a congregation point as a project centre where the project staff can interact with the community as a whole, display and distribute IEC material and provide information on referral services. The project should invest in making the point attractive and comfortable for the target population.
- If an existing congregation point is not found to be appropriate, the project should create a new facility that can be used as a project centre.
- The project centre should have:
  - Outreach workers to provide information on HIV/AIDS and related subjects to migrant workers
  - IEC material available for easy access by migrant workers
  - Socially marketed condoms

3.1.7 Step 7: Creating an Enabling Environment

The process of the stakeholder analysis is an important component of creating an enabling environment for the TI. The TI should also have linkages with government departments in order to meet non-HIV needs of the target population. To be effective, it is essential that the TI create an environment where as many needs of the migrant population as possible are met relating to their living conditions, human and workers rights, etc.

Key government departments with whom enabling environment efforts in migrant TIs should focus include:

- **Health Department**: To access other health services under urban and rural health programmes
- **Labour Department**: For unionising and implementation of labour laws
- **Civil Services Department**: For basic amenities related to water, electricity, drainage, etc. at the place of stay
- **Transportation Department**: To develop support services for migrant populations and link them with their families in their source states
- **Industry Department**: To advocate for compliance with codes of conduct for HIV/AIDS
## 3.2 PROGRAMME MANAGEMENT

### 3.2.1 Service Package

<table>
<thead>
<tr>
<th>Location</th>
<th>Package of services</th>
<th>Agency responsible for service delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hot spots</strong></td>
<td>- Condom promotion and distribution</td>
<td>- Social marketing organisations (SMOs)</td>
</tr>
<tr>
<td></td>
<td>- Large-group format activities (e.g. street theatre, games, etc.)</td>
<td>- NGO partner (for setting up referral linkages and overall monitoring)</td>
</tr>
<tr>
<td></td>
<td>- Referrals to qualified medical practitioners for treatment of STIs</td>
<td></td>
</tr>
<tr>
<td><strong>Industry/ workplace centres</strong></td>
<td>- Condom promotion and distribution</td>
<td>- Informal workplace</td>
</tr>
<tr>
<td></td>
<td>- Large-group format activities (e.g. street theatre, games, etc.)</td>
<td>- Formal workplace (e.g. industrial house, corporate houses)</td>
</tr>
<tr>
<td></td>
<td>- Focused IPC (through peers and NGO workers)</td>
<td>- Corporate-backed NGOs</td>
</tr>
<tr>
<td></td>
<td>- Referrals to qualified medical practitioners for treatment of STIs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Development of point of congregation as project centre with availability of IEC material and socially marketed condoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Recruitment of volunteers, advocacy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Workplace policy guidelines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Linkages with other programmes and entitlements</td>
<td></td>
</tr>
<tr>
<td><strong>Residential clusters</strong></td>
<td>- Condom promotion and distribution</td>
<td>- NGO</td>
</tr>
<tr>
<td></td>
<td>- Large-group format activities (e.g. street theatre, games, etc.)</td>
<td>- SMOs (for condom social marketing and promotion)</td>
</tr>
<tr>
<td></td>
<td>- Focused IPC (through peers and NGO workers)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Referrals to qualified medical practitioners for treatment of STIs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Development of point of congregation as project centre with availability of IEC material and socially marketed condoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Recruitment of volunteers, advocacy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Linkages with other programmes</td>
<td></td>
</tr>
</tbody>
</table>
3.2.2 Operational Strategy and Implementation Plan

The following table lists the suggested activities for establishing an effective TI for migrants and identifies those who are responsible for conducting each activity, as well as the timeline. Such detailed activity planning could be prepared separately for each type of intervention site (hot spots, prioritised industry/workplace locations and residential locations). Separate implementation plans will indicate specific activities and relevant stakeholders.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time line</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Year 1</td>
</tr>
<tr>
<td>Train NGO staff in conduct of NASHA</td>
<td>Master trainers</td>
<td>X</td>
</tr>
<tr>
<td>Determine geographical areas for TIs</td>
<td>NGO management</td>
<td>X</td>
</tr>
<tr>
<td>Conduct baseline (BSS)</td>
<td>External agency</td>
<td>X</td>
</tr>
<tr>
<td>Conduct needs assessment and stakeholder analysis (NASHA)</td>
<td>Outreach workers / Master trainers</td>
<td>X</td>
</tr>
<tr>
<td>Advocacy activities with relevant stakeholders</td>
<td>NGO management</td>
<td>X</td>
</tr>
<tr>
<td>Identify VPLs</td>
<td>Outreach workers</td>
<td>X</td>
</tr>
<tr>
<td>Identify individual migrants with high-risk behaviour</td>
<td>NGO outreach workers / VPLs</td>
<td>X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Detail activity plans in each of the intervention areas</td>
<td>NGO staff</td>
<td>X</td>
</tr>
<tr>
<td>Social Sanction Activities at intervention sites</td>
<td>Outreach workers</td>
<td>X</td>
</tr>
<tr>
<td>Train NGO staff in technical and operational aspects of the project</td>
<td>Master Trainers</td>
<td>X</td>
</tr>
<tr>
<td>Train VPLs</td>
<td>Outreach workers / Master trainers</td>
<td>X</td>
</tr>
<tr>
<td>Monthly review cum quarterly capacity building of VPLs</td>
<td>NGO supervisory staff</td>
<td>X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Regular field visits by NGO staff</td>
<td>Outreach and other staff</td>
<td>X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Streamline Monitoring system</td>
<td>NGO supervisory level staff</td>
<td>X</td>
</tr>
<tr>
<td>Conduct ongoing assessment of VPLs and project beneficiaries</td>
<td>NGO supervisory level staff</td>
<td>X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Conduct quarterly review meeting with all staff</td>
<td>NGO supervisory level staff</td>
<td>X X X X X X X X X X X X</td>
</tr>
</tbody>
</table>
### 3.2.3 Monitoring and Evaluation

Monitoring and evaluation (M&E) of TIs for migrants is an essential and integral part of the overall project design. This section presents the overall framework for M&E, including specific indicators for monitoring the project activities and those which need to be collected as part of project evaluation.

#### 3.2.3.1 Monitoring Indicators

The principle applied here is to collect monitoring data which is most relevant for taking decisions at the field level; the information generated from the monitoring system is used to provide feedback to the project activities on a regular basis to take any needed corrective actions. Various indicators along with numerator and denominators for computing indicators and sources of information are outlined in the following table:

<table>
<thead>
<tr>
<th>Activities</th>
<th>Responsibility</th>
<th>Time line</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor availability of condoms / strengthen social marketing efforts of SMO</td>
<td>NGO supervisory level staff / outreach staff</td>
<td>Q 1 Q 2 Q 3 Q 4 Q 1 Q 2 Q 3 Q 4</td>
</tr>
<tr>
<td>Network with Social Marketing Organisation for SM product placement</td>
<td>NGO management</td>
<td>X X</td>
</tr>
<tr>
<td>One-to-one contact with migrants for disseminating information, condom demonstration</td>
<td>VPLs / NGO outreach workers</td>
<td>X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Conduct mid-media activities at intervention sites</td>
<td>NGO staff / VPLs / SMOs</td>
<td>X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Conduct one-to-group meetings with migrant population</td>
<td>VPLs / NGO outreach staff</td>
<td>X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Identify qualified service providers for STI treatment</td>
<td>NGO staff</td>
<td>X X</td>
</tr>
<tr>
<td>Network with government health services for STI treatment</td>
<td>NGO staff</td>
<td>X X</td>
</tr>
<tr>
<td>Identify, refer and follow up on STI cases</td>
<td>VPLs / outreach workers</td>
<td>X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Stakeholder meeting and their involvement in the project</td>
<td>NGO staff</td>
<td>X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Conduct final evaluation survey (BSS)</td>
<td>External agency</td>
<td>X</td>
</tr>
<tr>
<td>SI</td>
<td>Indicators</td>
<td>Calculation</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Total number of migrant population who are identified as high-risk</td>
<td><strong>Numerator:</strong> Number of migrant population found to practice high-risk behaviours</td>
</tr>
</tbody>
</table>
| 2  | % of sites having trained VPLs as per the recommended ratio for (PE : Migrant population) | **Numerator:** Number of sites having trained VPLs as per the recommended ratio  
**Denominator:** Total number of intervention sites | Monthly | NGO Monthly Project Register (MPR)                                       |
| 3  | % of identified VPLs trained                                              | **Numerator:** Number of trained VPLs  
**Denominator:** Total number of identified VPLs | Monthly | NGO MPR                                                                    |
| 4  | % of trained VPLs that demonstrate adequate knowledge of STD/HIV transmission and prevention | **Numerator:** Number of trained VPLs that demonstrated adequate knowledge  
**Denominator:** Total number of VPLs included in the assessment | Quarterly | See Annexure 11, Tool for Ongoing Assessment of VPLs and Migrants (conducted by supervisory and higher-level NGO staff) |
| 5  | % of trained VPLs that demonstrate adequate condom demonstration skills    | **Numerator:** Number of trained VPLs that demonstrated adequate condom demonstration skill  
**Denominator:** Total number of VPLs included in the assessment | Quarterly | See Annexure 11, Tool for Ongoing Assessment of VPLs and Migrants (conducted by supervisory and higher-level NGO staff) |
| 6  | Average number of one-to-one contacts organised by VPLs during past month | **Numerator:** Sum of all one-to-one contacts made by the VPLs  
**Denominator:** Total number of VPLs | Monthly | ORW/NGO MPR                                                                |
| 7  | % of VPLs conducting one-to-one contacts in the intervention area         | **Numerator:** Number of VPLs conducting one-to-one contacts  
**Denominator:** Total number of VPLs | Monthly | NGO MPR                                                                    |
| 8  | Average number of one-to-group contacts organised by VPLs during past month | **Numerator:** Sum of all one-to-group contacts made by the VPLs  
**Denominator:** Total number of VPLs | Monthly | ORW/NGO MPR                                                                |
<table>
<thead>
<tr>
<th>SI</th>
<th>Indicators</th>
<th>Calculation</th>
<th>Frequency</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>% of VPLs conducting one-to-group contact in the intervention area</td>
<td><strong>Numerator:</strong> Number of VPLs conducting one-to-group contact&lt;br&gt;<strong>Denominator:</strong> Total number of VPLs</td>
<td>Monthly</td>
<td>NGO MPR</td>
</tr>
<tr>
<td>10</td>
<td>% of BCC events by type (Folk media, AV shows and Infotainment) organised against planned</td>
<td><strong>Numerator:</strong> Number of BCC events organised last month by type&lt;br&gt;<strong>Denominator:</strong> Total number of BCC events planned for the month</td>
<td>Monthly</td>
<td>NGO MPR</td>
</tr>
<tr>
<td>11</td>
<td>% of persons trained for TI against those planned to be trained&lt;br&gt;• NGO staff&lt;br&gt;• Qualified health service Providers&lt;br&gt;  • Public&lt;br&gt;  • Private&lt;br&gt;  • RMPs</td>
<td><strong>Numerator:</strong> Number of persons trained by category of participants&lt;br&gt;<strong>Denominator:</strong> Total number of persons planned to be trained for TI by category</td>
<td>Monthly</td>
<td>NGO MPR</td>
</tr>
<tr>
<td>12</td>
<td>% of migrants referred for STI/RTI who sought treatment</td>
<td><strong>Numerator:</strong> Number of migrants who sought treatment from referral service providers for STI/RTI&lt;br&gt;<strong>Denominator:</strong> Total number migrants referred to service providers for treatment for STI/RTI</td>
<td>Monthly</td>
<td>Referral slips, NGO MPR</td>
</tr>
<tr>
<td>13</td>
<td>% of functional service providers in the month&lt;br&gt;  • Public&lt;br&gt;  • Private</td>
<td><strong>Numerator:</strong> Number of functional service providers in the month&lt;br&gt;<strong>Denominator:</strong> Total number of service providers identified and included in the referral network for treatment for STI/RTI</td>
<td>Monthly</td>
<td>Referral slip, NGO MPR</td>
</tr>
<tr>
<td>14</td>
<td>% of active condom outlets by type (conventional and non-conventional) and by primary target group</td>
<td><strong>Numerator:</strong> Number of condom outlets having uninterrupted supply of free and SM condoms during the month&lt;br&gt;<strong>Denominator:</strong> Total number of condom outlets</td>
<td>Monthly</td>
<td>NGO MPR</td>
</tr>
<tr>
<td>15</td>
<td>% of migrants who can state or demonstrate correct use of condoms</td>
<td><strong>Numerator:</strong> Number of migrants who could state or demonstrate the correct use of condom&lt;br&gt;<strong>Denominator:</strong> Total number migrants included in the assessment</td>
<td>Quarterly</td>
<td>See Annexure 11, Tool for Ongoing Assessment of VPLs and Migrants</td>
</tr>
<tr>
<td>16</td>
<td>% of stakeholder meetings organised in the month by type (police, elected representatives, unions and associations, others)</td>
<td><strong>Numerator:</strong> Number of meetings organised by type and by primary target group&lt;br&gt;<strong>Denominator:</strong> Total number of meetings planned</td>
<td>Monthly</td>
<td>NGO MPR</td>
</tr>
</tbody>
</table>
3.2.3.2 Evaluation Indicators

While the monitoring indicators described above will provide information about project status on a regular basis, evaluation of the TI is to be conducted at the end of the project period to determine the success of the TI in reducing migrants’ vulnerability to acquiring HIV/AIDS.

Evaluation indicators are measurable parameters for each component and subcomponent of the TI with a verifiable source of information. The following table describes some of the relevant indicators for project evaluation purposes:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target</th>
<th>Means of Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>KNOWLEDGE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% knew that consistent condom use reduces the risk of HIV infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(among those who heard about HIV/AIDS)</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>% correctly aware (with no incorrect knowledge) of all 5 ways of HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>transmission (among those who heard about HIV/AIDS)</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>% rejecting at least two misconceptions about reducing the risk of HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>infection (among those who heard about HIV/AIDS)</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>BEHAVIOUR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% had sex with CSW or en-route CSW or non-regular non-commercial partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in last 12 months</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>Condom use in last sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. With any type of partner</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>2. With regular commercial partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. With non-regular commercial partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. With regular non-commercial partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. With non-regular non-commercial partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. With non-marital non-cohabiting partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SELF-REPORTING OF STD SYMPTOMS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% suffer from -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Genital Discharge</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>- Genital ulcers/sores</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>% had sex with any partner while suffering from STIs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RISK PERCEPTION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception of risk for contracting STIs</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>Perception of risk for contracting HIV/AIDS</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time of condom use (before first penetration)</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>Male to male sexual behaviour</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>Median age at sexual debut</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>Indicator</td>
<td>Baseline</td>
<td>Target</td>
<td>Means of Verification</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------</td>
<td>--------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>PROCESS INDICATORS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% heard about STIs</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>% seeking treatment for STIs (among those who reported having either genital discharge or genital ulcers)</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>% obtained medicines for STI (among those who sought treatment)</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>% reported completely cured (among those who received medicines)</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>% knew any persons from neighbourhood talking about unprotected sex and danger of STI or HIV/AIDS</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
<tr>
<td>% witnessed any BCC event on HIV/AIDS</td>
<td></td>
<td></td>
<td>BSS</td>
</tr>
</tbody>
</table>

**Tool**

Annexure 11  *Tool for Ongoing Assessment of VPLs and Migrants*
LIST OF ANNEXURES

Annexure | Title | Referenced in Guidelines
--- | --- | ---
Annexure 1 | Tool for Risk Assessment | Section 2.1.1.1.2, 3.1.3.2.1
Annexure 2 | Methodology for Mapping | Section 2.1.1.2.1
Annexure 3 | Tool for Preliminary Mapping | Section 2.1.1.2.1
Annexure 4 | Tool for Detailed Mapping | Section 2.1.1.2.2
Annexure 5 | Tool for FSW Assessment | Section 2.1.1.2.2
Annexure 6 | Tool for Hotspot Screening (Owners) | Section 2.1.1.2.2
Annexure 7 | Tool for Hotspot Screening (Patrons) | Section 2.1.1.2.2
Annexure 8 | Model HIV/AIDS Workplace Policies | Section 2.2.2.2
Annexure 9 | Tool for Information Collection in Stakeholder Analysis | Section 3.1.1.4
Annexure 10 | Referral Slip | Section 3.1.4
Annexure 11 | Tool for Ongoing Assessment of VPLs and Migrants | Section 3.2.3.1

NACO Guidelines and Tools referenced in these Guidelines

NGO/CBO Guidelines, NACO, March 2007
Introduction, Section 2.2.1, 2.2.2.8
Guidelines on Financial and Procurement Systems for NGOs/CBOs, NACO, March 2007
Introduction

ACKNOWLEDGEMENTS

The following individuals and organisations are acknowledged for their work which is quoted or used in adapted versions in the text of the Guidelines and the Annexures:

Avahan, Bill and Melinda Gates Foundation
CARE India
India Health Action Trust, University of Manitoba
Population Services International
International Labour Organisation