# Migrant Intervention Strategy for National AIDS Control Program IV

## 1. Background

Migrants bear a heightened risk of HIV infection, which results from the condition and structure of the migration process. Available evidence suggests that migration could be fuelling the spread of HIV epidemic in high out migration states such as Uttar Pradesh, Bihar, Rajasthan, Orissa, Madhya Pradesh and Gujarat. The recent sentinel surveillance data (2008-09) has shown an increase in HIV prevalence in these states. Of the 1.2 lakh estimated new infections in 2009, the six high prevalence states accounted for only 39% of the cases, while the states of Orissa, Bihar, West Bengal, Uttar Pradesh, Rajasthan, Madhya Pradesh and Gujarat accounted for 41% of new infections. In addition, data from integrated counseling and testing centers (ICTCs) in destination areas such as Thane District of Maharashtra State and Surat of Gujarat State have shown high prevalence of HIV among migrants. The HIV-positivity rate among male migrants from UP tested in Thane ICTCs was 9.1% and female migrants was 7.9%. Similarly, the male migrants from Andhra Pradesh tested in Thane ICTC had a prevalence of 23.8% and female migrants were 16.4%. Likewise, the Ganjam migrants tested in Surat ICTC also showed high HIV prevalence with 2.3% among male and 3.5% among female migrants. The high prevalence among migrants reported in ICTCs in the destination states is worrisome as it could spiral an epidemic in their places of origin which are currently low prevalence.

Studies have also shown that migrants per se are not at risk but it is the conditions and the environment that puts them at risk of acquiring HIV infections. Evidence from various studies has shown that over 30% reported sex with either a sex worker or non-spousal unpaid female partner in their places of destination. Data also has demonstrated that HIV infection in couples (sero-concordant or sero-discordant) was significantly more likely among those couples where a man is a migrant and those couples where man is a migrant as well as mobile, relative to those couples where men were neither migrant nor mobile.

Migrants are defined in many ways. The Census of India defines migrants as a person who has moved from one politically defined area to another similar area. For the purpose of HIV programming in the country the revised migrant operation guideline defines migrants as;

- People (Both male and female) who move from their place of origin in rural areas (source) to a town or city (destination) – irrespective of district/state/country
- Return to their place of origin at least once in 6-12 months
- Move frequently between districts for work purpose
- Move directly between the places (or) via the transit locations
- Move either alone or with their partners
- Those returned to places of origin (at source areas)
- Female spouses of migrants (at source areas)

Migration is a complex process. People migrate either due to distress or for better livelihood from their place of home to cities and towns within or outside their states for employment. The conditions at the destinations are not conducive as they are seen as outsiders who take away their jobs and also labeled as people who make the city dirty. Access of migrants to health care has become of paramount importance in a rights-based health system and to efforts aimed at reducing health inequities. Despite progress made in promoting the health of

migrants and improving health services for migrant populations, there are trends that fuel social exclusion of vulnerable migrant groups and leave their health needs unattended.

The migration interventions in India under NACP III until 2009 have been concentrated in destination areas. Recent epidemiological study conducted in seven districts of northern and eastern India with high out-migration suggests that, there were more migrant men and their spouses among HIV-positive than among HIV-negative populations. For eg., in northern Bihar migrants accounted for 89 percent of the HIV-positive group compared to 59 percent of the HIV-negative group. Similarly, in Ganjam district, migrants accounted for 79 percent of the HIV-positive population compared to 41 percent of the HIV-negative group. These proportions were 73 percent and 32 percent, respectively, in eastern UP. These data from the epidemiological study and increasing HIV prevalence noted in some of the districts in states with high out-migration guided the change in approach for migrant interventions from the typical destination site only interventions to more broader approach of Source-Transit-Destination interventions.

A revised National Migrant Strategy and Guidelines was developed (2010) and was further revised based on the lessons learned from the ground. Unlike the core group interventions, the migrant intervention is evolving and there are implementation challenges, including identification of sites within high out-migration areas where interventions could be initiated. NACP IV provides an opportunity to further strengthen strategies by enhancing the evidence and designing interventions tailored to the dynamics of migrant populations including the typologies that influences their vulnerability.

**II. Strategic Questions for NACP IV**

a) Enhance migrant data to strengthen evidence

   There is more bio-behavioral research needed to document the burden of HIV epidemic in the areas that are affected largely by migrant populations. It is critical to understand the epidemiology of HIV among migrants and geographies to focus the interventions and maximize the impact (needs to be addressed under SI working group).

   Need for a migrant specific strategic information system at the National level to track migrants on the move from source to destination and back specially for PLHIV migrants on ART or DOTS/TB to ensure adherence and decrease loss to follow up.

   Need to develop proxy indicators for migrants on the move as concurrent data generation strategy and improving evidence base linking source and destination districts.

b) Migrant populations are heterogeneous in terms of types, size, language and culture. HIV prevention strategies and services need to be tailored according to the needs of these populations.

   The migrants are classified in to different types such as source, destination and transit; in-migration and out-migration; permanent/long term and temporary/short term migration; and return migration and currently active migration. Similarly, the size of migrant populations varies based on occupations and types of industries. In some destinations, there are large concentrations while in some you have clusters and elsewhere it is widely

dispersed. It is important for the programs to understand at the local level the type and size of migrants and the HIV risks within those settings to make decision on type of interventions. The language and culture in migrant destination are different as they migrate from various states and temporarily settle in a particular location for work.

c) Structural Interventions is critical to address HIV vulnerability among migrants

Structural interventions such as making services more accessible, available, and increase demand through certain legal and social regulations that aims to improve the quality of life, health and citizenship of migrants are important. The migrant interventions need to include strategies/programs that addresses structural barriers.

d) Design strategies to improve access to services for migrant populations

The heterogeneous nature of migrant populations and their work conditions poses challenges in designing HIV services that are accessible and sensitive to their needs.

e) Focus on Quality/QA-QI system

The quality assurance system of targeted intervention program (TI) needs to be strengthened. The current TI program lacks a robust QA system to monitor the quality of prevention services.

## III. Guiding Principles for Migrant Interventions for NACP IV

*Rights based approach*

Adopt approaches that are sensitive to culture, religion and language and that recognize the diverse backgrounds and the needs of migrants. Programs that specifically target migrants as a "risk group" in particular need of HIV/AIDS-related services can further stigmatize groups that are already stigmatized. It is more appropriate to base programs on principles that stress access to health services as a fundamental right for all.

*Address structural barriers (laws, legislations, policies; norms, practices, culture)*

Policies should support universal access to prevention, treatment, care and support as a core element of health promotion. Most importantly, efforts should be made to advocate with Labor and Welfare Ministry and industries to improve their work conditions.

*Gender responsive*

Given that sexual transmission is one of the main means of HIV transmission, it is crucial to ensure that sexual and reproductive health services and HIV initiatives are integrated. Prevention, treatment and care have to go beyond the provision of HIV services and should include, among others, education programs, counselling on safer sex, contraception, pregnancy and birth. Programs should be designed to reach the greatest number of people possible. In this context, special attention should be paid to women, mothers and young girls from migrant communities, who are often extremely vulnerable and confronted with multiple

sources of discrimination and exclusion. Universal access to health services has a beneficial impact on the individual as well as on society at large, whereas exclusion exacerbates vulnerability, stigmatization, and discrimination. Inclusion is of vital importance in making health messages more effective and in insuring that they are communicated widely and appropriately.

*Adopt Health and Social Development Approaches*

Migrant interventions need to have an integrated health and social development approach. Addressing social development issues such distress migration will have a direct impact on HIV/AIDS, the sosiAs

*Community led and owned*

We stress the need for the meaningful involvement and representation of migrant community members including migrant women and PLHIV, in all phases of development, implementation and evaluation of intervention programs. In order to influence and shape decision making and policy development on migration and HIV, it is important that members of various migrant groups participate in decision making processes.

*Prevention to Care Continuum*

Appropriate strategies needs to be designed that ensures prevention to care continuum for migrant populations.

*Reducing stigma / discrimination*

NGOs and service providers need to be trained to ensure non-discriminatory approaches in providing services to migrant populations. In order to promote access, service providers should develop partnerships with migrant communities. Peer education and cultural mediation should be employed as means of reaching out to and supporting members of migrant communities.

*Innovations as part of service delivery*

The migrant intervention strategy should provide adequate scope for carrying out innovation in outreach interventions and services delivery.

## IV. Goal and Objectives for Migrant Interventions in NACP IV

a) Goal

To reduce HIV prevalence from 2.6% to less than 0.5% among migrant population

b) Objectives

- Increase coverage of high risk migrants (both Male and Female) from 30% in 2011 to 90% by 2015

- Increase consistent condom use among migrants from 25% to over 80% by 2015
- Reduce curable STI incidence among migrants and their sexual partners
- Increase HIV testing from 6 % in 2011 to 50% by 2015; and ensure 95% of HIV-positive receive treatment and care
- Promote integration of HIV and SRH services, convergence with departments at both source and destination areas.

## V. Migrant Intervention Strategies for NACP IV:

### A. Scale-up Migrant Intervention/Coverage at Source, Transit and Destination

As part of NACP IV, evidence-based strategies needs to be designed to scale-up coverage of high-risk migrant populations at source, transit and destinations. Experience from the ground has shown that mapping coupled with risk assessment has helped to target high-risk migrants. It is also important to map all categories of migrants and their sexual partners (active, return migrants and sexual partners both at source and destination) in all the states by adopting standard guidelines. There are lessons learned in mapping and size estimation of currently active migrants. However, there is limited experience in mapping and size estimation of return migrants. Significant experience have been gained in carrying out intervention among migrants in diverse settings at destination sites such as migrants in large concentrations (Bhiwandi site), migrants in clusters (construction sites) and dispersed migrants (plantation industry). The lessons learned from these interventions need to be tapped in planning the scale-up strategy for NACP IV. Some of the suggestions for scaling-up coverage in destination areas include adopting a district-level strategy; increasing the number of outreach workers based on migrant size and settings; collaborating with corporate sector, expanding workplace interventions in unorganized sectors; and sector/area specific outreach strategy. Another important strategy is to scale-up interventions based on corridors of migration. Most importantly, evidence needs to be generated on the extent of female migration and accordingly strategies designed to scale-up interventions.

At source level, the suggested strategies include rapid mapping to identify source districts, taluks and villages. Other suggested strategies include designing strategies to scale-up interventions for reaching wives of migrants, returned migrants and potential migrants (youth**).**

**Illustrative Activities**:

- Review mapping guidelines and revise to expand scope and improve size estimation at destination and source
- Develop standardized risk assessment tool for migrant populations.
- Design strategies for scaling-up intervention based on lessons learned at source, transit and destination (district level, sector/area specific, corridor approach etc)
- Review program management guidelines for migrant interventions at NACO, SACS and district/NGO levels

## B. Strengthen Out Reach Strategies for effective interventions at Source, Transit and Destination

The current outreach approach includes peer led interventions coupled with mid-media activities to reach migrant populations with prevention services. However, as experience has shown with diverse migrant populations which are large in size, uniform outreach strategy cannot be adopted as is the case with core populations. For instance, the peer led interpersonal communication can reach only small numbers. On the contrary, mid-media campaigns such as street plays, exhibitions and health camp approach are found to be effective. However, the outreach behavior change communication strategies need to be tailored to the dynamics of migrant populations at source, destination and transit. The revised migrant strategy has addressed these issues. But migrant interventions are evolving and the outreach strategies are being tested. Hence, the migrant guidelines needs to be dynamic and provide scope for ongoing revisions as lessons are learned. A migrant communication strategy and BCC campaign materials and tools have been developed. These needs to be reviewed in the light of the lessons learned from the ground. Some of the suggested strategies are to include sexual and reproductive health messages in migrant campaigns; select peer educators from the migrant community, engage folk media of migrant states; IEC material in mother tongue of migrants; engage community/village structures in demand generation and expand mid-media campaigns.

Another important outreach strategy is to strengthen the structural interventions for creating an enabling environment for migrant interventions. Some of the best practices include advocating and engaging management (Punj Loyd experience) to improve work conditions and formation of crisis committees among migrants. Suggested strategies include linkages with various ministries such as Labor, Health etc.

As the migrant interventions are evolving it is critical to carry out innovations to improve the effective ness of outreach strategies. Some of the innovations that have been undertaken are a comprehensive prevention program linking source – destination migrants (UNDP, ICHAP), rural migrant intervention and Nepali migrant intervention. However, these innovations need to be assessed for effectiveness and for possible scale-up. Some new innovations suggested for NACP IV include flexibility in models for scaling up (service scale up only, service and management scale up) the flexibility will have to developed in accordance to the local requirements and local assessment of the environment- there may change in approach or human resources, Use of UID/Smart card; leveraging existing NGOs in organized and dispersed settings; migrant helpline; comprehensive prevention, testing, treatment, care and support initiatives and radio-listeners approach. ; and use of technologies for monitoring of programs

As experience also suggests the programmes which offer more need based services which may have minimal cost implication would provide greater attraction for the target population to visit the intervention. This will also reduce the burden on outreach if we are able to bring the population in towards the programme. Services such as information on housing, local employment opportunities, linking to community groups and referral to legal services.

**Illustrative Activities:**

- Review outreach strategies and revise based on lessons learned

- Review the migrant communication strategy and materials and revise based on lessons learned
- Design a comprehensive structural intervention strategy
- Support innovations to improve effectiveness and sustainability of outreach interventions.

**C. Improve Access to Health and HIV services**

Unlike the core populations, there are challenges in increasing access to quality HIV prevention, care and treatment services for migrant populations. The challenges are primarily due to work environment and conditions associated with migration. Some of the strategies that worked are mobile ICTC van and outreach ICTC strategies. Some of the suggested strategies to improve access to services include designing migrant friendly services with respect to timing and venue; free/subsidized STI services through public-private partnerships (preferred providers) or static clinics; engaging AYUSH practitioners; strengthen the DICs; transfer protocols to be developed for migrant PLHAs; integration and linkages with other health services; free condoms complemented by social marketing programs. In addition, innovations need to be carried in NACP IV to improve the effectiveness of HIV services. In the case of migrant populations, it is critical to provide holistic health care in a nondiscriminatory environment. Innovative models could be developed for providing integrated HIV and general health care services. Another suggested innovation is respondent driven approach for uptake of HIV testing and treatment services could also be tested.

**Illustrative Activities**

- Multiple service delivery mechanism (mobile vans, health camps, outreach camps, training of PP)
- Free condoms/ STI services (including medicines)/ complemented by social marketing and PPP
- Linkages to Continuum of Care (CoC) (Transfer protocols)
- Strengthen counseling service; focusing on risk reduction, positive prevention
- Conduct innovations in service delivery approaches

**D. Community Mobilization**

Community mobilization needs to be a core strategy for migrant interventions. The programs on the ground have generated extensive experience of engaging the community structures in both source and destination districts. At the destination migrant interventions, the migrant community associations have been mobilized to expand coverage and in generating demand for services. These experiences provide an opportunity to strengthen the community mobilization strategy for migrant interventions in NACP IV. In order for the migrant interventions to be community led and owned, the migrant associations and migrant community need to be involved in all stages of migrant interventions including planning, implementation, monitoring and evaluation.

**Illustrative Activities**

- Engage and work through the existing community support structures at source and destination

- Involve women in planning, implementation and monitoring of migrant interventions.

## E. Integration and convergence for sustainability

One of the core strategies proposed under NACP IV is integration of HIV interventions with general health services. This would ensure long term sustainability of the program. There are different strategies for integrating migrant HIV services. For example, at destination site migrant HIV services can be integrated with municipal health facilities. However, the issue is that the migrants are non-locals and there will be challenges in integration. On the contrary, integration of migrant HIV services with general health services is feasible in source districts. As integration is a new phenomenon, various models need to be piloted and accordingly taken to scale. Other opportunities for convergence are workplace interventions and public-private partnerships.

### Illustrative Activities

- Convergence at destination districts with municipalities and Urban Health Mission.
- Convergence with NRHM at source districts
- Partnerships: ministries/departments –state & district level
- Public-Private partnerships
- Work Place Interventions
- Leveraging existing health system/Structures in different settings

## F. Strengthen monitoring and evaluation systems

There is a need to strengthen the existing monitoring and evaluation systems. The concern is that the existing system is cumbersome and takes away quality time of the outreach workers in filling-up forms. Some of the suggested activities to improve the systems are given below:

### Illustrative Activities

- Revisit the reporting formats to make user friendly
- Revisit the performance monitoring tools
- Create norms for gender audit ; develop tools
- Make simpler forms for STI documentation (STI syndrome incidence)
- Develop tools/indicators for link between source – destination corridors
- Concurrent behavior monitoring system (like polling booth)
- SIMU should include Migrant source-transit-destination indicators
- Include indicators for measuring access of HIV services in ICTC registers
- Use of technology for monitoring the program

## G. Cross cutting strategies

There various cross-cutting strategies that need to be addressed as part of migrant interventions and these are described below under separate headings:

1. Integrate gender in migrant intervention including developing indicators and conduct of gender audit.

- Conduct a gender assessment of migrant interventions
- Design strategies to address gender concerns at source, transit and destination
- Develop indicators and assess gender integration in migrant interventions.

2. Greater Involvement of migrant PLHIV (GIPA) in planning implementation, monitoring and evaluation of migrant interventions.

    - Develop a GIPA strategy for migrant intervention

3. Capacity building of NGOs, health care providers and stakeholders on migrant intervention (needs to be part of capacity building working group)

    - Develop migrant capacity building strategy (Training modules)
    - Update/Develop training modules for migrant intervention and carry out TOTs
    - Include sexuality issues, life skills education in capacity building program
    - Develop training programs on community mobilization, monitoring and evaluation at all levels (SACS, TSU, NGO, STRC)
    - Engage migrant communities and their associations for implementation and management of the program.

4. Epidemiological/Research studies related to migrant interventions

    - ICTC/SIMS should include migration related indicators
    - ART data should be analyzed to identify HIV burden among migrants
    - Conduct National IBBA for migrants and STI burden assessment
    - Expand sentinel sites with revised definition of migrants
    - Conduct studies on female migrants and their vulnerabilities to HIV
    - Initiate operations research of identifying and working with highly mobile migrants

5. Program Management

    - Need for a National/State level Program officer to manage migrant interventions.
    - Co-ordination between SACS of source and destination areas.
    - Better coordination between SACS and SMOs, STI services and Care and Support.

    - District level NGO managing the whole district program, guided by State level agency/TSU; but some districts can have more than one NGO managing the program at district level.
    - Empowerment of DAPCUs (one point person for migrants)
    - Flexibility in engagement of number and type of peer educators (based on contractors/stakeholders/from migrants communities)

6. Quality Assurance System

    - Develop QA/QI strategy for migrant interventions (checklist to monitor the services)
    - Make ORW accountable for the program targets
    - Strengthen outreach micro- planning
    - Set realistic targets for measuring the quality
    - Develop standardized tools and check lists to monitor and for quality checks
    - Periodic assessment by NGO/TSU-SACS on quality
    - Review/revise performance monitoring indicators
    - Revise quality benchmarks (based on the revised strategy) make a document

7. Financial management and funds flow; budget flexibility

    - Reduce gap in signing of contract and release of grants
    - Relook at the proposal development (Year 2 onward or re-contracting)
    - Standard remuneration structure for outreach staff, peer leaders across all the type of programs
    - Provision of travel expense, mobile expenses
    - Provide sufficient funds for program management including infrastructure, mid-media activities and for migrants operations research
    - Allow for flexibility on deciding the number of ORWs and VPL (ORW increase based on migrants)
    - Specific fund to reach out to the female partners of the migrant population

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