Targeted Interventions Under NACP III

OPERATIONAL GUIDELINES

Volume II

MIGRANTS AND TRUCKERS

National AIDS Control Organization
Ministry of Health & Family Welfare
Government of India

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FOREWORD

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The prevention of new infections in high risk groups is a major thrust in National AIDS Control Programme III. The most effective means of controlling the spread of HIV in India is through the implementation of Targeted Interventions (TIs) amongst persons most vulnerable to HIV/AIDS, such as female sex workers (FSWs), men who have sex with men (MSM) and transgenders (TGs) and injecting drug users (IDU). In addition, the bridge populations of truckers and migrants also require focused interventions. Both NACO and the States place a high priority upon full coverage of the States' FSWs, MSMs/TGs, IDUs and migrants/truckers with TIs. In order to standardise the approach to scaling up coverage among these core groups and bridge populations and maintain a high level of quality, it is important to provide detailed information on various operational issues in TIs.

NACO has prepared these Operational Guidelines after a series of consultations with Technical Resource Groups (TRGs), representatives of civil society, Government, core groups, donors and other stakeholders. The guidelines describe the operational details of TI projects with various core high risk groups (Part 1) and bridge populations (Part 2). The guidelines also provide detailed information on issues related to programme management, services required in terms of human resources, infrastructure, linkages and monitoring and evaluation indicators for each programme area.

I take this opportunity to acknowledge the contribution made by the TRGs, the TI Team of NACO and the NACO Technical Support Unit (TSU) in preparing these guidelines. I would also like to acknowledge and thank the various agencies mentioned in the acknowledgments section for their valuable inputs.

We hope that these guidelines will help State AIDS Control Societies, potential partners (NGOs, CBOs, and networks), programme managers and other staff working in TI projects and TSUs to implement and manage TI projects more effectively.

Let the scale up challenge begin!

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NACO Guidelines and Tools Referenced in these Guidelines

NGO/CBO Guidelines, March 2007

Guidelines on Financial and Procurement Systems for NGOs/CBOs, March 2007

TI Costing Guidelines

STI Guidelines

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- India Health Action Trust, University of Manitoba
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17. Representative from Transport Corporation of India

INTRODUCTION: MIGRANTS

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 Targeted Interventions for Migrants Under NACP III

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1.1 RATIONALE FOR TARGETED INTERVENTIONS (TIs) AMONG 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.

India, home to the third highest number of HIV positive people in the world, is characterised by widespread and fluid migration and mobility. More than 2 million Indians do not live in the place of their birth. 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.

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 husband's absences.

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 (TGs) – who are more prone to HIV infection. Similarly, 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

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

- Intersection with high risk sexual networks
- 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".

DEFINITION OF MIGRANTS FOR TIs UNDER NACP III

From an HIV programming perspective under NACP III, migrant TIs:

- Are **destination interventions for in-migrants** (i.e. at the point of destination) and not at the source
- 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

The broader transmission of HIV beyond high risk groups (or HRGs, which include FSWs, MSM and TGs, 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 as well as other partners of lower risk (general population) are called a "bridge population", because they form a transmission bridge from the key population to the general population. **Men are an important 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

This is illustrated in Figure 1.1. In this pattern of epidemic transmission, it is most effective and efficient to target prevention towards the HRG and bridge population members to keep their HIV prevalence as low as possible.

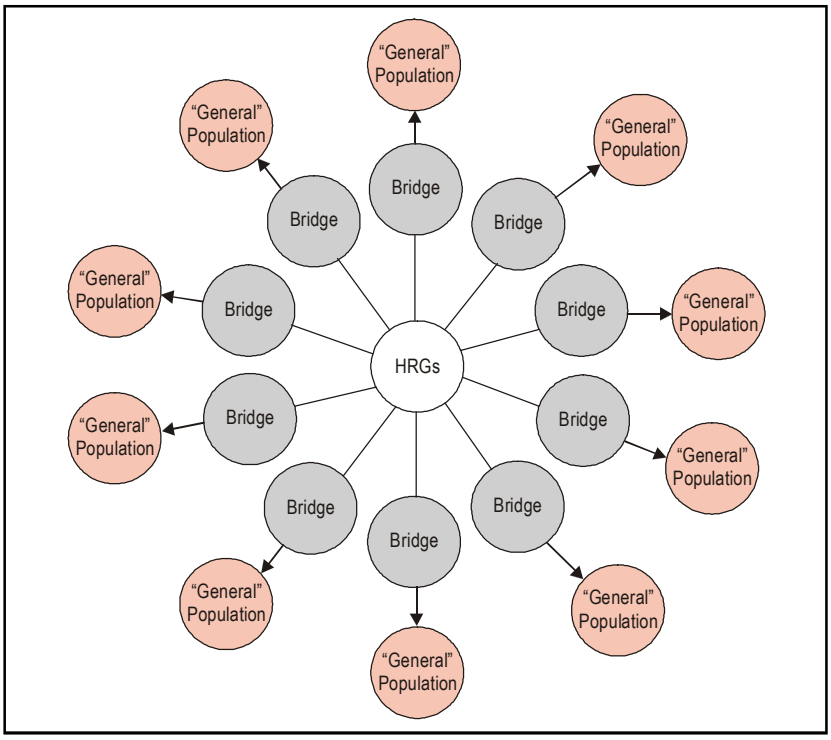

Figure 1.1 Illustration of an HIV Transmission Network

High risk migrants who are targeted through TIs are thus either in the **bridge population category** – that is as clients of high risk group (HRG) members (e.g. FSWs, MSM, IDUs) – or are **HRG members** themselves (as FSWs, MSMs or IDUs). Migrant interventions will focus on providing services to bridge population high risk men. Any migrant identified as an HRG member can be referred to the nearest TI for that risk group.

1.1.4 Sources of Risk and Vulnerability for Male Migrants

- 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 other casual sex relationships.

1.1.5 Sources of Risk and Vulnerability for Female Migrants

- Poverty (usually reason for migrating in the first place) makes women more vulnerable to being pushed in to sex work at their destination to supplement their earnings
- Lack of HIV and AIDS awareness, information and social support networks at both source and destination points

- 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.
- 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 their husbands and other sexual partners
- Lack of decision making power and reticence about seeking STI treatment often lead 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.
- Lack of awareness of policies and laws which promote women's rights to reproductive and sexual health and equal access to education and information on health care

1.2 CONSIDERATIONS FOR MIGRANT PROGRAMMING

1.2.1 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 1.2 illustrates two main strategic issues:

- First, **only a proportion of all sex worker clients are migrants**. This proportion will vary by location.
- Second, **most migrants are not clients of sex workers (either FSWs or high risk MSMs)**.

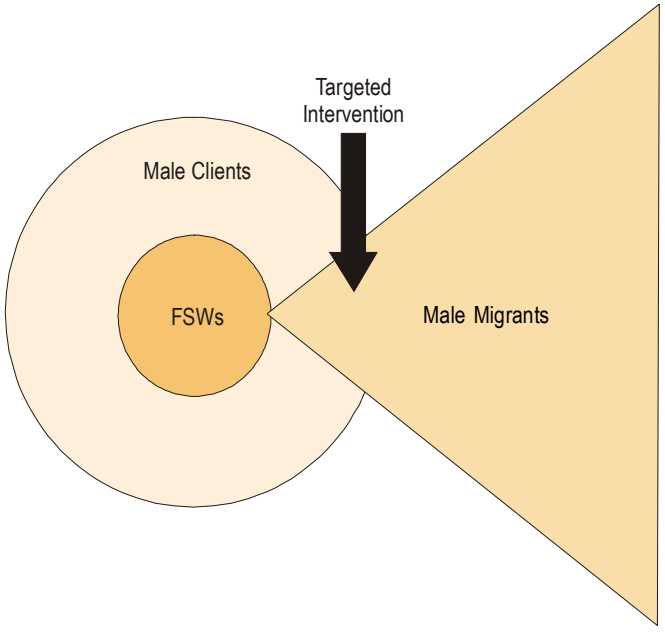

Figure 1.2. Population Approach to Targeted Interventions for Migrant Men

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 sex networks, usually as clients of FSWs or of high risk MSM.

Since many men who have sex with FSWs, high risk MSM and TGs 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 indicated in Figure 1.2. 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.

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 on the locations where risk occurs.

1.2.2 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.

1.2.3 Linking Migrants at Source and Destination Points

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 is directed as TIs towards migrants in their urban 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 a rationale for establishing effective linkages between source and destination programmes. An engaged source State can motivate and support destination States to address specific migrant sub-populations under their HIV prevention and care programmes, e.g. Rajasthani/Bihari/Gujarati/Kannada migrants. Based on the mapping data from destination States (shared with the source SACS by the destination SACS), the SACS should take the responsibility of covering 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.

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. See Section 2.2.2.B for more information.

1.2.4 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.

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)
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
Enabling Environment
■ Advocacy with key stakeholders/power structures ■ Linkages with other programmes and entitlements
Community Mobilisation
■ Building capacity of migrant groups to assume ownership of the programme ■ Project centres

CHAPTER 2

Operationalising Targeted Interventions for Migrants: Guidelines for SACS and TSU

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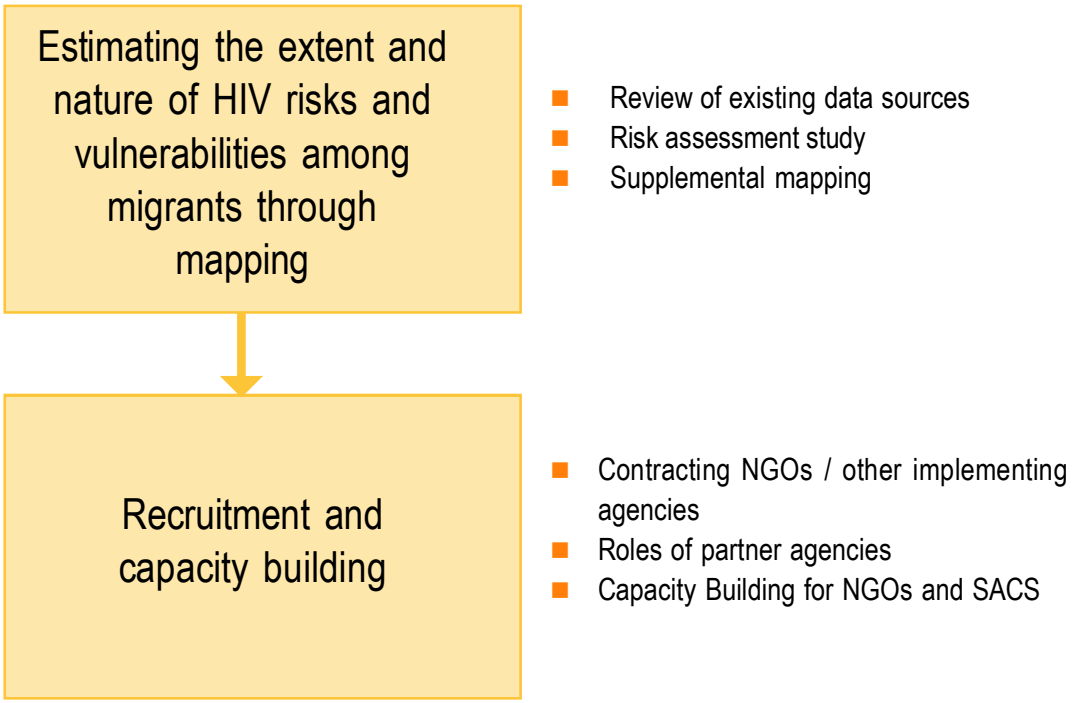
Steps in Mapping and NGO Selection



2.1 MAPPING MIGRANT COMMUNITIES – GEOGRAPHIC MAPPING, SIZE ESTIMATION AND SITE ASSESSMENT

2.1.1 Identifying Intervention Areas

A. 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.

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.

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:

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

Annexure 1, Risk Assessment provides details on the types of interviews conducted, sample size, etc. 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).

B. 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** – 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.

The emphasis of the mapping exercise for migrant TIs should be on identifying migrant men and women who form a part of high risk sexual networks, usually as clients of sex workers/high risk MSM/TGs or as practising 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.

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, *Mapping Methodology* and Annexure 3, *Preliminary Mapping*.

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, *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, *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, *Hotspot Screening (Owners)* and Annexure 7, *Hotspot Screening (Patrons)***).

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 for more information.

Tools	
Annexure 1	***Risk Assessment***
Annexure 2	***Mapping Methodology***
Annexure 3	***Preliminary Mapping***
Annexure 4	***Detailed Mapping***
Annexure 5	***FSW Assessment***
Annexure 6	***Hotspot Screening (Owners)***
Annexure 7	***Hotspot Screening (Patrons)***

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 a 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.D (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:

Migrant Coverage	VPLs: Migrants	ORWs: VPLs
5,000 Migrants (minimum unit for the migrant TI)	1:100 **50 VPLs** for coverage of 5,000 Migrants	1:10 **5 ORW** for coverage of 5,000 Migrants

2.2.2 Roles of Partner Agencies

A. 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

B. SACS

Advocacy with Government departments

Government departments play a critical role in both service provision and 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 and Gramodyog, DWCD, Education (vocational and skill based), etc.

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, *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 (e.g. 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
- Advocacy to include HIV/AIDS services into their CSR strategy, including provision of outreach, prevention and care services in their catchment areas

Best-practice examples of HIV/AIDS policy for the workplace from Gujarat Ambuja and TCIL are included in Annexure 8.

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

Linking programmes in destination and source SACS

An MoU between SACS provides a perfect structure for the pooling of information and resources. This 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. At the same time, outreach workers who speak the migrants' own language and dialects may be provided to the destination States from the source State (through SACS/NGOs). Further 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.

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. They could follow the same guidelines for a workplace policy as described in Section 2.2.2.B. 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

C. 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

D. Other Government departments

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

E. Core group TI partners

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

F. 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

G. 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

H. Summary table

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

Steps in Intervention	Actions and Agency Responsible						
	NACO	**SACS/TSU**	**NGOs and other implementers**	**Other govt departments**	**Core group TI partners**	**Social Marketing agencies**	**Other development agencies/ SACS at source**
Desk review of existing information		Hire consultants/ agency Compile data Database preparation	Provide available information	Provide available information	Provide available information		Provide available information
Supplemental Mapping if required	Develop standardised protocol Resource allocation	Hire consultants/ agency Develop TOR Monitor mapping studies	Facilitate mapping in respective geographic area	Provide available information	Provide available information		Provide experts Share experience of similar exercises in other programmes
Selection of partners (NGO, Corporate houses, SMOs)	Guidelines for partner selection	Advertise for project allocation Develop guidelines and appraisal system	Implement projects	Provide information on good agencies	Implement projects	Coordinate with NGOs	Provide list of networks of NGOs
Contracting NGO	Develop protocol for contracting	Develop contracts Monitor contracts					
Orientation of project team by SACS or TSU		Provide technical support and expertise Develop capacity building plan	Participate in capacity building excercises	Provide resource persons and material	Share experience and information on migrants clients and networks	Provide resource persons and material	Provide information on different approach of community participation, resource mobilisation

Steps in Inter-vention	Actions and Agency Responsible						
	NACO	SACS/TSU	NGOs	Other govt depart-ments	Core group TI partne rs	Social Market-ing agen-cies	Other development agencies/ SACS at source
Stake-holder advocacy	Advocacy with central Govern ment department	Hire experts for developing framework	Identify stakeholders Advocacy programme implementation	Facilitate linkages and mainstream ing Allocate resources	Implement programme	Facili tate linkages	Mainstreaming HIV/AIDS in other developmental programmes
Provision of services	Guide-lines for service provision Resource allocation	Channel programme services					
Ongoing capacity building	Document and share experience at national level	Develop plan, resource mobilisation and monitoring, networking	Participate in programmes and feedback on usefulness of programmes Suggest non-conventional ways of capacity building Mentor new organisation				
Reporting	Uniform reporting system development	Establish and develop system Monitor the system Revision of the system	Follow system Monitor programme based on system	Establish formal system of reporting of activities implemented for HIV/AIDS	Follow system Monitor program me based on system	Share the activities under-taken	Share the activities undertaken
Monitorin g		Set state-level pro-gramme indicators	Develop internal system of project monitoring				
Evaluation	Mid-term evaluation of programme	Contract agencies Develop protocol					

Refer also to Section11 ("Who will do what?") of *NGO/CBO Guidelines*, NACO, March 2007.

Tools
Annexure 8 ***Model HIV/AIDS Workplace Policies***
NACO ***NGO/CBO Guidelines***

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	Agencies Responsible			
	SACS	TSU	NGO	Industry
Basic information on HIV and STIs		X	X	X
Community development and strategies for personal development and empowerment of communities			X	
Human rights and violence	X	X	X	X
Community participation and empowerment			X	X
HIV testing and counselling	X	X		
BCC and development of IEC materials		X	X	
Peer education and community outreach			X	X
STI management	X	X	X	X
Condom programming	X	X	X	X
Safer sex negotiation		X	X	
Sex and sexuality		X	X	
Advocacy	X	X	X	X
Dealing with myths and misconceptions			X	X
National AIDS Control Programme III & Targeted Intervention Programme	X			
Reporting systems (CMIS)	X	X		
Project management		X		
Resource mobilisation		X	X	
Counselling		X	X	
Syndromic management of STIs	X	X		

A. 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

B. Capacity building approaches

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

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

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 Migrants: Guidelines for NGOs

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3.2.3 Monitoring and Evaluation

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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

A. 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 3.1.

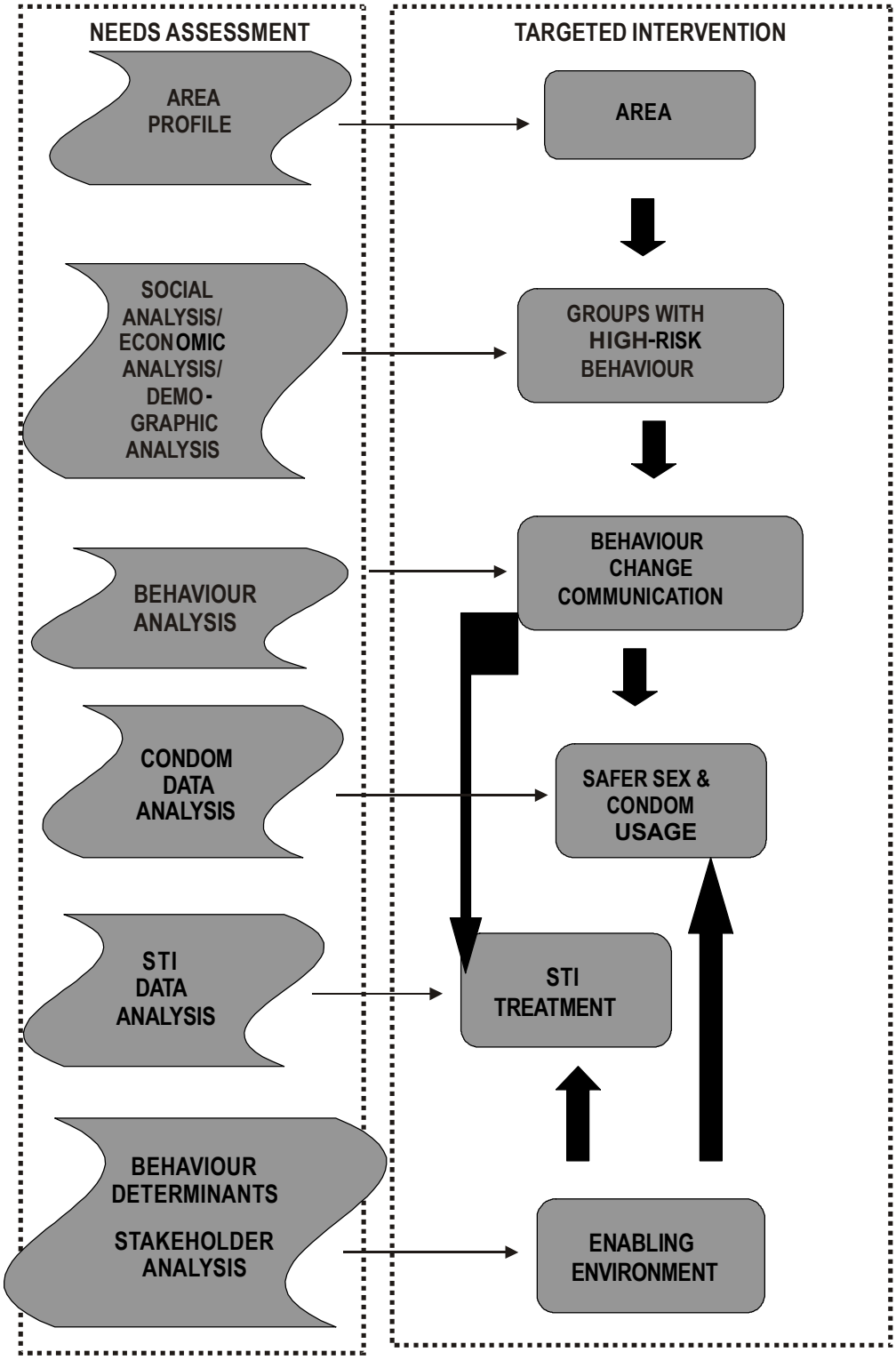


Figure 3.1 Relationship between Needs Assessment/SHA and TI

B. Defining Stakeholders in Migrant Interventions

Primary stakeholders (target population)

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

Placement agencies, brokers, *dalals* who "source" migrants and supply them to contractors form one of the main sets of stakeholders for migrant interventions. SHAs should clearly identify, and advocate with, this critical power structure.

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/TGs) 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

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

C. Location of Stakeholders

A separate needs assessment and stakeholder analysis has been envisaged for each type of intervention area (prioritised industrial/workplace locations, large residential locations and hot spots) 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.

Prioritised industrial/workplace centres

Working with the owners and social welfare officers of industrial/workplace centres is essential to create an enabling environment for successful implementation of the project. Many such industrial/workplace centres 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 tapped to reach out to the target population. Similarly, security agencies employed by the workplaces could emerge as another stakeholder.

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.

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).

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.).

D. 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, *Information Collection in Stakeholder Analysis.***

E. 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.

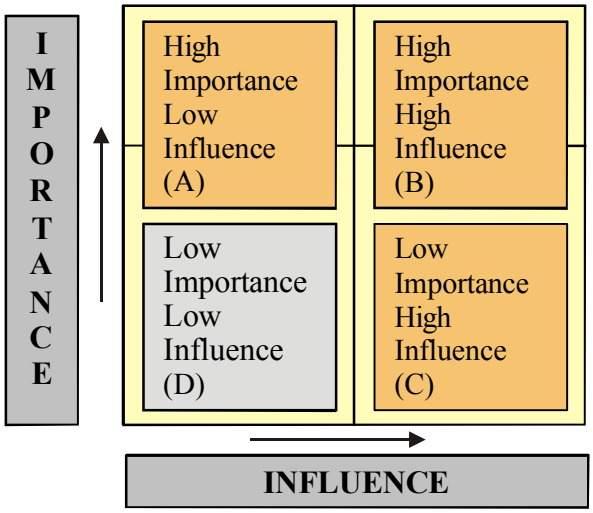
Since it is impossible to gather all stakeholders together, these groups should be met with separately in the initial stage of the project. Through the SHA, clarity about the various stakeholders' roles in the project cycle will help to ensure support based on mutually agreed expectations. Conflicting 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.

F. 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

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.

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.

Stake-holder No.	Stakeholders *[examples]*	Ranking according to importance	Influence in the community as well as on the migrants	Category of Participation			
				Inform	Consult	Implement	Partner
1.	Workplace owners	4	5	X	X	X	X
2.	Placement agencies	5	5	X	X	X	X
3.	Private Medical Practitioners	5	4	X	X	X	X
4.	*Riksha* Puller	5	2	X			
5.	*Riksha* Garage Owner	3	4	X			
6.	Money Lenders	3	1	X			
7.	*Dhaba* owner	1	4		X		X

Tool
Annexure 9 ***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.

Objectives of Peer Education	Advantages of Volunteer Peer Leaders (VPLs)
▪ 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	▪ 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

A. 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 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

B. 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

C. 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 casual 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.

D. 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:

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

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.

Materials required by VPLs

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

E. 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.

F. 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 TIs
- 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 TIs has two primary components: mid-media and interpersonal communication (IPC).

A. Mid-media

Mid-media is a creative and efficient way of generating awareness on certain key issues among large numbers of people. 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. 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).

B. 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 maximising 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

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.

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 flipcharts, 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.

A. 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.

	Referral to Public Sector	Referral to Qualified Private Sector
Advantages	▪ Free services	▪ Ensures confidentiality ▪ Sustainable services
Disadvantages	▪ May lack confidentiality ▪ Unpredictable quality ▪ Possible stigmatisation of STI patients by staff	▪ Cost

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

B. 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.

C. 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.).

A. 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.

B. 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 – Safe Spaces for Migrants

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 create "safe spaces" for migrants:

- The concept of "Space for Migrants" (SFM) takes into account the multiple needs of migrants, with a focus on building their social capital to reduce their vulnerability to HIV/AIDS
- SACS will contract NGOs/migrant support organisations to establish SFMs in partnership with the Urban Development Agency who work in slums and/or private sector organisations (if possible)
- Space for migrants (like Drop-In Centres for HRGs) should be located by NGOs through the following process:
  - Identify existing congregation points for migrant workers. These may include places of entertainment like video parlours, bars, etc. In the case of a workplace intervention, a congregation point may be a common resting area or lunch room.
  - 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
- SFMs are managed by VPLs and provide the following services:
  - VPLs to provide minimum information on HIV/AIDS and related subjects to migrant workers. Information could include awareness on HIV/AIDS prevention and care, combined in a creative way with information beyond HIV which addresses migrant needs (e.g. how to remit money home, banking options, social welfare services).
  - IEC material available for easy access by migrant workers
  - Socially marketed condoms
  - Referral to ICTCs and STI clinics
  - Recreational material including radio, TV, games, magazines/newspapers, etc.
  - Activities aimed at reducing drug and alcohol related vulnerabilities
  - Outreach facilities including periodic health camps

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

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

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.

Activities	Responsi-bility	Timeline											
		Year 1				Year 2				Year 3			
		Q 1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q 1	Q 2	Q3	Q 4
Train NGO staff in conduct of NASHA	Master trainers	X											
Determine geographical areas for TIs	NGO management	X											
Conduct baseline (BSS)	External agency	X											
Conduct needs assessment and stakeholder analysis (NASHA)	Outreach workers / Master trainers	X											
Advocacy activities with relevant stakeholders	NGO management	X											
Identify VPLs	Outreach workers	X											
Identify individual migrants with high risk behaviour	NGO outreach workers / VPLs	X	X	X	X	X	X	X	X	X	X	X	X
Detail activity plans in each of the intervention areas	NGO staff	X											
Social Sanction Activities at intervention sites	Outreach workers	X											
Train NGO staff in technical and operational aspects of the project	Master Trainers	X											
Train VPLs	Outreach workers / Master trainers		X										
Monthly review cum quarterly capacity building of VPLs	NGO supervisory staff		X	X	X	X	X	X	X	X	X	X	X
Regular field visits by NGO staff	Outreach and other staff		X	X	X	X	X	X	X	X	X	X	X
Streamline monitoring system	NGO supervisory level staff		X										
Conduct ongoing assessment of VPLs and project beneficiaries	NGO supervisory level staff		X	X	X	X	X	X	X	X	X	X	
Conduct quarterly review meeting with all staff	NGO supervisory level staff		X	X	X	X	X	X	X	X	X	X	

Activities	Responsi-bility	Timeline											
		Year 1				Year 2				Year 3			
		Q 1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q 1	Q 2	Q3	Q 4
Monitor availability of condoms / strengthen social marketing efforts of SMO	NGO supervisory level staff / outreach staff		X	X									
Network with Social Marketing Organisation for SM product placement	NGO management		X	X									
One-to-one contact with migrants for disseminating information, condom demonstration	VPLs / NGO outreach workers		X	X	X	X	X	X	X	X	X	X	X
Conduct mid-media activities at intervention sites	NGO staff / VPLs / SMOs		X	X	X	X	X	X	X	X	X		
Conduct one-to-group meetings with migrant population	VPLs / NGO outreach staff		X	X	X	X	X	X	X	X	X	X	
Identify qualified service providers for STI treatment	NGO staff	X	X										
Network with government health services for STI treatment	NGO staff	X	X										
Identify, refer and follow up on STI cases	VPLs / outreach workers		X	X	X	X	X	X	X	X	X	X	X
Stakeholder meeting and their involvement in the project	NGO staff		X	X	X	X	X	X	X	X	X	X	
Conduct final evaluation survey (BSS)	External agency												X

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.

A. 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:

Sl	Indicators	Calculation	Frequ-ency	Data Source
1	Total number of migrant population who are identified as high risk	*Numerator:* Number of migrant population found to practice high risk behaviours		Based on second layer of mapping methodology by NGO staff
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 STI/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, *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, *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

Sl	Indicators	Calculation	Frequ-ency	Data Source
9	% of VPLs conducting one-to-group contact in the intervention area	*Numerator:* Number of VPLs conducting one-to-group contact *Denominator:* Total number of VPLs	Monthly	NGO MPR
10	% of BCC events by type (Folk media, AV shows and Infotainment) organised against planned	*Numerator:* Number of BCC events organised last month by type *Denominator:* Total number of BCC events planned for the month	Monthly	NGO MPR
11	% of persons trained for TI against those planned to be trained ▪ NGO staff ▪ Qualified health service Providers ▪ Public ▪ Private ▪ RMPs	*Numerator:* Number of persons trained by category of participants *Denominator:* Total number of persons planned to be trained for TI by category	Monthly	NGO MPR
12	% of migrants referred for STI/RTI who sought treatment	*Numerator:* Number of migrants who sought treatment from referral service providers for STI/RTI *Denominator:* Total number of migrants referred to service providers for treatment for STI/RTI	Monthly	Referral slip, NGO MPR
13	% of functional service providers in the month ▪ Public ▪ Private	*Numerator:* Number of functional service providers in the month *Denominator:* Total number of service providers identified and included in the referral network for treatment for STI/RTI	Monthly	Referral slip, NGO MPR
14	% of active condom outlets by type (conventional and non- conventional) and by primary target group	*Numerator:* Number of condom outlets having uninterrupted supply of free and SM condoms during the month *Denominator:* Total number of condom outlets	Monthly	NGO MPR
15	% of migrants who can state or demonstrate correct use of condoms	*Numerator:* Number of migrants who could state or demonstrate the correct use of condom *Denominator:* Total number of migrants included in the assessment	Quarterly	**See Annexure 11, *Ongoing Assessment of VPLs and Migrants***
16	% of stakeholder meetings organised in the month by type (police, elected representatives, unions and associations, others)	*Numerator:* Number of meetings organised by type and by primary target group *Denominator:* Total number of meetings planned	Monthly	NGO MPR

B. 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:

Indicator	Baseline	Target	Means of Verification
KNOWLEDGE			
% knew that consistent condom use reduces the risk of HIV infection (among those who heard about HIV/AIDS)			BSS
% correctly aware (with no incorrect knowledge) of all 5 ways of HIV transmission (among those who heard about HIV/AIDS)			BSS
% rejecting at least two misconceptions about reducing the risk of HIV infection (among those who heard about HIV/AIDS)			BSS
BEHAVIOUR			
% had sex with CSW or en-route CSW or non-regular non-commercial partner in last 12 months			BSS
Condom use in last sex			BSS
1. With any type of partner			
2. With regular commercial partner			
3. With non-regular commercial partner			
4. With regular non-commercial partner			
5. With non-regular non-commercial partner			
6. With non-marital non-cohabiting partner			
SELF-REPORTING OF STD SYMPTOMS			
% suffer from -			
- Genital Discharge			BSS
- Genital ulcers/sores			BSS
% had sex with any partner while suffering from STIs			BSS
RISK PERCEPTION			
Perception of risk for contracting STIs			BSS
Perception of risk for contracting HIV/AIDS			BSS
OTHER			
Time of condom use (before first penetration)			BSS
Male to male sexual behaviour			BSS
Median age at sexual debut			BSS

Indicator	Baseline	Target	Means of Verification
PROCESS INDICATORS			
% heard about STIs			BSS
% seeking treatment for STIs (among those who reported having either genital discharge or genital ulcers)			BSS
% obtained medicines for STI (among those who sought treatment)			BSS
% reported completely cured (among those who received medicines)			BSS
% knew any persons from neighbourhood talking about unprotected sex and danger of STI or HIV/AIDS			BSS
% witnessed any BCC event on HIV/AIDS			BSS

Tool

Annexure 11 ***Ongoing Assessment of VPLs and Migrants***

ANNEXURE 1

Risk Assessment

Targeted Interventions Under NACP III: Migrants and Truckers

Objectives

A risk assessment seeks to ascertain whether male migrants in the potential intervention area are at risk by gathering the following information:

- Demographic profile of the risk population
- Different types of partners among the risk population
- Proportion who have correct knowledge about the modes of HIV transmission
- Proportion who do not have any myths about the modes of HIV transmission
- Condom related indicators
- Proportion who suffered from STIs in last 12 months
- Proportion who sought treatment from a qualified practitioner for STIs
- Proportion who feel high risk with a female partner if they have sex in exchange for money or in kind
- Proportion who feel it is important to know HIV status
- Proportion who intend to get themselves tested

Study Design

Nature of the study

- Quantitative - data collected through personal interviews with the help of a structured questionnaire

Target group

- Male
- SEC C, D, E1
- Aged 15 – 44 years

Sampling procedure

- Electoral rolls can be used as sampling frame
- Up to 100 polling booths selected through systematic random sampling procedure
- In each polling booth area, 2 households identified through systematic random sampling procedure
- In each household, 4 interviews conducted following the right-hand rule

Weighting procedure

- Weighting is necessary to ensure that data correctly represents the overall situation in the intervention area
- The weighting procedure adopted is detailed below:
  - List total number of males in the household. Weight all males aged 18+ to the male voter population
  - From this is derived the total population of those aged between 18-44 years

- Assuming that those aged 15-17 years are similar in number to those aged 18-20, the universe of those aged 15-44 can be derived
- For each male there is data at household level (bachelor/family households and SEC) and at individual level (age, education and marital status). Of these data, the most critical type is household and age.
- Hence for each of the cells of age X type of household the universal figures can be derived
- These weights are then applied to the individual section of responses

Definition of Those at Risk

In last 12 months fell into any one of the categories below one or more times:

- Had sexual intercourse
  - With female partner in exchange for money
  - With female partner in exchange for kind
- Had sexual intercourse with male partner in exchange for money
- Had sexual intercourse with eunuch in exchange for money

No.	Questions	Coding Categories		
1	Age	Age _____		
2	Ethnicity	Ethnicity _____		
3	Marital status	Never married		01
		Married, staying with wife		02
		Married, not staying with wife		03
		Other _____		04
4	Household type	Family		01
		Bachelor		02
5	Occupation	Unskilled		01
		Skilled		02
		Petty Trader		03
		Other		04
6	SEC			
7	Sexual partners (excluding wife) in the last 12 months:			
	Female for money	Yes	01	
		No	02	
	Female for kind	Yes	01	
		No	02	
	Male	Yes	01	
		No	02	
	Eunuch	Yes	01	
		No	02	
8	Alcohol consumption	At least once a week	01	
		Less often	02	
		Never	03	
9	HIV/AIDS knowledge – Which of the following can transmit HIV?	Sexual intercourse	01	
		Mouth-to-mouth kissing	02	
		Touching	03	
		Infected blood	04	
		Mosquito bites	05	
		Infected needles	06	
		Sharing toilet	07	
		Mother to child	08	
		Sharing utensils	09	
		Barber's blade	10	
		Sharing clothes	11	

No.	Questions	Coding Categories		
10	Perception of risk of sex with regard to contracting HIV			
	Female for money	Low	01	
		Medium	02	
		High	03	
	Female for kind	Low	01	
		Medium	02	
		High	03	
	Non-commercial	Low	01	
		Medium	02	
		High	03	
11	Beliefs/myths about how to tell if someone has HIV/AIDS	Blood test	01	
		Doctor	02	
		Looks weak	03	
		Weight loss	04	
		Continuous high fever	05	
		Spots on skin	06	
		Body pale	07	
		TB	08	
		Diarrhea	09	
12	Suffered from STI in past 12 months	Yellowish discharge	01	
		Watery discharge	02	
		Itching around genitals	03	
		Burning pain	04	
		Pain during intercourse	05	
		Genital ulcers	06	
		Swelling in genitals	07	
		Swelling in groin	08	
		Blood in urine	09	
		Failure to pass urine	10	
13	Treatment for STI in past 12 months	Visited government doctor	01	
		Visited private doctor	02	
		Other treatment	03	
14	Condom usage	Last time had sex	01	
		Every time in last 3 months	02	
		Every time in last year	03	
		Intend to use next time	04	
		Do not intend to use next time	05	

No.	Questions	Coding Categories		
15	Condoms used with which partners	Commercial for money	01	
		Commercial for kind	02	
		Non-commercial	03	
		Male	04	
		Eunuch	05	
16	Factors which make using condom difficult	_____		
17	Attitudes towards condoms	Shows lack of trust in partner	01	
		Breaks easily	02	
		Diminishes pleasure	03	
		Only to be used if you have a disease	04	
		Macho men don't use it	05	
		Forget to use after drinking	06	
		Uncomfortable doesn't fit	07	
18	HIV Testing	Important to know one's status	01	
		Not important to know one's status	02	
		Intends to get an HIV test	03	
		Does not intend to get an HIV test	04	

ANNEXURE 2

Mapping Methodology

Targeted Interventions Under NACP III: Migrants and Truckers

Preliminary and detailed mapping studies provide information on the presence of migrant workers who engage in high risk behavior, so as to accurately determine target group size and area coverage for effective field communication, two integral aspects of designing an evidence-based TI.

PRELIMINARY MAPPING

Objectives

A preliminary mapping study serves to acquire a geographic breakdown of the intervention area, as well as to gain insight into:

- The basic ethnic, religious and cultural background of its population
- The various congregation points of high-risk men
- The presence of sex workers
- The presence of various elements such as video parlours, mandals, NGOs, temples, hotels, lodges, bars and movie theatres that could be vantage points for target-efficient field communication

The preliminary mapping provides a general overview of the entire geographic area, and is the basis to accurately refine structured methods and tools needed to conduct a detailed mapping study.

Methodology

Time period: 5 weeks

1. Outreach workers (ORWs) are intensively trained on the methodology of conducting the study and familiarized with the mapping tool conducted in the area.
2. ORWs are provided with a map of the intervention area
3. ORWs initially cover the entire area on foot or by vehicle to observe and gain preliminary insight into the geographic characteristics of the area, as well as to cursorily identify locations of the different elements
4. In accordance with the map and their initial observations, ORWs demarcate the area into distinct closed areas or clusters for convenience of coverage to conduct the preliminary mapping tool.
5. Subsequently, ORWs visit each cluster, in which they:
6. Sketch the geographic location of the cluster
7. Interview three key informants in each cluster utilising the mapping tool (ensuring three responses to each question in the tool)

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

DETAILED MAPPING

Objectives

In order to ensure a target-efficient, streamlined field intervention among migrant workers, a detailed mapping study is conducted, focusing on:

1. An assessment of the target group size of high risk men in the intervention location
2. Identification of target-efficient hotspots/strategic locations for field communication
3. Identification of scope of coverage at existing hotspots
4. Determination of a possible range of field communication activities to be conducted at hotspots
5. An assessment of the presence of commercial sex workers (CSWs) in the area and type of sex work conducted

Methodology

Time period: Approximately one month to six weeks for each component

ORWs are intensively trained on the methodology of conducting the study and familiarised with the different mapping tools conducted in the area, to ensure that they interview at least eight respondents in one day.

The detailed mapping tool is developed based on the observations of the ORWs as well as the different responses of the key informants in the preliminary mapping study.

The detailed mapping has four primary components:

1. A **detailed mapping tool** to gain information on target group size as well as congregation points of high-risk men **(see Annexure 4)**
2. A **CSW assessment** to gain information on sites of sex work as hotspots for field communication activity **(see Annexure 5)**
3. A **screening of hotspots, including mandals and video parlours,** to gain information on high risk men and potential types and frequency of field communication activities **(see Annexures 6 and 7)**
4. A **drainage assessment** to avoid overexposure or underexposure of the target group to field communication activities

Component 1 – Assessment of Target Group Size and Congregation Points

1. ORWs map each lane in the area and demarcate the geographic area into six clusters, based on the preliminary mapping as well as on more detailed observations on foot or by vehicle.
2. Each cluster is further divided into smaller pockets, based on local names of respective areas.
3. In each smaller pocket, ORWs conduct detailed mapping using the tool with three key informants, to ensure that each question in the tool has three responses.

4. In each smaller pocket, ORWs observe and identify the total number of structures (counting each structure in each lane), as well as the proportion of structures that house single men and those that house men in families.
5. In each smaller pocket, ORWs interview three key informants to assess the number of men living in single-men households and the number of men living in family households.
6. The target group size is calculated according to the following formula:
(Average number of family-men structures X Average number of men in family household) + (Average number of single-men structures X Average number of men in single-men household).
7. In each smaller pocket, ORWs observe and identify the number of *mandals*, video parlours, sex work spots (including hotels, lodges and bars where sex work takes place), saloons, *bhissis*, daily labour job posting points as well as tea and paan stalls. Each element has a separate component in the detailed mapping questionnaire. In each pocket, for each element, ORWs collect responses from three key informants, based on the questions in the detailed mapping tool.
8. In each smaller pocket, ORWs observe and identify the number of congregation points of high risk men to ensure targeting efficiency with regard to field communication.
9. The key informants in each smaller pocket include shopkeepers, cinema hall employees, slum residents, housing colony residents, slum development officers, BMC officers, private doctors, government hospital doctors, police, NGOs, industry employers and employees, bar owners and clientele, railway station masters and bus depot in-charges.

Component 2 – CSW Assessment

1. In each smaller pocket, ORWs interview three key informants to gain insight into the location of sex work spots, average rates charged by CSWs for sexual encounters, types of sex work in the area, the manner in which clients approach CSWs, and work timings of CSWs.
2. The assessment can provide insight into whether male residents visit CSWs within the target area or frequent red light areas outside the target area.
3. If there are no visible sex work sites, ORWs can consult with any NGOs that have established focused interventions with CSWs. These can assist in providing an estimation of the total number of sex work sites as well as the types of sex work occurring at these sites.

Component 3 – Screening of Mandals and Video Parlours

1. In addition to the information on the number of mandals and video parlours and their basic characteristics provided in the main detailed mapping tool, ORWs can conduct a detailed screening of these elements to assess their suitability with regard to communication programming.
2. A detailed screening tool should be conducted for each video parlour and mandal situated in each smaller pocket.
3. **Video Parlours** – ORWs conduct in-depth interviews with patrons and owners of each video parlour, using separate tools for owners and patrons **(see Annexures 6 and 7)**. The questionnaire developed for patrons is quantitative, and the questionnaire developed for owners is qualitative. The latter also highlights the types of shows, number of shows on a daily basis, and the average number of patrons at each show.
4. **Mandals** – ORWs conduct in-depth interviews with presidents of mandals using the screening tool developed **(see Annexure 4).**

Component 4 – Drainage Assessment

The detailed mapping tool can provide refined information on target-efficient hotspots. However, it may remain unclear whether the men who frequent these different spots are from the same area (i.e. the same group frequenting different spots) or from different areas. To assess this possible duplication, the following steps are necessary:

1. First, current field communication locations are marked on a map of the intervention area. Then ORWs try to assess, for each particular spot, the predominant areas from which the target group members arrive, showing the drainage from various areas at that particular spot. These areas are marked on the map as areas that are being reached through current communication activities.
2. This assessment provides information on areas where there is overlap and consequently overexposure to field communication activities, as well as areas of non-drainage (areas that are not being reached at all). In areas of overexposure, the frequency of field communication activities can be reduced. Targeted interventions should be initiated for areas that are underexposed to field activities.

ANNEXURE 3

Preliminary Mapping

Preliminary Mapping

Location:

Draw a map of the geographical location (3 km radius, keeping the clinic as the centre). Specify landmark to make the map.

1. Which is the nearest railway station in this area and how far away is it?
2. Which is the bus depot in this area and how far away is it?
3. How many markets are there in this area? List those names and number of shops.

Respondent 1		Respondent 2		Respondent 3	
Markets	No. of Shops	Markets	No. of Shops	Markets	No. of Shops

4. How many cinema halls are there in this locality? List those names.

Respondent 1		Respondent 2		Respondent 3	
Cinema Halls	No. of shows and people	Cinema Halls	No. of shows and people	Cinema Halls	No. of shows and people

5. Are there any slums in the area? Please list their names.

Respondent 1		Respondent 2		Respondent 3	
Name of Slum	No. of houses and population	Name of Slum	No. of houses and population	Name of Slum	No. of houses and population

6. Are there any residential colonies in the area? Please list these.

Respondent 1		Respondent 2		Respondent 3	
Name of Colony	No. of houses and population	Name of Colony	No. of houses and population	Name of Colony	No. of houses and population

7. Is there any industry in the area?

Respondent 1		Respondent 2		Respondent 3	
Name of Industry	Shift and no. of employees	Name of Industry	Shift and no. of employees	Name of Industry	Shift and no. of employees

8. How many bars are there in this locality? If possible please list those names.

Respondent 1		Respondent 2		Respondent 3	
Name of bar	No. of clients in a day	Name of bar	No. of clients in a day	Name of bar	No. of clients in a day

9. Is there any RLD nearby? List those names.

Respondent 1		Respondent 2		Respondent 3	
Name of RLD	No. of CSWs	Name of RLD	No. of CSWs	Name of RLD	No. of CSWs

10. Is there any NGO working in the area? List those names.

Respondent 1		Respondent 2		Respondent 3	
Name of NGO	TG they work with	Name of NGO	TG they work with	Name of NGO	TG they work with

11. Is there any other point where adult males come together in the area? List those places. (Video Parlours, *bissi*, daily labour job posting points, etc.)

Respondent 1		Respondent 2		Respondent 3	
Type and No.	No. of Men	Type and No.	No. of Men	Type and No.	No. of Men

12. Is there any Truck Terminal, Auto/Taxi Stand, mechanic garage? List those places.

Respondent 1		Respondent 2		Respondent 3	
Type of Halt point	No. of Vehicles	Type of Halt point	No. of Vehicles	Type of Halt point	No. of Vehicles

13. Other Information

- Type of Work:
- Language:
- Religion:

Note: Key Informants for preliminary mapping include:

- Shopkeepers in the market
- Cinema hall employees
- Residents of slum
- Resident of housing colonies
- Slum development office
- BMC office
- Private doctor
- Government hospital doctor
- NGOs
- Industry people: Employee and employer
- Bar: owner and clients
- Railway station master
- Bus depot in-charge

Targeted Interventions Under NACP III: Migrants and Truckers

ANNEXURE 4

Detailed Mapping

Targeted Interventions Under NACP III: Migrants and Truckers

1. **Cluster Number:**
2. **Name of Locality:**
3. **Type of Locality: 1. Residential 2. Commercial 3. Residential & Commercial**
   4. Other _____
4. **Description of structures**:

Structure No.	Name of Sub-Locality	Type of Structure	Number of Structures	Number of single men staying in structure
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

5. **Number of mandals:**
6. **Number of *bhissis*:**
7. **Number of video parlours:**
8. **Number of DLJPP:**
9. **Number of bars: Number of ladies service bars:**
10. **Potential spots for our activity:**

Name of spot	Landmark	Type of activity (Suggested)	Average Crowd	TG Background

11. Mandal Assessment Sheet

	Respondent 1	Respondent 2	Respondent 3
Name of mandal			
Location			
Registration			
Type of mandal	Youth Mandal Society Mandal Ganesh Mandal Navaratri Mandal Krida Mandal	Youth Mandal Society Mandal Ganesh Mandal Navaratri Mandal Krida Mandal	Youth Mandal Society Mandal Ganesh Mandal Navaratri Mandal Krida Mandal
No. of members			
Type of activity carried out by the mandal			
Area of operation			
Relationship with NGOs			
Perception of community			
Potential for TI?			
Meeting day and timings			
Chairman & Secretary			
Telephone No.			
Comments			

12. Video Parlour Assessment

	Respondent 1	Respondent 2	Respondent 3
Location			
Name of video parlour			
Licensed or non-Licensed			
Number of theatres			
Average shows/day per theatre			
Average audience/show/theatre			
Peak show days			
Peak show timings			
Average audience/show/theatre at peak show			
Language of movies and Type of films shown	a) Family b) Hindi Erotic c) English Erotic d) English Action	a) Family b) Hindi Erotic c) English Erotic d) English Action	a) Family b) Hindi Erotic c) English Erotic d) English Action
Type of audience			
Area from where audience comes			
Willingness to participate in TI			
Potential for TI activity?			

13. Labour Job Posting Points

	Respondent 1	Respondent 2	Respondent 1
Location			
Number of labourers standing at a time	Men = Women =	Men = Women =	Men = Women =
Timings of gathering			
Peak time			
Type of workers			
Workers' area of residence			
Average amount of time workers stand at the spot			

14. *Bhissi* Assessment

Name of the *bhissi*	Respondent 1	Respondent 2	Respondent 1
Proprietor			
Location			
No. of People Eating (A)			
No of *dabbas* sent out (B)			
Total (A+B)			
Clients basically from the area			
Timings of eating			
Willingness to participate in TI			

15. Other Areas of High Male Congregation:

16. Saloons with more than 3 chairs:

1.

2.

3.

17. *Pan Bidi* + Tea Stall (More than 7 people standing at a time)

1.
2.
3.

18. Commercial Sex Activity:

	Opinion 1	Opinion 2	Opinion 3	Opinion 4	Opinion 5	Opinion 6	Opinion 7
Location							
Type of spot							
CSW staying at the spot?							
Type of CSW (Practice at same place, outside)							
CSW staying with?							
Number of Client/CSW/day							
Number CSW							
Activity place							
Number of fixed clients/CSW							
Clients from area							
Activity rate							
Other:Modus Operandi:							

Targeted Interventions Under NACP III: Migrants and Truckers

ANNEXURE 5

FSW Assessment

Targeted Interventions Under NACP III: Migrants and Truckers

Sr No.	Locality	Sub-locality	No of structures of FSW	No. of FSW	Type of FSW	Activity Place	Number of Clients of FSW/day	Client Area	Activity Rate	Modus operandi
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										

Targeted Interventions Under NACP III: Migrants and Truckers

ANNEXURE 6

Hotspot Screening (Owners)

Targeted Interventions Under NACP III: Migrants and Truckers

The script below is an example of how to ask questions to gather information about a hotspot and the population that frequents it. The example in this case is a video parlour, but similar information could be elicited from a different kind of hotspot. The factors to be investigated are:

- Length of experience of owner/facilitator of hotspot
- Days and times of operation
- Prices charged (where relevant)
- Languages/ethnic groups catered to
- Numbers of migrant population who frequent the hotspot, by each day of the week and at different times of day
- Proportion of people who return
- Any other factors that influence migrant population members to frequent hotspot/participate in its activities

The script below is for guidance only; as the ORW establishes a report with the interviewee, the real-life conversation can flow more naturally. However, it is important for the ORW to have a checklist of relevant questions so that he/she does not forget to ask for all the necessary information.

Namaste, My name is _____ and I work for an NGO named XXX. It is an NGO that works for the betterment of health of people. We are gathering information to learn more about people who are at risk of AIDS. Now, I want to gather some details about the different kinds of people who come to your parlour. This information will help us serve people at risk of AIDS in a better way.

1. Could you please tell me since when are you running this video parlour? How many screens do you have, i.e. at one particular time how many movies you can show?
2. How many days of the week do you operate? What is your day(s) off?
3. What languages are your movies in?
4. What categories of movies do you show (family, action, erotic, etc.)?
5. Do you show all categories of movie everyday, or is there any particular day assigned for the particular category? If so, which categories of movies are shown on which days?
6. If this parlour has multiple screens, on how many screens do you show which category of movies?
7. What is the time gap between two shows?
8. How much do you charge for each movie? Is there a price difference between the categories of the movies? What is the detailed pricing?
9. I would like to know more about the types of people who visit your parlour. Please tell me what types of men generally come here - their age, educational background and occupation.

10. Please give me a detailed idea of the average number of people coming per show on each day of the week.

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun

11. Among the people who come to watch any particular show, what proportion of them comes back for another show?
12. Is there a day in the week when a large number of people come in comparison to other days? Is there any particular reason behind it?
13. Is there a time during the day when a large number of people come in comparison to other times? Is there any particular reason behind it?
14. How frequently you do change the movies, i.e. for how many days generally do you show a particular movie?

ANNEXURE 7

Hotspot Screening (Patrons)

Targeted Interventions Under NACP III: Migrants and Truckers

The table below gives an example of the kinds of questions used to gather information about migrants who frequent a hotspot and their relationship to it. The example in this case is a video parlour, but similar information could be elicited from a different kind of hotspot, with a modified questionnaire. The factors to be investigated at any hotspot are:

- Age and educational background
- Geographic and linguistic origin
- Occupation and income
- Length of time in present location, and whom residing with
- Timings and frequency of visits to hotspot, reasons for doing so and particular interests there
- Whether frequenting other hotspots
- Frequency of sexual behaviour during past 3 months
- Sexual partners and locations of sex

The script below is for guidance only; as the ORW establishes a report with the interviewee, the real-life conversation can flow more naturally. However, it is important for the ORW to have a checklist of relevant questions so that he/she does not forget to ask for all the necessary information.

Name of Video Parlour	Code	Movie Timings									
	01										
	02										
	03										
	04										
	05										
	06										
	07										
	08										
	09										
	10										

Date_____ ID CODE_____ START TIME

Day_____ END TIME

Name of Interviewer _____

Section 1: BACKGROUND			
No.	**Questions**	**Coding Categories**	
1	Could you please tell me how old you are now?	Age _____	
2	Could you please tell me to which level you have studied?	Illiterate	01
		Literate but no schooling	02
		Primary (1-4)	03
		Middle (5-7)	04
		Secondary (8-10)	05
		Higher Secondary (11-12)	06
3	Could you please tell me, what is your occupation?	_____	
4	Which language do you speak?	Marathi	01
		Hindi	02
		Tamil	03
		Telgu	04
		Malayalam	05
		Urdu	06
		Other _____	
5	Could you please tell me which State you are from?	Maharashtra	01
		Andhra Pradesh	04
		Tamil Nadu	05
		Karnataka	06
		Kerala	07
		Uttar Pradesh	08
		Bihar	09
		Other _____	
6	Where do you stay in this city?	_____	
7	How long you have been living here?	No. of completed years	
		If less than 1 year	00
		Since birth	97
8	With whom do you stay?	Alone	01
		With wife	02
		With parents/parents-in-law	03
		With friends	04
		With relatives	05

No.	Questions	Coding Categories	
		With co-worker	06
		With wife and parents	07
		Others _____	
9	Could you please tell me, whether you are -_____? **(Use one code only)**	Single	01
		Married	02
		Divorced	03
		Widower	04
10	What is your average monthly income?	Up to Rs. 1500	01
		Rs. 1501 to Rs. 2000	02
		Rs. 2001 to Rs. 5000	03
		Rs 5001 to Rs 8000	04
		Refuse to say	05
		No income at all	06

Section 2: RELATIONSHIP TO HOTSPOT			
No.	**Questions**	**Coding Categories**	
11	In a week, how many times do you watch movies in this parlour?	☐☐	
12	In a week, on which days do you come to this video parlor? **(Multiple answers possible)**	Monday	01
		Tuesday	02
		Wednesday	03
		Thursday	04
		Friday	05
		Saturday	06
		Sunday	07
		Holidays	88
		No specific day	99
13	Which shows do you prefer to watch?		

No.	Questions	Coding Categories		
14	What type of movie do you generally prefer to watch?	Romantic Film	01	
		Horror Film	02	
		Comedy Film	03	
		Blue Film (Erotic film)	04	
		Action film	05	
		Other_____		
15	How much time it takes to reach this video parlour from the place you stay?	_____		
16	Do you go to other parlours to watch movie other than this video parlour?	Yes 01		
		No 02→	**Q21**	
17.	Where are these parlours located?			
18	How many times in a week do you go to other video parlours?			
19	Which days do you go to watch movies at this video parlours? **(Multiple answers possible)**	Monday	01	
		Tuesday	02	
		Wednesday	03	
		Thursday	04	
		Friday	05	
		Saturday	06	
		Sunday	07	
		Holidays	88	
		No specific day	99	
20	Which shows do you prefer to watch in those video parlours?			

Section 3: SEXUAL BEHAVIOUR

Introduction: Now I will ask you few questions related to your sexual behaviour in the past 3 months. Whatever information you provide will be kept confidential.

No.	Questions	Coding Categories		
21	Have you ever had sex in the last 3 months?	**Yes**	01	Continue
		No	02→	Thank and terminate
22	Think about the female sexual partners you've had in the last 3 months. Would you say they were:			
		REGULAR		
		Yes	01	
	"REGULAR" PARTNERS – Wife(s)	No	02	
		Don't know	98	
	"COMMERCIAL" PARTNERS – Partners with whom you had sex in exchange for money	**COMMERCIAL**		
		Yes	01→	Q23
		No	02	
		Don't know	98	
		NON-COMMERCIAL		
		Yes	01	
	"NON-COMMERCIAL PARTNERS" – Sexual partners you that you are not married to and did not pay, such as fiancée, girlfriends, mistress **(DO NOT INCLUDE SPOUSE in this category)**	No	02	
		Don't know	98	
No.	**Questions**	**Coding Categories**		
Instructions: Q23 IS ASKED TO THOSE WHO HAVE CODED '1' IN "COMMERCIAL PARTNER" IN Q22. OTHERWISE, PROCEED TO Q24.				
23	Could you please tell us which place(s) you went to to have sex with a commercial sex worker?		01	
			02	
			03	
			04	
			05	
24	Some people have sex with women or girls, and others have sex/*masti* with other men/boys. In the last 3 months, did you have sex/*masti* with another man or boy?	Yes	01	
		No	02→	Q27
25	What type of sex did you have with a male partner? **(Multiple answers possible)**			
		Anal sex	01	
		Oral sex	02	
		Manual sex	03	

No.	Questions	Coding Categories		
26	Could you please tell us where you went to have sex? (Anal sex, oral sex or manual sex)		01	
			02	
			03	
			04	
			05	
27	Some people have sex with men or boys, and others have sex/*masti* with *hijra*. In the last 3 months, did you have sex/*masti* with any *hijra*?	Yes	01	
		No	02→	Thank and terminate
28	What type of sex did you have with a *hijra* partner? **(Multiple answers possible)**	Anal sex	01	
		Oral sex	02	
		Manual sex	03	
29	Could you please tell us where you went to have sex with a *hijra* partner?		01	
			02	Thank
			03	and terminate
			04	
			05	

ANNEXURE 8

Model HIV/AIDS Workplace Policies

Targeted Interventions Under NACP III: Migrants and Truckers

Ambuja Cement

POLICY ON HIV/AIDS

We, at Ambuja Parivar, shall strive to inculcate the awareness of HIV/AIDS at the deepest level amongst our employees, contractual workers, their families, truckers and the community around us to prevent its occurrence. Necessary health care assistance shall be extended to those afflicted with assured confidentiality. We will not discriminate against any employee because of this disease and we will provide them treatment with Anti-Retroviral drugs, as and when necessary.

A rehabilitation programme for the epidemic with a strong message to eliminate the misconception of social stigma and discrimination would also be launched. A Core committee will be set up to develop and implement HIV/AIDS programme of GACL and suggest policy and programmatic changes as and when necessary.

Ambuja will collaborate with International Labour Organization (ILO), State AIDS Control Society and other concerned Organizations to get guidance/technical support in its HIV/AIDS workplace programme.

Suresh Neotia
Chairman

Place: New Delhi
Date: 17.08.2004

GUJARAT AMBUJA CEMENTS LTD.
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TRANSPORT CORPORATION OF INDIA LTD

Corporate Office
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Fax : +91-124-2381611
Website : www.grouptci.com
E-mail : corporate@tci.com

Transport Corporation of India (TCI) - Group
POLICY ON HIV / AIDS

TCI Group recognizes that HIV/AIDS can have adverse impact on the workers, families, communities and society at large. TCI, through TCI Foundation is already engaged in implementing an HIV/AIDS intervention programme for truckers.

We, as a proactive employer are committed to prevent the epidemic, provide care to those infected and affected by HIV/AIDS and make a difference to the industry and sphere in which we operate.

The components of our policy are as below:

(1) *We will not undertake or insist on pre-employment testing for HIV.*

(2) *We will not discriminate against employees infected or affected by HIV/AIDS*

(3) *Employees' HIV status will be maintained with utmost confidentiality*

(4) *We will enable our employees with HIV related illnesses to work for as long as they are medically fit in executing their official duties*

(5) *We will promote prevention efforts through information and education among our employees, vendors, operating crew and others connected with us in our business, thus ensuring HIV/AIDS education is provided to each and every worker, and their families.*

(6) *We will extend required support to the affected individuals in mitigating their suffering.*

(7) *We will treat HIV/AIDS like any other serous illness and provide treatment and support as per TCI medical policy*

The committee convened by Mr. A.K. Bansal, will also review the policy components and their implementation from time to time and make necessary revisions.

TCI will collaborate with the International Labour Organization (ILO), and other agencies for technical assistance in implementing its workplace programme on HIV/AIDS.

Date: December 7, 2005
Place: Gurgaon

D P AGARWAL
Vice Chairman &
Managing Director

K. Sujatha Rao
Additional Secretary & Director General
National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India

Dated the 18th April 2006

Subject : NACO guidelines for strengthening the HIV/AIDS interventions in the world of work

Dear Colleagues,

As you may know, protecting workforce is identified as a key priority by the National Council on AIDS, chaired by the Prime Minister.

I am pleased to send you the enclosed guidelines for strengthening the world of work interventions. I am sure you will find these guidelines useful in strengthening the HIV/AIDS response in the world of work and mainstreaming HIV/AIDS in the programmes of Government departments, private sector, employers' organizations, trade unions and civil society organizations. I encourage you to kindly share these guidelines with relevant State level partners.

There are several policy/training/communication materials developed by ILO India that are available for adaptation and use at your level. The list is included in the guidelines. Please feel free to ask ILO for these materials.

I Look forward to receiving your work plans on this component.

With regards,

Yours sincerely,

(K. Sujatha Rao)

Enclosure: As above

All PDs of SACS

RECEIVED
20 APR 2006
ILO, SRO-NEW DELHI

Copy to :

1. Ms. Leyla Tegmo Reddy, Director, ILO
2. Dr. Denis Broun, Country Coordinator, UNAIDS

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

9th Floor, Chandralok Building, 36 Janpath, New Delhi - 110001 Phone : 011-23325331 Fax : 011-23731746
E-mail : asdg@nacoindia.org

NACO guidelines on
Strengthening HIV/AIDS interventions in the world of work in India

To:

All Project Directors, State/District AIDS Control Societies

Health Secretaries, State Governments and Union Territories

The AIDS Policy of the Government of India stresses that *the organised and unorganised sector of industry needs to be mobilised for taking care of the health of the productive sections of their workforce*.

Nearly 90% of the HIV infections have been reported from the most productive 15-49 years age group in India. If urgent efforts are not taken, this will adversely affect workers, their families, enterprise performance and the national economy. India has a working population of around 400 million, 93% of whom are in the informal economy, who are more difficult to reach. These workers are especially vulnerable to HIV/AIDS. Generally, they have low access to health care facilities and low health seeking behaviour. They have either no or low social protection benefits. It is, therefore, necessary to strengthen HIV/AIDS programmes in the world of work in India on an urgent basis.

No organisation can do it alone. This can happen if HIV/AIDS response becomes truly multi-sectoral and HIV/AIDS is mainstreamed in the existing programmes of ministries, government departments, private sector, employers' organizations and trade unions/civil society organizations. To give highest priority to the mainstreaming process, a National Council on AIDS (NCA) has been set up in India, which is chaired by the Prime Minister. The objectives of NCA are:

- To mainstream HIV/AIDS in all ministries and departments by treating it as a development challenge, and not merely a public health problem;
- To provide leadership to mount a multi-sectoral response to combat HIV/AIDS in the country with special reference to youth, women and **the workforce.**

These guidelines are issued with a view to help State AIDS Control Societies and other relevant stakeholders in strengthening HIV/AIDS response in the world of work at the national/State levels.

HIV/AIDS workplace policy:

SACS can assist government departments, private sector, employers' and workers' organisations to develop workplace policy, based on the national policy framework and the guidelines of the ILO Code of Practice on HIV/AIDS and the world of work. Key principles of the ILO Code around which policy can be developed are:

Recognition of HIV/AIDS as a workplace issue, non discrimination due to HIV status, gender equality, creation of healthy work environment, social dialogue, no HIV screening for the purpose of employment, respecting confidentiality regarding HIV status, continuation of employment relationship as long as a

person is fit to work, provision for HIV prevention efforts through education and training of employees and their families, and care and support, including counselling of individuals/families and treatment.

Operational/programmatic issues:

- State/District AIDS Control Societies should designate a staff member to coordinate workplace interventions at the SACS level. If it is not possible to dedicate a staff member from the existing personnel, a request may be made to NACO for seeking approval of a dedicated person to be appointed on contractual basis at the level of the NGO adviser.
- SACS should develop a clear work plan, with timeline and budget, which could be presently supported from the inter-sectoral component under the SACS budget. If allocation is not available, SACS should seek funds from NACO by sending a work plan along these guidelines. SACS should include this component under the State PIP being prepared for NACP III. SACS work plan for this component should cover the following areas:
  a. Sensitisation/capacity building programmes for key departments, employers' organisations/ chambers, trade unions, starting with main sectors in the states.
  b. Assisting partners in developing their work plans, and supporting them in terms of training/ materials/condoms. **Enterprises** should be encouraged to implement their work plans at their own cost. The support from SACS should be technical in nature related to policy development, training of peer educators, provision of communication materials, condoms and facilitating linkages with the voluntary counselling and testing centres/STI clinics/ART centres. Enterprises should be encouraged to support the cost of treatment, including treatment with Anti Retroviral drugs, for their employees/families as part of their policy. For contractual employees, they can set up linkages with government hospitals/ART Centres or Employee State Insurance Corporation (ESIC scheme), wherever applicable.
  c. SACS can offer technical as well as financial support for projects of small and micro enterprises and trade unions in the formal and informal sectors. It would be critical to identify entry points through industry associations, unions and other bodies' while developing these interventions. SACS can engage their partner NGOs to help in this process.
  d. SACS should support setting up Voluntary Counselling and Testing Centres in enterprises which have their own clinical set-up. This will enhance the coverage of VCTCs in the State.
  e. SACS should also collaborate with the State labour departments, Central Board For Workers Education and Employees State Insurance Corporation, two key institutions of the Ministry of Labour and Employment GOI, who are engaged in the HIV/AIDS programme. ESIC scheme also covers for ART drugs. However, SACS may like to collaborate with them for training of doctors, so that treatment protocols are correctly followed.
  f. Involvement of People Living with HIV/AIDS (PLWHA) is an effective strategy in the advocacy/ training programmes which should be implemented in collaboration with the State-level PLWHA networks. This is also a good strategy for fighting HIV/AIDS related stigma and discrimination.
  g. For covering workers in the **informal economy**, SACS are already supporting mobile and migrant workers through NGOs in their targeted interventions projects. This coverage can be enhanced by carefully mapping the State-specific vulnerable groups and developing composite projects through NGOs. In addition, some more approaches can be attempted for enhancing

coverage. First, mainstreaming HIV/AIDS in the programmes of various government departments/ schemes. Second, engaging civil society organisations - NGOs working in areas like adult education, health, Income generation, etc.- to mainstream HIV/AIDS within their activities. Third, engaging trade unions in their areas where they have their sectoral unions like the agriculture workers unions, postal workers unions, plantation workers unions, transport workers union, construction workers union, etc. Fourth, encouraging corporate sector to cover their contractual workers as well as workers in their supply chains.

Technical support/materials for the world of work programme:

SACS can utilise the following set of materials that have been developed by ILO India to support HIV/ AIDS interventions in the world of work:

- The ILO Code Of Practice, available in English and Hindi, for policy and programmatic guidelines.
- An Indian Employers Statement of Commitment on HIV/AIDS, signed by seven key employers organisations/chambers in India: All India Organization of Employers (AIOE), Associated Chambers of Commerce and Industry of India (ASSOCHAM), Confederation of Indian Industries (CII), Employers' Federation of India (EFI), Federation of Indian Chambers of Commerce and Industry (FICCI), Standing Conference of Public Enterprises (SCOPE) and Laghu Udyog Bharati (LUB). This statement is published along with a working paper on "Enhancing Business response to HIV/AIDS in India- Operational Guidelines with estimated Cost Analysis".
- A Compendium of Workplace HIV/AIDS policies.
- A Training manual for Master Trainers/Peer Educators of enterprises (includes the enterprise-based strategy as well).
- A CD containing an advocacy film for enterprise, training manual, key presentations and collocation of audio-visual spots for enterprise-based programmes.
- A bilingual (English and Hindi) card game for workplace peer educators.
- A training manual for trade unions in English and Hindi, a handbook and a film on role of trade unions on HIV/AIDS in English and Hindi.
- A set of six posters on HIV/AIDS and the world of work.
- A flip book for unorganised sector workers, produced by ILO and CBWE.
- A handbook for labour administrators in English, produced by ILO and V.V. Giri National Labour Institute.

The ILO materials are available at www.ilo.org/hivaidsindia. ILO will be sending a complete set of materials to SACS. The ILO is also willing to share the text/art work of posters/materials with SACS, which could be adapted/ translated into regional languages and replicated by SACS.

ANNEXURE 9

Information Collection in Stakeholder Analysis

Targeted Interventions Under NACP III: Migrants and Truckers

Introduction

Participatory tools are particularly useful when outreach work involves the exchange of sensitive or private information. Groups like migrants and sex workers themselves can give key insights on existing behaviour, attitudes and practices and barriers to safer behaviours. Hence it is worth investing in training NGO partners and peers in the basics of participatory techniques. These can be useful not only in the start-up phase but throughout the project cycle when different messages and behaviour change communication need to be planned, designed and developed.

There are many references and guidelines for participatory techniques for collecting quantitative and qualitative data. Some of these are summarized below.

Mapping

Mapping is an effective PRA technique for gathering information that captures the complexity of local situations. It helps locate important landmarks in an area and identifies key informants or guides. Mapping permits the rapid assessment and analysis of a particular situation with the goal of providing accurate, timely information that can be used to develop intervention strategies. An important advantage of this method is that it can be used effectively with uneducated target groups.

Mapping can collect information on:

1) Exact locations within the clusters in which the target population reside/operate
2) Validation of estimates of target population in each intervention site
3) Social networks, brothels, truckers halt points, drug-using points, beer bars, lodges, video parlours, and places where street based sex workers operate
4) Service facilities such as government or municipal health clinics, family planning clinics, hospitals, STI or drug abuse treatment centres, primary health care centres, medical colleges, voluntary counselling and testing centres and other health care facilities. This information can be useful for building a referral network during intervention.
5) Traditional and non-traditional outlets which currently stock or sell condoms
6) Other outlets/persons/places which are potential condom outlets
7) Other infrastructure, e.g. parks and gardens, water tanks, public toilets and private properties

Mapping Information Form

City/Town/District Information about Migrant Locations/Sites		
Date		
Name of the Town/city		
Name & contact information of the Key Informant		
Key Informant type		
Key Informant gender		
Locations of migrants with estimated numbers		
No	**Place Name**	**Estimated Number (Range)**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
Notes :		
Investigator's signature:		Supervisor's signature:

Key Informant Interviewing

Separate interviews can be conducted with key informants (KIs) of the community. This is considered an effective methodology to collect correct information about migrants, as KIs are intimately involved with or exposed to them. KIs are individuals with special knowledge, status, or communication skills who are willing to share what they know with the intervention team. They usually have direct expert knowledge, or are identified as an expert by others and can give detailed as well as contextual information. They also have a different relationship to the migrant community than the interviewer/researcher in terms of providing information, introductions and interpretations, often an a day-to-day basis, as well as access to observations that an outsider would not normally have.

An illustrative list of who could be productive KI could include:

- Administrators and officials, e.g. lawyers, judges, police, doctors and paramedics, teachers, etc.
- Street vendors, taxi or auto drivers, traditional healers, youth club members, community leaders, NGO personnel, *dhaba* owners, barbers, etc.
- Members of the migrant community and power brokers, migrants, FSWs, union and Labour Department officials.

Key informants Interview Checklist

Date	
Name of town/city	
Name of location/site	
Name & contact information of the Key Informant	
Key informant type	
Key Informant gender	Male: 1 Female: 2
Questions	**Probe points for recording answers verbatim**
1. What are the main occupations/work of the people living at this location? Are they the usual residents of this place or have they migrated from nearby places or villages?	Probe for the main occupations/work of the people living in this locality
2. Are these migrants mainly males living alone, or do they live with their family?	Probe for the number of male single migrants and also for those living with the family
3. From which areas mainly are the migrants living in this locality?	Probe for their place of origin – in-state or out of state
4. Do you know people who gather in and around this locality in search of employment, who come from the nearby villages and go back to their place of residence in the evening?	Probe whether any daily migrants congregate in this locality
5. Are the migrants living in this locality here permanently (the majority for more than a year or so) or do they come here and go back during particular months/seasons of the year?	Probe for seasonal pattern of migrants who come to live here
6. Do you think that the migrants living in this locality (either male or females) are at risk of getting HIV infection? If so, why do you think so? In your opinion, which behaviours of these migrants make them more vulnerable to getting HIV/AIDS?	Probe for sexual behaviours / drug usage, etc.
7. Do you know any other person(s) who could tell me more about the questions which I have asked you? Please let me know their names and contact addresses.	Write down the names and contact details of these persons.

Validation and recording the numbers of migrants at the location	
8. Total number of the migrants at this location (may be in range)	
9. Males	
10. Females	
11. Males without family	
12. Females without family	

Secondary Sources

Secondary sources are materials already published or recorded by others (individuals, research institutions and papers, records and registers), including reference works, data from surveys and existing records.

Focus Group Discussion (FGD)

Focus group discussion (FGD) is a method for eliciting qualitative information from a homogeneous group interaction, in order to produce data and insights that would be less accessible without the interaction found in a group. The key concept here is group interaction. Unlike simple group interviews, FGDs depend as much on the exchange of ideas among participants as they do on answers to specific questions from the interviewer. In a FGD, the interviewer is in fact called a moderator, underscoring the role of guide and facilitator in the group process.

FGDs can be highly effective sources of data for studies that focus on social norms, expectations, values and beliefs. These stimulate people to share their own ideas and debate the view of others. Most FGDs have relatively homogenous groups with respect to age, sex and backgrounds, e.g. a group of migrant laborers of the same age and sex, or a group of community influencers from a particular community.

Checklist for FGD

Discussion points (not questions)	Notes
1. Place(s) of origin of migrants (District, block, etc.)	
2 Type(s) of work in which migrants are mainly involved	
3 Awareness about HIV/AIDS among migrants	
4 Awareness about STIs	

Discussion points (not questions)	Notes
5 People suffering from STIs and their treatment seeking behaviour	
6 Multiple partners for sex or other extra-marital sexual behaviours	
7 Visits to FSWs	
8 Homosexual activity	
9 Injecting drug use	
10 Knowledge about condoms	
11 Availability and use of condoms	
12 Any type of sexual harassment heard about by migrants	
13 Any other relevant information	

In-Depth Interview

The in-depth interview is a qualitative research technique used to get more detailed information on issues which can not be fully elicited from a focus group discussion, e.g. a life history. It is similar to a FGD, but the interview takes place with one individual rather than a group of individuals. The facilitator uses a pre-designed flexible discussion guide, leaving most questions open-ended.

In-depth interviews require an experienced facilitator with the skills to carry an interview by him- or herself to gain maximum information. As with the FGD, the interview is so far as is possible to be recorded manually or by tape recorder after receiving the respondent's permission.

Individual in-depth interview form

In-depth interview form for migrants(to be filled in while interviewing migrants at the selected locations)		
Migrant profile		
1	How many months per year do you spend in nearby towns/cities like these for work?	
2	How many months per year do you spend in your home village?	
If the above questions do not indicate that the migrant fits the definition for TIs, terminate the interview, otherwise continue.		
3	Where are you from? (Village, Mandal/Taluk/Block, District, State – record all of these)	
4	For how long have you been migrating (year)?	
5	What kind of work do you do in the town/city? ■ Digging ■ Construction labour ■ Road laying ■ Masonry ■ Carpentry ■ Agricultural labour ■ Other (specify)	
6	Have you currently migrated: ■ With all your family members ■ Some family members, but not including spouse ■ Some family members, including spouse ■ No family members (alone)	
7	How do you get work? ■ Stand in *naka* everyday, trying to get work ■ Have a fixed arrangement with a contractor for whole period of migration ■ Have a fixed arrangement with a contractor for some period of migration ■ Other (specify)	
8	What are the major reasons you have come to this specific town/city (over others) as a migrant? (Not reasons for migrating from source, but reasons for choosing **this specific destination**.)	
9	Where do you stay in this town/city? Where do you solicit for work (if you do)?	

Knowledge and Behaviour about HIV/AIDS		
10	Have you heard the term HIV or AIDS or both? **If yes, continue, otherwise go to 13.**	
11	How does HIV spread / how is it transmitted? ■ Mosquitoes ■ Hugging ■ Heterosexual practices – penetrative ■ Kissing ■ Using the same toilet ■ Blood transfusion ■ Lesbianism (female having sex with female) ■ Sharing blades for shaving in barber shop ■ HIV infected mother to child ■ Oral sex ■ Sharing same syringes for injections ■ Heterosexual practices – non-penetrative ■ Homosexual practices ■ Anal sex ■ Sharing food	
12	How can we prevent acquiring HIV/AIDS? **(Do not prompt)** ■ Using sterilised needles ■ Accepting only HIV tested blood for transfusion ■ Abstinence ■ Be faithful to one partner ■ Using condoms ■ All of the above ■ None of the above ■ Don't know	
13	We would like to ask you a sensitive question about sex life… ■ Have you visited a sex worker in the last one month ? ■ In the last 12 months ? ■ If you did visit, did you use a condom every time? ■ If not, in how many sexual contacts did you use a condom (out of how many contacts during the last one year)? ■ If not in all sexual contacts, why (specify)?	

14	In the last 3 months, have you ever had any problems such as genital ulcer, urethral discharge, swelling in groin, burning urination)? If yes, what did you do? ■ Any treatment? ■ Where? ■ Got cured? Did you have sexual intercourse with anyone while suffering from STI?	
15	Have you ever used a condom? From where do you procure condoms?	
16	Ask if migrant is married: ■ Do you use condoms when having sex with your wife (whether she is living with you here or when you go back to your place)? ■ Do you use condoms with your wife in all sexual acts or occasionally?	

ANNEXURE 10

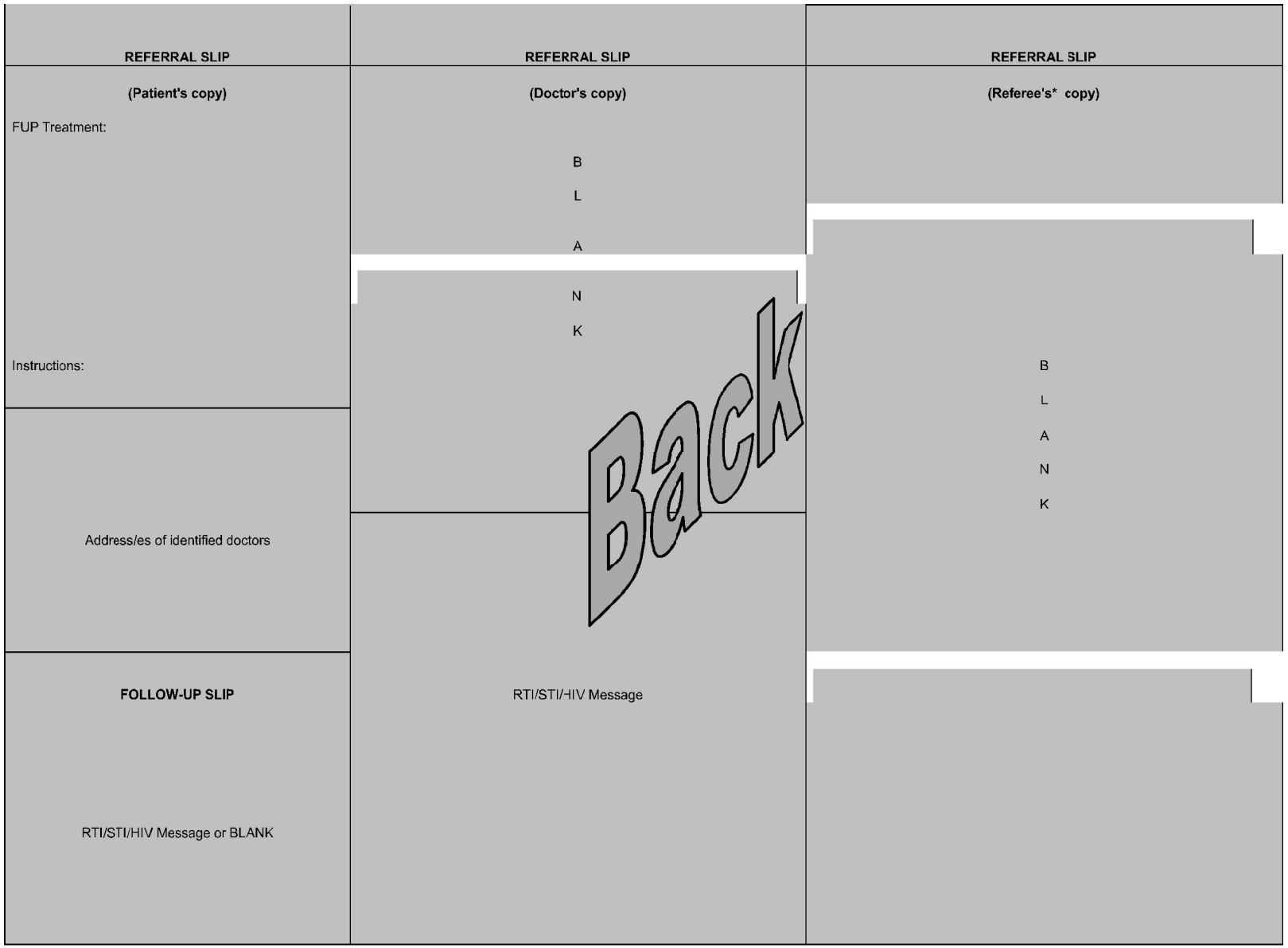
Referral Slip

Referral Slip

Targeted Interventions Under NACP III: Migrants and Truckers

REFERRAL SLIP	REFERRAL SLIP	REFERRAL SLIP
(Referee's* copy)	**(Doctor's copy)**	**(Patient's copy)**
No: Date: Name of City: ..... State: ..... Name of referree: Designation: PE/ORW/RMP/CARE/..... Name of person referred: Age _____ Sex M/F/O_____ Mohalla/Slum/Basti/..... General RTI/STI T/SW/M/O	No: Date: Name of City: ..... State: ..... Name of referree: Designation: PE/ORW/RMP/CARE/..... Name of person referred: Age _____ Sex M/F/O_____ Mohalla/Slum/Basti/..... Please tick the syndrome Partner came for treatment: Yes / No 1 2 3 5 6 7 Follow-up date (*if required*):	No: Date: Name of City: ..... State:..... Name of referree: Designation: PE/ORW/RMP/CARE/..... Name of person referred: Age _____ Sex M/F/O_____ Mohalla/Slum/Basti/..... Diagnosis: Rx:
HIV/RTI/STI Message		**FOLLOW-UP SLIP** No: Date: Name of City: ..... State: ..... Name of patient: Follow-up date (if required): ***Give to the patient if follow-up required, otherwise put in the box. On follow-up visit if further treatment required then write on Pt's copy and put this in box.***
		Partner came for treatment: Yes / No

Front


REFERRAL SLIP
(Patient's copy)
FUP Treatment:
Instructions:
Address/es of identified doctors
FOLLOW-UP SLIP
RTI/STI/HIV Message or BLANK
REFERRAL SLIP
(Doctor's copy)
B
L
A
N
K
RTI/STI/HIV Message
REFERRAL SLIP
(Referee's* copy)
B
L
A
N
K
Back

ANNEXURE 11

Ongoing Assessment of VPLs and Migrants

Ongoing Assessment Tool for VPLs under Migrant TIs

City		State	
Occupation of the Migrant		Site name	
Interviewer name		Date	

Sl	Questions	Options	
1	Have you heard about AIDS?	Yes.....1	
2	Do you know the ways by which HIV/AIDS cannot be transmitted from one person to another? (Tick all the options spontaneously provided by the VPL)	By shaking hands……..1	
		By mosquito bite……...2	
		By sharing food together……..3	
		By sharing clothes……4	
		By accompanying the infected person…5	
3	Do you know the ways by which HIV/AIDS can be prevented?	Abstinence……..1	
		Be faithful, one partner……..2	
		Use condom in every sexual contact…..3	
		Blood safety……4	
		Precaution for needle use……5	
4	Do you think a healthy-looking person can get AIDS?	Yes.....1	
5	How does HIV spread?	HIV infected blood transfusion.....1	
		Sharing of HIV infected needles.....2	
		Unprotected intercourse with HIV infected person.....3	
		HIV infected mother to the infant.....4	
		Other.....5	
6	What is the difference between other STIs and AIDS?	AIDS is not curable ……1	
		STIs are curable ……..……2	
		Both AIDS & STIs are preventable ……3	
		Other (specify)___ _____	
7	Can you describe the steps for correct use of a condom?	Correctly described……...1	
8	Do you know the places where condoms can be obtained?	Hospitals……..1	
		Medical shops ……2	
		Health workers……..3	
		VPLs 4	
		Free condom boxes at public place …..5	
		Other (specify)……..……6	
9	As a VPL and being associated with the project, how many persons do you contact per week?	Less than 5……1	
		Less than 10……...2	
		Less than 15……3	
		More than 15……4	

Sl	Questions	Options	
10	Are you aware of any disease of reproductive/sexual tract (RTI/ STI)? Can you name any three symptoms of such diseases?	Not aware.....0	
		Itching……..……1	
		Boils around genitalia……2	
		Discharge……3	
		Ulceration ……...4	
		Burning / Painful urination……5	
		Pain during intercourse……..……6	
		Warts on genitalia……..7	
		Lower abdomen pain……8	
		Others (Specifiy) _____	
11	What advice would you provide to a person who is suffering from an STI?	Seek treatment from a doctor ……...1	
		Seek advice from traditional healers……2	
		Use condoms……..…..3	
		Complete treatment……..4	
		Others (Specify)____ _____	
12	Do you refer patients who have some signs or symptoms of STIs?	Yes……..1	
13	If yes, where do you refer them?	Name of referral places _____	
14	Do you follow up with the referred cases about their treatment compliance?	Yes……..1 No……2	
15	Do you keep condoms for distribution (Free supply & SM)?	Yes……..1 No……2	

Ongoing Assessment Tool for Migrants within TIs

City :		State	
Occupation of the VPL		Site name:	
Interviewer name		Date	

Sl	Questions	Options	
1	Have you heard about AIDS?	Yes.....1	
		No……2	
		No response……3	
2	Do you know the ways by which HIV/AIDS cannot be transmitted from one person to another? (Tick all the options spon-taneously provided by the VPL)	By shaking hands……..1	
		By mosquito bite……...2	
		By sharing food together……..3	
		By sharing clothes……4	
		By accompanying the infected person…5	
3	Do you know the ways by which HIV/AIDS can be prevented?	Abstinence……..1	
		Be faithful, one partner……..2	
		Use condom in every sexual contact…..3	
		Blood safety……4	
		Precaution for needle use……5	
4	Do you think a healthy-looking person can get AIDS?	Yes.....1	
5	How does HIV spread?	HIV infected blood transfusion.....1	
		Sharing of HIV infected needles.....2	
		Unprotected intercourse with HIV infected person.....3	
		HIV infected mother to the infant.....4	
		Other.....5	
6	Can you describe the steps for correct use of a condom?	Correctly described……...1	
7	Do you know the places where condoms can be obtained?	Hospitals……..1	
		Medical shops ……2	
		Health workers…….....3	
		VPLs 4	
		Free condom boxes at public place …..5	
		Other (specify)…….6	
8	Are you aware of any disease of reproductive/sexual tract (RTI/ STI)? Can you name any three symptoms of such diseases?	Not aware.....0	
		Itching……1	
		Boils around genitalia……2	
		Discharge……3	
		Ulceration ……...4	
		Burning / Painful urination……5	
		Pain during intercourse……6	
		Warts on genitalia……..7	
		Lower abdomen pain……..…8	
		Others (Specifiy) _____	

Sl	Questions	Options	
9	From where did you come to know about STIs /RTIs & HIV/ AIDS? (Tick the answers reported by the respondent)	Watched on TV……..1	
		Listen on Radio……..2	
		From Poster / Hoarding / wall writings....3	
		From VPL 4	
		From NGO staff……5	
		News Paper ……6	
		RMP/ Quack ……7	
		Any other (specify) _____	
10	Did anyone provide you information about HIV/AIDS in the last one month?	Yes……..……1	
11	If yes, please tell me who provided this information.	Government Doctor..……..1	
		Nurse……2	
		Private Doctor……..3	
		PMP……..…..4	
		Medical stores/pharmacy……5	
		VPL 6	
		NGO worker……..7	
		Friend……..……..8	
		Family member……..……..9	
		Any other (specify)_____	
12	Do you keep condoms readily available with you?	Yes……..…....1	
		No……...2	
		Sometimes.....3	
13	Do you use a condom regularly with **all** partners?	Yes……..……1	
		No……...2	
		Don't use with spouse……3	
		No response ……4	
14	Did you use a condom in your last sexual contact?	Yes……..…..1	
		No……2	
		No response……3	
15	Did you suffer from RTI / STI during the last 3 months?	Yes……..…..1	
16	If yes, where did you seek treatment?	Government hospital……..1	
		Private practitioners……2	
		Traditional healers……...3	
		Self……..4	
		Did not take any treatment…..……..5	
		Others (specify)____ _____	
17	Did you complete the treatment as prescribed by the doctor?	Yes……..…..1	
18	If no, why did you stop treatment?	Side effects ……..……1	
		Symptom not cured ……..2	
		Peer Pressure ……3	
		Monetary problems ……..……..4	
		Others (specify)_____	

Targeted Interventions
Under NACP III

OPERATIONAL GUIDELINES

OPERATIONAL GUIDELINES

Volume II

MIGRANTS AND TRUCKERS

National AIDS Control Organization
Ministry of Health & Family Welfare
Government of India