Policy, Strategy and Operational Plan

HIV Intervention for Migrants

National AIDS Control Organization
Department of AIDS Control
Ministry of Health and Family Welfare
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CONTENTS

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FOREWARD

In India there is increasing evidence and growing recognition of the importance of migration/mobility in the spread of HIV infection. Highest burden of HIV is amongst migrants, after the High Risk Groups -3.6 % - and ten times that of the general population. There are studies that have shown that informal workers are significantly at higher risk than general population – their knowledge levels are lower; two to four times more number of informal workers has non-regular partners or visit sex workers.

This has led to the National AIDS Control Programme III referring to migrants as one of the core groups which need to be addressed at Source, Transit and Destination. NACO has revised its Migrant strategy; it now envisages identifying high out migration locations at Source, Transit and destination, providing them information about HIV/AIDS, STI, and safe migration. Linking this population to the public health services for Sexually Transmitted infection, Integrated Counselling & Testing Centre, Anti Retro Viral Therapy, Rashtriya Swasthya Bima Yojana, Janani Swasthya Yojana, Village Health Nutrition Day etc and then their follow up is one of the key areas that is expected to be addressed by village level workers and Volunteer Peer Leaders.

In order to achieve the desired objectives of the strategy, the operational aspects of intervention were revised with due consultation with experts, Technical Resource Group members, and State AIDS Control Societies. Greater emphasis has been given for convergence with existing facilities and structure, and data sharing among Source and Destination States

I hope that these guidelines will help State AIDS Control Societies to roll out the Policy and Migrant Strategy more effectively.

10/6/10

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ABBREVIATIONS

AN Mothers	Ante-Natal Mothers
ANC	Ante-Natal Check-up
ANM	Auxiliary Nurse and Midwifery
ART	Anti-Retroviral Treatment
ASHA	Accredited Social Health Activist
AWW	Angan Wadi Workers
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CCC	Community Care Centre
CSO	Civil Society Organisation
DACS	District AIDS Control Society
DAPCU	District AIDS Prevention and Control Unit
DIC	Drop-In-Centre
ESI	Employees State Insurance
FSW	Female Sex Workers
HIV	Human Immuno Deficiency Virus
HRG	High Risk Groups
HSS	HIV Sentinel Surveillance
ICDS	Integrated Child Development Scheme
ICT	Integrated Counselling and Testing
ICTC	Integrated Counselling and Testing Centres
IDU	Injecting Drug Users
IEC	Information Education and Communication
IPC	Inter Personal Communication
LSG	Local Self Government
MIS	Management Information System
MoU	Memorandum of Understanding
MSM	Men Having Sex With Men
NACO	National AIDS Control Organisation
NGO	Non Government Organisation
NREGA	National Rural Employment Guarantee Scheme
NRHM	National Rural Health Mission
NYK	Nehru Yuva Kendra
PDS	Public Distribution System
PHC	Primary Health Centre
PLHIV	People Living with HIV
PPTCT	Prevention of Parent To Child Transmission
RSBY	Rashtriya Swasthya Bima Yojana
SACS	State AIDS Control Societies
SC	Sub Centre
STI	Sexually Transmitted Infections
STRC	State Training and Resource Centre
TB	Tuberculosis
TSU	Technical Support Unit

UNAIDS	United Nations AIDS Programme
UNDP	United Nations Development Programme
VCT	Voluntary Testing and Counselling
VHND	Village Health and Nutrition Day

RATIONALE

RATIONALE – WHY MIGRANTS

Introduction:

'Migration' is the spatial mobility of people from one geographical area (place of origin / source) to another (place of destination), with the intention of settling temporarily or permanently or semi-permanently. There are a variety of reasons for migration - economic (livelihood, economic imbalance, job opportunities etc.), environmental factors (drought), demographic reasons (family migration, movement of young and retired persons) or political reasons (refugee movements etc.). Some of these are factors related to origin (push factors) and others opportunities in the place of destination (pull factors). Migration over long distances also involves temporary stops, also called 'Transit points'.

Migration is a highly complex human behaviour, as old as human existence itself. There are many typologies (and combinations of typologies), some of which are described below:

- Rural vs Urban - Rural to Urban, Urban to Urban, Rural to Rural
- Persons – Single male, Single female, Couples, Couples with children (sometimes some), whole family
- Location – Inter-state, intra-state, inter-district, intra-district, international
- Distance – Long distance, Short distance
- Length of stay – Temporary (up to 3 months), semi permanent (up to 6 months in a year, returning to villages during rainy season) and permanent (only returning for key holidays)

- In and out – From the point of view of a geographical location, In-migration or Out migration or both
- Others – Step migration (transit itself become a place for short migration), relay migration (one family member living in the destination and others taking turns to relieve, reverse migration (Urban-Rural)

Mobility and Migration are two distinct concepts. Mobility is when a person moves from the place of origin, travels / works and returns back to origin the same day or week (for example people who live in Pune and work in Mumbai). On the other hand migration involves movement of those people who establish residence at the destination place for a significant period of time.

In the 2001 census, using the 'change in residence' concept, 30.1% of the population is considered to have migrated (that is, 314 million of the total 1028 million persons), which shows a considerable increase from 27.4% in 1991. In the case of males it increased from 14.7% in 1991 to 17.5% in 2001. In the case of females, it increased from 41.6% in 1991 to 44.6% in 2001 (Population Council, 2008; Population Council, 2009). The migration during 1991-2001 has increased rapidly.

The primary destinations for migrants (22% to Maharashtra, 7.8% to Andhra Pradesh, 7% to Gujarat and 5% to Karnataka) are also the states with higher HIV prevalence (Verma and Saggurti et.al., 2007). The migrant workers seeking employment in these destination locales are often from tribal and rural communities with low technical knowledge and high rates of illiteracy, offering a cheap labour force for urban settings (Patel, 2002). Male migrant workers including unskilled labourers, construction and industrial workers, leaving behind their families and spouses at their native places dominate the traditional rural to urban migration in India (Basu et.al., 1987). Migration in India is predominantly short distance, with around 60% of migrants changing their residence within the district of enumeration and over 20% within the state of enumeration while the rest move across the state boundaries (Srivastava and Sasikumar, 2003).

Previous research on migration in India has shown that the migration is highly selective by age, sex and education. Rapid urbanization coupled with poor housing facilities in city areas leads to migrant labourers staying away from families.

Most migration literature makes a distinction between 'pull' and 'push' factors, which, however do not operate in isolation of one another. Migration occurs when workers in source areas lack suitable options for employment/livelihood, and there some expectation of improvement in circumstances through migration (Srivastava and Sasikumar, 2003). The proportion migrating for economic reasons is greater among long-distance migrants; most male migrants moving between states did so for economic reasons.

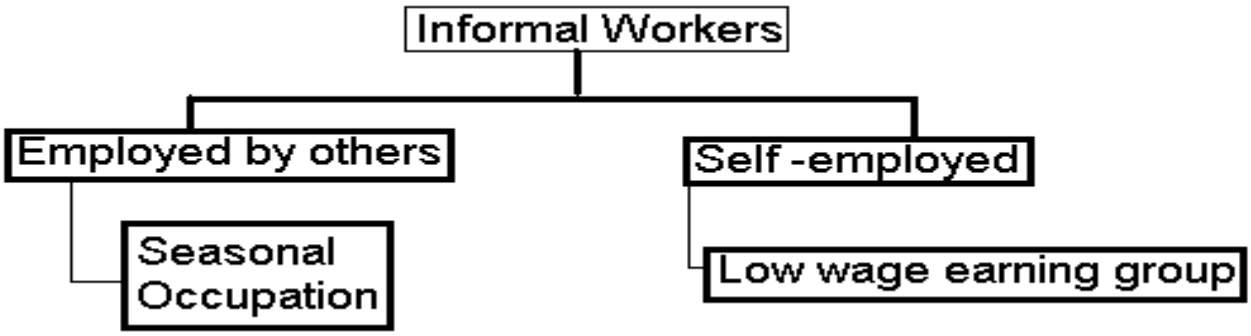
Migrants vs. Informal workers: Migration could include formal and informal workers, rural to urban, etc – the typification are many. Informal workers are unskilled labourers who work largely in unorganised sector, many times are migrants from rural to urban/semi-urban areas in search of work. Thus informal workers include a large section of migrant workers[1].

Sectors	Workers	Employment Share to total workers (385 Million)	Informal Workforce	Informal Workforce as % of total workforce
Agriculture	203	53%	200	98%
Manufacturing	50	13%	46	93%
Construction	21	6%	20	93%
Textiles	19	5%	18	93%
Tobacco	7	2%	6	93%
Mining	2	1%	2	93%
		79%	292	
Source: Economic Survey - 2004-05				

Informal workers, many of whom are migrants, are hired on a daily or seasonal basis for short stretches of time, working in low skill activities, not within the mainstream of the sectors, but in the small and unorganised part of the sector. When they do work in formal settings, it is to address fluctuations in production or in low skill activities which support the formal entities within the sector (like allied activities, supply chains – up or down stream) or in small and medium enterprises. Some of the informal workers (like construction) work in cities which are growing due to industries – but not directly working in those industries.

1 An ILO study in 2008 in Panvel, Maharashtra shows that majority (77 %) of the construction workers were migrants.

Informal workers can be categorised further as follows and this is important in view of understanding the vulnerability to HIV.



The above framework indicates that informal labours who are employed by others constitute 29% as casual employers and among them those who are into seasonal occupations are at vulnerable to HIV because of lack of social and economic security, involvement in peer driven risk taking and pleasure seeking activities like exposure to alcoholism, casual sex with unknown partners etc. The important industries where a large proportion of informal seasonal workers are employed are: Brick Klins (10 million, Source: Migration and Human Development in India, UNDP,April2009), Textile Industry (35 million, out of which 78% are in smaller power looms and handlooms, Source: Migration and Human Development in India, UNDP,April2009), Leather Industry (2 million), Mines and Quarries (4-5 million), Agriculture (35-40 million approx.), Food Processing (7.85 million).

The low wage earning group of self employed section of the informal work force includes migrants working in the service sector like domestic work (20 million mostly women and girls), Rickshaw pulling, Hotels, Dhabas, Construction (40 million). These informal workforce constitutes both local as well migrants and hence their vulnerability to HIV is also important in the context of interventions.

The public and private sectors in India employ 385 million workers[2], of which 93 percent are informal workers. The top six sectors employ 79 percent of the work force (see table). Agriculture sector, which employs the largest labour force, is rural, and is partly addressed through the 'Link Workers Programme', supported by the Global Fund Grant Round 7[3]. In addition, agricultural labourers who migrate to urban areas work mainly in construction[4] sector and are covered under current destination TIs. Other than the Agriculture sector, the five key sectors of manufacturing, construction, textiles, tobacco and mining employ 99 million workers account for 59 percent [5] of the workers, of whom 34 percent[6] are female.

2 Economic Survey, 2004-05

3 India has several 'sending' districts, which are typically rainfed areas from where large number of migrants move to nearby or far away cities, which are largely industrialized and urbanized. The 'receiving' districts employ substantive number of migrants from rural areas, largely as informal labour. Round 7, working in 186 districts in rural areas are 'sending' districts. This proposal addresses migrants and informal workers from rural areas in urban settings in the 'receiving' districts.

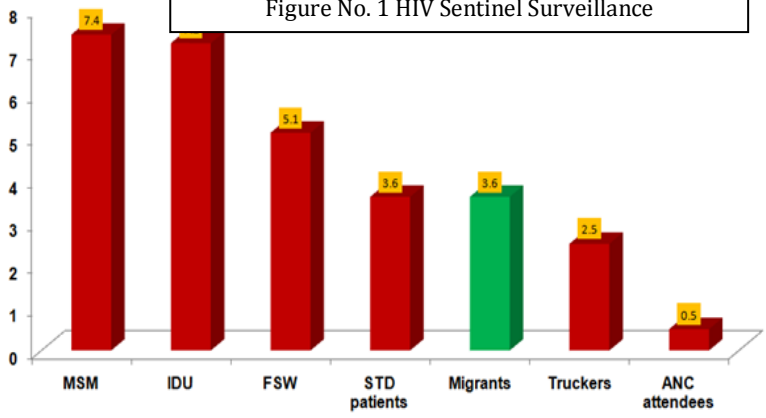
4 Some amount of double counting is inevitable as most people move and take up more than one job for diversified livelihood in resource poor settings.

5 Excluding Agriculture

6 Economic Survey, 2004-05

Migration and HIV – The links: There is increasing evidence and growing recognition of the importance of migration/mobility in the spread of HIV infection. Prevalence of HIV amongst Migrants (many of whom are informal workers) is the highest in any group, after the High Risk Groups of FSW, MSM and IDUs. This has led to the National AIDS Control Programme III referring to migrants as one of the core groups which need to be addressed. Evidences of following correlate Migration and HIV.

Figure No. 1 HIV Sentinel Surveillance



Kerala has shown a low prevalence of HIV and of the total cases reported, 90% were among the migrants (Xavier, 2004). An analysis of HIV positive individuals in Kerala shows, of the 70 HIV positive cases detected out of 4932 samples, the rural to urban ratio is 5:1 which was rather unexpected since the rural-urban population ratio is 3:1. This result confirms the belief that the epidemic in Kerala is migration induced because the HIV prevalence is more in the rural population (Prasanna Kumar, 2000).

A cross border study between Bangladesh and India has indicated a link between migration, mobility and HIV vulnerability due to the presence of mobile and hidden sex trade along border area, reported STDs and HIV positive cases among mobile people and the infection is significantly associated with practicing sexual risk behaviour in the border region, trafficking and violence against migrant women (Tajer et.al., 2004). An awareness study among patients attending STD clinics indicate a low levels of knowledge about HIV and poor early treatment of STDs among the migrants (Changedia and Gilada, 2000).

A number of studies in India further indicate that migration propels the HIV epidemic by creating living conditions that heighten engagement in risky behaviours (e.g., husbands residing without wives go to FSWs) and by providing a vehicle through which infection can move from high to low epidemic regions (Singh, 2001; UNAIDS, 2006; Rego et.al., 2002; Decosas et.al., 1995). Studies document that men living without wives, not being married or migration away from wives, are engaging in transactional sex (Singh, 2003; Mishra, 2004; Gangakhedkar et.al., 2007). Additional research further documents that certain migrant jobs, such as heavy load labour (*mathadi* labour) in port cities, which provide higher wages are providing these men who do often reside without wives greater disposable income with which to indulge in risky alcohol use and transactional sex (Kutikuppala, 1998; Saggurti et al., 2008). While residence without wives and access to higher wages facilitates involvement with risky alcohol use and sex for migrant workers, these risks are exacerbated by high density of alcohol and transactional sex venues and locales within migrant male communities (Chakraborty, 2004). Further, migrant men report that peer pressure and monotonous working and living conditions support their involvement in these risky activities as a social norm within the migrant male workgroup (Chakraborty, 2004). Simultaneously, HIV knowledge and risk perceptions are low in this population (Chakraboty, 2004); illiteracy and lack of access to HIV and alcohol education in either their places of origin, or destination, leave these men engaging in these behaviours

without recognition of their risks (Carlier, 1999; Mishra, 2002). These social, contextual and cognitive factors come together to create high HIV/STI rates in this population and to support behaviours among them that bridge these infections to new regions (Gupta et.al. 2002; Thappa et.al. 2002; Singh KK et.al. 2004). These findings parallel that research from Population Council with male migrant workers, showcasing the need for migrant male HIV interventions that addresses the groups and the individuals.

There are studies that have shown that informal workers are significantly at higher risk than general population – their knowledge levels are lower, two[7] to four times more number of informal workers have non-regular partners or visit sex workers, only 25-29 percent use condoms in these encounters – compared to 42 percent by others. 5 percent and 13 percent (M/F) report STI symptoms – nearly double the national average. In another study, 2/3rd of the locations where informal workers operate, sex workers were also found to operate. Studies have also shown evidence that informal workers, are at a higher risk than the general population, to acquire STIs or HIV. The country's National Family Health Survey (NFHS), which covered over 15,576 households, reiterates the vulnerabilities.

In another study in Mumbai[8], operation of sex workers is reported in around 2/3rd of the construction sites and women informal workers reported to work as part-time[9] sex workers. A study carried out by the (United Nation's Development Fund for Women) UNIFEM among Railway workers states that about 44 percent of the respondents had more than one sex partner in the preceding 12 months, 71percent of those who visited sex workers did not use condoms[10]. The Annual Sentinel Surveillance reports spouses of truckers, unskilled workers and factory workers are amongst the top categories of ANCs tested positive for HIV[11]

A study by Population Council[12] examined the patterns of migration/mobility among male workers and their links with HIV risk in four states that have a high HIV prevalence and found that contracted male labourers are largely young (70 percent between 18 to 29 years) and over half were married, and a third resided away from their wives because of work. 31 percent reported sex with either a sex worker or non-spousal unpaid female partner in their places of origin over the past 2 years.

An interesting example is Ganjam (in Orissa state) which is a district where out-migration is substantial to Surat (in Gujarat) which is a migration hub due to its textile and diamond polishing industries. A local member of the Gujarat chapter of the Indian Network of People Living with HIV (INP+), reports that as many as 70 new HIV-infected cases emerge every month in Surat. As was mentioned earlier, a large percentage of the migrants visit sex workers and have unprotected sex. The returning migrants have been fuelling the epidemic in their home district of Ganjam, which has seen a rapid increase in prevalence levels in the last few years, particularly amongst migrants.

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7 Behaviour Surveillance Study of NACO, 2006 and other studies – More on this in sections 4.5.1

8 ILO Rapid Assessment among migrant workers in the construction sector on HIV risk and vulnerability in Raigad district, Maharashtra, 2008

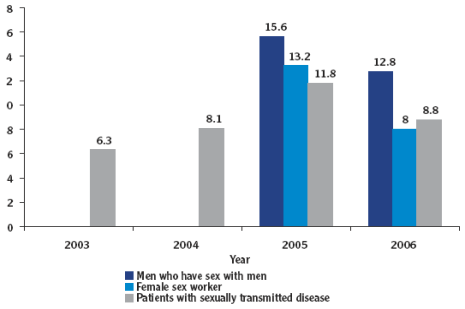
9 Sex work is one of the livelihoods – not the only

10 Shiv Kumar, Julian Joseph, Stock Taking of the Railway-UNIFEM Project on Equalizing Gender Relationship in the Context of the HIV/AIDS Epidemic, 2005 (unpublished report)

11 Annual HIV Sentinel Surveillance Country Report (2006) - Prevalence among antenatal clinic attendees by occupation of spouse, India, 2006. Graph in this page also from same report by National AIDS Control Organization (NACO)

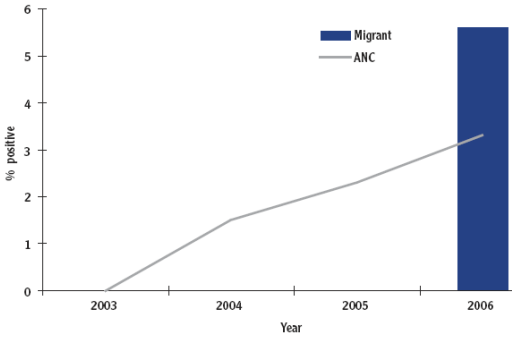
12 Saggurti, Niranjan et al. 2008. "HIV risk behaviors among contracted and non-contracted male migrant workers in India: Potential role of labour contractors and contractual systems in HIV prevention,"

graph below shows the HIV prevalence ıngst high risk groups in Surat.



ɔrevalence amongst groups with high risk behaviour urat, Gujarat. (*Ref: Annual Sentinel Surveillance ırt, 2006, NACO)*

The graph below shows the rising trend of HIV in the general population in Ganjam,Orissa.



HIV prevelance amongst migrants and ANC attendees in Ganjam district, Orissa, 2006 (*Ref: Annual Sentinel Surveillance Report, 2006, NACO)*

The story of Ganjam is not unique – there are several such districts where informal workers migrate for survival and livelihood. Some within their district (rural-urban), some outside their district and sometime outside their state (or even country).

Some of the other links which are emerging are:

- Movement of sex workers between administrative borders
- Sexual behaviour pattern of Male migrants, particularly Men who have sex with men and Injecting Drug Users
- Sexual exploitation of migrant women at transit and destination and those left behind in source

Vulnerability of women: Apart from the biological fact that women are more vulnerable to HIV, for women who are informal workers, their vulnerabilities are related to their work situation (where sexual exploitation is reported). Occasionally, some of the female informal workers also involved as part or full time sex work, many times not using condoms. For women who are spouses of informal workers, they are vulnerable to infections from their husbands ($1/4^{th}$ visit sex workers, $1/4^{th}$ use condoms[13]). Sometimes they are not travelling with their husbands and are in rural areas and are likely to acquire the infection from their husband on their return. If they have other sexual relations, they are also likely to pass the infection to others (as is evident in some of the rural high prevalence districts like Bagalkot).

The male migrants from the poorer parts of the country going in search of work to the more developed parts are now well recognised to be carrying back the infection to their places of residence and contributing to the emergence of hotspots in the low prevalent area. While under the national programme, technical support is available to companies to scale-up interventions for formal workers, it is now increasingly realized that reaching out to informal workers in the high priority areas that requires much more focused effort and outreach, which goes beyond the formal settings.

13 **Consolidated data of KABP studies under taken under the ILO Project in 7 corporate and 7 unorganized sector workers projects (2005-2006)**

An analysis of flow of migrants based on 2001 census data shows that, Uttar Pradesh, which constitutes 41 percent of all out migrants, migration to Maharashtra accounts for 32 percent. Likewise, out migrants from Orissa preferred Gujarat and Maharashtra as the destination even when these states are not border states. Out-migration to these states made up to 34 percent of total out-migrants from Orissa. From the flow matrix, Maharashtra, Gujarat and Haryana attract over 80 percent of all interstate migrants during the intercensal period 1991-2001[14].

In conclusion:

- Highest burden of HIV is amongst migrants, after the High Risk Groups (3.6 %) and ten times that of the general population. There is a clear and increasing evidence of HIV and Migration. Migrants are at risk and need specific and focussed programmes that address the linkages.
- Not all migrants of 314 million migrants are at risk. There is a need to identify the migrant sub-groups that are most at risk for HIV and prioritise interventions.
- There are different kinds of migrants; however those who migrate across state borders, particularly from low prevalence source to high prevalence destinations. These migrants have the highest chance of acquiring HIV and taking it back to the source districts.
- Informal labours (not the formal labour) is more at risk and are overwhelmingly the largest groups (93%). Prevalence levels and services for formal labour is best addressed through work place interventions and currently prevalence levels with this group is lower than informal labour.
- Current interventions are not effectively identifying and addressing the HIV risks. A discrete intervention in source or destination or transit is less than useful (see more in section on response and gaps).

Therefore, inter-state migration (20 % of all migrants) of informal labourers from high migration districts to large developing towns/cities, particularly those in high prevalence states is an important priority. The National AIDS Control Programme will now focus on Source, districts and villages which send large number of migrants to high prevalence states (towns/cities).

14 Internal Migration and Regional Disparities in India, *commu*nity.eldis.org/.59b6a372/Internal%20Migration%20and%20Regional%20Disparities%2

RESPONSE AND CHALLENGES

1. RESPONSE AND CHALLENGES

National AIDS Control Programme (NACP) Phase II had identified Migrants as one of the risk populations to be reached, in order to accelerate the HIV prevention response in the country. In the third and ongoing phase of NACP, the migrants along with truckers are reached out to as 'bridge population' (link between the core transmitter group and the general population).

Interventions amongst migrants and HIV can be broadly classified under:

- Targeted Interventions, led by NACO and SACS
- Non TI migrant HIV programmes, implemented through NGOs
- Work place programmes, addressing unorganized labour

Targeted interventions, led by NACO/SACS:

National AIDS Control Program in India has been implementing migrant interventions since Phase II of the program. Efforts are focused on 8.64 million temporary, short duration migrants who frequently move between source and destination areas. By the year 2010, National AIDS Control Organization (NACO) has been implementing 196 migrant targeted interventions (TI) in 124 districts across the country, reaching out to approximately 1.5 million single migrant informal workers engaged in construction, manufacturing, stone cutting and daily wage agricultural labour.

While the NACO TI guidelines are largely followed by most interventions there are different programmatic strategies used by implementers. Details of the program strategies are given below.

- **Outreach & 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.) and 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) and referral and follow-up system
- **Enabling Environment:** Advocacy with key stakeholders/power structures and linkages with other programmes and entitlements
- **Community Mobilisation:** Building capacity of migrant groups to assume ownership of the programme and having project centers

This model reaches out to men who are both migrants and part of high-risk sexual networks, usually as clients of FSWs or of high-risk MSM.

Non TI migrant HIV programmes, implemented by NGOs

Other Interventions for migrants implemented in India include the AVERT project in Maharashtra supported by USAID, MAMTA led interventions in Uttar Pradesh, CARE led interventions in Delhi and Uttar Pradesh.

i. **Migrant Intervention Models in Maharashtra by Avert Society:** Initiated in 2003, Avert Society implemented 30 migrant interventions in Maharashtra including a source-destination model. They work with construction labour, loom workers and sugarcane workers, using the NACO TI guidelines as reference. Avert's technical strategy includes use of data to prioritize districts (mapping and need assessment), making district the basic unit of organization for planning and implementation of migrant program and use the lessons learned for further segmenting of high risk migrants.

ii. **The source-destination intervention** of Avert involved migrants from Tirunelveli (Tamil Nadu) to Dharavi (Mumbai). The strategy at source included tracking migrants in the district, intervention among migrants in the villages and on the trains from Tirunelveli to Madurai (3 hrs) and sharing information on the migrants with the NGO at destination. While the intervention at destination included intervention in Pongal houses (short stay houses) ,intervention among incoming migrants in the trains from Pune to Mumbai, establishing DIC (BCC, recreation, counseling, etc), train Peer Leaders among migrants, linkages to STI/VCT services, establishing Condom outlets and developing IEC materials in Tamil. This intervention was subsequently handed over to Mumbai DACS.

iii. **REVAMP: Reducing Vulnerability of AIDS in Migrant Populations (REVAMP)** is a CARE India initiative, in partnership with NACO, in the states of Uttar Pradesh and Delhi spanning nine districts for reaching out to 100,000 migrants over three years. This model followed the NACO TI intervention model with an added component of documentation and dissemination.

iv. **HAMARA-HIV-AIDS and Migrants of Rajasthan:** A source-transit-destination model demonstrated by the erstwhile ICHAP in Rajasthan. It was a program in Shekhawati region of Rajasthan for rural out-migrants and families which involved risk reduction and services at origin, transit and destination points (especially Gujarat and Mumbai). It covered 30,000 migrants, 24,000 migrant's wives, 6,000 potential migrants in 133 villages at district of origin and 4,500 migrants in Ahmadabad and 3,000 in Mumbai. Its key features were that a biological and behavioral baseline was conducted; inter-state MOU was signed defining roles, responsibilities and coordination; NACO's role found to be crucial to facilitate inter-SACS cooperation. It is found to be a cost effective model.

v. **Reaching Across Borders (RAB): HIV Prevention, Care and Treatment for Nepali Migrants at Source and Destination Communities in Nepal and India by Family Health International (FHI):** Annually, an estimated 600,000 to 1.3 million Nepali migrants travel across the Indo-Nepal border in search of better economic opportunities, and an estimated 400,000 go to Mumbai often without their families (UNGASS National Report, Nepal, 2005). Migration from low prevalence source to high prevalence destination was a factor that was addressed and early detection and intervention at destination was stressed upon. Tracking of partners and using social networks (Buddy system) were some strategies used.

Work place programmes, addressing unorganized labour

A Trade union-led intervention model amongst migration workers in the construction sector: International Labour Organisation (ILO) supported initiative involves the trade union and has an element of cost sharing. This project is implemented through the Nirman Mazdoor Sanghathan, in 15 sites in Panvel in Raigad district of Maharashtra amongst the construction workers. The project planning involved mapping to identify sites/locations of migrant construction workers (place of origin and size of population), KABP study to assess the level of risk for HIV infection among the migrants and conducting stakeholder analysis (the stakeholders included Builders, Contractors, Mukadams, union/NGOs). Involvement of PLHIVs as Peer Leaders and outreach workers**,** referral linkages with government and private health care facilities for ICTC, TB and ART, Builders contribution on heath camps/ Child Centres and condom social marketing were some key features of the model.

The key lessons from this model were that the Unions can facilitate the access of workers to public health schemes. Government insurance/welfare schemes of the labour department, supporting the workers in getting compensation from contractors in case of accidents and getting employer's/contractor's contribution in project's activities. HIV intervention also helps unions to organise the unorganised workers. It was also realised that strong capacity building effort is needed for unions in the initial years but they can play a major role in national HIV/AIDS response.

	Migrants (Pop council study)		BSS - Overall (2005)			
	UP	AP	UP	AP	India	
% who have had sex with sex worker (last 12 months)	9.2	32	1.5	19	2.4	
% condom used with sex worker	85	48	48.4	82	80.9	
% had sex with non-regular sex partner (last 12 months)	4	34	5	15	5.8	
% condom used with non regular sex partner	32	25	48.4	58.4	58.3	
% reporting STI like symptoms in last six months	27	62	6.6	5.9	5.1	*
% reporting sex with women (other than spouse) in place of origin	31	32	9.2	21	8.9	#

* BSS indicator: Percentage of respondents who reported genital discharge or genital ulcer/sore or both in last 12 months by residence and gender

\# BSS: This is men reporting sex with non regular sex partner

Punj Lloyd's Corporate worksite intervention titled 'Life Enrichment Program': The Life Enrichment (LE) program was implemented in three constructions sites of Punj Lloyd in India; that covers the northern (Panipat in Haryana during August 2008-May 2009), western (Baroda in Gujarat during October 2008 - February 2010) and eastern (Haldia in West Bengal during October 2008 - November 2009) regions. The components of the program included the provision of on-site medical facilities, intensive communication and counselling, courses on nutrition and yoga, condom promotion and the adoption of a peer educator model to provide education on important health issues such as substance abuse, sexual and reproductive health, including HIV/AIDS, and tuberculosis. 'Mentors' and 'Ambassadors' were identified among the management personnel at each site, while 'Peer Leaders' (PEs) and 'peer coordinators' (PCs) selected from workers and junior level staff led the communication and behaviour change efforts among peers. Together, the management of the company and the workers demonstrated the commitment to support the objective of making the workplace environment a safe area for all. Findings from the evaluation suggest the appropriateness of LE program stems from the fact that it was not only about HIV prevention education, but covered a range of issues related to the lives of the workers such as safety, occupational health, hygiene and prevention of related health problems. The findings indicate that improvements in knowledge about safety, hygiene, diseases caused by an unhealthy life style, HIV and sexually transmitted infections were noted. The differences on awareness about HIV indicators for workers from intervention sites and control sites were statistically significant. There was a significant reduction in the incidence of sickness, malaria/dengue, minor and/or major accidents, agitations/strikes and these improvements were much more visible for workers in intervention than the control sites. Additionally, greater improvements were evident within intervention sites than the control sites in indicators such as regular briefing on safety, communication between workers and management, satisfaction with overtime value (Population Council, 2010).

Key lessons learnt and gaps identified:

The various models and efforts in the country during the years 2004-2009 have generated good knowledge and learning in planning of programmatic strategies for migrant interventions. Some of the critical lessons learnt and gaps identified from the past interventions are:

1) **Destination only interventions are insufficient:** The National Programme focuses on migrants only at the destination. This is insufficient for the following reasons:

   a. Spouses of migrants, particularly those who are in source are left out of the interventions. It is not that only the +ve migrants return home and they are the only ones who are infected; unprotected sex amongst non-regular partners, particularly migrants and their spouses is one of the key reasons why the low prevalence source districts have rapidly become high prevalent.

   b. Migrants who buy sex also buy sex at home (rural sex workers) and have other partners at source. Given that about 30-50 % of all sex workers in a district operate in rural areas and the sex work at source and the interplay with buying behaviour of migrants. As the Population Council study on single male migrants in four high prevalent states reveal, the migrants have casual sex networks even at the source which does not get addressed when intervention is focused only in the destination areas.

   c. Most migrants who are infected, when they are sick, tend to return to source – for rest, recuperation and recovery. Follow up for Treatment, Care and support needs (STI, ART, OI, PPTCT) is critical for these migrants, particularly keeping in mind positive prevention.

   d. Some of the women left-behind at source areas too engage in sex with other men in the communities for variety of reasons such as poverty, social dependency on other men for work outside the villages, loneliness as husband is away, and victims of sexual exploitation by the family relationships or return migrants. These women are totally ignored, if the interventions are implemented in only destination areas.

   e. With no source–destination link in interventions, follow up of high risk cohorts has been a challenge.

   f. Intervention in select source districts, particularly those which are low prevalent, high migration will cost about 25 lakhs per annum. Compared to this, cost of a district wide prevention and care initiative could be between 60 Lakhs to 120 lakhs per year (Ganjam and Bagalkot). Hence working at source (not all, but select), is cost effective; otherwise the district will have to spend 2.5 to 5 times more money; not including the human costs.

2) **Client based strategy instead of focused migrant worker interventions has several disadvantages including lack of reach to several at-risk migrant workers:** There are many reasons why addressing migrants as clients of female sex workers does not work. Firstly, in Indian sex work setting, client strategies have had very limited success. The reasons for this is not the lack of trying –it is impossible to differentiate clients (like migrants), based on occupation – simply not practical. Given that the main sex work settings are street and home based, it is difficult to reach and work with clients in these settings - time for intervention is limited, clients many times inebriated (> 50%) and there is usually no safe space for the clients to interact.

   Not all high risk migrants buy sex from brothel based or typical sex work settings. For example, a study from Population Council (Saggurti et al., 2008) indicates that 38% of the migrant workers reported at the last sexual encounter with a non-marital sex partner. Only one in six men (17%) reported sex with a sex worker in the past year; 12% reported sex with multiple sex workers in the

past year. Almost one-quarter of men (24%) reported sex with a non-spousal, unpaid female partner in the last year; 9% reported sex with multiple non-spousal, unpaid female partners in the past year. The data from the Population Council study and other studies indicate that between 65 and 90 percent of those men who have sex outside marriage do not buy sex. And not all those who buy sex are single male migrants. There are other risks for migrants – unprotected sex with non-regular high risk behaviour amongst migrants (non-paid) – 4-53 % of Migrants have other sexual partner than spouse, in source and destination.

The men who have sex with men (MSM) relationships and individuals with IDU use amongst migrants will not be addressed through client of female sex worker strategy.

3) **Single male migrants:** The notion that single male migrants are the ones at higher risk has been debunked; there is no significant variation in buying behavior of sex by males, whether they are married or not. Given this, migrant interventions need to address high risk migrants – irrespective of their marital status.

4) **Focus and Prioritization:** Migrants in the country are much more dispersed and are difficult to reach, requiring great investment and resources. A current intervention, particularly by the National Program, lacks processes for prioritization of migrants with highest risk to HIV. Given the resource crunch the need is high to identify appropriate structural systems and groups among the migrants that have the highest risk to the epidemic through formative research process.

5) **Lack of Integration with Treatment and Care Service:** Intervention models among the migrants did not adequately address the comprehensive treatment needs of primary stakeholders. STI/ICTC uptake and referral is poor and stand alone HIV services are not received well, therefore there is a need for building strong links, referrals and information sharing.

6) **Weak Focus on Female Migrants and Spouses of Male Migrants:** Apart from the biological fact that women are more vulnerable to HIV, for women who are informal workers, their vulnerabilities are related to their work situation (where sexual exploitation is reported). Occasionally, some of the female informal workers are also involved as part or full time sex worker, many times not using condoms. For women who are spouses of informal workers, they are vulnerable to infections from their husbands (1/4th visit sex workers, 1/4th use condoms[15]). Sometimes they are not travelling with their husbands and are in rural areas and are likely to acquire the infection from their husband on their return.

Key Learning and Suggestions for Way Forward, endorsed by the National Consultation on Migration and HIV in October 2009 is:

- Comprehensive intervention design to address migrants at source, transit and destination is key to prevention outcomes in the community.
- Prevention to care continuum approach at source and destination.
- The intervention areas will have to be identified carefully so that the resources available are used optimally.
- Focus on capacity building and system strengthening at all levels.
- A standardized procedure (without undermining flexibility) for implementation is needed to ensure the interventions maintain certain level of quality.
- Involvement of the stakeholders, the contractors, builders etc is important and should be a key delivery model. Appropriate advocacy packages and mechanisms for their involvement will need to be spelt out.

15 Consolidated data of KABP studies under taken under the ILO Project in 7 corporate and 7 unorganized sector workers projects (2005-2006)

- Being a seasonal phenomenon, the migrants to be targeted may or may not come to the same destination points; therefore sometimes it is cost effective to reach at source.
- Spouses of migrants who do not travel with their partners cannot be reached by destination strategy.
- Many of the poorest migrants working in construction industry are spread out in destination points or working and moving on the highways. They are unlikely to be reached through destination strategies, which focus on 'single male migrant aggregations'.
- Migrants are spread out across a large number of towns and the destination strategy cannot reach to all the towns.
- A client of sex worker strategy has limitations for the following reasons:
    - Reaching clients in Indian sex work settings has been challenging, given the sex work environment and role of police. Clients accessing services of sex workers, be it street based, brothel based or home based, prefer a quick entry and exit from the place of sex work (unlike in some countries where the pickup points are bars). Reaching out with BCC and condoms other than through sex workers has had serious limitations.
    - Unprotected casual sexual partnerships of male and female migrants are unlikely to be addressed.
    - Segregating clients as migrants and non-migrants is not feasible

POLICY, PRINCIPLES AND APPROACHES

2. POLICY, PRINCIPLES AND APPROACHES

While HIV and AIDS is a significant health issue, and the migrant population in the country (314 million) being a large sub-segment, it calls for a nuanced and cost effective policy and strategy, which is based on evidence and which addresses risks and vulnerabilities in an informed and strategic manner. This chapter not only lays out the Policy but also the Principles and Approaches that will be followed. It builds on existing knowledge, which in the past 5 years, has been growing.

1. **Definitions:**

   Migration: 'Migration' is the spatial mobility of people from one geographical area (place of origin) to another (place of destination), with the intention of settling temporarily or permanently or semi-permanently. There are a variety of reasons for migration - economic (livelihood, economic imbalance, job opportunities etc.), environmental factors (drought), demographic reasons (family migration, movement of young and retired persons) or political reasons (refugee movements etc.). Some of these are factors are related to origin (push factors) and others opportunities in the place of destination (pull factors).

   Mobility: Mobility is a construct where a person moves from the place of origin, travels substantial distance and returns back to origin the same day or week (for example people who live in Pune and work in Mumbai or truckers).

   Migrant: For the purposes of HIV and Migration, People who seek better livelihood and move from their place of origin in rural areas (source) to a town or city (designation), with the intention of settling temporarily or semi-permanently and return back to their origin for up to 3-6 months.

   Source: Source is the origin or place of permanent residence which the migrant not only calls home but returns to on regular intervals of once or more number of times every year.

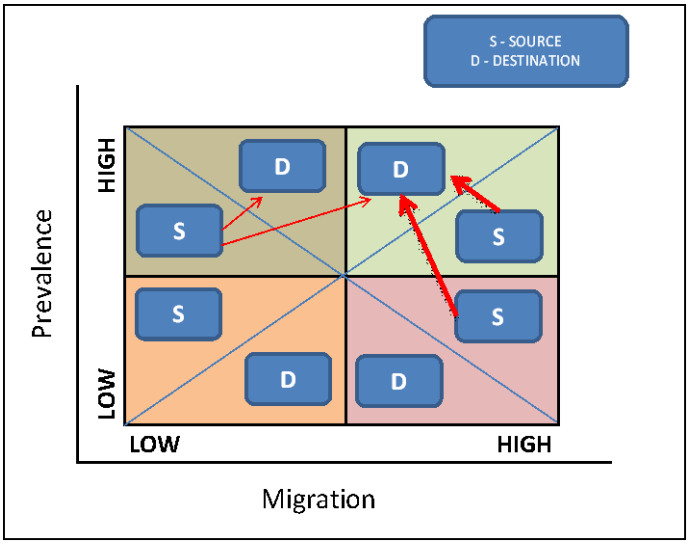
   Transit: Key towns and cities which are temporary halt points (few hours to days) for migrants who are on the way to the destination. Usually they do not work here but are only waiting for further journey.

   Destination: Is the place where the migrant seeks to reach to pursue their intended livelihoods. In many cases work and stay are nearby or within the same town or city. In some cases the stay and work may be far off (greater than 30 K M) and sometimes mobile (road construction, intercity cable laying)

2. **Focus on Migrants:** There are 314+ million migrants in India and not all are at the same risk of acquiring HIV. Given the various typologies of migrants and the differing prevalence levels, the endeavour is to seek to keep the low prevalence districts low by interrupting the transmission from the high prevalence towns/cities to the low prevalent districts. It is also important to focus on informal laborers, more than blue collared workers or formal workers as clearly their vulnerabilities are many fold and their knowledge levels, practices (sexual behavior, health seeking) amongst the poorest. Rural interventions are 3-10 times more expensive than Urban. General population interventions are even more. Given this it is important to interrupt the urban-rural transmission, particularly from urban high risk groups (which have the highest prevalence) to rural migrants. Given these factors and evidence in the first chapter, the National Programme has now two priorities:

Stage I: Inter-state rural to urban, informal laborers moving from high volume migration, high & Low prevalent districts to high volume destination, with high prevalence of HIV. Formal workers who migrate and work in formal sectors will be addressed through work place programmes which are already rolled out.

State II: Intra state, inter district migration, from rural to urban, by informal laborers. This could be from high or low prevalence districts, but those moving to high prevalence destinations (within the state. Special groups such as trafficked women, detained immigrants and other groups that maybe identified as vulnerable will also be addressed.



Poverty, illiteracy and other key determinants of human development should also be critical factors that could be used for filtering and focusing migrants who are the most vulnerable and need intervention support. Poverty and illiteracy are major challenges that prevent access to treatment and information services and increase the risk of HIV.

3. **Evidence based:** The links between Migration and HIV have emerged over time and the National Programme has made attempts to be responsive to this emerging evidence. This said, much more evidence and learning is required and these need to shape the current policies and the principles and approaches. Hence, the Policy will be agile and will ground truth itself over a period of time. To this end, strong Strategic information, including Monitoring and Evaluation, Outcome Studies and Operations research will continuously inform the policy, strategy and field tactics.

4. **Comprehensiveness:** In the past, migration and HIV was addressed only in the destination, through low impact programmes, with no links to the source. The vulnerabilities at the source (spousal transmission, local sexual networks that quickly fuel the rural epidemic, vulnerabilities of the high risk groups in rural areas) and the part time presence of migrants in the source, entails addressing HIV only the destination is insufficient. Addressing migrants only as clients of sex workers also have severe limitations – client strategies have been difficult to implement in the current sex work environment, not all migrants are buyers of sex but have other partners within migrants and others, some of the migrants are MSMs and IDUs and increased exploitation of women who are migrants (for transactional sex). Increasing, but much lesser evidence emerging from transit points indicate vulnerabilities of migrants and also opportunities for messaging to migrants. Given these, there is a need to have comprehensive interventions, which differentiate high risk migrants who are addressed at the source, destination and transit. These interventions will not be discrete but connected up, sharing information and referrals and ensuring tracking of migrants and follow up.

5. **Flexi-options at intervention level:** Given the diversity - cultural, social, educational and economic variations within the country, one size (re design) fit all will not work. Therefore the project implementation design and technical components for the migrant strategy will ensure adequate flexibility to address local variation and needs, while maintaining strategic intent and consistency. This will guarantee more effective outcomes on the ground and better impact on

the epidemic. Budgeting flexibility will also be provided and certain innovation components will be incorporated particularly for strategies in the transit point, where no experience is available in the country. A protocol has been developed which will inform the intervention delivery model decision making, both at the source and destination.

6. **Linking and piggy-backing:** The policy for Source interventions will not be to put up specific interventions for addressing migration and HIV alone; but to link and piggy back with existing health and / or livelihoods. This will ensure cost effectiveness and speed of set up and maximization of reach. Only where there are no interventions to link or piggy-back will source / transit destinations are set up as separate interventions. Blocks / villages where such a requirement is expected to be low.

   For provision of services, in source, transit and destination, particularly STI treatment, ART, ICTC and PPTCT, the programme will not replicate these services but effectively link and follow active referral mechanism. Linkages also will be built with existing health care providers both in the private as well as public sector for treatment of STIs and other diseases among the migrants. Wherever Social Marketing Organizations (SMO) is found to operate, project will be linked up to ensure uninterrupted availability and accessibility to condoms for migrants whether it is at source, transit or destination. Linkages also will be established with various government departments and programmes such as Department of Rural Development, ICDS, PDS, NREGA, NRHM, LSG etc to ensure better access to migrants for social protection as well as welfare schemes available in the country. For this purpose a detailed mapping of key departments, programmes and service providers will be made as part of Situational Assessment Study.

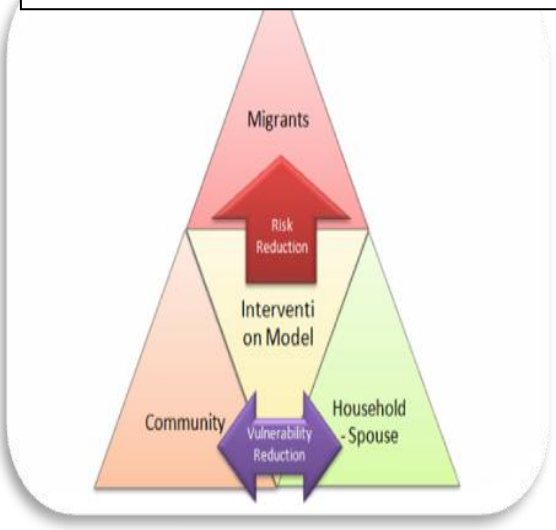
7. **Addressing Structural Factors:** In order to ensure the right environment in the country that would facilitate effective implementation of the services for the migrant labourers, policies, systems and guidelines will be reviewed and updated addressing the needs of the community. Wherever the policies and systems are proving to be an impediment for effective delivery of services, such instances and experience will be carefully examined and studied and would feed into processes for influencing changes in policies and systems at the country level.

8. **Sectoral Focus in destination:** Migration interventions in destination will not be of one type, but based on geography, dispersion of migrants and type of industry. Hence the following typologies of destination are envisaged:
   i. Heavy industry, with or without ancillary industries, with high concentration of migrants
   ii. Small and Medium Enterprise (Dense or Spread out Migrants Volume)
   iii. Labourers – Spread out across the City (e.g. Construction, Hotel Services etc)
   iv. Agricultural Labour (Seasonal – Dense Migrant Volume during season)
   v. Others – combination of any of the above or other typologies, requiring special design

9. **Social Mobilization and Community Participation:** Key thrust and focus of the implementation would be to ensure maximum participation of the migrant community in the delivery of the program. Community leaders, particularly Mukkadams and migrant opinion leaders will be identified early on in the project and will be made to participate in the delivery of services as well as in monitoring and managing the program. Wherever possible community mobilization strategies such as linkages with SHGs, micro credit, micro finance and micro enterprise will be introduced through linkages with existing programmes. Thus a focused effort toward community participation and sustainability of program services will be initiated right from the beginning of implementation.

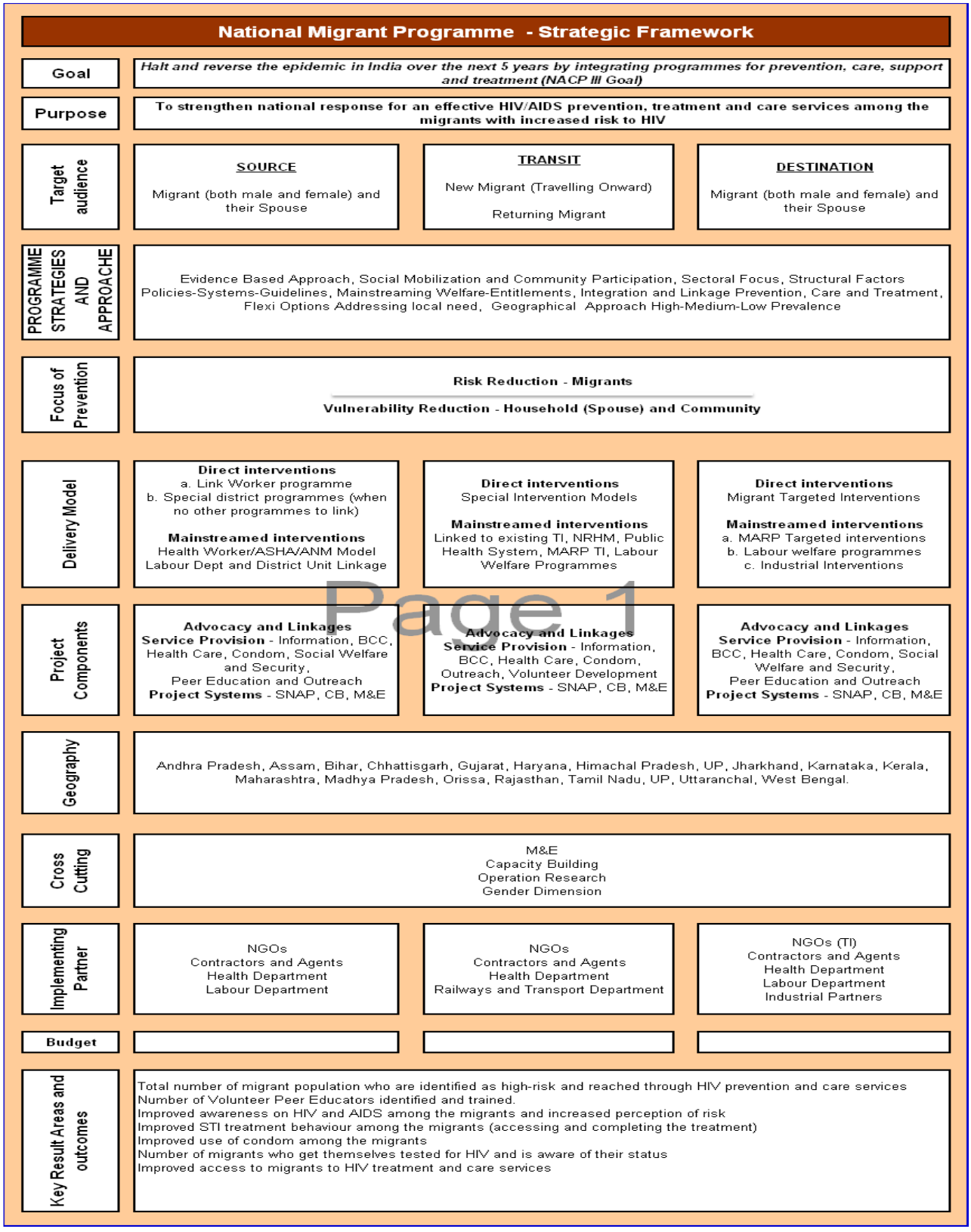
10. **Risk and Vulnerability**: While designing the intervention model, it is critical to evolve strategies addressing both risk and vulnerabilities. Therefore while the proposed strategies in this document would focus on addressing high risk behaviour of migrants, decisive efforts will also be made to reach to the spouses of migrants as well as to the community in which the migrants live both in the source and destination sites.

Figure No. 3 Risk and Vulnerability Reduction



11. **Gender:** Engendering strategies is critical for success of the migration and HIV strategies - Evidence from various migrant interventions across the country show that the focus on risk of female migrants and vulnerability of spouse of male migrant is a weak link in the programme. As seen earlier, there is enough evidence in the country that emphasize the vulnerability of female migrants and that of the spouses of male migrants to HIV. There is risk within the work environment due to exploitation, there is a practice of part time sex work among female migrants reported and there is heightened vulnerability to female partner of male migrants who do not travel but are infected due to risky behaviour of male partners. This strategy document has a focused attention on addressing gender related issues and migration in the context of HIV.

3. NATIONAL MIGRATION FRAMEWORK



National Migrant Programme - Strategic Framework

Goal	*Halt and reverse the epidemic in India over the next 5 years by integrating programmes for prevention, care, support and treatment (NACP III Goal)*		
Purpose	**To strengthen national response for an effective HIV/AIDS prevention, treatment and care services among the migrants with increased risk to HIV**		
Target audience	**SOURCE** Migrant (both male and female) and their Spouse	**TRANSIT** New Migrant (Travelling Onward) Returning Migrant	**DESTINATION** Migrant (both male and female) and their Spouse
PROGRAMME STRATEGIES AND APPROACHE	Evidence Based Approach, Social Mobilization and Community Participation, Sectoral Focus, Structural Factors Policies-Systems-Guidelines, Mainstreaming Welfare-Entitlements, Integration and Linkage Prevention, Care and Treatment, Flexi Options Addressing local need, Geographical Approach High-Medium-Low Prevalence		
Focus of Prevention	**Risk Reduction - Migrants** **Vulnerability Reduction - Household (Spouse) and Community**		
Delivery Model	**Direct interventions** a. Link Worker programme b. Special district programmes (when no other programmes to link) **Mainstreamed interventions** Health Worker/ASHA/ANM Model Labour Dept and District Unit Linkage	**Direct interventions** Special Intervention Models **Mainstreamed interventions** Linked to existing TI, NRHM, Public Health System, MARP TI, Labour Welfare Programmes	**Direct interventions** Migrant Targeted Interventions **Mainstreamed interventions** a. MARP Targeted interventions b. Labour welfare programmes c. Industrial Interventions
Project Components	**Advocacy and Linkages** **Service Provision** - Information, BCC, Health Care, Condom, Social Welfare and Security, Peer Education and Outreach **Project Systems** - SNAP, CB, M&E	**Advocacy and Linkages** **Service Provision** - Information, BCC, Health Care, Condom, Outreach, Volunteer Development **Project Systems** - SNAP, CB, M&E	**Advocacy and Linkages** **Service Provision** - Information, BCC, Health Care, Condom, Social Welfare and Security, Peer Education and Outreach **Project Systems** - SNAP, CB, M&E
Geography	Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, UP, Jharkhand, Karnataka, Kerala, Maharashtra, Madhya Pradesh, Orissa, Rajasthan, Tamil Nadu, UP, Uttaranchal, West Bengal.		
Cross Cutting	M&E Capacity Building Operation Research Gender Dimension		
Implementing Partner	NGOs Contractors and Agents Health Department Labour Department	NGOs Contractors and Agents Health Department Railways and Transport Department	NGOs (TI) Contractors and Agents Health Department Labour Department Industrial Partners
Budget			
Key Result Areas and outcomes	Total number of migrant population who are identified as high-risk and reached through HIV prevention and care services Number of Volunteer Peer Educators identified and trained. Improved awareness on HIV and AIDS among the migrants and increased perception of risk Improved STI treatment behaviour among the migrants (accessing and completing the treatment) Improved use of condom among the migrants Number of migrants who get themselves tested for HIV and is aware of their status Improved access to migrants to HIV treatment and care services		

OPERATIONAL GUIDELINES

4. PROGRAM COMPONENTS

4.1 PROGRAM SET UP ACTIVITIES

National:

A. Identification of Migration Corridors and Geography for Intervention.

Key migration corridors for male and female migration in the country have been already identified through an internal exercise in NACO and key states for source, transit and destination interventions have been identified based on Census 2001. Details of the identified geography (States and Districts) are provided in the Annexure -5.1. This can be used as a reference to finalise the districts for intervention by State. States can propose additional districts based on clear evidence from different sources.

B. Project Initiation

SACS will be provided details of the migration corridors in which ever state it is relevant. This will be undertaken through a project initiation workshop cum training that will be organized by NACO centrally. This will be training cum workshop for the nodal officers (JD- Joint Director/DD- Deputy Director/AD- Assistant Director TI) from each of the state SACS. Each state also will finalize their Project implementation plan based on the data provided for the state on migration. Outline of the workshop content and agenda is given in the Annexure 5.2.

C. Procurement Support

NACO TI Division will take the lead in preparation and procurement support for products and consumables that needs to be centrally distributed. Special attention needs to be given in getting ready the BCC kit, procurement and supply management for condom, STI drugs etc. NACO TI division will link up the migrant program to these services within NACO and SACS, and ensure regular supply of kits and other consumables to the field.

State Level

SACS with the support of the NACO TI Division will implement the migrant prevention package within the selected districts in the state. Once the state officers (JD/DD/AD TI) are trained by NACO through the centralized training, they will get back to the state and initiate the implementation of the migrant interventions as per the guideline. NACO TI division will continue to provide support to SACS to initiate the implementation process including preparation of a comprehensive implementation plan at the state level.

A. State Level Project Implementation.

Based on the plan prepared during the centralized training, migrant intervention implementation in the state will be initiated. Given the migration scenario in the state, SACS with the support of TSU and NACO TI Division, will further work on the implementation plan providing all the needed details.

Following are the key steps in State level implementation of migrant interventions:

Step 1: Mapping of migrant geography within the selected corridors of migration

Based on the analysis of secondary data from Census, ICTC, ART, HSS and other studies on migration pattern in the state, high volume blocks/areas and clusters of villages within corridors of migration (given in Annexure 5.1) will be identified to initiate the interventions. Mapping analysis will be initiated with the support of the lead agency in districts which are under LWS. This will also capture the following data:

For Source Districts:
Initial consultation with different stakeholders at district and block level as well as Mapping will identify high volume and high HIV prevalence blocks and cluster of villages in the source districts for program implementation. In addition to the areas, the consultation will also identify the NGOs or CBOs working with migrant populations (or) other high risk population groups on HIV prevention, areas that has Link Worker Scheme, other resources within the source districts such as livelihood promotion, women empowerment, poverty alleviation etc. In addition, the consultation and mapping shall also identify the resources or individuals within sources which/who could be used as implementing agents.

For Transit Locations:
For each corridor of migration, the consultation and mapping will identify the locations or routes that migrants take to reach preferred destinations within state or outside state. It is essential to identify the bus stations, railway stations and other public infrastructure that is used by individuals for travel within each corridor. The mapping shall also understand in those transit points (or) locations, the feasibility of implementation of interventions and identify the resources that can be used for program implementation (such as places where provision of condoms could be best placed, STI clinic, information centres, etc).

For Destination Interventions:
The destination sites mapping in each corridor of migration shall assess the locations for interventions including the sector / industry where large number of migrants congregate (or) reside. Identify the locations that have highly mobile populations' in particular economic sectors. The mapping in destination areas should also assess the occupations where large number of migrants working, prioritise the occupation types where the HIV risk behaviors are high and identify the groups who have been working in destination areas from particular district (outside or within the state) or language. The occupation categories for mapping could include construction workers, daily wage workers, fishing workers, different types of industrial (mining, tobacco, cotton, diamond, etc.) workers, agricultural labourers, etc. The mapping in destination areas shall also list the structural systems available within the areas in order for implementation of the program. For example, in any prioritized economic sector within the destination areas, all the contractors/agents (or) contract systems (or) health system (or) any other formal systems to implement the intervention.

Additionally the above information can be further build upon during the course of implementation by sharing of data between source and destination.

Step 2: State level migrant intervention implementation plan

The final plan, at this stage, will clearly include:

- The geographies to be covered in the state (District and Blocks, villages) and the resources for implementation of the program
- Number of interventions required (number at Source, Destination and Transit)
- Information on different existing NGO programmes to decide on the delivery model
- Finalized delivery model for each of the interventions in the state (to be selected from the options given under the chapter on delivery model in this document)

B. Selection and Contracting of the Implementer

Based on the options available within the delivery model, the organizations will be selected by SACS following the NGO hiring and procurement protocol of NACO. Details are available in NGO-CBO Guidelines for NACP-III.

Implementation Level

Once the implementing partner (whether it be an NGO (or) union/trade (or) private industry) is selected, following are the key steps that are suggested for initiating and setting up interventions at source, transit and destination. For already existing organizations that are implementing Link Worker Scheme or any similar scheme in the village certain steps will not be applicable.

1. **Recruitment and Office set up:** The selected implementing partner will initiate setting up the office and recruitment of the staff. This step will only be partially relevant for organizations already implementing programmes in the locality at source districts. Additional field level staff and some program cost needs to be added in the source districts to reach to return migrants, active migrants, potential migrants and spouses of migrants.

2. **Induction of staff:** The staff recruited by implementing partner will be inducted into the program through a formal induction package prepared for the purpose. The induction training will be done at two levels.
    a. Regional level induction of key staff from the implementing partner by the regional NGO. This training will be organized through a training of trainers (TOT) approach.
    b. Implementation Partner level induction training for all the staff recruited by the implementing NGO. This will be done through the TOTs trained at the regional induction and the training will be organized by the implementing partner.

Detailed capacity building plan is given in the chapter on capacity building.

3. **Rapid Assessment**: Once the staff and infrastructure is in place the first activity that will be implemented would be the Rapid Assessment with a focus on identifying the following:
    - Estimated number of migrants in the area (out migrants, in migrants, returning migrants, spouse of migrants etc)
    - Understanding extend of risk through assessment of sex behaviour, condom use, STI prevalence etc (destination)
    - Map out key hot spots especially in destination areas – the places where the migrants congregate and can be accessible for meaningful group sessions.
    - Identify local sex networks including their size, distribution and mobility
    - Identify local service providers and other programmes including TIs working with HRGs
    - Identify key stakeholders and particularly the contractors (or) agents (or) unions (or) contract systems
    - Migration pattern of the informal labour including seasonality, volume and related power brokers like labour contractors, unions
    - Key service providers and accessibility
    - Stakeholder analysis (at source and destination)

Detailed steps and process for mapping is available in the Annexure 5.3.

4. **Project Planning:** The findings from the Rapid Assessment will be used to prepare micro plan for implementation of the project at source, transit and destination corridor. This would cover outreach strategies and plan for service delivery, linkages, involvement of existing structural systems including contract systems of work and contractors, stakeholder management plan, coordination between SACS, linkage between source, transit and destination etc.

5. **Establishing Project System:** The implementing partner will establish key project systems such as: Planning, Monitoring and Evaluation, Documenting and Reporting, Stock Management, Financial Management etc.

6. **Key Linkages:** the implementing partner will establish key linkages which are critical at the start up and continuation phases of the project. This would be based on the stakeholder management plan. The key linkages of the migrant interventions will be made with other TI programs, health systems, support services, ICT centres for HIV testing and counselling, ART centres for treatment and care and livelihood entry points for women, etc.

SOURCE INTERVENTIONS

This chapter describes in detail key intervention strategies for reaching to migrants within the migration corridors: Source, Transit and Destination. As in the migrant interventions there is no standard approach that one can use, the key principle is that this chapter provides guidance and options that implementing organisations can use for program planning and implementation. However, the program implementation in any approach shall include the key components as per the guidelines of NACP III and they include: STI case management, Condom supply and distribution, BCC campaigns.

4.1.1 SOURCE INTERVENTION:

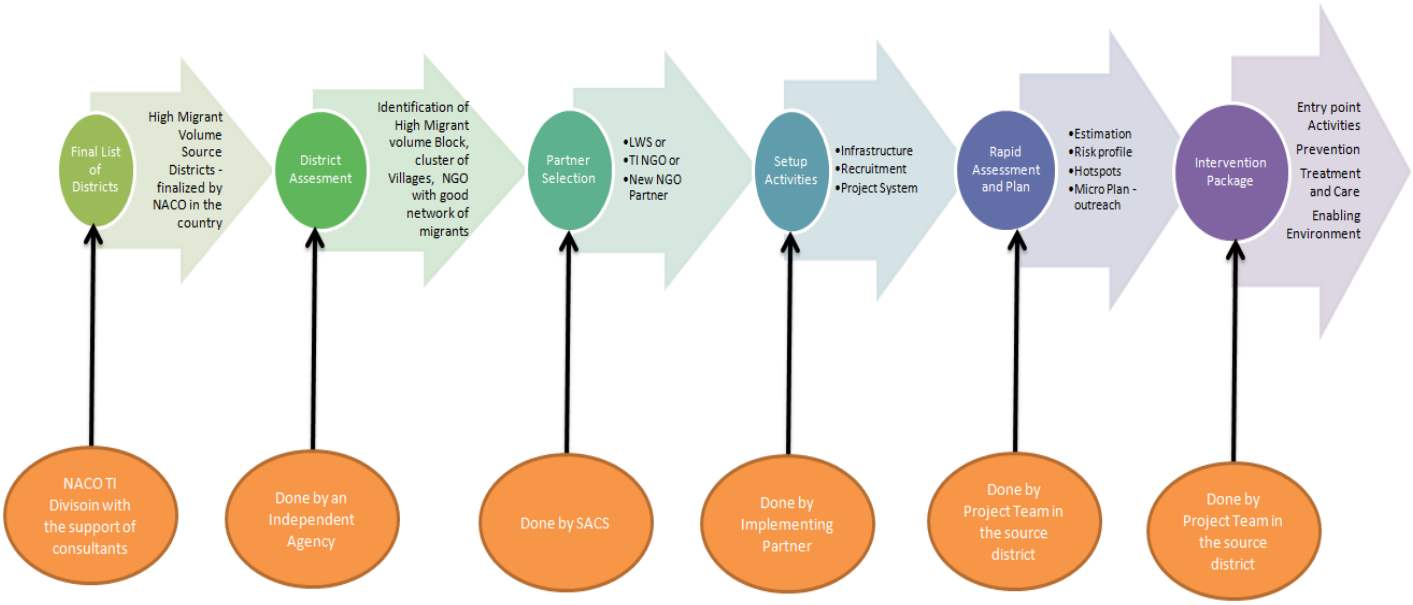
4.1.1.1 GEOGRAPHY

The given table highlights the key states in the country that have the districts with highest out migration pattern (as per the Census data of 2001) and ANC HIV prevalence of more than 1 % during the last 3 years of HIV Sentinel Surveillance.

States	No. of districts having high out migration	No. of districts having ANC prevalence more than 1% during last 3 years	Volume of migration (Source: Census,2001)
Andhra Pradesh	17	14	20,66,272
Assam	2		1,16,356
Bihar	12	5	1,270,893
Chhatisgarh	9	3	762,686
Gujarat	8	0	704,826
Jharkhand	6	2	398,751
Karnataka	21	20	18,89,423
Madhya Pradesh	14	3	1,028,146
Maharashtra	27	24	37,97,603
Orissa	11	2	737,989
Rajasthan	9	3	864,531
Tamilnadu	7	1	4,43,015
Uttar Pradesh	32	4	2,959,650
West Bengal	15	0	1,228,250
Total	190	81	9955722

Source intervention will primarily focus on districts within states given in the table initially, until country has updated data on migration through the studies planned (or) 2011 census data are available. Additional districts may be proposed by the State, however the data need to be based on enough evidence from a credible source indicating that the districts fall in the category of high out migration and has significance from HIV programme point of view. Details of the districts within each of the states are available in the **Annexure** 5.1.

4.1.1.2 IMPLEMENTATION STEPS



4.1.1.3 DELIVERY MODEL AT SOURCE:

Unit of intervention: The unit of intervention will be at identified villages with high out migration in identified districts and blocks. It is assumed that one unit of project will cater to maximum of 25-30 villages spread across 5-6 blocks – assuming an annual out migration of 50,000 or more including seasonal migration.

Direct Intervention:

a. **Through existing Link Worker Program**: NACO is already implementing the Link Worker program in the high prevalent districts in the country with a focus on risk reduction in the rural areas for prevention of HIV. LWS also targets potential and outgoing male migrants, adolescents, women in women-headed households, Youth population, hence it would be ideal that the LWS also emphasizes the issue of Migration and HIV in their activities. Such an integrated approach will ensure rapid scale up and effective implementation. Additional resources will be provided to the NGO implementing the link worker program also to reach out to the migrants and spouses of migrants and their community with HIV prevention messages and services. The existing staffs will be trained on module related to Migration and HIV, so that in their outreach activities the migration component is prioritised. In addition to the existing reporting mechanism, additional formats to segregate the components of migration will be implemented at block and district level. Migration kits and IEC/IPC/BCC materials for distribution among migrants will be provisioned centrally by SACS.

b. **Through existing Targeted Intervention (TI) Program**: TI projects are being implemented through NGOs by NACO across the country mostly focusing on urban locations. In areas where a source intervention is needed and if a TI project is operating in the nearby locality the same NGO can be contracted to implement the

migrant program at source with additional resources. While contracting the TI NGOs, it is to be ensured that, in no way the focus and objective of the TI intervention is diluted. For the staffing purpose additional Out Reach Workers and Village Level Volunteers will be provided to the NGO.

c. **Special District Program**: In those corridors where Link Worker as well as TI programmes do not exist direct migrant program will be established through NGOs operating locally. Following staffing pattern will be adopted for Special District Program: District Coordinator -1, Out Reach Workers (2: 1 block, one male and one female), 1 Part time Accountant, 1 M&E officer, and Village level Volunteers (for a maximum of 5 per block and 25 in a district).

Mainstreamed Interventions:

a. In geographic location where the intensity and volume of the migrants are inadequate for a full fledged intervention and at the same time government health service delivery system is well established and functioning, the HIV prevention and care services will be integrated within that existing system. Additional training, incentives and resources will be provided to health workers/ASHA/ANMs, multi-purpose workers, Panchayat workers for implementing HIV prevention programs with migrant workers. Additional financial support for STI drugs, IEC materials and condom can be given to the PHC and SC who would take the lead to reach the migrants, their community and household.

b. Other department functionaries. Project also will be linked to other departments such as Labour Department District offices, Department of Rural Development (Velugu program workers in AP (Andhra Pradesh), Kudumbasree workers in Kerala), ICDS Anganwadi Workers, Department of Agriculture etc and wherever linkages can be built by utilizing field level functionaries of these departments, additional capacity building and resource will be given to get their services to reach out to migrants in these districts.

4.1.1.4 ENTRY LEVEL ACTIVITIES

In order to start up program linked activities within the clusters of village, initial ice breaking and entry into the community is crucial. If a wrong step is taken at this stage, one may never succeed to enter that community, though it may have many migrant workers as well as reported risk profile. Therefore, it is important to carefully plan right at the start up stage, key steps and strategies to enter into the community. It is important to employ a multi-pronged approach and include combination of several activities. Some of the activities suggested are the following:

1. Rapid Assessment: Rapid Assessment study itself can be pitched as an entry level activity to build rapport with the community, involving them in the process of generating crucial information about the community. Refer **Annexure 5.3** for details.

A set of entry level activities including tools for village level migrant profiling is part of the training module under chapter of Capacity Building.

2. Mid Media Campaigns: Some of the mid media campaigns, focused on broader issues to enter the community would be useful at this stage. Could organize communication activities such as street plays, Community meetings, video shows, exhibition, health melas etc. Mid-media tools will be provided by SACS for use, these can be developed considering the local context and requirements also.

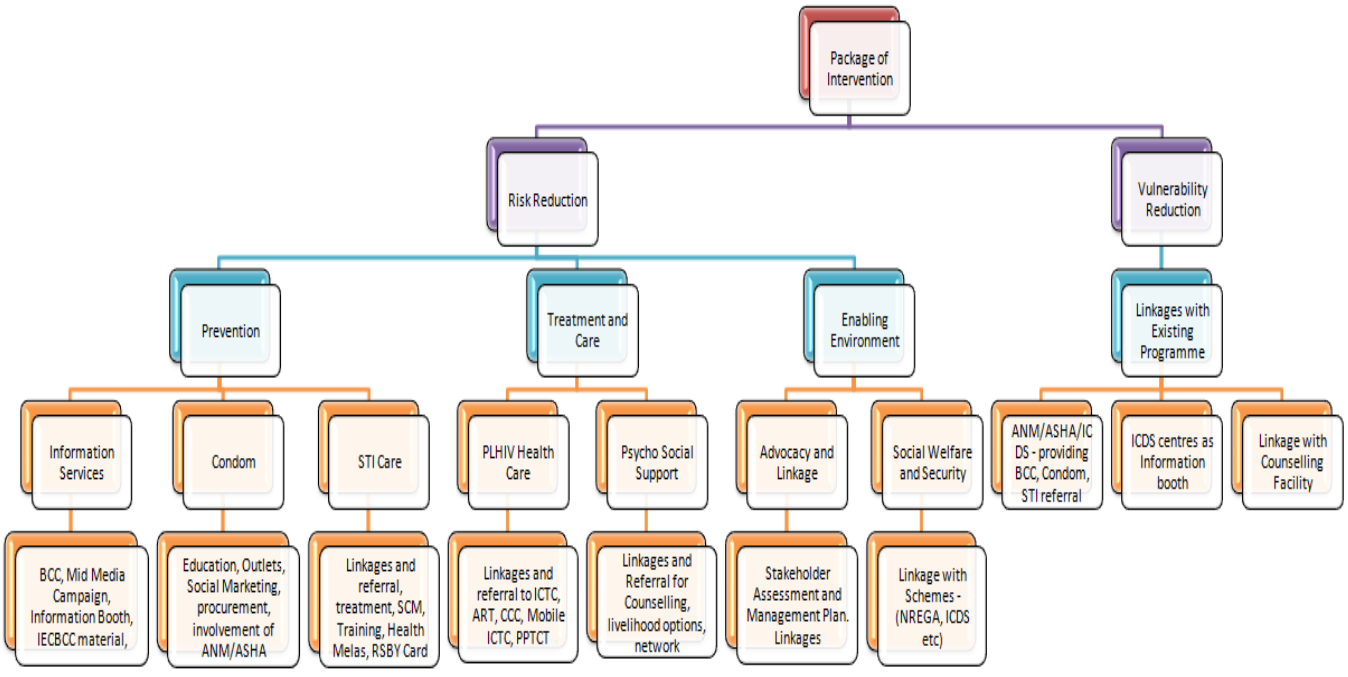
3. Meeting with Key Stakeholders: It would be important to identify the community leaders within the locations with high out-migration and they can include both traditional and elected members and then introduce the project to them explaining the need for intervention in such locations. Refer **Annexure 5.8** for details on tool to be used.

4. Identification of Interest Groups and Pressure Groups: Identify key influencers of migrants in the village and win their support for the project and through them enter the village. These people could be migrants who would have returned and have motivated migration from the village, contractor's men from the village, contractors themselves etc.

4.1.1.5 INTERVENTION PACKAGE AT SOURCE:

Through the intervention at source, the project will reach to migrants (potential, outgoing and returning), their spouse and the community in which they live focusing on risk reduction as well as vulnerability reduction. The project will be implemented either through the Link Worker Scheme, TI or independent NGO programme and if the volume is low it would be through existing health systems at the grass root level functionaries of other programmes.

Following is a package of services that will be delivered to the target group.



Risk Reduction Strategies:

Through risk reduction strategies the key focus would be to reach out to the migrant population who move between source and destination. In order to evolve appropriate strategies, it would be important to study mobility pattern of these migrants: Who migrate, reasons for migration, when they migrate – is there any seasonal consideration for migration in the geographical area, where do they migrate to, what occupation they are in, When do the migrants come back and what frequency, extent of risky behaviour at source etc.

Additional information on following will help to design the intervention focusing risk and vulnerability reduction:

Epidemic phase:

Whether at source the current phase of epidemic is generalized, localized or truncated. This is important to design the packages of interventions. The epidemic phase can be analysed from following source:

- Analysis of ICTC data of the source districts to understand the positivity trend among male, % of male are migrants against non – migrants (this would help to understand the risk pattern both for male non-migrants, migrants, local in-migrants, clients of local sex work network).
- Analysis of ART data for understanding the ART uptake by local residents , % of them being migrants, % of them being relatives/ spouses of migrants

Epidemic Potential:

- Analysis of ICTC data of the source districts to understand the nature of epidemic among the female i.e. among spouses, AN mothers (this would help to understand the risk pattern among female whether driven by local female sex workers, AN mothers – whose spouses are migrants, AN mothers – who are discordant couples).
- Analysis of ART data to understand the burden of epidemic in terms of contributed by the local migrants, because of anonymity usually people register themselves in nearby districts instead of their own districts.
- Size (% of sex workers in local areas in proportion to the total population), spatial distribution and mobility pattern (whether the local FSW, MSM operate in nearby high prevalence district, location because of economic potential) of FSW, MSM is important.
- Understanding of local traditions, norms about acceptance of polygamous relationship – since this would indicate individual high risk behaviour for migrants as well as non migrants whether they are at source or destination.

Analysis of occupation data of ICTC, ART and Positive network – this will provide the occupation categorization as well as spatial distribution of positive peoples for strengthening positive prevention services.

This information will be gathered through the rapid assessment and will feed into options for package of service.

A summary of package of services is given in the table below highlighting which services will be given to which category of migrants.

Package of services	Potential Migrants	Outgoing migrants	Returnee Migrants	Female Migrants	Spouses
One to group BCC	x	x	x	x	x
Peer education by returnee migrants		x	x		
Mid –Media campaigns		x	x		x
Information booth	x	x	x	x	
IEC materials	x	x	x	x	x
Condom provisioning		x	x	x	x
STI management		x	x	x	x
Linkages with RSBY	x	x	x		
Linkages with JSY and PPTCT				x	x
Linkages with ICTC and ART	x	x	x	x	x
Linkages with VHND				x	x
Linkages with NREGA and similar programmes	x	x	x	x	x
Linkages with contractors	x	x	x	x	

Detailed description of the package of service is given below:

1. **Prevention Package**

a. **Information Service:** Information that would influence behaviour change will be made available through standard activities such as one to group, peer education, mid media campaign, information booth at the contractor's office, NYK, Panchayat house, Anganwadi centre, Mahila mandal or self-help group offices, other resource centers established by either UN agencies or other programs, PHC etc.

- **Behaviour Change Communication:** Through village level volunteers (of NYK, literacy mission, local youth clubs), ANMs, ASHA, AWW and Outreach Workers of the project, one to one (wherever possible) and one to group sessions will be given to the identified high risk migrant individuals in the village. For this purpose, all the volunteers will be trained on behaviour change communications at a central location within the district to be organised by NGOs. Key messages will be related to information on HIV/STIs, risk perception focusing on consequence of risky behaviour, condom, treatment behaviour, key services and programmes etc. This will be an intense process requiring repeated interaction with the primary stakeholder focusing on behaviour modification. The prototype of IPC package that can be used by

Village Level Volunteers: Village Level Volunteers (of NYK, literacy mission, local youth clubs and NGOs) will be selected and trained for conducting one to one and one to group sessions, providing lay counselling etc. Wherever possible and available volunteer Peer Leaders (from among high risk migrants) will also be developed and trained. Each volunteer educator (including peers) will be given a BCC kit that would contain flip charts (IPC Package), condoms, list of centres for HIV related services, condom demonstration models etc. The training content and the package for the volunteers is expanded in detail in the chapter on capacity building.

Volunteers (as mentioned above), outreach workers, ASHA, ANMs, AWW will be made available by SACS.

- **Mid Media Campaigns:** Mid media techniques will be used to create interest and generate awareness among large number of people. Mid media campaigns are excellent approach to provoke discussion and reflection among the community members on key issues related to HIV prevention and care. Mid media techniques will include: Street Theatre, Games, Traditional Folk Media, Exhibitions, Debates and discussions etc. These programs shall be organised by village level workers with the support of outreach workers. Sufficient motivation is needed among the village level workers in order to organise such a mid-media campaigns and the program out-reach staff will work closely with key stakeholders in the initial period to work on these activities.

- **Information Booth:** Information booth will be established (as appropriate and most convenient for people to access) at the PHC, Panchayat office, Anganwadi centers, youth clubs, mahila mandal offices or at the office of contract agent (if available) in order to reach to both migrants as well as their spouses. Through these information booths, HIV related information as well as information on health and other support services at the destination for the out-migrants. Information booth will be the hub in the village from where the volunteers and outreach workers would operate and will be the nerve centre of activities as mentioned above, they will also be considered as drop-in-centers for the individuals from the local areas.

- **Development of IEC/BCC materials**: IEC and BCC materials will be developed according to the needs of the community and the migrant group for whom it is being made. The content and channel of sharing the information should be culturally sensitive and there is a need for implementing agencies to develop appropriate messages or adapt already existing IEC/BCC materials. Separate IEC materials will be developed to address the needs of migrants travelling out, returning migrants and spouses of migrants living in the village. Separate Flip Charts and IEC materials also will be developed to be used by ANMs and ASHA during VHND. NACO TI division along with IEC division will play crucial role in developing prototype of such materials which will then be adapted by SACS and implementing partner to local need and language. Detailed guidelines on IEC development is in the **Annexure no 5.4**

b. **Condom Programme:** Condom services will be provided through establishing condom outlets and providing revolving fund for social marketing in districts where Social Marketing Organisation do not operate. Wherever, Social Marketing Organization (SMO) is existing, their support will be sought to accelerate condom distribution as well as for demand generation. Besides this, efforts will also be made to increase the access to condoms by starting condom outlets in the shops in the village and ensuring regular supply through the PHC and SC.

Following are some of the key steps in promoting condoms at source:

- Focus on demand generation for condom usage within the community through IEC activities, BCC and IPC sessions
- Improved accessibility to condom by opening more number of condom outlets
- Supply chain management, including sustainable system for monitoring condom outlets, system of stocking and refilling the condom outlets
- Capacity of the ANMs and ASHA workers will be enhanced to talk about and distribute condoms, particularly to the spouses of the migrant workers. Similarly the capacity of the AWW as well as other resources within the community will be improved to ensure they talk about condom to people and promote use of condom.
- Linkages **with Social Marketing Organization and other condom programmes:** Linkages with Condom Social Marketing Programme of Govt of India will be established by the interventions (list of districts is **annexed at 5.5** as per available information, this can be referred for planning purposes. The updated list can be referred from SACS). Under this programme districts with high HIV prevalence-high fertility, low HIV prevalence – high fertility and high HIV prevalence – low fertility are targeted with demand generation activities like mid media activities, mobile theatres, mobile video shows, IEC activities like wall paintings and establishment of non traditional outlets. This programme is managed by Social Marketing Organisations selected by NACO for States. This programme will be linked if available within the district where migrant intervention will be implemented for provision of condoms.

c. **STI Health Care Services:** Health care services focused on prevention and care of STI will be provided through the linkages established with the existing health care system. Primary focus would be to provide these services through existing services by strengthening referral system and capacity building of service providers and development of infrastructure for effective case management. Following are some of the health care services that will be made available within the project for prevention and management of STI.

- **STI treatment and Management:** STI treatment service will be provided through the existing government public health delivery system. Linkages for referrals will be established.

- **Linkages with Preferred Providers for STI services:** A chain of preferred providers has been selected and trained by State AIDS Control Societies and they are available for providing treatment services. Besides, social marketing of STI drug kits is being implemented through these providers and the migrant interventions can be linked to this programme. The list of the service providers can be obtained from SACS for linkage.

- **Capacity Building:** The doctor in local hospital will be provided skills and knowledge in STI management through the Syndromic Case Management approach for treatment. This will be organized through support from the SACS

and DAPCUs. Guideline on STI Treatment and Care available in the **Annexure - 5.6**. The volunteers as well as ASHA/AWW/ANM and identified migrant Peer Leaders (if any) will be trained to provide counselling related to management and prevention of STIs. Details on STI Symptoms that is useful for training is available in the Operational Guidelines for Programme Managers under STI.

- **Health Camps:** Health *Mela* will be organized with the support of local Panchayat or youth clubs for identifying and treating STIs in the migrant community. The health Mela will be positioned for treatment of general illness, but focused efforts will be made to identify and treat STIs. This could be organized in the village especially during holiday or festival seasons when the migrants would return to the village. This could include, information services, counselling, testing services etc. Local PHC should be actively involved in organizing health melas and volunteers, ANMs, ASHAs and AWW would follow up identified STI cases to ensure treatment adherence and access to further information and counselling. Migrants with health card will be linked to transit and destination and those who do not have card will be given, so that they can be later followed up.

- **Linkages with VHND** (Village Health and Nutrition Day) at Anganwadi Centres/ Sub Centres will be used for meeting spouses and families of migrants to sensitise about risk of STI and HIV. Group meetings will be conducted by Block ORWs and District Coordinators with the help of volunteers to enable spouses to understand the risk associated with HIV and STIs.

- **Linkages with Janani Suraksha Yojana (JSY)** scheme of NRHM to promote PPTCT through training of Anganwadi Workers, ASHA and ANMs will be taken up at Source to ensure that the pregnant women are effectively covered under prevention services through distribution of condoms, linkages and uptake of PPTCT services.

- **Initiating RSBY Card Scheme:** Every effort will be made to link up with Rashtriya Swasthya Bima Yojana, the health insurance scheme for the persons Below Poverty Line. This will facilitate the migrants to access financial support during emergency hospitalization. The card holders will be linked with destination interventions so that the migrants will be able to avail the facilities under RSBY at destination also. **Detailed note on RSBY is attached for reference at Annexure 5.7.**

2. HIV Treatment and Care Package

a. PLHIV Health Care Service Linkage

Active referrals for treatment services related to HIV: Public health infrastructure where HIV related services are available will be linked up (Government ART Centres, CCCs, PPTCT clinics, ICTC – including mobile ICTC etc) for the PLHIVs among the migrants and their spouses. Linkages also will be built

with any of the CSOs program for HIV prevention and care available within the district. Information material on ART, ICTC, PPTCT available in the SACS IEC division may be used.

b. Psycho-Social Support Services

Linkages also will be made with PLHIV networks so that infected migrants can access various service components through the network. Through this linkage peer counseling support, group therapy, capacity building and financial support for livelihood options etc will be made more reachable to the migrants. The efforts shall be made to actively engage PLHIV networks within each district where there is a migrant workers program initiative.

3. Enabling Environment Related Services.

a. Enabling Environment through Advocacy and Linkages

Project should map out key agencies or individuals that need to be linked up for delivery of services. This will need to be included while doing situational assessment study. Following are some of the key activities that will be undertaken for local advocacy and linkages

i. Mapping out key Stakeholders using stakeholder analysis tool **(Annexure - 5.8)**
ii. Stakeholder Management Plan – specifying advocacy and linkage plan
iii. Implementation of the advocacy and linkage plan

Linkages with local youth clubs, trade union associations, community leaders and other key stakeholders will provide useful information and access to these migrants groups which would facilitate easier reach. Studies show that migration is closely linked to contractors and agents. One of the key risk reduction strategies to reach these migrants would be to work with these contractors and recruitment agencies.

b. Social Welfare and Social Security:

Project shall facilitate easy access to various welfare programmes as well social protection activities of the government, particularly for the spouses of migrant workers in source areas. This will ensure their awareness of other programs, access to entitlements and access to various schemes and services. The project will facilitate linkages with various agencies and also will work towards improving the knowledge of the community on various schemes existing such as NREGA, ICDS schemes and other welfare schemes.

Vulnerability Reduction Strategies:

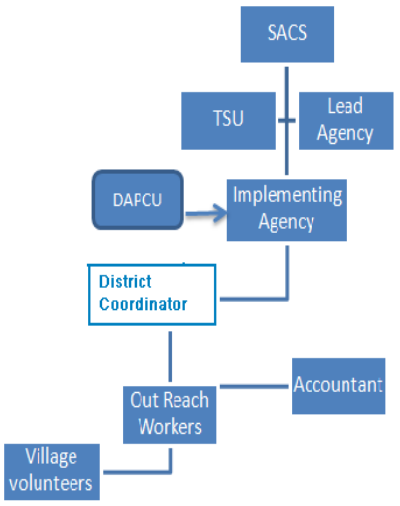
In order to reduce the vulnerabilities in the community as well as the spouses of the migrants, following activities will be under taken

a. Linkages with existing Program

- Identify the available resources in both Govt. and NGO sector like ANM, ASHA workers, Doctors, Health workers, Youth clubs, ICDS scheme etc. and provide training to them to work with potential population who migrate and families of already migrated. Build their capacity on HIV related issues and make this as an agenda during their community and house visits. Provide them with adequate IEC/BCC materials to effectively reach with appropriate messages. They should be also trained to identify STIs and get them treated. These grass root level functionaries will also be trained to identify risk and vulnerability and provide appropriate information. Those found to be having multipartner sex should be provided with intense BCC, condom and STI services.
- ICDS centres should be made centres of information especially reaching out to women and increasing their awareness on HIV and their vulnerability
- Linkages with counselling facility for those spouses who would require psycho social support and family counselling

4.1.1.6 MANAGEMENT STRUCTURE FOR SOURCE INTERVENTION

The intervention on the ground will be implemented through an existing NGO program (implementing Link Worker Scheme) or a new NGO selected. The key staff of the intervention would be the District Coordinator, Out Reach Workers (Block - level male and female) and village level volunteers.



NACO will implement and monitor these interventions through SACS and through the TSU or Lead NGO structures. In case of states with high migration pattern separate regional NGOs will be appointed for monitoring and managing the program. In case of smaller states with less migration pattern, SACS and TSU itself will take the lead in monitoring and managing the programme. The detailed roles and deliverables is attached at **Annexure -5.9**

The Role of Brokers/Contractors is important with respect to implementation at source. They can be involved in project planning i.e. identifying cluster of villages, project implementation i.e. as peer volunteer to organize one to group meetings, counselling at the time of departure, linkages with destination, project monitoring i.e. to understand the nature of services and information needs in line with implementation. The Brokers and Contractors can be used for advocacy with line departments.

4.1.1.7 SUMMARY BUDGET

Detailed budget is attached at Annexure 5.15

4.1.1.8 LIST OF KEY ACTIVITIES

The same is elaborated at Annexure 5.10

4.1.1.9 TRAINING MATERIALS

The same is part of the Capacity Building Chapter

4.1.1.10 REPORTING TOOLS

The same is part of the Monitoring and Evaluation Chapter

4.1.1.11 PERFORMANCE INDICATORS

The same is part of the Monitoring and Evaluation Chapter

DESTINATION INTERVENTIONS

Through the intervention at destination (in coordination with source areas along the route of migration - corridor), the project will reach to migrants, their spouse or sexual partners and the community in which they live focusing on risk reduction as well as vulnerability reduction. As stated in the section on delivery model the project will be implemented directly through NGOs as Migrant TI or through industrial partners, Labour welfare program, contract association etc.

4.1.1.12 GEOGRAPHY

Following are the key towns identified as destination sites based on the in migration patterns and HIV prevalence rate:

Adilabad, Ahmedabad, Alang, Amritsar, Anantapur, Angul, Aurangabad, Bangalore, Belgaum, Bellary, Bharuch, Bhatinda, Bhillai, Bidar, Bijapur, Chandigarh, Coimbatore, Dadra & NH, Daman & Diu, Delhi, Dharmapuri, Dungarpur, Durg, Gulbarga, Gurgaon, Ernakulum, Erode, Faridabad, Firozpur, Hanumangarh, Hyderabad, Jalgaon, Jamnagar, Jamshedpur, Jharsuguda, Kakinada, Khurda, Kolhapur, Kolkata, Krishna, Ludhiana, Mandya, Mangalore, Mumbai (Suburban), Nagpur, Nammakal, Nanded, Nashik, Navi Mumbai, Nellore, North Goa, Parbhani, Pune, Raichur, Rajmundry, Rourkela, Sangli, Solapur, South Goa, Surat, The Nilgiris, Thane, Thrissur, Tirupur, Tumkur, Trivandrum, Vadodara, Valsad, Udham Singh Nagar, Udaipur, Vapi, Vizag, Warangal, Yanam

4.1.1.13 DELIVERY MODEL AT DESTINATION:

Direct Intervention:

Migrant Targeted Intervention: Geographic location that has high volume of migrants (more than 10,000 – 15,000 high risk migrants available at any given year) at destination, Migrant TIs will be implemented through existing structural systems within different occupation categories that include the contractors, trade unions, market committees, NGOs, company partners, industry management. This will be a fully budgeted model with following staff structure: Project Coordinator, ANM/Counselor, ORW, Part time Accountant and Office administrative Assistant and Peer Leaders, Part time Doctor.

The design of delivery model will depend upon following:

1. Whether the intervention is aimed at work place or informal residential locations.
2. Understanding the risk exposure pattern of individuals/ group of individuals among the work force including % of migrants within the selected occupation category.
3. Understanding the HIV prevalence among FSW and MSM and their spatial distribution for accessibility by migrants in the locality.
4. Understanding the size of high risk population (e.g. in Surat the MSM population is estimated more than FSW population).
5. Understanding the role of gatekeepers, power structures in controlling the sex trade and their effect on in-migrants from outside.
6. Feasible entry points for implementation of programs and integration mechanisms

4.1.1.14 FIVE KEY SETTINGS FOR DESTINATION INTERVENTION

Following are the five key setting in which a migrant work and live at a destination site. The intervention package will be designed to suit the needs of these key settings. Separate intervention will be planned for each of these settings depending on the volume and known risk of migrants in the particular setting.

1. Large Industry/Ancillary Unit Setting (Dense Migrant Volume) e.g. Textile, Mining, Iron Ore/Alumina/Cement factories
2. Small and Medium Enterprise (Dense or Spread out Migrant Volume) e.g. Ship wrecking industry, hammals in transport sectors, diamond cutting, deep sea fisheries, stone quarries, brick kilns, leather accessories, salt panning.
3. Labourers – Spread out across the City (Construction, Hotel Services, domestic work, rickshaw pullers etc)
4. Agricultural Labour (Seasonal – Dense Migrant Volume during season) sugar cane processing, cotton processing, coffee and tea plantation
5. Others – combination of any of the above

The feasibility assessment tool for destination intervention is attached at **Annexure 5.22. In case the number of migrants specified in the above sector is less than 10,000 per year a separate proposal is required to be submitted to NACO for costing.**

Similarly if the assessment report indicates that the existing intervention in the district does not qualify for a migrant intervention, the project area to be covered with following strategies:

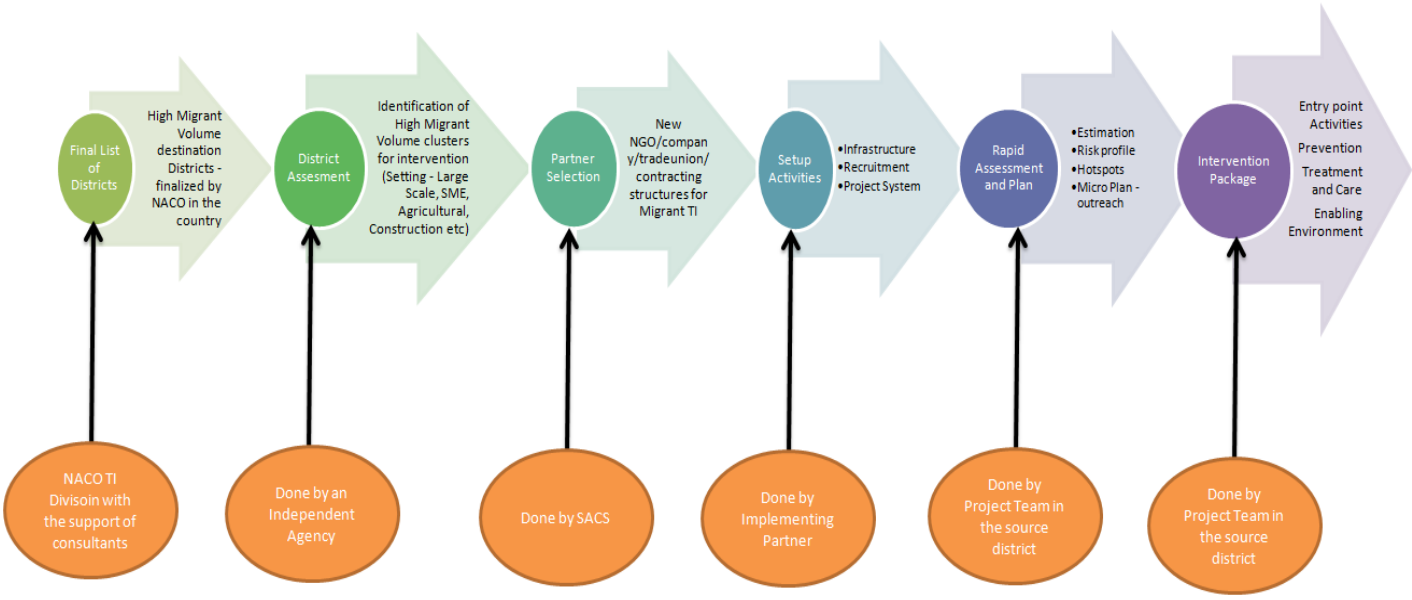
1. Strengthening client strategy and partner strategy in existing HRG interventions.

2. Strengthening condom social marketing with priority on visibility and accessibility.

3. Strengthening IEC and mainstreaming activities with focus on clients of HRGs for prevention , care and treatment.

Since intervention areas with less than 10,000 migrants per year does not have cost effectiveness as well as there are issues of coverage and service uptake by migrants. Hence priority should focus on both volume and vulnerability issues associated with migration at destination sites.

4.1.1.15 IMPLEMENTATION STEPS



4.1.1.16 ENTRY LEVEL ACTIVITIES AT DESTINATION

In order to start up program linked activities within the selected setting at destination, initial ice breaking and entry into the migrant community is crucial. Therefore it is important to carefully plan right strategies for entry at the start up stage. It is important to employ a multi-pronged approach and include combination of several activities. Some of the activities suggested are the following:

1. Rapid Assessment: Rapid Assessment study itself can be pitched as an entry level activity to build rapport with migrant community, involving them in the process of generating crucial information about the setting. This will also help to identify the role of gate keepers on migrants. Refer **Annexure -5.3** for details

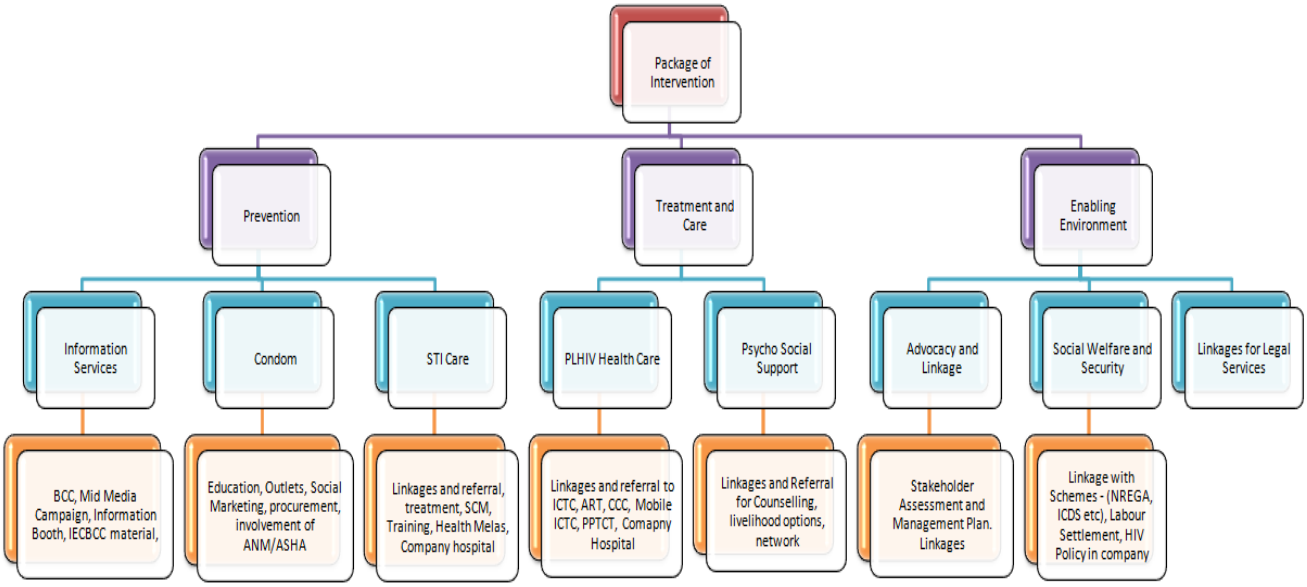
2. Mid Media Campaigns: Some of the mid media campaigns, focused on broader issues to enter the industrial setting would be useful at this stage. Could organize communication activities such as street plays, Community meetings, video shows, exhibition, health camps etc.

3. Meeting with Key Stakeholders: It would be important to identify the trade union leaders, leaders of migrants clusters based on geography, linguistic groups, Employers etc. and introduce the project to them explaining the need for such an intervention. Refer **Annexure 5. 8** for details of tools to be used for the purpose.

4. Identification of Interest Groups and Pressure Groups. Identify key influencers of migrants in these settings and win their support for the project and through them enter. These people could be contractor's or other pressure groups.

4.1.1.17 INTERVENTION PACKAGE

Following is a package of services that will be delivered to the target group. Key packages of services that will be delivered would be:



1. Prevention Package

a. Information Service: Information that would influence behaviour change will be made available through standard activities such as one to one, one to groups, peer education, mid media campaign, information booth at the contractor's office or in the DIC etc.

- **Inter Personal Communication:** Through peer leaders and outreach workers, one to one and one to group sessions will be given to the identified high risk migrant individuals in the destination. Key messages will be related to information on HIV/STIs, risk perception focusing on consequence of risky behaviour, condom, treatment behaviour, key services and programmes etc. This will be an intense process requiring repeated interaction with the primary stakeholder focusing on behaviour modification.

Peer Education: Peer Leaders from among the migrants operating in the destination will be selected and trained for conducting one to one and one to group sessions, providing lay counselling etc. Each peer volunteer will be given a BCC kit that would contain flip charts, condoms, list of centres for HIV related services, condom demonstration models etc. The training content and the package for the peers is expanded in detail in the chapter on capacity building.

- **Mid Media Campaigns:** Mid media techniques will be used to create interest and generate awareness among large number of people. Mid media campaigns are excellent approach to provoke discussion and reflection among the community members on key issues related to HIV prevention and care. Mid

media techniques will include: Street Theatre, Games, Traditional Folk Media, Exhibitions, Debates and discussions etc.

- **Drop in Centre cum Information Booth:** Drop in Centre cum Information booth will be established at the key spots where the migrant groups would congregate depending on the sectors of employment being addressed to reach the migrant groups.

  This could be hospital in the company, recreational clubs in the company, pick up points of construction labourers, youth clubs or at the office of contract agent (if ava**ilable) in order to reach to both migr**ants as well as th**e**ir spouses. This will be a hub where services such as counselling as well as HIV related information will be made available to the high risk migrants groups. There will be opportunity for recreational facility within these centres which will attract the migrant to drop in and access services. Migrants will be given a resource kit[16] that will broadly cover the following:

  a. Information on HIV/AIDS/STI
  b. Condom packs
  c. Names and other contact information details of support agencies at destinations / sites for that source destination pair
  d. Details of ICTC / ART Centre at destinations sites for that source destination pair
  e. Information on welfare / insurance schemes for migrants

- **Development of IEC/BCC Materials:** IEC and BCC materials will be developed according to the needs of the community and the migrant group for whom it is being made.

  The content and channel of sharing the information should be culturally sensitive and there is a need to develop appropriate messages or adapt already existing IEC/BCC materials. More guidance on development of appropriate materials on STI symptoms, services like ART, ICTC, PPTCT available with SACS IEC division may be used.

  Separate IEC materials will be developed to address the needs of migrants travelling out, returning migrants and spouses of migrants living in the village. Information/ IEC package for returnee migrants, spouses, potential migrants is available in the SACS may be used.

  NACO TI division along with IEC division will play crucial role in developing prototype of such materials which will then be adapted by SACS and implementing partner to local need and language.

  Based on the need IEC and BCC materials from source TIs /SACS will be kept for use at DIC cum information booths, with the ORWs, Peer Leaders.

[16] The contents of the kits will largely be informed by the needs of the migrants for any given corridor, train routes etc. The list of contents mentioned above is illustrative.

- **Linkages with HRG interventions:**

  Focussed activities will be undertaken by the intervention team to ensure regular sharing of information with TI HRG interventions in the same locality regarding the following:

  - Barriers to condom use
  - Knowledge and attitude of migrants clients towards risk acts
  - Attitude towards STI and ICTC
  - Information about the profile of migrant clients for triangulation of information within the destination as well as with source.

b. **Condom Programme:** Condom services will be provided through establishing condom outlets and providing seed fund for social marketing. Wherever, Social Marketing Organization (SMO) is existing, their support will be sought to accelerate condom distribution as well as for demand generation. Besides this, efforts will be made to increase the access to condoms by starting condom outlets in the shops in the destination points and ensuring regular supply through the company hospitals. Following are some of the key steps in promoting condoms at destination:

   - Focus on demand generation for condom usage within the community through IEC activities
   - Identifying and prioritizing spots for initiating condom outlets
   - Improved accessibility to condom by opening more number of condom outlets
   - Supply chain management, including sustainable system for monitoring condom outlet, system of stocking and refilling the condom outlets at Contractors sites/Work place/Video parlours etc
   - Linkages **with Social Marketing Organization and other condom programmes:** Linkages with Condom Social Marketing Programme of Govt of India will be established by the interventions (list of districts is annexed at **Annexure 5.5** for reference, this is prepared based on the information available. Updated list can be referred from SACS). Under this programme districts with high HIV prevalence-high fertility, low HIV prevalence – high fertility and high HIV prevalence – low fertility are targeted with demand generation activities like mid media activities, mobile theatres, mobile video shows, IEC activities like wall paintings and establishment of non traditional outlets. This programme is managed by Social Marketing Organisations selected by NACO for States. This programme will be linked if available within the district where migrant intervention will be implemented for provision of condoms.

c. **Health Care Services:** Health care services focused on prevention and care of HIV will be provided through the linkages established with the existing health care system. Primary focus would be to provide these services through existing services through

strengthened referral system. Following are some of the health care services that will be made available within the project.

- **STI treatment and Management:** STI treatment service will be provided through the existing government public health delivery system. The Peer Leaders will be trained to provide counselling related to management and prevention of STIs.

- Linkages **with Preferred Providers for STI services:** A chain of preferred providers has been selected and trained by State AIDS Control Societies and they are available for providing treatment services. Besides, social marketing of STI drug kits is being implemented through these providers and the migrant interventions can be linked to this programme. The list of the service providers can be obtained from SACS for linkage.

- **Capacity Building:** The doctor in local hospital will be provided skills and knowledge in STI management through the syndromic case management approach for treatment. This will be organized through support from the SACS and DAPCUs. Guideline on STI Treatment and Care available in the **Annexure 5.6**. The volunteers as well as ASHA/AWW/ANM and identified migrant Peer Leaders (if any) will be trained to provide counselling related to management and prevention of STIs.

- **Linkages with Company Hospital/ ESIC Facilities:** The management will be sensitized and motivated to provide free treatment services through the company hospital or health care facilities available with ESIC to migrant and informal workers, especially for STI treatment.

- **Health Camps:** Health camps will be organized with the support of Labour Unions, contractor association, youth clubs etc for identifying and treating any STIs in the community. The health camps will be for treatment of general illness, but doctor will be trained to identify symptoms of STI and treat. This will be used as an opportunity to provide information on HIV and other STIs. Revolving fund is made available to procure drugs at the rate specified by the State and the same need to be purchased by the migrant clients at no profit basis. Similarly funds have been made available to procure basic medical equipments as prescribed by STI division of SACS at the rate prescribed by SACS for use of examination of cases, general check up in camps. A maximum of 3-4 part time doctor can be engaged for health camps, they are to be trained by STI division of SACS. Each camp need to have 8 hours for 3 times in a month at the same locality.

- **Referral System:** Referral system will be strengthened between the source and destination through the introduction of health card system. Using this, individual migrants cases will be tracked through corridors of migration. Web based system will be introduced to track access to

service from the project team both at source and destination. The system will be piloted in one of the corridors which have the highest volume and risk profile. If it s found to be working, will be scaled up to other corridors.

2. Treatment and Care Package

a. Health Care Service Linkage

- **Active referrals for treatment services related to HIV:** Public medical infrastructure where HIV related services are available will be linked up (Government ART Centres, CCCs, PPTCT clinics, ICTC etc). Linkages also will be built with any of the CSOs program for HIV prevention and care available within the district.

- **Linkages with Company Hospital:** The management will be sensitized and motivated to provide free treatment services for the PLHIV through the company hospital to migrant and informal workers. The hospital will be linked to government programmes that provide ART medicine and motivate the company management to include among its free medical services also ART medication, PPTCT services, counselling to PLHIV and their family etc.

b. Psycho-Social Support Services

Linkages also will be made with PLHIV networks so that infected migrants will be linked to various service components through the network. Through this linkage peer counseling support, group therapy, capacity building and financial support for livelihood options etc will be made more accessible.

3. Enabling Environment Services

a. Enabling Environment through Advocacy and Linkages

Project should map out key agencies or individuals that need to be linked up for delivery of services. This will need to be included while doing situational assessment study. Following are some of the key activities that will be undertaken for local advocacy and linkages

i. Mapping out key Stakeholders using stakeholder analysis tool (**Annexure 5.8**)
ii. Stakeholder Management Plan – specifying advocacy and linkage plan
iii. Implementation of the advocacy and linkage plan

Linkages with local youth clubs, trade union associations, community leaders and other key stakeholders will provide useful information and access to these migrants groups which would facilitate easier access. Studies show that migration is closely linked to contractors and agents. Primary risk reduction strategy to reach these migrants would be to work with these contractors and recruitment agencies.

b. Social Welfare and Social Security: Project will facilitate easy access to various welfare programmes as well social protection activities of the government. This will ensure their access to entitlements and access to various schemes and services. The project will facilitate linkages with various agencies and also will work towards improving the knowledge of the community on various schemes existing.

i. **Linkages to Labour Welfare and Social Security Schemes.** First of all awareness will be built on various schemes available with the government that the migrant can access. Will also build adequate linkages with various departments so that migrant labourers will be able to access these facilities and avail services and entitlements.

The workers are eligible for a variety of insurance[17] and social protection schemes. Under existing schemes of Ministry of Labour and Employment, certain types of employees are eligible for reimbursement of cost of treatment of TB. Though HIV/AIDS is not specifically covered but PLHIV suffering from any consequential illness are reimbursed cost of treatment. The outreach worker will ensure that the workers access these schemes, where eligible

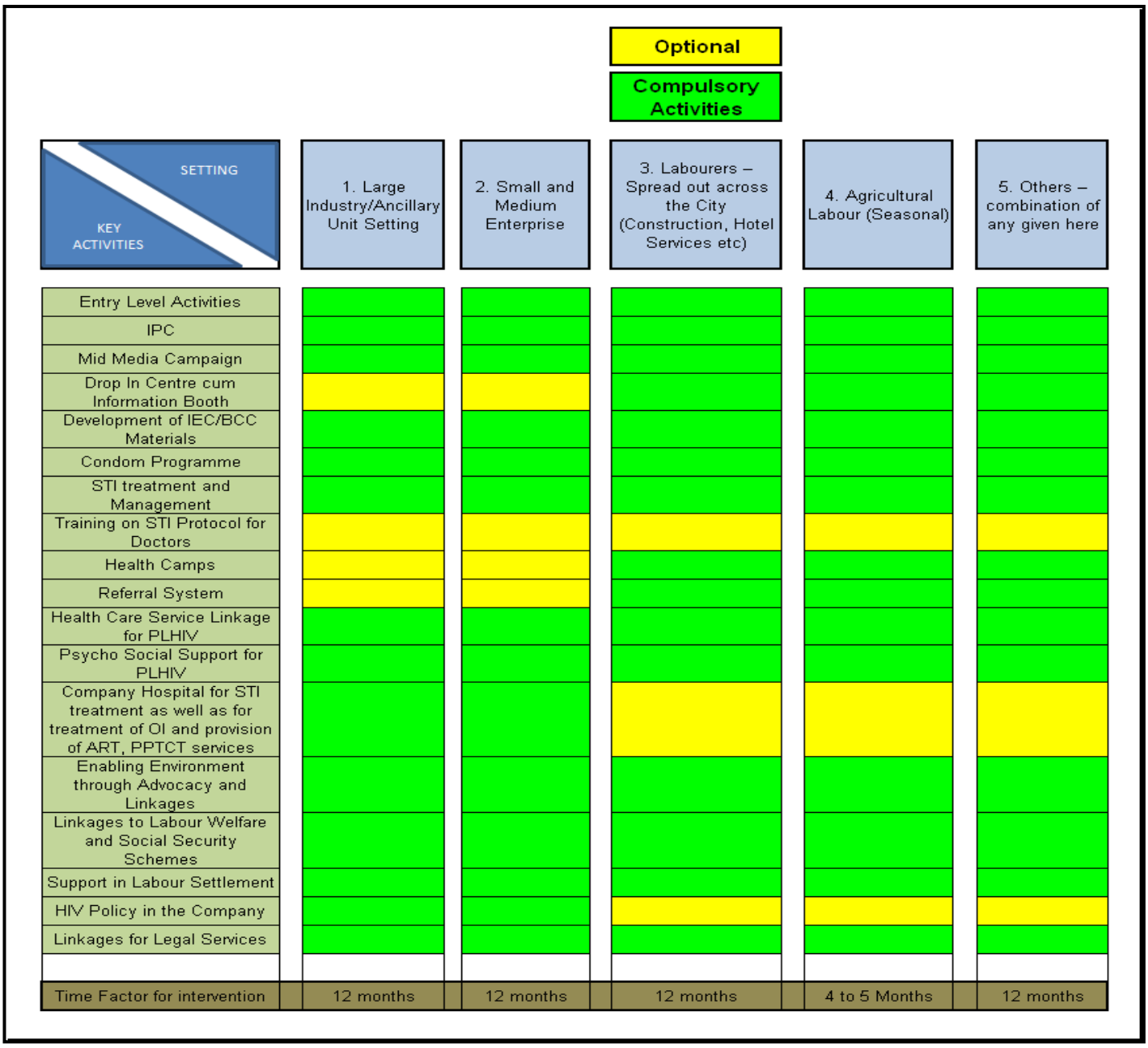
ii. Support in Labour Settlement: The project team, with the support of labour unions will support and facilitate labour settlement and ensure unpaid wages are paid by the employer. This will increase the level of trust and credibility of the project to the migrant workers. The project need to cater needs of labour settlement like basic hygiene, drinking water, RCH services, crèche facilities, temporary schools, vocational training sessions, SHGs for the left out family members of the migrants. These initiatives will reduce disease burden, build in rapport and increment the livelihood support of migrant families.

iii. HIV Policy in the Company: Support will be provided for advocating with company management for preparation of the HIV policy for the company. Support will be given in drafting the policy, arriving at consensus and finalizing the policy. For this purpose, the implementing partner will follow the process and protocol already available with NACO on workplace policy for HIV.

c. **Linkages for Legal Services:** This migrant community is not often aware of their rights and legal protections and is exploited. The legal services will extend to those workers who are denied employment on the basis of their HIV status, denied treatment, benefits or such situations where there is a violation of the right of the worker. Project will make all efforts to provide information and with the help of Lawyer's Collective and such other organization will facilitate access to legal services.

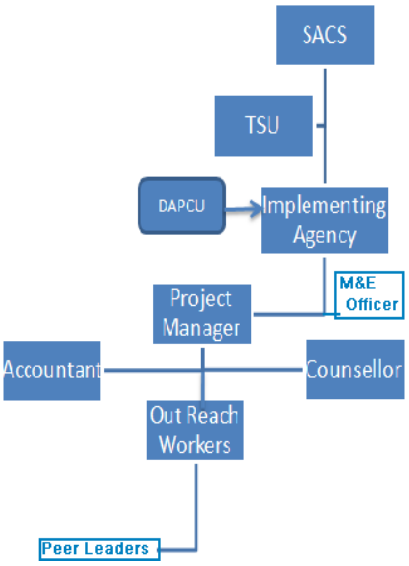
[17] Rashtriya Swasthya Bima Yojana (RSBY) a Government scheme, where a family unit of five is insured for Rs. 30,000 per annum. Only Rs. 30 is to be paid for registration and a smart card is issued for claiming reimbursement. Under the scheme 100 per cent cost is borne by Central/State Government. Eligibility is unorganized sector workers in Below Poverty Line (BPL) category.

Given the above package services following table summarizes options of services that are relevant to each of the setting as was mentioned at the start of the section on destination interventions.



4.1.1.18 MANAGEMENT STRUCTURE FOR DESTINATION INTERVENTION

The intervention on the ground will be implemented through an existing NGO program (implementing TI) or a new NGO selected. The key staff of the intervention would be the Project Manager, ANM/Counsellor, M& E Officer, Out Reach Workers and Peer Leaders.



NACO will implement and monitor these interventions through SACS and through the TSU or Lead NGO structures. The PO in the region will be responsible for day to day handholding and monitoring.

The detailed roles and deliverables is attached at **Annexure -5.11**

4.1.1.19 SUMMARY BUDGET

Detailed budget is attached at Annexure 5.16

4.1.1.20 LIST OF KEY ACTIVITIES

The same is elaborated at Annexure 5.12

4.1.1.21 TRAINING MATERIALS

The same is part of the Capacity Building Chapter

4.1.1.22 REPORTING TOOLS

The same is part of the Monitoring and Evaluation Chapter

4.1.1.23 PERFORMANCE INDICATORS

The same is part of the Monitoring and Evaluation Chapter

TRANSIT INTERVENTIONS

The national program attempts to reach out to the migrants at transit point to ensure reinforcement of messages on risk reduction and vulnerability reduction among migrants. Hence set of strategies are suggested here and few pilot projects will be implemented to evolve appropriate models before scaling up to more number of transit interventions within migration corridors for HIV prevention.

4.1.1.24 GEOGRAPHY

Some of the key transit points within key migration corridors is known based on the census data and the details is given in the **Annexure -5.1.** More operational research is needed to fix the geography, migration pattern and nature of operation at transit points which is being proposed in this operational guideline.

4.1.1.25 DELIVERY MODEL AT TRANSIT:

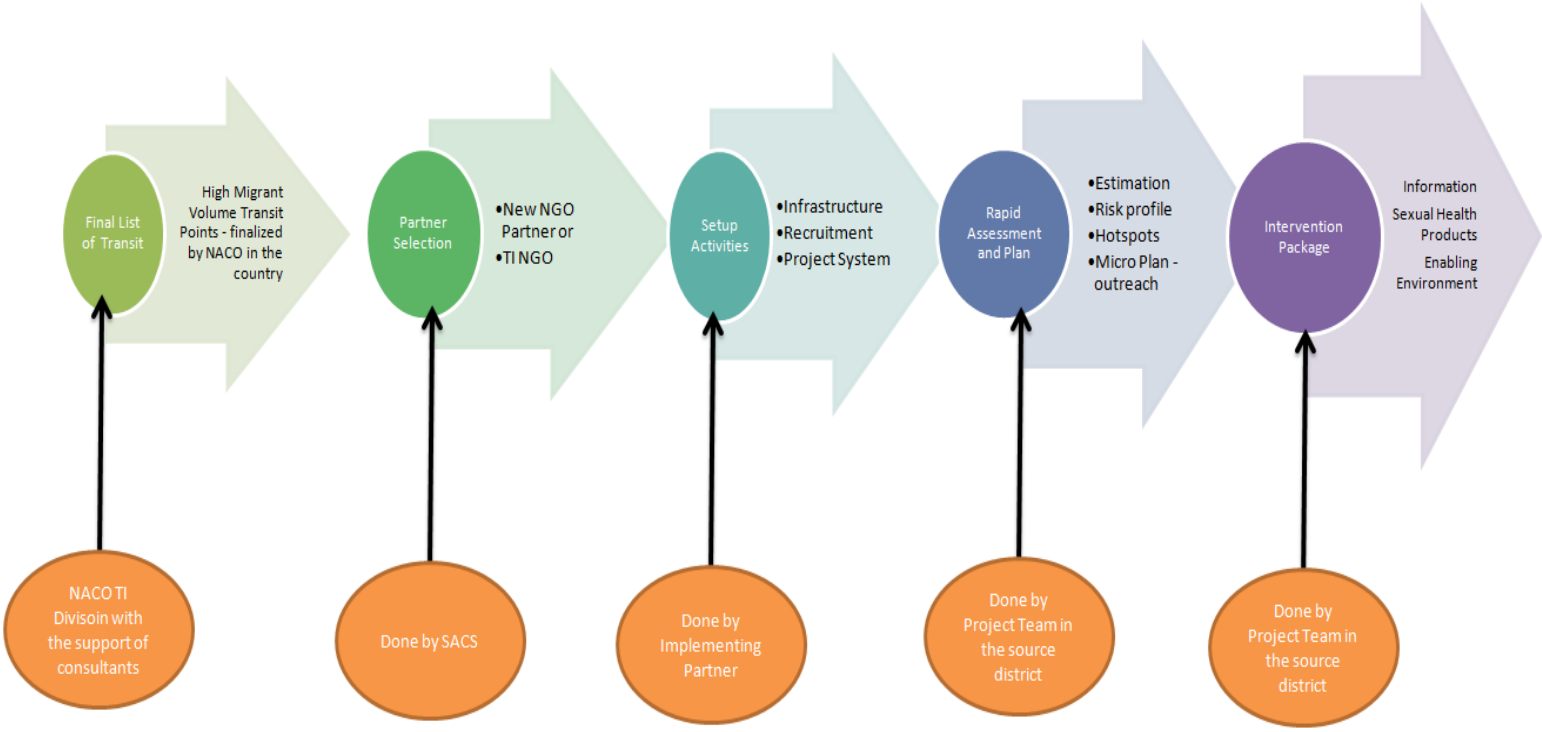
Direct Interventions:

a. Special Intervention models: in corridors where the volume of movement of the migrant is high in the transit point and if no other HIV prevention programmes available, NGOs will be contracted for intensified intervention services. Typical characteristics of such transit site will be that, there is high volume of migrant movement, longer stop over by migrants, easy access and availability of Key Population Groups such as sex workers and MSMs, HIV high prevalent profile of the district etc. This model will have part time Out Reach Workers and volunteers (street vendors, shop keepers etc)

Mainstreamed Interventions:

a. If there are already existing TI program in the transit point, additional resources will be given to NGO also to reach out to the high risk migrants at the transit point. While doing this it has to be ensured that the focus on TI should be not be diluted and affected. Additional ORWs will be provided. In such cases the SACS is expected to increase the scope of existing contract by amending the current contract and provide additional resources as indicated in the costing guidelines for transit interventions. In such cases a separate utilization certificate and expenditure statement need to be produced in addition to monthly reporting formats to be submitted to SACS. The copy of model MOU with instructions is annexed at **Annexure 5.23.**
b. Linkages with other programmes and departments: In corridors where there are low volume of migrants and requiring low intensity intervention model, linkages should be built with existing programs like NRHM, government health delivery structures, labour welfare programmes and transport department to anchor minimum services for prevention of HIV. Additional support and resources will be provided to reach to the migrant population for prevention of HIV.

4.1.1.26 IMPLEMENTATION STEPS

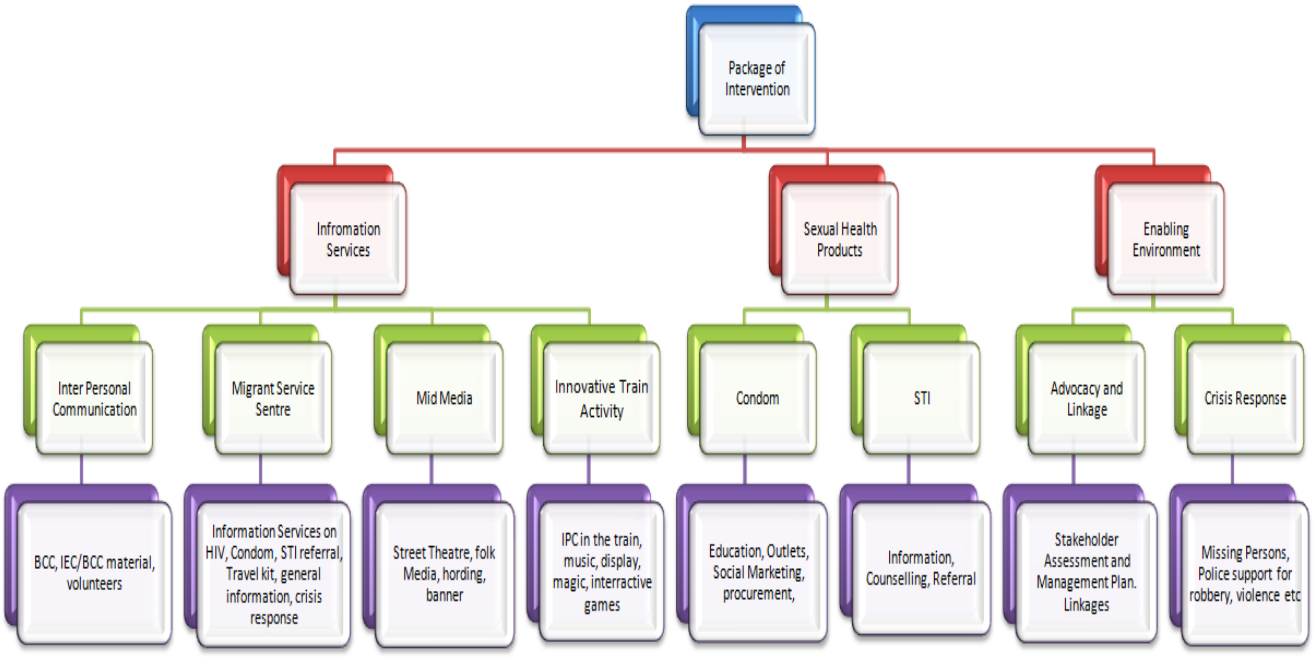


Rapid Assessment:

A rapid assessment of intervention locations and size of target population will help to design the intervention in terms of important locations (like bus stations, motels, dhabas, railway stations, adjoining areas of railway stations, bus stations, lodges and hotels around, rest houses within the railway stations / outside the railway stations), important stakeholders whose support is required and the volume of migrations including its pattern (seasonality, timing etc.). Besides activities like rapid need assessment will precede program activities, which will assess needs of the migrants and also give insights into the profile of target audience this program intends to reach. The needs assessment will be initiated by outreach staff of the implementing partner at transit site.

Detailed rapid assessment of the transit site will be worked by the ORWs. Necessary tools will be part of the Chapter on Capacity Building.

4.1.1.27 INTERVENTION PACKAGE



Transit interventions will predominantly involve activities that focus on information and awareness building on HIV/STI/AIDS and reinforcing the strategy employed at source and destination**.**

1. Information Services

a. Focused BCC Activities

BCC programs at transit points will comprise of mixed packages of mid media activities, IPC and group sessions carried out by ORW and distribution of communication materials developed in the project. The later would include: pamphlets; information booklets; posters and flash cards / flip charts.

The design of activities should have following principles:

a. Addresses the reinforcement of risk reduction messages
b. Should be in tune with local culture, traditions
c. Should have wider reach in terms of coverage
d. Should be implemented ideally where the exposure to the interventions is significant (i.e. at waiting areas of migrants/ general public, within the buses, train etc).

Where ever possible, Outreach Workers (ORWs) will conduct prevention education sessions at transit railway stations or bus stations. These sessions will comprise of one to one sessions and wherever possible, one to group sessions. IPC will be given to:

i) Migrant railway/bus passengers[18] waiting at the station to board the train.
ii) Migrant passengers[19] traveling in the train or bus.
iii) Migrants (in transit)[20] residing/working at a relatively closer proximity to railway or bus station. The outreach workers would reach migrants at the bus stations situated close to the station chosen for transit intervention.

These migrants / passengers could include new migrants migrating from source to destination for the first time or returnee migrants. If the selected transit site is in a Link Worker Scheme (LWS) district, Link Workers (LWs) will be involved in IPC & Mid media activities. The outreach workers & Link Workers will maintain records on the coverage and feed into monthly technical reports which in turn will be fed into the project management information system.

Appropriate information material relevant for the migrants and transit corridors will be developed by SACS based on prototypes developed by NACO IEC division. Messages and materials (Flip charts, brochures, leaf lets) need to be carefully developed so as to not to stigmatize the passengers. While developing the materials for the best impact, messages can be categorized for three segments of migrant passengers as below:

1. Migrants travelling in groups of friends
2. Single Migrants travelling alone
3. Migrants travelling with family.

Besides the above categorization, depending on the context and the time available with migrants, types of materials and messages need to be developed. For example, passengers who come into the station and waiting time is very little – simple pamphlets and attractive picture based materials can be handed over. Migrant Passengers who have longer waiting time materials that will aid IPC and one to group session need to be developed.

Protocol for Field Work in the Railway or Bus Station:

- ORW and Volunteers will need to be specially trained to provide information at Transit without stigmatizing the migrant passengers
- Authorization need to be obtained from the railways and transport department both from the Division and local office so that the authorities are fully aware of the activities and the purpose.
- All the ORWs and Peer Leaders should carry with them Official ID Card authorizing them to conduct these sessions.

[18] The migrants in this group congregate at these transit stations from neighbouring districts and regions and use the station to travel to their chosen destination site. They spend few hours at the station premise before boarding the train thus giving an opportunity to intervene. For example people come to Gorakhpur station from Khushinagar, Sidharthnagar and Maharajganj.

[19] Migrants of this group are passengers en route from a source area and travelling to a destination site on that train route

[20] The migrants in this category are those who have migrated to the transit site district in keeping with the mobility patterns of inter-state and intra-state migrants. These migrants stay at these transit site districts for a specified period of time (up to 6 months to one year) before moving to another site.

- Should always carry with them BCC Kit that contains, IEC materials appropriately categorized for relevant segments of migrant passengers, Condom Supply, information and contacts of service hubs in the destination or source to which they are travelling, referral slips for STI treatment, information of various health hazards and occupational hazards, information on welfare schemes for migrants, entitlements at destination etc.

b. **Setting up Migrant Facilitation Booth at Portals of Migration:**

Wherever feasible, Migrant Facilitation Booth cum Mobile Information Booths will be set up at the railway station and bus stations. For transit interventions, the project will set up portable stalls on the premises. These stalls will be easy- to- install, cost effective alternative to permanent structures. This will also be effective in catering to larger audience given the flexibility of setting up wherever and whenever traffic of migrants is anticipated. The opening times of the centre will be reflected by the migrant flow through these points at any given time and frequency of trains identified in the intervention. The centre will be manned by NGO outreach workers and will be equipped with all necessary communication materials. Materials will include posters, pictorial leaflets, flipchart, and audio visual setup. Provision will also be made for activities like puppet shows and interactive games. Migrants who are identified as high risk through one to one interaction, will be given a Travel cum Resource kit[21] that will broadly cover the following:

a. Information on HIV/AIDS/STI
b. Condom packs
c. Names and other contact information details of support agencies at destinations / sites for that source destination pair
d. Details of ICTC / ART Centre at destinations sites for that source destination pair
e. Information on welfare / insurance schemes for migrants
f. Travel kit (tooth brush, tooth paste, towel etc)
g. Train and bus timings (source and destination)

Condom boxes will also be placed at the information booth and condoms will be distributed free, on a need-to-have basis and in an appropriate fashion taking into consideration the sensitivities involved. Interactive & educational games will be set up at these booths and ORWs & volunteers will encourage migrants / passengers to participate in these games.

Besides providing sexual health information and products, this will also act as a migrant service centre for general information about destination points, crisis mitigation services, police protection etc

c. Conduct Mass Awareness

Mid Media Programs: Depending upon feasibility and availability of resources, mass awareness programs on HIV/AIDS will be conducted on a periodic basis. The project will use folk media, street theatre, film shows, wall paintings and poster exhibitions at railway stations. For folk

[21] The contents of the kits will largely be informed by the needs of the migrants for any given corridor, train routes etc. The list of contents mentioned above is illustrative.

media, the project will build linkages with the songs and drama division of their districts. Street theatre scripts will be developed and pre-tested. The script will incorporate messages to address issues of safe mobility, HIV/AIDS /STIs, gender and reduce stigma and discrimination. Street plays, on a periodic basis may be conducted by staff of the implementing partner involved in this program.

Provision of cloth jackets with STI/HIV/Health messages for vendors for wider publicity would be an effective IEC at the transit point.

Hoardings for Mass Awareness: At the identified bus-stops, NGO will put up a hoarding / banner at a strategic location and also conduct HIV/AIDS information dissemination activity through ORWs. Wherever possible, closed circuit television installed in stations will be used to air HIV/ AIDS spots.

d. Innovative Train activities

Dedicated migrant focused 'Train intervention' in transit route will be planned. Two ORWs of implementing agency based at transit points (depending on frequency of trains, convenience of travel and other logistical constraints) will board the trains at the transit (or base station) station and travel with migrants for duration up to two hours to another stop on that train route. Wherever possible, ORWs would conduct these activities during their return journey. These transit level interventions will include awareness generation activities through distribution of IEC materials and at a more intensive level- small group meetings and dyadic communications. Other innovative activities include use of folk songs and contemporary popular songs to pass information, interactive educational games, magic show etc. These transit intervention will at all times feed in to other communication activities at source and destination points.

e. Identification of Volunteers

ORWs will also identify and sensitize volunteers at the railway station and bus stands. These volunteers will help in organizing mid -media activities. The identification of volunteers for this intervention will be done from secondary audience like railways staff, vendors / porters at railway platforms, auto driver association, rickshaw puller association and from NGOs who have a presence in the station premises (NGOs working on run-away kids, anti trafficking etc) etc. With the help of established modes of communication, volunteers will contact and mobilize the target group to attend in the mid-media activities like street plays, video shows, mobile exhibitions conducted by NGO staff.

Sexual Health Products and Services

f. Condom Promotion

At transit points, the focus would be more on passing information about condoms and its role in prevention of STI and HIV. It will also address some of the common misconceptions surrounding condoms and its use (reduced pleasure, breakage, etc.). The outreach activities in

the project will include condom education/ demonstration at select sites depending upon the appropriateness of conducting such an activity at these sites. This will also include distribution of free condoms at the migrant booths on platforms and through ORWs in trains as per the need.

g. STI Information and Treatment Linkages

Facility will be made available at the information booth to provide, STI related information and counseling and information on treatment available at the destination site. This will also be linked to smart card system and if any individuals with STI symptoms are identified, they will be given a referral slip to get themselves treated at the destination or source

2. Enabling Environment

a. Conduct Sensitization and Advocacy Meetings

To mobilize resources and support for organizing focused IEC programme for migrant workers at railway stations, NGOs will conduct sensitization meetings and follow-up meetings with railway authorities and other stakeholders. (See the list of gatekeepers identified as secondary and tertiary audience below).

b. Crisis Response System

Project will help in establishing crisis response system in order to help and support migrants in crisis situation (loss of belongings, loss of dear ones etc). Crisis response system will essentially help in quickly accessing support from Police, access legal support etc.

Stakeholders in Transit Interventions for Migrants

The table below shows the target audience /stakeholders who will be involved in Transit Interventions.

Primary Audience[22]	Secondary Audience	Tertiary Audience
• Potential migrants • New migrants • Returnee migrants	• Railway staff, Bus Station staff, auto / rickshaw unions, vendors, porters at railway platform, train attendants and other functionaries who directly or indirectly interact with the migrants through the journey • NGOs & CBOs staff working on issues such as trafficking etc. with street children and who have a presence on the rail/bus station premises	Railway Ministry / Road Transport Department, Local Self Governments (corporation, municipality, Panchayath)

[22] Transit would include a) situations where migrant from a 'source' area stay for a significant time (6-12 months) at a given 'halt' point (also included as transit point) before moving to the 'destination' community b) situations where the migrant travels to 'destination' community without spending time at any given place as mentioned above.

4.1.1.28 MANAGEMENT STRUCTURE FOR TRANSIT INTERVENTION

The intervention on the ground will be implemented through an existing NGO program (implementing TI). The key staff of the intervention would be the Part time Out Reach Workers and volunteers (Vendors). Whereas the role of Project Manager of the TI to support and mentor the ORWs in managing crisis, planning and monitoring of the intervention at transit.

NACO will implement and monitor these interventions through SACS and through the TSU or Lead NGO structures. The PO in the region responsible for the concerned HRG TI will be responsible for day to day handholding and monitoring.

The detailed role and deliverables is attached at **Annexure 5.13.**

4.1.1.29 SUMMARY BUDGET

Detailed budget is attached at Annexure 5.17

4.1.1.30 LIST OF KEY ACTIVITIES

The same is elaborated at Annexure 5.14

4.1.1.31 TRAINING MATERIALS

The same is part of the Capacity Building Chapter

4.1.1.32 REPORTING TOOLS

The same is part of the Monitoring and Evaluation Chapter

4.1.1.33 PERFORMANCE INDICATORS

The same is part of the Monitoring and Evaluation Chapter

LINKAGES BETWEEN SOURCE AND DESTINATION

The Need

The project model for migrants across the corridor will not be stand alone interventions. Since the migrants keep moving between source, transit and destination, the project will try to track the movement for follow up, referral, service delivery – ensuring risk reduction and behaviour change while the migrant moves around. The services and information package at the three sites will need to be complimentary and therefore require good coordination. Following are some of the mechanisms suggested for Linkages.

Mechanisms for Linkages

1. **MoU with SACS/DAPCU source and destination states**, initiating cross border programmes. This would primarily result in linking with NGOs involved implementing the prevention program both at the source and destination. This MoU will cater following deliverables:

    a. Sharing of information between the States on volume of migration, the place of origin/destination for service linkages, information on beneficiaries of HIV related services among migrants to ensure continuum of services.

    b. Provision of necessary budget in the IEC and TI of source States to ensure provision of required language specific IEC/BCC materials and training for staffs of destination interventions.

    c. Provision of activities to sensitise workers, staffs at all level regarding the needs of migrants from source.

    d. Sharing of information on labour contractors, brokers who are known to have networks with source States

    e. Provision of recruitment of at least 20% field staffs based on the requirement from source States and their training in their local language to cater needs of migrants from source States

2. **Linkage system using Referral Card and Unique No. within a particular corridor of operation:** Until the smart card system is operationalized, an active communication channel using referral slips and emails will be initiated to maintain contact between the source and the destination. Referral slip and unique identification number would be issued at both source and destination for a new migrant who is getting registered for a service with the centre and will be advised to carry the referral slip to the destination or source, as the case may be, and quote the reference number while accessing services. This will be manually entered into the computer and monthly reports for all the migrants who have received service from a centre will be generated and shared with the source or destination, as the case may be, within the same corridors.

3. Past experience of working with migrants at destination has indicated that often due to lack of understanding about the language, norms, culture of the in-migrants the

projects has not been able to deliver their best through local volunteers, peers and ORWs. Hence it is desired that SACS at destination sites to ensure that there is representation from the in-migrants group in the project planning and implementation as well as the staffs to be trained by local experts with an understanding of issues and context of source States.

GENDER DIMENSION IN MIGRANT STRATEGY

4.3 GENDER DIMENSION WITHIN INTERVENTION STRATEGY

With the primary shift in labour demand from industrial to service sectors, highly gendered niches have appeared in some sectors (domestic work, health, child and aged care), that are likely to be more female dominated. In India economic liberalization and in particular trade liberalization has created gender specific labour demand where women either migrate in groups or with their families to avail the newly found opportunity. The preference for women employees on the part of employers is mainly because women accept lower wage, are not unionized and do not protest much against unpleasant working conditions.

The real world phenomenon indicates three distinct types of female migration (Fawcett et al, 1984) **(a) (A) Autonomous female migration:** Many middle and upper middle class women migrate to cities for improving their educational credentials and also to get suitable employment apparently in a quest for social advancement and also to enhance their status in the marriage market. 3 Among the semi-literate, young girls migrating to towns/cities to work in export processing units, garment industry, electronic assembling and food processing units is continuously on the increase in the recent years;

(B) Relay migration: To augment family income, families which have some land holdings in the rural area, send the daughters to work mostly as domestic servants where they are safe in the custody of a mistress. First the elder daughter is sent out and she is replaced by the second , third and so on, as one by one get married.;

(C) Family migration: Here the wife instead of staying back in the village prefers to join her husband in the hope of getting some employment in the destination area. Family migration among agricultural wage labourers who have no land or other assets to fall back at times of crisis is becoming increasingly common. Moreover in the poorest groups male dominance is generally tempered by women's contribution and marriage works in a more inter-dependency mode. It is such groups which migrate in family units to urban destinations in search of employment prospects for both.

Migration is generally expected to have empowering impact on women in terms of increased labour force participation, economic independence and higher self esteem. But this does not always happen. Female rural to urban migrants continue to be vulnerable to gender based discrimination in wages and labour market segmentation which reserve the most repetitive, unskilled, monotonous jobs for women. They mostly work in the informal sector and experience long working hours for a very low wage, un-healthy or dangerous working conditions, and psychological, physical and sexual aggression.

In the Indian context it is not clear whether wage employment has helped them to overcome poverty since for an outsider there is nothing emancipating in bad working conditions, low wages, over-work and discrimination. The limited research studies that are available in the Indian context for the earlier periods indicate that these women are exposed more to the risk of sexual harassment and exploitation (Acharya, 1987 and Saradamoni, 1995). They often have to work till the last stages of pregnancy and have to resume work soon after child birth

exposing themselves and the child to considerable danger (Breman, 1985). Women migrant workers in sugarcane cutting, work almost twenty hours a day (Teerink, 1995) Female labour mostly from Kerala in the fish processing industries in Gujarat are subject to various forms of hardship and exploitation at the hands of their superiors (Saradamoni, 1995). With the entry of more and younger women in the export processing zones, market segmentation is being accentuated, female dominant jobs are being devalued, degraded and least paid. Though this does not augur well with women development it has not deterred women from contributing to family survival and studies are not wanting which highlight that it is women who settle down in the labour market as flower/fruit vendors, domestic servants and allow the men to find a suitable job leisurely or improve their skill (Shanthi, 1993). Case studies indicate that it is the men who were 'associational migrants' and not the women. Families had migrated in response to female economic opportunity (as domestic servants, as vegetable vendors, flower vendors in front of the temple etc) and they are the primary or equal earners, male employment often being irregular and uncertain.6 While entry barriers are many in male jobs (in the form of 'informal property rights) and the waiting period is long it is not so in the case of female jobs where they have easy entry and exit in domestic service and personalized services (Premi, 2001, Meher, 1994 and Shanthi, 1993, 1991). Their earnings may be low but crucial for family survival. They get paid in 'kind' as well, which help to combat malnutrition especially among infants.

Marriage is a dominant factor in female mobility around 85-95% of female migration takes place within the state. Coming to female migrants from other states (inter-state) Haryana (16.3%) Punjab (15.8%) and Maharashtra (15.2%) top the list with more than 15% of the migrants from other states. The reasons could be numerous. Maharashtra is one among the very few states which attracts migrants from almost all over India. Moreover in-migration from other states constitutes less than 10% of total migrants for all the states except for Haryana, Punjab and Maharashtra.

The percentage of female migrants from other countries is an insignificant figure (Col 6). Except for West Bengal which is close to Bangladesh, no other state receives more than one percent of the total women migrants from other countries. In the case of West Bengal, women from Bangladesh enter legally and illegally in search of employment and also for marriage because of the porous borders. Next to West Bengal, Tamil Nadu and Karnataka receive women migrants from other countries, may be from Sri Lanka. Of late Tamil Nadu attracts lot of foreign students which includes women as well and this could be one of the reasons. The percentages are 0.83 and 0.76 respectively.

A study in India reveals health hazards due to unpleasant working conditions, worsening of work burden on women and increased risk to sexual harassment (Ghosh, 2001 and Swaminathan, 2002, 2004). A very small proportion of the cases of sexual assault are reported. Women are not provided with any extra facilities to take care of their children while they are on work. While men normally work in groups women go for individualized work environments (eg. Domestic service) where there is greater isolation with the least possibility of establishing networks of information and social support. So measures designed to 'protect' migrants must be accompanied by measures that empower them.

Migrant women who opt for self employment as vendors and service providers remain invisible in official labour statistics and hence are unprotected by national labour legislations. Subcontracting has also led to invisibility of these women workers who are at the bottom of the employment hierarchy, lack of recognition of their rights and instability of employment. These women choose to support their families in low waged work since the only other alternative is unemployment and consequent dire poverty.

Migrants living in poor urban slums suffer from the lack of basic public provisions. Most of the migrants living in these slums suffer from lack of running water, toilet facility and lack of clean drinking water, face open sewers and infestation by flies, rats and mosquitoes making migrants and their children vulnerable to various health problems.

The prevailing gender norms and inequalities render women more vulnerable to the HIV infection. These gender dynamics not only facilitate the spread of HIV but they also get reinforced in those infected and affected. Gender norms impact the way in which infected men and women are perceived, thus influencing the ways in which they cope with HIV.

Most of them are migrating due to poverty, once at their destination place, they are more vulnerable to being pushed in to sex work to supplement their earnings. This is reinforced by a lack of HIV and AIDS awareness, information and social support networks at both source and destination points. Loneliness, drudgery and long periods of separation from family/spouse/sexual partner and limited or no skills to cope with the overall pressures and environment at destination places may lead to behaviours associated with risk for HIV infection, i.e. drinking and sometimes drugs as well as sex with male colleagues, casual sex relationships or sex work. Additional vulnerabilities include the risk of being trafficked along the way and the risk of sexual exploitation, violence or harassment by sexual network operators/local power structures or by workplace superiors. Lack of knowledge and negotiation skills make it difficult for women to negotiate condom use with both their husbands and other sexual partners. Women's lack of decision-making power and reticence about seeking STI treatment often leads to a suppressed demand for health services even when the need is obvious. This results in prolonged untreated STIs and increases the risk of HIV infection.

Thus, the vulnerability of the female migrants as well as the spouses of male migrants to HIV is quite well established. Focus on reaching out them in the current migrant TI has been a major weak link in the program as stated earlier. Therefore there is a need for conscious effort to mainstream gender focused programmes within the interventions at Source, Transit and Destination. Following are some of the strategies and activities to be undertaken to ensure gender related needs are addressed within the migrant intervention for HIV prevention.

Steps for Operationalizing Gender Mainstreaming

1. **Human Resource with NACO**: It is proposed to include a human resource for gender mainstreaming for the migrant program within the TI division. She/He will have the mandate to ensure, gender issues at all level (National, State and District) is taken care and issues of female migrants are adequately addressed within the intervention. This will be achieved through, capacity building at various level, advocacy, generating evidence that would feed into decision making as well as regular gender audit in sampled sites.

2. At the Implementation Level

i. Set Up Stage:

- Recruitment: While recruiting various staff positions equal opportunity and preference should be given to female candidates. This will ensure a well balanced coverage and reach of female migrants and spouses of male migrants.
- Rapid Assessment: While sampling for rapid assessment adequate attention be given to select sample from female migrants as well spouses of male migrants. This will ensure better understanding of the needs and issues being faced by them and can addressed adequately while designing and implementing the program.

ii. Implementation Stage:

- Information Services: While designing the BCC and IEC materials care should be taken to be gender sensitive while developing messages. Specific IEC for female migrants as well as spouses of male migrant needs to be developed. The Training package for volunteers as well as for other staff within the project should enable them to be more gender sensitive and provide knowledge and skill to address the needs of women.
- While developing Resource Kit for Transit or destination to be distributed through the information centre, it would be important to prepare kits separately for female migrants.
- Adequate attention should be given to focus on information need of female migrants while designing the DIC and information booth.
- Referrals and Linkage: Gender sensitivity is an important consideration even while planning referral clinics and health camps. It would be important to ensure male doctors to treat male migrants and female doctors to treat female migrants.
- Condom outlets to be established also in the toilets of women
- While designing clinics during health camps, privacy should be ensured for physical examination.
- While designing the social welfare and social security schemes, should ensure linkages with program of women and child welfare department that has lot of scheme for women.
- Awareness building among women should also focus (beyond sexual and reproductive health) on the following:
    a. Rights of Women
    b. Empowerment initiatives
    c. Legal protection available for women – particularly for female labourer
    d. Sensitization towards the needs and rights of women adolescent and other gendered identities, e.g. transgender
- Male involvement
    e. Garner collective efforts with male partnership in responsible behaviour
    f. Facilitate behaviour change of male migrants towards the female (respect, trust, care and concern)
    g. Focus on marital harmony

- Sensitize health service providers towards gender friendly service delivery.
- Advocacy and Enabling Environment: work with local self government, companies, contractors, law enforcement agencies, health care providers, social welfare department etc to be women friendly while providing various services. Build their capacity to develop gender friendly environment in the work space.

4.4 SUSTAINABILITY AND EXIT STRATEGY

The project sustainability and exit strategies are crucial steps within the project design that empower the community and build capacities of stakeholders, strengthen the systems to manage its own resources effectively and sustain project benefits beyond the project period. Project sustainability and exit strategies are often mistakenly kept aside at the project design stage and are kept for the last year of the project to even think about which would be often too late for any meaningful and effective actions.

Therefore it is important to emphasize the need for incorporating strategies for sustainability right from the beginning of the project. NGOs, will be invited to incorporate sustainability and exit strategies in the proposal of the first year itself so that the focus is not lost. The planning for sustainability of interventions shall start from the planning stage and work with existing structures, mainstreaming of migrant interventions into other formal and informal sectors, work for building capacities of stakeholders on programmatic implementation with/without the support of NGOs, strengthening of systems, etc.

4.5 OVERALL DELIVERY MODEL AND COORDINATION

Corridor Management: The key approach of the delivery model is to initiate interventions in all the three defined migration corridors such as Source, Transit and Destination. While independent agencies will be involved in delivery of services in the three places, it is important ensure coordination between these three location. Two key strategies are suggested to ensure this coordination:

- **Referral Card System:** In order ensure tracking of migrant across corridors, Unique id and refferal card system will be introduced at all the three locations. It is proposed to introduce color coded referral cards to track the migrants on pilot basis.

- **Managing the Corridor:** In order to facilitate linkage between these defined migration corridors, coordinate the services being provided at each of these points of contact and follow up the migrants who access services across the corridor, there is a need for better coordination. This will be done through SACS and DAPCUs with support of TSUs and where ever intense intervention is needed requiring more number of NGO programs, Separate agency will be appointed as Regional NGO to coordinate and monitor the implementing partners.

ROLES OF KEY IMPLEMENTATION PARTNERS

5. ROLES OF KEY IMPLEMENTATION PARTNERS

Key stakeholders involved in implementing the migrant interventions in the country are: NACO, SACS, DAPCU and Implementing Partners at the field (NGO). Following are the key roles that will be played by various stakeholders.

5.1 ROLE OF NACO:

Role of NACO will be to steer overall implementation of the migrant interventions in the selected geographical location within the country. NACO will facilitate smooth implementation of the scheme by ensuring all the administrative and financial bottlenecks will hinder the implementation of the program on the ground. Specific responsibility would include the following:

- Provide policy level support and enabling environment in the implementation of the program, through liasoning with various other line ministries and facilitating their cooperation in implementing the project on the ground.
- Coordination with SACS and Technical Resource Group (TRG) to ensure adequate technical support to the program as well as ensure quality implementation across.
- Conducting regular review meeting at the national level to assess performance of the project on the ground. This will be done during the Project Director SACS meetings
- Ensuring proper communication channels established for correct and timely information flow to all levels of project implementation
- Ensuring regular fund flow to SACS that will facilitate uninterrupted funds available for program implementation.

5.2 ROLE OF SACS

SACS will be responsible for overall coordination of the implementation of the project for migrants within the state. Following are the key roles that will be played by SACS:

- Selection and finalization of all key migrant sites within the state.
- Selection of the implementing partner following selection protocol.
- Ensure provision of financial allocation for development of IEC/BCC materials, bus panels, hoardings, training materials related to migrant interventions for source, transit and destination as per requirement.
- Facilitating coordination of district functionaries (ICTC, TI, CCC etc.) with implementing NGOs
- Fund flow to the implementing NGOs or other partners
- Conducting regular monitoring meetings with organization implementing the program
- Regular field level monitoring visits
- Coordination with STRC for training to implementing partner

- Coordination with TSU to ensure technical and monitoring support to the implementing partner
- Collecting monthly reports from implementing partners and reporting to NACO. Analysis and feedback on the reports received to implementing partners.
- Providing technical and supervisory support to the implementing NGOs including adequate training to the staff.
- Ensuring coordination among all the partners working at source, transit and destination
- MoU with the SACS of the destination or source states and ensuring collaboration between source, transit and destination.
- Achieving scale and coverage of the migrant program within the state
- Liaisoning with various other line departments connected to project and migrant community to ensure HIV is mainstreamed within this department and services are provided to migrants. Also facilitate process of access to various welfare schemes and entitlements for the migrant community.
- Ensuring regular submission of the accounts by the implementing NGOs
- Facilitating coordination between other prevention interventions within the state.
- The Project officer (Regional) under TSU or SACS would be responsible for day to day handholding and monitoring of TIs at destination interventions. While in addition to the existing scope with HRG TIs at transit, the POs would be responsible for handholding and monitoring of transit interventions.

5.3 ROLE OF TSU

Technical Support Unit, attached to SACS can play a crucial to provide monitoring and technical support to the NGOs implementing the Migrant Interventions. Following are some of the roles that can be played by TSU Project Officers.

- Regular monitoring visit to the NGO site
- Provide technical support during the field visit to the staff of interventions.
- Be part of training for the staff as resource persons
- Support the SACS in carrying out some of the roles described above.
- The Project officer (Regional) under TSU or SACS would be responsible for day to day handholding and monitoring of TIs at destination interventions. While in addition to the existing scope with HRG TIs at transit, the POs would be responsible for handholding and monitoring of transit interventions.

5.4 ROLE OF STRC

STRC will have a key role to play in designing and implementing appropriate training program for the staff and community within the migrant interventions at source, transit and destination. Key roles would include:

- Conduct training needs assessment
- Prepare training plan for staff
- Conduct regular training for the staff as per the needs assessment and training plan.

5.5 ROLE OF REGIONAL LEAD NGO

States that has high migration pattern and requiring more number of interventions, Regional Lead NGO will be selected by NACO to support SACS in the day to day management of implementation interventions. Following will be some of the roles played by the Regional Lead NGO:

- Support SACS in selection and finalization of all key migrant sites within the state.
- Support SACS in selection of the implementing partner following selection protocol.
- Facilitating coordination of district functionaries (ICTC, TI, CCC etc.) with implementing NGOs
- Conducting regular monitoring meetings with organization implementing the program
- Regular field level monitoring visits
- Coordination with STRC for training to implementing partner
- Collecting monthly reports from implementing partners and reporting to SACS and NACO. Analysis and feedback on the reports received to implementing partners.
- Providing technical and supervisory support to the implementing NGOs including adequate training to the staff.
- Ensuring coordination among all the partners working at source, transit and destination
- Facilitating MoU with the SACS of the destination or source states and ensuring collaboration between source, transit and destination.
- Facilitating to achieve scale and coverage of the migrant program within the state
- Ensuring regular submission of the accounts by the implementing NGOs
- Facilitating coordination between other prevention interventions within the state.

5.6 ROLE OF DAPCU

DAPCUs will play a crucial role in coordination and monitoring of the migrant intervention within the district. Following are key roles that will be played by the DAPCUs.

- Support to SACS in identification of migrant location with the district
- Support to SACS in identifying the Implementing Partner
- Technical support in situation needs assessment and planning to implementing partner
- Support to implementing partner in the selection of the staff
- Training to staff of implementing partners
- Coordination and liaisoning with line departments within the district to mainstream HIV, particularly those departments that are involved with migrants.
- Establish systems for fund management, programme management, information flow, monitoring and supervision.
- Facilitate regular reporting to SACS by the implementing partner
- Supervisory visit by DAPCU officers to migrant site
- Coordination with other HIV related district level program.

5.7 ROLE OF IMPLEMENTING PARTNER

The implementing partner will play a crucial role in the direct delivery of quality services to the field. Following are the critical roles that will be played by the implementing partner.

- Selection and appointment of staff
- Conducting situation needs assessment and planning
- Implementation of project as per implementation plan
- Regular training to staff
- Regular training of community stakeholders including contractors, agents, self-help groups, panchayats, etc.
- Establish linkages with community system and other local service providers
- Establish systems of planning, monitoring and financial management
- Ensure the coordination with other implementing agencies along the corridor of migration
- Timely submission of program and financial reports to SACS through DAPCU
- Ensure proper and regular system of field visit by the concerned staff to ensure quality delivery of various services.
- Networking with allied line departments to ensure access to various welfare schemes and entitlements for the migrants.
- Coordinate with key HIV related services available in the district to facilitate access to these services for migrants.

5.8 ROLE OF LWS NGO

The LWS NGO will play a crucial role in the direct delivery of quality services to the field for migration component in districts which are under LWS. Following are the critical roles that will be played by the implementing partner.

- Regular training to staff by the Training Officer at District level in close coordination with SACS and STRC
- Regular training of community stakeholders including contractors, agents, self-help groups, panchayats, etc.
- Establish linkages with community system and other local service providers
- Establish systems of planning, monitoring and financial management
- Ensure the coordination with other implementing agencies along the corridor of migration
- Timely submission of program and financial reports to SACS through DAPCU
- Ensure proper and regular system of field visit by the concerned staff to ensure quality delivery of various services.
- Networking with allied line departments to ensure access to various welfare schemes and entitlements for the migrants.
- Coordinate with key HIV related services available in the district to facilitate access to these services for migrants.

STRATEGIC INFORMATION

6. STRATEGIC INFORMATION

MONITORING AND EVALUATION PLAN

A comprehensive monitoring system not only helps in measuring progress and the performance of a program but also helps in consolidating learning, taking corrective actions and ensuring accountability while implementing the program. Monitoring and evaluation (M&E) for migrant interventions 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 mechanisms.

To strengthen Monitoring and Evaluation, the following needs to be incorporated:

- Designated M & E Consultant to provide technical support to implement and revise the M & E framework for the programme and to align it with the national systems.
- Capacity building of personnel at all levels on various aspects of M & E to be planned to ensure generation of quality data and optimal use of the information for programme purposes.
- A Project Steering Committee which includes members from the Implementing NGOs, State AIDS Control Society and National AIDS Control Organisation should be formed. This will further facilitate oversight and sharing of knowledge and experiences.

Key areas that need to be monitored include:

a. Inputs: Resources invested in the program for the recruitment and training of the project staff at various levels. These will be monitored through a set of recording and reporting formats.

b. Outputs: Immediate achievements of the programme in terms of the deliverables, such as the number of migrants reached out to, number of condoms distributed, number of migrants effectively linked to the services etc. These will be monitored through a set of recording and reporting formats.

c. Outcomes: Changes observed in the overall condition of migrants covered by the scheme including the trends in the percentage of migrants using condoms, accessing services, experiencing reduced stigma and discrimination etc. The outcomes will be monitored through a series of outcome studies including polling booth surveys and focus group discussions at regular intervals during the implementation of the scheme.

d. Impacts: The long term impact that occurs at large as a result of implementing a programme, including changes in the prevalence of HIV and incidence of STIs amongst migrants covered by the scheme. This will be carried out through special analysis of the secondary data.

Key Indicators for Monitoring

- Input level Indicators
    - Number of personnel recruited for the program (by gender, age and educational qualification)
    - Number of personnel trained for the program (by gender, age and educational qualification) NGO staff, Qualified public and private health service providers and RMPs
    - Number of area level (source and destination) volunteers identified and trained
    - Infrastructure development vis a vis plan

- Output level Indicators
    - Number of migrants who are identified in the risk group
    - Number of migrants in the risk group that were contacted/provided BCC by area level trained volunteers in the reporting month
    - Number of new migrants in the risk group that were contacted/provided BCC by area level trained volunteers for the first time
    - No. of BCC events organised by type (folk media, AV shows and infotainments) organised against planned
    - Number of condoms distributed directly to members of the migrant risk groups in the reporting month
    - Number of migrants in the risk groups that were referred separately for each type of services including STI treatment, ICTC/PPTCT, TB diagnosis/treatment, ART during the reporting month
    - Number of migrants in the risk groups who received/ utilized the services, separately for each type of services including STI treatment, ICTC/ PPTCT, TB diagnosis/treatment, ART during the reporting month.
    - No. of active migrant community groups involved with prevention of HIV. The groups can be in the form of SHG and other groups including Life Skill Education groups.
    - Total number of meetings held by the groups on monthly basis.
    - Cadre-wise, module-wise training status.
    - Capacity building sessions in review meetings.
    - Number of source and destination areas mapped and selected for implementation of the program
    - Number and type of stigma reducing events organized theme wise
    - Linkages developed with other organizations and Govt. schemes and Departments
    - Number of stakeholder meetings organized in the month by each type (police, elected representatives, unions and associations, others)

- Outcome level indicators
    - No. of migrants who can state or demonstrate correct use of condoms
    - Consistent and correct condom use by high risk migrant groups
    - Utilization of services (testing, care and support and other social schemes) by the high risk migrant groups
    - Utilization of services (care and support and other social schemes) by the positive migrants

- Reduction in stigma and discrimination-related experiences of the positive migrants
- Knowledge and attitudes of general migrant population
- Behaviour of migrants – Number of partners, safe sex practices
- Utilization of services (testing, care and support and other social schemes) by general migrant population

- Impact level indicators
  - Prevalence of HIV in the source and destination area amongst migrants
  - Incidence of STIs in the source and destination area amongst migrants
  - Percentage of migrants, both men and women aged 15-24, reporting the consistent use of condoms with non-regular partners
  - Percentage of migrants (women and men) of 15-24 years of age correctly identifying ways of preventing the sexual transmission of HIV and rejecting major misconception about HIV transmission

Performance Indicators:

A set of performance indicators indicating benchmarks for source, destination and transit interventions has been developed. These indicators measure the performance of different components of the intervention across a specific time period as indicated.

The Performance Indicators for Source, Destination and Transit is attached at Annexure 5. 18.

These indicators will be part of the contract during first year. For subsequent year the same principle need to be used while developing project proposals based on the need of the project.

Mechanisms for Monitoring
Key monitoring mechanisms will include the following:

- Recording and Reporting Systems- Structured Recording and Reporting systems at three major levels- namely implementing NGO, SACS and NACO would be critical for comprehensive monitoring of the program. Within the implementing organization, records and reports would flow from Volunteers to Supervisors and further to the Manager of the project on monthly basis to feed into the central MIS.

- Review Meetings- Fortnightly review meeting with all major stakeholders at District level Monthly review meeting at SACS level and a bi-monthly review meeting at NACO level would support in gauging the progress of the project and facilitating strategy and process amendment as required.

- Supportive Supervision Field Visits- Supervisory field visits are an important monitoring mechanism that will provide first hand information on the quality of implementation of the activities and ensuing results in the field. The regional project officers under SACS or TSU and supervisors in LWS would provide supportive supervision to facilitate

identification of strengths and weaknesses of program implementation and ensure efficient and effective delivery of services.

Reporting Tools and User Manual:

A set of reporting tools and user manual has been developed. The same need to be used for data collection, compilation, analysis and sharing. These tools will accumulate necessary data to be used for reporting in SIMS format.

Annexure 5.19 : SOURCE REPORTING TOOLS
Annexure 5.20 : DESTINATION REPORTING TOOLS
Annexure 5.21 : TRANSIT REPROTING TOOLS

Evaluation

While the monitoring indicators described above will provide information about implementation status on a regular basis, evaluation of the program is to be conducted at the end of the project period to determine the success in reducing migrants' vulnerability to acquiring HIV/AIDS. Evaluation indicators are measurable parameters for each component and subcomponent of the program with a verifiable source of information.

- Knowledge
    - % of migrants who knew that consistent use of condoms reduces the risk of HIV
    - % of migrants correctly aware about the five ways of HIV transmission.
    - % of migrants reducing at least two misconceptions about reducing the risk of HIV infection.
- Behaviour
    - % of migrants who had sex with CSW or non regular partner in last 12 months
    - Condom use in last sex
- Self Reporting on STD symptoms
    - % of migrants who suffer from genital discharge or genital ulcers/sores
    - % of migrants who had sex with any partner while suffering from STIs
- Risk Perception
    - Perception of risk for contracting STIs
    - Perception of risk for contracting HIV/AIDS
- Process
    - % of migrants who have heard about STI
    - % of migrants seeking treatment for STIs
    - % of migrants obtained medicine for STIs
    - % of migrants reported completely cured
    - % of migrants who knew any person from neighborhood talking about unprotected sex and danger of STI and HIV/AIDS
    - % of migrants who have witnessed any BCC event on HIV/AIDS

OPERATIONS RESEARCH

Effective policy responses must anticipate and address HIV vulnerability at each stage of the migration process in both migrant source and destination areas. Migration itself is not a risk to health, but the migration process can increase vulnerabilities to poor health, especially for migrants who move involuntarily, fleeing natural disasters or humanitarian crises, or those who find themselves in irregular or exploitative conditions.

The links between migration and HIV are complex, with evidence showing that much more needs to be done to promote and mainstream the health of migrants. Research will be conducted to better understand migration and HIV transmission dynamics. This will help establish clear links between migration, informal sector employment and vulnerability to HIV. Several Smaller research studies would be conducted at all the three stages of the program namely- commencement, during the implementation and closure to feed into the overall operational research findings from the project.

Some data exists to establish the correlation between migration and vulnerabilities of informal sector work force; better evidence is required to position this as a major area of HIV interventions. By carrying out this research, NACO will have concrete data sets for fine tuning implementation strategies for HIV prevention amongst migrants.

A research committee would be constituted to guide and oversee the research component of the program. This committee would comprise of representatives NACO, SACS, one academic institution and independent experts in the area. The committee will identify few areas for further Operations Research (based on emerging areas for further study).
Scheduling of Research component in the Program

- Setting up of the Research Committee
- Terms of reference (ToR), commissioning and completion of baseline
- Mid line study and evaluation
- End line study and evaluation
- Other Operation research (subjects to be decided by Research Committee)

Suggested areas of Operational Research with reference to Migration and HIV

- Process of migration from source to destination areas, linkages, transit pattern and vulnerabilities to HIV
- Inter-state (source) dynamics of migration with respect to HIV prevalence and incidence with special focus on gender and age
- Comparative study of destination regions of migration with respect to HIV prevalence and incidence with special focus on gender and age
- Comparative study of work place/type of work for migrants vis a vis HIV incidence
- Implication of migration on overall health status- comparative with the health status before migration
- Case study documentation of migrant beneficiaries of the project- following select case from the commencement till the closure of program
- A randomized control study with one group of migrants undergoing BCC interventions compared with its counterpart not undergoing it.

Research component would need to be intrinsically built into the project to encompass several small operations research studies with defined completion time, in order to utilize learning from the study for review/modification of project design, ensuring requisite capacity building and strengthening of the monitoring system.

CAPACITY BUILDING

Human resource capacity development of is a key aspect of Program implementation. Capacity Building of the implementing team to bring change in migrant community perspective in the context of HIV needs to be extremely methodical. The Program aims to work on HIV prevention and care amongst migrants in the source and destination areas with the focus on community participation and sustainability.

To fulfill this objective, efforts will be made to train the staff in this program to make them understand the situation and dynamics in the source and destination areas and utilize it for community mobilization. Acceptance and Involvement of community members in the change process also requires honing of skills. Hence, the capacity building agenda under this scheme will be cross cutting and shall include technical knowledge of HIV and STI to making the migrant community self-reliant and sustaining the change process.

The responsibility of capacity building of the staff will lie mainly with the Implementing NGOs that would be selected on the basis of their extensive experience in the field. STRCs identified by NACO will support the NGOs in training the staff and also creating a Training resource pool. Given the diversity of languages and culture of communities in India in general and migrants group in particular because they move between extremely diverse cultural settings, the key challenge will be to standardize the training scheme. It will have to take regional differences into account and provide adequate operational flexibility for incorporating local needs and issues. The training will be given in the local language and the methodology will be adapted to suit the various cultural ethos and practices.

Capacity building inputs at all levels of implementation, i.e. SACS, NGOs and industrial centers/workplace, other government departments, service providers, project staff and Volunteers should be planned for working with migrant population. The capacity building inputs should include:

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

Following institutions/ personnel will be trained:

- Implementing NGOs/SACS– Since the role of these organizations will be to manage and oversee the implementation of the program, their staff will be trained on conceptual and contextual understanding of the project and its technicalities.

- Work place/Industrial centres- Migrant workers vulnerabilities in the destination area, exposure to information on prevention of HIV and non discriminative behaviour with those infected would be the key aspects of training for this group to ensure required support for implementation of the program.

- Health service providers- Attitudinal training of health service providers for creating a non discriminatory and non stigmatized environment for migrants to access HIV care

and prevention and understanding of their critical role in context of migrant intervention is extremely significant.

- Project Personnel – Project Coordinator, ORW, Counselors, Peer Leaders and volunteers-These are the people who will carry out the actual implementation of the program. Hence, their capacity building will focus on developing their implementation skills and focusing on enhancement of knowledge and attitudinal training

Personnel involved in implementing the Program will undergo modular training. While some of the sessions in the training will be conducted in a classroom setting to focus on theoretical aspects and concepts, the other sessions will provide field based experiences (both of the intervention areas including service delivery centers). One section will include immersion programmes where the participants will visit an intervention site or learning site and live with the community to get first-hand experience of migrant life. The subsequent trainings will be conducted as close to the migrant destination areas as possible to ensure that the participants witness and address implementation related issues.

Modules to be covered under capacity building for the implementation of the program include:

Module 1: Understanding the context of migrants in the source and destination area, rationale and features of the scheme, risk and vulnerability of the migrants, facts of HIV/ AIDS, prevention and care issues and learning to use mapping data for developing a Area Implementation Plan.

Module 2: Understanding theory and concepts of community mobilization, entry level activities in source and destination areas, building trust and community ownership, conducting participatory assessments, understanding migrant community needs and developing plans to address them. Conducting household surveys, converging with other programmes in the area, establishing linkages with institutions, project monitoring, reporting and documentation.

Module 3: Developing outreach plans, profiling at-risk and vulnerable migrant population in the source and destination area, conducting behavior change communication, referrals and linkages with services and follow up, forming interest-based groups, selecting and motivating volunteers, strengthening community groups, program monitoring, reporting and documentation.

The specific topics that need to be covered under trainings are:

- Basic information on HIV and STIs
- Migrant Community development and strategies for personal development and empowerment of communities
- Stigma and discrimination
- Human rights and violence
- Community participation and empowerment
- HIV testing and counseling
- BCC and development of IEC materials
- Peer education and community outreach

- STI management
- Condom programming
- Safer sex negotiation
- Sex and sexuality
- Advocacy

The capacity building plan will follow the phases of implementation. In the scaling-up phase, the capacity building plans will be very intensive. In the continuing phase, capacities of staff will be built based on the needs emerging from the field. Keeping the workforce motivated and sustaining the change will be focused upon.

Technical assistance for organizations implementing the program would be in the following areas:

1. Mapping, needs assessment and vulnerability studies
2. Planning
3. Training of Trainers (Master Trainers)
4. Development of training manuals
5. Documentation of Best practices
6. Development of training aids
7. Communication material development
8. Development of Standard Operation Procedures and quality assurance protocols
9. Impact assessments
10. Baseline, midline and end line studies
11. Other research studies

A cascade training approach is envisaged for building capacity of Implementation personnel. A cadre of "Master Trainers" will be developed by SACS for overall support of migrant intervention in the State and districts.

Regular reviews will help the Implementing NGOs/SACS to develop need based training plans. As the program starts getting implemented, it is visualized that the migrant community will begin to make various demands from the Implementation personnel which they will be expected to meet. Hence, the capacity building process will have to be continuous, in order to equip them with skills and knowledge to enable them to fulfill the demands of the migrant community. Besides the stipulated training, the monthly meetings will be also used as a platform to build capacity.

Separate ORIENTATION TRAINING MODULE FOR SOURCE, DESTINATION AND TRANSIT to be used by STRC, SACS, TSU, Implementing partners to provide orientation of staffs at the start of the implementation. State level TOT can be planned by SACS in coordination with LWS NGOs and STRCs for a pool of resource persons for continous support.

SYNERGY WITH OTHER INITIATIVES

Migrant interventions for prevention of HIV in the country will not be a stand-alone program model, but will build synergy with other programmes in order to channelize benefits to the community to the maximum. In order to facilitate sharing of resources the program will ensure synergy built at three levels: at the centre or national level, state and district or at the point of implementation.

At the Centre: NACO will facilitate inter departmental/ministerial collaboration and sharing of services, resources and information through its mainstreaming cell. Already system exist to facilitate this. Migrant theme will be added to ensure the services available also reach to the migrants. The card system that is being introduced in the migrant program will also be used to reach the services of the other departments to the migrants. Mainstreaming cell of NACO will help in moving the necessary papers so that, the same card can be used by the migrants to access similar services from other departments.

At the State level: SACS will facilitate through the mainstreaming unit the interdepartmental collaboration which will ensure better sharing of resources and facility.
At the district level, the implementing partner will ensure, the departments are linked up in reality and the services are actually made available to the target community through the effort at the state and central level. If adequate results are not found, will inform the state and the centre for more concerted effort so that concrete support is received by the community. Following are some of the already existing programmes with which Migrant program will collaborate

Global Fund Round 7: As stated in the earlier section of this document, wherever the Link Worker Program being implemented by NACO in reaching to the rural village which are within the designated source districts, no separate program will be initiated through the migrant interventions, but provide additional resources both money and human resources to reach out to the migrants through the existing structures of Link Worker Programme. In around 97 districts which are designated as high volume migrant source districts, Link Worker Program already exist or will be covering in the second phase of its program. Therefore this will be an opportunity to synergize with the existing program to reach out to the migrants with information and services in the additional migrant villages in these districts. Within NACO, the TI team will collaborate with LWS team to ensure, migration is also included as one of the key criteria while mapping and prioritizing the villages for interventions, so that additional villages in these districts with high volume of out migration can be included to select the village besides the already existing parameters for village selection under LWS.

Care and support initiatives: NACO already has very well established network of care program in the country, particularly in the high prevalent districts. Wherever the migrant program will be implemented, the intervention will link up with the existing district network of PLHIV, Community Care Centres, PPTCT program, ART program etc to ensure, migrants who require these services are able to access them without any difficulty and the smart card that is being introduced within this program can be used to access care and support services as well.

Global Fund Round 9: This is largely a destination area strategy working with companies in the urban areas with set of services. NACO will reach out to the migrants at destination through 500 interventions in round 9 and therefore in these urban sites, no new migrant intervention as described in this document will be initiated but will ensure services reach through the round 9 interventions. Thus the migrant strategy will need to reach to only those destination district not covered within round 9.

Other National Programmes: There are several national progammes being implemented in the country that address social welfare and security needs of the migrant community. NACO through its mainstreaming unit will ensure interdepartmental collaboration to improve the access of migrants to these schemes and services. Of particular focus will be schemes like NREGA, RSBY, and ESI etc. In the case of NREGA, when migrants return to their native, they should be able to access NREGA employment scheme by using the smart card system. The card system also can be used to access other schemes. Necessary linkages and advocacy will be initiated through the mainstreaming cell of NACO so that the system can be implemented and be beneficial to the community.

5.1 DISTRICT CATEGORIZATION - LIST OF PRIORITY DISTRICTS

Source (High HIV prevalence, High volume of out migration)
Destination (High HIV prevalence, High volume of in-migration)

No	Source		Transit	Destination		
	States	Districts identified for Source intervention	Transit points in the inter-district corridor/inter state cooridor	States	Destination Districts	Volume of migrants for interstate corridor (Census,2001)
1	AP	East Godavari	Vijaywada (AP)	Andhra pradesh	Yanam	237668
2		West Godavari	Hyderabad, meheboob nagar	Karnataka	Raichur	184351
3		Nellore	Renigunta		Bangalore	140057
4		Prakasam	Guntakal		Bellary	137743
5		Nalgonda	Hyvderabad	Maharashtra	Mumbai (Suburban) *	137159
6		Chittoor	Renigunta	Karnataka	Bangalore	135897
7		Anantapur	Dhone		Tumkur	119581
8		Srikakulam	Vizyanagaram	Orissa	Gajapati *	119151
9		Kurnool	Dhone (Kurnul	Karnataka	Bellary	115985
10		Mahbubnagar		Maharashtra	Thane	109492
11		Cuddapah	Chittoor	Karnataka	Bangalore	102630
12		Karimnagar		Maharashtra	Thane	99202
13		Khammam		Chattisgarh	Dantewada *	97311
14		Vizianagaram		Orissa	Rayagada *	96238
15		Warangal		Gujarat	Surat	95428
16		Adilabad	Nizamabad	Maharashtra	Nanded	70650
17		Medak		Karnataka	Bidar	67729
AP		**17**	**8**	**14**	**17**	**2066272**
1	Assam	Kamrup	Guwahati	West Bengal	Kolkatta	61242
2		Kokrajhar				55114
Assam		**2**	**1**	**1**	**1**	**116356**
1	Bihar	Patna	Patna	Delhi	Delhi (South)	1,53,274
2		Darbhanga	Darbhanga	Delhi	Delhi (North East)	99,541
3		Madhubani	Patna	Delhi	Delhi (South)	97,247
4		Siwan		UP	Deoria	95,638
5		Gaya	Gaya	Jharkhand	Dhanbad	88,895
7		Saran	Patna	West Bengal	North 24 Pgs	76,788
6		Muzaffarpur	Gorakhpur	Delhi	Delhi (North West)	74,153
8		Bhojpur	Gorakhpur	Jharkhand	Dhanbad	62,631
9		Gopalganj	Goplaganj	UP	Kushinagar	58,587
10		Sitamarhi	Muzaffarpur	Maharashtra	Mumbai (Sub urban)	55,401
11		Begusarai	Patna/Barauni	Delhi	Delhi (North East)	54,191
12		Vaishali	Gorakhpur	West Bengal	Kolkata	53,227
Bihar		**12**	**6**			**12,70,893**

No	Source		Transit	Destination		
	States	Districts identified for Source intervention	Transit points in the inter-district corridor/inter state cooridor	States	Destination Districts	Volume of migrants for interstate corridor (Census,2001)
1	Chattisgarh	Raipur	Bhandara	Maharashtra	Nagpur	1,52,113
2		Korba	Korba	Maharashtra	Nagpur	86,650
3		Mahasamund	Korba	Maharashtra	Mumbai (Suburban) *	84,573
4		Raigad	Raigad	Maharashtra	Mumbai (Suburban) *	62,000
5		Kanker	Raipur	Maharashtra	Nagpur	52,000
6		Dhamtari	Raipur,Vishakapattnam	Maharashtra	Mumbai (Suburban) *	51,290
7		Durg	Durg	Maharashtra	Mumbai (Suburban) *	1,13,018
8		Bilaspur	Bilaspur	Madya Padesh	Shahdol	1,05,657
9		Rajanandgaon	Raipur	Maharashtra	Nagpur	55,385
Chattisgarh		**9**	**6**			**7,62,686**
1	Jharkhand	Ranchi	Ranchi	West Bengal	North 24 Pgs	81,684
2		**Hazaribag**	Hazaribagh	Maharashtra	Mumbai (Suburban)	56,456
3		Deoghar	Deoghar	Maharashtra	Mumbai (Suburban) *	52,300
4		Bokaro	Bokaro	Maharashtra	Mumbai (Suburban) *	83,498
5		**Dhanbad**	Dhanbad	Andhra pradesh	Hyderabad	72,399
6		Purbi Singhbhum	Jamshedpur	Maharashtra	Mumbai (Sub urban)	52,414
Jharkhand		**6**	**6**			**3,98,751**
1	Karnataka	Belgaum	Sangli	Maharashtra	Kolhapur	2,25,359
2		Bangalore	Bangalore	TN	Dharmapuri	1,40,198
3		Dakshina Kannada	Mangalore	Maharashtra	Mumbai (Suburban) *	1,33,568
4		Bijapur			Sangli	1,28,293
5		Gulbarga			Pune	1,00,954
6		Tumkur	Bangalore	AP	Anantapur	1,00,273
7		Uttara Kannada	Dharwad	Goa	South Goa	94,424
8		Dharwad				86,136
9		Mysore	Mysore	AP	The Nilgiris	83,172
10		Bagalkot		Maharashtra	Kolhapur	80,283
11		Hassan		Maharashtra	Mumbai (Suburban) *	77,810
12		Udupi				77,486
13		Mandya				72,414
14		Shimoga				70,900
15		Bellary		AP	Anantapur	69,830
16		Kolar		AP	Chittoor	67,207
17		Gaveri		Goa	North Goa	62,198
18		Chitradurga		AP	Anantapur	56,328
19		Davanagere		Goa	South Goa	54,880
20		Gadag			North Goa	54,280
21		North Goa				53,430
Karnataka		**21**	**5**	**13**	**16**	**18,89,423**

No	Source		Transit	Destination		
	States	Districts identified for Source intervention	Transit points in the inter-district corridor/inter state cooridor	States	Destination Districts	Volume of migrants for interstate corridor (Census,2001)
1	Maharashtra	Jalgaon	Dhule	Gujarat	Surat	2,85,748
2		Ahmadnagar	Silvasa			2,78,810
3		Satara	Sangli	Karnataka	Belgaum	2,46,610
4		Solapur	Solapur		Bijapur	2,41,173
5		Kolhapur	Sangli	Karnataka	Belgaum	2,07,193
6		Bid				1,80,313
7		Sangli				1,63,397
8		Yavatmal		AP	Adilabad	1,59,056
9		Dhule	Dhule	Gujarat	Surat	1,50,591
10		Ratnagiri	Silvasa			1,47,552
11		Aurangabad	Aurangabad	Punjab	Ludhiana	1,41,643
12		Amravati	Nagpur		Betul	1,38,356
13		Chandrapur	Nagpur	AP	Adilabad	1,35,228
14		Raigarh		Gujarat	Surat	1,34,030
15		Buldana				1,24,897
16		Nanded		AP	Adilabad	1,13,296
17		Akola	Dhule	Gujarat	Surat	98,645
18		Latur	Solapur	Karnataka	Bidar	97,636
19		Jalna		Gujarat	Surat	95,033
20		Parbhani	Solapur	Karnataka	Bagalkot *	85,923
21		Osmanabad			Gulbarga	78,713
22		Wardha		Madhya pradesh	Chhindwara	78,472
23		Bhandara			Balaghat	70,812
24		Nandurbar	Silavasa	Gujarat	Surat	70,571
25		Sindhudurg		Goa	North Goa	69,248
26		Gondiya		Pmadhya Pradesl	Balaghat	53,410
27		Gadchiroli	Nagpur	Chattisgarh	Rajnandgaon	51,253
Maharashtra		**27**	**6**	**18**	**22**	**36,97,609**
1	MP	West Nimar		Maharashtra	Jalgaon	72,863
2		Chhindwara	Seoni, Sausar, Amla		Nagpur	72,511
3		East Nimar			Jalgaon	71,177
4		Balaghat	Seoni,Lanjhi, Gondia, Kamptee		Nagpur	71,126
5		Dhar	Ratlam	Gujarat	Vadodara	65,354
6		Indore	Indore	Maharashtra	Mumbai (Suburban) *	60,339
7		Jhabua		Gujarat	Vadodara	60,171
8		Jabalpur	Seoni, Katni	Maharashtra, Delhi	Nagpur	58,677
9		Katni	Katni		Amravati	42,000
10		Panna	Katni, Jhansi, Gwalior		**Nagpur**, Delhi	51,000
11		Betul			Amravati	55,813
12		Ujjain	Ratlam	Rajasthan	**Tonk**,Jhalawar	53,623
13		Tikamgarh	Jhansi,Gwalior	Delhi	Delhi	58,000
14		Datia	Jhansi,Gwalior	Delhi	Delhi	57,000
MP		**14**	**11**			**10,28,146**

No	Source		Transit	Destination		
	States	Districts identified for Source intervention	Transit points in the inter-district corridor/inter state cooridor	States	Destination Districts	Volume of migrants for interstate corridor (Census,2001)
1	Orissa	Ganjam	Berhampur	Gujarat	Surat, Mumbai	1,62,306
2		Gajapati	Bolangir			45,000
3		Balasore	Balasore	West Bengal	Kolkatta	54,000
4		Bolangir	Rourkela	Purbi Singhbhum	Jamshedpur	62,000
5		Kendrapara	Bhubaneswar	Chhattisgarh	Raipur	53,000
6		Cuttack	Cuttack	Maharashtra	Mumbai, **Thane**	77,863
7		Nuapada	Bolangir, Sambalpur	Andhra Pradesh	Vishakapattnam	51,000
8		Kalahandi	Kesinga,Titlagarh,Bolan	Andhra Pradesh	Vijayawada	62,300
9		Mayurbhanj	Balasore	Delhi	Delhi	63,707
10		Sundargarh	Rourkela	Gujarat	Ahmedabad	56,563
11		Khordha	Bhubaneswar	Gujarat	**Surat**,Vapi,Valsad	50,250
Orissa		**11**	**10**			**7,37,989**
1	Rajasthan	Jodhpur	NO stay	Maharashtra	Mumbai (Suburban) *	87,329
2		Nagaur	Jodhpur (Bus and Rail)			84,664
3		Pali	NO stay		Thane	84,348
4		Sikar	Jaipur (Bus and Rail)	Gujarat	Surat	67,622
5		Udaipur	NO stay			66,979
6		Ajmer	NO stay	Maharashtra	Mumbai (Suburban) *	59,727
7		Bikaner	Jodhpur (Bus,Rail)	Gujarat	Kutch, **Jamnagar,** Ahmedabad,Alang	54,749
8		Bhilwara	Ajmer, Udaipur (Bus and Rail)			53,970
9		Ganganagar		Punjab	Firozpur	1,03,906
Rajasthan		**9**	**4**			**8,64,531**
1	UP	Jaunpur	Allahabad	Maharashtra	Mumbai (Suburban) *	58,579
2		Gorakhpur	Gorakhpur	Maharashtra	Thane	1,41,945
3		Azamgarh	Azamgarh	Maharashtra		1,39,806
4		Allahabad	Allahabad			1,35,661
5		Muzaffarnagar	Allahabad	Maharashtra	Mumbai (Sub urban)	1,06,286
6		Varanasi	Varanasi	Maharashtra	Mumbai (Suburban) *	96,737
7		Bulandshahr	Ghaziabad	Delhi	Delhi (North East)	92,235
8		Sultanpur	Allahabad/ Varanasi	Maharashtra	Mumbai (Suburban) *	86,923
9		Pratapgarh				85,675
10		Meerut	Meerut	Delhi	Delhi (North East)	85,239
11		Deoria	Gorakhpur	Maharashtra	Mumbai (Suburban) *	84,824
12		Ballia	Allahabad/ Varanasi/ G		Thane	82,000
13		Aligarh	Aligarh	Delhi	Delhi (North East)	80,906
14		Basti	Basti/ Lucknow	Maharashtra	Mumbai (Suburban) *	74,111
15		Ghazipur	Varanasi		Thane	73,781
16		Ghaziabad	Ghaziabad	Delhi	Delhi (North East)	71,551
17		Gonda	Lucknow	Maharashtra	Mumbai (Suburban) *	66,727
18		Etah	Aligarh	Delhi	Delhi (North East)	64,909
19		Bijnor	Meerut	Maharashtra	Thane	63,374
20		Lucknow	Lucknow	Maharashtra	Mumbai (Suburban) *	62,735
21		Faizabad	Lucknow	Gujarat	Surat, Rajkot	59,573
22		Rae Barelli	Lucknow	Punjab	Ludhiana	59,568
23		Budaun	Aligarh	Delhi	Delhi (North East)	54,118
24		Etawah	Etawah	Maharashtra	Mumbai,Thane	51,500
25		Siddharthnagar	Gorakhpur	Maharashtra	Mumbai (Suburban) *	50,932
26		Unnao	Kanpur	Maharashtra	Thane	52,000
27		Mathura	Mathura	Delhi	Delhi	51,230
28		Baharaich	Lucknow	Maharashtra	Mumbai, Thane	56,400
29		Mau	Varanasi	Maharashtra	Mumbai, Thane	62,300
30		Maharajganj	Gorakhpur	Maharashtra	Mumbai, Thane	67,000
31		Kushinagar	Gorakhpur	Maharashtra	Mumbai, Thane	63,400
32		Ambedkarnagar	Gorakhpur	Maharashtra	Mumbai, Thane	52,000
UP		**32**	**15**			**29,59,650**

No	Source		Transit	Destination		
	States	Districts identified for Source intervention	Transit points in the inter-district corridor/inter state cooridor	States	Destination Districts	Volume of migrants for interstate corridor (Census,2001)
1	WB	Medinipur	Kharagpur	Maharashtra	Mumbai (Suburban) *	1,82,664
2		North 24 Paragana	Kolkatta	Maharashtra	Mumbai	1,64,349
3		**Barddhaman**	Asansol	Maharashtra	Mumbai	1,34,210
4		Nadia	Moghalsarai	Punjab	Ludhiana	1,29,031
5		Hugli	Kolkatta	Maharashtra	Mumbai	1,18,687
6		Haora	Kolkatta	Maharashtra	Mumbai, Thane	1,78,920
7		**Murshidabad**	Moghalsarai	Delhi	Delhi	1,07,765
8		**South 24 paragar**	Kolkotta	Gujarat, Maharas	Surat, Mumbai	91,730
9		Maldah	Kishanganj	Gujarat	Surat	77,143
10		Bankura	Asansol	Delhi	Delhi	76,702
11		Jalpaiguri	Jalpaiguri	Delhi	Delhi	70,637
12		Bribhum	Kochbihar	Maharashtra	Mumbai	61,596
13		Koch Bihar	Kochbihar	Maharashtra	Mumbai (Suburban) *	58,399
14		**Purulia**	Purulia,Gaya	Maharashtra	Mumbai (Suburban) *	67,230
15		**Uttar Dinajpur**	Kishanganj, Jalpaiguri	Maharashtra, Del	Mumbai , Delhi	56,200
WB		**15**	**10**			**12,28,250**
1	Gujarat	Junagadh			Mumbai (Sub urban)	1,46,830
2		Amreli			Mumbai (Sub urban)	1,14,700
3		Jamnagar	Ahamadabad		Thane	1,00,248
4		Kachchh			Mumbai (Sub urban)	84,586
5		Kheda			Mumbai (Sub urban)	73,046
6		Bharuch			Mumbai (Sub urban)	71,225
7		Valsad	Silvasa		Thane	62,594
8		Anand			Mumbai (Sub urban)	51,597
Gujarat		**8**	**2**			**7,04,826**

5.2 AGENDA AND BRIEF CONTENT FOR THE WORK SHOP ON PROJECT INITIATION

Timings	Proposed Activity	Expected Outcome
15 mins	Introduction	
45 mins	Introduction to the revised migrant strategy	Development of understanding about the changes in the strategy
1 hour	Discussion on the list of districts identified	Clarity on geographies of implementation
1 hour	Discussion on role clarity and budget	Clarity on implementation and monitoring
1 hour	Development of MoU and work plan for implementation	
30 mins	Feedback session	

5.3 STEPS,PROCESSES FOR RAPID ASSESSMENT AT SOURCE AND DESTINATION

The Rapid Assessment will be carried by the selected intervening NGO – at source and destination. This is after the decision has been made by the SACS on the area of intervention, based on the Migration intervention plan developed (using basic mapping and corridor information). Hence this presumes that the area selected has substantive numbers of migrants and has other risk factors.

The purpose of the Rapid Assessment is the following:

- To provide a deep understanding to intervening NGOs in the issues of HIV and migration
- To prepare a detailed field action plan, to address the largest number of migrants at risk of HIV.

This will be done by Consultants from Lead NGO of the LWS, TSU mainstreaming / Strategic Planning Consultant, ICTC Division, IEC and TI Division officers as well as short term consultants.

Information that will be available from the broad mapping includes districts where intervention is required and cluster of villages. The scope of the rapid assessment is as follows:

- Estimate of migrants in the area (out migrant, in migrant, returning migrant, spouse of migrants etc)
- Understanding extend of risk through assessment of sex behaviour, condom use, STI prevalence etc (destination)
- Map out key hot spots
- Identify local sex networks including their size, distribution and mobility
- Identify local service providers and other programmes including TIs working with HRGs
- Identify key stakeholders and particularly the contract labour system
- Migration pattern of the informal labour
- Key service providers and accessibility
- Stakeholder analysis (at source and destination)

The Rapid Assessment will be carried out only by the intervening NGO (not contracted out), once the staff and infrastructure are in place; this will be one of the first activities that will be implemented.

At Source districts:

Tools to be used for rapid assessment and further planning of interventions at source:

Tool Identifying high out migration volume blocks and villages

Useful for

- Identifying blocks in a district with high out migration
- Identifying villages with high out migration in a block
- Identifying villages which require focus from HIV programme point

To identify priority villages following **five steps** need to be followed-

Step 1 (by a team from SACS comprising Division officer from TI, STI, ICTC and State Epidemiologist through a sensitisation workshop).

Desk review of available information from following sources to identify priority blocks/clusters

a. ICTC data of the source districts to understand the positivity trend among male, % of male are migrants against non – migrants (this would help to understand the risk pattern both for male non-migrants, migrants, local in-migrants, clients of local sex work network). To understand the nature of epidemic among the female i.e. among spouses, AN mothers (this would help to understand the risk pattern among female.

b. Analysis of ART data for understanding the ART uptake by local residents , % of them being migrants, % of them being relatives/ spouses of migrants

Step 2. (by a team from SACS comprising Division officer from TI, STI, ICTC and State Epidemiologist) Informal discussion at district and block level with following functionaries:

Discussion at district level with district level stakeholders like District Administration, District Statistical officer, District labour officer, District Rural Development Officer, District Nodal Officers for Rural Development, W& CD, Poverty Allieviation, Education and Health. NGOs working with Women Empowerment, Poverty Allieviation, Livelihood Promotion, Education, Child Health.

These discussions should focus on following:

a. Identify blocks with high out migration (indicators may be blocks with poor performing NREGA programme, poor immunisation, better livelihood promotion programmes etc.)
b. Identify block with tradition of high out migration

Step 3 (by District Programme Manager supported by SACS) Match Migration Villages with HIV related data as per following table:

Villages shortlisted in Step 2	**Total Population**	**No. of HIV positive identified during last 12 months (Source; ICTC data)**		**No. of discordant couples identified during last 12 months (Source; ICTC data)**	**No. of people ever on ART (Source; ART centre)**	**No of positive people living (Source; Positive Network)**	**Presence of local sex networks in the village (Yes/No)**	**Approx. no.of FSWs in the village**
		Male	Female					
Village 1	5400	12	5	2	30	28	Yes	30
Village 2	3000	18	20	Nil	20	10	No	No
Village 3								

The above data indicates that although both the villages have of similar priority in terms of HIV – the migrant population data / migrant family data in the villages will help to design the intervention strategy for both these villages.

Step 4.(**by District team comprising of District programme manager and block out reach workers)**

The top 20 villages from above table will be taken to undertake following activities with an objective to identify:

1) No. of migrant families

2) Estimated number of migrants by category (potential, outgoing, returning, female and spouses of migrants)

3) No. of stakeholders (gatekeepers, service providers) this is only required for planning.

This will be done by village level meeting (Gram Sabha meeting, VHND and VHSC meeting, SHG meeting) facilitated by Block ORW and District Programme Manager. Local NGOs working in the village, NREGA programme functionaries, Anganwadi House Hold Register, ANM eligible couple register will be referred for their household data to understand the profile of families and migrants.

Finalise village level denominator for migrants, which may take 3 months.

Step 5.(**by District team comprising of District programme manager and block out reach workers)**

The top 10 villages from above activity to prepare village level programme plan for implementation of: prevention package

a. IEC activities – wall writing, tin plates

b. Condom outlets

c. Identification of village volunteers while carrying out Step 4 as per NACO norms

d. Positive prevention packages

e. Linkages and networking with different stakeholders

These activities need to be planned as per the profile of migrant in the village. The various exercises given in chapter on village migrant profiling would help in understanding the need of migrants and when to reach them. These services should be planned accordingly.

<u>Tool for implementing entry level activities</u>

Useful for

- Understanding the different kinds of entry level activities to be planned at district, block and village level
- Making an action plan for the same in the overall action plan for the next three months

After finalisation of the villages and recruitment of staff and volunteers, it is important that the team plans activities that will give them an opportunity to introduce the program as well as build rapport with identified stakeholders.

These activities can be planned at three levels:

1. District level
2. Block level
3. Village/panchayat level

DISTRICT LEVEL

The following steps will help the district program manager build strong linkages and advocate for support in the district. The stakeholder list developed during the assessments can be used to determine who are the key persons to interact with in the district.

1. Orientation workshop

A half day program should be planned by the program manager by inviting the key stakeholders to a half day workshop. This can be planned in coordination with the DAPCU since they are the key focal point of all HIV related services in the district.
In addition other stakeholders will include those from the stakeholder list (contractors, labour division, WCD, Social welfare, ZP etc).
In this program, the topics covered will incorporate basic facts of HIV AIDS, understanding the relationship of migration and HIV, introduction of key components of the source migrant program and determining the roles and responsibilities of the stakeholders present.
See Handout-1 for specific content details of suggested schedule of the workshop.

No.	Topic	Objective	Time required	Remarks
1	Welcome / introduction	To introduce each other	½ hour	All participants can introduce themselves
2	Introduction to NACO program for migrants	To explain the context of NACO program for migrants	½ hour	Power point presentation on Migrant program
3	Migrants and HIV	To enable the participants to understand the risks and vulnerabilities faced by migrants	½ hour	Group exercise (Why is it so?) OR Film on migrants (45 mins)
4	Basic facts of HIV/AIDS	To ensure that ll have correct knowledge of transmission, prevention and care for HIV AIDS; as well as to know the existing HIV related services in the district.	½ hour	Myths and misconceptions/Prevention / Care and support/ HIV related services. Can be done in the form of a quiz Give resource directory with all HIV related services available as handout.

4	Stigma and discrimination	To understand the issues related to stigma and discrimination and its negative impact on the program	½ hour	Having a PLHA as the resource person for this session make a very significant impact.
5	Roles of key stakeholders	To determine in what way the stakeholders can support the program and reduce stigma and discrimination	½ hour	Interactive session to give each person a chance to list out what roles and responsibilities each one can take
6	Action plan for next 6 months	To develop a joint action plan as a sign of commitment to this program.	½ hour	This should be a group session where key common activities can be planned – one mass level program and a few specific programs for the next 6 months.

The outputs of the workshop will include:

1. Formal **introduction** to the program
2. Formation of a **consultation coordination group** for future regular reviews
3. List of **stakeholders** with potential areas and **details of support**.
4. **District map** with all key service centres, migrant villages, stakeholder offices/ institutions marked
5. **Action plan** to include the stakeholders in a mass level entry program for the district.

2. Mass level program for district source migration program.

Following the consultation workshop, the District Coordinator/DRP will have a clearer idea of who can help the program and in what way. S/he must then use this in a constructive way to help strengthen the source migrant program.

Some of the key joint activities that can be held are planning and conducting mass level programs – these can be planned depending on the time of the year and corresponding occasions:

a. World AIDS Day observation (month of December)
b. World Health Day - April
c. International women's day – March
d. Religious festivals – Dassera – Oct/Nov
Holi – March
Diwali – Nov
Sankaranthri/ Ugadi – April
Id – Aug – Dec

If programs are planned at these times, it is easy to get support from various sources. Also, migrants are usually available at this time, either returning from destination points or not yet gone.

3. **Regular coordination review meetings**

Once a commitment is made at the initial workshop, the program manager must follow up by organizing regular reviews once a quarter. This will keep up the commitment. These can be in the form of meetings, or special functions where one of the stakeholders takes a lead. It could be health melas, special programs to support children and spouses, support for PLHA families etc. This is also an opportunity for the stakeholders to understand the progress of the program, areas where specific support is required; and for the program manager to leverage this support for the community members.

BLOCK LEVEL

Just as planned at the district level, the block outreach worker needs to plan similar activities at the block level.
Starting off with a sensitization workshop and followed by individual consultations, group meetings, joint field visits etc. will help the block outreach worker to leverage support form the block level stakeholders in the area. The same schedule described for district level above can be used for the block level sensitization workshop.

VILLAGE/ PANCHAYAT LEVEL

At this level, the block outreach worker and volunteers need to spend more time with both stakeholders and the community to introduce the program activities.

1. HAMARA GAON/ NAMMA HALLI/ NAMMA OORU PROGRAM (OUR VILLAGE)

This programme is ideally held over a two or three day period depending on the size of the village. The whole team resides in the village during this period. This will help the team get to meet maximum number of people, who return from work/ trips to the market etc. Also, in the evening, the community is relaxed and ready to spend time with the team.

Preparation steps for doing village entry programs

1. Please select the villages in advance. Try and work out the logistics so that 2-3 teams are in nearby villages. This will help reduce the costs of transport etc.
2. Inform the village leaders. ANM and anganwadi teacher in advance.
3. Arrange for accommodation (if staying back in the village) and food. Try and mobilise from the community as much as possible. In most cases, NGOs have been able to get the food and accommodation from the local people free.
4. Carry all materials on first day itself: brown sheets, markers, rangoli, bindis, FGD checklist, blank forms to fill out secondary data details; blank sheets for recording key informant interviews/ group discussions.
5. Also please carry IEC material on HIV, STIs, flip charts, penis model and condoms, posters etc. Whenever the team gets a chance, they should also do some awareness with small groups of people.
6. Check out the transport arrangements. Work out a schedule where 2-3 teams can be dropped off one after the other in the same transport instead of hiring separate transport. Please use local transport as much as possible.

7. The budget per village should be decided upon. This will be required for honorarium charges to volunteers, food and transport, accommodation etc. Most of the budget can be leveraged form local sources if planned in advance.
8. Collect all secondary data of that village from the taluk level offices before going to the village itself. You can confirm some of the results when you are in the village.
9. It is very useful to get a letter from the CEO for cooperation from the gram panchayats. The program manager can meet the CEO and explain that the NGO is implementing a rural HIV prevention program, and that one of the exercises is to build a stronger rapport and introduce the program to the village. Once you get the letter from the CEO, you can share it with the concerned GP in advance.
10. Please ensure that the team carries water, umbrellas/ hats etc and wears good walking shoes.

DAY 1

1. **Inauguration:**

The leaders of the village should inaugurate the programme and other important persons in the village such as the school headmasters. Anganawadi workers etc. must also be present on the occasion. These key persons in the village should be kept informed about the agenda for the two-day programme and they should also be informed about the venue and time of the street plays that have been planned.

2. **Community based activities**

a) Understanding the village – if a transect walk has not yet been done, then this is the best time to do it. A couple of members form the team and a few community members and leaders should take a walk around the village to get an idea of the size, distribution of structures and the various community groups and landmarks in the village. This will help them to decide how to plan the rest of the activities for the 2 days.

b) Awareness programs through small group discussions and games/ competitions.

Suggested activities that take place in such a programme include:

- One to group discussions – with men and women separately.

  These can be held in different parts of the village so that maximum coverage is possible. During these sessions, the volunteers can discuss issues related to health, migration and then HIV. Myths and misconceptions regarding HIV can be addressed. In the men's group, a condom demonstration can also be done after getting their permission.

- Awareness for young women and young men

  Separate sessions should be held for the youth. This will give them an opportunity to express their ideas and feelings without being dominated by their parents, relatives and elders. The areas to be covered are issues related to adolescence, personal hygiene (menstrual hygiene in young women's group) , risks and vulnerabilities of youth in general, for HIV in particular; their thoughts on migration- its advantages and disadvantages; role of youth in health and HIV awareness programs.

- Competitions for youth, men & women.

  These are ways to engage the community in a fun way as well as make them aware of several facts. Several interactive games have been developed and can be used for this purpose[23]. Quiz competitions are very popular with the youth. For the women, rangoli competitions and drawing competitions get their attention. Both young men and adult men like outdoor games. In the evening, after the street play the winners can be awarded. This competition should not only have a focus on health or HIV AIDS. It is more for building rapport and getting the community together

- treet Plays

  This is best done at the end of the day, when the adult community is free and relaxed. These plays should not exceed 20 – 30 minutes .The topics for the street play should have one issue related to migration and HIV ; and another on a more general issue – such as girl child education/ care of pregnant women/ NREGA/ nutrition/ alcoholism etc. The team can leverage resources such as PA system, local actors etc. from the community, youth groups and leaders during their preparation visit.
  More than one location may be required if the village is big.
  At the end of the street play, reiterate the key message of the play and invite questions form the audience.

In any rural based street play program. Expect small children, and older people to be part of the audience. They cannot be thrown out. Therefore, avoid issues that are very sensitive. Also, it is important for the older generation to be present to hear facts so that myths and misconceptions can be cleared.

DAY 2

3. **Focus group discussions**

   In order to get a better understanding of the situation in the village, the team should plan at least 2-3 focus group discussions. The FGDs should be conducted with male migrants, spouse of migrants, contractors, agents, community leaders and health functionaries (GP members, ASHA, ANM, school teacher, anganwadi teacher etc.). The output of these group discussions will be –

   a. Understanding of the pattern of migration,

   b. health issues in the village

   c. the local variations and seasons when people out migrate or return

   d. the risk and perceptions of the people regarding HIV.

[23] Card games, jigsaw puzzles, carom with HIV messages, card puppets, parrot toolkit etc. are tested games developed by Avert, JHU and NACO.

e. kind of services required

f. role of different groups in migrant intervention

4. **Continue with the activities** scheduled the previous day and not yet completed. Other group discussion can be held with SHGs, pregnant women, mothers of children in the anganwadi centre etc.

5. **Complete the village profile** – This has to be done based on the observations and information gathered over the past 2 days. The format is included in the handout.

6. **Final Discussion with Key People in the village**

Hold a discussion with all the key people in the village and give them a detailed report about the activities that have taken place over the last two days. Inform them about the activities planned for the future and the follow up plan; with this the programme can be concluded.

When you leave the village, please thank all the people who helped you. Make sure you take back all the materials you brought except IEC material which may have been distributed. Leave your contact details with the village people in case any person needs to contact you.

Outputs from this entry level activity

1. Community level - the community gets to know about the project goal and objectives, are introduced to the team, have an initial awareness on HIV AIDS, STIs, personal hygiene and other related issues, and get an opportunity to meet one on one with the team members.

2. Program level –

    a. basic information available and recorded in the village profile

    b. Initial awareness built at a mass level on HIV AIDS – helps to reduce stigma

    c. Buy in from the local stakeholders – GHP members, ASHA. ANMs, Anganwadi teachers etc.

    d. More detailed understanding the village specific risks and vulnerabilities, and profiles of migrant families.

3. Staff level – an opportunity to introduce themselves to the community, to get to know the geographical, cultural and community profile of the village; interact with various community groups; determine the local key stakeholders, understand the specific situation of migrants for that village. Staying in the village gave them a chance to know the village geography, meet with people who are usually out the whole day, as well as build a rapport with the community members.

2. Setting up information booths/ kiosks

After the initial village program, the block outreach worker and volunteers can leverage support form the local panchayat or youth group to set up a simple information booth or kiosk in the village. The space should be a safe place provided by the community, and some group or individual should take responsibility for the security of the material kept there.

The material should include simple IEC material for reading. This space can also be open on specific days and timings and have opportunities for groups to gather and discus HIV and other health related issues. Youth can get together and play interactive games related to health and HIV.

3. *PUTTING UP RESOURCE CHARTS/ DIRECTORY*

A very useful tool for the community is a resource chart which highlights all the available services with their contacts and service details. This can be put up in the form of wall writings/ flexi banners/ printed charts etc/ and the cost can be sponsored by the community. An example of information on a resource chart is in Handout

Village Health Resource Directory

Service	**Key Services available**	**Address and contact number**	**Contact person**
Nearest PHC			
STI referral clinic			
Taluk hospital			
Nearest ICTC			
Nearest Positive network			
Nearest ART centre			
CD4 testing centre/ lab.			
Drop in centre for PLHAs			
Care and support centre			
Nearest NGO office			
Blood bank			
Lawyer/ crisis team			
Gram panchayat office			

4. *CONDUCTING HEALTH MELAS/CAMPS*

After at least a week of the first entry point program, the team can organise a health mela/ camp in collaboration with the health department and local gram panchayats.

This camp can be planned during the district and block level orientation workshops. At this camp, doctors form the local PHCs, counsellors and lab. technicians form the ICTC and other community workers can be called to conduct health checkups. While the focus will be on STIs and HIV, other diseases should not be neglected. Drugs can be mobilised form the government or donors. This is a chance to do counseling and testing for HIV, conducting group discussions on nutrition, showing films on HIV, putting up posters, etc.

It may not be feasible to conduct a camp in every village. These camps can be held at sub centre or PHC level.

STEPS IN PLANNING A HEALTH CAMP

1. Before the health camp:
   a) Fix the date and place in consultation with both the community and the health centre. Choose a holiday if possible so that maximum number of community members can benefit.
   b) Collect all equipment, drugs to be used in advance and keep a stock. Drugs should be indented in advance from the DHO or taluk hospital. The doctor will give the suggested list. Make sure STI drugs are also included.
   c) Referral slips to refer cases need to be available.
   d) Collect IEC materials which can be used during the health camp.
   e) Select local volunteers from youth groups, SHGs and GP to help plan the logistics. They can help to register all the patients, assist the doctor by taking weight, height, etc.
   f) Keep drinking water, biscuits etc. for all the resource persons and for children and community members.
   g) List out all possible referral centres in case any person has to be referred.
   h) Arrange for transport in case you have to refer some emergency or serous case.

2. During the camp
   a. Make sure all the volunteers come at least 2 hours in advance. Keep enough place for patients to register with at least 2 volunteers to do registration.
   b. Arrange a separate room for female patients
   c. There should be a separate place for counselling and testing if it is going to be done
   d. Drugs should be dispensed last.
   e. In one corner, group health education sessions can be held. If possible, a TV and DVD player can be arranged and HIV related films can be shown.

3. After the camp
   a) Check stock of drugs left. Return all unused drugs back to where you got them from.
   b) Reconfirm register list.
   c) Follow up cases that require follow up. The volunteers must get the lsit of patients that need to be followed up.
   d) Thank all the volunteers.

Tool for Village Migrant Profiling

Useful for

- Understanding the differences between the different categories of migrants.
- Understanding the issues such as seasonal patterns, behaviour patterns in different groups of migrants and link them to outreach planning

In all the identified villages, a rapid assessment will be carried out, using the following methods:

a) Transect walk
b) Key informant interviews
c) Focus Group Discussions with migrants
d) Polling booth
e) Village summary sheet preparation

a. Transect walk is used to secure an understanding of the layout and distribution of the village; which ends with a map of the village. Other than the map and the perspectives the field team gains, the transect walk is also used to meet important Key Informant's such as Anganwadi teachers, school teachers, Grampanchayat members and staff, opinion leaders, ANM, formal & informal groups (SHGs/CBO/NGO); and to identify congregation places (Shops, events), health facility in around the village where community usually visits, hot spots (sex work site) etc.

b. Individual Key Informant Interview: One to one discussions during which the interviewer collects information from the respondent by using the key informant check list. The purpose of using the individual key informant tool is to collect the following information

- Estimates of total migrants from the village
- Typology, duration and destination points of migration
- Months of migration (and return back)
- Names of key contractors and migration facilitators.
- Reported deaths due to HIV and AIDS, PLHAs in the village.

Possible list of key informants available are listed below. This is indicative and not exhaustive:

- Panchayat Leader
- Formal /Non formal Leader
- Functionaries (ANM, Anganwadi teacher/ helper, village accountant, Gramapanchyat secretary/ Bill collector, etc)
- SHG / Community groups
- Local labour contractors and migration facilitators
- Shop owners (Arrack shop, Medical, Kirana..Etc)
- Ministry of Labour representatives
- Doctors
- Conductors
- Bus driver
- Postman
- Opinion leaders

Key informant interviews will be with secondary and tertiary stake holders who are residents of the village and are staying in the village for more than 3 to 4 years.

c. Focus Group Discussions: Four FGDs will be held those persons who live in the village and go out to the nearby or far away cities/towns for short term or long-term works. Each FGD should have 5-10 persons. In case the required number is not available in-depth interviews with the available persons using the checklist. Given below are checklists of issues (not questions).

1) What is the total number of House Holds (HHs) in the 'Village'

2) What are the patterns of migration in the Village…. If there HHs where there is migration
   a) Which is for long distance and long duration, address question 3
   b) On a daily basis (return home same day), address question 4
   c) If there is in-migration into the village, address question 5
   d) If none of the above, probe again on reasons for no migration and close interview.

3) HHs where these is long distance, long duration migration:
   a) How many such HHs exist in our Village?
   b) What is the estimate of such persons – male & female?
   c) Does the entire family migrate or only the men?
   d) Do single women migrate separately (estimate HHs)?
   e) Typically for when and how long do they migrate and where do they go (preferred places)?
   f) Typically, what kind of work do such migrants carry out?
   g) What kind of living arrangements exists for these migrants?
   h) When migrating with families, are the women and girl children at risk of exploitation? If so, are there any instances?
   i) On return, how do migrant's spend their saved money; any change in entertainment or other patterns
   j) Are there any reports of migrants being 'very sick' after returning from migration

4) HHs where migration is on daily basis (return home on same day)
   a) How many such HHs exists in our Village?
   b) What is the estimate of such persons – male & female
   c) Do single women go for work separately (estimate HHs & Nos)?
   d) What are the typical timings and where do they go (preferred places)?
   e) Typically, what kind of work do such migrants carry out?
   f) Are women and girl children at risk of exploitation? If so, are there any instances?

5) In migration:
   a) How many persons come to work in our village – male & female?
   b) Do single women come for work separately?
   c) What are the typical timings and where do they go?
   d) Typically, what kind of work do such migrants carry out?

d. Polling Booth: There are various survey methods to measure behavior. As this issue is related to individuals, most of the methods have several limitations. Polling booth is a

method more suitable to collect information on sensitive and personal issues related to sexual health in a confidential and anonymous manner. Unlike in a survey or in-depth interview or focus group discussion, the respondent remains anonymous. The method thus increases the sense of confidentiality among the respondents, which may reduce the biases in reporting sensitive and personal information. Polling booth is conducted with a homogenous group of about 8-10 individuals. It can be made more effective by recruiting a random and representatives of the Village (Various socio-demographic characteristics, as well as locations). It is a group exercise in which members respond individually. It involves the following procedure

Procedure:

a. Create a polling booth environment by using cartoon box or any cloth & rope;
b. Separate the participants from each other, where they can sit with enough privacy. Distribute a box and set of cards to each in which cards are arranged in a serial order (card having question number 1 at top) according to the question numbers.
c. The facilitator reads out a questions one after the other and the participants answer each question by putting the card carrying the respective question number into the polling box for an 'yes' to the question or by keeping it out side of the polling box for a 'no' to the question. In case the answer is 'Don't know or not applicable' then they will place the card under the box.
d. The process continues till the facilitator completes the prescribed questionnaire, after completing the exercise cards inside the box and outside the box and under the box are grouped separately for compilation & analysis of the results
e. After getting the results have discussion on the questions asked in the exercise and record their view and expressions.

Checklist for polling booth:

Unmarried females

1. Do you know what are HIV and AIDS?
2. In the last 3 months, have you ever had any of these problems (like vaginal discharge, lower abdominal pain or genital ulcer /sore)?
3. If you have had any of these problems (e.g. vaginal discharge, lower abdominal pain or genital ulcer /sore), did you have difficulty in getting treatment?
4. Have you ever seen a condom?
5. If you want a condom, can you get it easily?
6. Did you ever have sexual intercourse with a man?
7. Have you and your sexual partner ever used a condom?
8. Do you think you are at the risk of getting HIV / AIDS?
9. Were you ever forced to have sex with someone else?
10. Did you ever have an abortion?

Unmarried males

1. Do you know what is HIV and AIDS?
2. In the last 3 months, have you ever had any of these problems (like genital ulcer, Urethral discharge, swelling in groin, burning urination)

3. If you have had any of these problems (e.g. like genital ulcer, Urethral discharge, swelling in groin, burning urination), did you have difficulty in getting treatment?
4. Have you ever seen a condom?
5. Have you ever used a condom?
6. If you want a condom, can you get it easily?
7. Have you ever had sex with a commercial sex worker?
8. Did you ever have sex with a woman who is not a commercial sex worker?
9. Did you ever have sex with another man?
10. Do you regularly use a condom with sexual partners?
11. Do you consume alcohol?
12. Do you think you are at the risk of getting HIV / AIDS?

Married females

1. Do you know what is HIV and AIDS?
2. In the last 3 months, have you ever had any of these problems (like vaginal discharge, lower abdominal pain or genital ulcer /sore)?
3. If you have had any of these problems (e.g. vaginal discharge, lower abdominal pain or genital ulcer /sore), did you have difficulty in getting treatment?
4. Have you ever seen a condom?
5. Has your husband used a condom with you in the last 3 months?
6. If you want a condom, can you get it easily?
7. Do you think you are at the risk of getting HIV / AIDS?
8. Have you had sex with a male other than your husband?
9. Have you ever been forced to have sexual relations with someone other than your husband?
10. Does your husband go to sex workers?

Married males

1. Do you know what is HIV and AIDS?
2. In the last 3 months, have you ever had any of these problems (like genital ulcer, Urethral discharge, swelling in groin, burning urination)?
3. If you have had any of these problems (e.g. like genital ulcer, Urethral discharge, swelling in groin, burning urination), did you have difficulty in getting treatment?
4. Have you ever seen a condom?
5. Have you used a condom with your wife in the last 3 months?
6. If you want a condom, can you get it easily?
7. Do you consume alcohol?
8. Do you think you are at the risk of getting HIV / AIDS?
9. Have you ever had sex with a commercial sex worker?
10. Did you ever have sex with another man?
11. Did you ever have sex with a woman other than your wife?

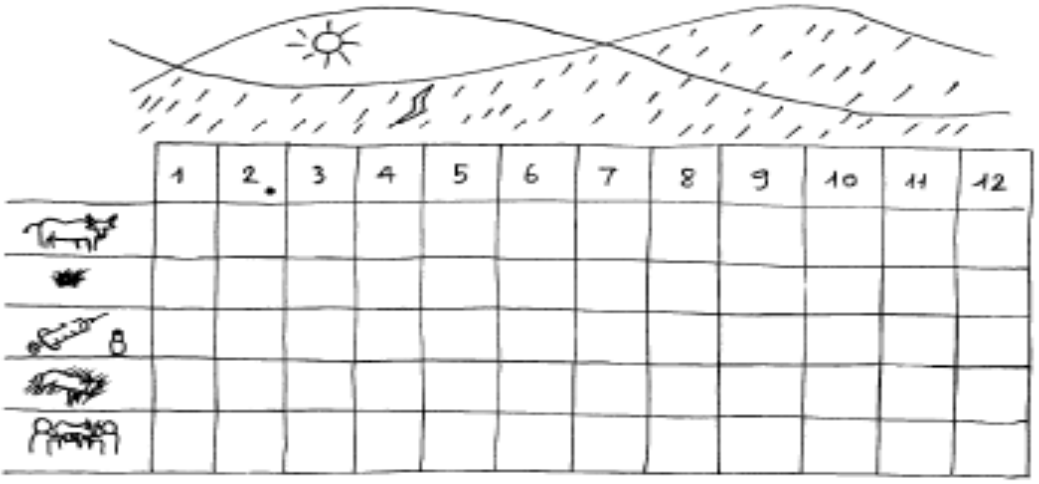
In addition to the above steps all staff involved in the data collection will prepare a village level summary sheet and a map of the village.

Seasonal patterns of migrants.

Each type of migrant has various seasonal patterns. This can be understood through a seasonal calendar.

What is a Seasonal Calendar?

A seasonal calendar is a **visual method** of showing the **variation in any pattern being studied** over time. In the case of a migrant program, it can be used to understand the variations in the volume of migrants, months which have more migrants either going out or coming in etc. This calendar is drawn up with the help of the community using PRA principles.



The exercise should be done to capture information about 3 groups – potential migrants, out migrants and returnee migrants. 15-20 members from each group should be selected for the exercise

The steps to develop a seasonal calendar are:

Step 1: Draw 12 columns on a chart and explain that these are the months of the year. The community members can use other ways of depicting the 12 months in a year (pie chart etc.)

Step 2: Ask the group to list out the months where key festivals are celebrated in the village

Step 3: Ask probing questions to find out all seasonal activities and events related to the migrant community- when they leave, when they return etc.

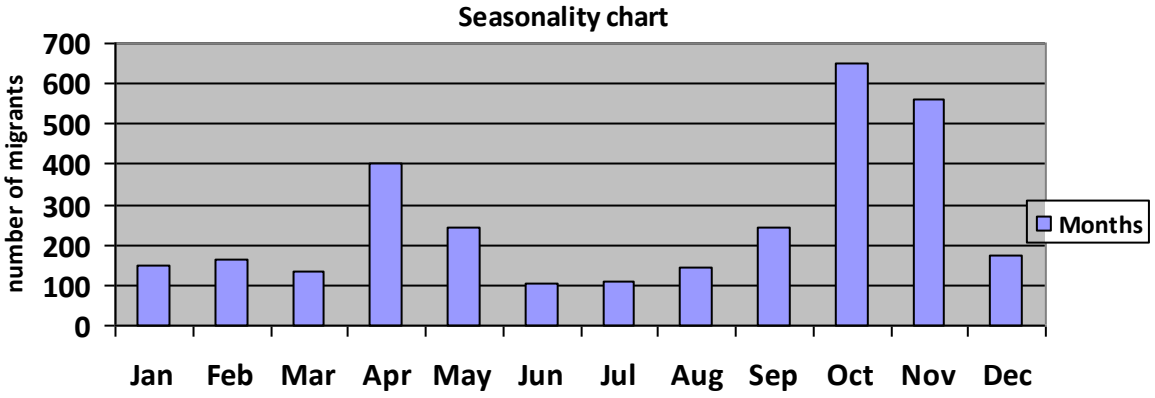
Step 4: Also try and look at other behaviour patters- spending capacity; illnesses etc. Other risk factors such as the presence of sex workers in some months, agricultural patterns etc. can also be marked on the calendar.

The seasonal calendar will depict both the time of occurrence and the intensity of that activity/ pattern in relative terms. The information collected through seasonality diagram should be put together in the following table-

	Peak Week		Peak Month		Lean Month		Period Spent	
	Month	Average Number	Month	Average Number	Month	Average Number	At destination	At Source
Out migrant								
Returnee migrant								

Step 5: Discuss how this Seasonal Calendar can be used to plan programs in the field. For example, just before the months of out migration, the team will focus on BCC and mid media activities to increase awareness amongst the migrants about potential risks at destination points. At the time the returnee migrants arrive, the team will focus on providing or linking up with health services etc.

Step 6: Once completed, the results should be documented on the paper.

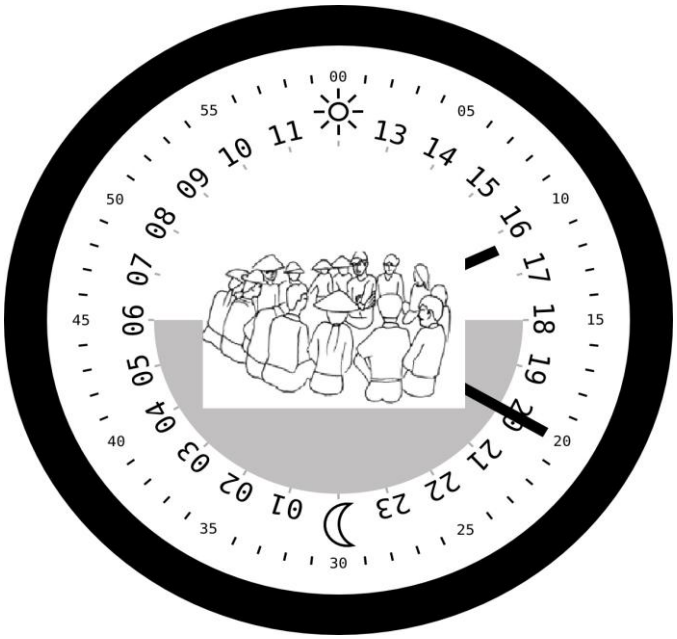


This exercise is best done using whatever material is comfortable to use in the field. At the village level, you can use sticks, stones, leaves, coloured seeds etc to depict the various activities and intensity.

The patterns vary for different types of migrants. This difference needs to be taken into account when making a micro plan for the village so that the team knows what programs to plan and when.

Daily Routine of Migrants

Understanding daily routine of migrants would help in planning timings of activities with migrants.



The exercise need to be done with a group of 15-20 migrants. Key steps involved in the process are-

Step 1: Welcome all the participants and explain the purpose the exercise

Step 2: Draw a clock on the chart paper and mark the different time slabs

Step 3: Ask the participants what they do in different slabs, for ex. What time they are free, what time they sleep etc.

Step 4: Discuss the responses with group and add it to following table-

	5:00 – 9:00 am	9:00 – 1:00 pm	1:00 – 5:00 pm	5:00 – 9:00 pm	9:00 – 1:00 am	1:00 – 5:00 am
Potential Migrant						
Out Migrant						
Returnee Migrant						
Spouse						

Activities done on Sunday/ holiday

As the daily routine Sunday or any other holiday is different hence it should be noted separately

	5:00 – 9:00 am	9:00 – 1:00 pm	1:00 – 5:00 pm	5:00 – 9:00 pm	9:00 – 1:00 am	1:00 – 5:00 am
Potential Migrant						
Out Migrant						
Returnee Migrant						
Spouse						

The analyses of the information collected would help in planning the outreach activities with different migrant groups.

Behaviour pattern of migrants

Different types of migrant groups portray differing patterns of behaviours. Prior to leaving the village, when they are still potential migrants, they are naive, sheltered by the family and unaware of several risks they may face in their destination points. They borrow money to plan for their trip. Some of them are excited about the new venture but many are apprehensive and anxious. They have never faced serious peer pressure and not had many opportunities to pick of assertiveness skills. Many of them are illiterate and poor and their health status is average if not poor.

After being in the destination for some time, they acquire new behaviours. On their return, they are more confident, independent, and feel empowered because they now have some money. Peer pressure and monotonous working and living conditions further drive them to get involved in high risk activities such as drinking, taking drugs, unsafe sex with commercial sex workers, sexual activities with other male migrant roommates or friends etc. These are behaviours they pick up because of peer pressure and a need to feel part of the regular migrant male workgroup.
They are also excited at seeing their family. Those who are married with children are happy to be with their spouses and children. They are restless and want to continue their high risk activities in the village also- drinking, visiting local sex workers, gambling, etc.

Once the managers understand the specific patterns of different migrants, s/he can plan specific interventions at appropriate times and places to address these sub types.

Checklist for the group exercise

What are the patterns of migration in the Village…. If there HHs where there is migration

- Households where these is long distance, long duration migration:
- Does the entire family migrate or only the men?
- Do single women migrate separately (estimate numbers)?
- Typically for when and how long do they migrate and where do they go (preferred places)?
- Typically, what kind of work do such migrants carry out?
- What kind of living arrangements exists for these migrants?
- When migrating with families, are the women and girl children at risk of exploitation? If so, are there any instances?
- On return, how do migrant's spend their saved money; any change in entertainment or other patterns
- Are there any reports of migrants being 'very sick' after returning from migration

A simple compilation of this information can be made at village level and used for micro planning.

Sl. No.	Name of migrant	Age	Sex	Marital status	Education status	Typology of migrant	Migrant for how many years	Destination site	Month/s when available at source	Months when she leaves the village	Uses alcohol/smoker/ takes drugs	Income status	Health problems

At Destination:

In all the destination towns / cities, a rapid assessment will be carried out. A dual-layer location mapping (preliminary and detailed) will be adopted to identify sub-pockets of risk within larger locations and to gather information for intervention purposes.

Step 1. Preliminary mapping (identifying top pockets where migrants live / operate)
Preliminary mapping provides a general overview of the entire geographic area and is the basis for a detailed mapping study.

Information will be collected from key informants (Labour Contractors, District Labour Office, District Industries Centre, Trade Unions of informal labour, Slum Development Officers, Municipal Corporation Officers, NGOs and other key stakeholders) to gather information about presence of major pockets of migrants in the districts where there are 5,000-10,000 migrants. The top 5 prominent male migrant pockets in each district will be short listed for detailed mapping and risk assessment.

Step 2. Detailed mapping (identifying locations and populations for intervention)
Detailed mapping is needed in order to ensure a target-efficient, streamlined intervention among migrant workers. The study will cover the aspects enumerated in the scope through two key methods:

Key Informant interviews: In each of the selected migrant pockets 25 KI interviews will be conducted to gather detailed information on target group size as well as congregation points of high-risk men and women. The purpose of using the individual key informant tool is to collect the following information:

- Estimates of total migrants
- Typology, duration and source points of migration
- Months of migration (and return back)
- Names of key contractors and migration facilitators.
- Number of Female Sex Workers who operate in nearby areas

Possible list of key informants available are listed below. This is indicative and not exhaustive:

- Formal /Non formal Leader / Opinion leaders
- Local labour contractors and migration facilitators
- Shop owners (Arrack shop, Medical, Kirana..Etc)
- Doctors
- Local NGO workers
- Ministry of Labour representatives
- ESI Hospital

Key informant interviews will be with secondary and tertiary stake holders who are residents of the area and are staying in the area for more than 3 to 4 years.

Polling booth: The risk assessment by using polling booth method – 5 of them. The selection of key informants and Polling Booth participants will be carried out in a way that they are reasonably representative. Process to be followed is similar to the one described in earlier para (source).

The results are reported in the prescribed format. In addition to the above steps all staff involved in the data collection will prepare an area level summary sheet and a map.

At Transit:

In all the transit locations, a rapid assessment will be carried out. This assessment will be adopted to identify locations within the transit locations where migrants congregate before leaving / after arriving and to gather information for intervention purposes.

A set of following tools can be used for the purposes:

Tool for Transit Mapping

Useful for:

- Understanding the different mapping methodology and prioritize the congregation points/ areas for intervention
- Listing out the key stakeholders in a transit place
- Determining in what way these stakeholders either influence or support the program

Tool for Broad Mapping

A broad map provides with a geographical and social overview of a city, including details regarding landmarks, bus stations, railway stations and the major congregation points. Information about migrant population presence at the site can also be collected.

This method is to be used with the general population as well as the migrants in the site. The PSA team can approach the people who know migrant closely.

- Start by asking general questions about the city. Spread chart paper on the ground, hand out sketch pens, and request the participants to draw the geographical outline of the city.
- Request participants to mark the important landmarks in the city. Whilst marking landmarks, services such as railway stations, bus stations and district labour office.
- Next, ask participants to mark the specific locations or congregate points where key populations tend to congregate.
- Whilst the participants draw the map, ask them probing questions to generate information on number of migrants at different congregation points.
- Note down all the information collected in the map

Site Map

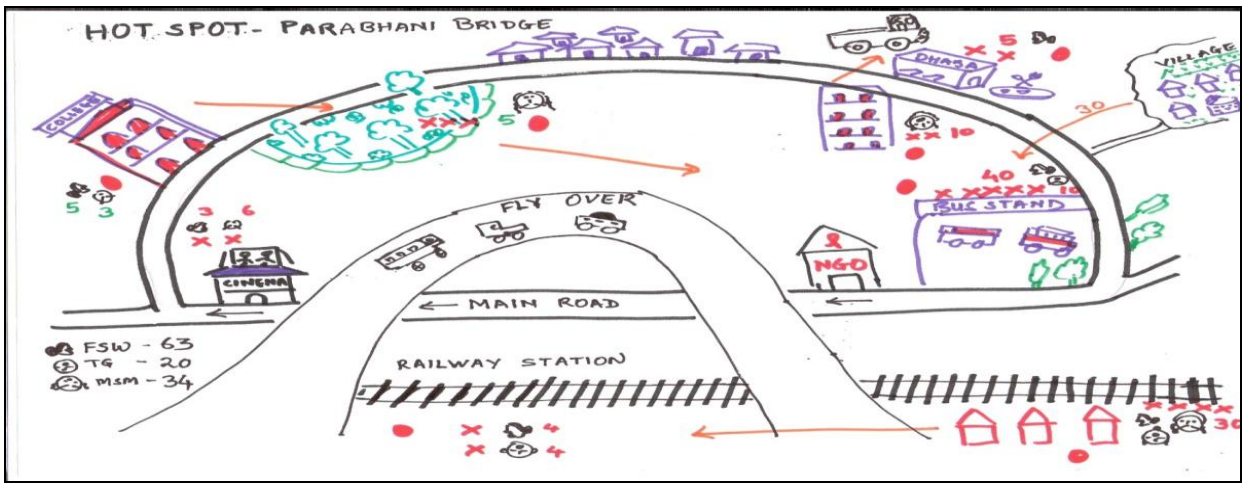
Site map provide information about number of migrants at the congregation site and the nearby places frequently visited by migrants. This map needs to be drawn for every congregation site.

Participants

Migrants and other people who knows migrant closely

Locations

All major bus station, railway station and congregation/ transit points.



Process

- Ask the group to draw a map of the site, including any local landmarks to orient the map.
- Ask the group to write down estimated number of migrants at the site.
- Ask the participants to mark the places migrants frequently visit like bars, brothels, other entertainment places etc near the site

Type of Place	Name of place
Bar/ Liquor shops	
Brothel / lodge/ any other sex work site	
Other Entertainment places	
STD booth	
Short stay place	
Any other place	

Information about Transit Routes

The collection of information about major train between source and destination would help in planning the activities for migrants travelling in the train.

Participants

Migrants and secondary stakeholders like railway station managers, hawkers, porters etc.

Locations

All major railway stations and congregation points.

Process

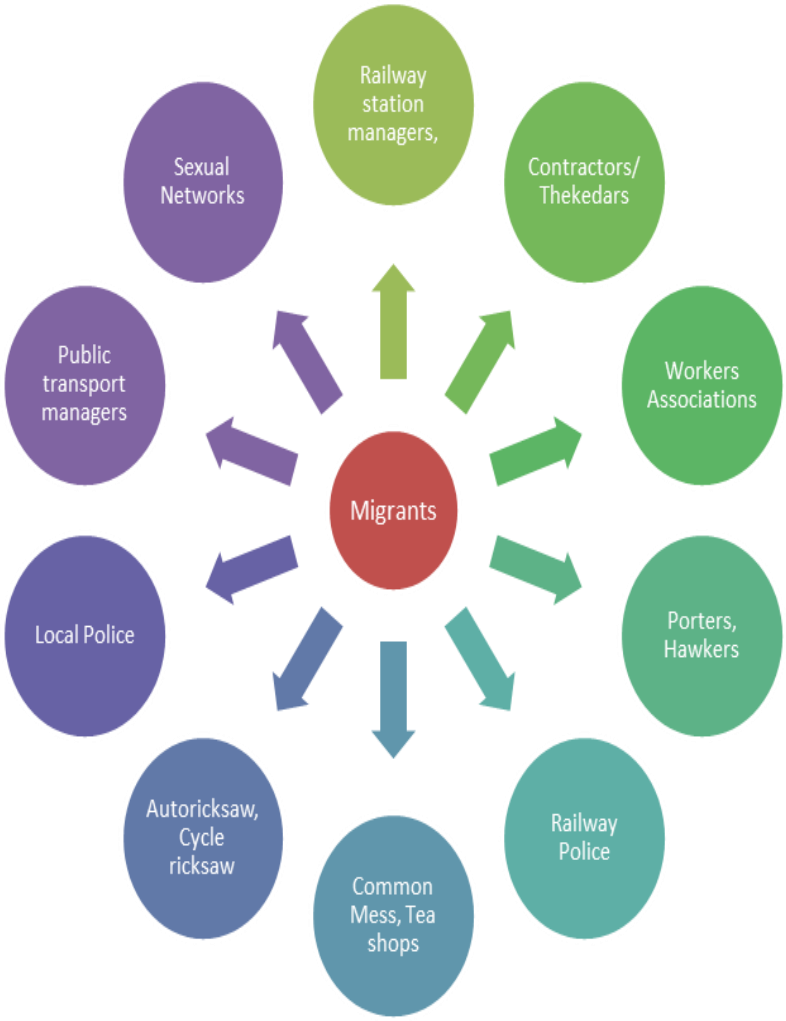
- Ask the participants about the major trains through which migrant travels
- Note down the timing, origin and destination station of train
- Also discuss with the participants, the number of migrants travelling in the train in peak and lean period

- Add the information to the table given below

Name of train/ bus	From	To	Time	Number of migrants in peak period	Number of migrants in lean period

Stakeholder/Power analysis

The most important step in creating an enabling environment is a careful analysis of the power structures in which migrants are involved. It has to identify, and strategies to address, the various stakeholders who influence migrants, whether directly or indirectly, positively or negatively. These are the people whose support can help to create an enabling environment for the migrant program.



A stakeholder analysis could use the following table for identification of role of different stakeholders at different level.

Possible Stakeholders	**What influence/ support on migrants**	**Current role**	**Expected role in intervention**	**Support/ advocacy required**
Labour contractor/ Thekedar				
Railway station manager				
Railway Police				
Hawkers, Porters				
Autoricksaw, Cycle ricksaw				
Common mess				
Barber shops				
Tea shops				
Public transportation manager				
Sexual networks				
* based on discussion list to be added				

Guidelines for Using the Tool

General Guidelines

- **Facilitators:** It is ideal to have a combined team of facilitators comprising programme/project staff and senior community members.
- **Group size:** A group of 15-20 participants is an ideal size.
- **Preparation:** It is essential for the facilitators to go through the tool carefully as a group before running it with the participants.
- **Recapturing the process:** The group of facilitators must meet at the end of each day to recapture the process and outcomes. A good analysis of this will serve as the basis for taking the analytical process forward.
- **Recording the output:** Outputs can be generated using large sheets of card or paper. Coloured cards can also be used to facilitate the process of participatory analysis. As and when possible, digital recording of generated outputs is helpful. Outputs generated must be put together in a structured report.
- **The tool is a guide, not a set of rules:** The tool is an illustrative guide and the matrices in it are outputs meant to facilitate data collation, encourage analysis and prepare for action. If you can think of a better way of reaching the goals of understanding the bodies and the means of control, go for it!
- **Facilitative and empowering, not extractive:** The tool attempts to facilitate concicentisation and empowerment and to lead to action by the community groups. Any data produced is meant primarily for the community themselves. To use this tool for the purpose of extracting data would defeat its purpose.

Guidelines for Conducting Participatory Structural Assessments

- **Look, listen and learn.** Facilitate. Don't dominate. Don't interrupt. When people are mapping, modeling or diagramming, let them focus.
- **Give adequate time.** Participants should be given ample time to think and discuss before replying.
- **Embrace error.** We all make mistakes, and do things badly some times. Don't hide it. Share it.
- **Ask yourself –** who is being met and heard, and what is being seen, and where and why; and who is not being met and heard, and what is not being seen, and where and why?
- **Relax.** Don't rush. Allow unplanned time to walk and wander around.
- **Meet people** when it suits them, and when they can be at ease, not when it suits you. This applies even more strongly to women than to men.
- **Probe**. Interview the map or the diagram.
- **Ask about what you see.** Notice, seize on and investigate diversity, whatever is different, the unexpected.
- **Use the six helpers –** who, what, where, when, why and how?
- **Ask open ended questions.**
- **Show interest** and enthusiasm in learning from people. Be sensitive to people.

Tool for Transit migrant profiling

Useful for

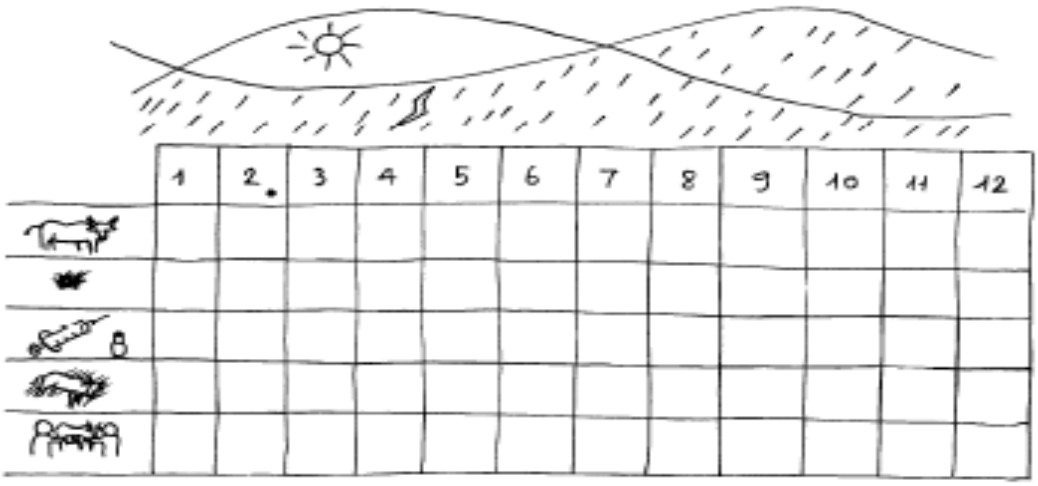
- Understanding the differences between the different categories of migrants.
- Understanding the issues such as seasonal patterns, behaviour patterns in different groups of migrants and link them to outreach planning

Seasonal patterns of migrants.

Each type of migrant has various seasonal patterns. This can be understood through a seasonal calendar.

What is a Seasonal Calendar?

A seasonal calendar is a **visual method** of showing the **variation in any pattern being studied** over time. In the case of a migrant program, it can be used to understand the variations in the volume of migrants, months which have more migrants either going out or coming in etc. This calendar is drawn up with the help of the community using PRA principles.



The steps to develop a seasonal calendar are:
Step 1: Draw 12 columns on a chart and explain that these are the months of the year. The community members can use other ways of depicting the 12 months in a year (pie chart etc.)

Step 2: Ask the group to list out the months where key festivals are celebrated in the village

Step 3: Ask probing questions to find out all seasonal activities and events related to the migrant community- when they leave, when they return etc., how much time they spent at

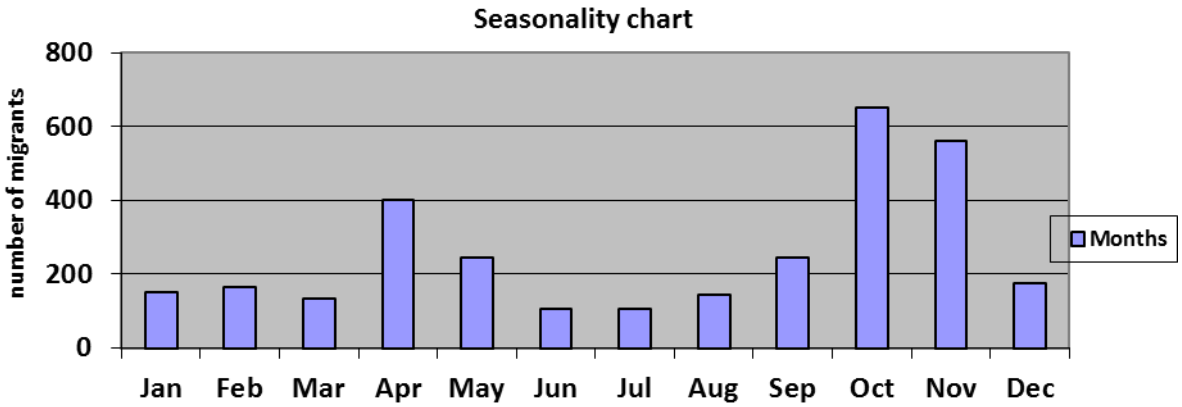
Step 4: Also try and look at other behaviour patterns- spending capacity; illnesses etc. Other risk factors such as the presence of sex workers in some months, agricultural patterns etc. can also be marked on the calendar.

The seasonal calendar will depict both the time of occurrence and the intensity of that activity/ pattern in relative terms. The information collected through seasonality diagram should be put together in the following table-

	Peak Day		Peak Week	Peak Month		Peak Season		Which Source	Which destination
	Day	Average Number	Average Number	Month	Average Number	Season	Average Number		
Out migrant									
Returnee migrant									
Migrant at Transit									

Step 5: Discuss how this Seasonal Calendar can be used to plan programs in the field. For example, depending upon the peak season for migrants at transit activities need to be planned.

Step 6: Once completed, the results should be documented on the paper.

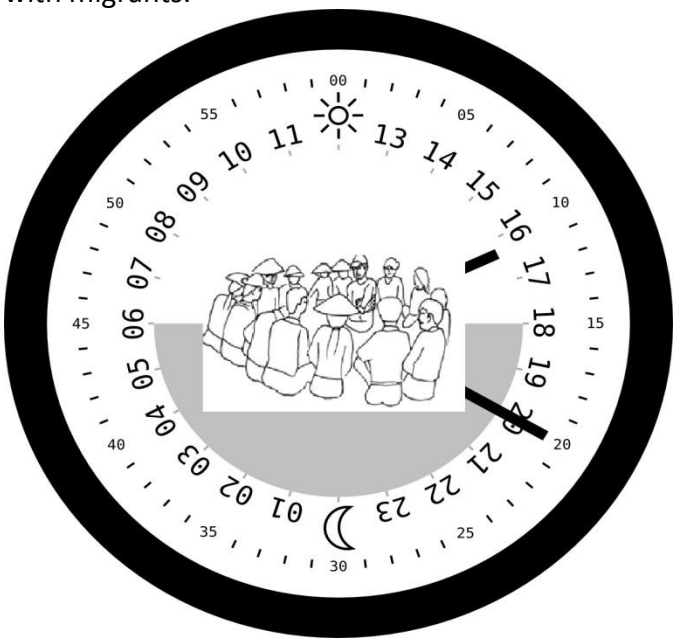


This exercise is best done using whatever material is comfortable to use in the field. At the village level, you can use sticks, stones, leaves, coloured seeds etc to depict the various activities and intensity.

The patterns vary for different types of migrants. This difference needs to be taken into account when making a micro plan for the village so that the team knows what programs to plan and when.

Time spent by Migrants at Transit

Understanding time spent by migrants at transit would help in planning timings of activities with migrants.



The exercise need to be done with a group of 15-20 migrants for each transit point. Key steps involved in the process are-

Step 1: Welcome all the participants and explain the purpose the exercise
Step 2: Draw a clock on the chart paper and mark the different time slabs
Step 3: Ask the participants at what time their train arrives and leaves, what other activities they do in between.
Step 4: Discuss the responses with group and add it to following table-

Mode of Travel (train/ bus)	Time of arrival	Time of departure	Activities - time spent by migrants after arrival or before departure at transit points	
			Out Migrant	Returnee Migrant
Train 1				
Train 2				
Train 3				
Train 4				
Train 5				

The analyses of the information collected would help in planning the outreach activities with different migrant groups.

5.4 IEC INTERVENTION FOR MIGRANTS

IEC Intervention for Migrants:

During the planning of Annual Actions Plans of the states to implement special IEC interventions focusing on migrants at source, transit and destination points in identified districts with high out-migration, the following primary communication objectives will be followed:

1. Increasing awareness of HIV/AIDS issues particularly transmission and prevention and related services with emphasis on condom promotion, STI treatment and HIV testing
2. Increasing risk perception associated with migration

Campaign Components:

The campaign will have following components:

(i) Distribution of information pamphlets to migrants boarding the trains at the railway stations from where they originate and also at the important intermediate stations and destination points.
(ii) Installing information displays such as messages on tin plates at the important railway stations and bus stations
(iii) Hoardings at railway and bus stations.
(iv) Wall paintings in the migrant settlements and migrant villages
(v) Information panels and stickers inside the general compartments of the trains
(vi) Sensitization sessions with labour contractors

Programme Monitoring: It will be done by visiting teams of NACO and SACS. The reporting formats for each transit location will indicate the IEC materials distribution and stock issues every month to SACS, which in turn will plan out corrective action.

5.5 DISTRICTS UNDER SOCIAL MARKETING PROGRAMME OF GOVT. OF INDIA

Targeted Condom Social Marketing Programme 2010-11		
SMO	**States**	**Districts**
Population Services International (PSI)	Karnataka	Bagalkot
		Bangalore Rural
		Bangalore Urban
		Belgaum
		Bellary
		Bidar
		Bijapur
		Chamarajanagar
		Chikmagalur
		Chitradurga
		Dakshina Kannada
		Davanagere
		Dharwad
		Gadag
		Gulbarga
		Hassan
		Haveri
		Kodagu
		Kolar
		Koppal
		Mandya
		Mysore
		Raichur
		Shimoga
		Tumkur
		Udupi
		Uttara Kannada
	Andhra Pradesh	Adilabad
		Anantapur
		Chittoor
		Cuddapah
		East Godavari
		Guntur
		Hyderabad
		Karimnagar
		Khammam
		Krishna
		Kurnool
		Mahbubnagar
		Medak
		Nalgonda
		Nellore
		Nizamabad
		Prakasam
		Rangareddi
		Srikakulam
		Visakhapatnam
		Vizianagaram
		Warangal
		West Godavari

Targeted Condom Social Marketing Programme 2010-11		
SMO	**States**	**Districts**
Population Services International (PSI)	Rajasthan	Ajmer
		Alwar
		Barmer
		Bharatpur
		Bhilwara
		Bikaner
		Chittaurgarh
		Churu
		Ganganagar
		Jaipur
		Jhunjhunun
		Jodhpur
		Karauli
		Nagaur
		Pali
		Sikar
		Tonk
		Udaipur
	Orissa	Anugul
		Balangir
		Baleshwar (Balasore)
		Bargarh
		Bhadrak
		Cuttack
		Ganjam
		Jagatsingpur
		Kalahandi
		Kendrapara
		Keonjhar
		Khordha
		Koraput
		Mayurbhanj
		Puri
		Sundargarh
	Madhya Pradesh	Balaghat
		Betul
		Bhopal
		Chhatarpur
		Chhindwara
		Dewas
		Dhar
		Guna
		Gwalior
		Harda
		Indore
		Jabalpur
		Jhabua
		Mandsaur
		Panna
		Rajgarh
		Ratlam
		Rewa
		Sagar
		Satna
		Shahdol
		Shajapur
		Shivpuri
		Sidhi
		Tikamgarh
		Ujjain
		Vidisha
		West Nimar

Targeted Condom Social Marketing Programme 2010-11

SMO	States	Districts
DKT India	Maharashtra	Ahmadnagar
		Akola
		Amravati
		Aurangabad
		Bhandara
		Bid
		Buldana
		Chandrapur
		Dhule
		Gadchiroli
		Gondiya
		Hingoli
		Jalgaon
		Jalna
		Kolhapur
		Latur
		Mumbai
		Mumbai (Suburban)
		Nagpur
		Nanded
		Nandurbar
		Nashik
		Osmanabad
		Parbhani
		Pune
		Raigarh
		Ratnagiri
		Sangli
		Satara
		Solapur
		Thane
		Wardha
		Yavatmal
DKT India	Gujarat	Ahmadabad
		Anand
		Banas Kantha
		Bharuch
		Bhavnagar
		Dohad
		Jamnagar
		Kachchh
		Mahesana
		Navsari
		Panch Mahals
		Porbandar
		Rajkot
		Sabarkantha
		Surat
		Surendranagar
		Vadodara
		Valsad

Targeted Condom Social Marketing Programme 2010-11		
SMO	**States**	**Districts**
Population Services International (PSI)	Tamil Nadu	Ariyalur
		Chennai
		Coimbatore
		Cuddalore
		Dharmapuri
		Erode
		Kancheepuram
		Kanniyakumari
		Karur
		Madurai
		Nagapattinam
		Namakkal
		Perambalur
		Pudukkottai
		Ramanathapuram
		Salem
		Sivaganga
		Thanjavur
		The Nilgiris
		Theni
		Thiruvallur
		Thiruvarur
		Tiruchirappalli
		Tirunelveli
		Tiruvanamalai
		Toothukudi
		Vellore
		Viluppuram
		Virudhunagar
	Pondicherry	Pondicherry
	Delhi	Central
		East
		North
		North East
		South
		North West

Targeted Condom Social Marketing Programme 2010-11

SMO	States	Districts
Hindustan Latex Family Planning Promotion Trust (HLFPPT)	Uttar Pradesh	Allahabad
		Agra
		Aligarh
		Ambedaker Nagar
		Azamgarh
		Bahraich
		Ballia
		Balrampur
		Banda
		Barabanki
		Bareilly
		Basti
		Bijnor
		Budaun
		Bulandshahar
		Chandauli
		Deoria
		Etah
		Etawah
		Faizabad
		Fatehpur
		Firozabad
		Ghaziabad
		Ghazipur
		Gonda
		Gorakhpur
		Hardoi
		Jaunpur
		Jhansi
		Jyotiba Phule Nagar
		Kanpur Nagar
		Kaushambi
		Lakhimpur Kheri
		Kushinagar
		Lucknow
		Maharajganj
		Mainpuri
		Mathura
		Mau
		Meerut
		Mirzapur
		Moradabad

Hindustan Latex Family Planning Promotion Trust (HLFPPT)	Uttar Pradesh	Muzaffarnagar
		Pilibhit
		Pratapgarh
		Rae Bareli
		Rampur
		Saharanpur
		Sant Kabir Nagar
		Sant Ravidas Nagar
		Shahjahanpur
		Shrawasti
		Siddharthnagar
		Sitapur
		Sonbhadra
		Sultanpur
		Unnao
		Varanasi

Targeted Condom Social Marketing Programme 2010-11		
SMO	**States**	**Districts**
Parivar Seva Sanstha (PSS)	West Bengal	Barddhaman
		Darjiling
		Howrah
		Jalpaiguri
		Kolkata
		Maldah
		Medinipur
		Murshidabad
		North 24 Parganas
		Puruliya
		South 24 Parganas
		Uttar Dinajpur
Pashupati Chemicals & Pharmaceuticals Ltd. (PCPL)	Chhattisgarh	Bastar
		Bilaspur
		Durg
		Raigarh
		Raipur
		Rajnandgaon
		Sarguja

Targeted Condom Social Marketing Programme 2010-11		
SMO	**States**	**Districts**
HLL Lifecare Limited	Punjab	Rupnagar (Ropar)
		Amritsar
		Jalandhar
		Ludhiana
		Pathankot(Gurdaspur)
	Haryana	Bhiwani
		Faridabad
		Gurgaon
		Panipat
	Chandigarh	Chandigarh
Janani	Bihar	Araria
		Aurangabad
		Banka
		Begusarai
		Bhagalpur
		Bhojpur
		Buxar
		Darbhanga
		Gaya
		Gopalganj
		Jamui
		Jehanabad
		Kaimur (Bhabua)
		Katihar
		Khagaria
		Kishanganj
		Lakhisarai
		Madhepura
		Madhubani
		Muzaffarpur
		Nalanda
		Nawada
		Pashchim Champaran
		Patna
		Purba Champaran
		Purnia
		Rohtas
		Saharsa
		Samastipur
		Sapaul
		Saran
		Sitamarhi
		Siwan
		Vaishali

Targeted Condom Social Marketing Programme 2010-11		
SMO	**States**	**Districts**
Population Health Services India (PHSI)	Jharkhand	Bokaro
		Deoghar
		Dhanbad
		Dumka
		Giridih
		Gumla
		Hazaribagh
		Palamu
		Pashchimi Singhbhum
		Purbi Singhbhum
		Ranchi
	Goa	North Goa
		South Goa
	Kerala	Ernakulam
		Kannur
		Kasargod
		Kollam
		Kozhikode
		Malappuram
		Palakkad
		Thiruvananthapuram
		Thrissur
		Wayanade
	Assam	Barpeta
		Dhubri
		Kamrup
		Sonitpur
	Manipur	Bishnupur
		Chandel
		Churachandpur
		Imphal East
		Imphal West
		Senapati
		Tamenglong
		Thoubal
		Ukhrul
	Meghalaya	East Khasi Hills
		West Garo Hills
	Mizoram	Aizawl
		Champhai
		Kolasib
	Nagaland	Dimapur
		Kohima
		Mokokchung
		Mon
		Phek
		Tuensang
		Wokha
		Zunheboto
	Tripura	West Tripura

5.6 STI CARE AND TREATMENT DELIVERY MECHANISMS UNDER NACP-III

Level of Care	Service Providers	Service Provision Modalities	Service Package
▪ **Village**	▪ ASHA/Link Worker ▪ Health Worker (F) ▪ Non-modern medicine practitioners	▪ Village health and nutrition day ▪ Outreach group meetings ▪ ANC and contraceptive clients	▪ Information on prevention, causation and transmission on RTIs/STIs ▪ Referrals ▪ Condom provision ▪ Screening for RTIs/STIs as per guidelines ▪ Promoting condoms as a method of dual protection ▪ Information and counselling for adolescent girls on menstrual hygiene ▪ Information on places for safe delivery and early and safe abortions
▪ **Sub-Health Centres**	▪ Health Worker (F) ▪ Health Worker (M)	▪ Routine MCH clinics at village/sub-centre ▪ Group Meetings ▪ Household contacts	▪ Screening ANC and contraceptive clients ▪ Condom provision ▪ Referrals for RTIs and STIs ▪ Information on causation, transmission and prevention on RTIs/STIs ▪ Information and counselling ▪ Adolescent Reproductive and Sexual Health (ARSH) services ▪ Post-partum care
▪ **Primary Health Centre/CHC** ▪ **Urban health Post**	▪ Medical Officer ▪ Staff Nurse ▪ LHV	▪ Routine OPDs ▪ ANC clinics ▪ Contraceptive provision ▪ RCH camps	▪ Medical care, STI/RTI treatment ▪ Partner treatment ▪ Screening and diagnosis ▪ Behaviour change communication (BCC) for safe sex and early treatment seeking ▪ Counselling ▪ Condom provision ▪ Simple diagnostic tests ▪ ARSH services
▪ **Designated private allopathic service providers**	▪ Doctor ▪ Nurse	▪ Routine private clinic	▪ STI /RTI diagnosis and syndromic treatment ▪ Counselling ▪ Condom promotion ▪ Partner treatment ▪ Referral to ICTC and other services (if necessary)
▪ **Designated private AYUSH /Other health care providers**	▪ AYUSH / Other health care providers	▪ Routine private clinic	▪ Counselling ▪ Syndrome identification and referral for treatment ▪ Condom promotion ▪ Referral for ICTC and other services

5.7 RASHTRIYA SWASTHYA BIMA YOJANA (RSBY)

HOUSEHOLD ELIGIBILITY CRITERIA

Coverage under the scheme would be provided for BPL workers and their families [up to a unit of five). A family would thus comprise the Household Head, spouse, and up to three dependents. The dependents would include such children and/or parents of the head of the family as are listed as part of the family in the BPL data base. If the parents are listed as a separate family in the data base, they shall be eligible for a separate card. The definition of BPL would be the one prescribed by the Planning Commission for the purposes of determining the eligible BPL population in each State/district. It would be the responsibility of the respective State Government to verify the eligibility of specific BPL workers and their family members who would be the beneficiaries of the scheme, and to share such information with the insurance provider. To this end, an authenticated BPL list [or lists where the covered area includes urban and rural areas] providing the details of each BPL family will be prepared by the State Government/Nodal agency. The data would be provided in the prescribed electronic format to the insurer. The State Governments may, if required, seek the assistance of an outside agency for the task of data entry. However, the responsibility for providing the correct data shall be that of the State Government and it would be expected of the State Government that it shall put in place a foolproof system of supervision and authentication of the data.

Proof of the eligibility of BPL households for the purposes of the scheme will be provided by issuance of smart cards to all beneficiary households.

ENROLMENT OF BENEFICIARIES

The enrolment of the beneficiaries will be undertaken by the Insurance company selected by the State Government and approved by the Government. The Insurer shall enroll the BPL beneficiaries based on the soft data provided by the State Government/Nodal Agency and issue Smart card as per Central Government specifications through Smart Card Vender and handover the same to the beneficiaries at enrolment station/village level itself during the enrolment period.

- At the time of enrolment, the government official shall identify each beneficiary in the presence of the insurance representative.
- At the time of handing over the card, the INSURER shall collect the registration fee of Rs.30/- from the beneficiary.
- This amount will be adjusted against the amount of premium to be paid to the INSURER by the Nodal Agency.
- The Insurer's representative shall also provide a pamphlet along with Smart Card to the beneficiary indicating the list of the networked hospitals, the availability of benefits and the names and details of the contact person/persons. To prevent damage to the smart card, a plastic jacket should be provided to keep the smart card.
- The beneficiary shall also be informed about the date on which the card will become operational (month).

HEALTH SERVICES BENEFIT PACKAGE

The beneficiary shall be eligible for coverage of the financial costs of such inpatient health care services as would be negotiated by the respective State government with the insurer(s), as well as agreed daycare procedures not requiring hospitalization.

However, the following minimum features of the health insurance plan would be as follows :

(a) Total sum insured of Rs.30,000 per BPL family per annum on a family floater basis.

(b) Pre-existing conditions to be covered, subject to minimal exclusions. An indicative list of exclusions is provided as follows:

1. Conditions that do not require hospitalization, 2. Congenital external diseases

3. Drug and Alcohol Induced illness, 4. Sterilization and Fertility related procedures

5. Vaccination,6. War, Nuclear invasion,7. Suicide, 8. Naturopathy,Unani, Siddha, Ayurveda

(c) Coverage of health services related to hospitalization and services of a surgical nature which can be provided on a daycare basis. An indicative list of daycare treatment is given below:

1. Haemo-Dialysis ,2. Parenteral Chemotherapy,3. Radiotherapy,4. Eye Surgery,5. Lithotripsy (kidney stone removal),6. Tonsillectomy,7. D&C,8. Dental surgery following an accident,9. Surgery of Hernia, 10. Surgery of Hydrocele, 11. Surgery of Prostrate, 12. Gastrointestinal Surgery,13. Genital Surgery, 14. Surgery of Nose,15. Surgery of Throat,16. Surgery of Ear,17. Surgery of Appendix,18. Surgery of Urinary System,19. Treatment of fractures/dislocation (excluding hair line fracture),Contracture releases and minor reconstructive procedures of limbs, which otherwise require hospitalization, 20. Laparoscopic therapeutic surgeries carried out in day-care,21. Any surgery under General Anaesthesia, 22. Any disease/procedure mutually agreed upon.

(d) Cashless coverage of all health services in the insured package. (e) Provision for a smart-card based system of beneficiary identification/verification and point of service processing of client transactions.

(f) Provision for reasonable pre and post-hospitalization expenses for one day prior and 5 days after hospitalization, but subject to a maximum share of the total costs of the hospitalization.

(g) Provision for transport allowance (actual with limit of Rs.100 per visit) but subject to an annual ceiling of Rs.1000.

ELIGIBLE HEALTH SERVICES PROVIDERS

Both public (including ESI) and private health providers which provide hospitalization and/or daycare services would be eligible for inclusion under the insurance scheme, subject to such requirements for empanelment as agreed to between the State Government and insurers.

5.8 STAKE HOLDER ANALYSIS TOOL

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		
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
	Questions	Probe points for recording answers verbatim
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	Probe for sexual behaviours / drug usage, etc.

	more vulnerable to getting HIV/AIDS?	
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) Total	
9.	Males	
10.	Females	
11.	Males without family	
12.	Females without family	

Observation

This is the oldest and most basic source of human knowledge. After gaining access to the relevant target group, the non-reactive technique of observing without participation can be more effective than participating as an insider. This is because the quality of data is enhanced by watching and listening without interrupting the natural flow of activity.

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 sterilized needles - Accepting 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?	

5.9 ROLES AND DELIVERABLES OF MANAGEMENT SYSTEM AT SOURCE

Staff/Volunteers	Cost involved	Norms	Roles	Deliverables
VILLAGE LEVEL				
Village level Volunteers **in Non-LWS districts only (to be identified separately including** from returnee migrants, their family members, mukkdams, labour contractors**). However, link workers will not be paid any honorarium.**	Rs 500/-pm	Rs 500 per month as honorarium. 5 per block, hence 25 in a district	Prevention message to the community Identification of HRG migrants and provide prevention services (Treatment of STI, Condom, BCC) Referral to treatment of STI and care and support services for PLHIV Provide lay-counseling	One village level volunteer will cover at least 2000 migrants per quarter a combination of returnee, potential, outgoing migrants and their spouses
BLOCK LEVEL				
Out Reach Workers (non link workers districts/blocks) – male and female	Rs. 5000/-pm 2 for 1 block (1 male and 1 female) considering 5 blocks would be covered in a district	Each supervisors will monitor 5-10 voluntary Peer Leaders Must be a resident of the same district Should have proficiency in local language Should be Class 10 passed 3 to 5 years of experience in development sector	Supervisory support to voluntary peer educator, Training to voluntary Peer Leaders, BCC and information services to community members Coordinate orientation of ANM, MPW, AWW and ASHA on HIV/AIDS Ensure regular supply/availability of condoms Maintain rapport with local health units and facilitate access to services	Supervisory visit to at least one location of the volunteers once a month. Will supervise 5 volunteers. Hold at least 10 meetings at various levels i.e. VHND, Youth Clubs, PRIs, Returnee migrants and sensitise on Migration and HIV. Ensure visit to information booths, collation of reports, monitoring of condom outlets

DISTRICT LEVEL				
District Coordinator (to be identified separately)in districts with no LWS	Rs 8000/- to 12000/- pm	Should possess Masters Degree preferably in Social Science 3 to 5 years of development work at supervisory level HIV positive persons with required qualification will be given preference	Overall coordination of the project at source district Manage recruitment Project performance management and timely reporting Facilitate the Assessment and planning process Training to staff at various level within the project Establishment of systems Coordination of Mid media campaigns and other IEC activities Create linkages with various agencies and program in the district Play a strong role in advocacy and in creating an enabling environment at the district level	Supervisory visits Timely submission of reports Ensuring achieving overall outputs of the project deliverables.
District Supervisor in districts with LWS to be involved			Same as above	Same as above
Part time Accountant	Rs 3000/- pm	Preferably with B com with experience of computer Experience of having worked in NGOs PLHIVs with qualification will be preferred	Maintain regular accounts Support in data management of the program Administration related work within the project Maintain data records, compilation and analysis, sharing with destination districts	Sending financial and programmatic reports Updating data base of project deliverables
M&E Officer Both in LWS NGO led	Rs6,000/- pm(applicable in NGO led	Should possess Bachelors/Masters degree in	Responsible for following: 1. Monthly report	Timely submission of reports

migrant interventions or NGO/CBO led (in Non-LWS districts) migrant interventions at source	interventions only)	Statistics/Computer Application/ Demography/Bio Statistics 2-3 yrs experience of development work especially handling data analysis, report writing etc. HIV positive persons with required qualification to be given preference.	compilation at district level from different reporting tools 2. Sharing the reports with SACS/DAPCU on time 3. Sharing of feedback of SACS/DACPU with staffs for appropriate action. 4. Compilation of migrant profiles by ORW wise and sharing the data with SACS at source and destination. 5. Computerisation of all datas related to migrant profiles. 6. Sharing of data received from destination states, segregate by ORWs for follow up. 7. Help ORWs to understand and analyse the data to find out gaps and inform District Coordinator. 8. Train ORWs on reporting tools 9. Play a strong role in data analysis, gap identification and provide key inputs for improvement	Ensuring all data are computerized and shared with destination and source SACS

5.10 KEY ACTIVITIES AT SOURCE

Key Activities at Source

Sl no	ACTIVITIES	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
1	Set up Activities												
1.1	Recruitment and Office Set up												
1.2	Situational Needs Assessment												
1.3	Project Implementation Plan including stakeholder management plan												
1.4	Establishing Project System												
1.5	Establishing Key Linkages with key stakeholders as per stakeholder management plan												
	Prevention Package												
2	Information Services												
2.1	Adaptation or procurement of BCC kit												
2.2	Selection and training of Volunteers, ASHA, ANM, AWW as well as Peer Leaders												
2.3	Identification of Potential youths for Migrants, Returnee Migrants, Family/Spouses of Migrants												
2.4	Conducting One to One with Migrant Population (where possible)												
2.5	Conducting One to Group with Migrant Population, Spouses/Families of Migrants, and potential youths for Migration												
2.6	Mid Media Campaigns - street play, exhibition, folk art etc.												
2.7	Establishing Information Booth at Panchayath, PHC, youth clubs etc												
2.8	Procurement and supply of IEC materials												
3	Condom Services												
3.1	Procurement and stocking of condom for both social marketing and free distribution												

Sl no	ACTIVITIES	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
3.2	Training to volunteers, ASHA, ANMs. AWW etc on condom demo and improve skill in providing information on condom												
3.3	Establishing Linkages with SMOs												
3.4	Establishing condom outlets at strategic location in the village												
4	STI Health Care Service												
4.1	Establish Linkages with Health Care Providers both in the government and in private												
4.2	Training and capacity building HCP on STI and HIV												
4.3	Identification and Treatment of STIs												
4.4	Organizing health camps												
4.5	Introduction of Smart Card System to track cohort for treatment of STI across the corridors of migrations - source, transit and destination												
4.6	Link to RSBY Card System												
5	HIV Health Care Packages												
5.1	PLHIV Health Care Service Linkage to be established												
5.2	Linkage established and referrals made to PLHIV network												
6	Enabling Environment Packages												
6.1	Mapping out key stakeholders using Stakeholder analysis tool												
6.2	Linkages will be established with Nehru Yuva Kendra, Youth Clubs, PRI members, contractors, brokers,												
6.3	Social Welfare and Social Security Schemes will be linked up (NREGA, ICDS, JSY)												
7	Vulnerability Reduction Strategies												
7.1	Training on HIV and STI to ANMs, ASHA, AWW, Youth Club Volunteers												
7.2	Establish information booths at ICDS centres												
7.3	Activity points like mothers meeting, Village Health and Nutrition Days												

5.11 ROLES AND DELIVERABLES OF STAFFS AT DESTINATION

Staffs/Volunteers	Cost involved	Norms	Roles	Deliverables
Peer Leaders (labour contractors, stake holders, members of the labour unions) The ratio of Voluntary Peer Leaders will vary from settings to settings, but the ration should not be more than 1:750 migrants in any setting. **The selection of Peer Leaders is a progressive activity- as and when the volume of migrant identification increases, the peer leaders can be selected from different hot zones instead of from one area.**	Rs.1000/- pm for 40 sessions across 20 working days	At least reaching out 1000 high risk migrants through 40 sessions per month. At least 20 days / 40 sessions in a month for each session covering 10-12 target population.	Prevention message to the community Identification of HRG migrants and provide prevention services (Treatment of STI, Condom, BCC) Referral to treatment of STI and care and support services for PLHIV Provide lay-counseling	One Volunteer Peer to cover 750-1000 Migrants 20 Outreach group sessions List of participants Number of referrals
Out Reach Workers 1:3 Peer Leaders	Rs. 5000/- per month	Each supervisors will monitor 4 Voluntary Peer Leaders Must be a resident of the same district Should have proficiency in local language Should be Class 10 passed 3 to 5 years of experience in development sector	Supervisory support to voluntary peer educator, Training to voluntary Peer Leaders, BCC and information services to community members Coordinate orientation of ANM, MPW, AWW and ASHA on HIV/AIDS Ensure regular supply/availability of condoms Maintain rapport with local health units and facilitate access to services	- At least attending 25% of the sessions conducted by the VPLs under him/her - Networking with local stake holders - linkage development with referral systems - coordinating with RSBY, local doctor, SMO, contractors - managing condom outlets

DISTRICT LEVEL				
Project Director	Rs. 40000 as honorarium per annum	Should possess minimum of post graduate degree Should have had 7 to 8 years of experience in the development sector Part of the NGO Board Readiness to involve in the project par time	Overall monitoring of the project Attend regularly the meetings Financial Control Involve in recruitment of staff Involve in training staff Regular supervisory visit to the project	Ensure the Project Manager is able to deliver the project outputs.
Project Manager	Rs 8000/- to 12000/- pm	Should possess Masters Degree preferably in Social Science 3 to 5 years of development work at supervisory level HIV positive persons with required qualification will be given preference	Overall coordination of the project at destination district Manage recruitment Project performance management and timely reporting Facilitate the Assessment and planning process Training to staff at various level within the project Establishment of systems Coordination of Mid media campaigns and other IEC activities Create linkages with various agencies and program in the district Play a strong role in advocacy and in creating an enabling environment at the district level	Supervisory visits Timely submission of reports Ensuring achieving overall outputs of the project deliverables.

ANM/Counselor	Rs. 7000/- pm	Post Graduate in Social Science Two to three years of experience in counseling Having worked in HIV programmes Preference for HIV positive persons particularly women The individual must have sensitivity of working with marginalized groups, including people affected by HIV/AIDS and high-risk groups	Regular counseling to target community both at the information centre or at the field level Would require travel to villages to provide counseling to individuals from the migrant community that require counseling Home visits Facilitate linkages to welfare services for the migrants Support in organizing mid media campaign and other IEC activities Training to volunteer Peer Leaders and ORW on lay counseling	Counseling Reports and Case Records
Part Time Doctor (at least 3 times in a month for 8 hours each service is required)	Rs 9000/- pm	Maximum of 3 part time doctor for a population of 5000 migrants, the same may be scaled up to 5 for Tis with 10000 or more migrants (the same need to be based on local needs)	Identification and treatment of STIs and other illness among Migrants Motivate the high risk persons to get themselves tested at the ICTC Referral for Care and Support for PLHIV migrants to ART, CCC, PPTCT centres Maintain records of treatment	Number of STIs treated
Part time Accountant	Rs 3000/- pm	Preferably with B com with experience of computer Experience of having worked in NGOs PLHIVs with qualification will be preferred	Maintain regular accounts Support in data management of the program Administration related work within the project Maintain data records, compilation and analysis, sharing with source districts	Sending financial and programmatic reports Updating data base of project deliverables

M&E Officer	Rs6,000/- pm	Should possess Bachelors/Masters degree in Statistics/Computer Application/ Demography/Bio Statistics 2-3 yrs experience of development work especially handling data analysis, report writing etc. HIV positive persons with required qualification to be given preference.	Responsible for following: 1. Monthly report compilation at district level from different reporting tools 2. Sharing the reports with SACS/DAPCU on time 3. Sharing of feedback of SACS/DACPU with staffs for appropriate action. 4. Compilation of migrant profiles by ORW wise and sharing the data with SACS at source and destination. 5. Computerisation of all datas related to migrant profiles. 6. Sharing of data received from destination states, segregate by ORWs for follow up. 7. Help ORWs to understand and analyse the data to find out gaps and inform Project Manager. 8. Train ORWs on reporting tools 9. Play a strong role in data analysis, gap identification and provide key inputs for improvement	Timely submission of reports Ensuring all data are computerized and shared with destination and source SACS

5.12 KEY ACTIVITIES AT DESTINATION

Sl no	ACTIVITIES	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
1	Set up Activities												
1.1	Recruitment and Office Set up												
1.2	Rapid Assessment												
1.3	Project Implementation Plan including stakeholder management plan												
1.4	Establishing Project System												
1.5	Establishing Key Linkages with key stakeholders as per stakeholder management plan												
	Prevention Package												
2	Information Services												
2.1	Adaptation or procurement of BCC kit												
2.2	Selection and training of Peer Leaders												
2.3	Identification and enrolment of High Risk Migrants												
2.4	Conducting One to One with Migrant Population												
2.5	Conducting One to Group with Migrant Population												
2.6	Mid Media Campaigns - street play, exhibition, folk art etc.												
2.7	Establishing DIC cum Information Booth at company sites, government hospitals, pick up points etc												
2.8	Procurement and supply of IEC materials												
3	Condom Services												
3.1	Procurement and stocking of condom for both social marketing and free distribution												

Sl no	ACTIVITIES	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
3.2	Training to Peer Leaders, on condom demo and improve skill in providing information on condom												
3.3	Establishing Linkages with SMOs												
3.4	Establishing condom outlets at strategic location in the village												
4	STI Health Care Service												
4.1	Establish Linkages with Health Care Providers both in the government and in private												
4.2	Training and capacity building HCP on STI and HIV												
4.3	Identification and Treatment of STIs												
4.4	Organizing health camps												
4.5	Introduction of Smart Card System to track cohort for treatment of STI across the corridors of migrations - source, transit and destination												
4.6	Link to RSBY Card System												
5	HIV Health Care Packages												
5.1	PLHIV Health Care Service Linkage to be established												
5.2	Linkage established and referrals made to PLHIV network												
6	Enabling Environment Packages												
6.1	Mapping out key stakeholders using Stakeholder analysis tool												
6.2	Linkages will be established with Nehru Yuva Kendra, Youth Clubs, PRI members, contractors, brokers,												
6.3	Social Welfare and Social Security Schemes will be linked up (NREGA, ICDS, JSY)												
7	Vulnerability Reduction Strategies												

Sl no	ACTIVITIES	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
7.1	Training on HIV and STI to ANMs, Youth Club Volunteers etc												
7.2	Establish information booths at ICDS centres or community c												
7.3	Activity points like mothers meeting, Village Health and Nutrition Days												

5.13 ROLES AND DELIVERABLES OF STAFFS FOR TRANSIT INTERVENTIONS

	Cost involved	Norms	Roles	Deliverables
PART TIME Out Reach Workers (both in link workers and non link workers districts)	Rs. 3000/- (per month)	Must be a resident of the same district Should have proficiency in local language Should be Class 10 passed 3 to 5 years of experience in development sector	Supervisory support to voluntary peer educator, Training to voluntary Peer Leaders, BCC and information services to community members Coordinate orientation of ANM, MPW, AWW and ASHA on HIV/AIDS Ensure regular supply/availability of condoms Maintain rapport with railway and transport authorities, local health units and facilitate access to services	Conduct prevention and awareness program in the transit
Project Manager			Overall coordination of the project at various transits within the district Manage recruitment Project performance management and timely reporting Facilitate the Assessment and planning process Training to staff at various level within the project Establishment of systems Coordination of Mid media campaigns and other IEC activities Create linkages with various agencies and	Supervisory visits Timely submission of reports Ensuring achieving overall outputs of the project deliverables.

			program in the district particularly with railways and transport authorities Play a strong role in advocacy and in creating an enabling environment at the district level	

5.14 KEY ACTIVITIES AT TRANSIT INTERVENTIONS

Sl no	ACTIVITIES	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
1	Set up Activities												
1.1	Recruitment and Office Set up												
1.2	Situational Needs Assessment												
1.3	Project Implementation Plan including stakeholder management plan for transit												
1.4	Establishing Key Linkages with key stakeholders as per stakeholder management plan												
1.5	Establishing Crisis Response System												
	Prevention Package												
2	Information Services												
2.1	Identifying bus routes and involving bus operators for bus branding and in – bus messaging												
2.2	Selection and training of Peer Leaders/Link Workers/ORW												
2.3	Identification and enrollment of High Risk Migrants												
2.4	Conducting One to One with Migrant Population												
2.5	Conducting One to Group with Migrant Population												
2.6	Mid Media Campaigns - street play, exhibition, folk art etc. At the railway station and bus stands												
2.7	Establishing Mobile Information Booth at Railway station or bus stand												

Sl no	ACTIVITIES	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
2.8	Procurement and supply of IEC materials												
3	Condom Services												
3.1	Procurement and stocking of condom for both social marketing and free distribution												
3.2	Training to Peer Leaders on condom demo and improve skill in providing information on condom												
3.3	Establishing Linkages with SMOs												
3.4	Establishing condom outlets at strategic location in the Railway or bus station												
4	STI Health Care Service												
4.1	Establish Linkages with Health Care Providers both in the government and in private in and around the railway station and bus stand												
4.2	Training and capacity building HCP on STI and HIV												
4.3	Identification and Treatment of STIs												

X-19014/05/2008- NACO(TI)
Government of India
Ministry of Health and Family Welfare
Department of AIDS Control

To
The Project Directors,
All State AIDS Control Societies.

Dated: 3rd January,2011

Sub: Revised budget for Migrant Interventions at Destination, Budget for Migrant Interventions at Source and Transit.

Sir/Madam,

This is with reference to the revised Migrant Strategy for implementation of HIV prevention programmes at source, transit and destination. As you are aware that, NACO has circulated the strategy paper on revised migrant strategy earlier for your kind information and necessary action.

Please find here with the details of the budget to be used for implementation of source, transit and destination migrant interventions with following instructions:

(i) At source, the migrant interventions will be implemented by NGOs as well as through Link Worker Scheme. In case of Link Worker Scheme, where the proposed migrant districts overlap, the migrants are already being covered as one of the target group under vulnerable population. Hence in cases of LWS, no implementation or management cost is allowed. However, SACS would provide additional training of staffs of LWS, provision of IEC materials and migration kits. An instruction sheet with details of the budget heads for NGO led interventions in Non-LWS districts is attached for your perusal.

(ii) Procurement of services of NGOs for destination and source interventions should strictly comply with NACP-III selection and procurement norms.

(iii) At transit, the interventions are expected to be carried out by expanding the scope of existing interventions in compliance with revised migrant strategy. Detailed instruction sheet on budget heads is attached for your perusal. Budget for current FY has been worked out for 3 months and the same will be provisioned in the AAP if separate proposals are submitted by SACS.

(iv) At destination, a number of budget heads have been modified and additional budget heads have been introduced to comply with activities proposed in the revised migrant strategy. Accordingly the instruction sheet with detailed budget note is attached for your perusal. Budget for current FY is to be worked out for 3 months as per instructions thereof and the same will be provisioned in the AAP of current FY.

(v) The existing contracts of migrant interventions need to be amended in terms of the scope of interventions as per revised migrant strategy, amendment of the budget if required, modification of the TOR and deliverables of staffs and modification of performance bond with indicators of the contract.

(vi) The IEC activities for all migrant interventions need to be separately provisioned from IEC budget of SACS and the same need to be reflected in the AAP in the AAP of IEC division of SACS.

(vii) For all monitoring purposes, the concerned TSU Project Officer will be responsible for supervision, handholding and monitoring of interventions at transit and destination.

This has the approval of Secretary (DAC) and DG,NACO.

Yours faithfully,

(Kanwaldeep Singh)
Director (Finance)

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5.15 BUDGET FOR SOURCE INTERVENTIONS

Instructions on budget formulation and regulation of expenses on Migration TIs at Source:

As per the revised strategy on migrant interventions the activities are to be undertaken at source, transit and destination. Because of the mobility of the population, it may not be effective if these points are not separately covered considering the duration of stay at each of these places.

In order to have better clarity in budgeting of these differential interventions the following guidelines are issued which should be followed meticulously by the SACS and impressed upon to the implementing partners.

SACS would provide training through STRC, which need to be budgeted as part of AAP. SACS will also provide flip books, training aids and communication materials – which need to be budgeted as part of training materials under AAP. SACS will also provide IEC materials, migration kits, hoardings, bus panels, wall writings at village level - which need to be budgeted as part of the IEC budget of SACS.

A. **Source Interventions** (implemented by NGOs in non-LWS districts)

New NGOs to be identified by following the selection and procurement procedure under NACP-III guidelines. Refer note (i) and (ii) in the covering letter.

Each Source Intervention is expected to be implemented in 5 blocks covering 30-50 villages with annual outmigration of > 50,000 migrants per year.

Activity Number	Cost Category	No of Units	Timeline	Unit cost	Cumulative Unit Costs	Norm/Requirtments
1	**Salary/ Honorarium of Staffs/ Volunteers**					
1.1	District co-ordinator	1	12	10,000	120,000	The range is Rs 8000 to 12000, the higher limit taken for budgeting. Norms and deliverables are as per Migrant Operational Guidelines.
1.2	Travel of District Coordinator for admin and programme purposes	1	12	1,000	12,000	Travel to districts/blocks for programme monitoring, facilitate programme implementation as well as administrative activities
1.3	M&E officer	1	12	6,000	72,000	For M & E purposes, since data is to be shared with destination districts and states. Norms and de;iverables are as per Migrant Operational Guidelines.
1.4	Part time accountant	1	12	3,000	36,000	For the purpose of maintenance of office records and accounts.Norms and deliverables are as per Migrant Operational Guidelines.
1.5	Honorarium of Village level volunteers For a maximum of 5 blocks	25	12	500	150,000	Rs 500 per month as honorarium. 5 per block, hence 25 in a district.Norms and deliverables are as per Migrant Operational Guidelines. Maximum of 25 volunteers (i.e. 5 per block, 25 per district)
1.6	Block level Out reach workers	10	12	5,000	600,000	2 for 1 block (1 male and 1 female) considering 5 blocks would be covered in a district.Norms and deliverables are as per Migrant Operational Guidelines.
1.7	Travel of Block level Out reach workers	10	12	500	60,000	Travel for programme purposes within the block to conduct village level meetings, meetings with stake holders, migrants, as per the deliverables of migrant guidelines
2	**Infrastructure and Recruitment (For New Interventions Only)**					
2.1	Table	3		2,000	6,000	For office
2.2	Chair	6		1,500	9,000	For office
2.3	Computer peripherals for office	1		40,000	40,000	The configuration of computer need to comply with SIMS requirement as per guidelines by SACS.
2.4	Recruitment	1		15,000	15,000	Recruitment of all staffs and volunteers as per the norms there in the guidelines. The recruitment will be conducted through work shop mode in each block to idenify ORWs and Volunteers as well as entry level activities

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Activity Number	Cost Category	No of Units	Timeline	Unit cost	Cumulative Unit Costs	Norm/Requirtments
3	**Office Administration costs**					
3.1	Rent		12	2,500	30,000	Rent for Office at District and Block level including Electricity & Water Rs. 2800/ PM, Office Maintenance - Rs250/-pm, Printing and Stationary - Rs.750/-pm and Xerox and Postage incldding courrier charges - Rs 150/- pm.
3.2	Electricity and water		12	300	3,600	
3.3	Office maintenance		12	250	3,000	
3.4	Printing and stationery		12	750	9,000	
3.5	Xerox and Postage including courrier		12	150	1,800	
3.6	Meeting Costs-District and Block level		12	3,000	36,000	Project level monthly and quarterly monitoring and review Meeting cost at District and Block level
4	**Prevention Package**					
Information services						
4.1	Street Theatres/Puppet shows/Nukkad Natak (8 events **in a year per district)** preferably during festive seasons, when migrant come back to source places.	8		1,000	**8,000**	This budget is for the street plays at Block level and village level, for Migrants, the interactive techniques like Street theatre, games will be used to provoke a discussion on community norms.Street play, exhibition, folk art etc.
4.2	Establishment and Maintenance of information booths - 20 booths per district (**Cost for materials and maintenance only).Establishing Information Booth at Panchayath, PHC, youth clubs etc**	20		500	**10,000**	This budget is for the setting up Information centers and their maintenance at Block & villages; it should be located at/near the prime location of village/Block. It should contain a large room for rest with recreational materials and space for conducting group discussions. Rent agreement and payment receipt should be available in the project office. **In case the same is being managed in the project office, establishment cost should not be taken into account.**
5	**Condom Services**					
5.1	Procurement and supply management costs	1		15,000	**15,000**	**Only Applicable for Districts with no SMO programme.** The cost is on basis of rolling funds, the cost will be recovered/ dedcuted from 2nd year.The fund is for Condoms procurement only.Procurement and stocking of condom for social marketing.
5.2	Establishment and Maintenance of Condom Depots - 50 per district (Cost for materials and maintenance only)	50		200	**10,000**	**Establishment of Non Traditional outlets in Districts which are not under SMO programme.** 50 per districts, condom depot maintenance in terms of wall writing, training of depot holders.Condom depots need maintenance in terms of wall writing, training of depot holders
6	**STI Health Care Service**					
6.1	Health melas (3 melas in each district per quarter)	12		5,000	**60,000**	This budget is for the organising health melas in each village/block at month with the help of volunteers, ASHA, AWW, ANM etc. to encourage the uptake of STI services.Per health camp costs include tents, doctors, medicines, food, water.These health melas need to closely coordinate with nearby Govt. facility to ensure that maximum services are provided by these facilities.
7	**Enabling Environment Packages**					
7.1	District level stake holders meeting expenses (at least once in a month at district level)	12		200	**2,400**	This budget is for the organising the Group discussion, one to group meetings to provoke a discussion on community norms, to encourage the uptake of STI, HIV/AIDS information & services,Linkages which can be used at village level, Information & Demonstration of Condom etc.
7.2	Meeting and training of other stake holders at village level and block level for ASHA, ANM, other volunteers like NYK	60		200	**12,000**	Training of other stake holders on migration strategy to strengthen linkages
8	Lumpsum management cost per NGO				40000	
		Total In INR			**1,360,800**	

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5.16 BUDGET FOR DESTINATION INTERVENTIONS

Instructions on budget formulation and regulation of expenses on Migration TIs

As per the revised strategy on migrant interventions the activities are to be undertaken at source, transit and destination. Because of the mobility of the population, it may not be effective if these points are not separately covered considering the duration of stay at each of these places.

In order to have better clarity in budgeting of these differential interventions the following guidelines are issued which should be followed meticulously by the SACS and impressed upon to the implementing partners.

SACS would provide training through STRC, which need to be budgeted as part of AAP. SACS will also provide flip books, training aids and communication materials – which need to be budgeted as part of training materials under AAP. SACS will also provide IEC materials which need to be budgeted as part of the IEC budget of SACS.

C. **Destination interventions**

REVISED MIGRANT COSTING NORMS FOR DESTINATION INTERVENTIONS (COVERING 10,000-12,000 Migrants)								
S.No.	Cost Category	Existing Budget (in Rs.)	REVISED Costing Norms					Remarks
			Number of units	Period (in months)	Unit Cost (in Rs.)	Revised Budget (in Rs.)	Norms/Requirments	
1. One time cost								
i.	Computer, UPS and Printer	54400				40,000	The configuration of computer need to comply with SIMS requirement as per guidelines by SACS.	Not applicable for existing projects. Only applicable for new projects
ii.	Furniture and other							
a.	Table	6,000	3		2,000	6,000	For office/ DIC	Not applicable for existing projects. Only applicable for new projects
b.	Chair	9,000	6		1,500	9,000	For office/DIC	
c.	Dari/Carpet	0	2		800	1600	To be used in DIC	Applicable for existing and new projects
iii.	Recruitment cost	2000				10000	Towards local advertisement (if required), cost towards conducting interview for all category of staffs and volunteers under the project	In case of existing projects this is applicable for recruitments from 1st April, 2011
iv.	Needs Assessment	15000				20000	To be used for base line needs assessments for preparing the project proposal on the initiation of the contract. The needs assessment need to compile migrant wise source (state, district) information as per requirement of master migrant register. The data to be shared with source SACS.	Only applicable for future activities from 1st April, 2011 in case of existing projects
v.	AMC					6000	AMC contract for computers, printers. Procurement procedures to be followed and document should be available in the project office. Annual one time cost.	
2. Salary of Staff								
a.	Project Director	0	1			40000	The PD is expected to do the following: 1. Attend at least one project review meeting each month 2. Attend SACS meeting as required 3. Network with key district officials such as District Magistrate, SP, DAPCU, Labour officials, labour leaders, migrant leaders to sensitise them about the programme. 4. Ensure financial integrity of the project.	Applicable w.e.f the date of issue of this order at prorata basis for existing migrant Tis till 31st March, 2011.
b.	Programme Manager	96,000	1	12	10,000	120,000	The Programme Manager is the overall incharge of the TI. S/he should be a post graduate in social science or graduate with minimum of 3 yrs of experience with social development. The TOR and deliverables as per migrant operational guidelines.	Applicable w.e.f the date of issue of this order at prorata basis for existing migrant Tis till 31st March, 2011. The TOR and Deliverables are to be amended in the contract.
c.	M&E Officer	0	1	12	6,000	72,000	For M & E purposes, since data is to be shared with source districts and states. Norms and deliverables are as per Migrant Operational Guidelines. Basic qualification need to be graduate in statistics, population sciences, bio statistics or computer application with knowledge of advanced software on data analysis like Epi info, SPSS.	Applicable w.e.f the date of issue of this order at prorata basis for existing migrant Tis till 31st March, 2011. The TOR and Deliverables are to be amended in the contract.
d.	Honorarium of Peer Leaders(For a maximum of 15 peer leaders, at a ratio of 1:750 migrants)	20,000	15	12	1,000	180,000	Peer leaders preferably from Labour contractors, returnee migrant s. They are to be paid honorariums for their support to the programme , atleast 20 days / 40 sessions in a month for each session covering 10-12 target population. The ratio of peer leaders will vary from settings to settings, but the ration should not be more than 1:750 migrants in any setting.	Applicable w.e.f the date of issue of this order at prorata basis for existing migrant Tis till 31st March, 2011. The TOR and Deliverables are to be amended in the contract.

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REVISED MIGRANT COSTING NORMS FOR DESTINATION INTERVENTIONS (COVERING 10,000-12,000 Migrants)

S.No.	Cost Category	Existing Budget (in Rs.)	REVISED Costing Norms					Remarks
			Number of units	Period (in months)	Unit Cost (in Rs.)	Revised Budget (in Rs.)	Norms/Requirments	
2. Salary of Staff								
e.	Honorarium to Doctors for Health Camps (3 times in a month for 8 hours per camp)	0	1	12	9,000	108,000	The doctor is provisioned for conducting health camps (3 times in a month, for providing services 8 hours per camp). The qualification will be as per STI operational guidelines. S/he is expected to conduct health camps with specific priority on STI cases among the migrants. Internal examination should be preferably done during the camps.	Applicable w.e.f the date of issue of this order at prorata basis for existing migrant Tis till 31st March, 2011. The TOR and Deliverables are to be amended in the contract.
f.	ANM/Counsellor	120000	1	12	7000	84000	ANM –in charge of the following activities: 1. Counselling of migrants 2. Primary examination, preliminary screening of STIs, referral, follow up and record maintenance. Qualification: Qualified ANM from any govt. recognised institute. Must have minimum 3 yrs exp. In case, ANM is not available in the State, SACS can suggest Counsellor with qualification of Post graduate in Psychology, MSW or graduate with minimum 2 yrs exp. In counselling in TI projects.	Applicable w.e.f the date of issue of this order at prorata basis for existing migrant Tis till 31st March, 2011. The TOR and Deliverables are to be amended in the contract.
g.	Out reach workers	600,000	5	12	5,000	300,000	1: 4 Peer leaders in any settings. Norms and deliverables are as per Migrant Operational Guidelines.	
h.	Part time accountant	36,000	1	12	3,000	36,000	TOR and deliverables as per Migrant Operational Guidelines	
3. Travel Cost								
a.	Travel of Programme Manager	12,000	1	12	750	9,000	For admin and programme purposes	Applicable w.e.f the date of issue of this order at prorata basis for existing migrant Tis till 31st March, 2011.
b.	Travel of Out reach workers	0	5	12	500	30,000	Travel for programme purposes within the project area to conduct meetings with stake holders and migrants as per the deliverables of migrant guidelines.	
4. Office Administration Expenses								
a.	Rent	48,000		12	4000	48,000	Rent for Office Rs 4000/pm	
b.	Miscellaneous Office expenses	12000		12	1000	12000		
5. Programme Delivery Costs								
a	Street Theatres/Nukkad Natak	72000	24		1000	24000	This budget is for the street plays in the project area for Migrants. The interactive techniques like Street theatre, games will be used to provoke a discussion on community norms.	Applicable w.e.f the date of issue of this order at prorata basis for existing migrant Tis till 31st March, 2011.
b.	Establishment and Maintenance of DICs- (2 DICs per project in any setting)		2	12	3,000	72,000	This budget is for establishment and maintenance of DICs. These DICs are to be established in and around the work place / congregation areas in any settings The budget should be used for hiring premises with facility for meeting, recreation etc. by the migrants. The same can be used for conducting health camps.	Applicable w.e.f the date of issue of this order at prorata basis for existing migrant Tis till 31st March, 2011.
c.	Target group congregation events for migrants	8000	8		1,000	8000	The theme for such events should be need based with an objective to enhance participation of migrants for service uptake and utilisation. **2 times in a quarter.**	Applicable w.e.f the date of issue of this order at prorata basis for existing migrant Tis till 31st March, 2011.
d.	Health camps at least 3 times a month in a project area	96000				45000	This lumpsum budget is for the organising health camps in the project area. The budget is a **revolving fund for procuring medicines of Rs.40,000/- and the same is to be provided during the camps on cost recovery basis to migrants. Rs.5,000/- is towards procuring instruments, equipments required for conducting camps.** **SACS would recover the revolving fund as per existing provision.**	Applicable w.e.f the date of issue of this order at prorata basis for existing migrant Tis till 31st March, 2011.
e.	Advocacy with key stake holders/ power structures	15000	36		200	7200	This budget is for the organising the Group discussion, group meetings to provoke a discussion on community norms, to encourage the uptake of STI, HIV/AIDS information & services, strengthening linkages.At least 3 meeting to be conducted per month in the project area.	Applicable w.e.f the date of issue of this order at prorata basis for existing migrant Tis till 31st March, 2011.
	TOTAL	1,221,400				1,287,800		

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5.17 BUDGET FOR TRANSIT INTERVENTIONS

Instructions on budget formulation and regulation of expenses on Migration TIs

As per the revised strategy on migrant interventions the activities are to be undertaken at source, transit and destination. Because of the mobility of the population, it may not be effective if these points are not separately covered considering the duration of stay at each of these places.

In order to have better clarity in budgeting of these differential interventions the following guidelines are issued which should be followed meticulously by the SACS and impressed upon to the implementing partners.

B. Transit Interventions:

For selection procedure refer note (iii) in the covering letter.

1. (a) One time cost (to be budgeted only once during the initiation of the project)

(i) Purchase of kiosk/temporary tentage, two chairs and one table @ Rs. 40,000/-. This will act as information booth and can be transported across railway station and bus station.

(ii)Purchase of audio equipment for miking, the same is costed @ Rs 15,000/-.

(b) One time cost (to be budgeted only once during contract period of 12 months)

(i) Recruitment cost is Rs.2000/- towards local advertisement (if required), cost towards conducting interview.

2. Fixed Cost to be budgeted for 12 months (for 3 months in the current financial year w.ef. from the date of issue by SACS)

(i) Salary of staff:

Cost Category	Number of units	Period (in months)	Unit Cost	Cumulative Unit Costs	Norms/Requirements
Outreach workers	2	12	Rs.3000/-	Rs.72000/-	2 for 1 transit location (both railway station and bus station). Norms and deliverables as per the deliverables of migrant guidelines.
Current year	2	3	Rs.3000/-	Rs.18,000/-	

(ii) Travel cost

Cost Category	Number of units	Period (in months)	Unit Cost	Cumulative Unit Costs	Norms/Requirements
Travel of Outreach workers	2	12	Rs.300/-	Rs. 7200/-	Travel for programme purposes within the location area to conduct BCC and mid-media activities, meetings with stake holders, migrants, as per the deliverables of migrant guidelines. Reimbursement to be made as per actual limited to Rs.300/- per month.
Current year	2	3	Rs.300/-	Rs.1,800/-	

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3 . Programme Delivery cost

Programme delivery cost has two parts. Funds for certain components are provided in the budget of the NGOs.

Funds for components requiring centralised procurement such as migration kits and printing of IEC material are provided in the IEC budget of SACS.

(a) Activities :

	Cost Category	Number of units	Period (in months)	Unit Cost	Cumulative Unit Costs	Norms/Requirements
(i)	Mid Media Activities such as street plays, docu-drama (24 units in a year per transit locations) preferably during festive seasons	24		Rs.1000/-	Rs.24,000/-	This budget is for the street plays, docu-drama at transit locations for Migrants. The interactive techniques like Street theatre, games will be used to provoke a discussion on community norms.
	Current Year	6		Rs.1000/-	Rs.6,000/-	
(ii)	Meetings		12	Rs.200/-	Rs.2,400/-	Meeting cost at transit level with different stake holders such as with representative of railway, transport , department of labour etc. as per migrant operational guidelines.
	Current Year		3	Rs.200/-	Rs.600/-	

3. Condom :- In case the transit location does not fall in the Condom Social Marketing by SMOs in the State, an amount of Rs.15,000/- can be provisioned as revolving fund for the same, as per existing provision.

In case the transit location falls in the Condom Social Marketing by SMOs in the State. It is proposed to have at least 40 outlets in the vicinity of the transit locations both at railway station and bus station.

(b) SACS Budget

Funds will be provided for the following:

(i) Printing of target specific IEC materials and Migration Kits
(ii)Hoardings
(iii) Bus panels
(iv) Wall writings
(v) Flip books for use by ORWs
(vi) Training of staff-to be budgeted in training under TI and to be transferred to STRC

Centralised printing for IEC materials and migration kits to be done by SACS based on the prototypes shared by NACO for the same purpose. Bus panels, hoardings for transit locations are to be provisioned under IEC budget. Funds for the same will be provided in the IEC budget of the SACS under IEC budget. Flip books for group sessions are to be provided by SACS. It is proposed to supply 20,000 migration kits, IEC materials are to be provided to each transit locations.

TOTAL BUDGET for ONE TRANSIT LOCATION (both railway and bus station) per year:

Heads of Budget	**Budget per year (in Rs.)**
One time (to be budgeted only once during the initiation of the transit migration activities)	
Purchase of kiosks/tentage	Rs. 40000/-
Purchase of audio equipment	Rs. 15000/-
One time (to be budgeted only once during the contract period of 12 months)	
Recruitment Cost	Rs. 2,000/-
Fixed Cost	
Salary of two part time ORWs	Rs. 72,000/-
Travel cost of two part time ORWs	Rs. 7,200/-
Programme Delivery Cost	
Mid – Media Activities	Rs. 24,000/-
Stake holder meeting	Rs. 2,400/-
TOTAL	**1,62,600/-**
Social Marketing Revolving Fund (in exceptional cases)	Rs.15,000/-

REFER TO NACO WEBSITE: WWW.NACOONLINE.ORG/DIVISIONS/TARGETED INTERVENTIONS/BUDGETS & AAP

5.18 PERFORMANCE INDICATORS

Performance Monitoring Indicators for Migrants (Source Interventions)

The contract for the financial year of Migrant Interventions at Source will have following set of performance indicators. These indicators are based on NACO's MIS tools and the *NACO TI Operational Guidelines*

- **The contract** is for the current year financial year subject to renewal every year based on annual evaluations as per the NGO/CBO guidelines.
- The indicators in this document are broken out component-wise -- e.g., outreach, condoms, STI services, referrals and enabling environment.

Some notes on key indicators

- **The "denominator": This denominator represents the basis for assessing performance of the intervention in the district.**
- **It captures the annual coverage target on the ground for each district and is based on the project proposal developed for the district – the steps to develop the project proposal is a continous process for 1st quarter of the project.**
- **In case of a new intervention, the denominator is the annual coverage target determined as above.**
- **In case of existing intervention i.e. renewed for continuation the denominator should be the target decided based on the proposal developed for the district afresh.**

No.	Area	Indicator	Detailed to be used	Frequency of Reporting	Data Source	Definitions
1	**Outreach**	Denominator	1. No. of migrant villages identified with HIV focus in the district 2. No. of total number of migrant families identified in the district	**Monthly**	Project proposal	The total number of high out migration villages have been worked out and identified to be having HIV focus as per guidelines. The total number of migrant families identified in these villages for intervention for the proposed contract period.
2		% of migrants by category are serviced by the intervention in the district	1. Village wise profile for: a. Potential Migrants b. Out going Migrants c. Returnee Migrants d. Spouses of Migrants e. Female Migrants f. Labour Contractors Definition of these are part of the guideline.	Monthly	9A-IPC format for village volunteers 9B- Information Booth reporting register	No. of migrants covered by each category through: a. One to group sessions b. Mid-media activities c. Information booth
3		No. of One to group sessions conducted in a month	At least 10 sessions per village per month to be planned and at least 2 of them are attended by Block ORW/ Supervisor	Monthly	9D- Referral and Linkages register 3A- Migrant Tracking Register	*Numerator:* No. of One to group sessions conducted at village level *Denominator:* No. of One to group sessions planned at village level
4		% of Village Health and Nutrition Day meeting organized	At least one meeting per ANM centre per month- to be attended by Block ORW/Supervisor	Monthly		*Numerator:* Number of meetings held in the district *Denominator:* Total number of meeting planned

No.	Area	Indicator	Detailed to be used	Frequency of Reporting	Data Source	Definitions
5	**Condoms**	Total no. of condom outlets and total no. of socially marketed condoms in the project	Each village will have following criteria: **Total Population No. of outlets** 5,000 10 10,000 20 (2 functional outlet per 1,000 population as per Condom Social Marketing Strategy)	Monthly	9C – Format for Condom Programming Register	Total No. of condoms socially marketed in a month through clinics and Outlets.
6	**Clinical Footfalls in Health Melas**	% of migrants visiting health melas	Proposed Total clinic footfalls in health mela per year (60% of the clinic footfalls will be migrants)	As per plan	2 A- Health Mela Register	Total no. of migrants mobilized and attended the health melas for information, counseling and treatment.
7	**STI treatments**	% of STI treatments for migrants by category	STI episodes treatments by following category (10% of clinical footfalls in health mela) a. Potential Migrants b. Out going Migrants c. Returnee Migrants d. Spouses of Migrants e. Female Migrants f. Labour Contractors Definition of these are part of the guideline.	Monthly	2 A- Health Mela Register	Total no. of migrants by category treated for STI divided by total no. of clinical footfalls (benchmarked earlier)
8	**Linkages**	% Migrants who are have been registered with Rashtriya Swasthya Bima Yojana (RSBY) scheme	Proposed activity includes liasoning with District labour welfare officer and conducting regular camps of appropriate insurance agency for registration of migrants in RSBY scheme	Monthly	9 D-Referral and Linkage Register	Numerator: No. of migrants registered with RSBY scheme during the month Denominator: No. of migrant families in BPL category in the district
9		% Migrants who are tested at ICTC monthly	10% of the total covered as in Indicator no. 2 per quarter	Monthly	9 D- Referral and Linkage Register	Numerator: No. of migrants tested at ICTC during the month Denominator: No. of migrants serviced by the district intervention during the quarter
10		% of Migrants referred to ART	All Migrants whose HIV positive status is known should be referred to ART for CD 4 testing, ART treatment	Monthly	9D- Referral and Linkage Register	Number of Migrants referred for provision of antiretroviral therapy (ART) divided by the total number of migrants consented that they are positive
11	**Enabling Environment**	% of Stakeholder meetings organised in the month by type (district level stakeholders, village level functionaries e.g. PRI members, NYK volunteers, community events organized with SHGs, Youth Clubs)	Sensitisation and follow up meetings on action plan for advocacy and networking is to be considered as meeting. Each meeting should have an approved agenda, action plan and responsibility. Block ORW/ Supervisor should attend at least 4 meeting i.e. once in a week and District PM should attend 2 meetings in a month	Monthly	*8 A and 10 C*	*Numerator:* Number of meetings organised by type and by Stakeholder *Denominator:* Total number of meetings planned

Performance Monitoring Indicators for Migrants (Destination Interventions)

The contract for the financial year of Migrant Interventions at Destination will have following set of performance indicators. These indicators are based on NACO's MIS tools and the *NACO TI Operational Guidelines*

- **The contract** is for the current year financial year subject to renewal every year based on annual evaluations as per the NGO/CBO guidelines.
- The indicators in this document are broken out component-wise -- e.g., outreach, condoms, STI services, referrals and enabling environment.

Some notes on key indicators

- **The "denominator": This denominator represents the basis for assessing performance of the intervention.**
- **It captures the annual coverage target on the ground for each intervention and is based on the project proposal developed – the steps to develop the project proposal is a continous process for 1st quarter of the project.**
- **The project proposal to ensure that the geography of the project is assigned, the number of migrants to be covered in terms of their availability in the project area across the year considering the seasonality and circular nature, risk pattern of migrants**
- **In case of a new intervention, the denominator is the annual coverage target determined as above.**
- **In case of existing intervention i.e. renewed for continuation the denominator should be the target decided based on the proposal developed for the district afresh.**

No.	Area	Indicator	Detailed to be used	Frequency of Reporting	Data Source	Definitions
1	**Outreach**	Denominator	1. No. of migrant sites/ hotspots (congregation points) identified in the project area	**Monthly**	Project proposal and SNA reports	The total number of migrant congregation points are points where the migrants can be reached by the project for the purposes of BCC sessions, Mid-Media Activities, Service Provisioning. These can be the places of work, places of residence, places of recreation, places where migrants spend time and can be engaged with the project
			1. No. of total number of migrant who are seasonal and circular identified and registered in the congregation points in the project area	**Monthly**	Project Proposal	The number of migrants who have been identified and registered being seasonal, circular, having high risk behaviour in each congregation points.
2		% of new migrants registered by the intervention	The total number of seasonal, circular migrants are registered with the project	**Monthly**	Form 2 (Individual Migrant Tracking Sheet)	The number of new migrants identified and registered with the project during the month
3		% of high risk migrants by are serviced by the intervention	Number of total individuals contacted (provided any or all project services - e.g condom, Lubricant distribution, Information on BCC, clinic services)**At least 60% new migrants are registered during a quarter by the project. In case the project contract is for 10,000 migrants, it is expected that project will cover 60% new and 40% old migrants during each quarter.**	Monthly	Form 1 (Master Register for Migrants) Form 2 (Individual Migrant Tracking Sheet) Form 3 &4 Form 5 Form 8	No. of migrants covered by each services: a. One to group sessions b. Mid-media activities c. DIC services d. Counseling e. Clinic services

No.	Area	Indicator	Detailed to be used	Frequency of Reporting	Data Source	Definitions
4	Outreach	No. of One to group sessions conducted in a month	At least 10 sessions per congregation point per month to be planned and at least 2 of them are attended by ORW	Monthly		*Numerator:* No. of One to group sessions conducted by each Peer Leader *Denominator:* No. of One to group sessions plannned by the Project
5	**Condoms**	Total no. of condom outlets and total no. of socially marketed condoms in the project	Each congregation point will have out lets considering following criteria: **Total Population No. of outlets** 5,000 10 10,000 20 (2 functional outlet per 1,000 population as per Condom Social Marketing Strategy)	Monthly	7 A and 7 B	Total No. of condoms socially marketed Outlets.
		Total number of new outlets established during the month	Each project is expected to establish at least 20% of its outlet (target as above) each month i.e. new out lets or moving from traditional to non-traditional	Monthly	7 B	Total number of new outlets opened during the month Total number of functional non traditional outlets available at the end of reporting month.
6	**Clinical Footfalls in Health Camps**	% of migrants visiting any project linked clinic/Govt./PPP clinics/Health Camps	Total number of individuals visited any project linked clinic/Govt./PPP clinics, Health Camps during the month (expected to have 40 % of the target population to visit health camps/clinics from 4th month onwards, to reach 60% at the end of 1st year, 80% by the end of 2nd year)	Monthly	3 A ,3B, 7	Total no. of migrants mobilized and attended any project linked clinic/Govt./PPP clinics, Health Camps for information, counseling and treatment.
7	**STI treatments**	% of STI treatments for migrants by category	STI episodes treatments by following category (10% of clinical footfalls per month) a. New cases b. Repeat Infections c. Partners	Monthly	3 A, 3 B	Total no. of migrants by category treated for STI divided by total no. of clinical footfalls (benchmarked earlier)
8	**Linkages**	% Migrants who are tested at ICTC monthly	10% of the total covered as in Indicator no. 2 per quarter	Monthly	6 and 6 A	Numerator: No. of migrants tested at ICTC during the month Denominator: No. of migrants serviced by the project during the quarter
		% of Migrants referred to ART	All Migrants whose HIV positive status is known should be referred to ART for CD 4 testing, ART treatment	Monthly	6 and 6 A	Number of Migrants referred for provision of antiretroviral therapy (ART) divided by the total number of migrants consented that they are positive

9	**Enabling Environment**	% of Stakeholder meetings organised in the month by type (labour contractors, union leaders, employers, brokers, police, migrant club members, HRG TIs, govt. / pvt. Health officials)	Sensitisation and follow up meetings on action plan for advocacy and networking is to be considered as meeting. Each meeting should have an approved agenda, action plan and responsibility. ORW should attend at least 4 meeting i.e. once in a week and PM should attend 2 meetings in a month	Monthly	*10,11,12,13*	*Numerator:* Number of meetings organised by type and by Stakeholder *Denominator:* Total number of meetings planned
		Number of stakeholder advocacy committee has been formed and they are part of project management decisions	It is expected that each project will have advocacy committees at local level to address vulnerability issues of migrant workers and the decisions/suggestions/resources are to be part of project	Monthly	*13*	The advocacy committee need to address vulnerabilities associated with migrants at their work and residence.

Performance Monitoring Indicators for Migrants (Transit Interventions)

The contract for the financial year of Migrant Interventions at Transit will have following set of performance indicators. These indicators are based on NACO's MIS tools and the *NACO TI Operational Guidelines*

- **The contract** is for the current year financial year subject to renewal every year based on annual evaluations as per the NGO/CBO guidelines.
- The indicators in this document are broken out component-wise -- e.g., outreach, enabling environment.

Some notes on key indicators

- **The annual coverage target on the ground for each transit location by all modes of travel (specially rail and road which cater to long distance interstate migration) and is based on coverage by different modes BCC i.e. One to Group and Mid-Media activities performed by ORW.**

No.	Area	Indicator	Detailed to be used	Frequency of Reporting	Data Source	Definitions
1	Out reach	No. of migrants captured per day through the intervention at the transit location	It is desired at least 500 migrants are captured through one to group session and mid-media activities during or around the timings of long distance migrant specific trains / and buses by each ORW. The target is based on specific days of the month during which long distance migrant specific buses and trains depart/arrive at the transit locations	Monthly	Outreach Tools	No. of migrants covered by each category through: a. One to group sessions b. Mid-media activities c. Information booth
2		No. of One to group sessions conducted in a month	At least 20 sessions per transit location per month to be planned	Monthly		*Numerator:* No. of One to group sessions conducted at transit location *Denominator:* No. of One to group sessions plannned at transit location
3	**Condoms**	Total no. of condom outlets and total no. of socially marketed condoms in the project	Each transit location should have at least 20 functional outlets at any given time of the project period	Monthly	Out reach tools	Total No. of condoms socially marketed in a month through clinics and Outlets.
4	**Enabling Environment**	The project need to have strong networking with structures like railway authorities, transport department, hotels, lodges, telephone booths, cycle rickshaw and auto rickshaw owners association, porters association, hawkers association etc. who influence migrants life	Sensitisation and follow up meetings on action plan for advocacy and networking is to be considered as meeting. Each meeting should have an approved agenda, action plan and responsibility. Block ORW/ Supervisor should attend at least 4 meeting i.e. once in a week and District PM should attend 2 meetings in a month	Monthly	Monthly reporting formats	No. of stakeholders identified and network has been built to ensure that crisis situations at transit locations for migrants are addressed.

5.19 REPORTING TOOLS FOR SOURCE INTERVENTIONS

Target Audience:

1. Officers of CMIS division and TI division of SACS and NACO

2. Programme officers of TSU

3. Staffs working with Source and Transit Migrant Interventions

Objective:

1. To familiarise with various data collection tools regarding its use, analysis and interpretation

RESPONSIBILITY FOR DATA COLLECTION TOOL

Name of the staff	Type of forms used	Frequency of usage	Number of formats responsible for
ORW	1A. Patient Register (Health Mela) ***facilitated by doctor***	On the day of the health mela. To be filled during the Health Mela	**5**
	1B. Stock and Issue Register for Medicine and Consumables	At the end of each month	
	1C.Format for Information Booth Register	After each day at the Information Booth	
	1D.Format for condoms programme register	At the end of each month	
	1E. Format for referral and linkage register	At the end of each month	
VILLAGE LEVEL VOLUNTEERS	2A. Format for IPC (One to Group Session)Activities by Village Level Volunteers	During/after every one to group session activity	**2**
	2B. Format for Master Migrant Register		
DISTRICT COORDINATOR	3A. Field Visit Report	At the end of the field visit	**3**
	3B.Minutes of Meeting	At the end of each meeting	
	3C: Monthly Reporting Form: Critical Level of IEC Material	At the end of each month	

REPORTING FORMAT
HEALTH MELA
1A. Patient Register (Health Mela)

Frequency: On the day of the health mela. To be filled during the Health Mela
Where: At the clinic during the *Health Melas*
By Whom: By the ORW facilitated by the doctor
For what: To understand the profile of clients attending the clinic, the burden of STI, type of STI diseases, using the data for effective IEC activities, condom promotion and follow up activities.
Guidelines for filling the form:

- The format can be written down on the top of a hard bound register/ or can be printed as a leaf and attached at the covers of the hard bound register

How-
Name of the village:- The name of the village where the *Health Mela* is taking place.
Name of the Block:- Self explanatory
Name of the District:- Self explanatory
Name of the reporting person:- The name of the person filling the format
Date of the Health Camp:- The date in the DD/MM/YYYY format when the Health Camp has taken place
Month:- The month in which the Health Camp is taking place
Year:- The year in which the Health Camp is taking place.
Registration Number:- Serial number of individual (first individual at health mela will be 1, second will be 2 and so on)
Referral ID(in case referred) :- In case the individual is referred to any other services linked with the programme like ICTC, the ID number will be created serially.
Name of the patient:- The name of the patient in the First Name, Middle Name and Last Name format. If the individual is willing to provide only the First Name, this may also be accepted. However, nicknames are not acceptable.
Address:- Permanent Residential address of the patient. For instance, if the patient is of another village and has been visiting the village during the Health Mela, his/her actual address of residence where he/she can be contacted later needs to be registered.
Sex:- Self Explanatory
Category (Out going Migrant/ Returnee Migrant/ Potential Migrant/ Female Migrant/Spouses of migrants/General Client):-
Outgoing Migrant: Individual who is leaving source for destination within next 2 months
Returnee Migrant: Migrant Individual who is returning to/ has returned to source from destination
Potential Migrant: Individual who is currently at source but may migrate in the near future
Female Migrant: Self explanatory
Spouses of Migrants: Self explanatory
General Clients: Non-migrant individuals
Age:- Age of the patient. If the patient appears to be unsure, an approximate age may be recorded with the word "approx." placed after the numeric.
Diagnosis:- Brief record of Doctor's diagnosis of ailment (if any)
Treatment given:- Brief record of Doctor's prescription or immediate medicine administered.
Follow up Date:- If the Doctor feels that a follow up is required based on diagnosis and treatment given, the date s/he gives is to be recorded here.
Reasons for referral:- In case the individual is referred, the reason for referral is to be recorded here under **Treatment or Diagnositc Test** as applicable In case the

treatment/ counselling provided at the health mela requires follow up treatment or diagnosis by a higher health care centre.

Remarks:- This column is for any remark pertaining to the individual's medical history, issues to be followed up etc

Usefulness of the information:-

The information collated in this format will be used for following purposes:

1) Understanding STI burden by types segregated by sex, age, residential address

2) Understanding the requirements for BCC and mid-media activities for effective STI prevention and control among different groups

3) Understanding the efficacy of condom programme among the clients attending the health mela

4) Understanding the efficacy of treatment provided during health mela including counselling done for the clients.

1A. Patient Register (Health Mela)

Name of the Village: _____ Month : _____

Name of the Block: _____ Year : _____

Name of the District: _____

Name of the reporting person: _____

Regn.No.	Referral ID No. (in case referred)	Name of the Patient	Address	Sex (M/F/TG)	Category (Out going Migrant/ Returnee Migrant/ Potential Migrant/ Female Migrant/Spouses of migrants/General Client)	Age	Diagnosis	Treatment given	Follow up date	Reasons for Referral		Remarks
										Treatment	Diagnostic Test	
Example		Ram Kumar	Haripur,WB	M	Migrant	35	UD	Azithromycin(1g)OD STAT, Cefexime(400mg)ODSTAT	NA		No	

INSTRUCTIONS

1. The format is to be filled during the health melas
2. The relevant informaation is to be compiled for the district reporting format

The above format can be written down on the top of a hard bound register/ or can be printed as a leaf and attached at the covers of the hard bound register

1B. Stock and Issue Register for Medicine and Consumables

Frequency: On the day of health mela
Where: At the *Health Mela*
By Whom: ORW
For what: This is a record of the drugs bought in, distributed
Guidelines for filling the form:

- Opening balance is the amount of drugs you start with. If you have indented and received the drug on that day than add to the opening balance. This becomes your new opening balance for the day.
- The drug distributed today should match the patient wise drug distribution.
- Closing balance is opening balance minus drug distributed.
- Closing balance of previous day is opening balance of today.
- Indent the drug when it reaches the critical level. The critical level for each drug will depend on the average consumption on any day during last health mela session in the same area. Suppose Tab. Azithromycin was distributed of 250 numbers during last health mela of 3 days. At least same quantity need to be maintained for future melas.
- Use FEFO (First ENTRY and First Out) principle in distributing the drug. This will help to distribute the stocks which are purchased earlier.
- The clinic should have buffer(at least 10% of the critical level) on any day.

How-
Name of the village:- The name of the village where the *Health Mela* is taking place.
Name of the Block:- Self explanatory
Name of the District:- Self explanatory
Name of the reporting person:- The name of the person filling the format
Date of the Health Mela:- The date in the DD/MM/YYYY format when the Health Mela has taken place
Month:- The month in which the Health Mela is taking place
Year:- The year in which the Health Mela is taking place.
Opening Balance:- Number of files/vials of drug mentioned in the corresponding column at the time of opening of health mela for the day. If drug is indented and received on the day, to be added to opening balance.
Drug Distributed:- Total number of files/vials of drug mentioned in the corresponding column distributed. To be filled during the day closing of the health mela.
Closing Balance:- Number of files/vials of drug mentioned in the corresponding column left after distribution from opening balance at the end of the Health Mela (Opening Balance – Drug distributed)
Usefulness of the information:-
1. This will help us to track and monitor the drug consumption during health melas
2. To understand the requirement of various drugs by quantity to be indented

1B. Stock and Issue Register for Medicine and Consumables

Name of the Village:

Name of the Block:

Name of the District:

Name of the reporting person:

Date of the Health Camp :

Month : _____

Year : _____

Sl.No.	NAME OF THE DRUG	Opening Balance	Drug Distributed	Closing Balance
1	Azithromycin (500 mg)	150	5	145
2	Cefexime (200 mg)			
3	Metronidazole (400mg)			
4	Doxycycline (100mg)			
5	Acyclovir (400mg)			
6	Inj Benzathine Penicilline (2.4million unit)			
7	Fluconazole (150 mg)			
8	Distilled Water phials (10ml)			
9	Disposable Syringe (10ml) with 21 gauge needle			

Note

Opening balance is the amount of drugs you start with.

If you have indented and received the drug on that day than add to the opening balance. This becomes your new opening balance.

The drug distributed today should match the patient wise drug distribution.

Closing balance is opening balance minus drug distributed.

Closing balance of previous day is opening balance of today.

Indent the drug when it reaches the critical level.

Use FEFO principal in distributing the drug.

The clinic should have buffer for at least one quarter.

1C. Format for Information Booth Register

Frequency: After each day at the Information Booth
Where: At the location of the information booth in the village
By Whom: Village Level Volunteers/ Block Supervisor
For what:
1. To record different activities conducted in the information booth or its vicinity
2. To record the profile of participants accessing services of information booth and the linkages there of established by the information booth.

Guidelines for filling the form:

- The format is to be filled daily by village volunteers/Block Supervisor
- The relevant information is to be compiled and fed on a monthly basis into the MIS

How-
Name of the village:- The name of the village where the *information booth* has been set up.
Name of the Block:- Self explanatory
Name of the District:- Self explanatory
Name of the reporting person:- The name of the person filling the format
Date:- The date in the DD/MM/YYYY format when the format is being filled
Month:- The month in which the information booth has been set up
Year:- The year in which the information booth has been set up.
Location:- The area where the Information Booth has been set up. For instance if it is set up at the Panchayat Office, fill in with 'Panchayat Office'
Date:- The date in the DD/MM/YYYY format when the information booth is set up
Name of activities:- Each activity or session are titled. This is for putting in the title.
Timing (From) (To):- From refers to the time when the activity started and to refers to the time where the activity got completed inclusive of the discussion pertaining to it.
Exposed (No.):- Number of individuals who were present during the activity. Here, 'other' refers to non migrant individuals.
Refer to other services:- If any individual has been referred to other services during or after the corresponding activity, the same number is to be reflected here. If the individual is a migrant, the number is to be reflected under the column for migrants. If the individual is a non migrant the same is to be noted under "OTHERS"
Total exposed :- Total exposed is the sum total of the number of migrants exposed and the number of non migrants exposed. It is a total of the numbers under the column of 'migrants' and 'others'.
Total Refer to other services:- Total Refer to other services is the sum total of the number of migrants referred to other services and the number of non migrants referred to other services. It is a total of the numbers under the column of 'migrants' and 'others'.
Usefulness of the information:-
1. To help understanding the profile of participants and their need in terms of services and information.
2. To help in planning the desired services in any information booth in the locality
3. To understand the issues related with linkages and networking with other services based on the feedback of the participants – this will help to plan out activities in strengthening.
4. To reach out labour contractors through the participants
5. To record information about the issues and contexts at destination – helping to strengthen interventions at destination.

1C. Format for Information Booth Register

Name of the Village:

Name of the Block:

Name of the District:

Name of the reporting person:

Month : _____

Year : _____

S.No.	Location	Date	Name of the activities performed	Timing		Exposed (No.)		Refer to other services (No.)	
				From	To	Migrants	Other	Migrants	Other
Example	Panchayat Office	23/06/09	IPC sessions	11:00	11:30	12	3	4	0
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
						0	0	0	0

Total Exposed 0

Total Refer to other services 0

INSTRUCTIONS

1. The format is to be filled daily by village volunteers/Block Supervisor
2. The relevant information is to be compiled and fed on a monthly basis into the MIS

1D.FORMAT FOR CONDOMS PROGRAMME REGISTER

Frequency: At the end of each month
Where: At the village level.
By Whom: Village Level Volunteers/ Block Supervisor
For what:
1. To understand the profile of condom demand (in terms of most accessible outlets, most acceptable brands, most cost- effective and popular brand, group of clients having most demand for condoms by age group, by migrant profile).
2. To understand the issues related to uptake and access – which will help to design the midmedia and BCC activities, to position outlets in most accessible points.
3. To understand the demand – supply issues
Guidelines for filling the form:

- The format is to be filled daily by village volunteers/Block Supervisor
- The relevant information is to be compiled and fed on a monthly basis into the MIS

How-
Name of the village:- The name of the village
Name of the Block:- Self explanatory
Name of the District:- Self explanatory
Name of the reporting person:- The name of the person filling the format
Month:- The month or reporting
Year:- The year of reporting
Date:- The date in the DD/MM/YYYY format when the format is being filled
S.No.:- Serial Number. The first outlet established is marked as 1, the second outlet established marked as 2 and so on.
Type of Outlet (Traditional - TO, Non-Traditional - NTO):- Outlet is the space from where the condoms are made available for being sold.
Traditional Outlets (TO) are outlets which have been stocking condoms traditionally, like Chemists, druggists and pharmacists.
Non-Traditional Outlets (NTO) are outlets which are not Chemists, Pharmacists and Druggists, but have taken it up like Paan Shops, Mechanic Stores, Hardware Stores etc.
Name of the Outlet:- If the outlet does not have a registered name or a name on a board signifying the outlet, a name by which the outlet is commonly known like "Ravi's Cycle Shop" may be used along with a landmark as a reference point.
Address of the Outlet:- The complete available address, along with a reference to the nearest landmark/ crossroads
Operational from (Mention the date from which this shop started keeping socially marketed condoms for your program): Self Explanatory
Quantity of Condoms Last Supplied during the reporting month:- If the report is for Month of June, quantity of condoms supplied to the outlet through 1st of June to the 30th of June.
Total Stock available during the month:- This is the total number of condoms in stock in the particular outlet on the1st of the month inclusive of any left over from the last month. Kindly check that packets whose expiry date has crossed before this month are not counted and disposed off immediately.
Total Quantity sold by the out let during the month:- This is the sum total number of condoms sold by the outlet in the month to be calculated on the last day of the month.
Quantity available at the end of the month(Closing Stock):- This is difference between the Total stock available and the Total Quantity sold by the outlet.
Total number of Condoms Distributed/ Sold during the month:- The following table under this head is indicative of a sum total of condoms distributed (free of cost due to some programme sanctioned through various channels) / sold from all the outlets in the month.
Condoms Distributed through various channels:-

Village Level Volunteers:- When a village level volunteer in course of some sanctioned programme distributes condoms, s/he is to keep a count of the number distributed and fill in this column with the sum total of all the condoms distributed at the end of the month.

Other Volunteers (ASHA/ANM/Migrants/Spouses of Migrants/SHG Members):- When a village level volunteer in course of some sanctioned programme distributes condoms, s/he is to keep a count of the number distributed and fill in this column with the sum total of all the condoms distributed at the end of the month.

Independent Outlets: - When an independent outlet in course of some sanctioned programme distributes condoms, s/he is to keep a count of the number distributed and fill in this column with the sum total of all the condoms distributed at the end of the month.

Any other:- When any other than the above is the source for distribution of condoms free of cost, the name indicative of the source- an individual/organization/store is to be noted and the number distributed over the last month also noted here in the cell.

TOTAL: - A sum total of the abovementioned figures under Condoms Distribute through various channels.

Condoms Sold through Social Marketing:-

TOTAL: - A sum total of the condoms sold in all the outlets over the 1st to the last date of the reporting month. This is the grand total of the figures in the column under label **Total Quantity sold by the out let during the month**

Usefulness of the information:-

To understand the demand-supply issues including location of most preferred outlets.

1D. FORMAT FOR CONDOMS PROGRAMME REGISTER

Name of the Village:
Name of the Block:
Name of the District:
Name of the reporting person:

Month : _____
Year : _____

S.No.	Type of Outlet (Traditional - TO, Non-Traditional - NTO)	Name of the Outlet	Address of the Outlet	Operational from (Mention the date from which this shop started keeping socially marketed condoms for your program)	Quantity of Condoms Last Supplied during the reporting month	Total Stock available during the month	Total Quantity sold by the out let during the month	Quantity available at the end of the month(Closing Stock)
1	NTO	Shyam Pan Bhandar	Village Chowk	3 May'09	5000	1000	4000	2000
2	TO	Krishna Medicos	Chemist Shop	1 July'09				

Total number of Condoms Distributed/ Sold during the month	Total				
	Village Level Volunteers	Other Volunteers (ASHA/ANM/Migrants/Spouses of Migrants/SHG Members)	Independent Out lets	Any other	TOTAL
Condoms Distributed through various channels					
Condoms Sold through Social Marketing					2000
				TOTAL	2000

INSTRUCTIONS

1. The format is to be filled at the end of the month
2. The relevant information is to be compiled and fed on a monthly basis into the MIS

1 E. FORMAT FOR REFERRAL AND LINKAGE REGISTER

Frequency: At the end of each month
Where: At the village level
By Whom: By the ORW or Village volunteers
For what:
1. For record purposes, to understand the service needs
2. To understand the profile of beneficiaries of different services

Guidelines for filling the form:

- The relevant information is to be compiled and fed on a monthly basis into the MIS
- A list needs to be made of the social welfare schemes applicable for the villagers and this list needs to be updated by the Supervisor marking how many people in the village come in contact with have availed of the schemes. The format maybe as follows:

Scheme	Number of people who have availed of it

This would enable the team to identify gaps and strengthen linkages.

How-

Name of the village:- The name of the village **Name of the Block:-** Self explanatory
Name of the District:- Self explanatory
Name of the reporting person:- The name of the person filling the format
Month:- The month of reporting
Year:- The year of reporting
Date:- The date in the DD/MM/YYYY format when the format is being filled
S.No.:- The column is filled.
Category of the target population referred to services:-
No. of Potential/ New (who are about to leave within 2 months) Migrants reached :- This refers to all the individuals who have made a decision to leave within 2 months who have been interacted with by the team through sessions or otherwise with the intention of disseminating information over the reporting month.
No. of Returnee Migrants reached :- This refers to all the individuals who have returned from a destination to the village which is their homestead for either some occasion or otherwise and have been interacted with by the team through sessions or otherwise with the intention of disseminating information over the reporting month.
No. of Out going (who are leaving)Migrants reached:- This refers to all the individuals who are in the process of migrating within 15 days who have been interacted with by the team during sessions or otherwise and have been interacted with by the team through sessions or otherwise with the intention of disseminating information over the reporting month.
No. of Female Migrants reached:- This refers to specifically female migrants, married/unmarried travelling with/without family who have been interacted with by the team through sessions or otherwise with the intention of disseminating information over the reporting month.
No. of spouses of migrants reached :- This refers to specifically spouse of migrants, who are not accompanying their husband who have been interacted with by the team through sessions or otherwise with the intention of disseminating information over the reporting month.
No. of Labour contractors reached
No. of other stake holders reached: PRI members, Local Money Landers, SHG groups, Mahila Mandals, NYK Volunteers
No. of persons reached in the nearest ICTC centres:- Self Explanatory
No. of persons reached at the nearest STI providers (PRIVATE):- Self Explanatory
No. of persons reached at the nearest STI providers (GOVT.):- Self Explanatory
No. of Female Migrants / Spouses of Migrants received PPTCT services:- Self Explanatory

No. registered in the RSBY scheme: Self Explanatory
No. linked with PLHIV Network:-. Self Explanatory
No. are on ART during the month:- Self Explanatory
No. benefitted by any other social welfare scheme during the month:- Self Explanatory
TOTAL:- The sum total of the numbers noted for the relevant column
Also prepare case studies on issues and challenges that has been resolved or require to be resolved to ensure that the target population is effectively linked with various programmes.
Usefulness of the information:-

1. To achieve an understanding of referrals and linkages established- achievement and gaps if any.
2. To analyse reasons behind the above and thereby ensure strengthening of linkages.

1E. FORMAT FOR REFERRAL AND LINKAGE REGISTER

Name of the Village: _____ **Month :** _____

Name of the Block: _____ **Year :** _____

Name of the District: _____

Name of the reporting person: _____

S.No.	Category of the target population referred to services	No. of persons reached in the neareast ICTC centres	No. of persons reached at the nearest STI providers (**PRIVATE**)	No. of persons reached at the nearest STI providers **(GOVT.)**	No. of Female Migrants / Spouses of Migrants received PPTCT services	No. registered in the RSBY scheme	No. linked with PLHIV Network	No. are on ART during the month	No. benefitted by any other social welfare scheme during the month
1	No. of Potential/ New (who are about to leave within 2 months) Migrants reached								
2	No. of Returnee Migrants reached								
3	No. of Out going (who are leaving)Migrants reached								
4	No. of Female Migrants reached								
5	No. of spouses of migrants reached								
6	No. of Labour contractors reached								
7	No. of other stake holders reached								
	TOTAL								

Also prepare case studies on issues and challenges that has been resolved or require to be resolved to ensure that the target population is effectively linked with various programmes.

INSTRUCTIONS

1. The format is to be filled at the end of the month
2. The relevant information is to be compiled and fed on a monthly basis into the MIS

2A. Format for IPC (One to Group Session) Activities by Village Level Volunteers

Frequency: During/after every one to group session activity
Where: At the location of the activity in the village
By Whom: Village Level Volunteers
For what:
1. To record group sessions by the category of participants met through sessions during a month.
Guidelines for filling the form:

- Village Level Volunteers need to enter information related IPC (One to Group Session) activities in terms of coverage in the format on daily basis.

- The same need to be verified by Block Supervisor/ District Programme Manager during their supervisory visit to the villages

How-
Name of the village:- The name of the village where the *session* is taking place.
Name of the Block:- Self explanatory
Name of the District:- Self explanatory
Name of the reporting person:- The name of the person filling the format
Date:- The date in the DD/MM/YYYY format when the session takes place
Month:- The month in which the IPC is taking place
Year:- The year in which the IPC is taking place.
Category of the participants exposed (please use the code):

Category Description	Code
No. of Potential/ New (who are about to leave within 2 months) Migrants reached	1
No. of Returnee Migrants reached	2
No. of Out going (who are leaving)Migrants reached	3
No. of Female Migrants reached	4
No. of spouses of migrants reached	5
No. of Labour contractors reached	6
No. of other stake holders reached	7

Sex:- Self Explanatory
Age:- Age of the patient. If the patient appears to be unsure, an approximate age may be recorded with the word "approx." placed after the numeric.
Calendar Days in a Month :- The columns beneath this title are dates of the month (1-31). Volunteer is to indicate beneath the calendar date, the number of people of the category s/he has conducted the session with
Usefulness of the information:-
1. To understand the pattern of reach of the sessions
2. To understand the distribution of participants by their profile
3. To monitor and supervise the field level sessions conducted by volunteers.

9A. Format for IPC (One to Group Session)Activities by Village Level Volunteers

Name of the Village: | **Name of the Block:** | **Name of the District:** | **Month : _____**

Name of the reporting person: | **Year : _____**

S. No.	Category of the participants exposed (please use the code)	Sex (M/F)	Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
1																																			0
2																																			0
3																																			0
4																																			0
5																																			0
6																																			0
7																																			0
8																																			0
9																																			0
10																																			0
11																																			0
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22																																			0
23																																			0
24																																			0
25																																			0
26																																			0
27																																			0
28																																			0
29																																			0
30																																			0
31																																			0

Instructions: Village Level Volunteers need to enter information related IPC (One to Group Session) activities in terms of coverage in the format on daily basis. The same need to be verfied by Block Supervisor/ District Programme Manager during their supervisory visit to the villages

No. of Potential/ New (who are about to leave within 2 months) Migrants	1	No. of spouses of migrants reached	5
No. of Returnee Migrants reached	2	No. of Labour contractors reached	6
No. of Out going (who are leaving)Migrants reached	3	No. of other stake holders reached	7
No. of Female Migrants reached	4		

2 B. Master Migrant Register

Frequency: During/after every one to group session activity
Where: At the location of the activity in the village
By Whom: Village Level Volunteers
For what:
1. To record details of the migrants who are under the scope of the intervention. This includes potential, outgoing and returnee migrants.
Guidelines for filling the form:

- Village Level Volunteers need to enter information on following in details:
    - Name of the migrant, Gender, Age
    - Skill level – Skilled or Non skilled (as per the reference made by the migrant)
    - Type of work involved in (In case of potential and outgoing this refers to where they will work if they travel to destination. In case of returnee migrant the same refers to where they have last worked before leaving the destination)
    - State /District/ Town/Village (In case of potential and outgoing this refers to where they will work if they travel to destination. In case of returnee migrant the same refers to where they have last worked before leaving the destination)
    - Status of migration – First time (potential / out going) OR Returnee
    - With whom he/she is visiting (labour contractor, friend, family)
    - Places visited during last 3 months (refers to places where he/she has worked)
    - HIV testing status (refers to whether HIV testing due to any reason has been done)
    - Registration with RSBY (refers to whether registered with RSBY, if not but eligible the volunteer need to provide the same information to the district office for facilitating registration by District labour office).
- The same need to be verified by Block Supervisor/ District Programme Manager during their supervisory visit to the villages

Usefulness of the information:-
1. The information entered in this format will be shared with destination States so that they use the same for tracking of services through TIs (in case of potential and out going migrants).
2. The information in this format will be used for tracking of services and need to be validated with information sheet obtained from destination SACS in case of returnee migrants.

Reporting Format - for Data Sharing with Destination States (To be segregated for State wise and to be shared with respective States on monthly basis)

Name of Block ORW in charge					Contact No. of reporting person:				Name of the Site:						State:	
Sl. No	Date of registration	UID No./ Health card No. (issued at source)	Personal Details			Type of work involved in		Mobility details						HIV test conducted earlier Yes/No Date (at source or at transit) If yes, Entermonth and year tested	Whether having registered with RSBY programme (if yes, registration number)
			Name	Gender (M/F/other)	Age	Whether Skilled / Non -skilled	1. Industrial worker 2. Construction worker 3. Rati worker 4. quarry 5. Loom Worker 6. hotel boy 7. food stall 8. Sugar cane cutter 9. Hammal 10. Labour 11. farm worker 12.Bricks 13. Hawkers 14.Daily wage earner 15. Security Guard 16. Rickshaw puller 17. Minining Worker 18. Agriculture Worker 19. Any other	State visiting currently	District	Name of the town / village	Whether a first timer or returnee migrant	With whom he is visiting (labour contractor, friends, family)	Other places visited during last 3 months		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

Coding: 1-One to one, 2- One to Group, 3-Condom demo, 4-Condom redemo, 5-Condom distribution, 6-Counselling, 7-STI Referral, 8-STI Treated, 9-ICTC referral, 10-HIV tested, 11-VDRL test, 12-ART Registration, 13-TB referral, 14-Ref to PLHA network, 15-Clinic attendance

3A. Field Visit Report

Frequency: At the end of the field visit
Where: At the block level
By Whom: By the PC
For what:
1. For record purposes, to understand the service needs and keep details of field visits
2. To understand how to strengthen the field visits

Guidelines for filling the form:

- Report only whatever is applicable in the format
- The relevant information is to be compiled and fed on a monthly basis into the MIS
- Kindly refer to notes made during each field visit to fill in the first portion of the form which is a monthly format

How-
Name of visiting person:- Self explanatory
Date of visit:- The date in the DD/MM/YYYY format when the format is being filled
MONTHLY FORMAT:
S.No.:- The column is filled.
Name of the village:- The name of the village visited
Number of times visited:- Self explanatory
Inputs provided:- Inputs provided in terms of specific instructions or feedback given to the team during visits.
Plan of action prepared for next month:- The plan of action for the particular village for the next month prepared on the basis of the needs identified and the inputs provided
FORMAT TO BE FILLED EVERY FIELD VISIT
Direct Observation of IPC session:- This refers to any overall observations made during IPC sessions attended. This is to put down what you "see"
Name of the Block Supervisor facilitating the session:- Self explanatory
Remarks:- This refers to any remarks corresponding to the observations made. This is for recording comments regarding what you "see"
Assessment of IPC Session (as observed):- This refers observations made in particular and specific reference to the list that follows:

a	Facilitation skills
b	Knowledge of HIV/STI
c	Attitude and behaviour of the Block Supervisor
d	Whether the session was planned in advance and well notified
e	Clarification of the misconception during the session
f	No. of active participants
g	No. of referrals done

Corresponding to each of the above please indicate under the relevant columns – Satisfied/Unsatisfied ; Improvement suggested and remarks (if any)
Direct observation of 2 condom outlets/ CVMs:- This refers to observations made during visits to 2 specific condom outlets/ CVMs
Name of the Outlet:- Self Explanatory
Location:- The abbreviation of available address, along with a reference to the nearest landmark/ crossroads
Condoms Available/ Functioning:- Please note if the condoms were available and if the CVM/ the outlet is functioning
Meeting with any Stake Holders (if applicable):- This refers to people met in particular and specific reference to the list that follows:

a	Labour Contractor
b	Returnee Migrants Group
c	Provider in the facility (PHC/CHC/CDPO/ART/ICTC)
d	District /Block Administration
e	RSBY Insurance Company representative
f	ASHA/Anganwadi Worker/ANM/Village Administrative Officer
g	Panchayati Raj Institution Members
h	Any other (Specify)
i	Target Group met (Migrants/ Spouses of Migrants)

Corresponding to each of the above please indicate under the relevant columns –
Name of Person(s) Met:- Self explanatory
Reason for meeting: Kindly note the agenda of the meeting, a brief on what was planned to be discussed and what was discussed.
Remarks/Plan of Action: Corresponding to column of reason for meeting, this is to record your comments on the meeting and plan of action formulated to take the discussion forward to strengthen the implementation
Usefulness of the information:-

1. Documenting observations for later analysis
2. To help in formulating a road map according to the needs observed
3. To achieve a yardstick regarding the nature of services required and services provided and address the gaps if any.

3 A. Field Visit Report

(To be filled by District Units every month for every field visit done)

(Report only whichever is applicable in the format)

Name of the Visiting Person

Date of visit

Sl. No				
I	**Direct Observation of IPC session(One to Group Session)**	**Name of the Block Supervisor facilitating the session**	**BCC /IPC Tools used**	**Remarks**
a				
b				
c				
I.I	**Assessment of IPC session (as observed)**	**Satisfied/Unsatisfied**	**Improvement suggested**	**Remarks**
a	Facilitation skills			
b	Knowledge of HIV/STI			
c	Attitude and behaviour of the Block Supervisor			
d	Whether the session was planned in advance and well notified			
e	Clarification of the misconception during the session			
f	No. of active participants			
g	No. of referrals done			
	Direct observation of 2 condom outlets/CVMs			
II	**Name of the Outlet**	**Location**	**Condoms Available/ Functioning**	**Remarks**
1				
2				
III	**Meeting with any Stake Holders (If applicable)**	**Name of Person(s) Met**	**Reason for meeting**	**Remarks/Plan of Action**
a	Labour Contractor			
b	Returnee Migrants Group			
c	Provider in the facility (PHC/CHC/CDPO/ART/ICTC)			
d	District /Block Administration			
e	RSBY Insurance Company representative			
f	ASHA/Anganwadi Worker/ANM/Village Administrative Officer			
g	Panchayati Raj Institution Members			
h	Any other (Specify)			
i	Target Group met (Migrants/ Spouses of Migrants)			

INSTRUCTIONS

1. The format is to be used by the District Coordinator for keeping details of his field visits.
2. The relevant information is to be compiled and fed on a monthly basis into the MIS

3B.Minutes of Meeting with _____ (a group name like "Officials from..." is to be provided here)

Frequency: At the end of each meeting
Where: At the block level
By Whom: By the PC
For what:
1. For record purposes, to keep details of meetings
2. To refer to later during follow up or related meetings
Guidelines for filling the form:

1. The format is to be used for minuting the details of the following meetings by the disrict unit:
i) Advocacy meetings
ii) SHGs meeting
iii) Meeting with Block/ District Administration
iv) Staff meetings
v) Any others
2. Number of people attended by designation is to be mentioned. Attendance sheet mandatory along with minutes
3. Some data from the format is to be compiled on a monthly basis into the MIS

How-
Date:- The date in the DD/MM/YYYY format when the format is being filled
Venue:- Self Explanatory
Purpose:-The agenda for the meeting
PARTICIPANTS (Names and Designation) :- Self Explanatory
Discussions held: A brief on the discussions held with specific highlights on major points discussed
Plan of Action and Decision taken
Decision Taken:- Self explanatory
Plan of Action:- How it is planned to go about to ensure that the task to be undertaken is completed satisfactorily
Team/Person Responsible:- Self explanatory
Target Date:- An approximate date by when the task shall be completed
Usefulness of the information:-
This information shall help in understanding the way forward to bring about the change required in order to ensure greater uptake of services and effective behaviour change communication.

3 B. MINUTES OF MEETING WITH ……

Date:

Venue:

Purpose:

PARTICIPANTS (Names and Designation)

Discussions held:

Plan of Action and Discussion taken

S.No	Decision taken	Plan of Action	Team /Person Responsible	Target Date
1 (Example)	Share review tool		**District Programme Manager**	Early July
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				

INSTRUCTIONS

1. The format is to be used for minuting the details of the following meetings by the district unit:

i) Advocacy meetings

ii) SHGs meeting

iii) Meeting with Block/ District Administration

iv) Staff meetings

v) Any others

2. Number of people attended by designation is to be mentioned. Attendance sheet mandatory along with minutes

3. Some data from the format is to be compiled on a monthly basis into the MIS

3C: Monthly Reporting Form: Critical Level of IEC Material

Frequency: At the end of each month
Where: At the block level
By Whom: By the PC
For what:
1. For record purposes
2. To understand the requirement of and the corresponding stock of IEC materials

Guidelines for filling the form:
How-
Month:- Fill in the reporting month
Name of IEC Material:- Self explanatory
Amount of material received last:- Indicate the number of corresponding material received last from the last time of record
Stock as on last date of previous month :- Add in the month and number of corresponding IEC material currently in hand including left over of earlier received stock
Villages with stock outs: Villages which are currently out of stock in the block of the corresponding IEC material
Remarks (Whether IEC available in adequate quantity, Y/N or any other remarks, if required):- Kindly note as indicated

Usefulness of the information:

1. This is to ensure that adequate IEC materials are there.
2. This will also help to highlight where the IEC materials are lacking

3 C. Monthly Reporting Form : Critical Level of IEC Material

Month : _____

Sl.No.	Name of IEC Material	Amount of material received last	Stock as on last date of previous month	Remarks (Whether IEC available in adequate quantity, Y/N or any other remarks, if required)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

SIMS REPORTING FORMAT for SOURCE INTERVENTIONS

National AIDS Control Organisation

DISTRICT MONTLHY REPORTING FORMAT FOR SOURCE MIGRANT INTERVENTIONS

Name of the Reporting Officer:						Contact No.		
Designation:								
Month:			Year:		STATE:			
District:			No. of Blocks under implementation					
Number of villages Proposed for implementation in the district			Number of villages covered during current month			Total proposed migrants to be reached during current year		
Number of activities and their coverage conducted during the month in the district for the first time only	No. of One to group sessions conducted	No. of mid-media campaigns held	No. of information booth are functional	No. of health melas organised	No. of RSBY camps organised for registration	No. of VHND meetings attended by implementation team	No. of persons reached in the neareast ICTC centres	No. of persons reached at the nearest STI providers (pvt. And govt.)
No. of Potential/ New (who are about to leave within 2 months) Migrants reached								
No. of Returnee Migrants reached								
No. of Out going (who are leaving during the current month)Migrants reached								
No. of Female Migrants reached								
No. of spouses of migrants reached								
No. of Labour contractors reached								
No. of other stake holders reached								
TOTAL	0	0	0	0	0	0	0	0

A. Human Resource:							
Category of the staff (as applicable in the budget)	Number of man power approved	Number of manpower in place	Trained during the month	Cumulative Trained during the year	Number of days of visits made	No. of meetings with other stake holder s held	
District Programme Manager							
Block Supervisor							
M&E Officer							
Village Health Volunteers							

Service Delivery:							
1. Condom							
	a. No. of condom depots established	b. Uptake of condoms through condom depots	c. Uptake of condoms through free distribution				

2. Involvement of Volunteers							
	Number approved	Number in place	Trained	Cumulative Trained			
Identification of volunteers							

3. Linkages and utilization of serivces							
	Total identified during the month	Total referred during the month	Tested / Treated during the month	Cumulative referrals till the month	Cumulative tested/service provided till the month		
a. TB referrals (DMC center)							
b. TI NGO/CBO (only for HRG population)							
c. PLHA network							
d. No. identified positive							
e. STI/RTI cases							
e. ART referral							

4. Outreach activites:							
	Total Number	Cumulative no.	Date	Objectives	Key Outcomes	No. of person particpated	
a. Advocacy meeting with district level stakholders							
b. Meetings with other village functionaries (Panchayat/NYK etc)							
c. Community events and meetings organised with SHG/Youth clubs							
d. Others (Specify)							

5. Financial Status	Budget Approved for the FY	Expenditure made till reporting month	SOE submitted till date

6. Major Highlights (if any)- annex the detail reports of the events

7. Activities planned for next month:

National AIDS Control Organisation

STATE MONTLHY CONSOLIDATED REPORTING FORMAT FOR SOURCE MIGRANT INTERVENTIONS

Name of the Reporting Officer:						Contact No.		
Designation:								
Month:			Year:		STATE:			
Total no.of districts reporting			No. of Blocks under implementation			0		
Number of villages Proposed for implementation in the district			Number of villages covered during current month		0	Total proposed migrants to be reached during current year		
No. of Blocks under implementation during the month	**District 1**	**District 2**	**District 3**	**District 4**	**District 5**	**District 6**	**District 7**	**District 8**
Number of villages covered during current month								
Number of activities conducted and their coverage during the month in the State	No. of One to group sessions conducted	No. of mid-media campaigns held	No. of information booth are functional	No. of health melas organised	No. of RSBY camps organised for registration	No. of VHND meetings attended by implementation team	No. of persons reached in the neareast ICTC centres	No. of persons reached at the nearest STI providers (pvt. And govt.)
No. of Potential/ New (who are about to leave within 2 months) Migrants reached								
No. of Returnee Migrants reached								
No. of Out going (who are leaving during the current month)Migrants reached								
No. of Female Migrants reached								
No. of spouses of migrants reached								
No. of Labour contractors reached								
No. of other stake holders reached								
TOTAL	0	0	0	0	0	0	0	0
A. Human Resource:								
Category of the staff (as applicable in the budget)	Number of man power approved	Number of manpower in place	Trained during the month	Cumulative Trained during the year	Number of days of visits made	No. of meetings with other stake holder s held		
District Programme Manager								
Block Supervisor								
M&E Officer								
Village Health Volunteers								
Service Delivery:								
1. Condom								
	a. No. of condom depots established	b. Uptake of condoms through condom depots	c. Uptake of condoms through free distribution					
2. Involvement of Volunteers								
	Number approved	Number in place	Trained	Cumulative Trained				
Identification of volunteers								
3. Linkages and utilization of serivces								
	Total identified during the month	Total referred during the month	Tested / Treated during the month	Cumulative referrals till the month	Cumulative tested/service provided till the month			
a. TB referrals (DMC center)								
b. TI NGO/CBO (only for HRG population)								
c. PLHA network								
d. No. identified positive								
e. STI/RTI cases								
e. ART referral								
4. Outreach activites:								
	Total Number	Cumulative no.	Date	Objectives	Key Outcomes	No. of person particpated		
a. Advocacy meeting with district level stakholders								
b. Meetings with other village functionaries (Panchayat/NYK etc)								
c. Community events and meetings organised with SHG/Youth clubs								
d. Others (Specify)								
5. Financial Status	Budget Approved for the FY			Expenditure made till reporting month			SOE submitted till date	
6. Major Highlights (if any)- annex the detail reports of the events								
7. Activities planned for next month:								

5.20 REPORTING TOOLS FOR DESTINATION INTERVENTIONS

Target Audience:

1. Officers of CMIS division and TI division of SACS and NACO

2. Programme officers of TSU

3. Staffs working with Destination Migrant Interventions

Objective:

1. To familiarise with various data collection tools regarding its use, analysis and interpretation

LIST OF DATA COLLECTION TOOLS FOR MIGRANT TI

Data capturing tools	Content of the form	When to fill and Who has to fill	Usefulness of the Information	Staff Responsible and accountable
Master register for destination intervention (Form 1)	Contains information on basic profile of a migrant. It gives comprehensive information of the migrant - e.g. name, age, category, sub category and location of MIGRANT. Date of identification and date of registration. Code of migrant is given. This form is confidential and kept in safe custody by the M&E officer / PROGRAM MANAGER.	For each migrant once during the project period. Filled in by the ORW after identified as new to the program by the ORW.	1. Number of registration forms also about the number of migrants registered with the program. 2. This is an authenticated document of an MIGRANT of having enrolled in the program to avail project services.	ORW with the support Peer Leader for identification of Migrant and registration by outreach worker for registering in the project

Data capturing tools	Content of the form	When to fill and Who has to fill	Usefulness of the Information	Staff Responsible and accountable
Individual Migrant tracking sheet **(Form 2)**	The sheet is used by the ORW for the activities conducted at the site/hotspot level during a given month with the support Peer Leader. For each site / hotspot, one form will be used. Every month beginning a fresh sheet will be used with the names generated through the computer. At the end of each month, the ORW will use the "outreach level analysis" (the last four columns) columns to know on the performance in each site/hotspots. The sheet contains basic services given to each of the migrant met and status on the referrals. At the end of each month, the filled in forms is to be returned to ORW.	On day to day basis the ORW will fill in the format after each contact made with the migrant in his/her hotspot for the project services given.	1. Helps in tracking the migrants being met on day to day basis and tell about performance of ORW and site behavior. 2. Helps in knowing the referrals made during a month. 3. Helps in knowing the number of free condoms distributed and social marketing of condoms to each migrant 4. Helps in knowing type of services provided to each migrant during a given month. 5. Helps in knowing type of contacts made. 6. Helps in knowing number of new and old registered migrants met during a given month.	Outreach worker

Data capturing tools	Content of the form	When to fill and Who has to fill	Usefulness of the Information	Staff Responsible and accountable
NETWORK CLINIC REGISTER (STI-RTI) **(Form 3)**	The register has the provision to record, STI symptom details, type of treatment given, any lab test conducted etc which is comprehensive information on the visit made by the MIGRANT to the clinic. This is individual sheet for recording information for each MIGRANT visiting the clinic. On every visit of the MIGRANT to the clinic, a fresh form is filled in.	The patient register form is to be filled in by the doctor for each patient visiting the clinic. Every time a new form is to be filled in though the patient has been repeated more than once during a given month.	1. The patient register form gives details of information of the patient visiting the clinic. 2. It gives information on the type of diagnosis made treatment given and further any lab test done. 3. It also reveals that whether the patient has been referred to referral centers.	Doctor

Data capturing tools	Content of the form	When to fill and Who has to fill	Usefulness of the Information	Staff Responsible and accountable
Clinic Service Record Register **(Form 4)**	This is a summary sheet where, all the requisite information from the **filled in Network clinic register** during a given day is transferred. This form gives summary details of each MIGRANT visited the clinic and on number of clinic patients visited each day and type of diagnosis and treatment given. The second part of the summary register captures the drugs dispensed on day to day basis to track of type of drugs dispensed which will be tallied with the stock registers	The MIGRANT clinic summary sheet is to be filled in by the end of each clinic day(which includes clinic activities conducted through mela, camps) by the ANM or by the counselor. To ensure quality, at the end of each clinic day, the doctor verifies the entries made in the summary sheet.	1. It reveals that how many patients have visited the clinic on each day. 2. It also reveals how many patients have been treated for STI, RMC, Abscess, general ailments, 3. It also reveals on type of STIs treated. 4. It also reveals on the number of new MIGRANTs visited clinic in a given month 5. This sheet is used by the MIS officer in entering the data into the computer. 6. Gives information on day to day type of drug consumed.	ANM / Counselor

Data capturing tools	Content of the form	When to fill and Who has to fill	Usefulness of the Information	Staff Responsible and accountable
Counseling Service Register **(Form 5)**	It contains information on details of counseling done for each MIGRANT by the ANM / Counsellor. Each patient information one row is allocated. This needs to be filled in on day to day basis.	The counselor or the ANM is responsible to fill in this format. After each patient is counseled, the record is updated.	1. It helps in know number of counseling session conducted in a given period of time. 2. It helps in knowing the type of counseling given. 3. It also help in knowing whether a MIGRANT has been given pre and post counseling especially for the cases of STI.	ANM/ Counselor

Data capturing tools	Content of the form	When to fill and Who has to fill	Usefulness of the Information	Staff Responsible and accountable
Monthly consolidated referral register and referral slips **(Form 6 & 6A)**	The referrals slips are in triplicate and used for referring the MIGRANTs. One slip is retained by the referral center, one by the MIGRANT and third one is kept at the project office. Once the referral slips are issued, the information is noted in the referrals registers. It contains information for recording MIGRANTs who have been referred to various referral centers. It also tracks whether a MIGRANT referred actually treated at the referral center(s).	The ANM is the responsible person to issue the referral slips. All the referrals cases referred – either through outreach, clinic, has to be given a referral slip and t he same is noted in the referral register for tracking. The register is filled in as and when a referral is made.	1. The referrals register helps in tracking number of MIGRANT being referred and being tested each month. 2. From the referral registers, it can be tracked who has been referred and when the person has been referred. 3. The registers reveal that each month how many referrals have been and how many have been tested.	ANM / Counselor

Data capturing tools	Content of the form	When to fill and Who has to fill	Usefulness of the Information	Staff Responsible and accountable
Medicine Stock Management **(Form 7)**	It contains information on the status of each medicines distributed to the patients and balance available at the clinic (Only STI medicines are recorded). The second part of the stock register is the indent register which will be used for indenting the stock of essential STI drugs	ANM / Counselor on day to day basis, updates the information on the stock received, consumed and balance available for each type of medicine. ANM/Counselor places the order of essential STI drugs through indent register.	1. One can know the status on number each STI medicine available in the project at any given point of time. 2. It gives status on stock consumption pattern of each medicine in each given period. 3. A written documentation available for ordering STI medicines through a indent register which keeps a track of the medicines being indented data and quantity. 4. It helps in validating the stock consumed versus stock in balance.	ANM / Counselor

Data capturing tools	Content of the form	When to fill and Who has to fill	Usefulness of the Information	Staff Responsible and accountable
Drop in Center register. **(Form 8)**	This is a register kept at every drop in center to track MIGRANTs who are visiting the drop in center on each day. It contains information - name of the MIGRANT, when visited, purpose of the visit, number of condoms/syringes received from the drop in center).	The Program Manager appoints a MIGRANT (who is willing to take up). The accountability lies with the program Manager for the management of the drop in center and the register maintenance.	1. Number of MIGRANT visited the DIC in a given period. 2. Purpose of visit to the Drop in center. 3. Time spent in the drop in center by each MIGRANT.	ANM/Counselor
Capacity Building Register **(Form 9)**	Periodically, all the TI project staffs are to be trained (e.g. refresher training, skill enhancement training for different cadre of staff at the TI level), To keep track of training being conducted from time to time, a training register is maintained. The training could be conducted by the SACS/TSU or in-house training organized at the TI level.	The Program Manager is responsible to fill in this register. At end of each training session conducted this register has to be filled in.	1. Gives information on the number of training conducted in a given period. 2. Gives information on the type of training given (topics covered etc.) to the staff has been conducted 3. Gives information on the type of staff trained.	Program Manager

Data capturing tools	Content of the form	When to fill and Who has to fill	Usefulness of the Information	Staff Responsible and accountable
Advocacy activity report **(Form 10)**	The NGO has to conduct a set of advocacy activities during the project period. The form has provision to record detailed information for each advocacy activity undertaken by the project from time to time. Each advocacy activity one form will be filled in.	The program manager is the responsible to document all the advocacy or advocacy related activity. After each advocacy activity, the Program Manager fills in the format. For each advocacy, one form to be filled in. The form is stored.	1. The format gives information on number of advocacy activity conducted in a given period 2. The formats also speak on type of the advocacy conducted from time to time. 3. It gives information on the type of stakeholders with whom the advocacy activity has been conducted.	Program Manager
Crisis Management register. **(Form 11)**	This is a format to document an incident of violence occurred in the community. It contains information on the violence reported/occurred and whether it has been resolved or attended .	As and when an violence has been reported to the project either by PEER LEADER/ORW or any other staff, the project manager has to fill in the form for documentation purposes. Each violence reported, one form to be prepared.	1. The format reveals on the number of violence occurred in each site/hotspot. 2. Reveals Whether any action taken on the reported violence. 3. During of addressing violence - within 24 hours or not.	Program Manager

Data capturing tools	Content of the form	When to fill and Who has to fill	Usefulness of the Information	Staff Responsible and accountable
Mid Media / Event Register **(Form 12)**	It contains information on details of events conducted by the NGFO / TI for the migrants. It gives information on the type of event and number of people participated. Number of IEC materials distributed and used during each event will speak about the quality of event conducted.	The program Manager is responsible to fill in this format. After each event is completed.	1. It helps in know number of events conducted. 2. It helps IEC materials used in event. 3. It also help in knowing the topics or themes covered . 4. It also helps in knowing number of people referred to ICTC centers and number of condoms distributed or sold.	Program Manger
Linkages Strengthening register **(Form 13)**	The NGO has to strengthen the linkages as part of the project activities. The linkages could be for testing centers, private clinics and government clinics etc.	The program manager with the support of NGO project director is the responsible to strengthen the linkages. Each institute involved needs to be documented as per the register details.	1. The register gives type of institutes linked with the program. 2. The register gives the type of services linked with external agencies.	Program Manager

Data capturing tools	Content of the form	When to fill and Who has to fill	Usefulness of the Information	Staff Responsible and accountable
Stock Maintenance register – condom management . **(Form 14)**	All Migrant TI projects distribute commodities (condom, lubes) as part of the project services. This register has been divided into 3 part – for Free condom distribution, social marketing and condom at outlets. The stock register is maintained to track the number of commodities being received from sources and distributed through different channels.	The Program Manger maintains the stock register. The register is updated on day to day basis (based on the transaction made – received from different sources and distributed),	1. Number of commodities available at the end of each month. 2. Number of commodities received during a given period. 3. Number of commodities distributed / sold during a given month. 4. Number of channels used for distribution.	Program Manager

Data capturing tools	Content of the form	When to fill and Who has to fill	Usefulness of the Information	Staff Responsible and accountable
Stock Recruitment Register **(Form 15)**	This registers gives information on the staff recruitment details. This also tracks the turnover of staff in each cadre. The register is stored at the NGO office and should be made available to SACS /TSU and NACO officials.	The Program Manager is responsible to fill in this register. As and when a staff member is added or resigned in the project, the project manager updates this register.	1. Gives information on number of staff recruited in each cadre as per project. 2. Gives information on the status of turnover of the staff in each cadre and how frequently the turnover is happening and in which cadre. 3. Gives information on reasons for leaving the project which will be useful in knowing the turnover.	Program Manager

Data capturing tools	Content of the form	When to fill and Who has to fill	Usefulness of the Information	Staff Responsible and accountable
Field Supervision Report- Project Manager **(Form 16)**	The Project Manager suppose to make visits to the field every month to do monitoring of project activities. The registers contains the information and activities conducted during each visit made. For each visit, one form to be used and the same to shared with project director of the NGO as well as with the SACS/TSU staff as and when asked for.	The Program Manager is responsible to fill in the form. The project is accountable for the activities of PM and hence the project should keep track of the visits made by the PM.	1. Gives information on number of visits made by the Project Manager in each month. 2. Gives information on validating activities conducted by staff of project. 3. Gives information on the type of activities conducted by the project manager in the field. 4. Gives information on the type of challenges persists in the field	Project Manager

TI STAFF RESPONSIBLE FOR DATA COLLECTION TOOL (MIGRANT -INTERVENTION AT DESTINATION)

Name of the staff	Type of forms used	Frequency of usage	No.of formats responsible for.
ORW	MASTER REGISTER FOR MIGRANTS (**FORM 1**)	AS AND WHEN A NEW MIGRANT IDENTIFIED (THE LIST WILL BE COMPUTERISED AND UPDATED ON WEEKLY BASIS)	**2**
	INDIVIDUAL MIGRANT TRACKING SHEET (**FORM 2)**	ON DAY TO DAY BASIS, THE ORW WILL CONTACT AS PER MASTER REGISTER WITH THE SUPPORT FROM PEER LEADER AND GIVE SERVICES	
Doctor	Clinic Net work Card **(FORM 3)**	ON DAY TO DAY BASIS WITH ALL THE LINKED PREFERED PROVIDER AND DURING CAMP DAYS	**1**
ANM / Counselor	Clinic SERVICE RECORD REGISTER (**FORM 4)**	DAY TO DAY BASIS	**5**
	COUNSELING SERVICE REGISTER (**FORM 5**)	DAY TO DAY BASIS	
	MONTHLY CONSOLIDATED Referral Register / slips. **(FORM 6 & 6A)**	ON WEEKLY BASIS THE CONSOLIDATION AND SLIPS TO BE ISSUED ON DAY TO DAY BASIS	
	MEDICINE STOCK MANAGEMENT REGISTER **(FORM 7)**	ON WEEKLY BASIS UPDATE	
	Drop in center register**. (FORM 8)**	Day to day basis	
PROGRAM MANAGER /M&E OFFICER / ACCOUNTANT	CAPACITY BUILDING REGISTERS **(FORM 9)**	Once / twice in a month	**8**
	ADVOCACY FORMAT**. (FORM 10)**	Once / twice in a month	
	CRISIS MANAGEMENT REPORT **(FORM 11)**	Day to day basis	
	MID MEDIA EVENT REGISTER **(FORM 12)**	Usually once or twice in a month	
	LINKAGES STRENGTHENING REGISTER **(FORM 13)**	On day to day basis	
	STOCK MAINTAINANCE REGISTER – CONDOM MANAGEMENT **(FORM 14)**	Once in a week update	
	STAFF RECRUITMENT REGISTER **(FORM 15)**	Once in a month	
	FIELD SUPERVISION VISIT REPORT – PROGRAM MANAGER (**FORM 16**)	Once in a week	

FORM 1: MASTER REGISTER FOR MIGRANTS

Frequency: As and when a Migrant is identified

Where: At the site or at the hotspot

By Whom: By the ORW

For what:

- To know the basic profile of migrant identified at the Destination – name, age, date of registration
- To know on the demographic details of the migrant – Source/transit from where the migrant has migrated, Type of work involved, Mobility pattern of the migrant, sexual preference and vulnerability status of the migrant.

Guidelines for filling the form:

The form is to be filled in by the ORW with the support of the Peer Leader in the allocated area given to the ORW. It is a onetime information gathering process and need to be updated. The ORW before filling up needs to confirm that the migrant has not been registered by any other ORW of the destination project intervention in the same area. The form contains 27 sets of information and last two sections are of sensitive in nature and could not be collected in first time. The form is to be stored at the NGO level. Each migrant information is to be entered into excel format in the computer for day to day use.

FORMAT FILLING DETAILS

Type of Information		Column No.	Description
Name of site			**Enter Name of the site – Usually name of the area, locality which is known and easily locatable by the project staff**
Name of PEER LEADER in charge for the site			**Enter Name of the PEER LEADER working with the project and in charge of the site / hotspot**
Sl. No		**1**	**Enter the serial number of the migrant being registered with program. This serial number (five digit code number will be master serial used by the project)**
Date of registration		**2**	**Date on which the PEER LEADER/ORW fills in this form**
UID No./ Health card No. (issued at source / transit)		**3**	**The health card is issued to every migrant identified at source / transit point. The ORW should ask for the health card number and note down the same in this format**
Personal Details	Name of the Migrant	**4**	**Name of the Migrant being registered**
	Gender	**5**	**Enter the gender of the migrant being registered (Male / female)**
	Age	**6**	**Ask for the age of the migrant as reported.**

	Marital Status	**7**	**Ask for marital status of the migrant being registered. (Unmarried/Married/Divorcee/widower/Widow)**
	Education	**8**	**Ask for the education level of the migrant being registered. Record highest education attained .**
	Contact Number (mobile/ tel.) at Destination	**9**	**Ask for the contact telephone number (official as well as mobile number (if any)**
	Work Place address	**10**	**Note the address of the work place where the migrant is working. If the migrant is working in more than one place, take the address of the work place which is primary. For contract basis, it is not feasible to document workplace address. It is suggested to have the address /phone no. of the contractor/broker/employer**
Type of work involved in	1. Industrial worker 2. Construction worker 3. Rati worker 4. quarry 5. Loom Worker 6. hotel boy 7. food stall 8. Sugar cane cutter 9. Hammal 10. Labour 11. farm worker 12.Bricks 13. Hawkers 14.Daily wage earner 15. other (specify)	**11**	**Ask from the choices on the type of work being carried out by the migrant. If the work involvement do not figure in the 14 listed work type, then categorise in others (with details of the work involved).**
Mobility details	Home State (originally belong to)	**12**	**Ask for state to which the migrant original belongs to. The original state could be categorize as the state where the migrant was born or lived for more than a decade and where the migrant has family or property.**
	District	**13**	**Ask name of the district from where the migrant hails from.**
	Block/Taluka	**14**	**Name of the block/taluka to which the migrant belongs to**
	Name of the town / village	**15**	**Ask for the name of the town or village the migrant hails from**
	Since when is she/he living in Destination? (No. of Months)	**16**	**The ORW will ask the migrant since how long he has been in the present place (where the registration is being done). The ORW needs to probe if the answer is vague. The duration needs to be recorded in months. Please round off, if the duration is in fraction.**
	Does S/he stay 1. Alone, 2.with immediate family,3. with relatives, 4. with colleagues/ Friends	**17**	**Ask whether the migrant is staying with whom. The options are spelt out. Choose one option and accordingly fill in the form.**
	How often does She/he	**18**	**The ORW will ask the migrant how often s/he**

	go to meet her/his Spouse/ Family		**visits/meets the spouse or immediate family members. Please mention duration. (take the average visits made in the last 3 months)**
Sexual Preferences	No. of Sexual activity in the month apart from spouse (Average of last 3 months)	**19**	**This is a sensitive question to be asked very strategically. This information is very sensitive. In the very first meet, this information may not be recorded.** **The ORW will get the information whether S/he had sex other than his or her spouse in the last 3 months.**
	Where does she/he go for sexual activity 1. brothel 2. street based, 3. lodge, 4. bar, 5. Home based,6. Dhabha 7. Workplace 8. Regular Partner 9. Lover 10.Co-workers 11. Others (specify)	**20**	**This is a sensitive question to be asked very strategically. This information is very sensitive. In the very first meet, this information may not be acquired and recorded.** **The ORW with the support of PEER LEADER needs to probe to get this information more accurately**
Addictions 1-Alcohol, 2-Smoking, 3. Gutka/Tobacco 4. IDU 5.Drugs 6. whitner/solvents 7.cough syrup 8. other specify		**21**	**This is a sensitive question to be asked very strategically. This information is very sensitive. In the very first meet, this information may not be recorded.** **The ORW with the support of PEER LEADER needs to probe to get this information more accurately**
HIV test conducted earlier Yes/No Date (at source or at transit)		**22**	**This is a sensitive question to be asked very strategically. This information is very sensitive. In the very first meet, this information may not be recorded.** **The ORW with the support of PEER LEADER needs to probe to get this information more accurately**
If yes, Enter month and year tested		**23**	**This is a sensitive question to be asked very strategically. This information is very sensitive. In the very first meet, this information may not be recorded.** **The ORW with the support of PEER LEADER needs to probe to get this information more accurately. The recorded information could be "mm/yy"**

Master Register - Registration form - Migrant Intervention at Destination

Name of VPL in charge					Name of the ORW						Name of the Site:							Ditrict:			State:	
Sl. No	Date of registration	UID No./ Health card No. (issued at source / transit) Color coded cards like yellow for all source, pink for all transit can be issued	Personal Details						Type of work involved in		Mobility details							Sexual Preferences		Addictions	HIV test conducted earlier Yes/No Date (at source or at transit or at destination) If yes, Enter month and year tested	Whether having registered with RSBY programme (if yes, registration number)
			Name of the Migrant	Gender (M/F/other)	Age	Maritial Status (married/ Unmarried/separated)	Education (illeterate/literate/ graduate/PG)	Contact Number (mobile/ tel.) at Destination	Work Place address, if not available write the name of the labour contractor/broker/employer with address/phone no.	1. Industrial worker 2. Construction worker 3. Rati worker 4. quarry 5. Loom Worker 6. hotel boy 7. food stall 8. Sugar cane cutter 9. Hammal 10. Labour 11. farm worker 12.Bricks 13. Hawkers 14.Daily wage earner 15. other (specify)	Home State (originally belong to)	District	Name of the taluka/Block	Name of the town / village	Since when is she/he living in Destination ? (1- less than 6 months, 2- more than 6 months to 1 yr, 3 - more than 1 yr)	Does She/he stay 1. Alone, 2.with immediate family,3. with relatives, 4. with collegues / Friends	How often does She/he go to meet her/his Spouce/ Family	No. of Sexual activity in the month apart from spouse (Average of last 3 months)	Where does she/he go for sexual activity 1. brothel 2. street based, 3. lodge, 4. bar, 5. Home based,6. Dhabha 7. Workplace 8. Regular Partner 9. Lover 10.Co-workers 11. Others (specify)	1-Alcohol, 2-Smoking, 3. Gutka/Tobacco 4. IDU 5.Drugs 6. whitner/solvents 7.cough syrup 8. other specify		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23

Coding: 1-One to one, 2- One to Group, 3-Condom demo, 4-Condom redemo, 5-Condom distribution, 6-Counselling, 7-STI Referral, 8-STI Treated, 9-ICTC referral, 10-HIV tested, 11-VDRL test, 12-ART Registration, 13-TB referral, 14-Ref to PLHA network, 15-Clinic attendance

FORM 2: QUARTERLY INDIVIDUAL MIGRANT TRACKING SHEET

Frequency: Daily

Where: At the Site / Hotspot

By Whom: ORW

For what:

- To track the type of services given by the project on day to day basis.
- To know the number of migrants met each month
- To track number of condoms sold or distributed in a given month
- To track number of referrals reached the service point in a given month
- To track number of migrants given condoms as per requirement.

Guidelines for filling the form:

At the beginning each month, the ORW will print/write names of the migrant as per master register. On day to day basis, the ORW will visit the field and provide services to the migrants met. At the end of each month, the ORW will do a performance analysis based on the last four column of the format. This performance will be shared with the PM and also during the monthly review meeting.

Type of Information	Column No	Description
Sl No	**1**	Serial number given by the ORW in order of contact and which will change every month. This will be useful in knowing number of migrants being contacted each month.
Name of the Migrant / UID number	**2**	The list of names and UID will be generated by the computer from the master register
New / Old (first time interacting or interacted earlier by the project)	**3**	The ORW will write whether the migrant is first time being met and given services (new= first time interacted for the services ; old = already interacted earlier and given services)
Condom requirement per month (based on the number of sex acts involved in last month)	**4**	The ORW will ask for number of sex acts involved during the last month. Based on the number of acts specified, the condom requirement will be noted in this column (number of sex acts = number of minimum condoms requirement. If the migrant was not involved in the sex acts in the last month, then the ORW will ask for sex act involved in the month before last month.
Services	**5-16**	Codes to be used:(1- one-to-one, 2-one-to-group, 3- condom distribution, 4-Condom demo only 5- STI referral, 6-STI treated, 7-ICTC referral, 8-ICTC tested)
Reported condom use	**17**	During interaction, if the migrant has given

during last sex (yes / No)		information on the use of condom during last sex act involved, then the ORW will accordingly record – If used "yes" If not used " No". Before recording, the ORW need to do probing to find the fact on the condom usage.
Condoms distributed as per requirement (yes / No)	**18**	If the condom distributed or sold (both) as per the requirement recorded in column 4 then the ORW will write "1" or else "0".
Referred to ICTC and tested (yes / No)	**19**	If the migrant has been referred during the month and confirmed tested in ICTC, then the ORW will write "1" ; if No "0" if not applicable leave blank

Quarterly Outreach level Individual Migrant tracking sheet for In migrants (By ORW)																	
Name of the ORW:			Name of the VPL					**For the Month:**								**Outreach level Analysis**	
Sl No	**Name of the Migrant / UID number**	**New / Old (first time interacting or interacted earlier by the project)**	**Condom requirement per month (based on the number of sex acts involved in last month)**	**Mention the code of services provided as mentioned at the bottom of the format in each case. Incase of repeat contacts in a week, please mention codes together against the migrant**												**Reported condom use during last sex (yes / No)**	**Referred to ICTC and tested (yes / No)**
				1st month				**2nd month**				**3rd month**					
				Week 1	**Week 2**	**Week 3**	**Week 4**	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 1**	**Week 2**	**Week 3**	**Week 4**		
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	The ORW will update this information sheet on daily basis after complition of his/her daily activities.																
	Codes to be used:(1- one-to-one, 2-one-to-group, 3- condom distribution, 4-Condom demo only 5- STI referral, 6-STI treated, 7-ICTC referral, 8-ICTC tested)																

FORM 3: NETWORK CLINIC REGISTER (STI-RTI)

Frequency: On each clinic days

Where: Location of the clinics functions – PP doctors, Health Camps, Designated STI Referral Centre (preferably Govt. STI clinics).

By Whom: by the Doctor (in Health Camps), by the Counsellor/ANM (in other settings)

For what:

To record details of each patient visit details. This includes Regular Medical Check up (RMC) STI syndromes identified and treated, medicines advised or given. Type of referrals made.

Guidelines for filling the form:

- One form is to be filled in for each patient visiting the clinic. All these forms are to be stored at the NGO/TI level. ANM / Counsellor is responsible for the storing the forms in a systematic way which can be made available for future dates.

How-

The net work clinic card contains the following information:

Basic details of the patient visiting the clinic

Name of the Patient: Write name of the patient who has visited the clinic.

Index Number: The health card is issued to every migrant identified at source / transit point. The ORW should ask for the health card number and note down the same in this format. In case the same is not issued at source/ transit – the same need to be issued by the destination TI and the UID number is to be shared with source States.

Type of Patient: (New= first time to the clinic during the project period**)**

(Old= Migrant visiting the clinic second time or nth will be declared as old**).**

Purpose of the visit: (for the following purposes)

- **Symptomatic:** If the patient is visiting with STI/RTI symptoms or diagnosed as STI/RTI case by the doctor or follow up visit for the previous STI/RTI treated.
- **Asymptomatic:** If patient is visiting for the first time visit to the clinic and no STI has been diagnosed or the migrants is visiting the clinic with 6 months gap.
- **RMC (Regular Medical Check up):** Medical Check up (internal examination to exclude any form of STI) to be done for migrants during their clinic visits.

STI/ RTI SYNDROMIC DIAGNOSIS: If the patient is diagnosed as symptomatic then the doctor will tick one of the categories of symptom or multiple symptoms as per the case.

KIT PRESCRIBED: The doctor after diagnosing the patient as symptomatic case will prescribe the kit according to the diagnosis treated. The doctor will tick on the kit(s) prescribed to the patient.

Name of the Drug: The doctor will also tick on the type of drug prescribed to the patient based on the kit prescribed. In case there is no kits, the name of the drugs are to be noted.

Counselling: If the patient has been counselled at the clinic, then the doctor will tick on "yes" else on "No".

Referrals: If the doctor has referred to any other services (ICTC, ART CENTER, ANY LAB TEST) then the doctor will tick on the corresponding column and issue a referral slip.

Findings: Based on the examination done, the doctor will write in detail the diagnosed made, treatment given etc.

Others: If partner notification has been done then the doctor will tick on "yes" else "No".

Name of the reporting person:- The name of the person filling the format.

At the end, the doctor will sign the form of having conducted the activities for authenticating the diagnosis and treatment done.

FORM 3: NETWORK CLINIC REGISTER (STI-RTI)

Date of visit:

Doctors Name :_____ Qualification:_____ Phone No.:_____ Email:_____	Name of the clinic:_____ Address:_____

NAME OF PATIENT:…….. UID No. ----------.

AGE:……SEX: ☐ MALE ☐ FEMALE

PATIENT FLOW: ☐ DIRECT WALK IN ☐ REFERRED Type of Patient:

Purpose of visit:

New ☐ New

Symptomatic

Follow up

☐ Old

Asymptomatic

RMC

Presenting complaint:…….. Since when……..

STI/ RTI SYNDROMIC DIAGONOSIS		**KIT PRESCRIBED**		**Name of the drugs**	**Counselling**	
						Yes
	UD/ARD/CERVICITIS/PT		KIT-1 GRAY	Azithromycin (1 g) OD STAT Cefixime (400 mg) OD STAT		No
	Vaginal Discharge (Vaginitis)		KIT – 2 GREEN	Secnidazole (2 g) OD STAT and 1 Cap. Fluconazole (150 mg) OD STAT	**REFFERAL**	
	GUD- Non Herpetic		KIT – 3 WHITE	Benzathine penicillin (2.4 MU) IM STAT, Azithomycin (1 g) OD STAT		ICTC /PPTCT
	GUD- Non		KIT – 4 BLUE	Doxycycline (100 mg) XBD		Condoms

	Herpetic(Allergic to Penicillin)			X 14 DAYS Azithromycin (1 g) X OD STAT		
	GUD- Herpetic		KIT – 5 RED	Acyclovir (400 mg)X TDS X 7 DAYS		ART CENTRE
	Lower Abdominal Pain (PID)		KIT – 6 YELLOW	Cefixime (400 mg) X OD STAT Metronidazole (400 mg) X BD X 14 DAYS Doxycycline (100 mg) X BD X 14 DAYS.		LAB TEST
	Inguinal Bubo		KIT – 7 BLACK	Doxycycline (100 mg)X BD X 21 DAYS. Azithromycin (1 g) X OD STAT		OTHERS

Findings:

OTHERS:

A) Partner notification undertaken: Yes ☐ No ☐

B) Condom use: Last sex with any partner ☐ Always with any partner ☐

C) Next visit date:

Signature of the Doctor

FORM 4: Clinic Daily Register

Frequency: After the end of each clinic day
Where: At the clinic
By Whom: by the counsellor / ANM
For what:

1. To record details of each patient who had visited the clinic on each day as per the indicators mention in the form.
2. To know on the number of patients visiting each day
3. To know on the type of STIs being treated.
4. Helps in tracking medicines being given to each patient and tallying the same with the stock register.
5. The filled in form will help in compiling information for reporting purposes.

Guidelines for filling the form:

- The format is to be filled daily by counsellor / ANM on day to day basis.
- The information will be compiled from the "network clinic card / register" as per form requirement.

How-

Type of Information		Column No	Description
Sl. No		**1**	Serial number given by the Counsellor / ANM in order of contact and which will change every month. This will be useful in knowing number of migrants being contacted each month.
UID No. / Health Card No.		**2**	The health card is issued to every migrant identified at source / transit point. The counselor / ANM should ask for the health card number and note down the same in the form pertaining to "network clinic register" and in this form.
Name of migrant		**3**	Name of the migrant who has visited the clinic as per network clinic register
Age	**(yrs)**	**4**	Write completed age in years (as reported by the migrant)
Gender	**M/F**	**5**	Write the patient is "M" for male and "F" for female.
Status of patient	**New/ Old**	**6**	**NEW**: First time visit to the clinic /camp during the project period; **OLD**: Already visited the project clinic / project linked clinics or camp once before/earlier.
Diagnosis		**7**	Type of diagnosis carried out by the doctor and mentioned in the "Network Clinic Register"
Treatment prescribed		**8**	Based on the diagnosis, the doctor prescribes treatment. Write the details of treatment given by the doctor from "Network Clinic Register"
Medicine given from clinic/medicine prescribed / Both		**9**	1 = If medicines given from the project, 2= Prescribed the medicine but no medicines given, 3= both – prescribed medicines (to be purchased from shops etc. and also given from the project.
Number of condoms distributed (in pieces)		**10**	If condoms are distributed by the doctor or by the counselor /ANM, the number of condoms distributed in pieces to be recorded
Referrals made (if any)* **		**11**	If the doctor or the counselor/ANM have referred the patient to ICTC/ART/VDRL/SYPHILLIS/DOTS, then this will be filled in with the details of referrals made.

FORM 4: Clinic Daily Register

Date **Name of Doctor:** **Name of Location:**
Name of ANM/Counselor:

Sl. No.	UID No. / Health Card No.	Name of migrant	Age (yrs)	Gender M/F	Status of patient New/ Old*	Diagnosis	Treatment prescribed	Medicine given from clinic/medicine prescribed / Both**	Number of condoms distributed (in pieces)	Referrals made (if any)***
1	2	3	4	5	6	7	8	9	10	11

* **NEW** = First time visit to the clinic /camp during the project period; **OLD**: Already visited the clinic or camp atleast once.

** 1 = if medicines given from the project, 2= prescribed the medicine but no medicines given, 3= both – prescribed medicines and also given from the project.

*** 1 = referred to ICTC, 2= Referred to ART, 3= referred to TB DOT center

FORM 5: COUNSELING SERVICE REGISTER

Frequency: As and when counselling is given to a migrant – On day to day basis

Where: The counselling could be given at clinic, project office, in the field

By Whom: Counsellor / ANM

For what:

1. To understand on number of migrants counselled during a given month.
2. The Counsellor need to note down the risk pattern of the migrant, should assess the social and sexual network map of the client, should plan for a risk reduction to ensure that safe practices are adopted.
3. The register will also reveal on the profile of condom demand (in terms of most accessible outlets, most acceptable brands, most cost- effective and popular brand, group of clients having most demand for condoms by age group, by migrant profile).
4. To understand the issues related to uptake and access – which will help to design the mid-media and BCC activities, to position outlets in most accessible points.
5. To understand the demand – supply issues

Guidelines for filling the form:

- The format is to be filled daily by village volunteers/Block Supervisor
- The relevant information is to be compiled and fed on a monthly basis into the MIS

How-

Type of Information	Column No	Description
Sl. No	**1**	Serial number given by the Counsellor / ANM in order of contact and which will change every month. This will be useful in knowing number of registered migrants being contacted for counseling each month.
Date of Counseling	**2**	Enter the date on which counseling has been done to the registered migrant
Place of Counseling	**3**	Counseling can be conducted at project clinic, project linked clinics, camps or at the site level. The counselor /ANM will write name of the place where the counseling was conducted
Name	**4**	Name of the Migrant who has been given counseling
UID No./ Health Card	**5**	The health card is issued to every migrant identified at source / transit point. The counselor / ANM should note down the health card number of the migrant being counseled.
Gender (M/F)	**6**	In this column write the gender of the migrant who has been counseled - “M” for male and “F” for female.

Age	**7**	Write the age in years (as reported by the migrant)
New/old/Follow up	**8**	Write the nature of migrant for the counseling. Whether the migrant is first time being counseled during the project period (NEW). Already counseling previous time (Old). If it is follow up on the previous counseling session
Status of person	**9**	The counselor /ANM will write in this column the status of the migrant at the time of counseling – whether general or STI patient or migrant is a HIV positive.
Type of Counseling	**10**	The counselor / ANM will write the type of counseling conducted. The type of counseling could be 1. Risk assessment ; 2. STI counselling; 3. Pre-test counselling; 4. Post-test counselling; 5. ICTC follow up counselling; 6. Risk Reduction; 7. Couple counselling; 8. PLHA counselling; 9. Condom counseling.
Duration of Counseling	**11**	In this column the counselor / ANM will write time spent on counseling the particular migrant in question.
Whether Referred to ICTC (Yes / No)	**12**	If the migrant has been referred or advised for referral to ICTC during the counseling session then the counselor will write "yes / No".
Referred to ART/DOTS/VDRL/Syphilis	**13**	If the migrant has been referred or advised for referral other than to ICTC during the counseling session then the counselor will write the place of referral – to ART, DOTS, VDRL / syphilis test.
Number of condom distributed (in pieces)	14	If condoms are distributed by the counselor /ANM, during the counseling session, the counselor / ANM will write the number of condoms given /distributed in pieces.

Besides filling up the register in each case, the counsellor is expected to plan out risk reduction strategies for high risk migrants, who drop in the DIC, Clinic, Health Camps etc. The risk assessment should include social and sexual network mapping (the same will be part of training of counsellor/ANM). The assessment should clearly come out the risk pattern of the migrant – both at source and / or at destination, high or low risk. Based on which follow up plan to be worked out and risk reduction plan to be worked out in subsequent sessions.

For reporting of each case, the counsellor need to use separate sheets with following details:

1. Name of the Migrant 2. Age 3. Sex 4. Marital Status 5. Address at destination

6. Social and Sexual Network map 7. Risk categorisation 8. Follow up plan and dates

FORM 5: Counseling service Register																
Sl. No	**Date of Counseling**	**Place of Counseling**	**Name**	**UID No.**	**Gender (M/F)**	**Age**	**New/old/Follow up***	**Status of person**			**Type of Counseling****	**Duration of Counseling**	**Whether Referred to ICTC (Yes / No)**	**Referred to ART/DOTS/VDRL/Syphillis**	Number of condom distributed (in pieces)
		Camp /Site / Project Office/ DIC						**General**	**STI patient**	**HIV +ve**					
* **New**= first time being counseling during the project period; **Old** = Counseled in earlier contact; **Follow up**= Counseled for follow up visits - STI, ICTC, ART, DOT etc.															
**** 1. Risk assessment; 2. STI counselling; 3. Pre-test counselling; 4. Post-test counselling; 5. ICTC follow up counselling; 6. Risk Reduction; 7. Couple counselling; 8. PLHA counselling; 9. Condom counselling, 10-Family planning, 11-Stress, 12-Alcohol, 13-Nutrition, 14-Hygiene**															

FORM 6 & 6A: MONTHLY CONSOLIDATION REFERRAL REGISTER AND REFERRAL SLIPS

Frequency: To be filled in on day to day basis - based on the filled in referral slips submitted by the ORW/Counsellor/ANM/Project Manager.

Where: At the NGO / TI level

By Whom: By the Counsellor / ANM

For what:

1. To know on the number of referrals made during a given period.
2. To know on the type of referrals made from the project
3. To know on the total tested during a given period.
4. To track the number of patients treated at referred centres.

Guidelines for filling the Referral Slips:

- The counsellor/ ANM will fill for each migrant referred to ICTC, ART, DOTS for TB, SYPHILLIS screening on day to day basis.
- The counter foil of the referral slip is to be kept / stored in structured manner at the project office / clinic.
- The referral slips should be prepared in triplicate:
  - Slip 1: To be retained at the referred centre
  - Slip 2: To be collected by the counsellor/ANM of the TI from the referred centre at the every reporting month or suitable and agreed time period.
  - Slip 3: To be given by the referred centre back to the client after providing services for which the client has been referred.

Guidelines for filling the consolidated referral register:

- The register is filled in by the counsellor / ANM for each migrant referred to ICTC, ART, DOTS for TB, SYHILLIS screening on day to day basis based on referral slip.
- On monthly basis, a fresh page is used to start the next month's referrals information.
- The register is maintained at the NGO /TI office.

How-

CONSOLIDATED REFERRAL REGISTER

Type of Information	Column No	Description
Sl No.	**1**	Serial number starting from "1" will be given by the Counsellor / ANM in order of referrals made through referral slip. Every month, the number will start a fresh. This will be useful in knowing number of registered migrants being contacted for referred each month.
Date	**2**	The date is the date on which the referrals has been made

Name of the Migrant	**3**	Name of the migrant who has been referred will be written (as per referrals slip)
ID No. Health Card No./UID No.	**4**	The health card is issued to every migrant identified at source / transit point. The counselor / ANM should note down the health card number of the migrant being referred.
Referred to (ICTC / ART / TB /STI /DOTS for TB/Detox center/ Syphillis	**5**	The counselor will write the type of referral made (whether made to ICTC, ART, TB, STI, DOTS for TB / Detox Center / Syphilis test.
Accompanied by (PEER LEADER / ORW / Counsellor/PM / Self)	**6**	IF the referrals made is accompanied by any staff member (including PE), then the counselor will write cadre of the person who has accompanied.
Status on referral (whether tested - date of testing)	**7**	Once the information on the tested cases from the referral centers are received, the counselor / ANM will write against corresponding referred migrant the date of testing done. This information should be backed up with the written information from ICTC counselor (stamped on the counterfoil of the slip).
Remarks / comments	**8**	If the counselor / ANM wants to add or make any information or comments on the referrals made or tested then it has to written in detail for future reference.

REFERRAL SLIPS

1 **(Slip for Facility/ referral center)**

-Name of the project / TI-

-Address-

Slip Number:

Name of the Client :_____

Number in Health Card/UID:_____

Referred to which type of Facility:_____

Name of the Facility:_____

Address of the facility

* Referred by (Name): _____

Date of referral:

Reason for Referral:

Syphilis results:

Name of the accompanying person (if any)

(Signature of the TI staff-in-charge) (Signature of the staff-in-charge of the referral centre)

2 **(Slip for NGO / TI)**

-Name of the project / TI-

-Address-

Slip Number:

Name of the Client :_____
Number in Health Card/UID:_____
Referred to which type of Facility:_____
Name of the Facility:_____
Address of the facility
* Referred by (Name): _____
Date of referral:
Reason for Referral:

Syphilis results:

Name of the accompanying person (if any)

(Signature of the TI staff-in-charge) (Signature of the staff-in-charge of the referral centre)

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3 **(Slip for the client)**

-Name of the project / TI-

-Address-

Slip Number:

Name of the Client :_____
Number in Health Card/UID:_____
Referred to which type of Facility:_____
Name of the Facility:_____
Address of the facility
* Referred by (Name): _____
Date of referral:
Reason for Referral:

Syphilis results:

Name of the accompanying person (if any)

(Signature of the TI staff-in-charge) (Signature of the staff-in-charge of the referral centre)

* Referred by: ORW, PEER LEADER, Counsellor, ANM, Project Manager.

The referral slips should be prepared in triplicate:

Slip 1: to be retained at the referred centre

Slip 2: to be collected by the Project Manager / Counsellor of the Migrant TI from the referred centre at the end of every reporting month

Slip 3: to be given by the referred centre back to the client after providing services for which the client has been referred

FORM 6: MONTHLY CONSOLIDATION REFERRAL REGISTER

For the Month:

Sl No.	Date	Name of the Migrant	ID No	Referred to (ICTC / ART / TB /STI (DOT)/Detox center/ Syphillis	Accompanied by (PEER LEADER / ORW / Counselor/PM / Self)	Status on referral (whether tested - date of testing)	Remarks / comments

FORM 7: STI MEDICINE STOCK REGISTER

Frequency: On day to day basis.

Where: At the health camps / PP clinic

By Whom: Counsellor / ANM

For what:

1. To keep track of the stock position of the STI medicines.

2. To ensure that no stock out of drugs

Guidelines for filling the form :

- To be filled in by the counsellor / ANM after medicine is given to each patient who has visited project/project linked clinic.
- For each medicine, separate sheet is to be maintained and tracked on the basis of consumption/ distribution.
- At the end of each clinic day the stock has to be tallied with the stock available at the clinic.

How-

The information set mentioned in the register is self explanatory.

FORM 7: STI MEDICINE STOCK REGISTER

Name of the Medicine:

Date	Opening Balance	Received / Purchased	Number of units / packets of medicine issued	Closing Balance

Guidelines:

- ✓ For each Medicine, a separate sheet to be maintained (in form of register) and stock to be tracked on day to day basis
- ✓ Medicine stock registers (to be filled in by Nurse / Counselor) and maintained and kept at the project clinics.
- ✓ At the end each clinic day the stock has to be tallied with the stock available at the clinic.

Frequency: As and when the medicines are consumed as per doctors' prescription on day to day basis.

FORM 7A: Indent register of essential STI/RTI drug

Guidelines for filling the form :

- The clinic / project should have supply of drugs for at least three months.
- There should be a critical level of stock for each STI/RTI drug. Whenever supply reaches less than one quarter of supply the Counsellor / ANM should indent the drug (s).
- The counsellor / ANM should follow the policy of FEFO (First Expiry First Out).

How-

The information set mentioned in the register is self explanatory.

FORM 7A: Indent register of essential STI/RTI drug

Date of Indent:

Sl No.	Name of the Drug	Balance on the day of indent	Amount to be indented	Amount received	Remark
1.	Azithromycin (500m mg)				
2.	Cefexime (200 mg)				
3.	Metronidazole (400 Mg)				
4.	Doxicycline (100 mg)				
5.	Acyclovir (400 mg)				
6.	Inj Benzathine Penicilline (2.4 million unit)				
7.	Fluconazole (150 mg)				
8	Any other (specify)				

Note:

1. The clinic must have supply of drug for at least three month.
2. There should be a critical level of stock for each STI/RTI drug. Whenever supply reaches less than one quarter of supply the ANM should indent the drug.
3. The ANM should follow the policy of FEFO (First Expiry First Out).

FORMAT 8: DROP IN CENTER (Safe Space) REGISTER

Frequency: On day to day basis.

Where: At the drop centre set up by the project

By Whom: Counsellor / ANM

For what:
1. To help keep track of the number of migrants visiting the Drop-in-centre in a given month.
2. To know the purpose of each migrant visiting the drop-in-centre.
3. To know on the number of condoms distributed through drop-in-centre.
4. To know on the timings of the visits made by the majority of migrants that can help in contacting them for programme deliverables.
5. To know in rescheduling the timings of project based clinics.

Guidelines for filling the form:

- The register with the set of information to be captured should be in the form of a register.
- Each migrant visiting the Drop-in-centre to fill in the register on the details of the visit made.
- The counsellor /ANM or person in-charge has to ensure that all the visitors are migrants and each one fills in the register.
- The in-charge also has to maintain the decorum of the Drop-in-centre (the purpose for which it has been established.)

How- The information set mentioned in the register is self explanatory.

FORMAT 8: DROP IN CENTER (Safe Space) REGISTER

Name of the DIC (location area): **For the month:**

Sl No.	Date of visit	Name of the HRG	UID number of HRG	Visiting time		Purpose of Visit*					
						Rest	Recreation	Condom demo	Clinical Services	Referrals	Counsellin
				From	To						
Total											

- **Please tick (√)** in the appropriate column.

GUIDELINES:

- It is recommended that the point person for managing the Safe space should be the person from the community, who will be appointed by the Program Manager. The Program Manager is accountable for over all maintenance of the drop in center.
- Every migrant visiting the DIC needs to fill in the register.
- The illiterate migrant will be assisted by the DIC in-charge / by the program staff deputed by PM.

FORM 9: NGO level Capacity Building Register
(for Project Staff only)

Frequency: As and when training on skill building exercises are conducted for the TI project staff.
Where: At the Project office

By Whom: Project Manager

For what:

1. To help document the training activities conducted by TI project for its staffs

2. To help keep track of training of staffs/ volunteers by SACS/ STRC

3. To help document the capacity building/ sensitisation activities done for stakeholders by the project.

Guidelines for filling the form:

- The register need to be filled in by the Programme Manager at the end of each month.

How-

FORM 9: NGO level Capacity Building Register

Type of Information	Column No	Description
Sr. No.	**1**	Serial number starting from "1" will be given by the project manager in order of training conducted. . This will be useful in knowing number of training conducted in a given period.
Date	**2**	Write the starting date of the training
Organized by & where (venue)	**3**	Write who has organized the training and where the venue of training
Topic	**4**	Write the topic (thematic area) of the training
Type of Participants	**5**	Specify the type of participants for example was it for project director(NGO), project Managar, Counsellor, ANM, M&E officers, Accountant, ORW or PE. IF it is combination then please mention the cadres covered.
Number of Participants	**6**	For each training conducted, give total number of participants (male separate and female separate)
Duration	**7**	Please mention the duration of the training (for example if it is one day training then in hours) else if it is more than day, then in days
Methodology	**8**	Write how the training was conducted? For example, was it Role plays, only lecture, games, class room, exposure visit, audio visual, slide etc or combination of two or more methods used during the training
Name of Resource person/s (if hire from out side NGO)	**9**	List the names of resource person who have hired or invited with their source organization).

FORM 9a: Secondary level stake holder Capacity Building Registers

Type of Information	Column No	Description
Sr. No.	**1**	Serial number starting from "1" will be given by the project manager in order of training conducted. . This will be useful in knowing number of training conducted in a given period.
Date	**2**	Write the starting date of the training
Organized by & where (venue)	**3**	Write who has organized the training and where the venue of training
Topic	**4**	Write the topic (thematic area) of the training
Type of Participants	**5**	Specify the type of participants for example was it – Police, Religious leaders, factory owners / supervisors, construction owners, Gate keepers, Condom Depot Holder, HCPs. If it is combination then please mention the cadres covered.
Number of Participants	**6**	For each training conducted, give total number of participants (male separate and female separate)
Duration	**7**	Please mention the duration of the training (for example if it is one day training then in hours) else if it is more than day, then in days
Methodology	**8**	Write how the training was conducted? For example, was it Role plays, only lecture, games, class room, exposure visit, audio visual, slide etc or combination of two or more methods used during the training
Name of Resource person/s (if hire from out side NGO)	**9**	List the names of resource person who have hired or invited with their source organization).
Outcome	**10**	Write on what is expected from this training from conducting training to the secondary level stake holders

FORM 9: NGO level Capacity Building Register
(for Project Staff only)

Sr. No.	Date	Organized by & where (venue)	Topic	Type of Participants @	Number of Participants		Duration	Methodology *	Name of Resource person/s (if hire from out side NGO)
					M	F			

@ Specify Project Director, Project Manager, M&E, Accountant, Counselors, ORWS, PEs, HCPS

* Role plays, lecture, games, class room, exposure visit, audio visual, slide etc.

Form 9a: Secondary level stake holder Capacity Building Registers

Sr. No.	Date	Organized by	Topic	Type of Participants @	Number of Participants		Duration	Methodology *	Resource person/s	Outcome
					M	F				

@ Specify – Police, Religious leaders, factory owners / supervisors, construction owners, Gate keepers, Condom Depot Holder, HCPs

* Role plays, lecture, games, class room, exposure visit, audio visual, slide etc.

FORMAT 10: Advocacy Activity Report

Frequency: As and when an advocacy activity has been conducted. Each advocacy or advocacy related activity one form to be used by the project.

Where: At the Project office

By Whom: Project Manager

For what:

1. To help keep track of the number of advocacy events conducted by the project.
2. To know the purpose and expected outcomes of advocacy activities conducted.
3. To know on the type of stakeholders with whom the advocacy was conducted.
4. The documented form will help the project know the type of issues raised and solutions to address challenges in the program.
5. To prepare road map to scale up successful initiatives as well as road map to address challenges.

Guidelines for filling the form:

- After completing an advocacy activity, the Project Manager will fill in this form.
- Each advocacy, one set of form is to be filled in.
- The project Manager needs to ensure that each advocacy activity conducted should have set of action points as part of the follow up activities.
- Each filled in form will be kept in a file in sequential order (by date and month).
- On monthly basis, count number of advocacy activities conducted during the reporting month and report in the SIMS/CMIS
- All the filled in forms should be stored at the TI office and should be available for future references.

How-

Advocacy Activity Report guidelines

Advocacy activity No.: Every advocacy activity conducted should be given a serial number. The number will start from "1".

Date & Month: Write the date and month of the advocacy activity was conducted.

Place of activity held: Write the place where the advocacy activity conducted: for example: " District community Hall".

What was the issue/barrier? Write the purpose of the advocacy activity conducted - Why the advocacy activity was initiated. Spell out the issues or barriers which will be the focus during the advocacy meeting.

How was the issue/barrier identified? Spell out on how these issues or barriers emerged in the program. Give actual situation example (not more than 3-4 lines).

What was the advocacy objective? (What did you want to achieve?): In this column, spell out the objective of the advocacy activity conducted. Based on the issues and barriers spelled out above, what the project is looking forward from this activity.

Whom did you advocate with? Write the cohort name (with names of people interacted or attended as part of annexure (Cohort could be - madams, pimps, local goondas, police, government officials, general community, family members, local military, religious groups, regular partners, clients, other)

Whether the local MIGRANT community members were involved in the meeting to resolve issue/barrier?: If MIGRANT members were involved in the meeting then circle on " Yes" else circle on "No".

What methods did you use? Give details (in not more than 3-4 lines) the methodology used during the meeting – for e.g. lecture/presentation, individual meeting, group meeting, health services, exhibitions, street plays, other)

What difficulties did you face in addressing the issue? While conducting the advocacy meeting, if any difficulty was encountered – for example place was not ideal to discuss sensitive matters, right participants were not invited etc.

Follow action on the advocacy activity: (action points, responsible persons with time line): Each advocacy meeting held should conclude with action points on the issues and barriers discussed with a time line**.** The action points should be clearly spelt out with each person's responsibility to act on the action points.

Meeting Conducted By: Write who was the point person or cohort in leading the activity – for example, was it project director or project manager or counsellor or ORW. The project Manger will give the responsibility to conduct the meeting well in advance and preparation depending on the topics to be discussed.

FORMAT 10: Advocacy Activity Report

Advocacy activity No. ____ **Date & Month:**

Place of activity held:

1. **What was the issue/barrier?**

_____

_____

2. **How was the issue/barrier identified?** _____

3. **What was the advocacy objective? (What did you want to achieve?)**

_____

_____

4. **Whom did you advocate with?** (e.g. madams, pimps, local goondas, police, government officials, general community, family members, local military, religious groups, regular partners, clients, other]

_____

_____

5. Whether the local HRG community members were involved in the meeting to resolve issue/barrier?: Yes / No

6. **What methods did you use?** (e.g. lecture/presentation, individual meeting, group meeting, health services, exhibitions, street plays, other)

_____

_____

7. **What difficulties did you face in addressing the issue?**

_____

_____

8. **Follow action on the advocacy activity: (action points, responsible persons with time line)**

Action points emerged	***Person(s) responsible to accomplish the action point activities***	***Time line***

Meeting conducted by:

Guidelines:

- Frequency: Whenever advocacy activity is organized for the TI migrant project.
- Use one set of form for each advocacy activity conducted.
- This form is to be filled in by the program manager.
- Each filled in form will be kept in a file in sequential order (by date and month).
- On monthly basis, count number of advocacy activities conducted during the reporting month and report in the SIMS/CMIS.

FORMAT 11: CRISIS MANAGEMENT REGISTER

Frequency: As and when an incident of violence or harassment reported at the NGO or to a staff of TI project.

Where: At the Project office

By Whom: Project Manager

For what:

1. Helps in knowing the number of violence / harassment incidents reported by the core group.
2. Helps in knowing the type of violence or harassment occurred which will help the project to address the issues as part of the project activities.
3. To know on the reported incidents have been resolved within 24 hours.

Guidelines for filling the form:

- Once an incident of violence or harassment has been reported, the project manager (in absence, the ORW or the counsellor) will fill in the form. After completing an advocacy activity, the Project Manager will fill in this form.
- Each advocacy, one set of form is to be filled in.
- The project Manager needs to ensure that each advocacy activity conducted should have set of action points as part of the follow up activities.
- Each filled in form will be kept in a file in sequential order (by date and month).
- On monthly basis, count number of advocacy activities conducted during the reporting month and report in the SIMS/CMIS
- All the filled in forms should be stored at the TI office and should be available for future references.

Name of ORW/PEER LEADER: Write the name of the PEER LEADER and the ORW in charge of the area from the reporting has been made.

Name of site /site code: Name of the site from where the incident was reported.

Date of incident: Date of the incident occurred as reported by the MIGRANT.

Name of the first informant: Name of the person who has reported the incident for the first time

Number of people affected: Write number of people who were affected from the violence / harassment reported as reported by the informant(s).

Type of incident: Write whether the incident is Harassment in nature or violence

Who committed the incident? From the list please tick the appropriate box as reported by the informant on who has committed in the incident. If there is more than one person committed the incident, then tick as tick as applicable.

Whether the incident reported, addressed within 24 hours: If the incidence of harassment or violence has been addressed from the time of reporting then circle on "YES" else on "NO".

The role of crisis management in addressing the issue (not more 200 words): Briefly describe on the process followed in resolving the issue by the project.

A brief description of the incident (not more than 200 words): Briefly describe on the incident reported with the support of informants and site level observations.

FORMAT 11: CRISIS MANAGEMENT REGISTER

(TO BE FILLED IN BY PROGRAM MANAGER)

When an incident of violence / harassment takes place in the migrant, the following details are to be documented after it has been addressed.

(Use one form for one incident)

Name of ORW/Peer Leader Name of site /site code:

Date of incident_____

Name of the first informant:_____

Number of people affected _____

Type of incident Harassment ☐ Violence ☐

Who committed the incident? (Tick as applicable)

Pressure groups ☐	Government officials ☐
Local leaders ☐	General community ☐
Police ☐	Labour Contractor ☐
Military ☐	Religious groups ☐
Madams /Pimps/ Bar ☐	Regular partner ☐
Managers and Owners ☐	Landlord/House Owner ☐
Local gundas ☐	Health care provider ☐
Fellow employee ☐	Employer ☐
Other (Specify) ☐	

Whether the incident reported, addressed within 24 hours? Yes /No

The role of crisis management in addressing the issue (not more 200 words):

A brief description of the incident (not more than 200 words):

Follow up action points with responsibility and timeline:

FORMAT 12: MID – MEDIA / EVENT REGISTER

Frequency: As and when an event is conducted. The form to fill up after the event is completed and documented for future reference.
Where: At the Project office
By Whom: Project Manager
For what:

1. Helps in knowing the number of events held by the project to strengthen the program in a given period.
2. Helps in knowing the type of events organised
3. To know on the coverage of the project related events.

Guidelines for filling the form:

Date	1	Enter the date of the event held. If the event has been for more than 1 day then enter the starting date of the event
Type of Event	2	Mention the type of event organised – type of events could be street plays, film shows
Place	3	Write the place of conducting a mid media or an event
Topic	4	Every mid media or event will have a thematic topic as part of event. Write the thematic topic.
Duration	5	IF the event was for one day then write in number of hours. If the event is more than day then mention number of days the event was organised.
No. of people Participated	6, 7 and 8	Write number of males, females and transgender attended the event. This should be based on the list of names recorded during an event organisation.
Condom Demo (No. of Times demo conducted)	9	Record number of times the condom demo was done. This includes each staff or resource person responsible conducting the condom demo. Count the number of demos each staff member or resource persons have conducted and add up the total demo done during an event.
Type of IEC material used	10	Enter type of materials used and number of materials used in the event.
IEC material distributed	11	If any IEC has been distributed, then mention type of IEC material distributed during the event. If no materials has been distributed, then write NO
	13	If distributed in the above column, then mention number of materials distributed during the event. If no materials have been distributed then write "0".
No. of condoms Distributed	14, 15	No. of target groups did condom redemo during the sessions.
No. of people referred to referral centers	16	During an event, if any of the migrants have been referred to ICTC, ART, DOT or FOR SYPHILLIS test, then enter number of migrants referred. Each referrals should be accompanied by referral slip

FORMAT 12: Mid – Media / Event Register

Date	Type of Event	Place	Topic	Duration	No. of people Participated			Condom Demo (No. of Times demo conducted)	Type of IEC material used	IEC material distributed		No. of target group did redemo condoms		No. of people referred to referral centers
					Male	Female	Trans Gender			Type	No.	Correctly	Incorrectly	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

FORMAT 13: Linkages strengthening register

Frequency: As and when a linkage has been established by the project then this form to be updated.

Where: At the Project office

By Whom: Project Manager and ORW

For what:

1. Helps in type of linkages available in a given site or a geographical area to support on HIV program.
2. Helps in knowing the number of linkages established by the project during the project period.
3. Helps in knowing the type of linkages established.

Type of Information	Column No	Description
Sl. No	**1**	Serial number starting from "1" will be given by the project manager as and when a linkage has been established. This will be useful in knowing number of linkages established during a project period
Date	**2**	Enter the date of initiation for establishing the linkages with the particular organization / institutions or individuals
Name of Institution/ Individual identified	**3**	Once the linkage is established, write the name of the institute / organisation / individual – the purpose of linkages could for Referral Network and Network with other NGOs for various other services for its Target Group. IF more than one institute is linked, then enter the second one in the next row
Type of Service provided by Institute/Individual	**4**	Enter the type of services which each of linked organization / institutes / individuals are providing and are going to provide to the target group or to the NGO for the HIV / AIDS program.
Name of the Point Person for contact	**5**	For each established linkages, identify a point person to be contacted from time to time**.** Enter the name of the point person for future use. Keep updating on the point person(s), if there is change in the point person at the linked organization / institute.
Contact Details	**6**	Enter the contact details of the institute / organization and communication address with phone, email etc.

FORMAT 13: Linkages strengthening register*

Sl. No	Date	Name of Institution/ Individual identified*	Type of Service provided by Institute/Individual**	Name of the Point Person for contact	Contact Details (Address, Phone E-mail etc.)

* Referral Network and Network with other NGOs for various other services for its Target Group

** Brief on the type of services provided by the institute or facility or individual which could be linked with the HIV/AIDS program

FORMAT 14, 14A & 14B: Stock Maintenance Register

Frequency: As and when the condoms/lubricants are received from SACS/other sources and issued to NGO/TI staff for further distribution or sale to the migrants through the project.

Where: At the Project office

By Whom: Project Manager

For what:

1. To know on the condom/lubricant (free /social marketing) stock at TI level.
2. To know on the supply requirement from SACS and from other sources.
3. To know on the distribution pattern of free and social marketing.
4. To know on the quantity of condoms/lubricant distributed or sold through outlets and direct through project staff.

Format 14 and 14A: Stock Maintenance Register – free condom and social marketing

Type of Information		Column No	Description
Date of receiving or purchased		**1**	Write when the stock of condoms/lubricants received / purchased from SACS or from different agencies. If more than one brand is received or purchased on the same date, then mention separately for each brand in different rows.
Brand Name		**2**	Write the brand name of the condom/lubricant received or brought
Received from / purchased from		**3**	Write from where the condom/lubricant mentioned above has been received or purchased from different agencies.
Batch Number & Manufacturing Date		**4**	Batch number and manufacturing date is available in every package of condom/ lubricants. Enter the batch number and manufacturing date written on the packets received or purchased
Expiry Date		**5**	Write the expiry date of the condom/ lubricant received which is mentioned on each packet.
Requisition No.		**6**	Every NGO / TI needs to maintain a requisition slip (which will used for issuing by the project staff . This slip should be filled in by each project staff to get requirement for further distribution to migrants through various levels
Distributed to*		**7**	Write to whom the condom/ lubricant were distributed in codes: 1. PEER LEADER; 2. ORW; 3. ANM / Counsellor; 4. Condom outlet boxes; 5. Identified shops
Quantity	**Opening Balance**	**8**	Write the opening balance (in pieces) for brand mentioned in column 2.
	Received	**9**	Write the quantity received (in pieces) during the month for the brand mentioned in column 2.
	Distributed	**10**	Write number of quantity (in pieces) distributed through (as per column 7)
	Closing Balance	**11**	Write the closing balance – calculation (opening balance +received) – distributed = closing balance.
Signature of the authorized TI staff		**12**	The project manager for every entry made in the form to sign as token of authenticating on the transaction happened.

FORMAT 14B: CONDOM OUTLET REGISTER

Type of Information	Column No	Description
Date	1	Write the date of entering the information on outlet related issue. All the completed transaction related to outlet management should be entered on the same day. IF a new outlet has been identified then write the date on which the new outlet has been located.
Area	2	Write the area where the outlet in question is located
Name of ORW in charge for the area	3	Write the name of the ORW who is in charge of the area
Name of outlet holder	4	Write the name of the outlet holder (identified shop, restaurant etc.).
Date of Training (to the in charge of the outlet holder)	5	Write when the outlet in charge has been trained on managing of condom (free or social marketing).
Location of the outlet@	6	Mention the location details where the outlet is located. Few examples of location could be: Urban slum, hotel, Pan Shop, factory out lets, rest room house, etc
Type of outlet	7	Write type of the outlet - Petty Shop, Pan shop, factory rest room, PEER LEADER / MIGRANT house / work place, chemist, Condom Vending Machine etc.
Date of Discontinuation (if Discontinued)	8	If an outlet has been discontinued from the project list of outlets, mention when it was discontinued.
Reason for Discontinuation	9	If an outlet has been discontinued, mention reasons for its discontinuation. These reasons should be documented in the monthly review meeting.

FORMAT 14: Stock Maintenance Register – Free Condom

Date of receiving or purchased	Brand Name	Received from / purchased from	Batch Number & Manufacturing Date	Expiry Date	Requisition No.	Distributed to*	Quantity				Signature of the authorized TI staff
							Opening Balance	Received	Distributed	Closing Balance	
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

- 1. PEER LEADER; 2. ORW; 3. ANM / Counselor; 4. Condom outlet boxes; 5. Identified shops

FORMAT 14A: Stock Maintenance Register – Condom Social Marketing

Date of receiving or purchased	Brand Name	Received from	Batch Number & Manufacturing Date	Expiry Date	Requisition No.	Distributed to*	Quantity				Signature of the authorized TI staff
							Opening Balance	Received	Sold	Closing Balance	
1	2	3	4	5	6	7	8	9	10	11	12

- 1. PEER LEADER; 2. ORW; 3. ANM / Counselor; 4. Condom outlet boxes; 5. Identified shops

FORMAT 14B: CONDOM OUTLET REGISTER

Date	Area	Name of ORW in charge for the area	Name of outlet holder	Date of Training (to the in charge of the outlet holder)	Location of the outlet	Type of outlet*	Date of Discontinuation (if Discontinued)	Reason for Discontinuation
1	2	3	4	5	6	7	8	9

* Petty Shop, Pan shop, factory rest room, PEER LEADER / HRG house / work place, chemist, Condom Vending Machine etc

FORMAT 15: Project Staff recruitment register

Frequency: As and when new staffs are recruited in the project or discontinued from the project, this register needs to be updated. This register is applicable for all staff member including Peer Leader.
Where: At the Project office
By Whom: Project Manager
For what:

1. The filled in register reveals number of staff on board at any given point of time.
2. This register reveals information in brief of the staff who has joined the project or who has resigned / discontinued from the project.
3. The register gives information on each staff on their qualification, years of experience, and special skills posses.

Type of Information	Column No	Description
Sr. No	**1**	Serial number will start from "1". Each staff member details will be entered in one row. The second staff member will be entered in second row. The number will continue as the staff keeps adding to the project as per project plan.
Name of staff	**2**	Enter name of the staff who has been recruited
Age	**3**	Enter age of the staff (as in bio-data or CV)
Gender	**4**	Enter the gender of the staff (Male = "M", Female = "F" and transgender = "TG")
Marital status	**5**	Enter the martial status of the staff recruited (for example: Unmarried, Married, Divorce, Widow, Widower)
Qualification	**6**	Enter the qualification of the staff member (as mentioned in the bio-data or CV. Enter highest qualification attained)
Address & contact details	**7**	Enter the address and contact details of the staff recruited. The information will initially come from bio-data or CV submitted and later updated as and when the staff changes his residential or telephone numbers. Every staff to inform the NGO/TI on the change of address and mobile numbers
Languages known	**8**	Enter the languages known by the staff member. (for example, Hindi, English, Oriya, Gujarati, Tamil, Telugu etc.)
Yrs. Of experience in HIV/AIDS	**9**	Enter the years of experience (for example "3 years") in HIV/AIDS field. This should be taken from the bio-data or CV submitted to the NGO / TI.
Special skills (if any)	**10**	Enter if the staff has attained any special skills. (knowledge on computer application – excel, word, internet, web designing etc.)
Date of joining	**11**	Enter when the staff has joined. The date of joining should be in (dd/mm/yy)
Date of Resignation	**12**	When any staff members resigns or discontinues, enter the date of resignation (as mentioned in the resignation letter submitted). For others this column will be left blank and will be updated if the staff member(s) resign or discontinues.
Reason for Resignation	**13**	When any staff member resigns, then the reason for resignation should be mentioned. The reasons given should be mentioned in the resignation letter by the staff member while submitting the resignation.

FORMAT 15: Project Staff recruitment register*

Sr. No	Name of staff	Age	Gender	Marital status	Qualification	Address & contact details	Languages known	Yrs. Of experience in HIV/AIDS	Special skills (if any)	Date of joining	Date of Resignation	Reason for Resignation
1	2	3	4	5	6	7	8	9	10	11	12	13

* For all category of staff including PEER LEADER

FORMAT 16: MIGRANT PROJECT
(Field Supervision Report- for Project Manager)

Frequency: After completing every field visit made by the program manger. As and when the project manager completes his/her field area visit, the project manager has to prepare a back office report on the activities conducted, observed and action taken.

Where: At the Project office

By Whom: Project Manager

For what:

1. To know on the activities conducted by the project manager at the field level.
2. To know on the issues arose during the field visit and status on the issues (action taken).
3. This register reveals information in brief of the staff who has joined the project or who has resigned / discontinued from the project.
4. The register gives information on each staff on their qualification, years of experience, and special skills posses.

Name of the field	Description
Date of Field Visit:	Enter the date on which the program manager has made the field visit. If it is more than day then enter dates (for example 2-3 Nov 2010)
Location:	Enter the place or places visited by the program manager
Name of the ORW:	Enter name of the ORW who is in charge of the place(site) where the program manager has visited
Name of the PEER LEADER:	Enter the name(s) of the PEER LEADERs who is in charge of the site (hotspots).
Time of visit:	Enter the time of the visit made (for example from 11 a.m. to 3 p.m.)
Date of last visit made Enter the date of the last visit made by the program manager.	
Number of migrants met at the site: Enter number of registered migrants met during the visit made (in numerical).	
Name of the Migrants met (in the below format): Enter the names of migrants met as per the format below.	
Observation on BCC session: Enter in detail as per the format, the observation made during the visit on BCC session at the field by PEER LEADER and ORW. Also enter the support provided on the BCC session on the spot.	
Observation made at the site: Based on the table, observations have to be made by the project manager at the site level. The broad observation expected for reporting in the back office report is on - condom depot functional, condom availability, knowledge on condom usage, overall outreach level performance, crisis management.	
Any other observation made: the program manager also make other observations like migrant perception on the program inputs and ask for feedback on how to improve further etc.	
Action taken: The program manager during the visit needs to give action points at the field itself and also to be documented through the back office report like this. As	

per the format, the project manager will detail out the action points agreed with time line and person responsible.

FORMAT 16: MIGRANT PROJECT
(Field Supervision Report- for Project Manager)

Date of Field Visit: **Location:** **Time of visit:**

Name of the ORW:

Name of the Peer Leader:

Date of last visit made:

Number of migrants met at the site:

Name of the Migrants met (in the below format)

SL. No	Name	Gender and Age
1.		
2.		
3.		

Observation on BCC session:

PARTICULARS	Comments / Remark / Action suggested
Nature of the session (One-to One, One to Group etc)	
Duration of the session (in minutes)	
Number of members in session (if the session is not one-to-one)	
Did the BCC culminate in uptake of any services (Yes/No)	
Which Service?	

Observation made at the site:

Services	Remark
Condom Depot functional	
Condom Availability	
Knowledge on condom usage	
Outreach level performance	
Functioning of Crisis Management Cell	

Meeting with Stakeholders:

SL. No	Name	Since when associated with the programme	How he/she can contribute to the program	What are the feedback on the program
1.				
2.				
3.				

Other Observations (if any):

Action Taken:

Action points / deliverables suggested	Persons responsible	Time line

SIMS Format for Destination Migrant Interventions

Monthly CMIS REPORTING FORMAT for TI Migrants at Destination Interventions					
TI code:		**Name of NGO:**			
State:		**District:**		**Block/Mandal:**	
Contract Period:				**Reporting Month:**	
Target Population as per Contract:			**No. of sites/hotspots in the project**		
Name of In-charge:			**Phone No.:**		
Email-ID :			**Having NGO STI Clinic (Y/N):**		

Indicators for reporting	Total
Section 1 : Coverage	
Total number of individual target population registered with the project till this month	
Of the total number registered, number of new individual registered this month:	
Number of total individuals contacted (provided any or all project services - e.g condom, Lubricant distribution, Information on BCC, clinic services)	
Number of group meeting (FGDs) conducted during the month	
Number of Health Camps organised during the month	
Number of persons covered through Health Camps conducted during the month	
Number of persons covered through exhibitions conducted during the month	

Section 2 : Stock Management

Type of Commodity	Opening Stock at the beginning of month	Received / purchased during the Month	Number distributed /sold	Closing Stock at the end of the month	Status on Buffer Stock	
					Sufficient for next three months (Yes / No)	Quantity
Free condoms				0		
Condom Social marketing				0		

Section 3 : Condoms	
Total number of outlets established for social marketing of condoms till this month	
Section 4 : Linkages	
Total number of individuals referred to ICTC during the month	
Number of referred individuals tested at ICTC during the month	
Number of individuals found HIV positive during the month	
Number of postive individuals under went CD4 testing during the month	
Total number of target population currently on ART	
Total number of target population currently on treatment for TB/DOTs	
Section 5 : Clinics	
Total number of individuals visited any project linked clinic/Govt./PPP clinics during the month	
Of the total number visited , number treated for STI symptoms during the month	
Number of individuals counselled by the ORW/VPL during the month	
Section 6 : Enabling Environment	
Total number of sensitisation meetings organised during the month: (eg:-street plays, Film shows)	
Section 7 : Program Management	
Number of project review meetings conducted by the project manager during the month	
Number of days spent in the field for monitoring of activities by the project manager during the month	
Number of days spent in the field by the ORW/ Health Educator for providing supportive supervision to the VPLs	
Number of Trainings conducted during the month	
Section 8 : Financial Management	
Amount sanctioned as per contract for the contract period	

Status on expenditure by module

Type of Module (core financial components)	Opening balance at the beginning of this month	Received during the month	Expenditure made during the month	Closing Balance at the end of this month
Infrastructure Cost				**0**
Human Resource				**0**
Program Delivery				**0**
Services & Commodities				**0**
Miscellaneous				**0**
Total	**0**	**0**	**0**	**0**

Amount for which SOE submitted for this month	
Section 9 : Human Resource	
Number of outreach workers sanctioned (as per contract)	
Total number of outreach workers currently working with the project	
Total number of Volunteer Peer Leader sanctioned (as per contract)	
Total number of Volunteer Peer Leader currently working with project.	
Number of other staff position vacant witnessed during the month (if any)	
Total number of New staff members recruited during the month (if any)	

5.21 REPORTING TOOLS FOR TRANSIT INTERVENTIONS

RESPONSIBILITY FOR DATA COLLECTION TOOL

Name of the staff	Type of forms used	Frequency of usage	Number of formats responsible for
Part time ORW	1. Monthly reporting format for IEC materials	After each day at the Information Booth	**4**
	2. Weekly reporting format for recording out reach activities	At the end of each month	
	3. Monthly reporting formant for recording out reach activities	At the end of each month	
	4 .Minutes of Meeting	At the end of each meeting	

1. Monthly Reporting Form: Critical Level of IEC Material

Frequency: At the end of each month
Where: At each transit interventions (a combination of all sites for railway and bus stations)
By Whom: By the part time ORW
For what:
1. For record purposes
2. To understand the requirement of and the corresponding stock of IEC materials

Guidelines for filling the form:
How-
Month:- Fill in the reporting month
Name of IEC Material:- Self explanatory
Amount of material received last:- Indicate the number of corresponding material received last from the last time of record
Stock as on last date of previous month :- Add in the month and number of corresponding IEC material currently in hand including left over of earlier received stock
Transit locations with stock outs: Transit locations which are currently out of stock of the corresponding IEC material
Remarks (Whether IEC available in adequate quantity, Y/N or any other remarks, if required):- Kindly note as indicated

Usefulness of the information:

1. This is to ensure that adequate IEC materials are there.
2. This will also help to highlight where the IEC materials are lacking

1. Monthly Reporting Form : Critical Level of IEC Material				
	Month : _____			
Sl.No.	Name of IEC Material	Amount of material received last	Stock at the end of the last reporting month	Remarks (Whether IEC available in adequate quantity, Y/N or any other remarks, if required)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

2. Weekly Reporting Format for Out Reach Activities

Frequency: At the end of each week
Where: At each transit interventions (a combination of all sites for railway and bus stations)
By Whom: By the part time ORW
For what:
1. For recording the results of out reach activities especially for following:
    a. Number of activities conducted during the week
    b. Number of migrants by different category reached by the activities in total
2. To understand the activities under condom social marketing especially number of functional out lets available and number of outlets visited by the part tine ORW.

Guidelines for filling the form:
How-
Month: Fill in the reporting week
Location of activities covered during the week by different activities, the activities may be:

a. Group sessions
b. Mid-Media activities
c. Functional information booths
d. Distribution of Migration Kits
e. Sensitisation meeting with stake holders

Number of migrants by category covered during the week by different activities, the activities may be:

a. Group sessions
b. Mid-Media activities
c. Functional information booths
d. Distribution of Migration Kits
e. Sensitisation meeting with stake holders

Condom Programming:

a. Target of condom outlets by locations
b. Total number of functional outlets
c. Number of outlets visited by the part time ORW

Usefulness of the information:

1. This is to ensure that the programme targets are reached as per the plan and requirement
2. This will also help to highlight the issues if any related to the performance especially coordination issues with stakeholders, condom programming.

WEEKLY (PART TIME) ORW REPORTING FORMAT for TRANSIT LOCATIONS								
Name of the Part time ORW:						Contact No.		
Month:			Year:		STATE:			
District:			Name of the reporting unit:					
Number of intervention points proposed for intervention		No. of intervention units under implementation:		Tick the reporting week	1st	2nd	3rd	4th
Number of activities and their coverage conducted during the month in each transit locations	No. of One to group sessions conducted	No. of mid-media campaigns held	No. of information booth are functional	No. of migrant kits distributed	No. of sensitisation meetings with stake holders	No. of persons voluntarily sought information about HIV/AIDS	No. of persons reached in the neareast ICTC centres	No. of persons reached at the nearest STI providers (pvt. And govt.)
At the Railway Station								
At the Bus Station								
Any other place								
No. of Returnee Migrants reached								
No. of Out going (who are leaving)Migrants reached								
No. of Female Migrants reached								
No. of spouses of migrants reached								
No. of Labour contractors reached								
No. of other stake holders reached								
TOTAL	0	0	0	0	0	0	0	0
Service Delivery:								
1. Condom								
a. No. of condom depots targeted in the intervention area								
b. No. of condom depots functional in the intervention area								
c. No. of condom depots visited during the week								

3. Monthly Reporting Format for Out Reach Activities

Frequency: At the end of each month
Where: At each transit interventions (a combination of all sites for railway and bus stations)
By Whom: By the part time ORW
For what:
1. For recording the results of out reach activities especially for following:
    a. Number of activities conducted during the month
    b. Number of migrants by different category reached by the activities in total
2. To understand the activities under condom social marketing especially number of functional out lets available and number of outlets visited by the part tine ORW.

Guidelines for filling the form:
How-
Month: Fill in the reporting month
Location of activities covered during the month by different activities, the activities may be:

a. Group sessions
b. Mid-Media activities
c. Functional information booths
d. Distribution of Migration Kits
e. Sensitisation meeting with stake holders

Number of migrants by category covered during the month by different activities, the activities may be:

a. Group sessions
b. Mid-Media activities
c. Functional information booths
d. Distribution of Migration Kits
e. Sensitisation meeting with stake holders

Condom Programming:

a. Target of condom outlets by locations
b. Total number of functional outlets
c. Number of outlets visited by the part time ORW

Advocacy Activities:

a. Advocacy activities with different stake holders including objectives, key out comes and number of persons participated from the different key departments.

Usefulness of the information:

1. This is to ensure that the programme targets are reached as per the plan and requirement
2. This will also help to highlight the issues if any related to the performance especially coordination issues with stakeholders, condom programming.

MONTHLY (PART TIME) ORW REPORTING FORMAT for TRANSIT LOCATIONS								
Name of the Part time ORW:						Contact No.		
Month:			Year:		STATE:			
District:			Name of the reporting unit:					
Number of intervention points proposed for intervention		No. of intervention units under implementation:		Tick the reporting week	1st	2nd	3rd	4th
Number of activities and their coverage conducted during the month in the district	No. of One to group sessions conducted	No. of mid-media campaigns held	No. of information booth are functional	No. of migrant kits distributed	No. of sensitisation meetings with stake holders	No. of persons voluntarily sought information about HIV/AIDS	No. of persons reached in the neareast ICTC centres	No. of persons reached at the nearest STI providers (pvt. And govt.)
At the Railway Station								
At the Bus Station								
Any other place								
No. of Returnee Migrants reached								
No. of Out going (who are leaving)Migrants reached								
No. of Female Migrants reached								
No. of spouses of migrants reached								
No. of Labour contractors reached								
No. of other stake holders reached								
TOTAL	0	0	0	0	0	0	0	0
Service Delivery:								
1. Condom								
a. No. of condom depots targeted in the intervention area								
b. No. of condom depots functional in the intervention area								
c. No. of condom depots visited during the month								
2. Advocacy activites:								
	Total Number	Cumulative no.	Date	Objectives	Key Outcomes	No. of person particpated		
a. Advocacy meeting with authorities of railways department								
b. Advocacy meeting with authorities of transport department								
c. Advocacy meeting with authorities/ representative of other stakeholders								
d. Others (Specify)								

4.Minutes of Meeting with _____ (a group name like "Officials from..." is to be provided here)

Frequency: At the end of each meeting
Where: At each transit interventions (a combination of all sites for railway and bus stations)
By Whom: By the part time ORW
For what:
1. For record purposes, to keep details of meetings
2. To refer to later during follow up or related meetings
Guidelines for filling the form:

1. The format is to be used for minuting the details of the following meetings by the district unit:
i) Advocacy meetings
ii) Any others
2. Number of people attended by designation is to be mentioned. Attendance sheet mandatory along with minutes
3. Some data from the format is to be compiled on a monthly basis into the MIS

How-
Date:- The date in the DD/MM/YYYY format when the format is being filled
Venue:- Self Explanatory
Purpose:-The agenda for the meeting
PARTICIPANTS (Names and Designation) :- Self Explanatory
Discussions held: A brief on the discussions held with specific highlights on major points discussed
Plan of Action and Decision taken
Decision Taken:- Self explanatory
Plan of Action:- How it is planned to go about to ensure that the task to be undertaken is completed satisfactorily
Team/Person Responsible:- Self explanatory
Target Date:- An approximate date by when the task shall be completed
Usefulness of the information:-
This information shall help in understanding the way forward to bring about the change required in order to ensure greater uptake of services and effective behaviour change communication.

4. MINUTES OF MEETING WITH ……..

Date:

Venue:

Purpose:

PARTICIPANTS (Names and Designation)

Discussions held:

Plan of Action and Discussion taken

S.No	Decision taken	Plan of Action	Team /Person Responsible	Target Date
1 (Example)	Share review tool		**District Programme Manager**	Early July
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				

INSTRUCTIONS

1. The format is to be used for minuting the details of the following meetings by the district unit:

i) Advocacy meetings
ii) Any
others

2. Number of people attended by designation is to be mentioned. Attendance sheet mandatory along with minutes

SIMS REPORTING FORMAT FOR SPECIFIC TRANSIT LOCATION AND STATE TRANSIT INTERVENTIONS

National AIDS Control Organisation								
DISTRICT LEVEL MONTLHY REPORTING FORMAT for TRANSIT LOCATIONS								
Name of the Reporting Officer:						Contact No.		
Designation:								
Month:			Year:		STATE:			
District:			Name of the reporting unit:					
Number of intervention points proposed for intervention			No. of intervention units under implementation:			Remarks:		
Number of activities and their coverage conducted during the month in the district	No. of One to group sessions conducted	No. of mid-media campaigns held	No. of information booth are functional	No. of migrant kits distributed	No. of sensitisation meetings with stake holders	No. of persons voluntarily sought information about HIV/AIDS	No. of persons reached in the neareast ICTC centres	No. of persons reached at the nearest STI providers (pvt. And govt.)
At the Railway Station								
At the Bus Station								
Any other place								
No. of Returnee Migrants reached								
No. of Out going (who are leaving)Migrants reached								
No. of Female Migrants reached								
No. of spouses of migrants reached								
No. of Labour contractors reached								
No. of other stake holders reached								
TOTAL	0	0	0	0	0	0	0	0
A. Human Resource:								
Category of the staff (as applicable in the budget)	Number of man power approved	Number of manpower in place	Trained during the month	Number of volunteers sensitised by the ORW	Number of days of visits planned at railway station	Number of days of visits conducted at railway station		
Out reach Worker								
Service Delivery:								
1. Condom								
a. No. of condom depots targeted in the intervention area								
b. No. of condom depots functional in the intervention area								
c. Uptake of condoms through condom depots								
d. Uptake of condoms through free distribution								
2. Involvement of Volunteers								
	Number approved	Number in place	Trained	Cumulative Trained				
Identification of volunteers								
3. Outreach activites:								
	Total Number	Cumulative no.	Date	Objectives	Key Outcomes	No. of person particpated		
a. Advocacy meeting with authorities of railways department								
b. Advocacy meeting with authorities of transport department								
c. Advocacy meeting with authorities/ representative of other stakeholders								
d. Others (Specify)								
4. Financial Status	Budget Approved for the FY			Expenditure made till reporting month			SOE submitted till date	
5. Major Highlights (if any)- annex the detail reports of the events								
6. Activities planned for next month:								

National AIDS Control Organisation

STATE LEVEL MONTLHY REPORTING FORMAT for TRANSIT LOCATIONS

Name of the Reporting Officer:						Contact No.		
Designation:								
Month:			Year:		STATE:			
District:			Name of the reporting unit:					
Number of intervention points proposed for intervention			No. of intervention units under implementation:					
No. of Railway Stations under implementation during the	**Transit 1**	**Transit 2**	**Transit 3**	**Transit 4**	**Transit 5**	**Transit 6**	**Transit 7**	**Transit 8**
Number of Bus Stations covered during current month								
Number of activities conducted and their coverage during the month in the State	No. of One to group sessions conducted	No. of mid-media campaigns held	No. of information booth are functional	No. of migrant kits distributed	No. of sensitisation meetings with stake holders	No. of persons voluntarily sought information about HIV/AIDS	No. of persons reached in the neareast ICTC centres	No. of persons reached at the nearest STI providers (pvt. And govt.)
No. of Returnee Migrants reached								
No. of Out going (who are leaving)Migrants reached								
No. of Female Migrants reached								
No. of spouses of migrants reached								
No. of Labour contractors reached								
No. of other stake holders reached								
TOTAL	0	0	0	0	0	0	0	0

A. Human Resource:						
Category of the staff (as applicable in the budget)	Number of man power approved	Number of manpower in place	Trained during the month	Number of volunteers sensitised by the ORW	Number of days of visits planned at railway station	Number of days of visits conducted at railway station
Out reach Worker						

Service Delivery:				
1. Condom				
a. No. of condom depots targeted in the intervention area				
b. No. of condom depots functional in the intervention area				
c. Uptake of condoms through condom depots				
d. Uptake of condoms through free distribution				
2. Involvement of Volunteers				
Identification of volunteers	Number approved	Number in place	Trained	Cumulative Trained

3. Outreach activites:						
	Total Number	Cumulative no.	Date	Objectives	Key Outcomes	No. of person particpated
a. Advocacy meeting with authorities of railways department						
b. Advocacy meeting with authorities of transport department						
c. Advocacy meeting with authorities/ representative of other stakeholders						
d. Others (Specify)						

4. Financial Status	Budget Approved for the FY	Expenditure made till reporting month	SOE submitted till date

5. Major Highlights (if any)- annex the detail reports of the events
6. Activities planned for next month:

5.22 FEASIBILITY ASSESMENT TOOLS FOR DESTINATION INTERVENTIONS

Feasibility Assessment Tools for Existing Destination Migrant interventions

Instructions: The sheet is to be used for one district only for interventions implemented by one implementing partner. In case of multiple partners - please use separate sheets. For different occupation category in a district - one sheet to be used. Please encircle the score which is appropriate across the occupation category and add as total score for the occupation category. Accordingly the total can be derived for each category or a combination of occupation category. The indicators for scoring are in line with requirement of revised strategy.

Name of the State		**Name of the implementing partner**	SACS
			Any other partner
Name of the District			

Occupation Category		Score	Total Volume of workers in the identified sector	Score	% of them are migrants	Score	Current Intervention coverage	Score	Whether current interventions target migrants at residence / work place/ both	Score	Total Score
Type of Occupation category with Dense Migrant Volume limited to geographical space	Textile	5	less than 20,000	1	less than 20%	1	5,000	1	workplace	4	
	Mining	5	20,000	2	21-49%	2	5,001-10,000	2	workplace and residence	3	
	Iron Ore	5	20,001-50,000	3	50-80%	3	more than 10,000	3	residence	2	
	Alumina	5	more than 50,000	4	more than 80%	4	none	0	any other	1	
	Cement Factories	5	none	0	none	0			none	0	
	None	0									
Type of Occupation category with Spread out Migrant Volume spread across a limited geographical space (a peripehry of 20 kms radius)	Diamond Cutting	4	less than 20,000	1	less than 20%	1	5,000	1	workplace	4	
	Deep Sea Fisheries	4	20,000	2	21-49%	2	5,001-10,000	2	workplace and residence	3	
	Stone Quarries	4	20,001-50,000	3	50-80%	3	more than 10,000	3	residence	2	
	Alumina	4	more than 50,000	4	more than 80%	4	none	0	any other	1	
	Brick Klins	4	none	0	none	0			none	0	
	Leather Accessories	4									
	Salt Panning	4									
	None	0									
Type of Occupation Category with Spread across a wide geographical area (spread out in small localities)	Construction	3	less than 20,000	1	less than 20%	1	5,000	1	workplace	4	
	Hotel Services	3	20,000	2	21-49%	2	5,001-10,000	2	workplace and residence	3	
	Domestic Services	3	20,001-50,000	3	50-80%	3	more than 10,000	3	residence	2	
	Rickshaw pullers	3	more than 50,000	4	more than 80%	4	none	0	any other	1	
	Transport workers	3	none	0	none	0			none	0	
	None	0									
Seasonal - Dense Migrant Volume	Sugarcane processin	5	less than 20,000	1	less than 20%	1	5,000	1	workplace	4	
	Paddy/wheat proces	5	20,000	2	21-49%	2	5,001-10,000	2	workplace and residence	3	
	Cotton Processing	5	20,001-50,000	3	50-80%	3	more than 10,000	3	residence	2	
	Tea plantation	5	more than 50,000	4	more than 80%	4	none	0	any other	1	
	Coffee plantation	5	none	0	none	0			none	0	
	None	0									
Any other combination of above											
										TOTAL	

Any district which is having a score of more than 20 will be considered for continuation

Less than 20 will be considered for IEC campaigns

Instructions for Feasibility Assessment of Destination Interventions:

Who will use: SACS and TSU officers

When: For both existing and new destination interventions

How to use:

1. The tool is to be used for one district with one implementing partner
2. In case of multiple partners, individual sheets to be used.
3. The following information required for scoring of the sheet:
    a) Occupation category
    b) Total volume of workers (Source: informal source, employees records)
    c) % of the workers are migrants (Source: informal source, employees records)
    d) Status of current intervention in the area including its coverage / proposed coverage
    e) Current location of intervention (Residence/Workplace/both)
4. Score the information according to the sheet.
5. If the total score is more than 20 – the site is feasible for migrant intervention, unless the site is suitable for Intensive IEC interventions.
6. Special cases will be considered through separate proposals.

5.23 MODEL AMENDMENT NOTE FOR TRANSIT INTERVENTIONS

AMENDMENT TO THE CONTRACT
Consultant's Services for Implementation of the (Give the Complete Title of the Contract) Targeted Interventions
Signed between
_____ (SACS)
and
_____ (TI Implementing Agency- Give the name of the NGO/CBO and Lead Partner and Associates if any)
on
_____ The date of signing of original contract, 2010

Further to the contract executed as said above, an amendment to the contract is made on the ____ (The date of signing the amendment)day of _____, 2010 between _____ (SACS) and _____ (TI Implementing Agency) (Name of the Lead Partner Only)

Article 1 – Purpose
The present amendment has the purpose to modify the [scope of work] of the contract and [cost of services] and [geography of modified scope of work].(Select Purpose (s) of amending the contract)

Article 2 –Expiration of contract clauses (This article to be deleted in case no extension is required beyond the original contract period**)**
SCC 2.4 to be read as "The time period shall be ___ months after the effective date or such period as the parties may agree in writing"

Article 3 - Validity of Contract clauses
All other clauses of the original contract including all the Appendices except the following Appendices remain unchanged (Mention only the sections which are amended and made them appendix to this amendments to the contract. All the pages to be signed by two parties)

(a) The Section – II - "Revised Scope of Work for implementation of Transit Migrant Interventions"
(b) The Section – III – "Revised Cost of Services for implementation of Transit Migrant Interventions"
(c) The Section – IV – "Geography of the modified scope of work"

Article 4 – Effectiveness of this Amendment
The present Amendment will be effective from _____, 2010.(Mention the date on which the amendments are to come into effect. This date could be future / past/ the date of signing the amendment.)

Read and Agreed
Place: _____ Dated: _____

For and on behalf of _____ (SACS)

(_____)
Project Director

For and on behalf of _____ (TI Implementing Agency)

(_____)
_____

NOTES