National AIDS Control Organisation
India's response to HIV & Sexually Transmitted Infections
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in

सत्यमेव जयते
Ministry of Health and Family Welfare
Government of India

Azadi Ka Amrit Mahotsav

GUIDELINES FOR INTERVENTIONS

Among Bridge Population Under NACP

2023

National AIDS Control Organisation
India's response to HIV & Sexually Transmitted Infections
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in

सत्यमेव जयते
Ministry of Health and Family Welfare
Government of India

Azadi Ka Amrit Mahotsav

GUIDELINES FOR INTERVENTIONS
Among Bridge Population Under NACP

2023

सत्यमेव जयते

वी. हेकाली झिमोमी, भा.प्र.से.
अपर सचिव एवं महानिदेशक
V. Hekali Zhimomi, IAS
Additional Secretary & Director General

आज़ादी का अमृत महोत्सव

राष्ट्रीय एड्स नियंत्रण संगठन
स्वास्थ्य और परिवार कल्याण मंत्रालय
भारत सरकार
National AIDS Control Organisation
Ministry of Health & Family Welfare
Government of India

FOREWORD

National AIDS and STD Control Programme Phase-V aims to accelerate reduction in new annual HIV infections among high-risk groups and bridge populations such as migrants and truckers. While emphasis is laid on continuing and evolving the existing peer-led targeted interventions (TI) projects and Link Worker Schemes (LWS) strategies, increasing evidences led to focuses on saturating the coverage of population who are migrating and have potential exposure to high risk activities that increases the risk of acquiring HIV and STI infections.

With this changing dynamics and risk exposures, National AIDS Control Organisation (NACO) has revised the Guidelines for interventions among Bridge Population. It envisages covering migrant population who are engaged in sectors but not limited to hotel industry, garments, tourism, construction and the very emerging service sectors, etc. The strategy is aligned with the changing operations in-transport industry, due to advancement of technology and expansion of roads etc. It suggests covering the population who shows overlapping risks and/or part of sexual and injecting networks of HRGs with the newer approaches under the HIV comprehensive service umbrella.

I, therefore take immense pleasure in the development of the Guidelines for interventions among Bridge populations, which has laid out strategies to support the prevention projects to reach out and cover a larger section of bridge populations who are "disproportionately at-risk" but left uncovered. This revised guideline will guide State AIDS Control Societies (SACS) to implement a comprehensive HIV response that is fully resourced and implemented with urgency and optimal efficiency towards achieving the Global Targets of ending AIDS as a public health threat.

(V Hekali Zhimomi)

6th Floor, Chandralok Building, 36 Janpath, New Delhi-110001 Tel.: 011-23325331 Fax : 011-23351700
E-mail : dgoffice@naco.gov.in

आज़ादी का अमृत महोत्सव

सत्यमेव जयते

AIDS Helpline 1097
जानें समझें, जुग-जुग जीयें!

निधि केसरवानी, भा.प्र.से.
निदेशक
Nidhi Kesarwani, I.A.S.
Director

राष्ट्रीय एड्स नियंत्रण संगठन
स्वास्थ्य और परिवार कल्याण मंत्रालय
भारत सरकार
National AIDS Control Organisation
Ministry of Health & Family Welfare
Government of India

PREFACE

National AIDS and STD Control Programme Phase-V aims to accelerate the reduction in new annual HIV infections with the provision for a basket of services tailored to the needs of high-risk, low, and at risk population group which includes the migrants and trucker's population, referred to as bridge population.

The recent round of HIV sentinel Surveillance (HSS 2021) shows an increasing prevalence of HIV among migrants at 0.89% in 2021from 0.51% in 2017 and in truckers 1.00% in 2021from 0.86% in 2017. This relatively high prevalence of HIV among migrants and truckers population which has always been higher than the general population at 0.22%, augment for an expanded coverage for the bridge population aligned with the principles defined in NACP Phase V. While evidence from various studies suggests high mobility of the above population augmented with inter-sectionality of risks and vulnerability among high risk groups, the universe of these populations expands. Their individual risk and vulnerability are dependent on the behavioral and environmental factors. The changing mobility patterns combined with risk of acquiring HIV and STI infections of these bridge populations necessitate a revisiting the existing interventions to saturate the coverage and aimed at bridging the gap of 95-95-95 goals.

This guideline for intervention among bridge population therefore, has been developed with due consultations with program experts, National Technical Resource Group (NTRG) and National Technical Working Groups (NTWG) constituted by NACO, participation of representatives from Communities, Civil Society, Government, and other stakeholders.

The guidelines will provide the programme with dynamic knowledge about the latest evidences on inter-sectionality of bridge and other vulnerable population, co-location of hotspot or congregation sites for outreach to align the implementation strategy. Thus, support the National HIV/AIDS and STD response to close the gap of first 95 with the provision of prevention and continuum of care services for the Bridge populations.

(Ms. Nidhi Kesarwani)

NACO

डॉ. शोभिनी राजन
मुख्य चिकित्सा अधिकारी (एसएजी)
Dr. Shobini Rajan, M.D. (Pathology)
Chief Medical Officer (SAG)

Tel. : +91-11-23731810, 43509956
Fax : +91-11-23731746
E-mail : shobini@naco.gov.in

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
राष्ट्रीय एड्स नियंत्रण संगठन
9वां तल, चन्द्रलोक बिल्डिंग,
36, जनपथ, नई दिल्ली-110 001

Government of India
Ministry of Health & Family Welfare
National AIDS Control Organisation
9th Floor, Chandralok Building,
36, Janpath, New Delhi - 110 001

MESSAGE

The HIV epidemic continues to be concentrated in nature in India. Besides HRGs such as Female Sex Worker, Men Who have Sex with Men(MSM), Hijra/Transgender (H/TG) and Injecting Drug Users(IDUs), the Migrants and Truckers are referred to as bridge population covered through Targetted Intervention projects, and Link Worker Scheme. The last operational strategies and guidelines for interventions among Migrants and Truckers population was developed during NACO III and continues to guide the Targeted Interventions (TI) projects implementation.

Evidence and learnings from existing interventions among migrants and trucker's population and various studies necessitated a revision of the existing operational guidelines. The changing dynamics of sex work, overlapping of risks among different HRGs and occupational categories of workers combined with high mobility among them signalled the expanding universe of bridge population. Evidence also points out that sexual activity among transport workers is diverse and underlined by risk. While Mobility patterns for bridge population impact the prevention, treatment and care continuum by making service continuity a challenge and impacts treatment adherence. In the light of above and as envisioned under NACP Phase V strategies, provision of a tailored made package of services through suitable intervention models for bridge population has been made under the revised guidelines for intervention among bridge population.

This revised Guidelines focuses on revision of definitions of bridge populations to be catered to with HIV/AIDS and STI services, strategic components of interventions, identification of new intervention sites, outreach strategies, risk assessments, health camps, and inclusion of spouse and partner testing in the package of services. The strategy is aimed at reaching the bridge populations with a comprehensive package of services covering the entire spectrum of the prevention, testing, treatment and care cascade. The success of interventions among bridge population also depend on the engagement of key stakeholders including governments, NGO partners and communities, by creating synergies to leverage resources including existing infrastructure and manpower.

The revised Guidelines is, therefore, an attempt to recalibrate the intervention in light of the changing dynamics making the HIV response comprehensive and up-to date.

Shobini

(Dr. Shobini Rajan)

Dr. Saiprasad Bhavsar
M.B.B.S, M.D (PSM)
Deputy Director
Tel: + 91-11-43509989
Fax: + 91-1123731746
E-mail: sp.bhavsar84@cghs.nic.in
spbhavsar.phs@yahoo.com

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
राष्ट्रीय एड्स नियंत्रण संगठन
छठा तल, चंद्रलोक बिल्डिंग, 36, जनपथ
नई दिल्ली – 110001

Government of India
Ministry of Health & Family Welfare
National AIDS Control Organisation
9th Floor, Chandralok Building
36 Janpath, New Delhi-110001

ACKNOWLEDGEMENT

The Guidelines for Intervention among Bridge Population under NACP is an outcome of a series of National Level consultations and meetings with subject experts, bi-lateral, multi-lateral partners, State AIDS Control Societies, members of the Technical Resource Group for Intervention among Bridge and Vulnerable Population and other development partners. The objective of these consultations was to evaluate the effectiveness and efficiency of the current intervention for bridge populations in light of various studies indicating dynamic mobility patterns of bridge populations.

We would like to express my heartfelt gratitude to Ms. V. Hekali Zhimomi (IAS) (Additional Secretary & Director General, NACO) for her dynamic leadership and unwavering guidance. We are also grateful to Ms. Nidhi Kesarwani (IAS), (Director, NACO) for her valuable experience in defining the content for the guidelines. Dr. Anoop Kumar Puri, (DDG - NACO), Dr. U.B. Das, Sr. CMO (SAG) (DDG – NACO), Dr. Shobini Rajan, Sr. CMO (SAG), (DDG – NACO), Dr. Chinmoyee Das (PHS Grade I – NACO), Dr. Bhawani Singh (DD – NACO) and Dr. Bhawna Rao (DD – NACO) for their valuable technical input, guidance and timely directions.

We extend our sincere appreciation towards Prof. Shalini Bharat, Chairperson, of the National Technical Resource Group (NTRG) for interventions among Bridge Populations and all the members of NTRG, Prof. Srikala Acharya, Chairperson of National Technical Working Group (NTWG) and all members of NTRG & NTWG, for their contribution and support for developing this guideline for intervention among Bridge Population. Special thanks to Dr. Subhash Ghosh, Project Lead - Accelerate, YRG Care, Mr. G. Shreenivas, PATH and Dr. Sudhir Chawla, CDC for providing technical insights and support in the development of this document.

We take this opportunity to acknowledge the efforts of Prevention Division, NACO namely Mr Rahul Ahuja, Mr. Dew Stanley Ephraim, Mr. Samresh Kumar, Ms. Ira Madan, and Ms. Gunjan Pandey. We extend our thanks to the consultant Ms. Pragya Mishra for framing this document. The in-depth programmatic understanding of all the above cited experts on the bridge population and their knowledge on the changing mobility patterns added immense value to the document.

Lastly, we acknowledge the technical support from PEPFAR/ CDC and PATH during this journey and for designing, editing and printing this document.

(Dr. Saiprasad P. Bhavsar)

Table of contents

Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ABHA	Ayushman Bharat Health Account
ATT	Anti TB Treatment
ANC	Ante Natal Clinic
AEP	National Adolescent Education Programme
ART	Anti-Retroviral Treatment
BCC	Behaviour Change Communication
BPCL	Bharat Petroleum Corporation Limited
CCC	Community Care Centres
CSO	Civil Society Organisations
DAPCU	District AIDS Prevention and Control Unit
DIC	Drop-in-Centre
DISHA	District Integrated Strategy for HIV/ ADS
DMC	District Microscopy Centre
DSRC	Designated STI/RTI Centre
ELM	Employer Led Model
ESI	Employee State Insurance Scheme
FSW	Female Sex Workers
HRG	High-Risk Groups
HSS	HIV Sentinel Surveillance
IBBS	Integrated Biological and Behavioural Surveillance
ICTC	Integrated Counseling and Testing Centres

IPC	Interpersonal Communication
LWS	Link Worker Scheme
MMD	Multi- Month Dispensation
MoU	Memorandum of Understanding
MSDS	Migrant Service Delivery System
MSM	Men who have Sex with Men
MoHUA	Ministry of Housing and Urban Affairs
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NHAI	National Highway Authority of India
PM-JAY	Pradhan Mantri Jan ArogyaYojna
PMMVY	Pradhan Mantri Matru VandanaYojana
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PPP	Preferred Private Provider
ORW	Outreach Worker
OVP	Other Vulnerable Population
SACS	State AIDS Control Societies
SBCC	Social and Behaviour Change Communication
SDNS	Secondary Distribution of Needles & Syringes
SOCH	Strengthening Overall Care for HIV Beneficiaries
SNA	Situational Needs Assessment
SSK	Sampoorna Suraksha Kendra
STI	Sexually Transmitted Infection
TB	Tuberculosis
TU	TB Units
TRG	Technical Resource Group
TWG	Technical Working Group

1

Introduction

1.1. Evolution of the national AIDS control programme

India's HIV programme is globally acclaimed as one of the most successful programmes[1].The initial phase of sentinel-surveillance, followed by a focussed targeted intervention for HIV prevention among high-risk groups of Female Sex Workers (FSW), Men who have Sex with Men (MSM), People Who Inject Drugs (PWID) and Hijra/ Transgender persons (H/TG) coupled with scale up of treatment has shown a steady decline in the HIV prevalence over the years. A quick snapshot of the National AIDS Control Program (NACP) over the years is given below.

NACP- I (1992-1999) marked the beginning of a well-thought-out and institutionalised response focussing on evidence generation through annual sentinel surveillance, awareness creation and blood safety for slowing down the spread of HIV infection. Another important step was creation of State AIDS Cells in the Directorate of Health Services in states and union territories. This phase also looked at intervention among trucker population as a means to contain the spread of HIV epidemic.

NACP- II (1999-2006) decentralised the programme to states and focused direct interventions on prevention, counselling, testing, and launch of treatment services. Phase II saw the introduction of many milestones including the launching of the National Adolescent Education Programme (NAEP), HIV counselling, Prevention of Parent to Child Transmission (PPTCT) and the launch of the National Anti-Retroviral Therapy (ART) programme and initiation of the Targeted Intervention (TI) programme. The first TI for the bridge population was also started under NACP-II[2].

NACP- III (2007-2012) was focused at the district level and aimed at "halting and reversing the epidemic" before the end of the project period. De-centralisation was further strengthened by establishing District AIDS Prevention and Control Units (DAPCU). This period saw scale-up of services with quality assurance mechanisms. It was a landmark phase for the TI in more ways than one. First, NACP- III saw the institutionalisation of the bridge population intervention under the TI programme through the development of the

[1] Mid-Term Appraisal of National AIDS Control Programme Phase IV- NACO- 2016

[2] Healthy Highway Project for Transport workers in partnership with DFID and Project Lighthouse with port authorities in association with PSI

Operational Guidelines for the bridge population in 2007. The guidelines were subsequently revised in 2010 based on the evidence of changing patterns of behaviour of the bridge population. The year 2009 witnessed mapping and size estimation of the bridge population being undertaken to deeply entrench its response to the evidence generated. Additionally, coverage of the bridge population through its rural intervention programme of Link Worker Scheme (LWS) was started in NACP- III.

NACP- IV (2012-17) aimed to strengthen gains, address new vulnerabilities, balance prevention and treatment, and integrate HIV/AIDS services. The TI program made great strides in addressing the changing patterns of the bridge population. It not only scaled up the bridge population intervention under NACP-IV but also expanded to include migrants at work through the 2016 Employer-Led Model (ELM) Operational Guidelines and HTS at the World of Work. Another achievement of the TI program was the introduction of Migrant Service Delivery System (MSDS), a web application that collects data on high-risk migrants from Targeted Intervention projects.

The NACP-IV Extension (2017-20) was committed to making concrete progress towards the "End of AIDS by 2030" with Test and Treat; The three years of extension geared towards revamping strategies of TI with an aim for improved coverage of the Key Populations through strengthening partnerships between community and civil society.

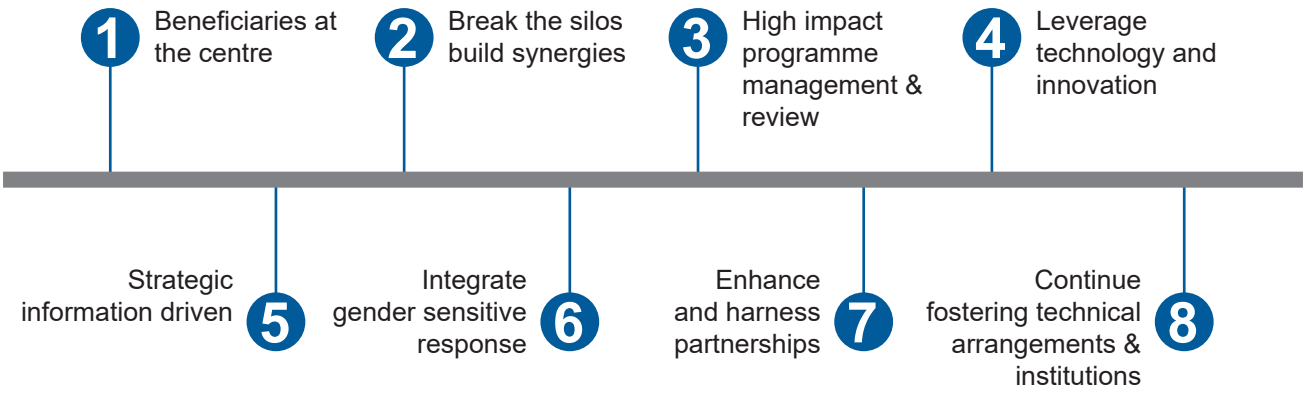
NACP- V (2021-2026) is committed to ending AIDS as a public health threat by 2030. Phase V takes into account the global contexts, targets and strategies in order to meet its ambitious goal of reducing annual new HIV infections and AIDS-related mortalities by 80% by 2025-26 from the baseline value of 2010. NACP- V would see an introduction of a hybrid model to cover core and bridge population with plans to cover allied population as well. NACP-V is centred around eight guiding principles that form the foundation for achieving the targets. The guiding principles under NACP Phase V are presented in the figure below:

Aligning with the above, guiding principles of NACP phase V aims to accelerate the reduction in new annual HIV infections through a basket of strategies tailored to the high-risk, medium – risk and low - risk population groups. It suggests continuing and evolving the existing peer led Targeted Interventions and Link Worker Scheme strategies for integrated services. This also highlights promotion of evidence backed comprehensive prevention packages tailored to location and population while, redefining and expanding coverage among the bridge population.

1.4. Current HIV prevention among bridge population

India's national HIV prevention response has been ever-evolving since its inception. In the last 4 decades, India has made huge gains in

Figure 1: Eight guiding principles of NACP-V



controlling the epidemic and has emerged as one of the most robust public health responses to HIV in the world.

The HIV prevention under the NACP focuses on FSW, MSM, H/TG and PWID as High-Risk Groups (HRG) and the migrants and truckers as Bridge Population (BP) and is implemented through Targeted Intervention projects. Under the current operational strategy, migrants are defined as people who seek better livelihood and move from their place of origin in rural/peri-urban areas (source) to a town or city (destination), with the intention of settling temporarily or semi permanently and return to their origin for up to 3-6 months. While the Long-Distance Truckers (inclusive of driver and helper), travelling 800 km or more in a single direction are covered under the trucker's intervention. These interventions are positioned at strategic places at destination sites, in locations (such as railway stations, bus stations, etc), through health camps in source villages, and under the LWS in the selected high priority districts.

The Targeted Interventions among migrants and truckers' population are implemented through NGOs, CBOs and associations through the State AIDS Control Societies (SACS). These organisations are contracted through the social contracting mechanism of NACP. Interventions are placed in the selected geographies and the beneficiaries are provided a package of services encompassing the prevention, testing and treatment cascade under NACP. Currently, more than 200 destination migrant interventions, 80 truckers' interventions and 156 LWS are implemented as of March 2023. Under TI approximately 7.44 million migrants and 1.06 million truckers are covered.

The sero-positivity among truckers (0.24% in 2017-18 to 0.12% in 2021-22) and migrants (0.20% in 2017-18 to 0.11% in 2021-22) has seen a steady decline (As per Sankalak,4th Edition 2022). NACO HIV Sentinel Surveillance (HSS) shows increasing prevalence of HIV among migrants from 0.51% in 2017 to 0.89% in 2021 and truckers from 0.86% in 2017 to 1% in 2021. This relatively high prevalence of HIV positivity among migrants and truckers augments for an expanded coverage for the bridge population aligned with the principles defined in NACP Phase V.

Evidence from NFHS-V establishes linkages between migration and vulnerability to HIV. Among the individuals surveyed (7,24,115 women and 1,01,839 men), 14.3% of men, 7.3% of women, and 20.6% of husbands of women have reported staying away from home for one or more months at a time in the 12 months prior to the survey and these men reported engaging in high-risk sexual behaviour compared to those who stayed at home (6.1% men and 1.2% women). Among mobile population, 43.2% of men and 29.7% of women did not use a condom during their last higher-risk sexual encounter[3]. These findings indicate a strong relationship between the mobility, high risk sexual behaviour, and likelihood of exposure to HIV/ STI. These are also suggestive of the vulnerability of the bridge population's spouses and partners who are left behind in source areas. Research further documents that certain jobs among migrants, such as heavy load labour (mathadi labour) in port cities, which provide higher wages, who often reside without spouses have greater disposable income with which to indulge in risky alcohol use and transactional sex (Kutikuppala, 1998; Saggurti et al., 2008). While residents without wives and access to higher wages facilitates involvement with alcohol use and sex among migrant workers, these risks are exacerbated by a high density of alcohol and transactional sex venues and locales within migrant male communities (Chakraborty, 2004). Sex under the influence of alcohol was also observed by a study conducted on truckers by TISS. In the study 21% of the respondents had sex under the influence of alcohol[4,5].

Based on literature review and latest evidence, NACP has identified migrants and truckers as one of the high-risk population to be reached out in

[3] NHFS-V

[4] Changing Sexual Networks and Unexplored Risk Behaviours / Drivers and Allied Population in India

[5] Migrants' Emerging Mobility Patterns, High-Risk Behaviours, HIV Vulnerabilities and Responses During COVID-19 in India-TISS-2023

order to accelerate the HIV prevention response in the country. Currently both these categories are covered under the term ‘bridge population’. However as per the NACP - V guiding principles of breaking the silos and the intersectionality of migrants and truckers based on their common vulnerability, common hot spots and changing dynamics and epidemiological context it has become imperative to align the strategy among bridge and other vulnerable population. The current Guideline for interventions among Bridge Population under NACP are an endeavour in the same direction.

2

Bridge population under NACP phase V

The NACP envisages ending AIDS as a public health threat by 2030. It has worked tirelessly and has been largely successful in putting additional focus to achieve the goal. With the renewed commitment towards achieving the goals of 95-95-95, acceleration of the pace to achieve the target is the need of the hour.

2.1. HIV and mobility

Mobility patterns for bridge population impact the prevention, treatment and care continuum by making service continuity a challenge and impacts treatment adherence. Migration is characterised by its patterns of mobility. Unlike the general population, there are challenges in accessing healthcare services and quality HIV prevention, care and treatment services among migrant population[6]. The study on migration patterns by TISS identified six types of mobility patterns based on periodicity[7]:

- Daily commuters
- People returning to the place of origin once a week
- People returning to their place of origin once a month
- People returning to their place of origin once a quarter
- People returning to their place of origin bi-annually
- People returning to their place of origin once a year

2.1.1. Risk and vulnerability of migrants to HIV

Both risk and vulnerability to HIV are heightened in migrants due to a combination of high mobility and high-risk sexual behaviour. The relative freedom at the new place, increased exposure to high-risk sex, peer pressure, consumption of alcohol and limited means of affordable entertainment are all sources for risk and vulnerability to HIV.

Migrants often cannot find quality employment in formal enterprises and have to take up a low-quality, informal activity on their own account in the service sector. This was corroborated by the study[8]

[6] National Operational Guidelines for ART- 2021

[7] Migrants' Emerging Mobility Patterns, High-Risk Behaviours, HIV Vulnerabilities and Responses During COVID-19 in India-TISS-2023.

[8] Migrants' Emerging Mobility Patterns, High-Risk Behaviours, HIV Vulnerabilities and Responses During COVID-19 in India-TISS-2023

conducted by TISS wherein 40% of their sample size were migrants working as skilled/ unskilled labour.

Female migrants have higher vulnerability to HIV due to several factors–[9] 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). Many of the female informal workers are also involved in part- or full-time sex work, many times not using condoms. More than 30% of FSWs in the states of Chhattisgarh, Madhya Pradesh, Jharkhand, Odisha, Assam, Andhra Pradesh and Karnataka reported having income from working as a labourer (agricultural/non-agricultural)[10].

Figure 2: Vulnerabilities of Migrant Population to HIV

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[11] to their places of residence and contributing to the emergence of hotspots in the low prevalent areas. Women who are spouses and partners of informal workers, are vulnerable to infections from their husbands/partners. Married women in source migrant districts may acquire the infection from their husbands on their return.

2.2. HIV among transport workers including truckers

India has about 63.86 lakh km of road network, making it the second largest road network in the world[12]. This comprises of National Highways, Expressways, State Highways, District Roads, Rural Roads, Urban Roads and Project Roads. Although National Highways constitute only 2% of the total road net worth, they bear approximately 40% of the total traffic[13].National Highways are the prime arterial route in the country.

As on March 31st 2019, there were a total of 53,30,182 trucks and lorries registered in the country[14]. In addition to the truck driver, each truck has a conductor and two helpers. The total number of registered vehicles has increased from 0.3 million in 1951 to 295.8 million in 2019 (Transport: 25.89 million; non-transport: 269.88 million).[15]

Sexual activity among transport workers is diverse and underlined by risk. They often engage in sex with multiple partners, such as FSWs along the roads or other regular partners at their stops. This exposes them to a higher risk of getting sexually transmitted infections than the general population. Some transport workers also have sex with male partners. A study on transport workers conducted by TISS[16] revealed that 87% of the respondents were sexually active at the time of the survey. Further, the survey revealed that 58% of the lorry drivers had multiple partners other than wife, and 29.6% engaged in sex under the influence of alcohol.

[9] Policy, Strategy and Operational Plan- HIV Intervention for Migrants-NACO-2010

[10] IBBS, 2014-15

[11] Male-Outmigration: A Factor for the Spread of HIV Infection Among Married Men and Women in India- 2012

[12] Road Transport Year book 2017-18 & 2018-19

[13] Estimates and Functions of National Highway Projects Including Bharatmal Projects- Committee on Estimates- Ministry of Road Transport and Highways-2020-21

[14] Road Transport Year book 2017-18 & 2018-19

[15] Road Transport Year book 2017-18 & 2018-19

[16] Truckers operational research on Changing Sexual Networks and Unexplored Risk Behaviours of Truckers/Drivers and Allied Population in India- TISS-2022-23

A study conducted in 2021 among transport workers revealed that 54% of the respondents have had sex with high-risk partners including FSWs and TGs. 17% had multiple high - risk sexual partners and 38% reported inconsistent use of condoms with their high-risk partners.[17] Majority of the labour work in the informal sector under extremely challenging conditions that include poor working conditions, low wages and no social protection. (World Bank 2020).

The changing mobility patterns necessitate a re-look at the existing intervention in order to saturate the coverage and contribute towards meeting the 95-95-95 goal. The revised strategy and aligned guidelines for bridge and allied populations are an attempt to recalibrate the intervention in light of these changes making the response comprehensive and contemporary.

2.3. Rationale for revised guidelines for the bridge population

The following learnings from the implementation of the bridge population intervention coupled with the evidence of the changing landscape within which they operate necessitates a revision of the existing guidelines.

- **Dynamic mobility patterns:** *Ever changing patterns of mobility based on the evolving needs of destinations and locations is referred to as Dynamic Mobility patterns. This also includes mobility for work at construction sites, where after the completion of construction, mobility changes to different locations*. The dynamic mobility patterns have led to an expanding universe of the bridge population. The operational research conducted by TISS among truckers identified 22 typologies of bridge population including big truck, lorry, dumper truck, mini truck, local taxi/magic taxi, Ola/Uber, intercity taxi, van/Omni, Rapido/Ola/Uber bike, e-rickshaw, intercity bus, city bus, minibus, sleeper bus, auto, shared auto etc.[18]. Similarly for migrants, the study on migrants' emerging mobility pattern conducted by TISS revealed that about 95% of the weekly commuters and 66% of migrants staying for more than 6 months were not covered by TI.[19]
- **Need for a rigorous risk assessment:** The current risk assessment tools need to be made more rigorous to adequately cover the most at-risk sub-groups among the bridge and other vulnerable population under the bridge population intervention.
- **Evolving congregation points**: Evolving nature of highway and formal/ informal industries employing bridge and OVP have impacted the scope of interventions across congregation points and the outreach hotspots. Strategically targeting the bridge population has also been recommended by the Mid-Term Appraisal of NACP-IV in 2016. This has warranted a need for newer outreach approaches like strengthened outreach approach, etc.
- **Intersectionality of risk:** FSW, MSM, TG/Hijra, PWID migrate to cities for various reasons and operate there wherein bridge and other at-risk population then develop relationships among them. Focus on intersectionality of high-risk behaviour attached to bridge population and OVP along with assessment of spaces for vulnerability would be a central theme under the revised Guideline for interventions among Bridge Population under NACP.
- **Co-location of hotpots and congregation points:** Often times the various HRG groups and the bridge population can be found frequenting the same sites/ hotspots (dhabas, hotels, motels, local pubs and bars, construction sites) thereby increasing the chances of inter-mingling and high-risk behaviour.

[17] Exploring Unsafe Sexual Practices Among Truck Drivers at Meerut District, India- A cross-sectional study: Ashish Pundhir-2021

[18] Truckers operational research on Changing Sexual Networks and Unexplored Risk Behaviours of Truckers/Drivers and Allied Population in India- TISS-2022-23

[19] Migrants' Emerging Mobility Patterns, High-Risk Behaviours, HIV Vulnerabilities and Responses During COVID-19 in India-TISS-2023.

- **Optimal resource utilisation:** Low case detection among the bridge population and concerted efforts by the TI programme has pushed for a need to realign service delivery and outreach to rationalise resources. Aligned to the guiding principles of NACP phase V to enhance and harness new partnerships, also reiterated the need towards reaching the unreached population while maximising existing resources.
- **Poor health risk perceptions:** The increase in awareness on HIV due to social media has yet to translate to self-risk perception. According to a study conducted by TISS among migrants in India, a significant percentage of the respondents (63.18%) reported that they believe that they cannot get infected by HIV at all.[20]
- **Engagement of gatekeepers:** Limited involvement of employers in the health and wellbeing of their workers was seen as a challenge. In the revised guideline, a focused and strategic advocacy with the gate keepers would be planned towards a greater impact.
- **At–risk sexual behaviour**: Recent national level studies and survey findings indicate high degree of at-risk sexual behaviour among the bridge population. As per the IBBS (2014-15) 48% of MSMs reported having paid male partners for sex and only 55% among them reported consistent condom use. It was also reported that men and women who were away from home for more than one month or more at a time in the past 12 months, are more likely to have paid for sex (3% versus 1%)[21].

2.4. Operational definitions used under the revised guidelines

For the purpose of intervention aligned to NACP phase V, *the bridge population are defined as population that has potential exposure with HRG group (sexual and injecting) and has a propensity to transmit HIV/STI to the low-risk population/ general population. The bridge population are primarily identified as migrants, transport workers, and other vulnerable population including clients or partners of male and female sex workers, trans-sex workers and men who have sex with men.*

Bridge and Other Vulnerable population (above 18 years of age) to be covered under Targeted Intervention are broadly covered below;

Migrants: Any person moving from one place to other and has the likelihood of exposure to HIV/STI risk irrespective of distance, time or occupation.

Transport Workers: Any person associated with transport industry and has the likelihood of exposure to HIV/STI. This may include commercial drivers, truckers, motor vehicle and population serving them like mechanic, helper etc.

Other Vulnerable Population: Any person, other than migrant or transport workers, who is a part of sexual and/or injecting network of high-risk group population.

It may be noted that any un-covered high-risk groups present in the area of interventions will be covered under Bridge and Other Vulnerable Population intervention.

[20] Tata Institute of Social Sciences (2023) Report on Migrants' Emerging Mobility Patterns, High- risk behaviours, HIV Vulnerabilities and Response during Covid 19 in India.

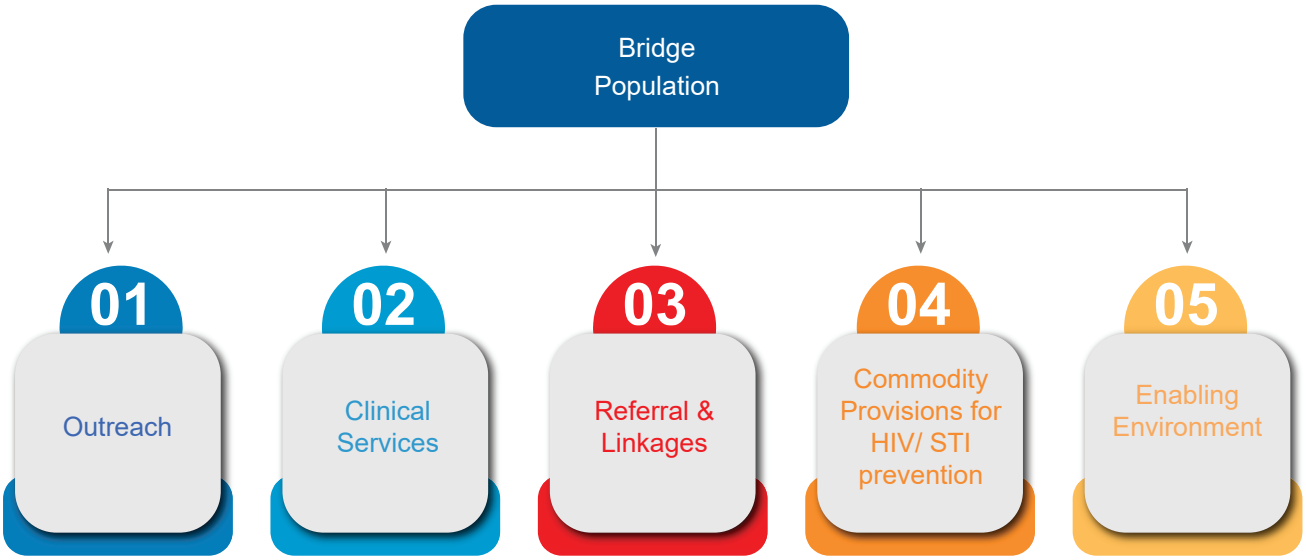
[21] NFHS-V

3

Comprehensive package of services

NACP-V envisages providing an integrated package of services to the beneficiaries and communities, keeping them in the centre of the HIV/AIDS response. In this light, the revised operational strategy aimed at reaching out to the bridge populations with a comprehensive package of services covering the entire spectrum of the prevention, testing, treatment and care cascade. The package of services for bridge and other vulnerable population employs a variety of methods to connect with the target group.

Figure 3: The Package of Services for the Bridge and Other Vulnerable Population Based on the Key Components are as follows:



The packages of services offered to the bridge and other vulnerable population is placed below in the table**:

Components	Comprehensive Package of Services
Outreach	• Peer-led outreach for behaviour change and increase access to health services • Multi-pronged IPC/SBCC material, mid-media, one to one, one to group sessions and counseling • Health camp to provide counselling, HIV/STI screening/ testing • Commodity distributions
Clinical Service	• Health camp in the strategic locations • HIV screening (Community Based Screening (CBS)) and testing • STI diagnosis and treatment facilities (including syphilis) • Colour coded STI drugs • TB screening (4S)[22] • Hep B/C screening • Spouse/ partner testing of HIV positive index cases • Peer navigation to ART services and VL services • Preferred providers' model to improve the availability of STI services
Referral and Linkages	• Referral to ICTC, ART, TB Units, NCD clinics • Referrals to DSRC/ preferred providers • Referral (inter and intra state) to be the focus for all PLHIV • Referral for Hep B and C services and Oral Substitution Therapy(OST) • Networking between DAPCU /DISHA, TI and SACS of source and destination districts
Commodity Distributions	• Condoms (free &social marketing) • Secondary distribution of needle &syringe • Community distribution of ART drugs
Enabling Environment/ Community Mobilization	• Demand generation activities • Awareness generation on HIV prevention, importance of early detection, partner/spouse testing, adherence to ART and viral load suppression (U=U) • Congregational events • Awareness generation on HIV/AIDS Control Act. 2017 • Advocacy meetings with key stakeholders[23] • Crisis management • Event- based activities • Establishing linkages to meet demands beyond HIV/AIDS /STI services • Referral and linkage to appropriate social entitlements

**:The service delivery package will remain same irrespective of the target population.

[22] Operational Guidelines | National AIDS Control Organization | MoHFW | GoI (naco.gov.in)

[23] Individuals whose support helps to create an enabling environment for the implementation of the bridge and other vulnerable population intervention, directly or indirectly.

3.1. Approach/Activities for providing comprehensive package of services

Provision of comprehensive service package for bridge populations is tied up with appropriate approaches to ensure increase access and optimum utilisation of services. Various approaches and activities under the service delivery package are as below. The target population in this section refers to migrants, transport workers and other vulnerable population as defined in earlier section

Components	Approach*	Target population	Proposed activities
Outreach	**Behaviour Change Communication activities**		
	Quality IPC session • One to one • One to group/FGD • Counselling	Bridge and other vulnerable population	• Provide key messages related to information on HIV/STIs, risk perception focusing on consequence of risky behaviour, condom, treatment behaviour etc. • Use of social media messaging platforms for Social and Behaviour Change Communication (SBCC) intervention • Conduct polling booth survey to assess the behaviour of the target population.
	Types of Outreach		
	Rotational Outreach	Bridge and other vulnerable population	The outreach team would move from one-site to another to identify new target population continuously resulting in saturation of existing sites and identification of new ones.
	Flexi Outreach	Bridge and other vulnerable population	• Outreach timings would be flexible to ensure availability of migrants for maximum coverage. ◆ Outreach timings be dependent upon the availability of the bridge and other vulnerable population.
	Geo- Prioritisation	Bridge and other vulnerable population	Outreach to be conducted in high priority geographical locations based on the newly diagnosed STI cases, newly identify People Living with HIV (PLHIV), Integrated Counselling and Testing Centres (ICTC) positivity and no of key population available in the sites.
	Health Camp		
	• Congregation sites or the places selected by the community	High- risk bridge and other vulnerable population	Health camps would be organised at sites which would ensure a high footfall of the bridge and other vulnerable population (Those qualifying under risk assessment).

Components	Approach*	Target population	Proposed activities
Clinical Services	**HIV Counselling & Testing Services**		
	Community Based Screening	High - risk bridge and other vulnerable population who are first time testers and seldom use clinical services and stay away from the services delivery points	• Hold CBS in the sites where the bridge and other vulnerable population stay or work • Screening will be conducted during health camps • Use social network for HIV screening • Hep B/C screening • Screening for Non Communicable Diseases (NCDs) (including hyper-tension and diabetes)
	Referral to nearest ICTC	High- risk bridge and other vulnerable population	• Referral after risk profiling • Counselling at heath camp
	Provision of spouse/ partner testing of index PLHIVs (bridge and other vulnerable population diagnosed with HIV)	The sexual partners, spouse, and injecting network members will be tested for HIV	Help the bridge and other vulnerable population PLHIVs to disclose close contacts (spouse, regular male/female partners, sexual/injecting partners)
	Referral to ART centre	PLHIV bridge and other vulnerable population and their sexual partners	Link with the ART centre as per the NACO CST guidelines
	Peer Navigation	PLHIV bridge and other vulnerable population and their partners	Follow-up of sero-reactive clients and link with ICTC and ART services in the destination locality or facilitate linkage in the preferred location • Regular follow-up on treatment adherence, viral load testing both at destination and source • Maintain at least quarterly once contact with the clients and encourage them positive prevention, partner case management.
	STI check up		
	Health camp	High- risk bridge and other vulnerable population who qualify the risk assessment.	• Plan the timing of health camp in consultation with the stakeholder (like weekly payment day etc.) • Combined with IEC exhibition, counselling facilities • Provide STI/RTI drugs free of cost. • Wherever possible medicines may be procured from the govt. health systems as per the direction of SACS.

Components	Approach*	Target population	Proposed activities
	Referrals		
	DSRC	High risk bridge and other vulnerable population and their sexual partners	Ensure visit to the DSRC and do appropriate follow up.
	Preferred provider		• Identification of referral clinics/ preferred providers. • Ensure mapping of service provider in the area and train them on STI treatments.
	Linkage with industry/ other health clinics of Govt., ESIC or private sectors		• Linkages with company hospital/ Employee State Insurance Corporation(ESIC) facilities. • Coordinate with local private or govt. hospitals, NGOs/CBOs run clinics, mobile clinics to link the population.
Commodity Distribution	**Provision of condoms, lubes, N/S, OST, ART**		
	• Free distribution of condoms as per eligibility under risk assessment • Through Social Marketing • Linkages with nearest TG/MSM TI, PWID TI if no TI is present in the intervention area • Linkages to nearest TI for OST	High risk bridge and other vulnerable population and other core identified HRGs who seek services	• Focus on condom demand generation activities • Prioritise spots for initiating condom outlets • Create outlets at the destination or congregation points • Provide information to the population about availability of time and brands of condom • Share the message on availability of condom during counselling. • Provision of condoms in the DIC and while conducting health camp • Cater to the population who require lubes primarily to be referred to nearest TI to increase access to services. As required N/S may also be procured and distributed with intimation to NACO. Existing operational guidelines for collection of needles /syringes and bio medical waste management for Secondary Distribution of Needle and Syringes (SDNS) to be used. • Cater to the population who require OST primarily to be referred to nearest TI to increase access to services. • Community ART distribution

Components	Approach*	Target population	Proposed activities
Enabling Environment/ Community Mobilization	• Demand generation activities • Congregational events • Advocacy activities • Crisis management	High - risk bridge and other vulnerable population and other core identified HRGs who seek services	• Vulnerability issues of bridge and other vulnerable population to be addressed. • Increase HIV related service uptake. • Increase non –HIV related service uptake. • Focus on new bridge and other vulnerable population sites (feasibility assessment), event-based activities. • Referral and linkage to appropriate social entitlements. • Awareness generation on HIV/AIDS Control Act. 2017.

The approach/activities mentioned above in the table are explained in detail in the subsequent chapter.

4

Strategic approach for service delivery

4.1. Outreach

Peer led outreach is the key to increase coverage and provide services to the beneficiaries under the bridge and other vulnerable population intervention. Use of an integrated multi-faceted IEC/ SBCC approach including mid- media events and organising congregational events like health camps to attract the target population is critical to expand coverage, service delivery and linkages with non-HIV and HIV services as per the individual needs.

4.1.1. Types of outreach

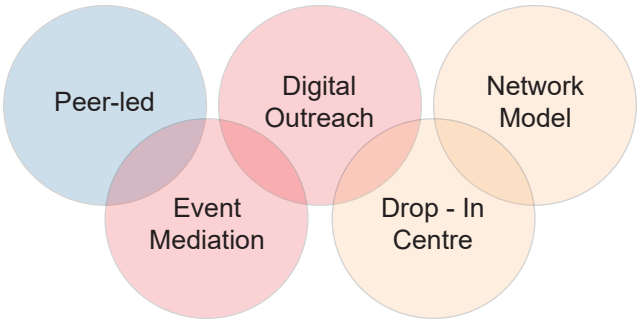
Several new outreach methods have been added in the revised guidelines for maximum coverage of the bridge and other vulnerable population.

- **Rotational outreach**: The outreach team shifts from one-site to another to identify new target population continuously with clear demarcation of geographies to avoid duplication. This may be applicable in seasonal migration, shifting occupations in certain settings. This would result in saturation of the identified sites and increase the coverage of the bridge population in the identified and selected geographies.
- **Outreach to newer geographical locations:** The team during their outreach activities will also find out newer hotspots or geographies where the target population congregates/ resides through the help of the brokers/ agents, stakeholders and target population themselves. The same will be added to the outreach site lists. Outreach would be conducted beyond the identified sites where the target population congregates/resides/ works.
- **Flexi-time outreach:** The timings of the outreach activity would be flexible to ensure availability of the target population for maximum coverage. The traditional outreach timings will not be applicable but will be dependent on the population and the times that they are available at a particular hotspot. However, safety of the field staff should be of priority considering this approach may warrant for evening outreach in the field to reach the target population.
- **Geoprioritisation:** This outreach strategy would focus on high- burden priority geographical locations/ congregation sites by assessing critical indicators like positivity in STI, number of newly identified HIV cases, ICTC positivity, and availability of key population at the sites/ location.

4.1.2. Outreach models

Peer-led intervention has been the mainstay of the outreach strategy under the TI programme. The revised guidelines go beyond the conventional norm of peer led outreach in an attempt to reach the unreached.

Figure 4: Outreach Models used for the Bridge and Other Vulnerable Population



- **Peer led Outreach**: Peer led approaches have been the hallmark of TI programme. A peer is a person from the target community and shares common attributes with the target population. These peers are important aspect of the community as they have adequate information about the risk and vulnerability issues associated with migration/mobility/ vulnerability associated with the work or its settings, they belong to the same culture and ethnicity, and they have good understanding about the issues related to the life of a migrant/ transport worker/other vulnerable population. For reaching out to high-risk bridge and other vulnerable population, the project will recruit and utilise the services of labour contractors, employer association, stake holders, members of the labour unions, etc as peer educators (PE) to conduct outreach sessions and provide the package of services to the target population. These PEs will work with the target population to influence attitude and behaviour change for participation in accessing services and use of prevention methods including commodities.
- **Digital Outreach:** Digital based behaviour change communication material will be provided through the following platforms:
  - Messaging app based digital communication: The PE/ ORW (Outreach Worker) will use application based digital communication to reach out to the target audience with standardised messaging on HIV/ AIDS and STI.
  - NACO toll free helpline: 1097 is a NACO toll free helpline number to get information on HIV/AIDS. This number is displayed on all IEC materials developed by NACO. PE/ ORW would make the bridge and other vulnerable population aware of it during the IPC sessions and demonstrate its use by making calls so that live demo is done with counsellor through 1097.
  - NACO AIDS App: NACO has developed an application that spreads awareness on HIV/ AIDS amongst masses with the help of its gamification feature. The application is available in 12 regional languages with features that include FAQs, NACO toll free helpline, interactive risk evaluator, social protection schemes, location of HIV/ AIDS related facilities, media jingles and social protection schemes. PEs/ ORWs can ask the bridge and other vulnerable population having smart phones to download the app. This will ensure that the information on HIV/ AIDS is just a click away.
  - Social media platforms: Social media platforms are an effective medium to share and disseminate information on various topics including HIV/ AIDS in an interactive manner. PEs/ ORWs will also ensure awareness on the various social media platforms of NACO to their target population.
  - Digital based SBCC material: ORW may use the digital based SBCC content in their smart phone/tablet for conducting SBCC activities and the same may also be used for documentation. Information will also be disseminated to population through messaging applications.
  - Ayushman Bharat Health Account (ABHA) ID: In order to ensure uninterrupted service delivery and treatment adherence among the target population, ABHA ID (Ayushman Bharat Health Account)-may be used to share and assess the health records

digitally. For more details on this please refer to ABHA number (ndhm.gov.in).

- **Social Network Model:** Several studies suggest that bridge and other vulnerable population sharing common attributes like geography, language and ethnicity continue to stay together in destination areas. Some of these networks have common group behaviours related to substance use, unprotected sex and health seeking behaviours. They are often controlled by leaders/agents representing the same community. This consequently results in an informal social network. Increased use of digital and social media platforms has added another layer of complexity and relevance of these networks. It is crucial for the intervention to identify these networks for saturating the outreach.
- **Drop-in-Centres:** Office cum Drop-in Centre (DIC) will be established within the premises of the TI office. There will be opportunity for recreational activities within these centres for the bridge and other vulnerable population. The DIC would also have a resource kit which will include information on HIV/AIDS/STI, commodities, resource directory, etc.
- **Event Mediated:** Organising events during key festivals can attract large groups of people. To ensure maximum attendance, services such as general health check-ups, HIV-related services, first-aid orientation, and services for the target population through the camp approach can be provided by local organisations. These events should aim to attract at least 30-40 new bridge and other vulnerable population members and offer them a package of services.

4.1.3. Multi-pronged SBCC

Multi-pronged SBCC using multi/mid media, IPC tools, individual and group sessions will be implemented. The SBCC strategy will also use various other mechanisms like social media, customised IEC materials, etc to provide key messages on priority topics.

Standard IPC tools will be used by the outreach team. The aim of IPC would be to elicit personal information in a non-discriminatory manner to identify risky behaviour among the population. This will also encourage increased personal risk perception. Some examples of IPC tools are as follows:

- **Daily routine of the bridge and other vulnerable population (KP Dincharya):** Understanding the daily routine of bridge and other vulnerable population helps in planning timings of outreach. The exercise needs to be done with a group of 12-target group individual where the outreach team will elicit information about their daily routine under different timeslots. The daily routine on off-days would be noted separately as it might differ from the working days.
- **Body mapping:** Through this tool the target population explore STI and HIV vulnerability factors relating to the body. It also increases comfort level in the people when speaking about different parts of the body related to sex.
- **Risk analysis:** Outreach team will facilitate the discussion on risk analysis among the bridge and other vulnerable population and the ways to reduce the risk and keep them safe from HIV / STI.

Under counselling, the TI staff will have one-to-one and one-to-group sessions with the identified high-risk bridge and other vulnerable population individuals. Key messages related to HIV/STIs, risk perception focusing on consequence of risky behaviour, condoms, treatment literacy, key services and programmes, etc., will be delivered during these sessions.

4.2. Clinical services

This will involve services related to STI treatment and management which will be provided through the existing government public health delivery system. The PEs will be trained to provide counselling related to prevention and management of STIs.

- **Static Clinics:** The bridge and other vulnerable population would be referred to nearest ICTCs for the HIV testing and

Designated STI/Centres (DSRC) in the government hospitals. In order to increase or improve the availability of STI related services, Preferred Providers Model would also be employed. PE/ORW will also talk about the preferred providers in area of intervention with the bridge and other vulnerable population in case of referrals for STIs. Preferred providers are private providers who are identified based on a focused group discussion with the target population, who are located in and around the intervention area and are preferred by the community.

- **Health Camps**: Health camps are an effective way to provide clinical services to the high-risk bridge and other vulnerable population. The guidelines have a provision for organizing health camps wherein the bridge and other vulnerable population will be introduced to the comprehensive package of health activities. Provision of health services through these camps at their location would overcome barriers to accessing these services. Following services are to be made available during the health camp.[24]
  - HIV & STI counselling
  - HIV & STI screening facilities
  - Condom promotion activities
  - including Inter-Personal Communication/ Behaviour Change Communication
  - Condom Social Marketing
  - Linkages to Hepatitis B & C screening/ treatment, ANC check-ups, immunization, TB 4S screening, ICTC and NCDs (hypertension, diabetes, etc)
  - Health exhibitions
  - General health check-up facilities
  - HIV & STI Information, Education and Communication activities

At the source districts, the health camps are primarily targeted at the individuals from the bridge and other vulnerable population who are visiting home and their spouses/partners. Since festivals serve as entry points for the bridge and other vulnerable population to come back home, these camps are organized during the key festival season to ensure maximum footfall. This also allows their spouses and partners who are often left behind, to access HIV services.

In order to provide HIV/STI services to at risk population, NACO has developed SOP to conduct integrated health campaign in selected geographies in the state. This SOP details out the modalities of conducting health campaigns, service packages, referral and linkages and leveraging the support of various stakeholders. The SOP is available at *www:// https://naco.gov.in/sites/default/files/Guidelines_for_organising_intensive_health_camps_and_communication_activities_in_out_migration_districts_Sep_2012.pdf*.

- **HIV screening and testing**: Community-based HIV screening (CBS) offers individuals who may typically be missed by the healthcare system an opportunity for screening for HIV at their preferred place. CBS is an important approach for improving early diagnosis, reaching first time testers and individuals who seldom use clinical services, including men and adolescents in high-prevalence districts. The intervention would follow the approaches outlined in the National HIV Counselling and Testing Services (HCTS) Guidelines of NACO (2016).
- **TB 4S Screening:** TB is the most common Opportunistic Infection (OI) among PLHIVs and a leading cause of hospitalization and death. PLHIV are 18 times more likely to get TB disease than a non- PLHIV[25]. 4S TB screening becomes an important tool for early diagnosis and treatment of TB. All individuals from bridge and other vulnerable population enrolled under the intervention would be screened for 4 symptoms of TB.
- **Referrals to ICTC, ART, TB Units (TU) Non-Communicable Diseases (NCDs):** Referrals would be made to public medical facilities

[24] Guidelines for Organising Intensive Health Camps and Communication Activities in Out-Migration Districts- NACO-2012

[25] India TB Report, 2023

where HIV and related services (NCD, NAAT/ DMC) are available. The individuals identified and registered with the intervention will be linked through referrals with ICTC, ART, TB and NCDs (Government ART Centres, Care and Support Centers, PPTCT clinics, ICTC, TUs etc).Linkages will also be made with Civil Society Organisations (CSOs) working on HIV prevention and care within the district.

- **Spouse and partner testing of HIV positive index cases.** Partner and spouse testing is a highly recommended strategy to increase reach and testing coverage of bridge and other vulnerable population and their social, sexual and injecting partners. Evidence proves that tracing the sexual/injecting partners of HIV-diagnosed clients is feasible and effective in identifying persons with undiagnosed HIV infection. The bridge and other vulnerable population will be helped/ counselled to refer their partners for HIV screening and testing. In case the spouses and partners of the bridge and other vulnerable population are not available at the project site, counselling and follow-up by the team is required to ensure that they are tested at the place they are available.
- **PLHIV navigation to link with ART services and VL services:** In order to ensure linkages to newly diagnosed PLHIVs through CBS and ICTC and for those who are already positive, the intervention would implement peer navigation services. Peer navigation approach comes highly recommended by the mid-term appraisal of NACP -IV. It also finds endorsement in the TI Strategy document to achieve the second 95 of the 95-95-95.
- Under the revised guidelines peer navigation would be the responsibility of the Counsellors/ ORW. Peer navigators would:
  - Enhance treatment literacy
  - Navigate PLHIV to the ART centre
  - Support in contacting drop out PLHIV for linkage
  - Support in ART adherence
  - Retain and mobilise all eligible target population PLHIV for viral load testing
- **Inter-state linkages:** India has a robust and extensive public health system with a strong inter-state referral mechanism. The endeavour, by leveraging the existing mechanism, is to keep the care continuum intact and seamless across geographies for the bridge and other vulnerable population. Inter-state linkages for individuals from bridge and other vulnerable population would be fostered and strengthened by tapping into the existing initiatives under NACP:
  - **TI Networks:** The multi- level networks of the target population groups can be utilised to ensure that the care cascade continuum is maintained across geographies.
  - **SOCH:** End-to-end beneficiary tracking, supply chain management and a provision of a unique ID of beneficiaries which can be linked to other MoHFW systems makes SOCH an ideal platform for inter-state linkages.
  - **DISHA:** Coordination with DISHA to be prioritised for effortless and timely services to the beneficiaries.
  - **Telephonic follow up:** PE/ ORW to follow up the beneficiaries telephonically to ensure that they are linked to appropriate services in a timely manner.
  - **Coordination with ART centres:** The National Operational Guidelines for ART Services 2021, also lay down a 6-step process to ensure the continuity of the care continuum for potentially mobile walk-in clients. Coordination with the ART centres and the TI would ensure the treatment adherence of the PLHIV from the bridge and other vulnerable population.
  - **Coordination between states:** In order to ensure uninterrupted service delivery and linkages of individuals with HIV/STI, data and information sharing between the State is envisaged. The State would need to adhere to the data confidentially and sharing guidelines of NACO.
  - **Ayushman Bharat Health Account (ABHA) ID:** Please refer to Chapter 4 page 18 for more details

- **Identification of clients with potential of mobility**: During the first visit to the ART centre, the counsellor must try and identify the PLHIV with potential for mobility. The identified individuals will then be connected with the bridge and other vulnerable population intervention.
- **Documentation of complete contact details**: Address and phone number of the permanent residence/source/destination site is taken from the clients. This will help track the client even if he/she/them chooses to migrate to a new location in future.
- **Focused counselling**: The ART counsellor will provide detailed options to the clients. This will be on multi-month dispensation, transfer-out mechanism and regarding the nearest ART centre where the client with their green book can access ART medication though the process of getting "transferred-in".
- **Follow-up visits**: The ART counsellor enquires about the travel plans of such PLHIV. If necessary, Multi Month Dispensation (MMD) or transfer out can be done.
- **Weekly telephonic follow-up**: Weekly telephonic follow-up will be done for mobile population to track the client till s/he reaches the destination ART centre.
- **Referral and linkages:** Under the revised guidelines referrals to services and linkages with various entities within the NACP would be provided to ensure smooth end to end service delivery.
- **HIV referrals:** All bridge and other vulnerable population who are eligible under the risk assessment would be tested for HIV in the health camp. Those diagnosed with HIV would then be referred for confirmatory tests to the nearest ICTC.
- **STI referral:** All bridge and other vulnerable population individuals who experience STI symptoms in the last three months would be screened for STI once again at the health camp. Individuals who exhibit symptoms of STI would be referred to DSRC/ private providers from the health camp for STI management.
- **TB referrals:** All bridge and other vulnerable population individuals who are screened for TB and found presumptive would be referred to the nearest TU. If the individual is HIV negative, the treatment would be initiated at the nearest TU. In case of PLHIVs, the TB treatment would begin at the same centre where he is taking his ART from.
- **Referral to OST centres:** Bridge and other vulnerable population individuals who inject drugs are at the dual risk of HIV. Such individuals would be referred to the nearest IDU TI to provide linkages to one of the three models for OST dispensation[26].
- **Referral for hepatitis screening:** The risk of viral hepatitis infection may be higher in HIV-infected adults, and therefore all people newly diagnosed with HIV should be screened for it. All bridge and other vulnerable PLHIV would be referred to the nearest hepatitis designated testing and treatment centres27.
- **Networking between DISHA, TI and SACS of source and destination districts:** Strong linkages would be developed between DISHA, TI and SACS of source and destination districts for uninterrupted service delivery across geographies as per the National Operational Guidelines for ART Services 2021(Chapter 7, section 7.2.2).

4.3. Availability of commodities for prevention of HIV & STI

NACO is committed to meeting the first 95 in the given timeframe. Thus, in the revised guidelines, distribution of commodities like condom, STI drugs and Needle/Syringe is provisioned for.

- Condoms: Social marketing of condoms would be supplemented with free condom distribution as per eligibility under the risk assessment. More condom outlets would be

[26] Standard Operating Procedure for Buprenorphine based Opioid Substitution Therapy Under NACO

[27] || NVHCP || (mohfw.gov.in)

opened to meet the condom demands.

- STI drugs: SACS would be responsible for providing free STI drugs to the bridge and other vulnerable population.
- NS distribution**:** Needles and syringes would be procured for the eligible bridge and other vulnerable population.
- Lube: Eligible bridge population individuals would be linked to the nearest TI.

4.4. Enabling environment

Creating an enabling environment is also a key focus approach for successful implementation of the bridge and other vulnerable population intervention. Following activities would be undertaken for creation of an enabling environment:

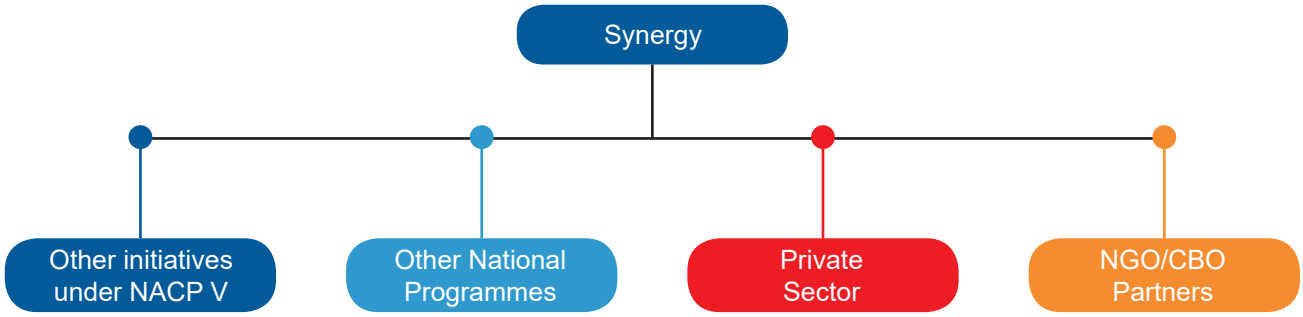
- **Linkages with stakeholders**: Stakeholder mapping would be undertaken to identify key agencies or individuals who can facilitate the linkage and delivery of services. Linkages with local youth clubs, trade union associations, community leaders, dhaba / hotel owners and other key stakeholders including contractors and recruitment agencies provide useful information and access to these bridge and other vulnerable population groups.
- **Linking with welfare and social protection***:* Linkages to existing social protection schemes contribute towards improving the quality of life of the individuals. They are also an effective way to cater to the wider needs of the target population thereby sustaining their interest in the intervention. The intervention provides for an easy access to social protection and welfare schemes of the government. The ORW will ensure that the workers access these schemes, where eligible.
- **Ministry of Labour & Employment/ Ministry of Housing and Urban Affairs / Department of Labour Welfare/ Department of Urban Development/, etc:** In order to provide access to social benefits/services under various government schemes, linkages and coordination will be strengthened. The benefits and services cover health, education, housing, recreation, and skill development for the workers.

A matrix on different areas of collaboration with Ministries and Departments is presented as below:

Partners for collaboration	Areas of collaboration
Ministry of Labour and Employment	Employee State Insurance Scheme (ESI) E-shram portal to collect information on workers, to plan existing provisions of welfare schemes for un-organized sectors.
Ministry of Transport and Highways	**Re-assessment** of halting points (E-passage), **Re-mapping** of congregation points (positioning of Transport Nagar in outskirt) and **Re-estimation** of commercial drivers for the feasibility of DIC services at resting point on highways
Ministry of Health and Family Welfare	Janani Suraksha Yojna (JSY) Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) Pradhan Mantri Matru Vandana Yojana. (PMMVY)
Department of Transport, NHAI, Port, IOCL, BPCL	Data on transport workers, local facilities available and leverage their premises and resources for intervention Pradhmantri Jan Arogya Yojna (PMJAY)

In the light of NACP phase V guiding principle, “breaking the silos and build synergies” has been the key strategic step to leverage and expand services to bridge and other vulnerable population. Collaborations and partnerships would be fostered to build synergies with other initiatives both within and outside of NACP including other NGOs/CBOs and private sector to maximise the benefits for the community. Synergies would be developed and strengthened at National, State and Districts levels.

Figure 5: Synergy with various Ministries/ Departments under TI



- **Crisis management system:** The bridge and other vulnerable population intervention has a provision for crisis response system to extend help and support in times of crisis like conflict with employer, Gender Based Violence or Intimate Partner Violence etc. Crisis management system will enlist support from police, and legal authorities to access legal support. The Gender Based Violence (GBV)[28] / intimate partner violence results in fear, limit the ability to negotiate safer sex and refusal to get tested for HIV among spouses/ partner. Support will be provided to victims of GBV through linkage with other support organizations.

[28] GBV is any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering that is directed against a person because of their biological sex, gender identity or perceived adherence to socially defined norms of masculinity and femininity. GBV includes intimate partner violence and can be physical, sexual, emotional, economic, or structural where that violence targets someone because of their gender or non-compliance with gender norms. It can be experienced by women and girls, men and boys, and transgender and intersex people of all ages and has direct consequences on health, social, financial, and other aspects of their lives: Council of Europe

5

Operational plan for targetted intervention

5.1. Site identification for intervention

Site identification is a crucial step towards reaching out to the bridge and other vulnerable population through program intervention. The bridge and other vulnerable population gather in different setting for rest, leisure or work. A comprehensive understanding of these sites is critical for reaching out to them. The target population in the below section will include migrants, transport workers and other vulnerable population as defined in earlier chapters.

Introduction of technology has impacted the way the target population functions within their workspace and consequently has impacted the site selection as well. An example of this can be seen in the trucking industry where the relay model has been established. Pit- spots are set up, a place along the highways where one driver hands over the truck to another for further journey. A truck driver is on the road for around 10 hours before going back home, as they live close to the pit spots. Technology is used for roster duty at pit stops, schedule pick-ups and deliveries.[29]

[29] Indian Trucking Industry - Skilling the Supply Chain (devalt.org)

- **Congregation points:** Any point where the target population come together for a special purpose. Labour naka/ chowk etc can be included here.
- **Service outlets**: Any point which offers any transactional services to the target population. Such points include fuel stations, garages, road side dhabas/ dhabas near to the congregation sites, barber shops, petty shop owners, alcohol outlets, money transfer outlets etc.
- **Entertainment points:** Places frequented by the bridge and other vulnerable population for their entertainment purpose. This would include video parlours, cinema halls, hotspots, parks, malls, dance bars etc.
- **Transhipment locations**: Transhipment locations are places where the transport workers get the consignment off-loaded and get a new consignment so that they can be on their return or onward journey. Transport nagars, ports, transhipment points, industrial yard/ corporate premises, loading and unloading points, transport offices, factory loading and unloading yards, ports, railway yards, etc are examples of transhipment locations.
- **Highway-based parking lots:** These designated resting points for the trucks during

their journey. They serve as congregation points for the truck drivers, helpers and cleaners.

- **Taxi/ bus stand**: Short-distance passenger transport vehicles like local taxis, buses etc have designated parking spaces where they wait for the customers.
- **Seasonal migration spots:** These are places where the bridge and other vulnerable population gathers on a seasonal basis for work. These places are determined by the yearly cycle of weather, and these sites are such places that serve as the points of movement for bridge and other vulnerable population like brick-kilns, agricultural lands, etc.
- **Workplace**: These are places where the bridge and other vulnerable population go for work like industries, factories, construction sites, etc. Many states in India promote small and medium-scale industrial development. These industrial zones or areas are concentrated in one particular location. Migrants may stay on the industry site or in the surrounding neighbourhoods. The workers here would be skilled or semi-skilled and would work in both formal and informal sectors. Example of these can be seen in Maharashtra Industrial Development Corporations (MIDCs) or Industrial Associations like Thane Belapur Associations of Industries (TBAI) etc.

These settings need to be prioritised based on the vulnerability and risk assessment, assessing the mobility pattern, current HIV testing trends and HIV positivity, access to HRGs and client profile of HRGs representing these bridge and other vulnerable population.

5.2. Activity flow

Evidence suggests that not everyone in the target population is equally exposed to the risk of HIV. The revised guidelines suggest a four-pronged strategy to ensure that the right individuals are reached out to and provided with the comprehensive package of services.

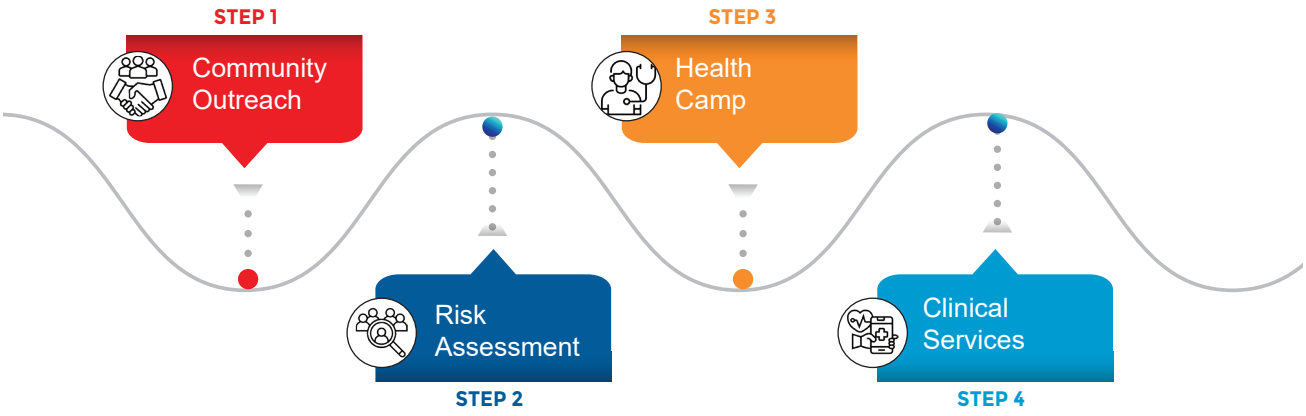
5.3. Operational plan

The operationalisation plan for the bridge and other vulnerable population intervention would be a three-step process detailing further activities under each step.

Step 1: **Planning:** Planning would involve the activities that would prepare the ground for effective risk assessment and service delivery.

Quarterly Situational Needs Assessment: A situational needs assessment (SNA) need to be conducted every quarter to assess the presence of bridge and other vulnerable population. This SNA should also take into account the time HRGs are available at various soliciting sites including

Figure 6: Flow of Activities with the Bridge and Other Vulnerable Population



hotspots, liquor shops, bar etc., where the target population is likely to engage in solicitation for Sex or congregate for injecting drugs.

While conducting the SNA activity, field team should understand the significance of collecting information related to spaces of vulnerability. The space-- whether social or physical-- in which the interplay of factors external to the individual increases their likelihood of engaging in risky behaviours that predispose to HIV infection or decreases their likelihood of accessing HIV prevention or treatment. This is central to the understanding of the risk transmission and in planning the response, hence, as part of the SNA exercise, data should be collected under different categories, i.e., physical, social, economic, policy that interact at the micro and macro levels of environmental influence. **The details pertaining to spaces of vulnerability is given in annexure**.

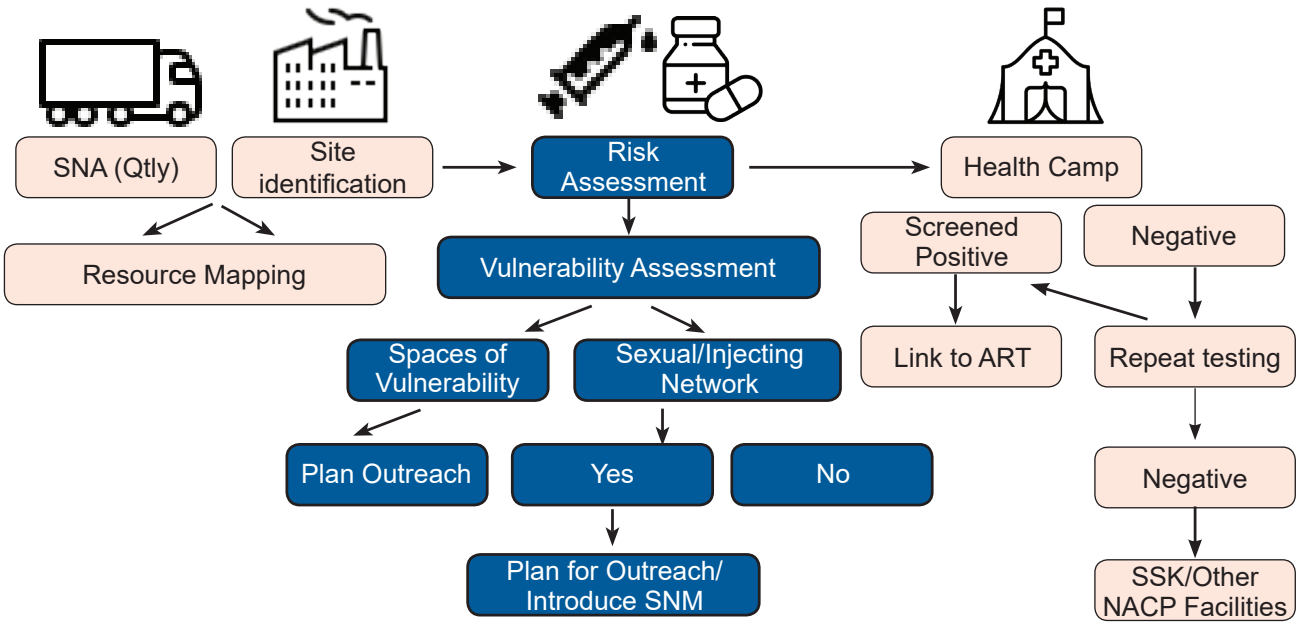
- **Site Identification:** Site identification would be done based on the factors of load, existence of TI, proximity of a hotspot, etc.
- **Resource Mapping**: Resource mapping would be done to identify resources related to HIV/ AIDS services, health facilities and other services.

Step 2: Population Mobilisation: Through mediums like mid-media, multi-media, interpersonal communication, SBCC the bridge and other vulnerable population will be mobilized for risk assessment.

- **Risk Assessment:** Once the population is mobilised, a standardised tool will be used to determine the risk of the bridge and other vulnerable population covered through outreach. This is a crucial step in order to prioritize the population for providing the package of services under the bridge and other vulnerable population.
- **Vulnerability Assessment:** Vulnerability assessment of the at- risk population is done by exploring spaces of vulnerability and social, sexual and injecting networks.
  - **Spaces of vulnerability:** This exercise identifies the time and space where the bridge and other vulnerable population is most vulnerable.
  - **Exploring social, sexual and injecting networks:** In case any bridge and other vulnerable population individual is a part of any of the social, sexual and injecting networks, enhanced outreach would be introduced.

Step 3: Health Camps / Clinical Services: The bridge and other vulnerable population at risk is provided appropriate clinical services / linkages in

Figure 7: Operational Plan for the Bridge and Other Vulnerable Population Intervention



a health camp. The linkages to services will be as per the need based on the HIV and STI screening including linkages to TIs, LWS, Sampoorna Suraksha Kendra (SSK), etc for prevention and ICTC and ART for testing and treatment. Sensitisation of the linked facilities would also be conducted to ensure smooth service delivery.

5.4. Outreach planning

Outreach planning is essential for the effective execution and implementation of outreach. Outreach **Micro Plan** is a defined mechanism with fixed responsibilities for each member of the outreach team. Both, PEs and ORWs develop their monthly micro-plan that includes SBCC sessions, events, health camps, condom distribution and crisis management for the migrants in their zone. ORWs monitor their peers' performance and the delivery of monthly services in consultation with project staff to ensure that the minimum package of health, communication and HIV prevention services reaches all bridge and other vulnerable population as per their needs in the intervention geography.

5.4.1. Elements of outreach micro plan

The outreach plan is developed for each site by the ORW and peers. The plan is updated and analysed on a monthly basis.

- **Site Map**: A site map is a planning tool used to understand availability of bridge and other vulnerable population at their work-place, congregation points, recreation points, peak & lean times/ seasons etc. It provides information about number of individuals at the congregation site and the nearby places frequently visited by bridge and other vulnerable population. This map needs to be drawn for every TI site.

  In case of seasonal migrants this needs to be repeated as per the need, in other instances at least once in six months.

- **Volume of Bridge and Other Vulnerable Population**: This exercise determines the approximate number of new bridge and other vulnerable population that frequent the sites and the ones that have relocated/ vacated the site.

- **Resource Map:** A resource map is a pictorial depiction of the location and distribution of health, recreation, workplace, companies and HIV services. Focus will be on health system service points like hospitals, health posts for referrals and linkages, and HIV/TB Units.

5.4.2. IPC session implementation plan

Under the bridge and other vulnerable population intervention, the outreach activity is conducted by PE/ ORW.

- **PE**: Each PE would conduct 20 IPC/ FDGs sessions per month. The sessions would be conducted based on the availability of the bridge and other vulnerable population members…. and as per the micro plan.
- **ORW:** Each ORW will monitor 50% sessions of the peers under them. They would also conduct 12 IPC session per month. ORW will play the role of facilitator and in the absence of peer educator they would conduct the sessions.

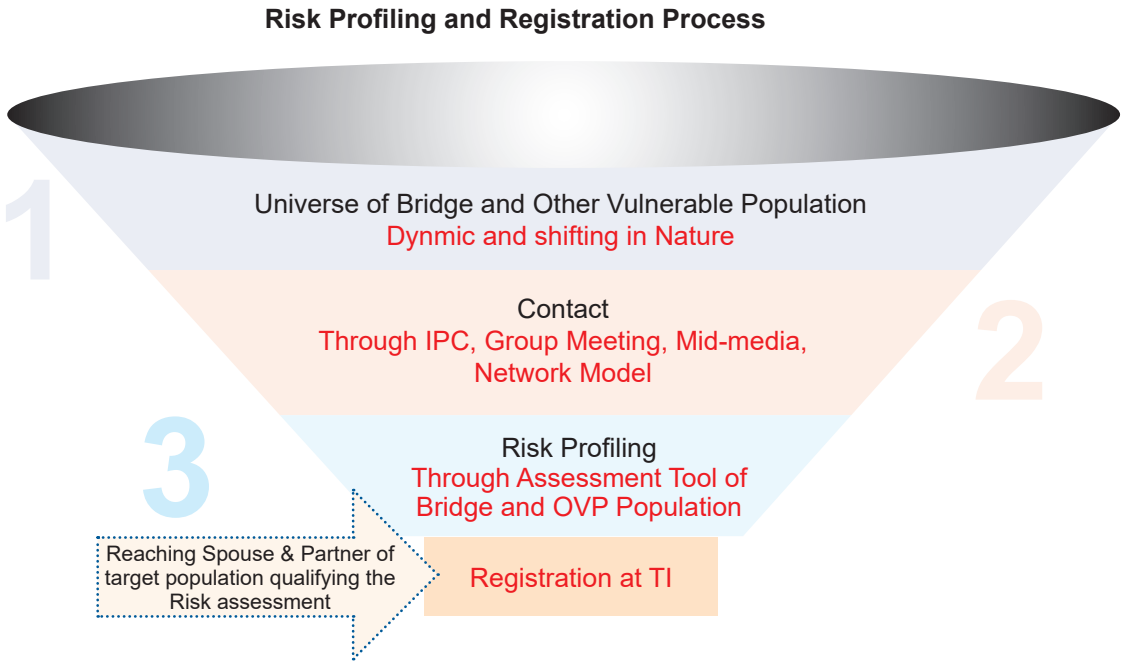
5.5. Risk and vulnerability assessment

Evidence suggests that all bridge and other vulnerable population do not have equal risk to HIV. Their individual risk and vulnerability are dependent on behavioural and environmental factors. The focus of revisiting the bridge and other vulnerable population intervention is to prioritise high-risk target population and provide tailor made comprehensive services.

5.5.1. Risk and vulnerability assessment definition

Risk and vulnerability assessment is an essential step that filters out the target population who exhibit high vulnerability and high risk to HIV for the purpose of enrolling the right individuals under the intervention. The Risk Assessment exercise will be conducted for all bridge population reached out to during outreach activity in the intervention area.

Figure 8: Process of Identification of Bridge and Other Vulnerable Population for delivering Comprehensive Package of Services



5.5.2. Risk and vulnerability assessment questionnaire

Risk Assessment questions are primarily based on the history of mobility, knowledge of HIV Status, sexual/injecting practices and reported history of STI / ART linkages of bridge and other vulnerable population. The following table lists down the set of questions to determine various areas of risk along with the expected responses.

Risk Areas	S No	Questions	Expected Responses
Mobility History	1	How frequently do you move for economic activity?	• Daily • Weekly • Monthly • Quarterly • Bi- annually • Annually
Sexual behaviour of the bridge and other vulnerable population	2	Do you have any sexual relationship beyond your spouse/partner? (if answer is No,skip to Q 5)	• Yes • No • Refuse to answer
	2.1	What kind of sexual partner(s) you have?	• Male • Female • TG • No Sexual Partner • Refuse to answer

Risk Areas	S No	Questions	Expected Responses
	3	Have you bought sex in the past from a man, woman or TG using money, goods, favours or benefits?	• Yes • No • Refuse to answer
	4	Have you provided sex in the past in exchange for money, goods, favours or benefits?	• Yes • No • Refuse to answer
Use of drugs (Injecting / sharing)	5	Do you have the habit of using /sharing injecting drugs?	• Used • Shared • No • Refuse to answer
History of STI infection	6	Have you experienced any STI symptoms in the last three months?	• Yes • No • Refuse to answer
Condom use in the last sex act	7	Have you used condom during the last sex act with your partner other than regular/spouse?	• Yes • No • Refuse to answer
HIV Status	8	Do you know your HIV status?	• Yes • No • Refuse to answer
Willingness for service uptake	9	Are you willing to get tested for HIV/STI check-up?	• Yes • No • Refuse to answer
Know more about ART	10	Do you want to know about ART?	• Yes • No • Refuse to answer

Please Note:
Question 1 is a method of rapport building.

If the answer to any two questions from ques 2-10 is yes, the individual is eligible for registration.
From the above table question number, 2-6 have been taken from the risk assessment factor in SOCH.

5.6. Registration of bridge and other vulnerable population

The bridge and other vulnerable population intervention activities are a combination of outreach and service delivery. While the outreach activities are aimed at large proportion of bridge and other vulnerable population at sites which have been identified based on the process described in section3.4, the service provision is designed for individuals from the bridge and other vulnerable population identified as high- risk.

After the risk assessment, individuals from the bridge and other vulnerable population who are identified as high risk will be registered in the TI and will be provided tailor made comprehensive services.

5.7. Documentation by outreach team (peer educator and outreach worker

The ORWs and PEs are to maintain the following documents under the intervention:

- **Daily Diary:** The PE and ORW should document the details of the activities conducted in the field. Number of target population met every day needs to be documented in their daily diary. The session wise list of bridge and other vulnerable population individuals

contacted by PE/ORW will be recorded in their diary along with category of sites covered (construction site, industrial site etc). At the same time, the details of the bridge and other vulnerable population who are contacted through health camp, mobile health camps, preferred providers, Government clinics, DIC, or through CBS should be maintained. The list of population that needs to be followed up will also be recorded in the same diary.

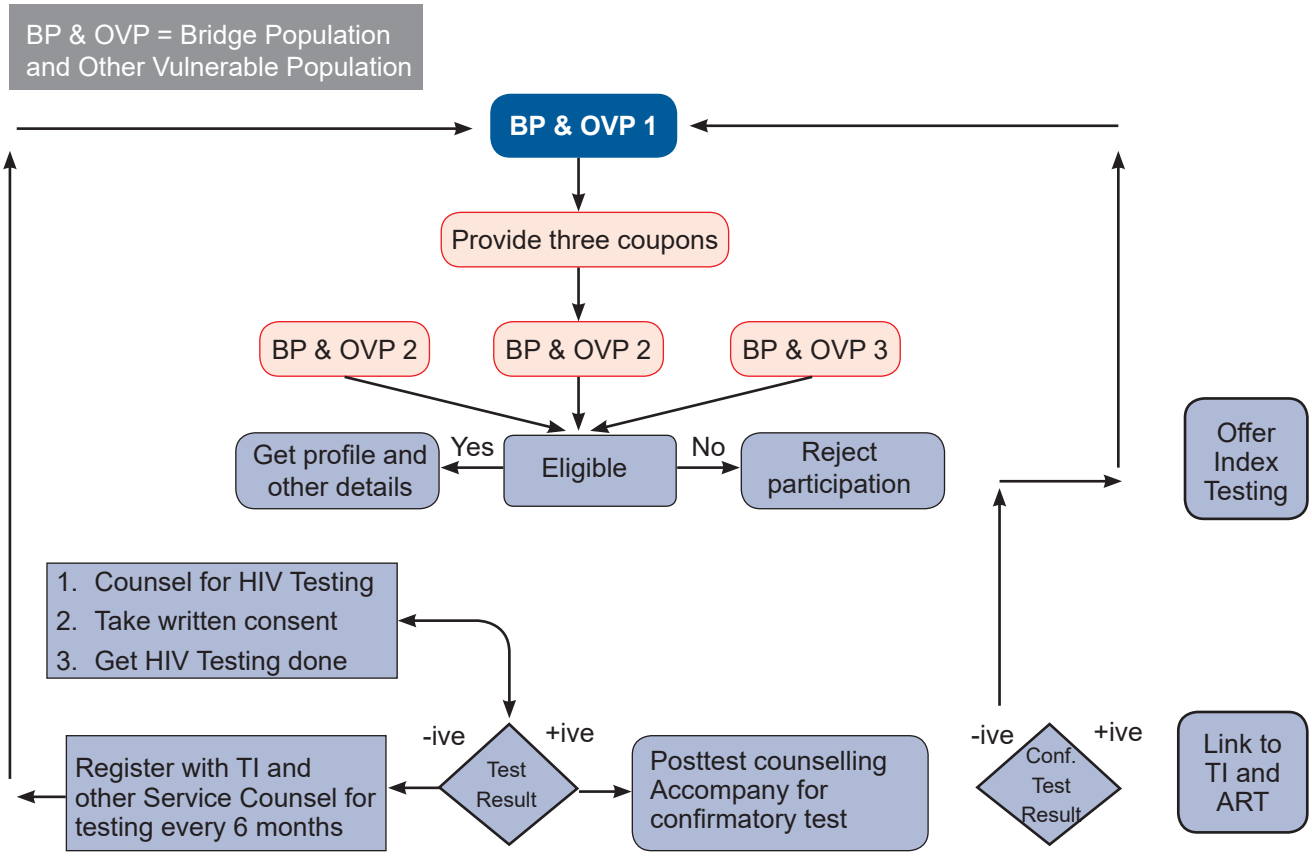
- **Master Register**: The master register would be compiled by ORW and M&E officer. Details of bridge and other vulnerable population members who qualify through risk assessment and are registered will be maintained in the master register and will be provided with a Unique Identification Number (UID). Most of the details/columns in master register need to be obtained and filled in, in next two – three follow-up visits. The data will be entered in the computer and the sources of data would be counselling, DIC register and clinic register. The registration ID should be assigned a unique ID number provided at the time of registration even if the same individual has availed multiple services.

The **M&E Officer** of the intervention is required to provide weekly/monthly analysis to each ORW and PE in close coordination with the PM, with the details of construction, industrial - congregation wise data that has been collected and collated. This will support for program planning, follow up visits and services.

5.8. Strengthened outreach approach

The strengthened outreach approach uses the identification of social, sexual and injecting networks of the bridge and other vulnerable population to reach out and provide the package of services. This approach support in expanding the reach of the program by way of reaching high risk individuals in the social, sexual and injecting network through the already registered client.

Figure 9: Strengthened Outreach Approach Service Flow



5.9. Stakeholders and power structures

Identification, engagement and sensitisation of stakeholders is an important step in ensuring smooth implementation of the intervention. These are individuals whose support help to create an enabling environment for the implementation of the bridge and other vulnerable population program, directly or indirectly.

Primary Stakeholders
• Partners of HRGs (Regular and casual partners)
• Spouses and partners of bridge and other vulnerable population
• Youth and adolescents who practice high- risk behaviour, who are known to be clients of HRGs, who have history of STI, living with HIV or on ART, people with TB, substance use disorder, victims of sexual violence, severing of family ties due to migration, lack of awareness, jobs and absence of responsible behaviour etc.
Secondary Stakeholders
• Families of high-risk bridge and other vulnerable population
• Families of bridge and other vulnerable population living with and affected by HIV and AIDS
• Sexual network operators (FSW, MSM-TG, Hijra)
• Health care providers including NACP facilities (government and private set up, qualified, unqualified)
• NGOs, CBOs and other agencies implementing TIs, livelihood programme, De-addiction centres (govt. or private), youth forums/clubs, etc.
• Workers' associations, employees' unions, trade unions, drivers associations, CSRs of companies, etc.
• PLHIV networks, and other community networks
Tertiary Stakeholders
• Community-level voluntary structures, e.g., youth forums/clubs, mandals, migrant clubs, safe spaces/drop-in centres for bridge and other vulnerable population
• Decision makers in the community i.e., social and political leaders, police, elected representatives (PRIs), development functionaries, Industries Management.

6

Building synergy between key stakeholders

The three-tier implementation system envisaged by NACP ensures synergy between policy, planning and implementation. Each tier has its specific roles and responsibilities which contribute towards making an intervention effective, efficient and efficacious. This coordination can be seen in the implementation of the bridge and other vulnerable population intervention as well.

6.1. Role of NACO

NACO's role in the bridge and other vulnerable population intervention would be two- fold (a): to provide an overall guidance on policy and planning and (b): facilitate smooth implementation by addressing administrative and financial bottlenecks. Specific responsibilities include:

- Provide policy level support and enabling environment in the implementation of the programme, through liaison with various other line ministries and facilitating their cooperation in implementing the project on the ground.
- Strengthen inter-state coordination by providing policy oversight.
- Coordination with SACS and DISHA to ensure adequate technical support to the programme as well as ensure quality implementation across the states.
- 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
- Designing IEC/SBCC/Social messaging templates to standardise the messages
- Ensure guidelines are issued to support procurement and/or supply of commodities to prevent transmission of HIV & STIs, provision and/or supply of colour-coded STI syndromic management kits, provision of CBS kits
- Support in data sharing across districts/ States including ART centers to benefit the target population who are currently on ART.
- Ensuring regular fund flow to SACS that will facilitate uninterrupted funds availability for programme implementation.

6.2. Role of SACS

SACS will be responsible for overall coordination and implementation of the intervention within the state. Following are the key responsibilities of SACS.

- Selection of NGO partner/on boarding specific Targeted Intervention for key target population within the states.

- Ensure provision of financial allocation on the implementation of Targeted Intervention, provision for developing quality SBCC materials and finalisation.
- Facilitate coordination of district functionaries (ICTC/DSRC, TI, CCC etc.) with implementing NGOs/CBOs
- Conducting regular monitoring/review meetings with implementing partners with the help of DAPCU/DISHA.
- Coordination with Kshamta Kendra for capacity building of implementing partners.
- Ensure timely reporting, documentation and analysis of the data generated from the field.
- Ensure coordination among all the partners working at source, transit and destination for seamless execution.
- Ensure achievement of TI wise targets.
- Liaison and advocacy with various line departments connected to varied aspects of the target population. for mainstreaming of HIV within that department and the target population has easy access to HIV services.
- Facilitate process of access to various welfare schemes and entitlements for the target population.
- Ensure regular submission of the accounts by the implementing NGOs/CBOs
- Facilitate coordination between other prevention interventions within the state.

6.3. Role of implementing partner (TI NGO)

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 at the district.

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

6.4. Role of LWS NGO/CBO

The LWS NGO/CBO will play a crucial role in the direct delivery of quality services to the field for reaching out to the bridge and other vulnerable population in districts which are under LWS. Following are the critical roles that will be played by the implementing partner.

- Cover the bridge and other vulnerable population in the source districts
- Organise health camps to provide clinical services to the high-risk bridge and other vulnerable population in the source& transit districts.
- Ensure referrals to various services (STI/ HIV/ Hep B and C/ NCDs and TB) and timely follow-ups with the target population for treatment adherence.
- Establish linkages with existing community mechanisms and other local service providers in order to link them with various welfare schemes and social entitlements.

6.5. Role of mentoring and technical support by DAPCU/ DISHA

DAPCU/DISHA plays a vital role in providing monitoring and technical assistance to NGOs/ CBOs that implement bridge and other vulnerable population intervention. Some of the responsibilities include:

- Conducting regular visits to NGO/CBOs sites.
- Conducting data validation exercise at the field level on a periodic basic.
- Facilitate inter-state level/ district coordination.
- Offering technical support to intervention staff during field visits.
- Serving as resource persons during staff training.
- Providing daily guidance and oversight of TIs.

7

Documentation and monitoring and evaluation

Effective documentation is essential to process and quality control and necessary for monitoring all your processes. NACP-V has a robust mechanism for documentation at every level.

7.1. Documentation of TI activities

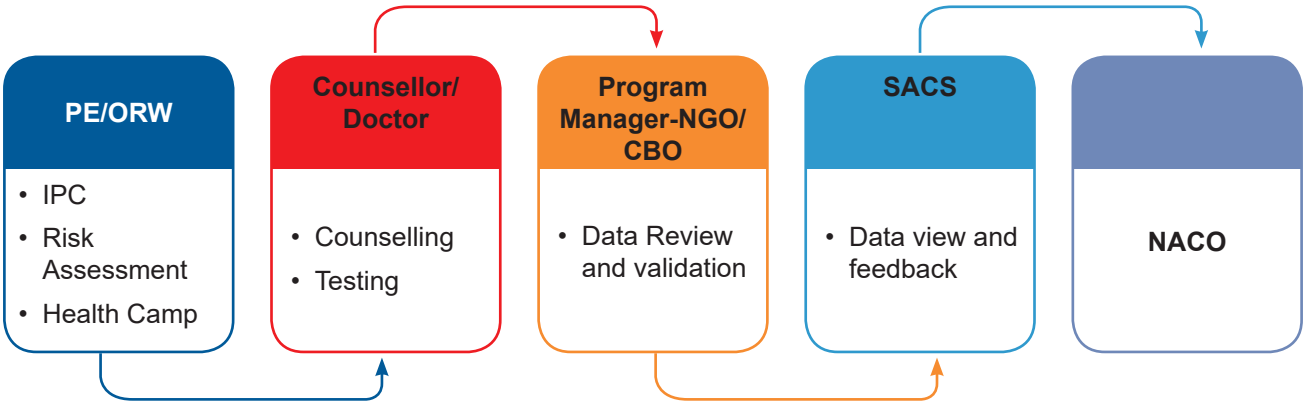
An indicative list of the documents to be maintained under the bridge and other vulnerable population intervention are listed below. As the programme has many activities the details of the register to be maintained will be highlighted in the capacity building modules.

Document	Periodicity	Responsible Person
Risk Assessment Tool	Daily	PE/ ORW
Daily Diary	Daily	PE/ ORW
Master Register	Daily	PE/ ORW
Situational Needs Assessment	Quarterly	PE/ ORW
Site Mapping	Quarterly	PE/ ORW
Resource Mapping	Annual	PE/ORW
Stakeholder Mapping &Analysis	Annual	PE/ ORW
Counseling Register	Weekly	Counsellor/ ORW
Clinical Register	Daily/ concurrent	Doctor/ Counsellor
Referral Register	Daily	Counselor/ ORW
Stock Register	Weekly	Counselor/PM
Advocacy Meeting Register	Monthly	PM
Stakeholder Meeting Register	Monthly	PM
Mid- Media Register	Monthly	Counselor/ ORW

7.2. Data flow

The data flow process in TI follows a bottom-up approach. This means that the data is consolidated at each level to provide both micro and macro-level pictures. This approach ensures that the data is analysed in detail and then combined to provide a comprehensive view of the situation. The process is designed to provide a clear understanding of the data at all levels, from individual data points to the overall picture.

Figure 10: Data Flow under TI



* SOCH entry would be done at the TI level in every steps

7.3. Performance indicators for bridge and other vulnerble population intervention

Annual targets are approved for the bridgeand other vulnerable population to ensure coverage and reach of deferential package of services to the maximum target population.

7.3.1. Performance indicator of targeted intervention project (Bridge intervention)

Performance Indicator of Targeted Intervention Project (Bridge Intervention)			
Indicator	**Denominator**	**Numerator**	**Means of verification / Data Source**
Outreach			
Percentage of Bridge Population covered through Outreach sessions/IPC sessions	Outreach/IPC sessions Coverage (@ 20 individuals need to be covered in each IPC/ outreach session)	Number of Bridge population covered through Outreach sessions/IPC sessions	Outreach sessions/IPC sessions planning sheets/ register records, ORW Daily Diary
Percentage of Bridge population registered with services (either through counselling or DIC or clinic/camps or CBS services etc)	New Registration (High Risk Bridge Population after Risk Assessment) 100% of the Bridge Populations target as per MoU in a year	Number of Bridge population registered with services (either through counselling or DIC or clinic/ camps or CBS services etc)	Bridge Population Registration Master Register
Percentage of Health camps conducted	Health camps during each month (Health Camp target @ 20 camps per month or @60 hours per month)	Number of Health Camp conducted	Health Camp Register/Record, Network Card/Case sheet
Clinic footfall/ Health Camp			
Percentage of Bridge Population visited to clinics/health camps	MOU target (50% of MOU target should be referred for clinic visit)	Number of bridge population visited to clinics/Health camps	Health Camp Register/Record, Network Card/Case sheet

Indicator	Denominator	Numerator	Means of verification / Data Source
Percentage of STI/RTI diagnosed	Total clinic visits	STI/RTI diagnosed	Health Camp Register/Record, Network Card/Case sheet, Counseling register
Percentage of STI/RTI treated	STI/RTI diagnosed (100% of total clinics/ health camps footfall)	Number of STI/RTI treated	Health Camp Register/Record, Network Card/Case sheet, Counseling register
Percentage of HIV Screening/testing conducted	MOU target (50% of MOU target should be Screened/ tested for HIV)	Number of HIV Screening/testing conducted	CBS camp register, referrals register & slips, ICTC slips
Percentage of TB Screening (4S) conducted	MOU target (50% of MOU target should be Screened/ tested for TB)	Number of TB Screening (4S) conducted	Counselling register, referrals register & slips
Percentage of symptomatic cases referred to nearest health facility/ Designated Microscopy Centre for testing	TB symptomatic cases referred to TB/DOT centre	TB symptomatic cases referred to TU and tested	Counseling register, referrals register & slips
Percentage of diagnosed TB put on Anti TB Treatment (ATT)	Number of TB diagnosed cases	Number of diagnosed TB put on ATT/	Counseling register, referrals register & slips
Referrals and Linkages			
Percentage of HIV Positive registered at ART Centre	Total HIV Positive identified (100% HIV positive should be registered at ART)	Number of HIV Positive registered at ART Centre	Counseling register, referrals register & slips, PLHIV line list
Percentage of HIV Positive on-ART	Total number of HIV Positive registered at ART centre (100% HIV positive should be registered on ART)	Number of HIV Positive on ART	Counseling register, referrals register & slips, PLHIV line list
Percentage of PLHIV having undetectable viral load	Number of individuals tested for viral load	Number of Viral Load resulted in undetectable viral load	Counseling register, referrals register & slips, PLHIV line list
Percentage of spouse/ partner of PLHIV bridge population screened for HIV	Number of spouse/ partner eligible for testing (All spouse/ partner of PLHIV bridge population)	Number of spouse/ partner screening for HIV	Counselling register, referrals register & slips, PLHIV line list
Condom Promotion			
Percentage of condom distributed against demand	Free Condom Demand (only Direct distribution through Camps, Counseling and DIC to high-risk Bridge Populations, STI cases & PLHIV)	Number of free condoms distributed	Counseling register, DIC register, Health Camps register, Stock register

Indicator	Denominator	Numerator	Means of verification / Data Source
Percentage of Condom outlets established	Condom outlets established Minimum 30 outlets for TI less than 10,000 target and minimum 50 outlets for TIs with 10000 or above targets	Number of Condom outlets established	List of Condom outlets, Stock register
Programme Delivery activities			
Percentage of Mid Media Activities conducted	Mid Media Activities target given by SACS as per proposal/target/ budget sheet	Number of Mid Media Activities conducted	Mid Media Activities Register/ Record
Percentage of Congregation events conducted	Congregation events target given by SACS as per proposal/target/ budget sheet	Number of Congregation events conducted	Congregation events Register/ Record
Percentage of Demand generation activities conducted	Demand generation activities target given by SACS as per proposal/ target/budget sheet	Number of Demand generation activities conducted	Demand generation activity Register/Record
Percentage of Advocacy meeting conducted	Advocacy meeting target given by SACS as per proposal/target/budget sheet	Number of Advocacy meeting conducted	Advocacy meeting register
Review and reporting			
Percentage of Monthly Review meeting in presence of TI NGO/ CBO Project Director conducted	Number of monthly Review meeting conducted (Target 12 in a year)	Number of Monthly Review meeting in presence of TI NGO/ CBO Project Director conducted	Monthly meeting register/ records
Percentage of Situational Need Assessment (SNA) conducted	Situational Need Assessment (SNA) Quarterly	Number of Situational Need Assessment (SNA) conducted	SNA reports

Note: This is the minimum performance indicators, however if SACS/State feel to increase or add few more indicators to improve the quality and efficiency of project, they can do as per the requirement.

7.3.2. Performance indicator of targeted intervention project (Other Vulnerable Population-OVP)

Performance Indicator of Targeted Intervention Project (Other Vulnerable Population-OVP)			
Indicator	**Denominator**	**Numerator**	**Means of verification /Data Source**
Percentage of (FSW, MSM, TG/ Hijra, IDU) tested/ screened for HIV	Total number of (FSW, MSM, TG/Hijra, IDU) registered	Number of (FSW, MSM, TG/Hijra, IDU) tested/ screened for HIV	Line listing, CBS register, referral register, Counselling register

Indicator	Denominator	Numerator	Means of verification /Data Source
Percentage of Spouses OVP tested/screened for HIV	Total number of Spouses of OVP identified/ registered	Number of Spouse OVP tested/screened for HIV	Line listing, CBS register, referral register, Counselling register
Percentage of Partners of OVP tested/screened for HIV	Total number of Partners OVP identified/registered	Number of partners of OVP tested/screened for HIV	Line listing, CBS register, referral register, Counseling register
Percentage of (FSW, MSM, TG/ Hijra, IDU) linked to ART centre	Total number of (FSW, MSM, TG/Hijra, IDU) diagnosed HIV Positive	Number of (FSW, MSM, TG/Hijra, IDU) linked to ART centre	Line listing, CBS register, referral register, Counseling register
Percentage of Spouses of OVP linked to ART centre	Total number of Spouses of OVP diagnosed HIV Positive	Number of Spouses of OVP linked to ART centre	Line listing, CBS register, referral register, Counseling register
Percentage of Partners of OVP linked to ART centre	Total number of Partners of OVP diagnosed HIV Positive	Number of partners of OVP linked to ART centre	Line listing, CBS register, referral register, Counseling register

Note: This is the minimum performance indicators, however if SACS/State feel to increase or add few more indicators to improve the quality and efficiency of project, they can do as per the requirement.
Other Vulnerable Population: Any person who is a part of sexual and injecting network of the above two, irrespective of their occupation. This may expand to un-covered high-risk groups present in the area of intervention

8

Capacity building

The revised guidelines envisage a continuous process of capacity building and strengthen at all levels that goes beyond training programmes.

8.1. Roles of key stakeholders

The responsibility of capacity building would be delineated between NACO, SACS and the implementing NGO. The training will be provided 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/CBOs and industrial centres/workplace, other government departments, service providers, project staff and volunteers should be planned for working with the target population.

8.1.1. Role of NACO:

- Preparation of training material, standardisation of training curriculum and, development of master trainers for each state.
- Conducting training for the master trainers.
- Facilitation of exposure visits.

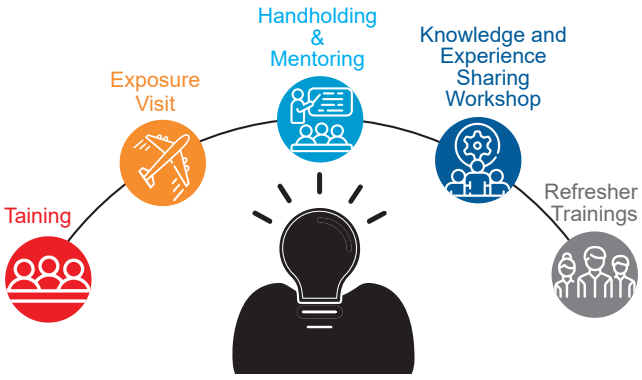
8.1.2. Role of SACS

- Develop a pool of state level / regional master trainers.
- Develop annual training plans with timelines.
- Ensure quality assurance and adherence of timelines of training through supportive supervision visits.

8.1.3. Role of implementing NGO

- Conduct induction and refresher trainings for the TI project staff.
- Ensure that the capacity building is conducted as per the capacity building module developed for the bridge and other vulnerable population intervention.

Figure 11: Capacity Building areas under Bridge and Other Vulnerable Population Intervention:



Reference documents

1. Central TB Division, Ministry of Health and Family Welfare, Government of India, “Leading the Way, India TB Report, 2023”, 2023
2. National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India, “Mid-Term Appraisal of National AIDS Control Programme Phase-IV”, 2016
3. Ministry of Health and Family Welfare, Government of India,, “Compendium of Facts, India and 14 UTs (Phase II), National Family Health Survey-V, 2019-2021”, 2020
4. National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India, “Sanalak, Status of National AIDS Response’“, Third Edition, 2021
5. National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India, “India HIV Estimation -2021”, 2022
6. National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India, “HIV Sentinel Surveillance 2016-17 Technical Brief”, 2017
7. National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India, “India HIV Estimation -2021”, 2022
8. National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India, “National Biological and Behavioural Surveillance (IBBS) 2014-15, High Risk Groups”, 2015
9. National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India, “Policy, Strategy and Operational Plan HIV Intervention for Migrants”, 2010
10. National AIDS Control Organization, Government of India, Ministry of Health and Family Welfare, Targeted Intervention Under NACP-III, Operational Guidelines, Volume -II, Migrants and Truckers”, 2007
11. Ministry of Road Transport& Highways, Transport Research Wing, Government of India, “Road Transport Year Book (2017-2018 & 2018-2019)

12. Tata Institute of Social Sciences, “Truckers Operational Research on Changing Sexual Network and Unexplored Risk Behaviours of Truckers/ Drivers and Allied Population in India”, 2022-23

13. Tata Institute of Social Sciences, “Migrants Emerging Mobility Patterns, High Risk Behaviours, HIV Vulnerabilities and Response During COVID-19 in India”, 2023

14. Ministry of Road Transport and Highways, “ Estimates and Functions of National Highway Projects Including Bharatmal Projects- Committee on Estimates”, 2020-21

15. Home | Government of India (censusindia.gov.in)

16. PMJAY - All About Ayushman Bharat Yojana, Eligibility and Application Process (bajajfinserv.in)

17. PMAY-HFA(Urban) (pmaymis.gov.in)

18. Directorate General Labour Welfare, Govt. of India

19. Indian Trucking Industry - Skilling the Supply Chain (devalt.org)

20. ABHA number (ndhm.gov.in)

21. || NVHCP || (mohfw.gov.in)

22. Operational Guidelines | National AIDS Control Organization | MoHFW | GoI (naco.gov.in)

Annexures

Annexure 1: Master register (For migrant TI)

Sr. No	Name of the site	Date of Registration (DD/MM/YYYY)	UID	Name of the Migrant	Gender (M/F/TG)	Age (In completed years)	Marital Status	Education	Types of Work involved in
	1	2	3	4	5	6	7	8	9
1									
2									
3									
4									
5									
6									
7									
8									

Column No.7. Marital Status-1. Un-Married, 2. Married, 3. Widow / Widower, 4. Divorced, 5. Separated, 6. Non known/ Not revealed

Column No.8. Education: 1. Illiterate, 2. Literate (can read and write), 3. Primary Education (upto 5th class of schooling), 4. Middle Education (upto 9th class of schooling), 5. Matriculation / Higher Secondary (10-12 year of schooling), 6. Graduate and above, 7. Not known / Not revealed.

Column No.9. Types of Work involved in: 1. Industrial worker, 2. Construction worker, 3. Daily Wages/MathadiKamgaar/ Auto, 4. Sand quarry worker, 5. Quarry worker, 6. Skilled workers (Furniture, Jewellery, Zari etc.), 7. Hotel worker, 8. Dairy

Home State: (State Originally belong to)	Duration of Stay at the Destination: <6month, 6-12 month,> 12 month	How often does she/ he go to their native place (Mention the Periodicity)	Whether Used condom during last sex?	Where does she/ he go for sexual activity	Addiction	Whether HIV test conducted earlier (Yes/No)	If HIV positive, then status of ART: 1.Registered,2.Not Registered	Does she/he have any history of STI
10	11	12	13	14	15	16	17	18

workers, 9. Hammal / Labour 10. Farm worker/ Agriculture, 11. Brick Kiln workers, 12. Hawkers, 13. Carpenter, 14. Mine worker, 15. Wooden polish, 16. Barber, 17. Plumber, 18. Wall Painting, 19.Motor Mechanic, 20. Juice/Ice Cream vendor, 21. Security Guard, 22. Loom Worker, 23. Diamond Worker, 24. Others (Please specify)

Column No.14. Where does she/he go for sexual activity 1. Brothel, 2. Street based, 3. Lodge, 4. Bar, 5. Home based, 6. Dhaba, 7. Workplace, 8. Regualr partner, 9. Lover, 10. Coworker, 11. Others (specify)

Column No. 1. Alcohol, 2. Smoking, 3. Gutka/Tobacco, 4. Injecting drugs, 5. Drugs, 6. Whitener /Solvents, 7. Cough Syrup for intoxication, 8. Others

Annexure 2: Terms of references

1. Project Director

One representative from the Executive Body / Governing Body of the agency/ or nominated by the Governing Body (lead agency in case of associations) with SACS is to be designated as Project Director for TI/LWS project.

The Project Director would be the sole person responsible for any communication with State/ District/Municipal AIDS Control Society. He /She would be one of the signatories in the contract designated for the project.

1. Project Director of implementing organization should ensure the appointment of all staff and PEs/PLs according to the approved proposal by SACS and ensue all documents pertaining to staff in the project office.
2. Conduct monthly project progress review meeting and attend other project level meetings as much as possible.
3. Attend SACS meetings as required.
4. Take lead to network with key district level officials such as District Magistrate, Superintendent of Police and other officials of departments to sensitize them about the project activities, HIV/AIDS and the role of community.
5. Participate in advocacy efforts with key stakeholders at the district level (political and religious leaders, other service providers, social welfare schemes, etc.).
6. Ensure coordination of project activities with other HIV/AIDS services in the district by engaging DAPCUs/DISHAs and District Health Society.
7. Conduct field visit regularly to meet target population and HRGs for collecting the feedback about project services, activities to strengthen the service delivery provisions.
8. Maintain oversight over the project activities and ensure financial integrity of the project.
9. Ensure and facilitate any other activities approved by SACS and NACO with the project.
10. Assets purchased and documents under the project to be ensured in the project office and it should be kept as per the guidelines.
11. Ensure handover of unspent balance of the project account, assets and all other documents/records related to project within 15 days of closure of the contract or intimate SACS in case of delay. Obtain No Objection Certificate from competent authority of SACS after handing over and settle all accounts of staffs and SACS to avoid legal action as per requirements under the Contract.

Recruitment Qualifications	
Education	S/he should be a **Post graduate** in any discipline of Social Sciences preferably with one year experience at district level programmes related to health, livelihood programmes, rural development, microfinance and HIV/AIDS programmes. **Graduate** in any discipline of Social Sciences with minimum three years' experience in development / health sector at district level programmes related to health, livelihood programmes, rural development, microfinance and HIV/AIDS programmes.
Knowledge and Skills	• Familiarity with government health policies and programmes Strong communication skills • Ability to work in small teams, and flexible ways of working • Proficiency in data analysis, reporting writing, case study compilation. • At least 10 days field visit required. • Overall management capacity to monitor, report and guide the team under him/her.

Functions / Key Results Expected

Summary of Key Functions:

The Project Manager will be responsible for managing overall programme in close coordination with SACS and implementing agency. He / She would be responsible to keep close liaison with Government Departments at districts level, SACS and TSU. Conduct data analysis and prepare monthly reports for review and reporting to SACS. Review the performance of TI staffs, prepare need based monthly action plan and follow up the action points, facilitate the SACS and TSU visits.

Duties and Responsibilities: will be responsible for performing the following functions:

Programme Management:

a. The Project Manager is the overall in-charge of the TI and is responsible for functioning of the project as per NACO guidelines.

b. The PM is tasked with achievement of the project deliverables as per project targets.

c. The PM will be based at the field office and organize weekly review meeting and supervise work of all other staffs.

d. Support in implementation of revamped TI strategy and programmatic Mapping Population Size Estimation (MPSE) as per NACP guideline.

e. Establish linkages with other referral services, stake holder meetings, and advocacy.

f. Organize in house capacity building of the other staff.

g. PM to travel to the project area / hotspots for purposes related to TI programme implementation like supervision of PE / ORWs and interaction with HRGs. PM should visit the field for about 10-15 days in a month records of the field visits are maintained.

h. Assist PH to organise advocacy and linkage activities.

i. Analyse the progress of the project activities and share the same with action points in the monthly project staff meeting.

j. Assess the capacity building requirements of project staff and communicate the same with DAPCU/ DISHA or/ and SACS.

k. Monitor the transit intervention activities where ever applicable.

l. Conduct weekly / biweekly/monthly review meetings with project staff and PEs.

Reporting:

a. Report to Project Director of the project and TI nodal officer in SACS and / or DAPCU/DISHA

b. Timely submission of monthly programme performance data in SIMS/CMIS or other reporting format.

c. Submission of SOEs, Provide data / information required for preparation of reports.

Training Requirements:

- Programme Management, Supervision and Monitoring Skills, Team Building Skills, Data Analysis, Community based monitoring and rapport building, advocacy and networking.

Annexure 3: Selection of peer for bridge and other vulnerable population intervention PEs

A PE is a person from the target community who works with her/his colleagues to influence attitude and behaviours change. These PEs are important aspect of the community as they have adequate information about the risk, vulnerability issues associated with migration, they belong to the same culture and ethnicity, they have good understanding about the issues related to the life of a migrant. Because they can connect with the life of migrants and can influence one's life, behaviour

A PE is paid an honorarium as per NGO/CBO costing guidelines for her/his contribution to the TI project.

PEs can be powerful role models for reaching communities and affecting change in community norms. PEs are knowledgeable "insiders" in migrant settings, and their involvement enhances trust and communication. A peer is one of equal standing with another, one belonging to the same societal group especially based on age, grade or status. The purpose of PEs (PEs) is to ensure that target population are reached and information on STIs and HIV/AIDS is shared with them to bring out a positive behaviour change. PE is a link between the bridge population and TIs. PEs are consequently a credible source of advice.

PEs are responsible for providing information on HIV/STIs and harm reduction, and promoting condom use among colleagues/peers, which ultimately results in peer pressure for behaviour change. They can also distribute condoms, lubes, needles and syringes. They also provide basic data for monitoring the project.

Criteria to Identify Potential PE

Must be of the same ethnic group as the migrant population

- Willing to work for the community preferably on a volunteer basis, would be financially incentivized based on the sessions conducted for the project
- Demonstrate self-confidence and show potential for leadership
- Good listening, communication, and interpersonal skills
- Understanding of the cause and committed to the goals of the project
- Has a good understanding & Knowledge of problems and difficulties of the community
- Should be acceptable among the target audience with whom She/he will work
- Ideally, they should be able to speak or understand the language of migrants hence preferably the PE should be selected from the source state
- Willing to have at least 20 sessions per monthbased on the requirements of the project

How to select a PE:

1. PEs are selected in the range of 750-1000 migrant per site.
2. The PEs are to be selected based on following priorities:
   a. More than 40% are to be from source States. That is PEs are representing each source states. A migrant himself can be a PE; especially those who are old to the area and have good understanding of the dynamics of the migration from his/her own state.
   b. of the PEs to represent from the contractors, brokers, and key informants (who qualify the above concept of PEs). PEs who are facilitators like petty shop owners, mess owners, landlord, members of various associations who influence the life of migrants. The project along with stakeholder need to list out a number of persons in these criteria and then take a consultation of migrants to finally select few of them as PEs.
   c. In case of migration, dropouts of the selected PEs – new PEs are to be selected from the same group as indicated above

d. PEs are not to be selected based on recommendations, preference. All process of selection to be documented.

3. The selection of PEs is based on consultations of community meeting at sites. This norm is applicable for setting where there is a dense population of migrants.
4. In case of scattered population of migrants the ratio may be relooked. This is a progressive activity- as and when the volume of migrant identification increases, the PEs can be selected from different congregation point's zones instead of from one area.

PEs play an important role in TI implementation as they can:

- Help to build trust and establish credibility with the vulnerable group
- Provide a vital two-way link between the project staff and the community
- Provide important information about the vulnerable group to other stakeholders and the wider community
- Reach a large number of people effectively
- Provide a link between the service and the community (for instance, by introducing people or accompanying them to the service facility)

Background

The HIV positive case detection in the migrant TI has been a challenge and one of the identified causes is the difficulty in conducting a robust risk assessment. It is also worthy to note that bridge and other vulnerable population are not at risk at all the times. Decosas and Adrien[30] opine that the association between migration and HIV is more likely to be a consequence of the conditions and structure of the migration process than the actual dissemination of the virus along corridors of mobility. They argue that a focus on the routes of spread tends to direct attention to the migrants themselves rather than the socio-economic context of migration. This in turn can easily lead to policies aimed at restricting movement and stigmatizing.

Building upon this analysis we need to understand the particular vulnerabilities of bridge population (and those with whom they interact) by focusing on their economic, social, sexual and gender regimes associated with mobility rather than focusing on them as individuals. Since a need for changing the existing HIV intervention for the bridge population has already been established there is a need for developing intervention models that are sensitive to issues around mobility and specific spaces (space and time) where the mobile population is most vulnerable. It is with this understanding that the concept of "Spaces of Vulnerability" is being introduced in the revised guidelines.

Spaces of vulnerability

The concept of "HIV risk environment" has been rightly described by Rhodes and colleagues[31] as the space— whether social or physical— in which the interplay of factors exogenous to the individual increases their likelihood of engaging in risky behaviors that predispose to HIV infection or decreases their likelihood of accessing HIV prevention or treatment[32, 33]. We term this as ***spaces of vulnerability***. This is central to the understanding of the risk transmission and in planning the response. These exogenous factors can be categorized in terms of types (i.e., physical, social, economic, policy) that interact at the micro and macro levels of environmental influence. There are several important implications of this perspective.

As we move towards people-centric approach in designing interventions for bridge population, it is important to recognize that vulnerability to HIV is not only related to sexual practices of the target group. The interplay of different factors like disposable income, peer group, availability of sexual network, spare time etc have an important role in deciding the risk behaviour that bridge population indulges in.

Therefore, it is important to enhance the HIV risk perception among bridge and vulnerable population. This can be done through a concept of coproduction. This coproduction is the backbone of outreach for bridge population and involves listening to the needs and challenges of the bridge population and guiding them towards an enhanced self-risk perception. As explained in earlier chapters this coproduction uses the techniques of interpersonal communication, to understand the specific spaces of vulnerability for the bridge population. This is done by having effective communication to understand the target groups world and their lived experience, thereby co-assessing their risk to HIV, their concerns and goals for prevention of HIV.

[30] Decosas J, Adrien A. Migration and HIV. AIDS. 1997;11 Suppl A:S77-84. PMID: 9451970.

[31] Rhodes T. The 'risk environment': a framework for understanding and reducing drug-related harm. *Int J Drug Policy.* 2002;13:85–94. [Google Scholar

Rhodes T. Risk environments and drug harms: a social science for harm reduction approach. *Int J Drug Policy.* 2009;20(3):193–201. [PubMed] [Google Scholar

[32] ibid 32

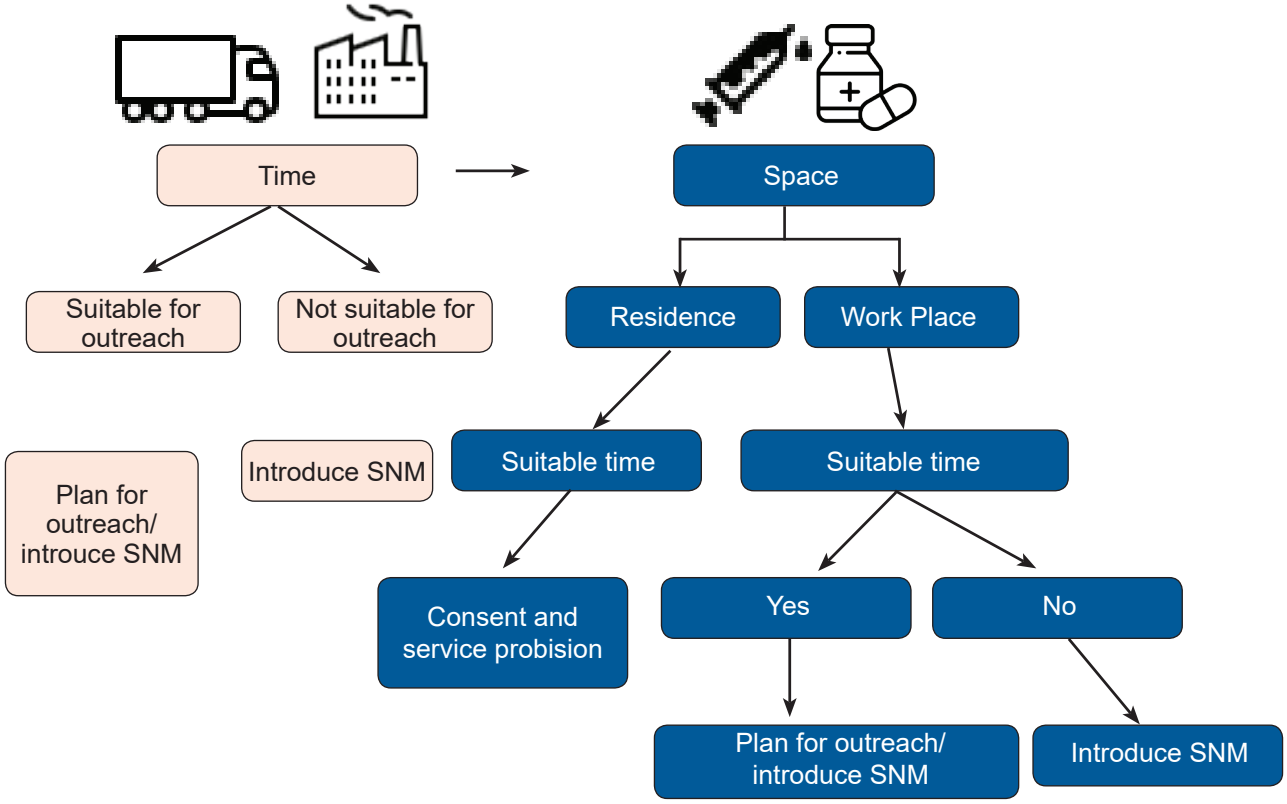
[33] Rhodes T, Singer M, Bourgois P, Friedman SR, Strathdee SA. The social structural production of HIV risk among injecting drug users. Soc Sci Med. 2005;61(5):1026–1044. [PubMed] [Google Scholar]

Conducting the spaces of vulnerability assessment

As established earlier the need for an assessment of spaces of vulnerability will help the bridge population TI in determining the risk of the population. Thereby making HIV screening and testing more focused. The target group's needs, and vulnerability will be coproduced with the outreach staff conducting the IPC and mid media sessions in a manner which will effectively elicit the vulnerability spaces of the bridge population. This will also lead to an effective outreach.

The exercise will follow the risk assessment tool mentioned previously and will elicit the following information:

1. Mobility patterns
2. Preferred sex networks (casual/paid)
3. Awareness of HIV transmission routes
4. Knowledge and access to health services especially HIV (knowledge, challenge etc)



National AIDS Control Organisation

India's response to HIV & Sexually Transmitted Infections

Ministry of Health & Family Welfare, Government of India

www.naco.gov.in