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DISCUSSION BRIEF

Reaching Out at the Source:

Making the Case for Focused HIV Interventions in Migrant Source Areas in Uttar Pradesh

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Migration is a significant livelihood and survival strategy for millions of people around the world, particularly for those living in poor and under-developed regions.[1] In India, one out of every five individuals is a migrant.[2] The state of Uttar Pradesh (UP) is home to over 166 million people, of which nearly one third (31%) live below the poverty line. UP has the highest net out-migration in India (-2.6 million annually).[3] Data show that both inter-district and inter-state male migration in and from UP have been on a steady rise since the 1980s.

Poor migrant workers, who typically move under conditions of distress, end up becoming part of the lower end of the labor market, with very few entitlements vis-à-vis their employers or the public services in the destination areas.[4] Employment-based migration takes people away from their families and social support structures for long periods of time. This isolation, combined with the difficult conditions migrants live in, may encourage them to engage in high-risk behaviors—such as visiting sex workers or injecting drugs—that increase vulnerability to HIV and other sexually-transmitted infections (STIs). Some migrants inadvertently transmit HIV to their spouses or sexual partners during periodic visits to their homes, often in low-risk rural areas that also have limited healthcare and HIV prevention services.

The lack of accessible, quality HIV services in both migrant source and destination areas, the absence of a continuum of services across areas, and low levels of HIV awareness—particularly among the rural, poor women in the state—create fertile ground for a steady spread of the virus among groups who do not realize they are at risk. Further, many people in rural areas may not learn their status for a long time, delaying their treatment and giving the false impression that migrant source/home areas do not need focused HIV prevention interventions.

This paper analyzes HIV vulnerability in migrant source areas in UP within the framework of the existing HIV programs for migrant populations and makes a case for focused interventions to ensure the provision of seamless prevention and care services through the entire migration cycle to check the spread of the epidemic, particularly in the rural migrant source areas. In particular, HIV programs are needed in source/home areas to promote HIV prevention prior to the migrants' departure; to help prevent HIV infection among spouses and partners who remain in the home areas; and to ensure access to uninterrupted treatment and care for HIV-positive people who migrate between source and destination areas.

The HIV Epidemic in Uttar Pradesh

Uttar Pradesh has a low adult HIV prevalence rate, with sero-positivity in STI clinics at 0.95 percent and in antenatal care (ANC) sites at 0.25 percent (2006).[5] However, numerous factors make UP vulnerable to a rapid increase in new HIV infections. One such factor is the migration of its male labor force for employment purposes from rural to urban centers within and outside of the state. Phase III of the National AIDS Control Program (NACP III) recognizes single, male migrants as a significant "bridge population" in the spread of the epidemic from urban to rural areas.

A notable concern is also the feminization of the HIV epidemic, with a growing number of

monogamous, married women contracting HIV from their husbands.[6] This trend assumes particular significance in the context of UP, where most of the migration is from rural areas where the HIV-related knowledge among women is abysmal. Gender disaggregated data from the 2005/06 National Family Health Survey (NFHS-3) show the correlation between gender and levels of awareness (see Table 1). Women, illiterate women, and, in particular, illiterate Scheduled Tribe women living in rural areas have the least awareness of HIV and/or knowledge about how to protect themselves from HIV infection. With an overall female literacy rate of 43 percent,[7] which is much lower in rural areas, a large number of women whose spouses are migrants are at heightened risk for HIV infection due to sheer lack of information. Whereas there is less difference in levels of awareness between men and women in the upper wealth bracket, poor women are more than three times less likely to have heard about AIDS than poor men.

Table 1. Awareness and Knowledge About HIV and AIDS In Uttar Pradesh, 2005/06

	% Who Have Heard of AIDS		% Comprehensive AIDS Knowledge	
	Women	Men	Women	Men
RESIDENCE				
Urban	72	90	37	45
Rural	36	73	9	23
EDUCATION				
No education	27	45	4	8
10 or more years	92	98	50	53
REGULAR MEDIA EXPOSURE				
Yes	68	87	28	36
No	20	51	3	9
MARITAL STATUS				
Never married	63	87	26	36
Currently married	40	76	13	26
Widow/divorced/ separated	35	55	11	13
CASTE				
Scheduled caste	34	72	11	24
Scheduled tribe	18	37	1	8
Others	66	88	28	42
WEALTH INDEX				
Lowest	15	52	2	10
Highest	87	97	48	59

Source: NFHS-3

Table 2. Migration Profile for Uttar Pradesh, 1991–2001

Category	1991 Census	2001 Census	% Increase
Total in-migrants	787,289	1,492,799	90
Total out-migrants	2,457,996	4,165,419	70
Net migrants	(1,670,707)	(2,672,620)	60

Source: Census, 1991 and 2001

Migrant Situation in the State

Uttar Pradesh has the highest net out-migration rate in the country. A comparative study of the migration flows between 1991 and 2001 shows that the total out-migration from UP increased by 70 percent during this decade (see Table 2).[8]

The most common destination for out-migrants from UP is Maharashtra,[9] which has one of the highest HIV prevalence rates in India. HIV prevalence among high-risk groups in Maharashtra is alarmingly high, at about 20 percent among sex workers and injecting drug users (IDUs) and 16 percent among men who have sex with men (MSM).[10] These prevalence rates assume tremendous significance in view of the nexus between migrants and sex workers. Moreover, despite negligible empirical research in these areas, there is a growing understanding of needle-sharing practices among migrants, as well as the practice of MSM behavior among single, male migrants. Hence, the high HIV prevalence among these high-risk sub-populations in Maharashtra has implications for UP's migrants and their sexual partners in their place of origin where they return to from time to time.

Nine out of the 10 districts listed in the Annual Action Plan (2007–08) of the UP State AIDS Control Society (UPSACS) from where maximum out-migration takes place are category "C" districts. These are Azamgarh, Bahraich, Gorakhpur, Jaunpur, Kushinagar, Lalitpur, Maharajganj, Mirzapur, and Pratapgarh. Deoria is the only category "A" district with high out-migration. Awareness about HIV is very low among men in these districts (see Table 3). For example, only 45 percent of the men surveyed in Lalitpur have ever heard of HIV/AIDS. The figures for comprehensive knowledge about HIV/AIDS, routes of transmission, and condoms as a means of prevention are much lower. Misconceptions about the spread of HIV are also common and a significant

proportion of the sampled population in each of the 10 districts believes that AIDS is curable, a belief that can negatively affect uptake of prevention behaviors.

In Deoria—which is classified in the "A" risk category (i.e., more than 1 percent HIV prevalence in any of the sentinel sites in the last three years) and where ANC sero-positivity in 2006 was reportedly 1.25 percent—awareness and comprehensive knowledge about HIV/AIDS are very low. Less than one-third of men in the district (31%) identified condom use as a prevention method. Although the data are not exclusive to migrants, they are indicative of the situation among male migrants who are a subset of this population.

As these migrant men move from areas of low HIV prevalence to destination sites that have high prevalence, their limited awareness about HIV and means of prevention and low self-risk perception significantly heightens their risk of infection. The low level of awareness of HIV among women in migrant source districts raises the possibility of HIV transmission from male migrants to their sexual partners/spouses. It is known from studies conducted at testing centers in Kerala that, until 1994, more than 80 percent of HIV-positive people had acquired the infection while working outside the state or were spouses of those who worked outside the state.[11] It can thus be said that, in the absence of comprehensive knowledge about HIV among both men and women in these migrant source areas, it is a matter of time before the status of category "C" districts changes for the worse.

Current Initiatives in the State

From a risk perspective, the NACP III defines high-risk migrants as "single men and all women in the age group of 15–49 years who move between source and destination within the country once or more in a year." Migrant Operational Guidelines state that "from an HIV programming perspective under NACP III, migrant TIs [targeted interventions] are

Table 3: HIV and AIDS Knowledge among Males in the Major Out-Migrating Districts of Uttar Pradesh, 2005/06

	Azamgarh	Bahraich	Deoria	Gorakhpur	Jaunpur	Kushinagar	Lalitpur	Maharajganj	Mirzapur	Pratapgarh
Ever Heard of HIV/AIDS	79	54	82	81	82	79	45	65	67	79
MODES OF TRANSMISSION										
Heterosexual Intercourse	54	66	90	73	32	86	74	74	67	70
Same-sex Intercourse	27	3	2	12	28	2	6	15	21	5
Mother-to-Child	7	1	4	11	13	4	5	9	18	19
MISCONCEPTIONS										
Handshake	22	22	20	22	18	26	15	19	10	16
Hug	23	23	22	27	23	28	16	24	10	16
Kiss	34	23	34	36	28	34	22	37	16	20
Share Clothes	31	24	29	32	23	30	23	27	14	21
Share Utensils	32	24	37	34	26	31	26	35	15	19
Step in Urine/Stool	25	18	28	31	21	23	24	25	9	15
Mosquito	30	31	50	45	30	39	26	46	21	22
PREVENTION										
Condoms	24	33	31	35	24	29	37	27	48	39
CURABILITY										
Yes	32	42	30	33	27	24	44	34	31	31
No	46	37	56	46	49	55	33	48	54	54
Don't Know	22	21	14	21	24	21	23	18	16	15

Source: NFHS-3

'destination interventions' for 'in-migrants' (i.e., at the point of destination) and are to focus on high-risk migrant men and women, i.e., those who are part of high-risk sexual networks, either as clients of sex workers and high-risk MSM, or as sex workers themselves."[12]

Currently, UP has six migrant targeted interventions (TIs) being implemented in destination sites at Agra, Ghaziabad, Gorakhpur, Kanpur, Lucknow, and Varanasi.[13] In addition to the nationally-guided initiatives, a few initiatives are currently being implemented in the state funded directly by donor agencies. This includes the USAID-funded Pact Community REACH project focusing on four districts of eastern UP, which account for a large share of the inter-state out-migrants namely, Azamgarh, Basti, Gorakhpur, and Jaunpur.

The operational guidelines state that interventions at the source sites for out-migrants do not fall within the scope of TIs for migrants and are to be covered by other programs, mainly the Link Worker Scheme (LWS). The LWS, introduced under the NACP III, aims "to reach out to the scattered (and often invisible) high-risk populations in rural areas with a comprehensive package of preventive services."[14] The LWS is currently being launched in UP. The success of the program will depend on the availability of skilled and devoted workers. Among other activities, the Link Workers are expected to map the migration patterns in the district. However, the possibility of the migrants being reached through this initiative may be limited given the primary focus on high-risk groups, identified as female sex workers, MSM, and IDUs.

Key Issues

1. Current HIV programs for migrants are largely urban centric.

In spite of the fact that migration is a continuum with different stages—source, transit, destination, and return—the bulk of HIV-related migration programming in India is provided through TIs for migrants mainly in their urban-based destinations.[15] While the rural-to-rural migration in the country is 2.5 times higher than the rural-to-urban migration (see Box 1), HIV programs for migrants are almost entirely focused in the urban areas. However, once the migrant reaches the destination, the demands of finding shelter, employment, and food are so pressing that HIV or even other health concerns are not a priority issue for them. The possibility of successfully reaching out to them and providing HIV-related information and services would be significantly enhanced if the migrants are already sensitized to HIV issues before their departure. This would make the migrants more receptive to HIV information at the destination and also help them to protect themselves from infection.

Box 1. Typology of Migration by Source and Destination in India

Rural-to-rural migration within the country	53.3 million
Rural-to-urban migration	20.5 million
Urban-to-rural migration	6.2 million
Urban-to-urban migration	14.3 million

An in-depth study of migrants in Maharashtra showed that married and unmarried male migrants—a majority of them from UP—maintained strong ties with their native villages. The study also found high levels of unsafe sexual activity among migrants. Male migrants perceived that their risk of acquiring HIV infection was low. Coupled with the fact that the migrants' knowledge about HIV transmission and prevention was exceptionally low, even in big cities such as Mumbai and Thane,[16] their vulnerability to HIV is a matter of concern that requires interventions through the entire spectrum of migration from source to destination and back to source areas.

2. Link Worker Schemes are reserved for category "A" and "B" districts, yet the majority of migrant source areas in UP do not fall in these categories.

An analysis of in-migrants from UP in Maharashtra identified the following as the key source districts in UP: Allahabad, Azamgarh, Bahraich, Ballia, Balrampur, Barabanki, Basti, Deoria, Faizabad, Fatehpur, Ghazipur, Gonda, Gorakhpur, Jaunpur, Kanpur, Kushinagar, Mau, Pratapgarh, Rae Bareli, Sant Kabir Nagar, Siddharth Nagar, Sultanpur, and Varanasi.[17] Only five districts in UP are classified under category "A"—Allahabad, Banda, Deoria, Etawah, and Mau—and none under category "B." Thus, only three key migrant source districts—Allahabad, Deoria, and Mau—will be eligible for

LWS. Out of the 10 districts listed by UPSACS as high out-migration districts requiring priority attention, only one is category "A." Hence, the large majority of districts with high out-migration in UP have no specific programs for reaching out to migrants or their spouses for HIV prevention.

3. Migration is a complex process that requires nuanced understanding of vulnerabilities faced by migrants and their partners/spouses at various stages of migration.

Migration is a result of a number of push and pull factors such as poverty, debt, deprivation, and marginalization, on the one hand, and the search for better living conditions and employment, on the other hand. From an HIV program perspective, migrants in source communities fall under two broad categories: (1) potential migrants, including those who are contemplating to migrate, in the process of planning their migration, or are ready to move; and (2) returnee migrants who come back temporarily to their source/home and leave again for the same or another destination after a few weeks or months. From an HIV vulnerability perspective, there is the additional issue of spouses or partners who stay behind in the place of origin. Aside from the risk of infection from their migrating partners, those who stay in home areas may have to deal with hardships that may force them to resort to sex-for-money, or they may choose to engage in other sexual relationships due to long periods of absence of their spouses. In either case, the limited knowledge about HIV and methods of prevention puts them at risk for infection.

Accordingly, the strategies for approaching these migrants vary. For example, the key thrust of activities for returnee migrants is to ensure that transmission of HIV to their spouses is prevented and that they are better equipped to protect themselves and their sexual partners. This would require empowerment of women, couple's counseling, access to condoms, and motivation to get tested for HIV. The fact that migrants usually return during festive seasons also has a bearing on the channels of communication for reaching out to the migrants. Festive seasons make it easier to spread awareness through mid-media, such as *nukkad natak*, puppet shows, role plays, and road shows. Depending on the stage at which potential migrants are reached, the strategies could also vary. At a very early stage of pre-planning, enhancing community members' access to education, vocational training, and relevant information enables them to make an informed choice about when, where, or whether to migrate. This is crucial for safe migration. Engaging returnee migrants as peers to advise migrants who are on the verge of leaving their homes and providing them ready reference materials would help them to be more aware of their risks and take necessary preventive action.

It is important to remember that the approach to reaching migrants may differ from the approach to MSM, IDUs, and sex workers due to the limited, if any, self-risk perception among migrants, as opposed to the latter groups. A sound understanding of such nuances is essential for designing and implementing effective programs to reach target groups. Current training programs for the Link Workers outlined in the Link Worker Operational Guidelines do not propose detailed sessions on migrant issues. The Link Workers may, therefore, be able to address only a limited number of the HIV-related program needs for migrants and their spouses.

4. No mechanisms exist for inter-state coordination between state AIDS control societies (SACS) to provide a source–destination continuum of services.

The National AIDS Control Organization (NACO) guidelines stress a strong need for effective linkages between migrant source and destination programs. It is anticipated that an engaged source state can motivate and support the destination state/s to address specific migrant sub-populations through their HIV prevention and care programs. Such links could be established through a Memorandum of Understanding (MoU) between the SACS of the source and destination states. Maharashtra is the destination for about half of all inter-state migrants in India, whereas UP and Bihar account for 70 percent of all out-migration in the country. More than half (56%) of out-migrants from UP have gone to Haryana, Madhya Pradesh, and Maharashtra in the past years.[18] However, no MoUs exist between UP and these states to ensure coordination of HIV services between migrant source and destination states. A concerted effort at the state level and within affected districts is needed to lead and facilitate such coordination.

5. Treatment adherence in a destination-focused approach is a challenge.

Health concerns, including HIV and AIDS, are not on the priority list for migrants as they struggle to manage the demands of their everyday lives. Thus, getting them to seek HIV testing and treatment and then ensuring that they adhere to the treatment is a monumental task that requires a continuum of services between destination and source areas. Most migrant source areas are poor in resources, including health facilities. Unless focused efforts are made to reach out to returnee migrants in their source area through community-based organizations, it is likely that their treatment will be disrupted. Such disruption could lead to deteriorating health, vulnerability to opportunistic infections, and the rise of drug-resistant strains of HIV. Moreover, a continuum of services is needed for HIV-positive migrants to help encourage safe practices for discordant couples in the source areas.

Recommendations

Focused interventions in source areas: Migrant source area interventions are required in partnership with nongovernmental and community-based organizations to foster safer migration. These initiatives should be complementary to the other efforts (e.g., LWS) in specific districts and address the spectrum of migrant-specific needs—ranging from pre-departure preparedness among potential migrants to support for returnee migrants and their families. Implementing organizations should also coordinate with mid-media campaigns to coincide with seasons when migrants return home or depart *en masse*. A migrant equipped with accurate HIV knowledge and information right from the source area *before* migrating would be more likely to make safe choices, and thus be at lower risk for HIV even in the destination area.

An important component of this initiative must be to reach out to women who stay behind while their husbands/sexual partners migrate. About 95 percent of HIV-positive married Indian women report being monogamous, demonstrating that the risk behaviors of husbands through extramarital affairs and sex with sex workers are increasingly putting women at risk for HIV infection.[19] NFHS-3 data show that condom use in UP is extremely low (9% total; 17% in urban and 6% in rural settings). Additionally, 42 percent of the women report incidents of spousal violence (36% in urban and 23% in rural settings), limiting their ability to refuse sex or insist on condom use.[20] Focused initiatives in source areas should not only be geared toward equipping men with the knowledge and services to protect themselves and their partners, but also the education and empowerment of women to negotiate condom use with their husbands or choose women-controlled methods (e.g., female condoms) to protect themselves. Such programs should also educate both men and women about the potential risk of transmission from mother to child and the services available for prevention of parent-to-child transmission (PPTCT). ANMs, ASHAs, and other outreach workers in high out-migration districts and villages must be oriented to reach out to the women whose husbands migrate, so as to be able to provide them with useful and timely information on HIV prevention, treatment, and care.

Strengthened capacity of Link Workers to address migrant-related issues: As the main responsibility for reaching migrant communities in source areas currently rests with the Link Workers, and given the complex nature of issues related to migrants—which vary significantly between potential and returnee migrants—it is important to include specific sessions on these issues in the training for Link Workers. UPSACS should work closely with the lead NGO implementing the LWS in the state to integrate specific sessions on safe migration into their training. Strengthening condom negotiation skills in women married to migrants and encouraging consistent and correct condom use among male migrants would form a part of this component.

Mainstreaming as a strategy to facilitate safe migration: The Migrant Operational Guidelines encourage mainstreaming migration issues into other development initiatives as a significant strategy to address migration-related vulnerabilities in the source areas. These efforts could be divided according to the stage of migration.

- *Pre-departure/potential migrants*: While distress migration makes young men and women vulnerable to infection, HIV programs should consider that this distress factor could be reduced by making a basket of options available to the potential migrants so that they are able to make an informed choice and plan their movement. From a mainstreaming perspective, this would require advocating with a range of

government departments to ensure that young men and women who are contemplating migration in the absence of local choices for livelihoods are provided access to the various government schemes that provide them with such options. This would, in turn, help them to make an informed choice to migrate or not migrate, as well as upgrade their skills so as to maximize their benefits from migration should they choose to migrate. Involvement of *Gram Sabhas* and older migrants is also recommended, given their local presence and experience. Migrant Information Centers could be set up through inter-departmental coordination to provide comprehensive information to migrants not only limited to HIV and AIDS.

- *Pre-migration stage*: Integrating sessions on safe migration in school programs could help rural youth develop a comprehensive understanding of migration that would help them in their later life to make decisions. Just as programs on disaster management are part of school curricula, migration preparedness could form an integral part of the education system (both formal and non-formal) in rural areas.

- *For the women who stay in source areas*: There is mounting evidence of sex work among women left behind at migrant source sites. With one or more male family members migrating for work, women who are left behind may turn to sex work for additional income. This may be especially common among illiterate, poor women in rural areas who find themselves with no other option. Given the nexus between poverty, marginalization, and HIV vulnerability, it is suggested that UPSACS, District AIDS Prevention and Control Units, and other mainstreaming initiatives within the state advocate with NGOs and government departments to provide income-generating activities, including vocational training, for women. Self-help groups for women whose husbands are migrants can also be formed. These could serve as a platform for income generation and savings, as well as for discussions and awareness raising on HIV and AIDS, condom negotiation, testing, and treatment and care.

- *Women migrants*: While there are limited empirical data about women migrants in the state, the risk of being trafficked and sold into sex work has been outlined by numerous reports and studies.[21] Understanding the vulnerabilities associated with women who migrate, as different from male migrants, is important to inform program design.

Proactive inter-state coordination: As suggested in the Migrant Operational Guidelines, inter-state coordination is essential for maintaining a continuum of services to ensure that migrants from UP have access to migrant-friendly services in key destinations. Toward this end, UPSACS should identify the main destination states and initiate a dialogue with the SACS of these respective states. An MoU could be forged between these states to ensure a continuum of HIV services. The Orissa-Gujarat model supported by UNDP can be an example in this regard.

Migrants sustain the economies of their home and destinations, while themselves living in conditions of hardships. Focused HIV initiatives for migrants by the government and civil society groups will not only help reduce their risk of infection, but also enhance migrants' sense of self worth and the health of families and communities.

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