National AIDS Control Programme Phase IV

Strategic Approach for Targeted Intervention among Men who have Sex with Men (MSM)

National Strategy for HIV prevention among Men who have Sex with Men (MSM)[1]

Contents

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Abbreviations and Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CBO	Community Based Organisation
DAPCU	District AIDS Prevention and Control Unit
GIPA	Greater Involvement of People Living with HIV/AIDS
HCP	Health Care Provider
HIV	Human Immuno-deficiency Virus
ICTC	Integrated Counselling and Testing Centre
IEC	Information, Education and Communication
MHP	Mental Health Professional
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non-governmental Organisation
PLHIV	People Living with HIV
SACS	State AIDS Control Society
STI	Sexually Transmitted Infection
STRC	State Training and Resource Centre
TI	(STI/HIV) Targeted Intervention
TSU	Technical Support Unit

A. BACKGROUND

In NACP-IV, men who have sex with men (MSM) will continue to be a high priority group for HIV interventions. Among MSM, HIV prevalence is estimated at 7.3%[2], more than twenty times the general population rate (NACO, 2010). Prevalence of sexually transmitted infections too is reported high among MSM (example: syphilis - 5.8%[3] to 14%[4]).

The achievements in NACP-III in relation to MSM (and TG) populations include:
• Expanded coverage: 2,74,000 (out of an estimated 4,12,000 population)
  − Seven-fold increase from NACP-II: More TIs: 155 exclusive and 200 composite
  − 67% coverage of most-at-risk MSM and TG populations
• About 150 surveillance sites for MSM/TG populations
• Initiation of reporting on discrimination/violence against MSM
• Presence of MSM TIs in almost all the states
(Based on the information from the mid-term review report of NACP-III)

NACP-IV will build on these achievements, and efforts will be intensified to prevent HIV infection among MSM and offer a range of necessary comprehensive services for MSM.

B. GOAL AND GUIDING PRINCIPLES

Goal
Towards zero new infections among MSM by the end of 2017; and universal access to HIV prevention, care, support and treatment services for MSM

Guiding Principles
• Universal access – inclusion of *all* high-risk MSM[5]– regardless of sexual identity, marital status, age or presumed/stated sexual practices (receptive or penetrative or both).
• Rights-based approaches[6] in health care to ensure that NACP-IV provides all comprehensive and necessary HIV-related services for MSM and continue with its national policy of voluntary HIV testing and clinical screening.
• Elimination of stigma and discrimination against sexual minorities in various settings (healthcare settings, workplace, family, and society)
• Community systems strengthening - investing in the formation and strengthening of MSM community groups and networks to promote community ownership of the HIV programme.
• Address multiple vulnerabilities such as sex work, marital status, multiple stigmas and lower socioeconomic status.
• Emphasis on both the scale of services as well as on the quality of messages and services to maximize effectiveness and ensure that interventions and services are to large extent evidence-based.

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[2] NACO (National AIDS Control Organisation). (2010). UNGASS Country Progress Report – India.
[3] Gupta A et al. Same-sex behavior and high rates of HIV among men attending sexually transmitted infection clinics in Pune, India (1993–2002). Journal of Acquired Immune Deficiency Syndromes, 2006, 43:483–490.
[4] Newman PA et al. Correlates of paid sex among men who have sex with men in Chennai, India. Sexually Transmitted Infections, 2008, 84:434–438.
[5] Not all individuals in a given subgroup of MSM are at high risk of HIV. For example, MSM in a mutually monogamous relationship with an HIV-negative partner are at a much lower risk of HIV infection. Also, there is overlapping risk between being MSM and also being an injecting drug user or sex worker. See Appendix 2 for the definition of 'high risk MSM' and size estimation.
[6] A rights-based approach to health is normatively based on international human rights standards and operationally directed to promoting and protecting human rights, and where governments and donors work to implement respect for, protection of, and realization of rights.

- Ensure that MSM TIs not just focus on providing services to only those MSM accessing TI services, but also focus on prevention of HIV/STIs to their steady partners – both men and women partners.
- Providing a comprehensive service package with a continuum of prevention, care, support and treatment services
- Flexibility to allow for adapting the TI design and implementation to suit the local context (urban/rural, concentrated vs. dispersed MSM communities, etc.)
- Transitions of certain services (such as STI clinical services) to NRHM/NUHM[7] will happen after ensuring proper sensitization of the government healthcare providers about the issues of sexual minorities and improving their competency to provide optimal clinical and counseling services.

A Rights-based Approach to HIV Programming for MSM in India

A comprehensive and effective response to HIV and AIDS requires addressing human rights. Since the early days of the epidemic, social, legal and economic marginalization have been associated with vulnerability to HIV; a rights-based approach to HIV endeavours to address these disparities and improve overall performance and impact of programming would be the best way to give stop the HIV epidemic and move towards zero prevalence in the MSM sector.

MSM have been heavily affected by HIV and AIDS from the start. Evidence indicates that the vulnerability of MSM to HIV is contingent on the degree to which their rights are recognized and addressed.

The 1948 Universal Declaration on Human Rights codified this connection between health and rights in Article 25 of the document. India voted in favour of this declaration and has affirmed its strong support of human rights over the years in its support of other international commitments and agreements.

The interconnection between human rights and health became more obvious and urgent as the AIDS pandemic emerged. A human rights-based approach to health looks beyond a clinical services model of disease control and provides a framework to address the contextual and structural factors that contribute to health and well-being.

By emphasizing human rights as a guiding principle of NACP-IV, India will address critical barriers that increase vulnerability of MSM and other most at risk populations. By protecting and affirming the human rights of these populations and ensuring that they are able to access services without experiencing discrimination, legal sanctions, social stigma, or violence, India will build on the foundation of India's earlier national AIDS strategies and help sustain the momentum of these efforts.

C. STRATEGIC OBJECTIVES

The goal can be achieved through the following strategic objectives.
1. To reach diverse subgroups of MSM through complementary outreach strategies - to contact all at-risk MSM and provide behaviour-change communication (to promote safer sex and access to services)
2. To offer a comprehensive package of prevention, care, support and treatment services to meet the specific needs of various subgroups of MSM (and to ensure continuum of prevention, care and treatment)
3. To create and sustain enabling environment that promote human rights and access to services for MSM
4. To mobilise and strengthen MSM communities to effectively contribute to national responses to HIV epidemic

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[7] NRHM – National Rural Health Mission; NUHM – National Urban Health Mission

STRATEGIC OBJECTIVE-1: OUTREACH STRATEGIES TO PROVIDE BEHAVIOR CHANGE COMMUNICATION

To reach diverse subgroups of MSM through complementary outreach strategies to contact all at-risk MSM and provide behaviour-change communication (to promote safer sex and access to services)

Traditionally outreach is conducted in hot-spots or cruising sites. However, the number of traditional 'hot-spots' or cruising sites are decreasing due to urban/rural development and also more and more MSM have started using mobile phones and internet to seek sexual partners which make cruising sites increasingly obsolete. Thus, outreach strategies will include both physical/traditional outreach strategies and virtual or technology-based outreach strategies.

Expanding the traditional outreach strategies to reach diverse subgroups of MSM
(See Diagram 1)
In NACP-IV, the traditional outreach model of MSM coming to hot-spots or 'cruising sites' will be expanded. The changes include: 1. employing outreach workers who are from different subgroups or typologies of MSM; 2. moving to sub-group-specific venues (e.g., bars for gay men, massage clubs that cater to same-sex attracted men); and 3. outreach in events for communities (e.g., Pride March) or where events in which high number of MSM come together (e.g., certain festival times). These are explained further below.

In NACP-III, in most TIs a significant majority of the ORWs are kothi-identified MSM[8]. This meant that those ORWs could primarily reach only their peers – that is, other kothi-identified MSM. Kothi ORWs themselves found it difficult to reach and talk to masculine-looking MSM who may be 'double-decker'-identified MSM or gay-identified MSM. Accordingly, depending on the proportion of the local typologies of MSM, ORWs need to be identified from those key MSM subgroups and employed for traditional outreach. In addition, subgroup-specific outreach strategies need to be developed and used. For example, in metros where there is a sizeable proportion of gay-identified MSM, a gay-identified MSM can be recruited in the TI as an ORW to work with gay communities. That ORW can preferably be nominated by or acceptable to the local gay community groups. If so, then that gay-identified ORW can reach gay-identified men in gay parties, gay-specific bars or other gay-specific venues.

Certain community-based events such as LGBT Pride Marches and LGBT film festivals can also be venues for reaching some at-risk MSM at least to provide basic information on safer sex and services available for MSM. Sometimes community events organised by the MSM agencies can be venues to provide information about HIV, safer sex and services. Certain festivals such as 'Ganesh Chathurti' (Maharashtra) and 'Dhandiya Ras' (Gujarat) may attract large congregations of MSM and in such events HIV-related messages and condoms can be provided.

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[8] **Kothi**-identified MSM generally present with feminine gender expression and are primarily receptive partners in anal sex with panthis. **Panthi** is usually a label given by kothis to their masculine partners and usually is not an identity. Kothis label those MSM who engage in both insertive and receptive sex as 'double-deckers' (some may also self-identify as '**double-deckers**' (Note: There are regional variations in the terms used). **Gay- and bisexual-identified MSM** are primarily from the middle and upper socioeconomic class and are relatively better educated when compared with kothi-identified MSM who are primarily from the lower socioeconomic status and less educated. (For more details, please refer to *Glossary*)

Diagram 1. Expanding the physical outreach strategies
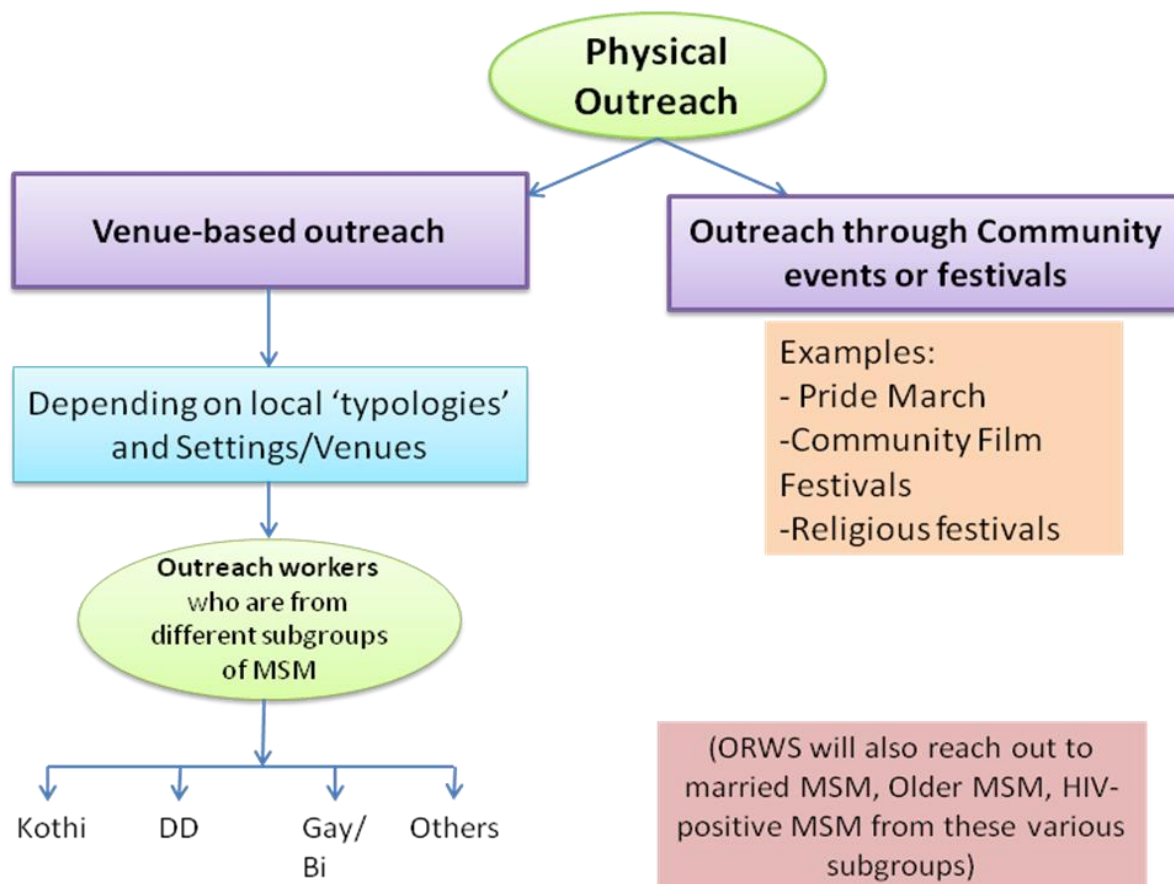
While local typology-based ORWs are recommended, it may not be possible to provide ORW for each certain 'categories' of MSM such as married MSM, HIV-positive MSM, and older MSM. However, to effectively reach these subgroups, ORWs need to be sensitized on the issues of married MSM, HIV-positive MSM and older MSM so that those subgroups could also be reached without being discriminated or left out by the ORWs. More details on potential strategies to reach currently 'hard-to-reach' MSM are listed in *Table 1*.

Appropriate TI models need to be developed in rural areas/districts where there are no significant number of hotspots and where MSM are 'not concentrated'. One model could be - a urban-based TI with satellite or sub-offices in interior parts of districts that have 'clusters' of MSM and then employ local peers to reach rural MSM and refer them to nearby health services. However, documentation of existing TI models for rural MSM and pilot-testing is needed for finding out the feasibility, acceptability and cost-effectiveness of one or more TI models for rural areas.

Technology-based Outreach or Virtual Outreach (See Diagram 2)
Mobile Phones
Increasingly mobile phones are used by people from all socio-economic classes and especially among MSM (any socioeconomic class), mobile phones are also used for contacting potential sexual partners by sharing numbers with their friends. Thus, it is possible that health promotion messages can be sent to the mobile phones of MSM (who are line-listed in TI projects or whose numbers are obtained with their explicit permission/consent to send such messages). For HIV-positive MSM who explicitly consented for getting messages and reminders, treatment-related messages and reminders for ART adherence and follow-up can be done through texting and making calls. Adequate mechanisms need to be developed to keep these mobile numbers confidential.

Phone help-lines
Many CBOs working with MSM have been using phone help-lines to provide information and counselling to MSM who may want to remain anonymous and who may not want to come to the drop-in centres. Sometimes, in crisis situations, these help-lines can be used to get rapid response. Phone help-lines can be part of the NGO/CBO-run TIs depending upon the perceived demand/need and the capacity of the agency to implement it. Where there is lesser capacity but demand is present, capacity of the TI implementing partner needs to be built.

Internet-based interventions
More and more number of MSM, especially those who are not accessing TI services, are using websites (national and international) for same-sex attracted men - to meet potential sexual partners. Thus, identifying such websites, building rapport with them (and talk about corporate social responsibility) and placing advertisements and links to HIV-related websites can be a strategy. Another strategy is to operate a state-specific website (in both local language and English) for same-sex attracted men in which the information about HIV, sexual and other health-related information are provided to decrease sexual risk behaviours and increase uptake of HIV and STI testing and counselling among MSM and where online counselling by peers are available. These websites can be operated by an experienced TI implementing agency or by a separate agency exclusively hired for this purpose.

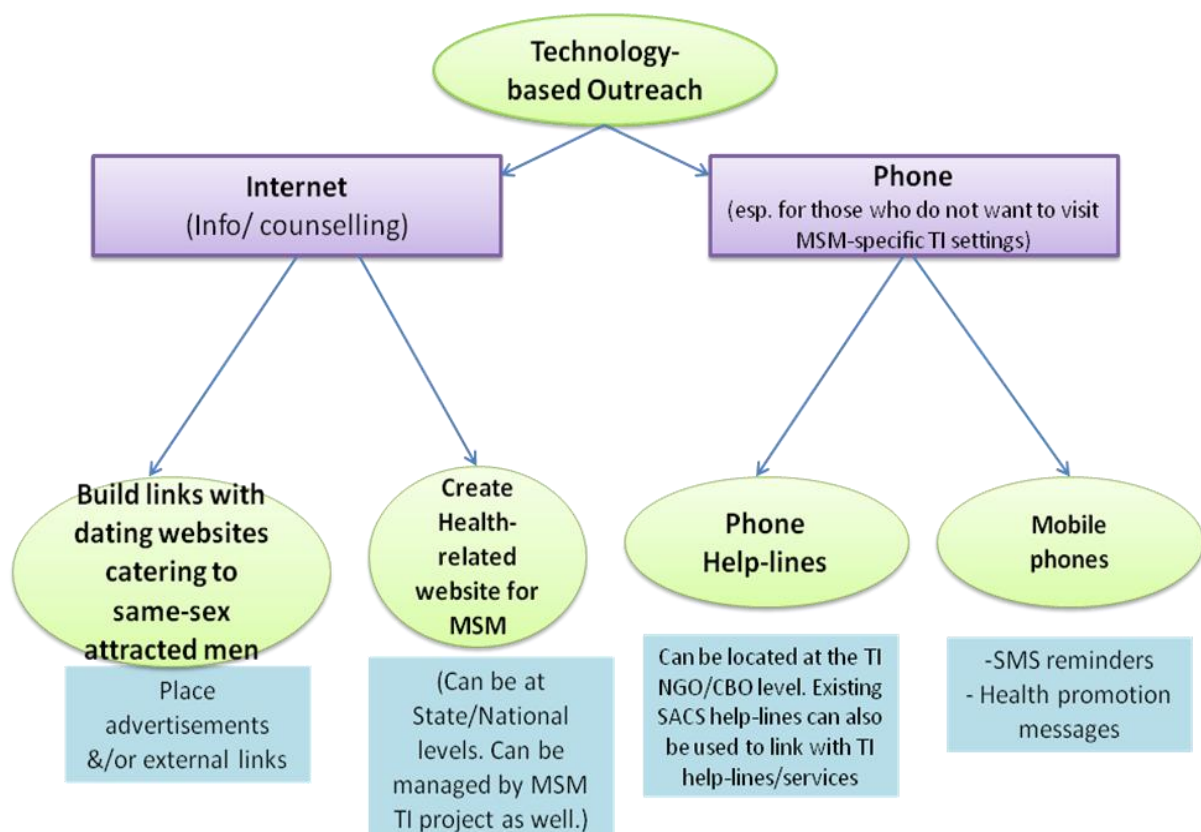**Diagram 2. Technology-based Outreach Strategies**

Table 1. Strategies to reach 'Hard-to-reach' MSM[9]

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[9] For definition and explanation of 'hard-to-reach MSM' please refer to *Glossary*.

Subgroups of Hard-to-reach MSM	Barriers to reach	Potential strategies to reach *(to provide info/counselling and link with services)*
Gay or bi-sexual identified MSM	- Do not visit current hot-spots of TIs - Socio-economic class differences between current TI outreach workers - Do not want to be seen talking to kothi-identified/feminine persons in public places or even allow kothi ORWs from TIs in gay parties or other gay-specific venues - Do not want to visit DICs located within CBOs/NGOs which are seen as predominantly kothi-oriented	- Sensitize the gay-specific local groups (e-groups) or other social groups on the importance of HIV interventions for gay-identified men and get their support. Gay peer ORWs can be identified with the help of these local gay groups - Employ gay-identified ORW acceptable to the gay community – depending on the settings (e.g., urban areas) who will then access gay-specific venues (parties, bars, etc.)
Married MSM	- Community stigma (kothi / gay) related to married status - Fear of disclosure of sexuality to wives and its negative consequences	- Create conducive environment for married MSM in TIs by addressing community stigma around married status of self-identified MSM - Anonymous referral and FU services (phone/internet) for married MSM who do not want to come to TI sites/DICs
Self-identified MSM who do not visit DICs/TIs and cruising sites	Want to receive anonymous services	- Help-line-based service referrals/follow-up - Internet-based interventions
'Older' MSM (> 50 years of age)	Not prioritized by HIV agencies especially in HIV agencies where mostly young MSM ORWs are employed	- Need to educate TI staff about importance of reaching out to older MSM
Same-sex attracted legal minors (below 18 years of age)	Legal barrier to provide services in the current TIs	Sensitize the existing youth/adolescent-friendly clinics on the issues of same-sex attracted legal minors and establish linkages with those govt. or non-governmental agencies. There is need for development of guidelines to address this issue (i.e., being a legal minor as a access barrier)
Non-self-identified MSM *(See Diagram 3)*	Not coming to cruising sites and TI projects; and not even using MSM-specific internet sites	- Integrate messages/counselling in existing HIV interventions for men (migrants, college youth, drug users, prisoners, truck drivers, etc.) - Mainstream Mass Media campaigns on HIV: Generic messages on safer sex with partners of any gender. - Strengthen the capacity of health care providers to sensitively ask same-sex sexual

		history among men who come to govt. health care settings (STI clinics, ICTCs, ART centres, etc.)

Diagram 3. Reaching Non-self-identified MSM
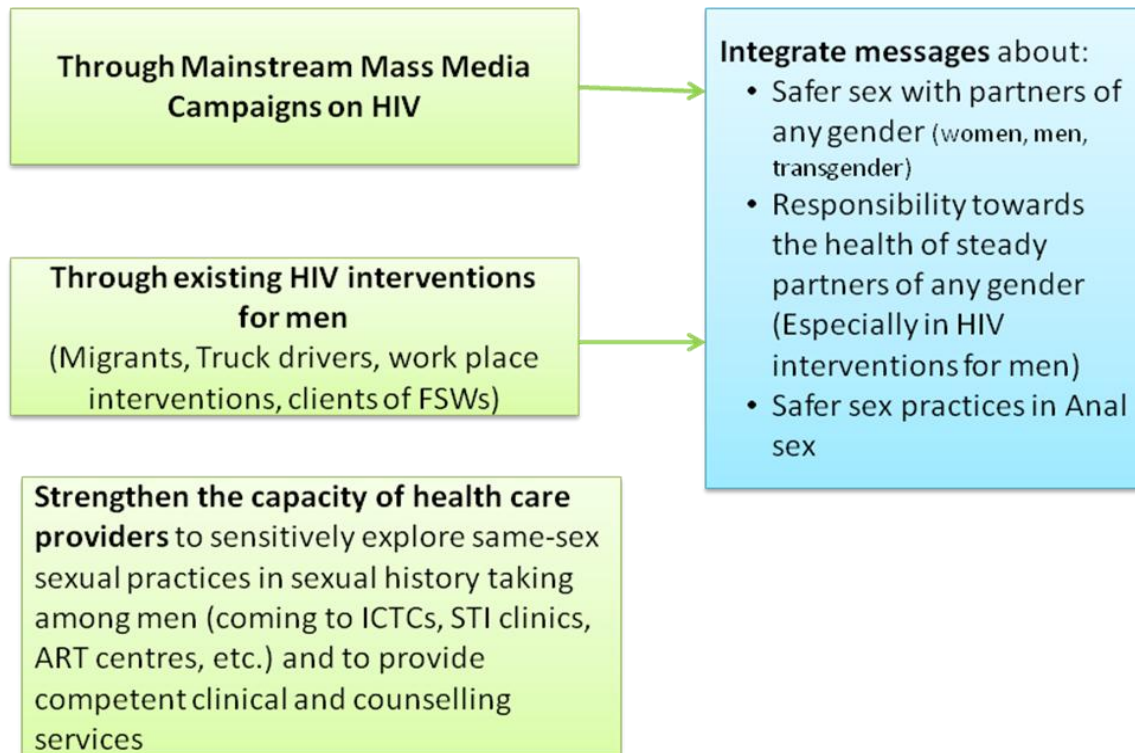
STRATEGIC OBJECTIVE-2: (COMPREHENSIVE PACKAGE OF SERVICES AND CONTINUUM OF CARE)

To provide a comprehensive package of prevention, care, support and treatment services to meet the needs of various subgroups of MSM and to ensure continuum of care

MSM will be provided a range of HIV-related services both directly through the TIs and by linking them with government (and sometimes, private/non-governmental) health facilities. Both essential package of services (that need to be available through TIs – both on-site services and essential referrals) and additional package of services (these are suggested list of referrals) are elaborated below. Together, they form the comprehensive package of services.

Table 2. Comprehensive package of services (includes referral services)

Essential Package of Services	Additional package of services (Usually referral services)
1. **Outreach and Behavior Change Communication** 2. **Condoms and Lubricants** 3. **Drop-in Centre (DIC)** 4. **STI screening** (Syphilis/Other STIs, HBV) **and management (including partner referrals)** 5. **Voluntary HIV testing and counseling, and risk reduction counselling** 6. **Crisis/Violence prevention and mitigation** (Crisis Response Team) 7. **Positive living and Positive prevention**	1. Counselling related to one's sexuality and mental health issues/marital issues 2. Anal cancer screening for HIV-positive MSM 3. Social protection/entitlements 4. Alcohol dependency treatment and drug-dependent treatment programs 5. Treatment of Hepatitis-B infection 6. Screening for Hepatitis-C, if history of injecting drug use

Essential package of Services (See Table 2)

Most of the following services are provided either through TIs or by linking with appropriate health care services (e.g., HIV testing and STI treatment).

1. Outreach and Behavior-change communication

The various physical and virtual outreach strategies have been elaborated earlier. Through these various outreach strategies, information/counselling on HIV/STIs and sexual health, availability of services for HIV/STI screening and treatment, condom and lube use, and human and legal rights will be provided. Depending on the nature of information/counselling, outreach workers or counselors will be the key staff who will be involved in providing information and behavior change communication. Appropriate tools to assist in behavior change will be developed in local languages and used. These tools will cater to the specific needs of diverse subgroups of MSM taking into account the diversity in sexual identities, socioeconomic and educational status, marital status and HIV status.

2. Condoms and Lubricants

Condoms and lubricants will continue to be provided free through TIs to cover all the estimated anal sex episodes of the beneficiaries they reach. Supply of free condoms and lubes will be timely and distribution will be made more efficient. Training will be provided to TI staff to calculate the condom and lube requirements. This training is of particular importance because water-based lubricants have relatively low shelf life (six months) and thus usage of lubes within stipulated period becomes essential. Methods of observing lube uptake and corresponding adjustments on lube indents will be fine-tuned to prevent wastage or stock outs at TI levels in parallel to the stocking of condoms (both super-lubricated and flavored).

3. Drop-in Centre (DIC)

The drop-in centre will be treated as a service to focus and strengthen collectivization that hasten community ownership of the TI. This will also ensure service uptake through TIs. The concepts of community ownership and collectivization will be defined through tangible activities or modules that help in fostering community spirit (e.g. by offering training on self-development and leadership skills development). DICs will focus on providing service to the community and will orient itself in terms of service quality and standards. The DIC will serve as the focal point that channelizes community synergy towards uptake of services both internal and external to TI. DIC protocols will be

strengthened to make efficient use of the space. DICs will be of a size to accommodate enough people to hold meetings and other related community activities. Hence, budgets for DICs will be commensurate with the city tier (category of the city/town) and the needs of the specific MSM community typology.

4. STI screening (Syphilis/Other STIs, HBV) **and management (including partner referrals)**
Not all TIs have clinics located within their office premises. Some TIs have established linkages with local government hospitals for STI screening and treatment and some other TIs have their own clinics. Wherever there are TIs for MSM, the local government health care providers will be sensitized and trained on the needs of MSM. Appropriate time-period (about 3 to 5 years) will be allowed for transition of STI care of MSM from TI-based clinics to the nearest government health care facilities. Referrals to government facilities will also help MSM getting general health facilities that the TIs presently do not provide.

The national STI guidelines that include guidelines for anal and oral STIs will be followed. Healthcare providers in the government STI clinics will be trained on these guidelines and about the issues of MSM and transgender people.

Anal and Oral STI screening will continue to form a part of the current STI prevention strategies. Although proctoscopy is a procedure for detecting symptomatic anal STIs, the same should be practiced with the consent of the patient and after taking his sexual history. Only on basis of such oral sexual history (e.g., history of unprotected anal sex in the past three months or condom breakage/slippage) any invasive procedure be followed with explicit consent of the patient. These are crucial steps to prevent charges of human rights violation of forcibly using invasive proctoscopic examination that drives away other potential beneficiariesfrom seeking such services.

Testing for Syphilis is recommended at a six-month interval for both individuals who are HIV-negative/unknown status and HIV-positive. Presumptive treatment for STIs among MSM will be provided after evidence for the same is available. If required, operational research on the efficacy of presumptive treatment will be conducted.

Because unprotected anal sex may result in transmission of Hepatitis-B (HBV) infection, screening for HBV is recommended as a routine practice when MSM are screened for STIs. HBV screening of MSM is a standard international practice. Hepatitis-B vaccination should be offered to those who are HBV-negative.

5. Voluntary HIV testing and counselling
While HIV screening for MSM at quarterly intervals are recommended, in consistentcy with NACO's policy this will not be made mandatory. MSM will be provided proper counseling on HIV testing and only those who consent for testing will be sent for HIV testing and counselling.

6. Crisis/Violence prevention and mitigation (Crisis Response Team)
Crisis forms a part of any outreach work and rapid response to crisis builds faith and confidence in a marginalized community that often finds itself on the receiving end of stigma and violence. Every TI needs to not only react to crisis but also look at preventive actions that can avert any unpleasant situations. Crisis response is a part of enabling environment and hence needs to be addressed by all TIs. A crisis response team usually includes the Project Manager, Counsellor, Community Mobilizer, ORWs and local (area) peers. Proactive advocacy strategies to prevent future crises will also be taken by the TI. Sexual and physical violence prevention will be part of such proactive strategies. Crisis response team will also take care of the service needs of victims of sexual violence by connecting them with medical services, helping them in filing cases and linking them to free legal aid. NACO will develop mechanisms to offer sexual post-exposure prophylaxis (S-PEP) in the government hospitals for victims (man, woman or transgender) of sexual violence.

7. Positive living and Positive Prevention[10]

Necessary services for MSM living with HIV need to be offered. These include:
- Treatment literacy and effective communication for better knowledge to access services
- Assistance in disclosure to steady partners and providing information about where to refer their steady partners (men and women) for HIV screening and treatment
- Counseling on safer sex with sexual partners and reducing the risk of sexual transmission (correct and consistent use of condom during any sexual encounter, condom negotiation and sexual communication skills)
- Prevent transmission through non-sexual routes (injecting drug use)
- Advise on how to prevent other infections such as STIs and TB
- Supporting and monitor MSM on care, support and adherence to ART
- Referral to ART centres and TB DOTS centres
- ART preparation, initiation and adherence support
- Nutrition support and encourage physical activity
- Supporting the formation of support groups of MSM living with HIV
- Referral to mainstream PLHIV networks and proper sensitization of network staff/members
- Buddy system for MSM living with HIV: Here one or more staff are given the responsibility of providing necessary referral services (Note: Some MSM living with HIV may require to be accompanied by the staff to the government services at least initially).

Additional package of services (Referral services)

Some of the referral services that can be offered through TIs include:
- Counselling related to one's sexuality (can be offered at TI site level too) and mental health issues regarding issues arising out of marital status (like legal aid).
- Anal cancer screening for HIV-positive MSM (especially for those who have had history of anal warts)
- Providing information about and offering referrals to social protection/entitlements
- Linkages to alcohol dependency treatment and drug-dependent treatment programs (needle syringe programs, opioid substitution treatment, etc.)
- Referrals for treatment of Hepatitis-B infection
- Screening for Hepatitis-C, if history of injecting drug use

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[10] Several definitions of 'Positive prevention' exist. In one way, it refers to protecting the health of people living with HIV by assisting them in adapting safer sex and safer injecting practices, and in protecting the health of their sexual or needle-sharing partners. However, positive prevention framework also includes the concept of 'shared responsibility' (that both HIV-positive and HIV-negative/unknown HIV status partner are responsible for their decisions in safer sex or needle/syringe sharing).

Diagram 4. Proposed MSM TI Model

Project Coordinator, M&E Assistant, Accountant

HIV testing, treatment care and Support

Internet-based interventions (Counsellor)

Mental Health

STI screening & Treatment

Counsellor

Community Mobiliser-A

Community Mobiliser-B

Mobile phone-based interventions and Help-lines (Counsellor)

ORW

Legal Rights

Peer Educators – 1:30-60
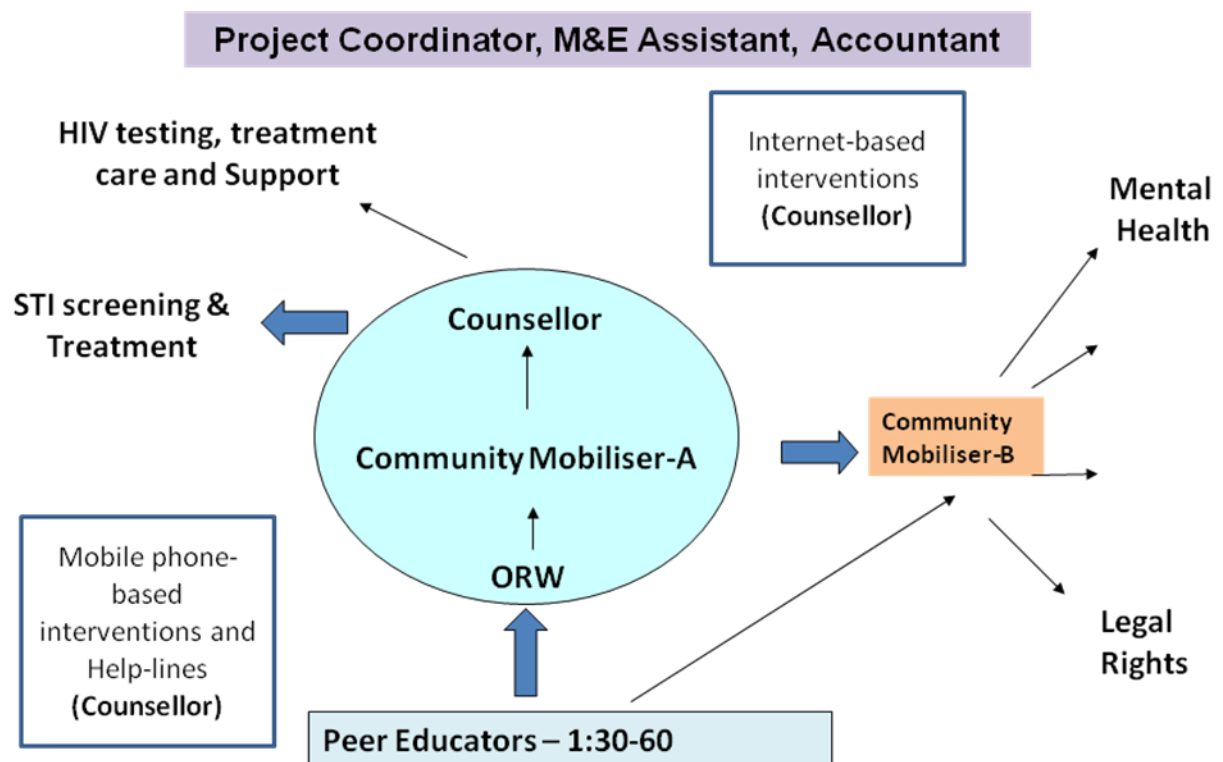
STRATEGIC OBJECTIVE-3: ENABLING ENVIRONMENT

To create and sustain enabling environment that promote human rights and access to services for MSM

A supportive or enabling environment, that includes policies and legislation that address stigma, discrimination and violence, and psychosocial vulnerabilities, is critical to achieving universal access to HIV prevention, treatment, care and support. Activities to promote enabling environment thus will not only be limited to advocacy with the immediate stakeholders around the TI implementing sites but changing the negative attitude of the general public and healthcare providers towards same-sex attracted people. Both proactive and reactive advocacy strategies will be used by key stakeholders to contribute to enabling environment. Depending on the nature of the issue, the activities could be training and sensitization, legal reform, and partnerships with agencies working on human rights issues.

Also, some of these advocacy activities will happen at the national level, state level, district level or TI site level.

Table 3. Key advocacy activities to create enabling environment

No.	Advocacy Issues	Activities	Agencies to be involved			
			NACO	SACS	TIs	Other agencies
1	**Mental Health concerns of MSM**	a) Training TI staff (especially the outreach team) on "mental health concerns of MSM".	Developing training module on "Mental health concerns of MSM" for TI staff	At the state level SACS to take lead in these trainings	Outreach team (including additional in-depth training to counsellors) to use this knowledge to provide mental health counselling	
		b) Training of Health Care Providers (HCP) including Mental Health Professionals (MHPs)	Advocating with Ministry of Health to include health concerns of sexual minorities (including mental health concerns) in the medical and nursing curriculum	--	--	Ministry of Health; Indian Psychiatric Society (IPS), Indian Association of Clinical Psychologists
			Developing an module for orientating / sensitizing existing HCPs and MHPs on these issues	To forge collaborations with the state level medical and psychiatrists associations in conducting these orientation sessions	To assist STRC in selecting participants for such orientation sessions	Training agency to use supportive mental health experts as resource persons for these trainings
2	**Enabling MSM (especially MSM in sex work) to access Social Entitlements** (identity documents, economic schemes) .	Training TI staff (especially the outreach team) on these issues, so that they can enable (through information dissemination, and guidance) their project beneficiaries to	Developing a module / information pack on the following : • Where and how to get these social identity documents • What kind of	SACS to conduct these trainings	Outreach team to use this knowledge to enable project beneficiaries to access social entitlements	In some cases referrals could be made to NALSA, SALSA, DALSA, and SACS legal aid cell where it exists

		access such social entitlements. Although these issues are not specific only for MSM, but this approach could be used to attract the population (especially un-reached MSM from economically / socially disadvantaged backgrounds) to TI services.	social protection schemes are available and how to access them			
3	**Advocacy with Police**	Training police personnel at all levels (using the Tamil Nadu model / UNAIDS nodal points) Note: each training to have personnel from the same level to ensure a more open discussion and better interaction among the trainees	Developing an appropriate training module (the Tamil Nadu model to be adapted / further developed)	SACS to train a group of Master Trainers (selected from TI staff / community members). SACS to collaborate with state police authorities to conduct these trainings	Master Trainers to be selected from the communities among other experts	DIG Police, Police Academies, and other relevant government departments
		Orientation / sensitization of police personnel at the local Police Station level	Developing training module for TI staff on - legal rights, various laws that can / are being used against MSM and how to deal with police harassment / rights violations faced MSM Motivating SACS to – initiate / scale up / strengthen their legal aid	SACS to train TI staff on these issues. SACS to initiate / scale up / strengthen their legal aid cells and pro-actively take such cases of rights violations / police harassment	To build rapport with the police stations with in their project area	Human Rights Commissions, various organizations and agencies working on human rights issues, local lawyers (who have been sensitized regarding these issues)

		cells			
4	**Advocacy with Judiciary**	Sensitizing Judges (at the National, State and District levels) and lawyers Using ADR, Lok Adalat for resolving conflicts / rights violations at the local level / rural settings	Developing a communication material using the Delhi High Court Verdict (July 2, 2009 on Section 377 IPC) To collaborate with relevant government ministries and department, and other development partners to facilitate such sensitization sessions	Facilitating sensitization sessions at the state and district levels	Sensitizing local lawyers / referring them to such sensitization sessions carryout by SACS	Judicial Academies, Ministry of Social Justice and Empowerment and Ministry of Law, HR Commission. Development partners (such as UNDP), Human Rights Commission NALSA, SALSA and DALSA
5	**Advocacy with people representatives**	Advocating with MPs and MLAs, towards getting the support of relevant ministries Ensuring community representation at the National AIDS Committee	Advocating with MPs regarding the need for NACO to work with MSM populations Advocating with the Parliamentary Forum on HIV/AIDS	Advocating with MLAs and with the State Level Legislative Forum Training TI staff / CBO board members to advocate with MLAs	TIs to support SACS in advocating with MLAs	National AIDS Committee, Parliamentarian Forum on HIV/AIDS, State Level Legislative Forums
6	**Crisis Management at the TI level**	Strengthening the Crisis Management Cells (CMCs) with the TI to deal with crisis	Developing a training module for TI staff for efficiently managing their crisis management cells	SACS to carry out these trainings	To involve CBO board members / community members to strengthen their CMCs	

STRATEGIC OBJECTIVE-4: COMMUNITY STRENGTHENING AND COMMUNITY ENGAGEMENT

To mobilise and strengthen MSM communities to effectively contribute to national responses to HIV epidemic

MSM communities are quite diverse. Not all MSM want to be part of informal or formal groups of MSM. The reasons behind formation of MSM community agencies may be different. Some of the MSM community agencies are formed to address the health needs and advocacy issues of same-sex

attracted men. Some other community groups are informal (non-registered) and maybe even primarily e-group-based and they may focus on the issues of importance to same-sex attracted communities and/or to socialize and meet with potential sexual or life partners.

Some of the MSM community agencies have formed national and state level networks. There are experienced national and state level networks of sexual minorities (such as Integrated Network for Sexual Minorities, INFOSEM, a national network; and Manas Bangla, a state level network in West Bengal). In addition, state level networks of MSM and transgender people are being formed and strengthened in Avahan-supported programmes as well.

Thus, community mobilization and strengthening processes need to take into account all these existing and emerging community structures. Community mobilization and strengthening, in general, will thus not only be focused on building the capacities of the communities to address HIV-related issues among the diverse communities but also to address the broader health-related issues and rights issues. The goal of community mobilization and strengthening from the national government's perspective is to strengthen the communities so that they can eventually take ownership in addressing HIV/health-related issues and rights issues of their communities.

At the targeted intervention (TI) level, community mobilization may refer to mobilizing the community members at the grass-root level to understand their health-related issues and rights, and to improve their access to services and to help them to collectivise and enjoy/realise their rights. This will in turn greatly assist in moving towards the national goal of zero new infections by 2017 through developing and strengthening community ownership to the programme.

Thus, the community strengthening strategies include:
1. Community mobilization at the TI level (established CBO/NGO)
2. Support for formation, and strengthening of formal and informal community groups
3. Support for strengthening of existing national and state level networks of sexual minorities, and formation of new state level networks of sexual minorities
4. Linking and docking these networks with other government agencies to facilitate their mainstreaming into national goals of progressive, rational and scientific thinking.

Community mobilization at the TI level (established CBO/NGO)
TI-based community mobilization activities include (but not limited to):
- Conducting events of importance and attraction to the communities with larger representation from the grass-root level community members (not just peer educators or CBO/NGO staff). Example: Community events like "Melukolupu" in Andhra Pradesh.
- Mixing information with entertainment ('Infotainment') in drop-in centre activities and in the field.
- Encouraging the community members to actively provide periodic feedback to check and ascertain whether the services meet the needs and are of acceptable quality to the beneficiaries.
- Community participation in planning of outreach at hotspot and cluster levels, and crisis management groups at intervention sites
- Participation of community members in planning, implementing and monitoring activities at TI level.
- Community involvement in designing of various capacity building modules and communication materials

Support for formation, and strengthening of formal and informal community groups
In NACP-III, community strengthening primarily supported formation of formal (registered) CBOs under the guidance of NGOs and transition of TIs from NGOs to CBOs. Also, capacity building support from SACS was provided to only those CBOs funded by NACO/SACS. In NACP-IV, a strategy will be to support formation of formal (registered) CBOs wherever necessary and to support

building the capacity of existing CBOs to address the health and rights-related issues of MSM. Capacity building will not be limited to only those CBOs that are funded by NACO/SACS, but active capacity building support will be provided for new/emerging formal and informal community groups (including e-group-based groups). Capacity building support for formal and informal community groups will be based on their needs and the stage/experience of the community groups/agencies.

Support for strengthening of existing national and state level networks of sexual minorities, and formation of new state level networks of sexual minorities
Support, either through NACO or through donor partner agencies must be offered to build the capacities of the secretariats of existing national and state level networks of sexual minorities (such as INFOSEM and Manas Bangla) by NACO/SACS.

In addition, support will be offered by SACS or other donor partners for the formation and strengthening of state level networks or federations of sexual minorities to build their advocacy capacities. In some cases, the secretariats of the state level networks of sexual minorities may also serve as the hub for overseeing and supporting the TIs implemented by the CBOs at the state level (for example, currently WBSACS support the secretariat of Manas Bangla to oversee and provide support to TIs implemented by its CBO members.

Community engagement in the decision-making processes
The government is committed to the principle of greater involvement of people infected and affected by HIV/AIDS (GIPA). Accordingly, MSM communities will be involved in the program/policy designing, implementation and evaluation in GIPA policy planning.

The formation of NACP-IV strategies for MSM involved active participation of community representatives from various parts of India. This shows the commitment of the government in involving affected communities in program/policy designing. Similarly, the support for the formation and strengthening of CBOs (and networks) to implement TIs shows the active involvement of the communities in implementation of the program by taking ownership. Community representatives will also be involved in the review and evaluation of national and state HIV programmes.
The recently approved national GIPA policy is also applicable for affected communities such as MSM (whether HIV-positive or not), and procedures set in the national policy will be adapted to involve the MSM communities in design, implementation and evaluation of HIV programmes.

D. CAPACITY BUILDING

Capacity building for successful implementation of the programme and creating enabling environment will be at all levels – NACO, SACS and TI levels, and with key stakeholders. As part of building the capacities of these various stakeholders, resource pool will be developed at district, state and national levels with professional and community experts in HIV interventions for MSM.

Capacity building of SACS
At the SACS level, capacity building of the relevant SACS officials will include but not limited to creation of state-specific scale-up plan (that includes mapping and size estimation); tailoring the HIV programme for MSM according to the local context, advocacy strategy development and implementation of SACS in collaboration with other partners, and involvement of MSM communities in state MSM program designing, implementation and evaluation.

Capacity building of TI-implementing partners
TI staff and management will be trained on all aspects for successful implementation of the project. These include training on both management and technical aspects, and providing ongoing technical support for implementing TIs.

Capacity building of community groups and networks
Capacity building will not be limited to only those CBOs that are funded by NACO/SACS, but active capacity building support will be provided for new/emerging formal and informal community groups (including e-group-based groups). Capacity building support for formal and informal community groups will be based on their needs and the stage/experience of the community groups/agencies.

Capacities of the national and state networks of sexual minorities will be built to effectively advocate with key stakeholders (healthcare providers, police, judiciary, etc.) to reduce stigma and discrimination in various settings, and to promote access to health services including HIV and sexual health services.

There is need for situation assessment of capacity of TI service providers in delivering MSM-specific interventions and identify areas for capacity building. Current capacity and resources of the NGO/CBOs that are implementing TIs are insufficient to comprehensively provide care and support. There is an urgent need for treatment literacy and effective communication so that MSM have better knowledge to access services. HIV-positive MSM need to be supported to build their own self-help-groups to build capacity on care, support and adherence to ART.

Capacity building of healthcare providers
Training will be provided for healthcare providers in the government hospitals (STI clinics, ICTC, ART centres, General Medicine and Surgery, Psychiatry, etc.) on:
- human rights-related issues of sexual minorities and to better understand sexual minorities as fellow humans;
- ensuring competent clinical and counselling services for MSM and their steady partners (men and women); and
- developing cross-linkages with agencies working with MSM

E. MONITORING AND EVALUATION, AND STRATEGIC INFORMATION

a. Programme planning and implementation
Formative research will help in designing the national/state programme as well as for designing projects according to the local context (TI level).

For example, at the national/state level, the type of information that are required in relation to HIV programme for MSM include:
- Who are MSM? What are the various subgroups/typologies of MSM? Who are at high risk for HIV?
- What are the various strategies to reach diverse subgroups of high-risk and at-risk MSM?
- Where the various subgroups of MSM (Mapping) and what is the estimated size of the various subgroups (Size estimation[11])?
- What are the driving factors for HIV transmission risk among MSM and how to address these factors? (These may require structural level interventions)
- By what ways, through individual level interventions risk can be addressed and behaviour change can be promoted?

Operations Research
Among other benefits, operations research can be useful to find out what works and why; and what did not work and why. These can help in improving the programme/project. Operations research can be conducted at different stages of the programme/project to identify the need for any mid-course correction or on the need to modify or expand the strategies.

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[11] Traditional venues and non-traditional venues – including estimation of the size of MSM who are internet users and mapping the frequently used internet sites and mobile applications

Sometimes, where there are limited information about developing intervention models for particular subgroups of MSM in certain settings (example, rural), *feasibility studies* to test potential intervention models may be necessary. Sometimes, models that worked in one part of the country may require modification in some other part of the country to suit the local context. Operations research studies will help in addressing these kinds of questions.

b. Programme monitoring and evaluation
Input/Output Monitoring and Process Evaluation
Programme/project monitoring requires using quantitative and qualitative indicators to find out whether the required outputs are achieved, within the stipulated time-period, and of adequate quality. Checking the kind of process that helped in achieving or not achieving the required outputs of the project come under process evaluation.

Outcomes and Impact Evaluation
Programmes/projects can be evaluated by finding out whether they resulted in the intended outcomes/impact. Base-line, mid-line and end-line assessments (using mixed methods – both quantitative and qualitative) are required. Impact, however, can be seen only after several years and often not in the programme period.

For measuring some of the short-term outcomes such as change in the behaviour and biological outcomes (HIV/STI prevalence), biological and behavioural surveys are necessary. Thus, periodic second-generation HIV/STI serosurveillance among diverse subgroups of MSM are necessary. Integrated Behavioral and Biological Survey among MSM in different parts of India needs to be undertaken and results should be disaggregated by age and MSM subgroups to identify differences in burden of disease, risk behaviours and dynamics of the epidemic.
SUGGESTED TARGETS AND INDICATORS AT THE NATIONAL LEVEL

- Saturation of coverage of all high risk MSM[12] accessing outreach sites (cruising sites or hot-spots) in terms of providing essential HIV prevention, care, support and treatment services. The estimate of high risk MSM accessing cruising sites comes around 3.5 Million (See Appendix 2).
- Annual validation of MSM populations at the physical outreach sites (and emerging virtual sites)
- All 'A' and 'B' category districts in terms of HIV prevalence covered with one or more MSM TI to saturate the coverage of estimated number of MSM.
- All metro cities (national and state) must have one or more MSM TI to saturate the coverage of estimated number of MSM
- All current MSM TIs with adequate capacity be upgraded with comprehensive package of services (include lubricants, vulnerability reduction interventions and linkages for social support)
- 70% of exclusive MSM TIs to be transitioned from NGOs to CBOs (higher from the NACP-III aim of 50%)
- 100% of anal sex acts to be protected by condoms and lubes

Note: The suggested targets and monitoring indicators at the TI level are given in Table 3.

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[12] For programmatic purposes (to provide information and condoms to needy MSM), all MSM who access cruising sites need to be regarded as 'high risk MSM' because of the high level of anal sex (85.6% - 90%) reported by studies that recruited MSM from cruising sites. For more details see Appendix 2.

Table 4. Monitoring indicators and Suggested Targets for a MSM TI Project

Sr. No.	Area	Indicator	Suggested Target	Frequency of Reporting	Number (For one year period)
1	**Physical / Venue-based Outreach**	Estimated No. of MSM			
		Denominator	One time	One time	1000
		No. of MSM ever contacted (at least once)		Annual	
		% Regular Contacts *(defined as once in every 15 days and received at least 2 essential services in a year)*	80%		800
2	**STI/Clinical**	% who come to TI-run STI clinic once	100%	Annual	1000
		% Who come to STI Clinic Quarterly	35%	Quarterly	350
		% treated with presumptive treatment for STIs	40%	Annual	400
		% who are screened for Syphilis	100%	Annual	1000
		If TI-run clinic present: % of those who reported unprotected anal sex and who consented for proctoscopy	100%	month	
3	**Condom**	% of monthly risky sexual acts covered by free peer-delivered condom/lube distribution and through depots	100% of estimated demand as per condom/lube gap analysis		
		% reporting condom use in the last time they had anal sex with male partner			
		Consistency of condom use in the past three months	100%	(can be measured in baseline and endline surveys)	
4	**Linkages**	HIV testing: % tested at ICTC	100%	6 months	1000
		No of registered MSM referred to HIV Testing & Counselling and who know their results		Monthly	

		Total number of persons who are diagnosed HIV-positive (as reported back to TIs)		Quarterly	
		No. of HIV-positive persons referred to and registered at ART centres	100% (of all HIV-positive persons)	Monthly	
		Number and percentage of eligible persons who are on ART	(100% of eligible persons should be on ART)	Quarterly	
		% of persons on ART who receive adherence support	100%	Monthly	
		% of HIV-positive persons referred to DOTS	100% (of all HIV-positive persons)	Monthly	
		% of HIV-positive persons with TB who received treatment for TB and HIV	100%	Quarterly	
5	**Enabling Environment**	All hot-spots have at least one local community group (formerly 'self-help group') to deal with crisis situations (such as police harassment or violence).			
		Proportion of reported incidents of rights violations or violence addressed within 24 hours	(at least 30-40% of incidents being responded to within 24 hours)	Monthly	
6	**Community Mobilization**	No. of community groups (formerly 'self-help group') formed.		Annually	
		No. of MSM reached through community mobilization meetings	20%	Quarterly	200
		No. of meetings/events held for >500 MSM	3	year	500
6	**Advocacy**	No. of sensitization meetings with police		Quarterly	
		No. of sensitization meetings with govt. healthcare providers		Quarterly	
7	**Internet**	No. of people who visited the state-specific website for MSM		Monthly	
		% of people who provided positive feedback in periodic online surveys		Quarterly	
8	**Phone help-lines**	No. of calls received on issues related to MSM		Monthly	

		No. of referrals made to access services (govt. or non-governmental)		Monthly	
9	**Mobile phone-based interventions**	No. of MSM who received SMS on health promotion messages		Monthly	

APPENDICES

Appendix 1. MSM TI Organogram

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                        │   Project    │
                        │   Director   │
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┌──────────────┐       ┌──────────────┐       ┌──────────────┐
│  Accountant  │◄──────│   Project    │──────►│ M&E Assistant│
└──────────────┘       │   Manager    │       └──────────────┘
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         ▼          ▼         ▼         ▼
┌──────────────┐ ┌──────────┐ ┌──────────────┐ ┌──────────────┐
│ Outreach     │ │          │ │ Community    │ │ Doctor       │
│ Workers      │ │Counsellor│ │ Mobilisers–2 │ │ (Where there │
│ (ORWs)       │ │          │ │              │ │ is in-house  │
└──────┬───────┘ └──────────┘ └──────────────┘ │ clinic)      │
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┌──────────────┐
│ Peer         │
│ Educators    │
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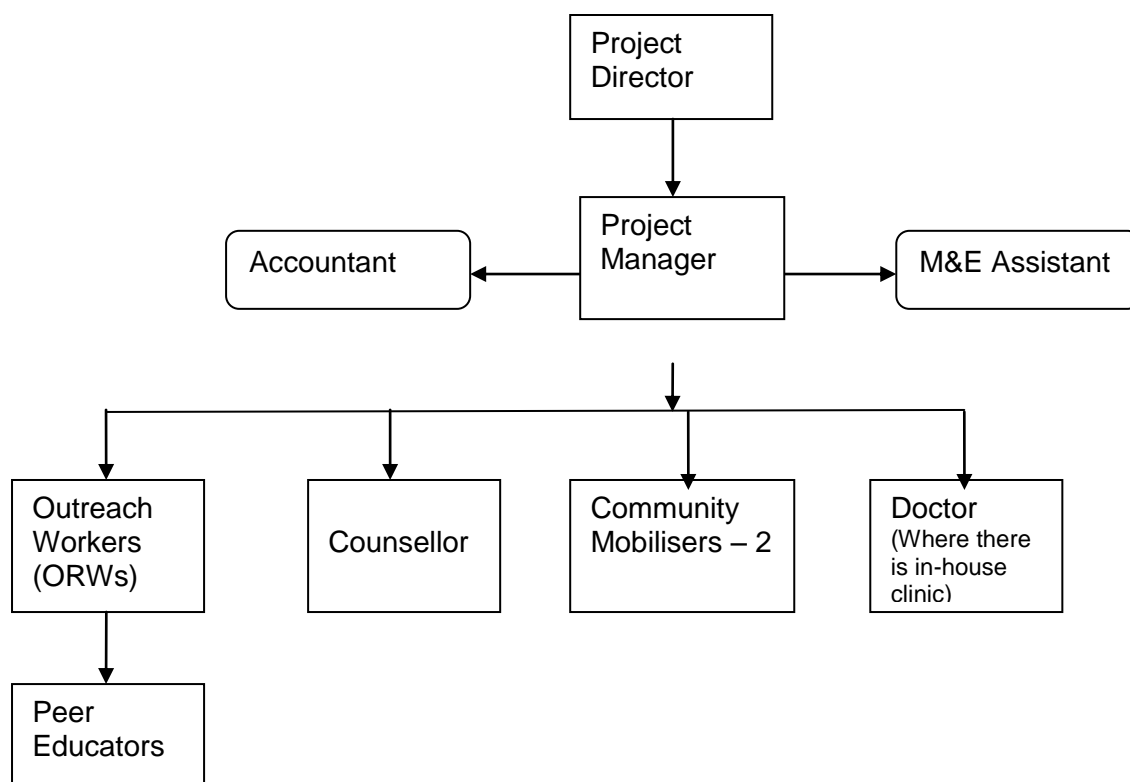
Appendix 2. Estimation of high risk MSM to be covered in NACP-IV

The estimation of MSM[13] (accessing cruising sites) to be covered in NACP-IV is based on a revised estimation method used in NACP-III. The estimate comes around **.41 Million (4.12 lakh).**

Details of the estimation process are given below.

According to the government of India census data (2011), the total number of male population = 623.7 million

Based on 2001 Census data[14], 57% of the total male population are between 15 and 59 years and this will be taken as a proxy for sexually active male population (even though males less than 15 years or more than 59 years are also likely to be sexually active).
That is, sexually active male population = 355.5 Million.

Five percent of this sexually active male population is estimated to be same-sex oriented and engage in same-sex behavior (5% of 355.5 Million)= 17.7 Million. This figure will be used for estimating the size of MSM coming to the cruising sites as the assumption is same-sex oriented people are more likely to come to cruising sites to seek sexual partners.

20% of males who engage in same-sex behavior (MSM) are estimated to visit cruising sites (0.2 x 17.7 Million) = 3.5 Million

About 85[15] to 90%[16] of MSM who visit cruising sites are estimated to engage in anal sex (receptive or penetrative or both), therefore all (100%) MSM who visit cruising sites need to be reached for the success of TI programme because one cannot find out who engage or not engage in anal sex.

Therefore, the number of 'high risk' MSM who attend cruising sites who need to be covered in NACP-IV = **3.5 Million**

(Note that this estimate excludes MSM who do not visit cruising sites but who might only or mainly use social/friendship networks and phone/internet to seek sexual partners. Estimation and target for services to be decided based on regular site validation at TI level).

Limitations of this estimation method:
This estimate of high-risk MSM visiting cruising sites is more likely to be an underestimate because:
- even males less than 15 years and more than 59 years can be sexually active with other males; and
- 5% of male population (irrespective of age) is generally estimated to be *same-sex oriented* and thus the current calculation basis of 5% of the *sexually active* male population estimated to engage in *same-sex behavior* is conservative.

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[13] For programmatic purposes (to provide information and condoms to needy MSM), all MSM who access cruising sites need to be regarded as 'high risk MSM' because of the high level of anal sex (85.6% - 90%) reported by studies that recruited MSM from cruising sites.
[14] http://www.censusindia.gov.in/Census_Data_2001/India_at_glance/broad.aspx
[15] **Article:** Dandona L et al. & ASCI FPP Study. Sex behaviour of men who have sex with men and risk of HIV in Andhra Pradesh, India. *AIDS*, 2005, 19:611–619.
*This study conducted among 6661 MSM (recruited from public cruising sites) reports that anal sex was performed in **85.4%** of the 19640 sexual encounters.*
[16] **Article:** Newman, PA, Chakrapani, V, Cook, C, Shunmugam, M & Kakinami, L. (2008). Determinants of Sexual Risk Behavior Among Men Who Have Sex with Men Accessing Public Sex Environments in Chennai, India. Journal of LGBT Health Research, 4 (2), 81-87.
In this study, 90% of MSM recruited from cruising sites (using time-space sampling, a probability-based sampling) reported having ever engaged in anal sex.

Final Version. NACP-IV – National Strategy for HIV prevention among MSM. Aug 6, 2011

Appendix 3. <mark>Draft</mark> Terms of Reference (ToR) for key TI staff (NACP-IV)

Staff	Qualifications	Frequency of field visits	Key Job Responsibility	Reporting officer
Project Manager	Post Graduate in social sciences from recognized University. **Experience for PM (NGO TI):** 3 years field experience in Health sector. Preferably in HIV/ AIDS sector **Graduate (CBO TI)** 5 years experience in Health sector-relaxed in case of new district or in case of unreached population .	Expected number of days to spend in the field is 12 days in a month. Covering sites, facilitating events, advocacy etc.	1. Maintain work schedules and plans for each outreach worker 2. Visit each ORW's field area at least once a month 3. Provide feedback to ORW on performance 4. Ensures that ORW conducts weekly field work review meetings at site level. 5. Identifies the capacity building needs of the TI staff and provide capacity building training or mobilize resources for enhancing the skills of the staff. 6. Ensures that MIS officers send programmatic monthly and quarterly reports (CMIS) on time. 7. Ensures that accountant sends the SOE and utilization certification to SACS. 8. Attend regular meetings with stakeholders and referral linkages 9. Make regular visits to referral resources 10. Participate in coordination meetings at the SACS and TSU 11. Authorising indents of commodities (condoms & Lubes) to SACS 12. Authorising indents of IEC and BCC materials 13. Handling Crisis and directing the advocacy co-ordinator Addressing Stigma and Discrimination 14. Rights Education 15. Treatment	Immediate supervisor: Project Director. Reports to Project Director for overall TI management at the NGO level on day to day activities Reports to PO (TI) in charge on **program performance on monthly** basis Ensures that the financial reports are sent by 5th of every month by the Accountant to SACS. Ensures that the MIS officer send the CMIS reports to SACS by 5th of

				each month
Community Mobiliser-A	Minimum 10th grade pass with basic skills of reading and writing. Should from MARP.		1. Strengthen collectivization and bring in community ownership of the TI 2. Maintaining DIC register 3. Welcoming drop ins and informing them of services available 4. Providing logistic support for support group meetings 5. Maintaining decorum and discipline in the DIC 6. Supporting community mobilization meetings in the DIC 7. Channelising and referring drop ins to services (indicator-target setting) 8. Inventory management of commodities-Condoms and lubes –Physical stock taking , expiry indications 9. Indenting for commodities with SACS-reporting to PC 10. Checking that all equipment in DIC is in working condition. (TV, VCR, water filters, weighing machine, tea machine, etc.). 11. Seeing the DIC is pleasant and client friendly. Posters put up or changed, Speakers for weekly meetings decided upon and okayed with PM. 12. Attend meetings to update himself on health issues so he can give appropriate advice to drop-ins. 13. Facilitate the availability of STI drugs with counsellor.	Project Officer –for DIC maintenance and support group details Counsellor – for referrals and reports MIS for MIS related inputs from registers Coordinates with Community mobiliser-2
Community Mobiliser-B	Minimum HSC pass with fluency in reading, writing and report making. Should from MARP		1. Handling Crisis along with Project Manager 2. Advocacy with local police 3. Maintaining contact and advocating with nodal uniformed staff	Reports into Project Manager Receives

			4. Facilitating referrals of KPs for psychosocial counselling with external counsellor	inputs from Counsellor and Community Mobiliser-1
			5. Facilitating linkages with local migrant programs	
			6. Facilitating service uptake of female partners of MSM to RCH service delivery.	
			7. Identify and facilitate linkage to empanelled lawyers for service uptake , and crisis related issues	
			8. Identifying agencies and facilitating Sexual Post-Exposure Prophylaxis (S-PEP) access in case of sexual violence.	
			9. Identifying local agencies and facilitating linkages for alcohol and substance abuse problems	
			10. Identifying and facilitating linkages to Hep-B/C-related services.	
			11. Facilitating linkages to non- formal education programs	
			12. Identify agencies working with same-sex attracted legal minors and facilitating linkages **	
MIS Officer	Should be a graduate. Should have basic computer skills – MS-Word, MS-Excel and have basic analytical skills. Experience in the development Sector will be desirable. A positive attitude towards the HRG is	Expected number of days to be spent at the field is 4 days in a month.	1. Co-ordinate with ORW to collect the outreach data on weekly basis and check for its completeness. 2. Enter the data collected from the field on **weekly basis** in the computer **after ensuring the completeness and correctness on outreach, clinic.** 3. Visit to critical site /hotspot for supervision to Outreach workers / Peer Educators for site level support on the filling of information in the tool for ensuring of quality data collection wherever and whenever required. 4. Analyze the information on monthly basis to track project performance on key performance indicators and share with the staff members during each monthly review meetings. 5. Ensures to document all the filled in tools received from the outreach (from ORW and PE) and clinic (ANM / Counselor) in safe custody and for future reference.	Immediate supervisor: Project Manager. Reports to Program Manager of TI on day to day activities Reports to M&E officer at

	a must. CBO: Minimum HSC graduate, with working knowledge of computers and MS word and Excel.		6. Ensure to send the CMIS reports on monthly basis through CMIS to SACS on time with the authorization of the Project Manager 7. Maintains book stocks of commodities (condoms and lubes) as well as IEC materials in the TI.	SACS on CMIS reporting.
Outreach Worker (ORW)	Minimum Higher secondary certificate. Graduate are Preferred. Willing to work with vulnerable and risky group (HRGs in the field). Should visit field at odd times as and when at odd times. Commitment and dedication and to take challenges CBO: minimum of SSC pass candidates, basic literacy in reading writing and report making.	Number of days to spent 20 days in a month in the field. (Minimum five days in a week). Covers 4 times all the sites/hotspots in the allocated area in each month.	1. Ensures that all the new HRGs identified are registered with the project and registration forms are filled in and submitted to the project office. 2. Ensures that all the HRGs are regularly met by the PEs (twice a month in case of FSWs and MSMs ; 20 times in case of IDUs) 3. Ensures that each PE has allotted timings to be in the field for carrying out the project services. 4. Ensures that a micro plan has been developed for each site and implemented by the PE on weekly basis. 5. Develops weekly plan for each PE under his/her supervision. 6. Ensures that a weekly movement plan is made and the same is shared with program manager. 7. Ensure to check the daily diaries of the PEs whether it is being updated on day to day basis. 8. Ensures that each PE has sufficient IEC/BCC material available with him or her. 9. Ensures that the PE is distributing the condoms as per demand analysis made for each site/hotspot. 10. Ensures to give feedback on the performance of each PE under supervision on the observation made during field visit during weekly meeting. 11. Ensures to document the activities conducted and observations made and challenges / gaps encountered with the program manager during monthly review meeting.	Immediate Supervisor: Project Manager. Reports on weekly basis to project Manager on the outreach management

			12. Ensure to compile weekly outreach data and shares the compiled data with the program manager	
			13. Conducts group meetings at site level with the support of PE at least once in a month in each site.	
			14. Assist the program manager in conducting advocacy or advocacy related meetings /workshop as per plan.	
			15. Maintains line listing for each Peer and in case of peer turnover ensures that the line list is identified and serviced by another peer.	
			16. Reporting and handling crisis	
			17. Piloting Social marketing of lubes and condoms	
Peer Educator	• S/he has to be from the respective community • Above 18 years of age but below 40 years • S/he represents the community of the area and accepted by them. • S/he has interest to work for the project / for the cause of the community.	Expected number of days to be spent at the field is 25 days in a month. Identifies new HRGs in his or her allocated area and ensure to registers with the project. Covers all the HRGs at least twice (for FSWs and MSMs) and 20 times (for IDUs) in a month in the allocated sites / hotspots. Ensures that S/he does not involve in sex activities during the official field timings	1. Ensure that the S/he has list of hotspots to carry out day to day outreach activities. 2. Ensures that S/he adhere to field timings as agreed upon with the ORW. 3. Ensures all the newly identified HRGs at the site/hotspot level are introduced to ORW within a week's time of identification. 4. Ensures that S/he covers all the HRGs in his/her given area/s and provides information about the project and its services. 5. Ensures that she carries field daily diary cum tracking sheet, IEC / BCC materials and sufficient condoms/syringes as per demand analysis done for the HRGs for his or her allocated site/hotspot for distribution. 6. Conducts demand gap analysis (for condom / needles & syringes) once in a quarter with the support of ORW in charge. 7. Demonstrates on how to use condom and use of lubes 8. Provides information and knowledge about STI/HIV/AIDS 9. Provides information on safer sex 10. BCC for regular HIV/STI testing 11. Ensures that all the registered HRGs are referred to the ICTC for testing 12. Ensure to follow up on STI cases and referral to ICTC.	Immediate Supervisor: Outreach Worker Reports to ORW on day to day basis on the outreach activities conducted

			13. Ensures that all the HRGs visit the project clinic at least once in a quarter for RMCs.	
			14. Ensures that all the HRGs who are on ART or on TB/DOT are availing treatment on regular basis.	
			15. Support ORW in conducting group meetings.	
			16. Reporting and handling of crisis	
			17. Helping ORWs in Social marketing of condoms and lubes	
Counselor	Educational Qualification: PG in Social Sciences from recognized university. (Flexibility may be given to candidates from MARP minimum requirement should be graduation). Alternatively: Experience of counseling in Health sector, preferably in HIV and clinic management) **Minimum experience for Counselor** 2 years of field experience in Health sector.	Expected number of days to be spent at the field is minimum 4 days in a month. (Minimum once in week for on-site support to ORW/PE on clinic related issues).	1. Ensures to maintain the clinic as per the standards 2. Ensures all the relevant registers are maintained on day to day basis and in safe custody. 3. Coordinate with PEs and ORWs to ensure clinic service uptake by HRGs in their respective sites (where there is no ANM). 4. Ensures that all the HRGs visiting the project clinics have undergone pre and post counseling sessions. 5. Ensures that all the HRGs coming for the STI treatment are being counseled. 6. Ensure all the STI treated cases are tracked for follow up visits. 7. Ensures that the HRGs visiting the clinics also visits the referrals centers (ICTC). 8. Ensures to keep a track of HRGs who have been referred to referral centers are actually visiting the centers and availing services and updates the Project Manager on the status during monthly review meeting. 9. Ensures to visit the field (at the hotspot level) for taking counseling sessions as per the plan and as per requirement of the outreach team. 10. Coordinate with the MIS officer on clinic/counseling data on weekly basis and assists MIS officer as and when required. 11. Identifying psychosocial counseling needs and making corresponding referrals through the Advocacy Officer. 12. Making appropriate linkages for "Positive Living" and "Treatment"	Immediate Supervisor: Doctor. Reports to Project Manager on clinic performance. Reports on the clinic data to MIS officer on weekly basis for updating the CMIS.
Accountant	Educational Qualification: Graduate in	Minimum once in a month to each site/hotspot of the TI	1. Maintains the book of accounts - the cash book, the ledgers, the bank books in safe custody. 2. Ensure all the vouchers in use are printed and have printed serial	Immediate Supervisor: project

	commerce and accounting. Alternatively: Experience of maintaining of books of accounts in a health related project/s (preferably in HIV prevention activities) 1 year of working as accountant in Health sector and has knowledge on tally package and excel package.	intervention area.	numbers. 3. Ensure that the cheque books, vouchers and other related financial documents are in safe custody. 4. On day to day basis, ensure that cash in hand tallies with expenditure made during the day. . 5. Ensures that cash in Hand does not exceed Rs. 1000 on daily basis. 6. Ensures that cheques are issues for all transaction made beyond 2000. 7. Ensure to follow the guidelines for procuring capital items, drugs, condoms, BCC materials. (e.g. getting three quotations, maintaining capital assets inventory) and procurement procedures are documented for each transaction. 8. Preparation of monthly financial reports and shared with the Project manager on the expenditure pattern in each of the component. 9. Ensures to send the SOE by 5th of each month to the SACS 10. Shares on monthly basis the financial status of the project during monthly review meetings. **Information Management related (where there is no MIS officer)** 1. Ensures to collect outreach data from ORW on weekly basis for entering in the computer. 2. Checks information from the register - mid event registers, advocacy registers, clinic registers including referral registers for its timely updating by the ORW. 3. Shares the results from the analysis from Programmatic data with program manager for use during monthly meeting. **4.** Ensures reporting the programmatic data through CMIS to SACS.	Manager Reports on the status financial management on weekly and monthly basis. Reports SOE and Utilization certificate to SACS by 5th of each month.
Doctor	Qualified Doctor (MBBS) Desirable: Experience of working in HIV related project Essential: Should be willing to work with the community members. Should be able to	Willing to travel to site as and when required	1. Ensures to visit the clinic as per the agreed clinic timings. 2. Ensures that the ANM / Counselors are adhering to the project clinic norms (as per NACO standards). 3. Ensures to fill in the requisite registers (to be filled in by the doctor) 4. Ensures to do internal examination for the all the HRGs visiting the clinic 5. Ensures that the ANM/Counselor has filled in the clinic registers completely and correctly. **6.** Ensures that the ANM is ensuring that a buffer stock is maintained at the clinic for each STI medicines.	Immediate Supervisor: Project Manager Reports to Project Manager on the clinic management

	visit site/hotspot areas for conducting health camps			

GLOSSARY

Men who have Sex with Men (MSM)
This term is used to denote all men who have sex with other men, regardless of their sexual identity or sexual orientation. This is because a man may have sex with other men but can still consider himself to be a heterosexual or may not have any particular sexual identity at all.

Hard-to-reach MSM
'Hard-to-reach MSM' are those MSM who are difficult to be reached through the traditional outreach strategies (cruising site-/hot-spot-based) due to a variety of reasons that include the constraints in the current programmatic approaches (e.g., lack of peer ORWs from other subgroups except predominantly kothi-identified outreach workers). 'Hard-to-reach MSM' include (but are not limited to) gay and bisexual-identified men, married MSM (irrespective of their sexual identity), same-sex attracted legal minors, older MSM, and non-self-identified MSM. Thus, 'non-self-identified MSM' who practice same-sex sexualities but who do not self-identify with any sense of sexuality from such practices are also 'hard-to-reach' MSM, because they do not identify with the social milieu and messages of much MSM-focused outreach and health promotion.

Non-self-identified MSM
A significant proportion of MSM who practice same-sex sexualities do not have a self-identity related to those practices and they can be referred to as 'non-self-identified MSM'. In general, the term 'MSM' refers to both MSM with self-identities such as gay, bisexual and kothis, as well as MSM who do not self-identify with any of these terms. However, in India, these days the term 'MSM' is frequently equated with feminine self-identified same-sex attracted males such as kothis and used as an euphemism to refer to same-sex oriented/attracted men. Hence, the current situation necessitates the introduction of the term 'non-self-identified MSM' to refer to those MSM who do not have any sense of identity related to their same-sexual practices. The introduction of this term is not intended to promote an idea that all MSM should self-identify with a sexual category or label. Rather this term is used to raise awareness among policymakers and national/state HIV program managers that a significant proportion of MSM may not self-identify with terms such as kothis and gays, and importantly, they may not even think of themselves as 'men who have sex with men'. Complementary HIV prevention strategies are needed to provide safer sex messages and other services to this vulnerable population.

Kothi
'Kothis' are a heterogeneous sub-group of MSM. They can be described as biological males who show varying degrees of 'femininity', which may be situational (only expressed in specific contexts). Some proportion of kothis have sex with or are married to women. Kothis are generally from lower socio-economic status and some engage in sex work for survival. Some proportion of hijra-identified people may also identify themselves as 'kothi'. But not all kothi-identified people identify themselves as hijra or even transgender.

Panthi
In most states of India, the term 'panthi' is used by kothis and hijras to refer to their masculine insertive male (regular or casual) sexual partners or anyone who is masculine and seems to be a potential sexual (insertive) partner. The equivalent terms used in different states are Gadiyo (Gujarat), Parikh (West Bengal), and Giriya (Delhi).

Double Decker
Kothis and hijras label those men who insert and receive during penetrative sexual encounters (anal or oral sex) with other men as 'Double' or 'Double Decker' or even 'DD'. These days, some proportion of such persons also self-identify as 'Double' or 'DD'. In West Bengal the popular term for Double Deckers is 'Dupli'.

Gay man (here 'gay' as a self-identity)
A gay man may be understood as someone who has significant (to oneself) sexual or romantic attractions primarily to members of the same gender or sex, or who identifies as a member of the gay community. One may identify as gay without identifying as a member of the gay community and vice versa. Though 'gay' is a common term for male and female same-sex attracted persons, it is more often used to denote same-sex oriented men. Self-identified gay men do not necessarily have sex only with men, but occasionally may engage in sex with women, especially in countries such as India where adult men face considerable social pressures to marry and/or practice heterosexuality.

Bisexual man (here 'bisexual' as a self-identity)
A bisexual man may be understood as someone who has significant (to oneself) sexual or romantic attractions to members of the same gender and/or sex and another gender and/or sex People who are attracted to members of both genders or sexes may be monogamous, polyfidelitous or non-monogamous.

Sexual Orientation. One's erotic, romantic, and affectional attraction. It could be to people of the same sex/gender, to the opposite sex/gender, or to both sexes/genders.
- *Heterosexuality*. Erotic, romantic, and affectional attraction to people of the opposite sex/gender.
- *Bisexuality*. Erotic, romantic, and affectional attraction to people of both sexes/gender.
- *Homosexuality*. Erotic, romantic, and affectional attraction to people of the same sex/gender.

Identity: How one thinks of oneself, as opposed to what others observe or think about one. However, there is a close symbiosis in societies between the formation of a sense of self-identity and the social and cultural application of labels to describe people. Identities are not acquired in isolation and are profoundly social in character.

Sexual minorities or Sexual minority community:
Refers to lesbian, gay, bisexual and transgender/transsexual persons as well as persons with other identities (such as kothis and hijras) as a minority group in a predominantly heterosexual population. (Sometimes referred to as '*sexuality minorities*'). These days, the terms '*Sexual minority communities*' or '*Sexual minority populations*' are used to stress that, like the people they comprise, these communities or populations are diverse.

(Most of the above definitions are adapted from:
Chakrapani, V; Kavi, A R; Ramakrishnan, R L; Gupta, R; Rappoport, C; and Raghavan, S S (2002). *HIV prevention among men who have sex with men (MSM) in India: Review of current scenario and recommendations.* SAATHII, Chennai, India. Available at www.indianLGBThealth.info

Chakrapani, V; Newman, P A; Mhaprolkar, H; Kavi, A R (2007). *Sexual and social networks of men who have sex with men (MSM) and Hijras in India: A qualitative study.* The Humsafar Trust, Mumbai, India. Available at:
http://www.indianlgbthealth.info/Authors/Downloads/Report_SxlNeworks_MSM_Hijras_Apr_07.pdf)