National AIDS Control Programme

Phase IV

Strategic Approach for Targeted Intervention among Transgender and Hijra

INTRODUCTION

In most parts around the world "Hijras and Transgender" continue to be included under the umbrella term "MSM", however it has been increasingly been recognized that Hijras and Transgenders have unique needs and concerns, and it would be more useful to view them as a separate group.

As the term "trans-gender" itself is the symbolic representation of crossing the boundaries, and it has been derived from the two different languages; the Latin word 'trans' and the English word 'gender'. The term "transgender" is generally used to describe those who transgress social gender norms. Transgender is often used as an umbrella term to signify individuals who defy rigid, binary gender constructions, and who express or present a breaking or blurring of culturally prevalent stereotypical gender roles[1].

OVERVIEW OF THE HIV EPIDEMIC INDIA

The HIV estimates 2008-09 highlight an overall reduction in adult HIV prevalence and HIV incidence (new infections) in India. Adult HIV prevalence at national level has declined from 0.41% in 2000 to 0.31% in 2009, although variations exist across the states. The estimated number of new annual HIV infections has declined by more than 50% over the past decade. One of the biggest and most immediate challenges in effectively responding to HIV in India is confronting the truly startling rates of infection among Hijras and transgender persons.

Clearly sexual minorities, such as men - who - have - sex - with – men (MSM), Hijras and transgender (TG), are significantly affected by the HIV epidemic. Since the practice of male to male sexuality in India is very complex and unique, it needs to be better understood. This will also help to improve the design of interventions in the current NACP Phase and proposed interventions in NACP IV.

CURRENT SITUATION

NACP III preparation exercises reconfirmed the importance of focusing efforts on prevention amongst high risk groups (HRGs). While much work has been done in India with female sex workers, it was recognized that the national programme had not given enough attention to injection drug users and "MSM." In addition to this, NACP III - for the first time - recognizes that "MSM" is not a homogeneous population. The programme especially acknowledges the unique HIV prevention, care, and treatment needs of Hijras and transgendered (TG) persons.

Coverage

- **NACO**
- **3 TIs – Denominator 3000 – 5000 (Mumbai, Maharashtra)**
- **BMGF**
- **TG – 7,400**
- **Mumbai and Bengaluru, 2 districts in AP, 5 districts in TN**

ESTIMATES

[1] HIV/AIDS among men who have sex with men and transgender populations in South – East Asia, WHO 2010

India UNGASS 2010 report estimates that there are 3.1 million MSM for India. Currently there are no national estimates of the either the enumeration or prevalence of HIV among transgender populations due to lack of data collection on transgender populations at the national level. Anecdotal guestimates peg the transgender populace between .5 – 1 million in India. UNDP study - *166,665* – reported by CBOs in 42 sites*

For working purposes the lower bound can be 166,665, the upper bound range will be explored through data triangulation using census, mapping and revalidation of data with existing Targeted Interventions.

ANALYSIS OF THE EPIDEMIC

HIV prevalence among MSM/Transgender populations was 5.7% as against the overall adult prevalence of 0.36%[2]. Until recently, transgender communities were not distinguished from MSM in HIV sentinel serosurveillance. As a result, limited data is available on the prevalence of HIV and STIs among transgender communities.
In 2002-03 a study was conducted in Mumbai, which indicated HIV prevalence among transgender (Hijra) sex worker were 56% (n = 163). In 2005, the prevalence rate among the same population went down to about 40%. In 2003, in Chennai city a similar study was conducted among 1200 Transgender population which revealed 45% prevalence rate.

A study conducted in Mumbai reported very high HIV prevalence of 68% and high syphilis prevalence of 57%[3]. Similarly, a study conducted among male sex workers in Mumbai that included Hijras as a major sub-group documented a very high HIV prevalence of 41%[4]. In Southern India, a study documented a high HIV prevalence (18.1%) and Syphilis prevalence (13.6%) among Hijras[5]. A study conducted in Chennai documented high HIV and STI prevalence among Aravanis: 17.5% diagnosed positive for HIV and 72% had at least one STI (48% tested seropositive for HSV-1; 29% for HSV-2; and 7.8% for HBV)[6].

Published data on sexual risk behaviours of Hijras/TG women are limited. The available information from the Integrated Biological and Behavioural Assessment (IBBA) survey 2007 conducted in select districts of Tamil Nadu, reported that, among Hijras/TG, the condom use during last anal sex with commercial male partners and 81% with non-commercial male partners is 85% and 81% respectively. Also, the survey documented low level of consistent condom use among Hijras/TG women: 6% with commercial male partners and 20% with non-commercial male partners.

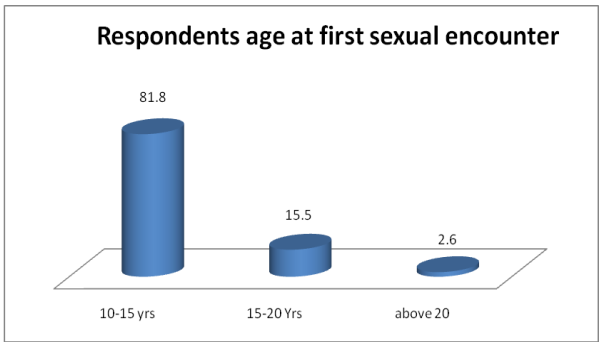
VULNERABILITY TO HIV AND RISK FACTORS

In India, Hijras and Transgenders are seen as a separate socio-religious and cultural group. Primary and Secondary data suggest that Transgender/Hijras are not a homogeneous group, they have various subgroups within them such as TGs/Hijras who earn their living as a sex worker on the street, TGs/Hijras who beg and those who are living in some *Dera* and are limited only to *Badhai-Toli* and as such have different health needs and concerns and also can be reached by varying approaches. Most of the

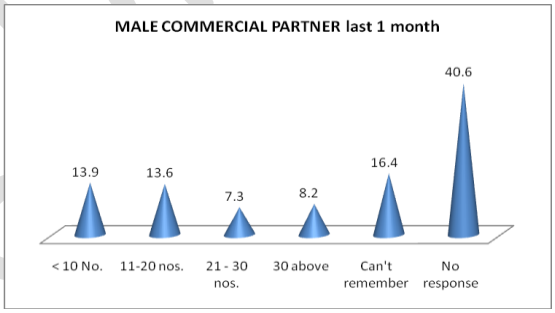
2 National AIDS Control Organisation (NACO). 2006, Annual HIV Sentinel Surveillance Country Report
3 Setia, M.S., Lindan, C., Jerajani, H.R., Kumta, S., Ekstrand, M., Mathur, M., Gogate, A., Kavi, A.R., Anand, V., & Klausner, J.D., (2006). Men who have sex with men and transgenders in Mumbai, India: An emerging risk group for STIs and HIV. Indian Journal of Dermatalogy, Venereology & Leprology, 72(6), 425-431
4 Shinde S, Setia MS, Row-Kavi A, et al. Male sex workers: are we ignoring a risk group in Mumbai, India? Indian J Dermatol Venereol Leprol 2009;75(1):41-46
5 Brahmam, G.N.V., Kodavalla, V., Rajkamur, H., et al. (2008). Sexual practices, HIV and sexually transmitted infections among self-identified men who have sex with men in four high HIV prevalence states of India. AIDS, 22(5), S45 - S57
6 Saravanamurthy, P., P. Rajendran, L. Ramakrishnan, G. Ashok, P.M. Miranda, S.S. Raghavan, V.S. Dorairaj, S. Sahu. STI and HIV prevalence in male-to-female transgender communities in Chennai, Southern India. International AIDS Conference, Mexico, 2008.

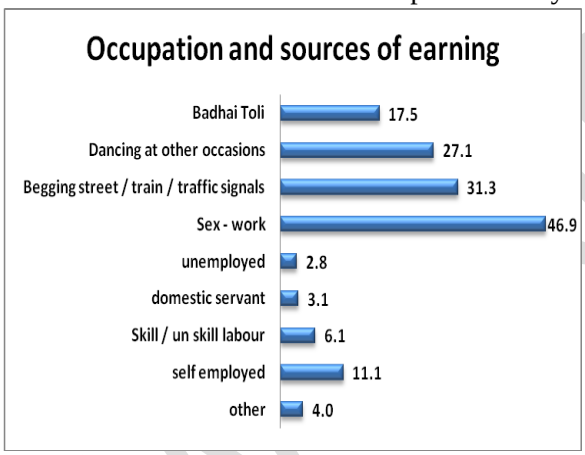
Transgender/Hijras are still a hidden population and largely out of reach. This makes it difficult to meet the prevention needs of transgender persons which continue to go largely unaddressed. The primary sexual practice among Transgender/Hijras is unprotected anal sex where most of the time they perform the role of a receptive partner. According to secondary data, various research studies report rvery limited access to water-based lubricant and overall low levels of condom use;[7] this practice makes them more vulnerable to become infected with HIV and other STI infections.

A review of the results from the data[8] collected from 772 self-identified TGs shows that 67% of the respondents recognize that their community is at high risk towards getting infected with HIV because of unprotected sexual practices of many members of the community.



Their sexual activities start at a very young age. Over 82% respondents reported that they had the first sexual experience with a male by the age of 15. They have multiple commercial partners in a month and they have more potential to get infected and to spread the virus to many others. According to our primary data, 43.3% (n=683) respondents reported having commercial partners in a month. More than 50% do not even remember the number of male partners they had in the past one month. About 47% are earning their livelihood by doing sex work. Moreover, it is a common practice almost a phenomenon among 78.6% of the transgender that they frequently visit other places for long periods. Over 63% respondents reported the purpose behind their travel as sex work.

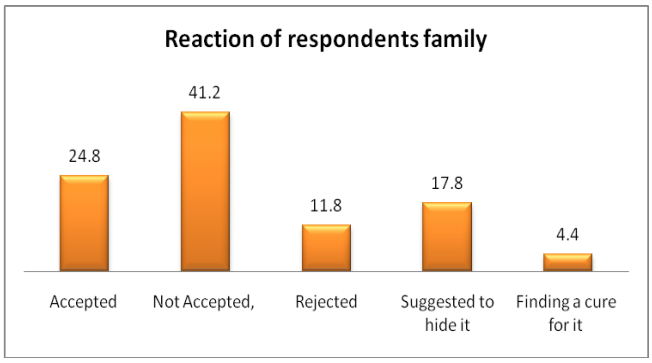


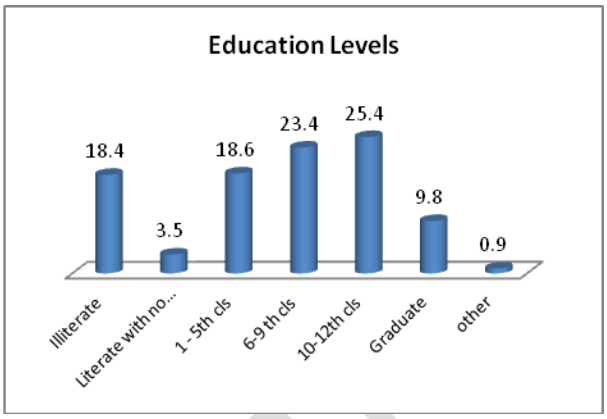


A majority also report periods of intense sex work which we understand includes ***Melas*** and festivals etc where the number of partners are many and are occasions for easy transmission to many members of the community and others. According to our data, 54% reported in indulging in "heightened or an intensive" period of sexual activity in the past 6 months. However, this also gives us a clue that this may present opportunities to reach them and their clients.*(for details please see the section-1 and annex-1 of research report).* Therefore, it's clear that TGs & Hijras are very mobile, are involved in sex work in various environments and places. Hence they are at risk to themselves and also at risk of infecting their partners.

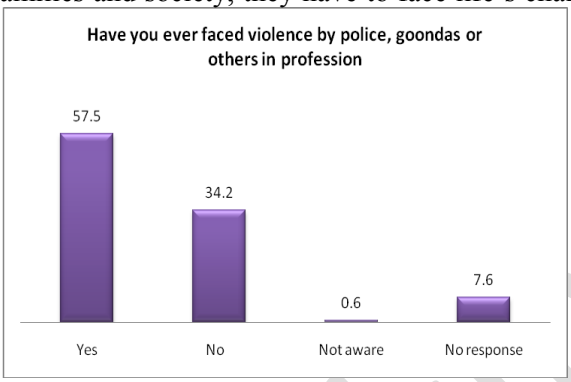
[7] Hijras in sex work face discrimination in the Indian health-care system by Venkatesan Chakrapani, Priya Babu, Timothy Ebenezer

[8] UNDP unpublished





Data also suggests that Transgender/Hijras are not accepted (75.2%) and supported by their families and society due to their gender status. Therefore, they are forced to leave their families and be on their own so that the family does not experience any discrimination and stigma. Being economically disadvantaged, semi-literate, unaccepted, away from their homes with no emotional and psychological support from their families and society, they have to face life's challenges on their own. According to our data, only 18.4% (N=772) are illiterate, 48.8% are drop-outs between 6th -12th standard. About 41.2% have indicated that they are not accepted by their families. Consequently they are pushed towards either traditional options (toli badhai) and/or unhealthy options of earning such as sex work to earn two meals a day. They sell themselves for as meager an amount as Rs. Ten or Twenty.[9]



They are stigmatized, discriminated and vulnerable to bullying by law enforcement agencies, goondas and often teased and harassed by general community members. They are not empowered adequately which prevents them from reporting any incidents of sexual harassment and rape to police. According to our data, the police refuse to register their complaints saying that they do not come under the existing laws. [10]Over 57% respondents have reported to have faced violence from police, *goondas* or others in profession.

The social hierarchy and community norms among Hijra communities influence HIV prevention behaviours among them and have both positive and negative influences on HIV risk behaviours among Hijras. In Eastern and Northern India s**exual silence in certain *Gharana*s is the norm and this** makes the situation worst. Hijras from certain *Gharana*s are not supposed to have sex as they are dedicated to the Goddess. *Guru*s from such *Gharana* may not approve the distribution of condoms to them.[11]

All these factors add up and together make TGs extremely vulnerable to HIV. The TGs continue to feel the need for an identity as a separate group which has to be made an acknowledged partner in the fight against HIV/AIDS. According to our data, over half of the respondents (53%) reported the requirement for a separate intervention program for TGs.

[9] Police refuse to file our complaints, say we don't come under law- an Indian Express Newspaper report by Mohana Dam **on Saturday, Feb 28, 2009**

[10] *"Police refuse to file our complaints, say we don't come under law"*, ***The Indian Express***, February 28, 2009

[11] Central India Regional Transgender-Hijra Consultation Report June 6-7, 2009 Bhopal, Madhya Pradesh

DEFINING AND DESCRIBING MSM AND TRANSGENDER POPULATIONS IN NACP 3 PROGRAMMING

In the third phase of the National AIDS Control Programme (NACP-III; 2007-12), National AIDS Control Organisation (NACO[12]) separately mentioned 'transgender people' as having different HIV prevention and care needs although some commonalities between men who have sex with men (MSM) and transgender people are present. Except for a few sites (such as Mumbai and Madurai), elsewhere interventions among TG are clubbed together with that of MSM.

Considering the high HIV prevalence (17.5%[13] to 41%[14]) among TG/Hijras when compared with that of MSM, it is crucial that HIV interventions among TG/Hijras need to be scaled up. And to assist NACO/SACS in scaling up TG interventions, operational guidelines for TG interventions are needed. A recent document from UNDP noted that there could be at least three ways for scaling up HIV interventions among TG/Hijras – by having NGO-/CBO-led intervention (similar to exclusive MSM TI intervention); Festivals/Functions-based intervention; and Gharana-based intervention. Building from these models, DFID TAST and UNDP will work with key stakeholders in preparing and testing operational guidelines.

UNDERSTANDING TG HIJRA POPULATIONS IN INDIA

The term 'transgender people' is generally used to describe those who transgress social gender norms. Transgender is often used as an umbrella term to signify individuals who defy rigid, binary gender constructions, and who express or present a breaking and/or blurring of culturally prevalent stereotypical gender roles. Transgender people may live full- or part-time in the gender role 'opposite' to their biological sex by birth. In India, people with a wide range of transgender-related identities, cultures, or experiences exist - including Hijras, Aravanis, Thirunangai, Kothis, Jogtas/Jogappas, and Shiv-Shakthis. *Glossary of transgender terms to be enclosed as annexure.*

WORKING DEFINITION

Hijra

"Individuals who voluntarily seek initiation into the Hijra community, whose ethnic profession is badhai but due to the prevailing socio economic cultural conditions, a significant proportion of them are into begging and sex work for survival. These individuals live in accordance to the community norms, customs and rituals which may vary from region to region".

Transgender

"Transgender is a gender identity. Transgender persons usually live or prefer to live in the gender role different to the one in which they are assigned at birth, this has got no relation with anyone's sexual

[12] More information on NACO at www.nacoonline.org

[13] Saravanamurthy, P.S., Rajendran, P., Miranda, P.M., Ashok, G., Raghavan, S.S., Arnsten, J.H., et al. (2010). A cross-sectional study of sexual practices, sexually transmitted infections and human immunodeficiency virus among male-to-female transgender people. American Medical Journal, 1, 87-93.

[14] Shinde S, Setia MS, Row-Kavi A, et al. (2009). Male sex workers: are we ignoring a risk group in Mumbai, India? Indian J Dermatol Venereol Leprol;75(1):41-46

preferences. It is an umbrella term which includes transsexuals, cross dressers, intersexed persons, gender variant persons and many more. A term that includes people who have not undergone any surgery or physiological changes".

Note on the hijra community

Hijras represent a socio cultural- identity, which renounces male sexuality, identifies with the creative power of the Mother Goddess, Shakti and with Shiva. Hijras are given an option of castration and a castrated Hijra commands a higher status in the hijra community. Castration is known as Nirvana in the Hijra community. The non-castrated are known as *akwa moorath* and the castrated as *nirvana moorath.* Their social structures are based on the Hindu Guru system and female identified family structure. Hijras should be perceived as a different gender altogether - perhaps as a "third gender". [1] Each Hijra belongs to a house or lineage. It is this relationship that designates Hijras in a formal relationship with the community. The head of the household is the nayak or guru and under the nayak are the chelas or disciples. Although the Guru-chela relationship is clearly hierarchical, with seniority among Hijras (as a principle of both social organisation and social control) being reckoned through the unequal power structure of Gurus and chelas, this relationship is a mutually beneficial and a reciprocal one. Chelas are expected to be obedient, respectful and loyal and to serve their gurus well by catering to all their domestic needs. In exchange for their chelas' services and earnings, gurus act as a 'mother, father, husband, sister and look after their health and well being, treat them fairly, provide them with clothes and food and give them the necessary training and knowledge about Hijra customs and manners to permit their rise in seniority. "

RISK PROFILE

All Hijra/Transgenders at hotspots would be catered by the Hijra/TG TI. Hijras under Gharanas involving in high risk behavior also need to be brought under the TI,

- Number of partners?
- Types of partners
- Types of sexual behaviour?
- Sex work?
- Vulnerability and non ability to negotiate safer sex?
- Migration- mobility- awareness/knowledge levels
- Proportion of them exposed to violence, emasculated status, anal sex, substance use and risk behaviours?

Other influencers: *Structural, biological, physiological, migration and mobility, awareness and knowledge levels?, proportion of them exposed to violence, emasculated status, anal sex, substance abuse and risk taking behaviours?, consistent condom usage.*

- Number of male partners-unprotected and oral and anal sex
- Commercial sex minimum 8 to maximum12
- High sex exposure /day in urban metro (Hamam, Highway Kothi)
    - HIV positive
    - IDU users /partners

INTERVENTION PACKAGES FOR TRANSGENDER AND HIJRAs

Hijras and Hijra/TG issues are separate from MSM and cannot be addressed under common intervention model emerged as one of the critical findings in NACP III Mid Term Review. Hence there is a need to develop a customized prevention model for TGs in India which is community driven and aligned with NACP III principles. Recent national and regional consultations by UNDP in India have highlighted the need to address TG – Hijra populations, some of the community recommendations with regard to NACO and NACP 3 are as follows:

NACP-III (2007–2012) has included "MSM and transgender" people among the 'core groups' for whom intensified HIV prevention and care programs are implemented. Interventions for transgender women are currently subsumed under 'MSM interventions'. Nevertheless, in some states (e.g., Tamil Nadu and Maharashtra) separate interventions for Hijras/TG are being implemented for some years. Some gaps that need to be addressed in relation to interventions among TG include the following.

1. ***Need for separate HIV sero-surveillance centers:*** In India, separate HIV sentinel sites for MSM were introduced only in 2000 and for Hijras/TG in 2005. As of 2007, there were 40 sites for MSM and 1 site for TG.

2. ***Need for interventions that provide holistic care to Hijras/TG:*** Preventing HIV and mitigating the impact of HIV epidemic is the primary focus of NACP-III. However, other health-related components which would have significance effects on HIV such as mental health counselling and counselling on sex change operation are not part of the existing MSM/TG interventions. Thus, there is a lack of holistic and comprehensive approach that includes health and social services for transgender people.

3. ***Greater involvement of Hijras/TG communities in decision-making process:*** In line with the guiding principles of NACP-III that include community involvement and greater involvement of people infected and affected by HIV/AIDS (GIPA), it is crucial to include representatives of Hijras/TG communities in HIV policy formulation and program development. Currently, national GIPA policy is being finalized, but it does not explicitly articulate the importance and ways of including Hijras/TG representatives in decision-making process.

4. ***Need for CBO formation and strengthening:*** NACP-III envisions that 50% of TIs would be transitioned from NGOs to CBOs by the end of 2012. However, so far, only a countable number of CBOs of Hijras/TG communities, with various levels of capacity exist. The capacities of

existing and emerging CBOs need to be strengthened so that they can effectively implement TI projects and other programs.

Transgender/hijras expect that the intervention packages/projects must be designed to address their overall welfare rather than just focusing on HIV/AIDS.They have often claimed that mainstream society does not understand their culture, gender, and sexuality. Dimensions of their social deprivation and harassment towards them have never received attention in development sectors. Violations of their human and sexual rights have been overlooked in the traditional Targeted Intervention Projects. The CBOs also do not provide any social or legal services to them in terms of establishing their citizenship rights. Sole promotion of condoms and lubricants ignores multidimensional ruptures and alienation that exist within any targeted population. Understanding the socio-cultural and human rights aspects of discrimination against the TG & hijra community and deprivation can help reduce STI/HIV transmission and safeguard this marginalized community.

NACP IV DESIGN AND APPROACH

Approach

- Evidence informed
- Strength-based
- Affirming sexualities and acknowledging sexual behaviours at risk
- Community driven interventions
- Enabling environment

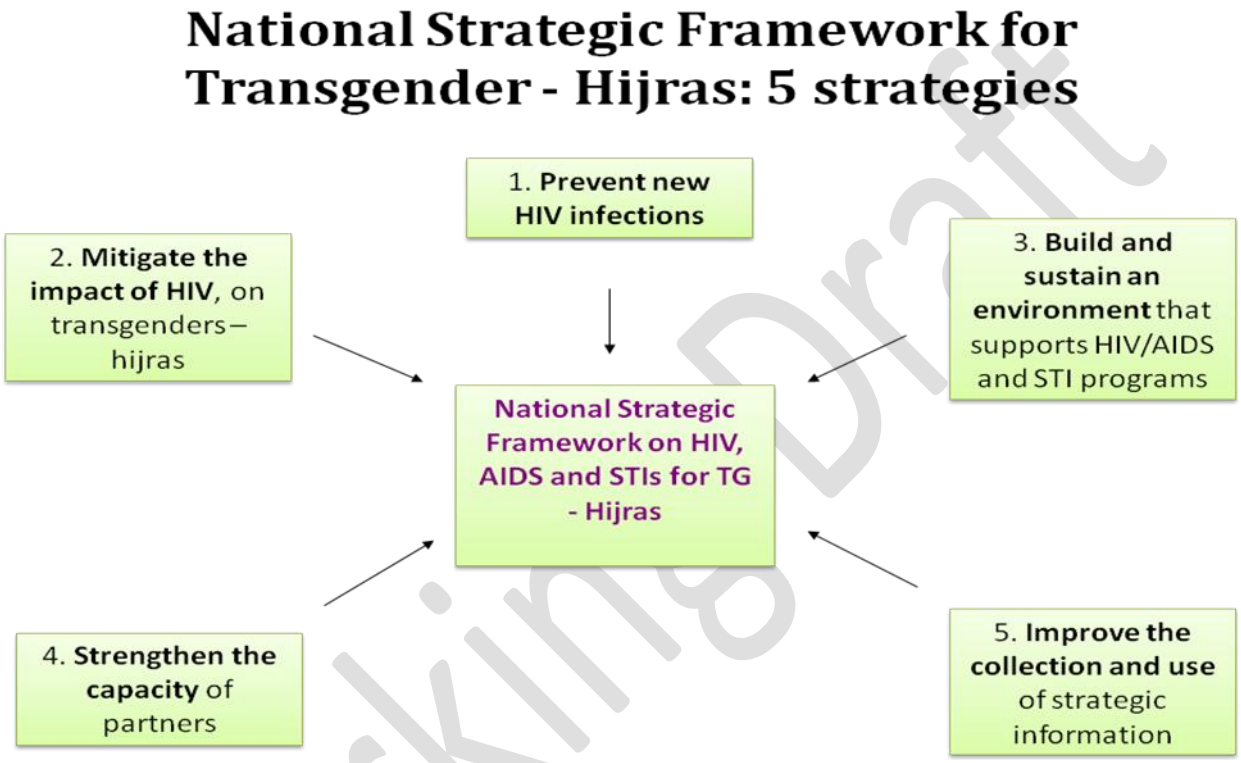
- Involvement
- Adequate resources

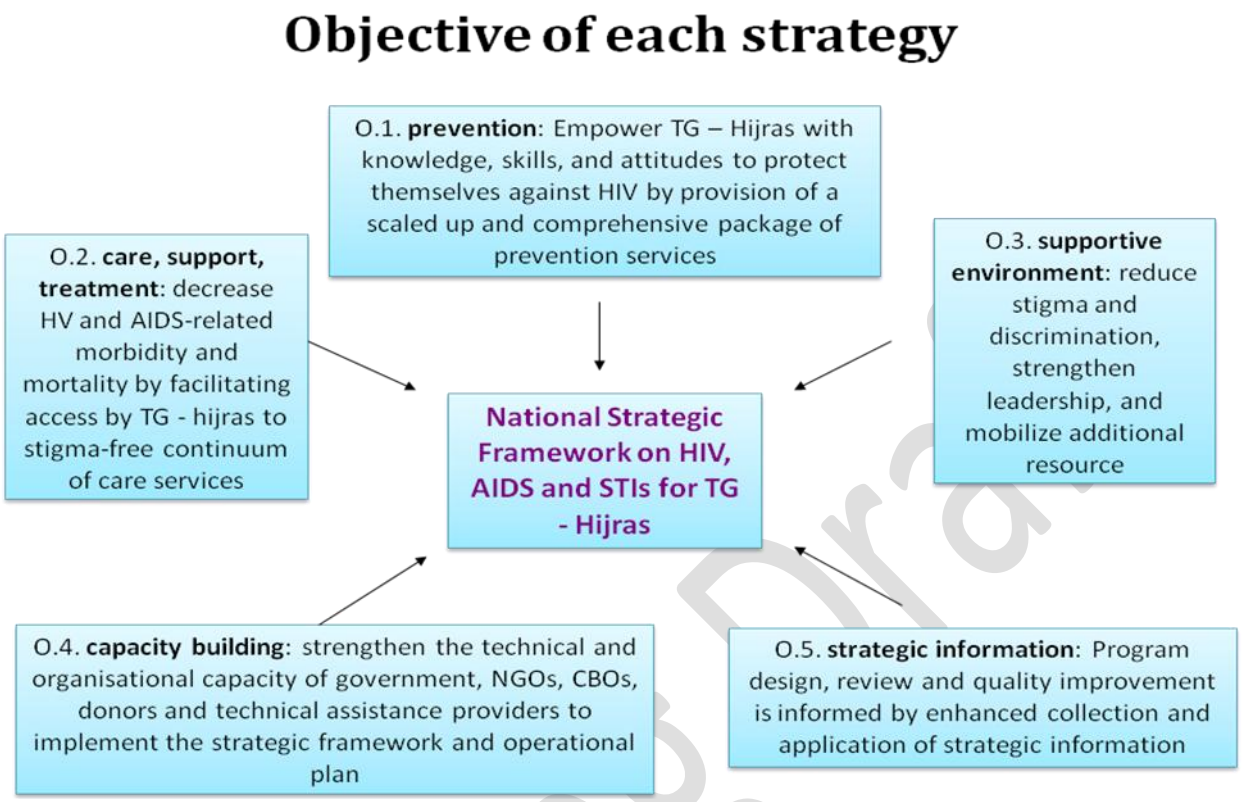
Design

- It is clear that there is an urgent need not just for more programming, but also for new and better approaches to programming.
- Attention to their needs in broader HIV responses, and bridge-building with broader efforts to achieve gender equality, promote human rights and protect public health.
- Ensuring the full involvement of government, nongovernmental and private sector organizations, and of civil society, including CBOs working with MSM and Hijras/ TG, through a broad-based partnership approach;
- Tailoring interventions to where the burden of the disease lies, taking into account the nature of the epidemic and the context in specific settings (e.g. HIV prevalence and risk behaviour, cultural traditions, social attitudes, and political, legal and economic constraints);
- Creating a supportive enabling environment by addressing stigma and discrimination in both the health-care services and the broader society, applying human rights principles and promoting gender equity, as well as reforming laws and law enforcement to ensure support for a public health response to HIV and AIDS;
- Ensuring equitable access to health-care services for Hijras and TG; providing a comprehensive approach, with a continuum of prevention, care, support and treatment services;
- Providing a combination of prevention interventions, delivered at scale and with intensity to maximize effectiveness; and ensuring that interventions and services are, to the largest extent possible, evidence based.

Objectives for enhanced action: Beyond ‘business as usual’

- **Objective 1:** Improve the human rights situation for transgender – hijras the cornerstone to an effective response to HIV
- **Objective 2:** Strengthen and promote the evidence base on hijras and transgender people and HIV
- **Objective 3:** Strengthen capacity and promote partnerships to ensure broader and better responses to hijras and transgender people and HIV





Key priorities (to improve the HIV response for TG - Hijras)

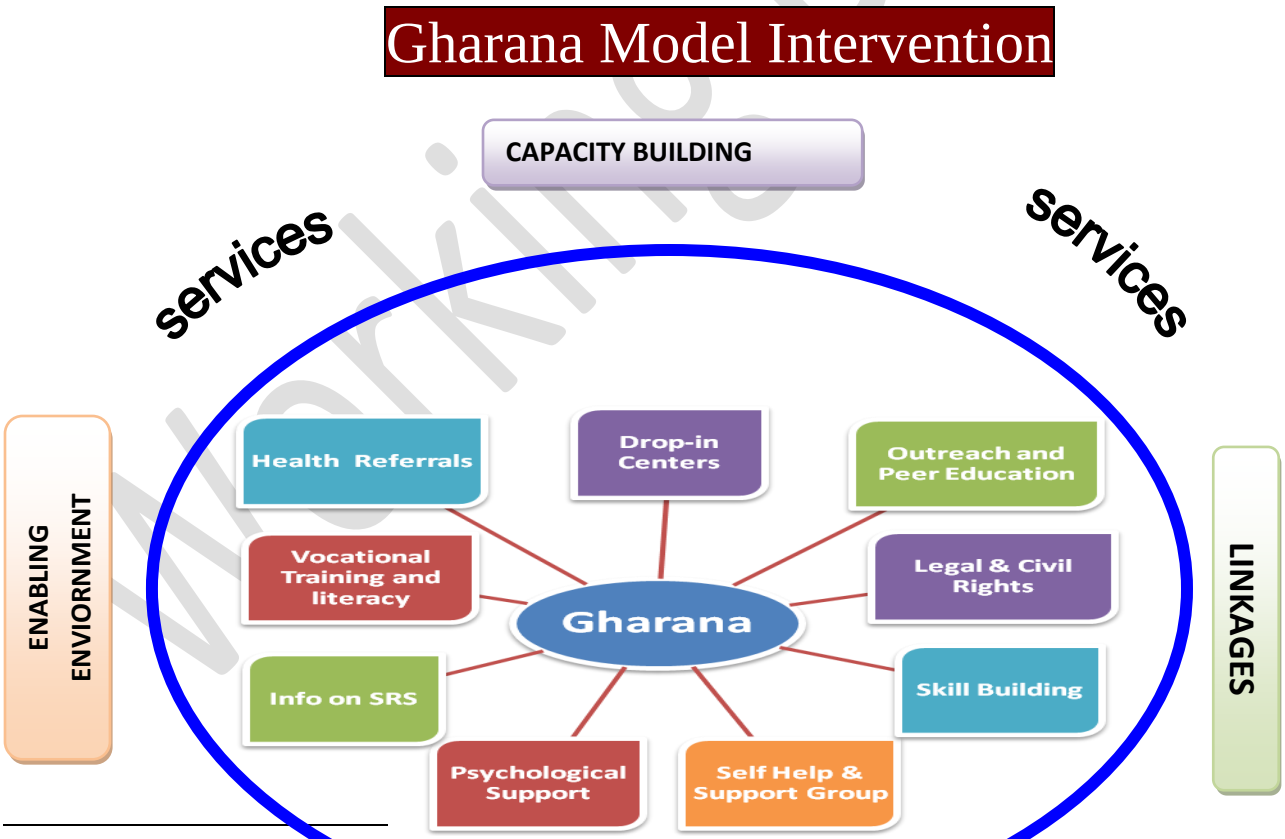
1. Scaling up of **comprehensive prevention package** to achieve significantly increased coverage, particularly where TG – hijras are concentrated and then scale up coverage where they are spread out/ scattered
2. Improving the **quality of prevention services**
3. Building the **technical skills and organizational capacity of CBOs and provide transition support where ever needed**
4. Strengthening the **involvement of TG - hijras in HIV/AIDS response** through community development and mobilization
5. Strengthening the **partnership** between government, non government organizations, CBOs, TG- hijras and technical assistance providers
6. Reducing **stigma and discrimination** against TG - hijras
7. Mobilizing **sufficient resource** for effective response

PROPOSED MODELS FOR INTERVENTIONS

1. <u>CBO led interventions – working with Gharana and hijra leaders in Dera – Jamath setting</u>

- For effective implementation of this model each Gharanas will have to be studied and understood as a separate entity as rules are specific to each and depends on the current Nayak. Based on the study an approach and strategy will have to be developed.

- Peer Educators may be recruited with the agreement of the Guru. In some Gharanas Shokens[15] could be identified as potential PEs.
- Capacity building and messages will need to be transparent and may need to be understood and approved by the Guru.
- An approach which clearly shows a benefit to the Gharana and its members as well as one that does not threaten in any way the authority and power of the Guru may have to be developed.



[15] *Souken* – In the Hijra clan, *saukens* are essentially elders who officiate over functions and rituals – they guide the community members on ways of the clan and maintain the sancity of the same. In colloquial sense they are also "facilitators" for managing disputes, settlement of claims and payments of dues, the *sauken* is the single most important catalyst for overseeing events, activities and rituals. The Lashkar gharana wherever they exist in India are known to be the saukens for the Hijra community.

Essential Components of Gharana Intervention

Psychological support: To build trust and confidence among Hijras**.** The challenge of dealing with any hijra community is their apprehension and insecurity that they live with. They are usually psychologically unprepared to face social stigma and humiliation of being a hijra throughout their lives. This can effectively be dealt with, by developing an efficient support group from within the community to give them a sense of belonging and security. A helpline can also be started to provide assistance to Hijras. The helpline would serve as a "crisis support" as well an "information" center for the Hijras. It would provide appropriate information on SRH and SRS issues. . This would also save them from going to quacks for various Sexual health issues, even Sex Reassignment Surgeries.

Health referrals: The health system is successfully established and has been operational for the past 4-5 decades in many states. However, the stages of development vary across the states. The delivery chain is strong, offering a good base on which reforms can be implemented and further strengthened for effective service delivery.

The interventions among the high risk population should establish linkages with the local health facilities so that the clients identified to suffer from STI by these interventions can be referred to the nearest PHC or health centre for treatment. Along with this, especially Hijars who are facing Sexual and Reproductive health related problems/issues should be referred to appropriate specialities. This would help them not to fall prey and to avoid the trap of quacks which otherwise gives rise to a lot of reproductive /tract infections in Hijras.

Drop in Centres: Drop in Centres (DICs) can be set up to provide a platform for psycho-social support to Hijras and provide information on linkages to services. Information and counseling on nutrition, adherence and legal issues may also be provided. This initiative was created with the objective of providing a safe space to the community members where they can drop in any time and be their true selves. In case of Gharanas registered as CBOs, the drop-in-centers would be the dera-jamath itself.

Vocational training & literacy: During NACP-III, with the support of vocational training centres of various government departments alternate income generation activities shall be planned for the Hijra population who are willing and interested. The training could be provided after assessing their interests.

Self Help & Support Group In order to, increase awareness, address stigma and discrimination and empower hijras to protect themselves, Self Help Groups should be formed through a systematic three-step

process involving State Institutes and NGOs. Training to create a cadre of master trainers can be proposed. These master trainers shall then take the process further.

Out reach and Peer Education: The outreach should be peer-led. Every peer educator should be from the hijra community and preferably from the same dera/jamath. Their capacity should be built in areas of communication and social skills. They should also be able to provide regular counselling to the target community and motivate them for regular medical checkups as well on regular basis. They should become the strength of the CBO and lead the outreach process which is most important in such interventions where the community prefers staying invisible to the larger society to save themselves from any kind of stigma or discrimination. The focus should also be on counselling. Through outreach, the Peer Educator should be able to assess the needs of the community and plan service needs accordingly. It is believed that effective outreach helps in successful implementation of the project's activities and in better service delivery.

Possible Advantages

- *I*n those gharanas where the Nayak can be convinced to accept an intervention which will be good for the gharana, it is likely that the message of safe sex will be effectively followed up as it will be seen as guidance from the Nayak and a part of the top- down directives
- This approach is also likely to mean that ownership will be taken by the gharana
- This approach is likely to reach all current and future hijra-members of that gharana.
- Overall, it can be an effective way to reach hijras in gharanas by convincing one person (Nayak) in each

Possible Challenges*:*

- Convincing the Nayaks may take a long time.
- It may need the help of one or more Saukans
- It may need specific communication material to be developed and used for hijras.
- The package may need to have adequate attention to issues which are a priority to the hijra community - like taking a right based legal approach, general health measures, capacity development components, etc

2. <u>Mela – event based interventions</u>

There are special festivals/melas/events of TGs/Hijras where a large numbers of TGs/Hijras congregate and also indulge in multi-partner sex and sex work.[16] The detailed report on two of such melas/festivals/events i.e. *the Koovagam and Kaliyar Sharif* can be found attached in Annex-A. Although the data collection did not follow a systematic sampling process, however the data has been collected from TGs hailing from 164 villages. The data was collected in 80 different towns and as such we feel that the data is provides an adequate insight into the views and behaviour patterns of the TG/Hijra population.

[16] Secondary data reviewed under this project

These gatherings which are periods on intense sexual activity as well as a platform for networking present a rare opportunity to reach out to TGs who are mostly integrated with the general community but do have periods of intense vulnerability to HIV. To effectively use this opportunity we may need to:-

- Access expertise from psychologists on the approaches those are likely to be effective in a holiday – party setting. This can be done through a national level consultation with experts & psychologists and institutions like TISS etc. along with articulate members from the TG community.

- Develop messages and materials based on the conclusion of such a consultation.

- Ensure that State AIDS Control Societies are asked to map all festivals in their State where there is significant participation of TGs in festival/melas or exclusive events for TG. The SACS may also commission a more extensive documentation effort to provide greater clarity on the time, location, numbers etc.

- Understand how these festivals get organized and whether they are managed by particular groups or forces so that entry to these can be appropriately planned.

- Develop a mechanism for appropriate flexible contracts. It may be necessary to use CBOs or NGOs to ensure that peer workers are placed in vantage positions in such melas. These organizations would be better off if they have prior familiarity with such events but since these intense activity may only be for a few days in each place their expertise may be used across many such events.

- Provide intensive and appropriate training and capacity building to the PEs so that they are effective in these settings.

To sustain the work done at such Melas and to maximize the benefit from this approach, efforts can also be made to network with willing TGs by reaching them with sustained inputs through mobile phone etc. and also allow them to access information about drop-in facilities, ICTC s etc.

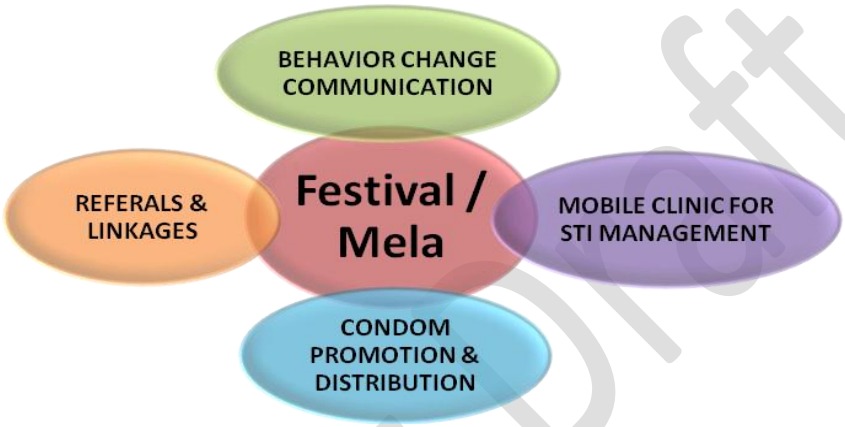
Festival / Mela Model Intervention

Possible Advantages

- We recognized that many TGs remain hidden and are difficult to reach through Gharanas or NGOs etc. We also understand that some TGs only indulge in multi partner sexual relationships only at the Melas/Festival.Melas can be an important entry point to reach out to hidden groups.
- TGs come from far and near to the Melas and for some it takes on a pilgrimage halo. And as such this approach is likely to reach some TGs who cannot be reached by NGO interventions and gharana interventions.
- Clients of TGs who frequent these melas can also be reached. It is likely these clients are not being reached through other HRG interventions.

Possible Challenges

- It may be a one time intervention or sensitization for some of the TGs if follow up mechanism is not well thought out.
- TGs may not be receptive to HIV messages in the environment of a Mela and as such a clearly thought out process is needed for the success of this approach

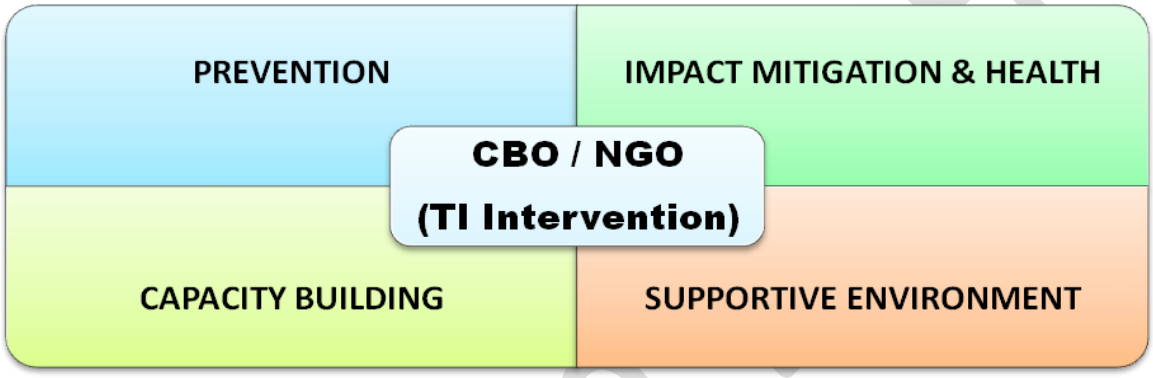


Some of the events identified are as follows

- Ajmer Sharif, Rajasthan
- Haji malam, Thane
- Kaliyath Sheriff, Haridwar
- Meeraj
- Udhavaru – Gujarat
- Koovagam
- Shahkalp poora
- Mahashivarathri – Orrisa, Gujarat
- Sambalpur mela
- Ghutiary sheriff- 24 parganas
- Surajpur mela – Haryana
- Bannarghetta jatra – Karnataka
- Kuttikulangara – Kerala
- Yellamma jatra – karnataka
- Kothadai – TN
- Bannari – TN

3. <u>Flexible TI approach delivering comprehensive package of services</u>

CBO / NGO-TI Model Intervention



PACKAGE OF SERVICES

Minimum/ basic / essential service package for TG - Hijras TI should include:

Condoms and Lubes

- Free distribution of condoms and lubricants (each condom with lube- 100% anal sex, out of 5 sex episodes-50- 60% will be anal sex- condom+ lubricant? To be decided)
  - Anal sex (with clients-customers, with partners, with regular partners) Condom + Lube
  - Oral sex (with clients-customers, with partners, with regular partners) condom
- All lubes(K Y Jelly) under social marketing- education to the TG/Hizra by other agency

Sexual health services that include:

- HIV counseling, testing and treatment
- STI screening and treatment
- Screening and treatment for genital and ano-rectal problems
- Linkages to existing mainstream health programs
- Hormonal management and monitoring for TG – hijras

HIV

- Services for HIV-positive TG - Hijras: community based care and support
- Treatment for HIV, including the treatment of opportunistic infections (OIs)
- Provision of antiretroviral treatment (ART) and monitoring of CD4 counts and HIV viral load together with adherence
- Prevention services such as: Care, counseling and testing for sero-discordant couples
- Psychosexual counseling , Psychosocial counseling, including substance use issues
- Positive prevention

Enabling environment

- Violence and crisis management

Targeted media campaigns

- IEC material for use of lubricants

FRAMEWORK FOR SERVICE DELIVERY

Prevention

Key Areas	Activities	Objectives	Key Messages
Outreach and Peer Education	• Provide HIV/STI prevention and safer sex education to TG & Hijra through outreach and peer education • Reach sub-groups of both visible and hidden TG & Hijra • Include information and activities on risk assessment and risk reduction skills • Incorporate positive prevention messages for positive TG & Hijra • Provide outreach at popular TG & Hijra gathering festivals, parks, melas	▪ To reach TG & Hijra with accurate information through effective peer education. ▪ To ensure outreach and peer education efforts reach at known TG & Hijra gatherings ▪ To include information for HIV positive TG & Hijra in prevention information and messages. ▪ To improve gatekeepers & other stakeholders understanding of the risks facing the rights of TG & Hijra	**HIV Prevention** ▪ Preventing sexual transmission of HIV. ▪ Condoms and other methods to promote safer sex (access, skills building in condom use etc) ▪ Prevention and treatment for sexually transmitted infection. ▪ Encouraging treatment - seeking behaviour ▪ Protecting yourself and your partner from HIV (including negotiation skills) ▪ Violence, trauma ▪ Links between HIV and drug use ▪ Positive prevention

Key Areas	Activities	Objectives	Key Messages
Drop in Centers	• Establish drop-in centers specifically for TG & Hijras (not combined with other target population) • Provide prevention education through staff, peer educators and support groups who can provide information and support on referrals for services, HIV prevention, ICTC and ART services for HIV positive TG & Hijra. • Ensure that drop-in centers are regularly supplied with condoms and lubricants • Ensure that drop-in centers are continuously supplied with attractive, relevant and up to date IEC materials	▪ To establish and maintain drop-in centers for TG & Hijra ▪ To receive information, support, condoms and training.	
Medical referrals	• Offer referral assistance in terms of information, transport and support for TG & Hijra to access health services, including STI testing and treatment and ICTC • Collaborate with public and private providers of testing and treatment facilities to ensure awareness of TG & Hijra needs and access to services • Collaborate with providers to also ensure services are TG & Hijra -friendly.	• To ensure all TG & Hijra reached by partners understand what services are available and which ones they should access. • To ensure all TG & Hijra wanting to access one or more services can do so. • To ensure all TG & Hijra accessing services receive information and /or treatment they need and are treated compassionately by service providers.	**Stigma & Discrimination :** • A transgender health centre • An informal network of practitioners, and • The expansion of existing health programs to include a transgender-specific component
Condoms and Lubricants	• Ensure free condoms and lubricants are available at drop-in centers and events. • Work with other sites such as clinics and treatment sites, markets and local shops to ensure that condoms and lubricants are accessible by TG & Hijra.	▪ To ensure that TG & Hijra communities have consistence and sufficient access to condoms and lubricants	

Key Areas	Activities	Objectives	Key Messages
Self – Help and Support Groups	• Establish and help maintain SHG for separate groups of TG & Hijra TG & Hijra and those who are positive) • Provide information on SRH, including HIV /STI prevention, drug use, and referrals to services. • Train SHG leaders to provide support to positive TG & Hijra and their partners.	▪ To establish and enable TG & Hijra SHG to work effectively to offer support, solidarity and information to other TG & Hijra groups	
Psychological support	• Provide psychological support to TG & Hijra in the community and offer counseling for specific challenges faced by them. • Include information on HIV/STI prevention and referrals to services • Facilitate post –test linked to ICTC services • Provide information on hormonal treatment & therapy • Provide information on surgery to change the genitalia and other sex characteristics	▪ To ensure all TG & Hijra have access to counseling services that are targeted to their specific needs.	**Stigma & Discrimination :** ▪ How to overcome rejection by partners families and communities. ▪ How to overcome rejections by employed and service providers. **Illness** ▪ Coping with STI ▪ Coping with HIV

Key Areas	Activities	Objectives	Key Messages
IEC materials	• Work with TG & Hijra and PE to create or adopt IEC materials • Collaborate with other partners in sharing relevant and effective IEC materials for TG & Hijra through mass media and other innovative methods. • Providing information on accessing HIV/STI testing and treatment, including VCCT. • Ensure the efficient distribution of IEC materials by developing or improving logistics plans for materials. • Reach all TG & Hijra (and their stakeholders and gatekeepers for TG & Hijra) by creating IEC materials with less text and more pictorial information. • Hold discussion sessions with TG & Hijra in order to receive feedback on IEC and inform future production (pre and post testing) • Ensure mention of TG & Hijra risks / prevention methods included in materials meant for the general public. • Ensure that IEC materials reach "hidden" TG & Hijra	▪ To ensure all TG & Hijra have access to IEC materials that are targeted specifically for their needs. ▪ To access and use materials that are effective in providing information and promoting behaviour change among TG & Hijra	▪ Preventing sexual transmission of HIV. ▪ Condoms and other methods to promote safer sex ▪ Prevention and treatment for sexually transmitted infection. ▪ Encouraging treatment – seeking behaviour ▪ Protecting yourself and your partner from HIV ▪ Positive prevention ▪ Accessing HIV and SRH services ▪ Risk reduction.

Key Areas	Activities	Objectives	Key Messages
Behavior Change Communication	• Ensure materials contains clear, concise, simple and short messages that are linked to behaviour change, such as " Use a condom every time you have sex" • Only refer people to services that are actually in place. • Collaboration with service providers so that they display and distribution BCC materials for TG & Hijra at their service delivery sites. • Ensure that service providers understand the BCC materials • Ensure outreach and peer personnel are trained to deliver BCC messages for TG & Hijra in interpersonal, outreach and peer education settings. • Highlight positive outcomes of behaviour change i.e improved health, economic and personal outcomes when delivering messages. • Create/ adapt messages to TG & Hijra • Develop mass media messages for TG & Hijra to encourage behaviour change • Including messages to TG & Hijra in HIV prevention message for the general population.	▪ To access and use materials that are effective in providing information and promoting behaviour change among TG & Hijra	▪ Preventing sexual transmission of HIV ▪ Condoms and other methods to promote safer sex. ▪ Prevention and treatment for sexually transmitted infection. ▪ HIV/STI testing and treatment ▪ Protecting yourself and your partner from HIV ▪ Positive prevention ▪ SRH information and services ▪ Risk reduction.

Impact Mitigation and Health

Key Areas	Activities	Objectives	Key Messages
Basic Medical care and treatment	• Help to ensure that testing and treatment facilities are TG & Hijra – friendly. ▪ Provide STI diagnosis and treatment through accessible preferred private and public clinical services to reduce STIs and other diseases; • Collaboration with public and private providers to inform them of changes / updates they could implement to make their services more TG & Hijra friendly (e.g. TG & Hijra – targeted IEC materials in clinics, start comfortable communicating with TG & Hijra, etc) • Work with SACS & other local NGOs to offer sensitivity training modules to provides and clinic staff • Facilitate transport to testing and treatment services	▪ To ensure providers offer better quality services to TG & Hijra ▪ To guarantee TG & Hijra-can access services without fear of stigma discrimination or any other kind of unfair treatment. ▪ To work with service providers to ensure that HIV positive TG & Hijra are treated fairly and compassionately ▪ Provide access to other health promoting services such as harm reduction; drug substitution, drug and alcohol treatment services; mental health services; and tuberculosis diagnosis and treatment services	
Psychological Support	• Train health care providers to provide service and support to HIV positive TG & Hijra and to be aware of the specific challenges faced by TG & Hijra • Establish and help maintain positive TG & Hijra self help groups.	▪ To provide adequate psychological support to HIV positive TG & Hijra to enable them to effectively cope with their status and communicate with their peers, partners, families and medical providers	
Health Care Providers	• Provide regular visits to HIV positive TG & Hijra and their partners and families	▪ To ensure all positive TG & Hijra receive the same range of comprehensive services as other PLHIV	
Self – help and support groups	• Establish and help maintain SHG for groups of TG & Hijra • Provide information in SRH, including HIV/STI prevention, drug use and referrals to services. • Train SHG leaders to provide positive prevention support to positive TG & Hijra and their partners.	▪ To enable SHG to work effectively to offer support solidarity and information to TG & Hijra	

Key Areas	Activities	Objectives	Key Messages
Stakeholders / employer education	• Provide stakeholders and employers with information on the health & psychological needs of TG & Hijra in general • Include information on where to refer TG & Hijra (and clients) for health services and ICTC • Other sensitization training and / or workshops, along with IEC materials to stakeholders.	▪ To ensure all gatekeepers are aware of the health needs of TG & Hijra and clients and can support them in seeking services. ▪ To train at least one stakeholder from every group of transgender/Hijra	
Promotion of Rights Based Approach	• Inclusion into economy • Provision of employment and livelihood opportunities • Inclusion into Politics & Citizen participation • Facilitate access to collectivisation • Removal of restricted rights of citizenship • Facilitate participation in decision making processes	▪ Persons should have the right to express their gender identity through changes to their physical appearance, including the use of hormones and reconstructive surgery. ▪ Facilitate access to their basic fundamental rights	▪ Providing help to the key population in crisis situations ▪ Building a network of transgender through quarterly meetings and telephone help-lines ▪ Campaigning for rights of transgender population ▪ Alliance building with other progressive groups and individuals

Capacity Building

Key Areas	Activities	Objectives	Key Messages
Strengthen TG & Hijra social Networks	• Build TG & Hijra solidarity through peer education sessions, SHG and drop-in centres, and by enabling regular meetings in comfortable environments	▪ To enable solidarity and freedom of expression among TG & hijras so that they share information and participate in advocacy efforts	

Peer Educator and Facilitator	• Offer regular trainings and skills building opportunities for PE and Facilitators to improve outreach efforts, accuracy of information in a sustained manner	▪ To reach all types of TGs & hijras with accurate information through effective peer education	
Advocacy	• Enable TG & hijra communities to choose representatives and then train those representatives to advocate for their needs and rights within their communities and nationally • Offer support to TG & hijra groups in advocacy efforts through provision of IEC, transport, and safe spaces for meetings	• To encourage TG & hijra to participate in and organize advocacy activities and to represent their rights	
Training on TG & hijra sensitivity	• Develop guidelines and implement model on TG & hijra sensitive training for NGO staff, police, public and private service providers, local authorities, religious leaders and other stakeholders	• To ensure that TGs & hijras are treated fairly, equally and compassionately by outreach workers, service providers, police and other stakeholders	
Community support	• Work with community stakeholders to include TGs & hijras issues/ needs in local development initiatives and agendas • Encourage and assist TGs & hijras representatives to meet with stakeholders to discuss their needs	• To encourage TGs & hijras to work with partners and other stakeholders to place TGs & hijras issues on development agendas	
Vocational training	• Conduct local level market research to find out what would be the most appropriate vocational training and income generation activities for TGs & hijras Offer vocational training through partners and drop-in centres • Connect TGs & hijras with Income Generation opportunities • Employ TGs & hijras in the program as outreach workers, peer educators and/or program assistants, when possible	• To offer or refer TGs & hijras to appropriate and economical viable vocational training or income-generation opportunities on a case by case basis.	

Supportive Environment

Key Areas	Activities	Objectives	Key Messages
Sensitivity Training	• Work to develop and implement modules on TG & hijra sensitivity training for service providers (health centre and referral hospital staff), police, local authorities etc	• • To ensure TGs & hijras are treated fairly, equally and compassionately by outreach workers, service providers, police and other stakeholders	
Stakeholders and employer education	• Educate stakeholders and employers on the health needs of TG & hijra communities • Include information on where to refer TGs and hijras and clients for SRH services and ICTC	• To ensure all gatekeepers are aware of the health needs of TGs & hijras and can support them in seeking services	
Develop partnerships	• Participate in or inform technical working groups on TGs & hijras needs and services • Develop linkages with other NGOs/CBOs and the government on: • IEC/BCC materials, research, STI/ICTC testing and treatment, condom and lubricant provision, vocational training for TGs & hijras • Work with National TGs & hijras Network, e.g. at public events, arranging state level events, and facilitating network groups	• To contribute to national efforts to support TGs & hijras and reduce HIV prevalence among TG & hijra communities	
Inclusion of TG & hijra	• Include TGs & hijras in the design, implementation and evaluation of interventions • Ensure TGs & hijras are involved in advocacy campaigns and activities • Promote inclusion of TGs & hijras in community response to their needs	• To ensure TGs & hijras involvement is integral in program design and evaluation process • To enable TGs & hijras to contribute to community and national level campaigns on HIV awareness • To enable TGs & hijras to contribute to community efforts to decrease HIV infection and improve community health	
Raise positive public awareness of TGs & hijras	• Facilitate TG & hijra involvement in mass media campaigns and public advocacy events	• To improve understanding and respect for the rights of TGs & hijras among the general population • To participate in BCC/media campaigns and represent TGs & hijras at planning meetings	

Documentation	• Collect case studies, best practices and success stories to inform national and international community of the needs of TGs & Hijras • Video documentation on positive aspects of life	• To share best practices and lessons learned with other partners and stakeholders working with TGs & hijras	

EXPECTED RESULTS AND MONITORING INDICATORS

- S.1: **5 Expected results**

S1	**Empower TG – Hijras with knowledge, skills, and attitudes to protect themselves against HIV by provision of a scaled up and comprehensive package of prevention services**	
Result 1	Scaled up delivery of strategic behaviour changes communications, community outreach and peer education programs for visible- concentrated and hidden- scattered TG – Hijras	Number of estimated/ mapped HRG in the project area No of HRG ever contacted (at least once) with project services % Regular contacts (HRG met and given services at least twice a month)
Result 2	Increased correct and consistent condom and lubricant use by TG – hijras	% of HRG received condom from project as per estimated condom demand % of hotspots having condom and lube outlets % of TG-Hijra reporting the use of condoms and lube in the last anal sex encounter
Result 3	Increased availability and use of quality and stigma-free STI services appropriate for TG – hijras	% of HRG referred atleast twice a year for STI services % of HRG visiting the clinic atleast twice a year % of HRG visited STI clinic for RMC % of HRG provided presumptive treatment

		% of HRG tested atleast once a year at clinic for syphillis
Result 4	Increased use of quality and stigma-free ICTC services by TG – Hijras	% of HRG referred atleast once a year for ICTC services % of HRG tested atleast once a year at ICTC for HIV
Result 5	Conducive environment for delivery of comprehensive prevention package through collaboration with gatekeepers and stakeholders	Number of HRG reached by CBO/NGOS with comprehensive package of services(basic services + comprehensive)

- S.2: **3 Expected results**

S2	**Decrease HV and AIDS-related morbidity and mortality by facilitating access by TG - hijras to stigma-free continuum of care services**	
Result 1	Better understanding barriers to TG - Hijras accessing HIV/AIDS care	Number of HRG in the project living with HIV referred to ART centre Number of HRG in the project registered at ART centre Number of HRG registered in TB/DOTS center
Result 2	Increased use of stigma-free HIV/AIDS care	
Result 3	Strengthened linkages between prevention services and care	

- S.3: **4 Expected results**

S3	**Reduce stigma and discrimination, strengthen leadership, and mobilize additional resource**	
Result 1	Reduced stigma and discrimination against TG - Hijras	Number of crisis management teams formed Number of advocacy meeting conducted with key stakeholders Number of cases reported on incidents of violence and harassment Number of Tg Hijras able to access identity documents Number of TG Hijras accessing atleast 1 social protection scheme Number of state wide redressal mechanism established for prevention and impact mitigation
Result 2	Leadership and advocacy demonstrated by all partners (government, donors, technical assistance providers, CBOs)	
Result 3	Increased coordination and collaboration among partners	
Result 4	Sufficient resources mobilized and allocated	

	Number of state level networks/ national networks supported for TG - Hijras

- S.4: **6 Expected results**

S4	**Strengthen the technical and organisational capacity of government, NGOs, CBOs, donors and technical assistance providers to implement the strategic framework and operational plan**	
Result 1	Strengthened leadership and advocacy capacity by all partners	Number of TG – Hijra CBO formed and registered Number of TG – Hijras trained in leadership skills Number of SHG formed and functional Number of SHG meeting reported quartely Number of CBOs trained in programme management
Result 2	Strengthened technical and organizational capacity of CBOs to undertake quality prevention activities and referral to care, support and treatment services	
Result 3	Strengthened involvement of TG- Hijras and CBOs in the HIV and AIDS response	
Result 4	Increased and more coordinated technical assistance to CBOs providing Hijras/TG prevention services	
Result 5	Strengthened capacity of STI services to provide quality and stigma-free STI services	Number of training modules developed for TG – Hijras sensitivity training Number of health care providers trained
Result 6	Strengthened capacity of care, support and treatment services to provide quality and stigma-free services to TG - Hijras	Number of service delivery centres increased from X to Y%(to be determined as there is no current baseline)

- S.5**: 4 Expected results**

S5	**Program design, review and quality improvement is informed by enhanced collection and application of strategic information**	
Result 1	HIV and STI surveillance and behavioural data is collected and used to inform the response	% of TG – Hijra sentinel surveillance sites
Result 2	Agreed TG-Hijras population size estimate and networks and entry points for interventions identified	National mapping of TG – Hijra completed and state wise estimated available
Result 3	Improved social and operations research on TG – Hijras interventions	Number of research studies initiated on TG – Hijra TG operational and costing

		guidelines available
Result 4	Improved monitoring of TG – Hijras programs and evaluation of the efficacy, effectiveness and impact of interventions	SIMS and NACO new CMIS is responsive to reporting on needs of the TG – Hijra community

* The indicators in blue are new indicators, the rest are existing NACO monitoring indicators

MANAGEMENT STRUCTURE TO PROVIDE SERVICES

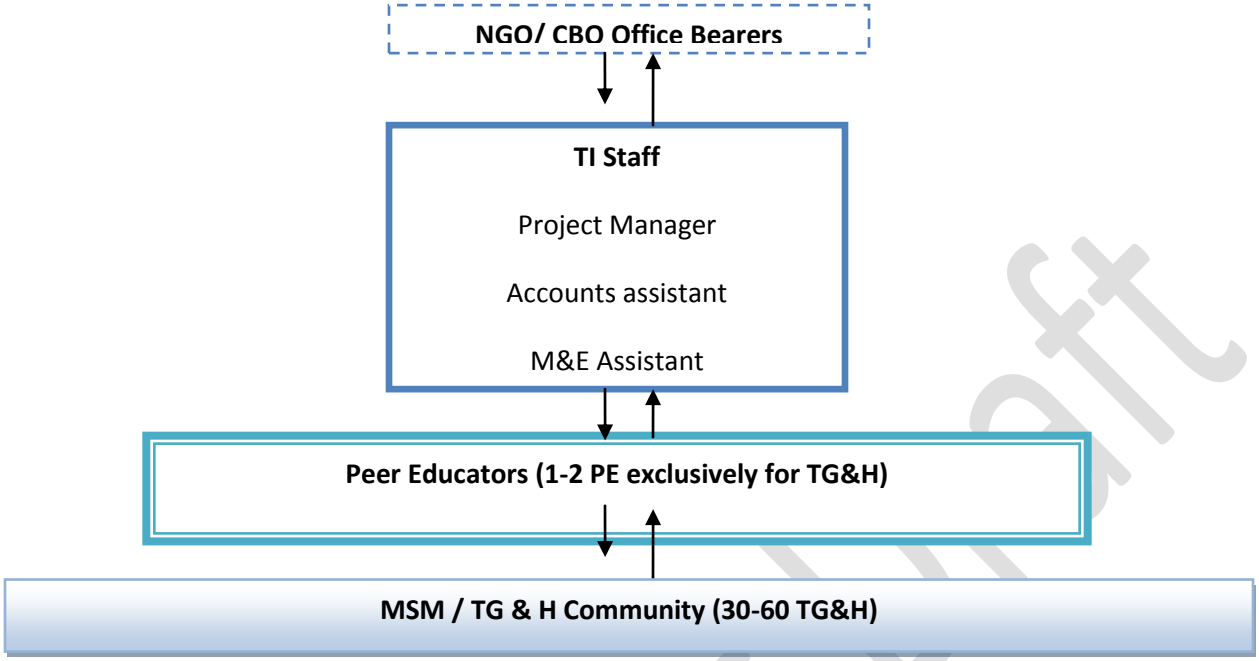
TI size 250 – 1000 (The TI will cater to TG & Hijra populations)

A different strategy and structure will be developed for areas where the population is less than 250 and there is a need for an exclusive TG&H TI. The draft on roles and responsibilities of all the staff, PE and including the PD to be developed. The involvement of the PD is low because of various reasons like lack of accountability, remuneration, governance, etc. The project directors should work on advocacy, linkages for the community

The management structures for working with Transgender and Hijra community are structured taking into consideration the need to provide intensive package of services and to cover them separately. The management structures for different types of intervention models are listed below:

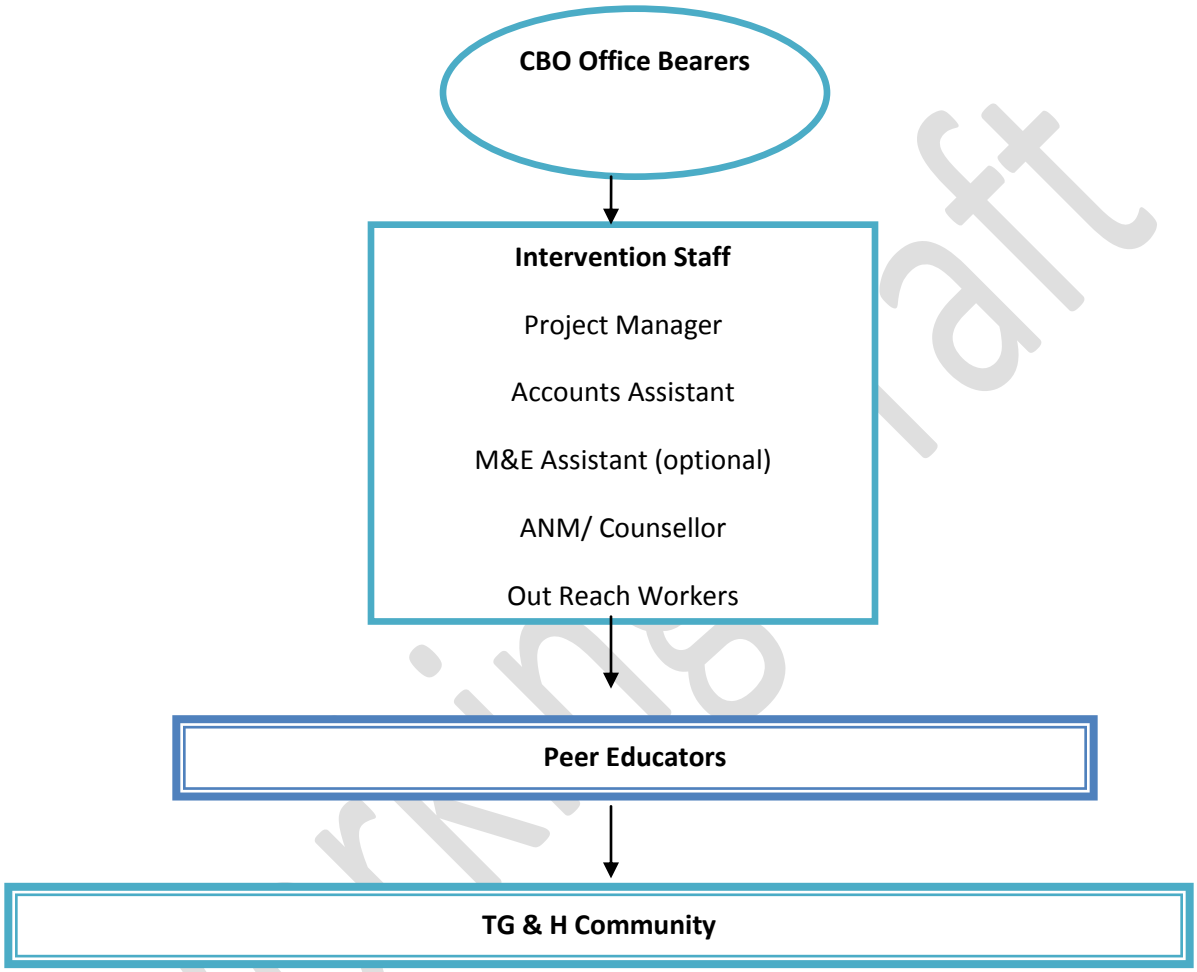
Classical NGO/CBO Intervention Model

NGO/CBO that are implementing HIV/AIDS interventions among MSM/TG&H composite interventions where the number of TG&H are less, exclusive Peer Educators would be recruited and trained to cover TG&H population in the PE: HRG ration of 1: 30 to 60. The PEs will be identified and trained based on the local situations (i.e. if the NGO is covering 60 TG&H population distributed across 5-10 sites spread over the intervention area then based on the distance and taking into consideration the need to provide intensive out reach for the TG&H community 1-2 PEs may be recruited). Exclusive community out reach workers could be recruited for TIs that are covering more than 150 TG&H.



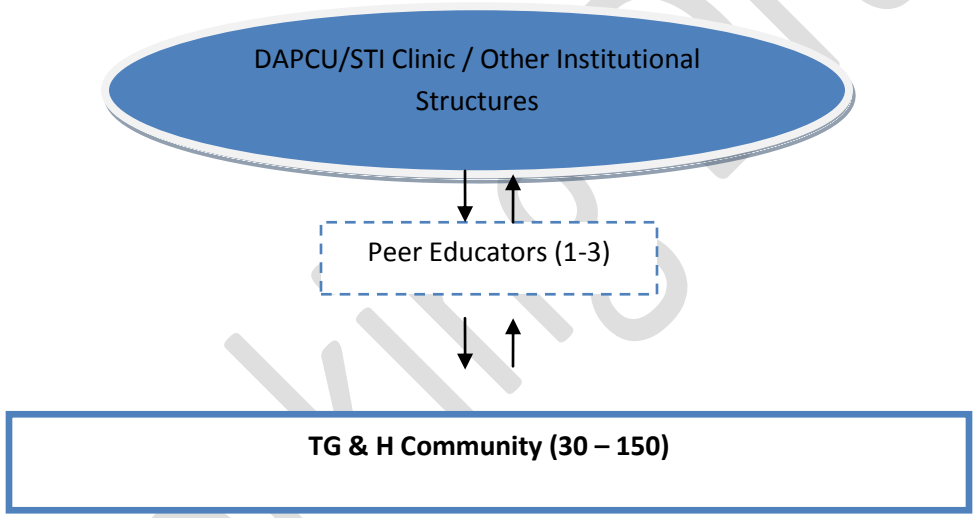
Exclusive TG&H CBO Intervention Model

Needs to explore the possibility to establish TIs with CBO of TG&H. The staff structures would be based on the coverage of the TI projects. The exclusive TG&H CBO would be provided the existing CBO costing with staff structures that as per their coverage.



Alternate Intervention Models

In order to effectively reach out the community it is proposed that a model utilizing the existing structures in the district (DAPCU/ STI Clinic/ Institutions Govt./ Quasi Govt./etc) can also be considered to cater to the TG&H community. The intervention structure will be peer led providing services to the TG&H community the staffing structure to mentor and monitor the out reach would be inbuilt with the existing structure. (eg. In an intervention that caters to 30 TG&H, the Peer educator will be tied up with the STI clinic/ICTC that is existing in the same location, the supervisory support will be provided by the existing structure). Places where HRGs are scattered or less in number, efforts should be made to link them effectively to exisiting TIs (core or compostive) .It needs to be ensured that TI staff of these interventions can work towards addressing the needs of Hijras/Transgenders.This intervention model is to be considered in situation where the location of the community is not being covered by other core intervention projects. This can also be considered in locations where there is felt need of the community to be addressed separately and not as a MSM TG composite intervention.



STAFFING STRUCTURES FOR TI PROJECTS

TI covering 1000 TG&H population

SN	Posts	No. requested	Remarks
1	Project Director	1	
2	Project Manager	1	Preferably from the community
3	Accounts Assistant	1	As per existing guidelines
4	M&E Assistant	1	As per existing guidelines
5	ANM/ Counsellor + 1 Community Counsellor	2	Based on the need to provide psycho social support to the community
6	Out Reach Workers	4-6	1 out reach worker for 150 to 250 TG&H
7	Peer Educators	17-20	1:30-60 HRGs taking into consideration the distribution of the community and the need for intensive intervention package for the community
9	Community Advocates	1	As per existing guidelines
10	Community Mobilizers	2	As per existing guidelines
11	Part time Doctor	1	As per existing guidelines

TI for 250 - 500 TG&H Population

SN	Posts	No. requested	Remarks
1	Project Director	1	
2	Project Manager	1	Preferably from the community
3	Accounts Assistant	1	As per existing guidelines
4			
5	ANM/ Counsellor	1	As per existing guidelines
6	Out Reach Workers	2-3	1 out reach worker for 150 to 250 TG&H
7	Peer Educators	8-16	1:30-60 HRGs taking into consideration the distribution of the community and the need for intensive intervention package for the community
8	Shadow Leaders	Nil	
9	Community Advocates	Nil	
10	Community Mobilizers	1	
11	Part time Doctor	1	Part time doctor to be provided for interventions that cover 500 or more TG&H populations

CAPACITY BUILDING PLAN

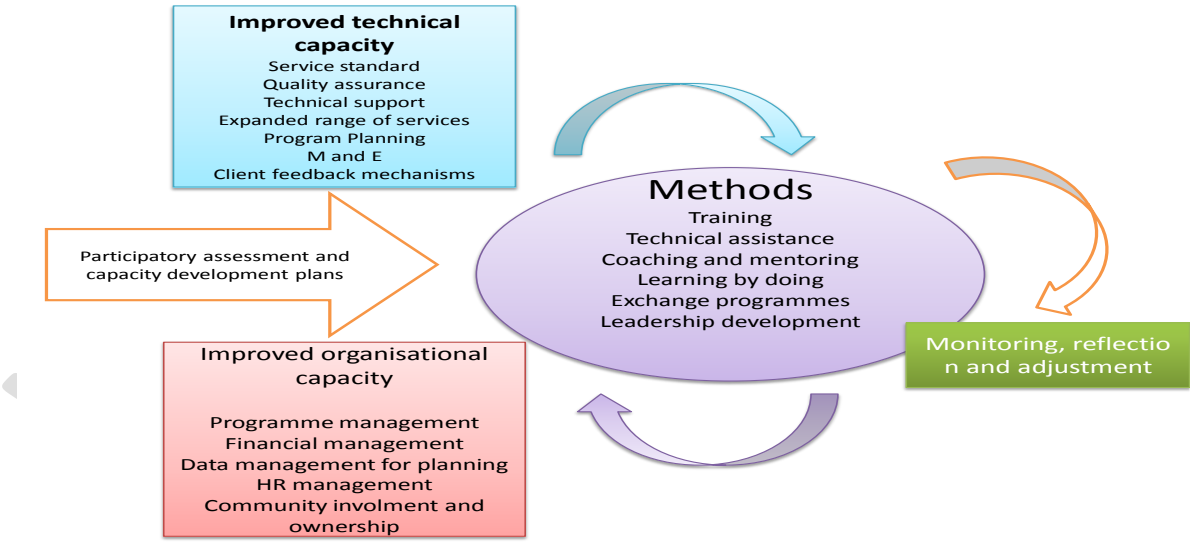
The vulnerability towards HIV /AIDS among Transgender (TG) and the Hijra community increase due to the sexual preferences and gender violence. The capacity building component in NACP IV is great opportunity to address the core and the need based issues of these communities. The core component of the capacity building issues can revolve around following principals,

- Preventive care
- Community strengthening
- Right based approach
- Greater support and involvement of the people living and affected with HIV / AIDS

Some of the important things that need to be followed in case of the TG and Hijra training are as follows;

- Adult learning principals
- Activity based during the classroom sessions
- Peer based module pre tested by community people
- Short sessions focused around the key messages that can be translated at the field level
- Mechanism to ensure training translation at the field level
- IEC material to support the training learnings
- Language
- Field level support for the training translation
- Training by community representatives
- Community consultants to monitor the training translation impact at the field level

Capacity building plan



The core areas of the capacity building for the TG and Hijra community can be as follows;

1. CBO strengthening and leadership development
2. Documentation, communication and Financial management
3. Implementation on the targeted intervention and basic services
4. Community mobilization and community system strengthening
5. Behaviour change and interpersonal communication

6. Sexual health, preventive measures and risk management
7. Mental Health and positive living
8. Care and support
9. Advocacy and crisis management
10. Life skill programs

Overall outline of the above topics are explained more in details below;

CBO strengthening and leadership development – This module will more focus on mentoring the community leaders with in the community. The effective community leaders will ensure the program ownership at the field level and support the overall program to buy community involvement and accountability in the long run. Strong CBOs will be ensure the healthy management systems, effective programme accountability and implementation for State AIDS Control Societies.

Documentation, communication and Financial management – It has been observed that the TG / Hijra CBOs fail to run the TI effectively due to the lack of capacity in documentation, communication and financial management. The training in these core aspects will ensure to build the sustainable programme implementation resource at the community level. The educational levels with these communities are poor and many times it becomes hindrance for such CBOs to approach the TI in proper manner. The correct knowledge and ongoing capacity building on documentation, communication and financial management will empower CBOs to effectively run the program and also achieve the desired targets as per the NACO IV.

Implementation on the targeted intervention and basic services – For the new targeted intervention training on the basic intervention design and the service delivery needs to be given in detail. The training should also involve the peers. The training can involve basic activities which need to be run under targeted intervention.

Community mobilization and community system strengthening – The community mobilization is the biggest challenge with these groups since they are organize and also scattered. The community mobilization through the community leaders is the core area the community needs training on. Working with influential gurus, leaders can be important aspect of this training. Community system strengthening should involve generating community ownership on the programmatic issues and community program implementation mechanism development. The training should address the initiatives community can take to create the sustainable action on the community interventions, community responsive systems and preparing community for the larger community entitlement scenario in the future.

Behaviour change and interpersonal communication – The backbone of the HIV/AIDS program is behaciour change among the high risk communities. However, the approach of the behaviour change and interpersonal communication will differ immensely working with the TG and Hijra groups. The HIV/AIDs does not fall on priority list of the community. Henceforth the behaviour change aspect should more focus on the issues related to overall health, feminization and health linkage, substance abuse and vulnerability factors. The techniques of the interpersonal communication will also differ at the larger scale. The techniques used in the classical TI settings needs to be pre tested at the community level.

Sexual health, preventive measures and risk management – The issues of the TG and Hijra regarding sexual health will involve around the sexual activity preferences, lifestyle, occupation, sex work, substance abuse and the emasculation status. The capacity building component can talk about the vulnerability factors and the risk management for TG and Hijra in vulnerable situations. The component can also talk about taking right decision on right time, saying no to vulnerability and also being concern about their own health and partner treatment.

Mental Health and positive living - Mental health, positive living is extremely poor in TG and Hijra population and this makes them vulnerable for the substance abuse, risky sexual behaviour, violence and suicidal tendencies. The mental health and positive living capacity building needs to be given to counselors, peer educators and the outreach workers to instigate the positive living among the highly vulnerable communities like TG and Hijra.

Care and support - Care and support component can look In to the issues of the pre ART registration, OI management, Community support to PLHIV, Community health workers, nutrition and dealing with the status disclosure issues.

Advocacy and crisis management – The advocacy and crisis management capacity building can focus on reducing the harassment issues and establish the sustainable community friendly services.

Life skill programs – Employment is the biggest concern of the TG and Hijra population that makes them more vulnerable for the HIV/AIDS. The life skills education that are more community specific can make the community more empower and responsible towards the risk management and healthy living.

Capacity building matrix

Sr. No.	*Topic*	*Key elements to be covered in the training*	*Target audience to be trained*
1	CBO strengthening and leadership development	CBO management CBO system establishment Leadership CBO resource building	CBO board members
2	Documentation, communication and Financial management	Overall documentation of the programme Monitoring and Evaluation reporting CBO book keeping	Program management staff, Finance person
3	Implementation on the targeted intervention and basic services	TI intervention basic services Activities	Program management staff
4	Community mobilization and community system strengthening	Community mobilization event management Community meetings	Peer Educators and outreach workers
5	Behaviour change and interpersonal communication	BCC and IPC skills IEC use in field Referral management	Peer Educators and outreach workers
6	Sexual health,	HIV/AIDS and STIs	Peer Educators and outreach

	preventive measures and risk management	Emasculation issues Situational management that enforce you for risk behaviour	workers
7	Mental Health and positive living	Dealing with mental health issues Self motivation Dealing with relationship crisis Positive living	Counselors, Community couselors
8	Care and support	Pre ART and post ART support Home based care Opportunistic infections Nutrition	Counselors, Outreach workers and Peer educators
9	Advocacy and crisis management	Crisis management Building crisis response teams Human rights and health Stakeholders analysis and networking	
10	Life skill programs	Community need based life skills programs that will assist the community to aware about the alternation options Knowledge about the government schemes for the TGs and Hijra populations	Peer Educators and community representatives

JOB DESCRIPTIONS FOR PROPOSED HR Drat

Job description:	**Community Mobilizer**
Reports to:	**Project Manager**
Responsible for:	**Community problems and needs.**
Base:	**particular state / District or Region**
Main Functions:	**The community mobilizer will be responsible for Collective analysis of community problem and collective action leading to the solution**

of those problem and to make that process self sustainable and self managing

Key Responsibilities: (DRAFT)

- To monitor social changes and new social information relevant to community empowerment.
- To identify potential leaders.
- To motivate and encourage potential leaders and their fellow community members about unity and self-reliance.
- To raise awareness among the community members about their fundamental rights and guide them on the various strategies and schemes through which they can support their living.
- To assist community members in identifying their needs, prioritizing their needs and their solutions.
- To encourage and stimulate community members to design action oriented achievable plans guided by the timelines.
- Build capacity of the community leaders on management skills and related knowledge so as to keep their interest intact in the project.
- To develop trust , tolerance and cooperation among the community members.
- To encourage and stimulate full participation by all the community members with special attention to those who are usually forgotten or PLHIV and AGED community members.
- To support community members in accessing information available at government and non-government agencies through extension and outreach programmes.
- To assist the community members in developing their own capacity and strength to the point where they are confident and self-reliant and do not need any external support for addressing their issues.

Qualification

- The community mobilizer should be from the community.
- Should have the ability to read, write, listen and speak in well local language.
- Ability to stand in front of a group with out showing any feer or arrogance.
- Ability to learn mobilization skills.
- A desire to contribute to the national development through community empowerment.
- Strong morals like honesty, transparency, generosity and respected is excepted.
- Well motivated and a team member willing to work alone or without any supervision.
- Ability to observe and analysis social indicators.
- Willingness to take up training offered as and when required by the programme team.
- Must have at least 1year of experience working as a peer or ORW in his region/ state or district.
- Must belong to TG/ Hijra community. Preference will be given only to Transgender and Hijra person.

Salary with commensurate with qualification and experience of the person.

Job description:	**Community advocates**
Reports to:	**Project coordinator**
Responsible for:	**advocacy issue**

Base: **particular state / District or Region**

Main Functions: The community advocates will be responsible for advocacy work and for informing, influencing and basic documenting advocacy work within the CBO/NGO Project. S/he will work closely with the Project Coordinator, to coordinate Local and community level advocacy work, capacity building of community (gurus, nayaks and malaks) and external stakeholders and will liaise with other teams to ensure the participation and emphasis on the role of community participation.

Key Responsibilities:

- Working in close consultation with Gurus, Malaks, Nayaks and Chelas.
- Do need assessment and provide training and orientation to the Gurus , Malaks, Nayaks and chelas.
- Collaborate, coordinate and attend multidisciplinary meeting with the community agencies such as : local law enforcement agency, faith professions/ religious leaders, similar networks etc.
- Develop or advice on social policy which sits in the community developments.
- Develop, document and disseminate good practise with stake holders.
- Identify and prepare the data by in the existing IEC materials related to the TG/Hijra community specifically.
- Build linkages with Civil society networks and facilitate local level engagement by CBO/NGOs.
- Take the responsibility for day to day management of advocacy project.
- Establish, maintain and strengthen effective relationship with relerent stake holders and district government agency.
- Participate in the development of the advocacy plans at the district /zila level which includes the activities for engaging people from the community.
- In consultation with the project coordinator represent the particular CBO/NGO in an appropriate district / zila level forums.
- Undertake other responsibilities not outlined above which are commensurate with a role of this nature and which have been discussed and agreed between the programme manager and the post holder.

Qualification

- The community advocates should be from the community.
- Must have at least 1-2 yrs. of experience working as a peer or ORW in his region/ state or district.
- Basic reporting skills on advocacy issue.
- Must have a hold on the local stake holders.
- Must have a knowledge on advocacy skills and networking.
- Must belong to TG/ Hijra community. Preference will be given only to Transgender and Hijra person.

Salary with commensurate with qualification and experience of the person.

BROAD IMPLEMENTATION PLAN

Activities proposed to be covered 1(2011 inception phase) + 5 years (April 2012- March 2017)

Pre NACP IV phase

Objectives:

- To have Hijra TG resource pool
- To initiate exclusive TIs for Hijra TG community.
- Involve Gurus as Leaders for health initiative
  - Setting up of stand alone 12 Hijra TG TI by Aug 2011- (To know how Hijra TG TI functions – issues)
  - Synergy with Round 9 and other efforts (To build capacities of Hijra TG CBOs)
  - Validation of KP population – by Dec 2011
  - Advocacy with Gharanas this year- Task force constitution
  - Working Group – will work as TRG
  - Communication strategy/ material
  - Analysis of 12+ Hijra TG TI in this year

NACP IV (2012-2017)

Goal:

- **100% community and community leaders will be empowered to deal with all the Health issues related to Hijra TG community.**
- **Bring down HIV incidence by 50%**

1st YEAR-

- As per validation start new TIs
- Out of previous TIs – develop 3? Learning Sites

2nd YEAR

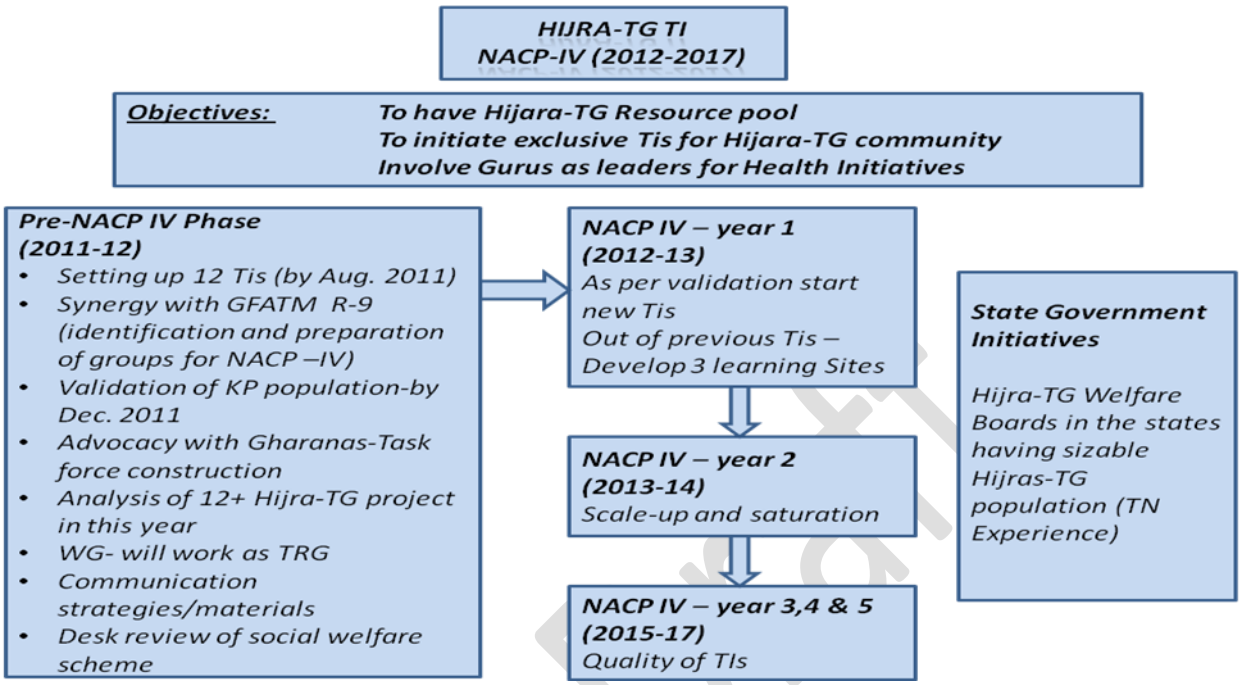
- Scale up and saturation

3rd YEAR onwards

- Quality TI

Other Structures through State Government -

- Hijra TG Welfare Boards in the States having sizable Hijra TG population



Expected outcomes

1. Improved HIV/AIDS program management capacity at the national and provincial level for a scaled up and more comprehensive range of services for TG - Hijras.
2. This includes the technical and organizational capacity to deliver a comprehensive package of services for TG - Hijras in HIV prevention, care, treatment and support.
3. Improved organizational management and leadership capacity of CBOs and NGOs working to deliver HIV prevention services for TG – Hijras leading to increased absorptive capacity for scaled-up, higher quality services fully accountable to donors and the community.