Situational Analysis and Strategies to Upscale an Evidence-Based HIV Response in Relation to MSM, Hijra and Other Transgender Populations in Rajasthan

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Rajasthan State AIDS Control Society
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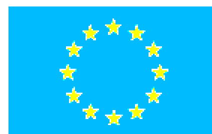
Solidarity and Action Against The HIV Infection in India



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List of Abbreviations

ANC	Ante-natal care
BCC	Behaviour change communication
CBO	Community-based organization[1]
DIC	Drop-in centre
IEC	Information education communication
MSM	Men who have sex with men (or males who have sex with males)
NACO	National AIDS Control Organization
NACP - II	National AIDS Control Programme – Phase II
NACP - III	National AIDS Control Programme – Phase III
NGO	Non-governmental organization
NPO	Non-participatory observations
OI	Opportunistic infection
PIP	Programme Implementation Plan
PLHIV	People Living with HIV
RSACS	Rajasthan State AIDS Control Society
SRS	Sexual reassignment surgery
STI	Sexually transmitted infection
TG	Transgender (in this document, it stands only for male-to-female transgender people)
TI	(STI/HIV/AIDS) Targeted intervention
TSU	Technical Support Unit
VCCTC	Voluntary confidential counselling and testing centre

[1] This document makes a distinction between the two terms "population" and "community". A population can be called a community if its members possess a sense of social bonding based on shared perceptions, realities and desires. A community, therefore, implies a certain level of political awareness. In that sense, Hijras and some male-to-female TG, gay and bisexual men's populations in Rajasthan (as in the rest of India) may be said to constitute communities or emerging communities. But the vast majority of MSM and TG people in the state or the rest of the country may not be in a similar situation. In general, this document uses the phrase "MSM, Hijra and other TG populations". But where there is a role for the existing or emerging communities of MSM, Hijras and other TG people, the term "community" has been preferred.

Executive Summary

Introduction: This document provides detailed information and strategy inputs for scaling up the HIV response in relation to MSM, Hijras and other transgender (TG) people in the state of Rajasthan. These inputs were gathered and collated through a **situational analysis** and **consultative process** spread over five months (end May to October 2007). The project was executed on behalf of Rajasthan State AIDS Control Society (RSACS) by Solidarity and Action Against The HIV Infection in India (SAATHII) with funding and technical support from Oxfam GB and European Commission.

Project Rationale and Purpose: HIV prevalence among MSM and Hijras was 8.74% and 43.90% respectively, in 2005 (NACO data). Despite such evidence that male-to-male sexual transmission of HIV makes significant contribution to the HIV/AIDS epidemic in India, few strategic HIV/AIDS interventions in the country address male-to-male sex and related HIV vulnerabilities. The situation is grimmer in northern India, including highly vulnerable states like Rajasthan, which have few dedicated STI/HIV/AIDS targeted intervention (TI) programmes for MSM, Hijras and other TG people.

This project was executed to help RSACS and NACO address these serious gaps in the state and national HIV responses. The project purpose supported the objectives of greater coverage of most-at-risk populations like MSM and Hijras as detailed in the NACP – III and Rajasthan State Programme Implementation Plan. Since an in-depth understanding of the populations concerned would be a pre-requisite for a scaled-up HIV response, the project sought to validate and improve on previous mapping studies undertaken by RSACS in 2005 and EPOS Health India in 2006. These studies had estimated MSM and Hijra population sizes in Rajasthan, but their data was considered inadequate for designing an effective HIV response strategy.

Project Activities: The situational analysis component of the project deployed qualitative research techniques like literature review, key informant and in-depth interviews and group discussions to prepare a socio-economic, demographic and cultural profile of the populations. Institutional assessment towards resources mapping and limited site mapping exercises were included. Enumeration was also included, but not prioritized. Data on 11 districts was collected through the analysis.

The situational analysis found that male-to-male sex in Rajasthan had a significant historical perspective and was far more common in both urban and rural areas than indicated by previous studies. A multi-state study in 2004 of homosexual activity among rural Indian men aged 18-40 years (Jalore in Rajasthan was one of the districts covered) found 9.50% of single and 3.10% of married respondents had anal intercourse with a man in the past year. If this data were extrapolated to the entire rural male population in the given age bracket in just Jalore district, the number of MSM would far exceed the population of 1,400 mapped by the RSACS study for the whole state in 2005.

Data provided by interview respondents on the number of their male sexual partners (commercial and non-commercial) and NGOs on the coverage of their TI programmes also indicated a much higher population size of MSM and TG people than the mapping studies. According to NACO, Rajasthan had nearly 1.30 lakh most-at risk MSM. But the current TI programmes for MSM and Hijras in the state (nine in all) were covering less than 1% of this estimated population. VCCTC data on routes of HIV transmission in the state also seemed to under-report male-to-male sexual transmission.

A social, economic and cultural profiling of MSM, Hijras and other TG people was also attempted. Diversity in gender and sexual identity constructs (including absence of such

constructs) came through, as did factors of vulnerability to STI / HIV infection. Lack of sexual health education was all pervasive, but community representatives emphasized more underlying causes like lack of psycho-social support, limited education and job opportunities, a violently stigmatized social environment and insensitive health services. Added features of the male-to-male sex scenario included significant in and out-migration from the state, and sexual interaction between tourists and tourist guides.

The findings of the situational analysis were validated through a two-phase consultative process. First, two Primary Stakeholder (Local) Consultations were organized in Jaipur and Udaipur. The participants included staff of NGOs working with MSM, Hijras and other TG groups, and representatives of these communities. Inputs received were used to improve on the situational analysis findings. Strategy recommendations were added to prepare a presentation for a final State Level Consultation in Jaipur, which was attended by community leaders, peer educators and NGO heads along with key stakeholders from RSACS and other government and multilateral agencies.

The consultations were conducted jointly by Oxfam GB and SAATHII. Mr. Rajiv Dua of Oxfam GB made key presentations at the Primary Stakeholder (Local) Consultations, while the State Level Consultation was addressed by Dr. Moti Lal Jain, the-then Project Director of RSACS. **The State Level Consultation resulted in:**

(a) Formulation of principles for an HIV response strategy for MSM, Hijras and other TG populations in Rajasthan, the first and foremost being leadership of MSM, Hijra and other TG communities and their capacity building as central to the response.

(b) Structural recommendations for the response strategy: Setting up of a State Resource Centre on MSM and Hijra issues, potentially as part of the state Technical Support Unit, to provide technical assistance to RSACS and build capacity of MSM and Hijra CBOs.

(c) Framing of a methodology sequence for starting TI programmes for the populations concerned: Beginning with action research to mobilize communities and build rapport with them, leading to comprehensive mapping (population profiling, enumeration, resources mapping, site mapping), sexual health needs assessments, and subsequently to full-fledged TI programmes. Starting HIV sentinel surveillance to acquire baseline data on HIV prevalence among MSM and Hijras in the state was also recommended.

(d) Recommendations for TI programme design with emphasis on strategic advocacy to protect the human rights of populations concerned, research-based BCC development, community based access to STI/HIV counselling, testing and treatment, provision of HIV care, support and treatment to MSM and Hijras living with HIV, and attention to social security needs like livelihood and shelter.

(e) Formulation of principles for gradual transfer of TI programme management from NGOs to CBOs (as envisaged under NACP – III).

(f) Response strategies alternate to the TI approach to reach out to MSM and TG people not accessible through any known place, institution or community forum. Example: Youth sexual health programmes and mass communication campaigns that would include issues concerning MSM and TG populations.

(g) Recommendations for immediate next steps: (i) RSACS and NACO to examine applicability of findings and strategies proposed in this document to Rajasthan State PIP (2006) and NACP – III. (ii) Preparation of an operational plan to act on findings and strategies endorsed by RSACS and NACO.

Section I

Introduction to the Project

1.1: Background of the Project

The HIV/AIDS epidemic has reached alarming proportions with nearly 2.50 million people determined to be living with HIV in India (National AIDS Control Organisation – NACO, 2006 data). Current steps taken by NACO for reducing transmission include STI/HIV/AIDS intervention programmes focused on the general population and interventions targeted at populations that have high risk of contracting and transmitting the virus. Among the populations recognized to be most-at-risk in India, MSM and male-to-female transgender (TG) people, particularly Hijras, have been identified by NACO as urgently requiring greater coverage and stronger targeted intervention (TI) programmes. HIV Sentinel Surveillance data provided by NACO indicate that HIV prevalence among MSM in 2005 was 8.74% (N = 4,303 at 18 sites), and among Hijras 43.90% (N = 82 Hijras at 1 site). The latter is the highest prevalence among any most-at-risk group in the country.

Despite evidence that male-to-male sexual transmission of HIV contributes significantly to the HIV/AIDS epidemic, few strategic HIV/AIDS interventions address male-to-male sex and related HIV vulnerabilities in India. The situation is grimmer in northern India, including states like Rajasthan, where dedicated TI programmes for MSM or Hijras are almost absent. Hence NACO is planning a major scale-up of HIV/AIDS interventions for MSM and Hijras across the country under its National AIDS Control Programme – Phase III (NACP – III).

Little is known about MSM, Hijras or other TG populations in Rajasthan. This does not mean that MSM and Hijras are absent in Rajasthan, or that they do not need HIV/AIDS services. If anything, social stigma makes these populations hidden and difficult to access. In fact, data from other states, including neighbouring Delhi and Gujarat, and NACO's MSM population size estimation in 2006 suggest that Rajasthan too urgently needs STI/HIV/AIDS TI programmes for MSM, Hijras and other TG populations.

Special attention is needed towards MSM and Hijra youth, who are sexually more active. In rural Rajasthan early sexual initiation is common also because of marriage at a young age. In the absence of reproductive and sexual health education, MSM and Hijra youth, their spouses and other sexual partners, all become vulnerable to STI/HIV infection. Thus a clear understanding of MSM, Hijra and other TG populations in Rajasthan is a larger public health necessity.

In 2005, Rajasthan State AIDS Control Society (RSACS) conducted a preliminary mapping of MSM and Hijra populations in the state. Another study was conducted by EPOS Health India Pvt. Ltd, New Delhi in 2006 to estimate the size of various most-at risk populations in Rajasthan. But it was necessary to validate this information, and more demographic and ethnographic data needed to be collected through a situational analysis.

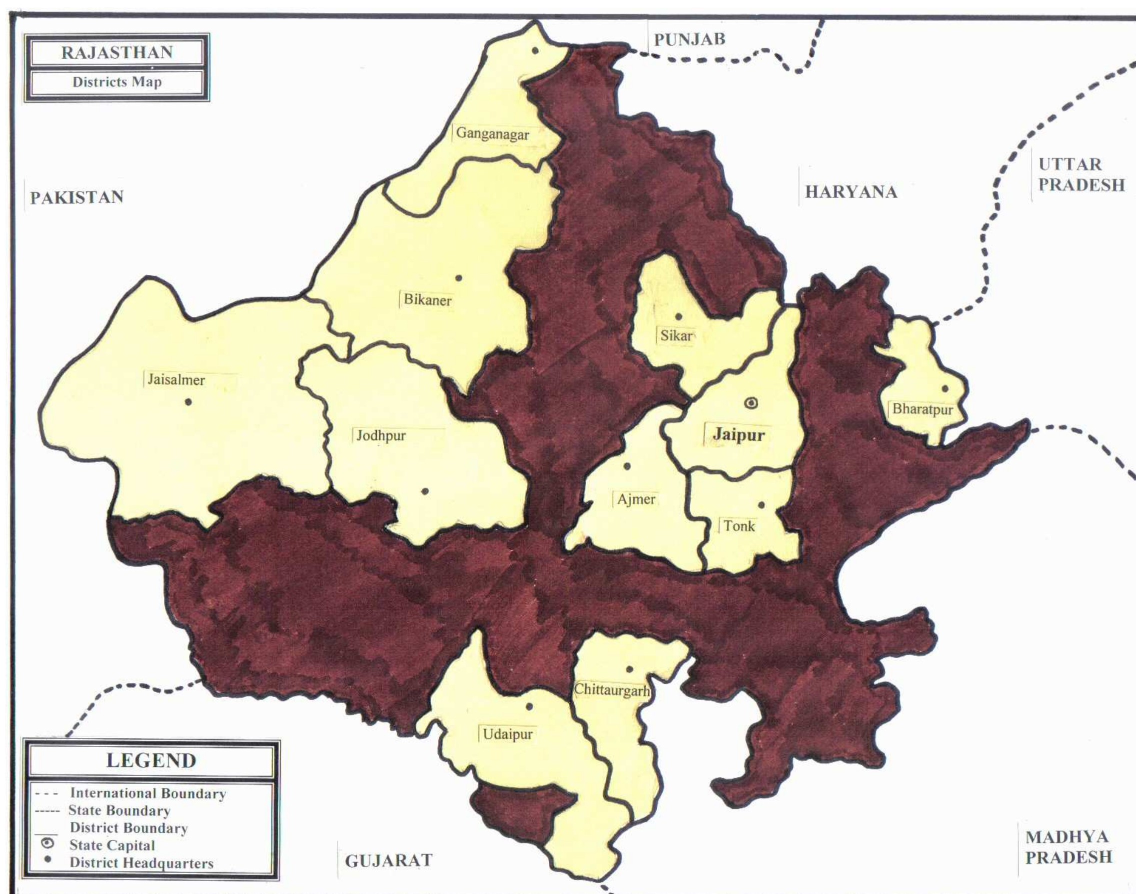
Strategies for further participatory and comprehensive mapping (population profiling, enumeration, resources mapping and site mapping), sexual health needs assessments and TI programmes were also needed to assist RSACS in developing an evidence base that would lead to a strong HIV/AIDS response strategy for MSM and Hijra populations in the state in keeping with the goals and objectives of NACP - III.

1.2: Project Goal and Time Period

"Providing technical assistance to RSACS for developing an HIV response strategy for MSM, Hijra and other TG populations in Rajasthan".

The project was undertaken as a joint effort by Oxfam GB and SAATHII on behalf of RSACS from end May to August 2007. Final data analysis and report writing was undertaken in September and October 2007.

1.3: Working Areas of the Project



Districts covered by the project included (marked in yellow colour in the map above): Ajmer, Bharatpur, Bikaner, Chittaurgarh, Ganganagar, Jaipur, Jaisalmer, Jodhpur, Sikar, Tonk and Udaipur

1.4: Project Activities

1.4a: Situational Analysis

As a first step, an understanding was developed by SAATHII and Oxfam GB on what kind of information would be needed for an HIV response strategy for MSM, Hijras and other TG populations in Rajasthan. In 2006, SAATHII provided technical assistance to NACO and UNAIDS India for a series of regional and national consultations on greater inclusion of HIV/AIDS concerns of MSM, Hijras and other TG people in NACP – III. This experience provided considerable insight into formulating the situational analysis plan. Finally, the following investigation issues were listed for the situational analysis:

- History of male-to-male sexual behaviours and relationships in India and Rajasthan
- General profile of MSM, Hijras and other TG populations in Rajasthan
- Profile of gender / sexual identities and sexual behaviours
- Enumeration data on MSM, Hijras and other TG populations in Rajasthan
- Extent of vulnerability of MSM, Hijras and other TG people to STI/HIV/AIDS and related epidemiological information
- Current extent of HIV/AIDS intervention among MSM, Hijras and other TG populations
- Current access to sexual health and other general health care services
- Strategies for implementation of STI/HIV/AIDS TI programmes for MSM, Hijras and other TG populations in Rajasthan

In order to conduct the situational analysis, the following **research activities** were undertaken by SAATHII over the first two months of the project period:

1. **Literature review of: (a)** Anthologies and papers giving an historical perspective of same-sex behaviours and relationships in Rajasthan, **(b)** State-specific studies conducted in the past on MSM, TG and HIV/AIDS issues (government / non-government epidemiological reports, needs assessments, mapping studies, research papers), **(c)** Programmes and annual reports of NGOs in Rajasthan, **(d)** Policy documents like Rajasthan State PIP, and **(e)** State-specific e-forums used by MSM and TG people.

   These documents were collected through a web search, interaction with RSACS, Oxfam GB, UNICEF and NGOs in Rajasthan. SAATHII's collection of documents in its reference library in the Kolkata Office also provided some of the literature. For the Literature Review Report, please refer to **Appendix I**, which also contains a full **bibliography** of the documents referred to.

2. **Key informant interviews (KIIs):** Nine KIIS were conducted to get an overview of issues concerning MSM, Hijras and other TG groups in Rajasthan, their likely population sizes, work undertaken so far on HIV/AIDS and sexual

health issues in the state, and further possibilities regarding provision of HIV/AIDS and associated health services to the populations concerned. Respondents included representatives of NGOs working on gender, sexuality and health issues of MSM and Hijras in Ajmer, Bharatpur, Ganganagar, Jaipur and Jodhpur districts, an official of multilateral agency UNICEF and a doctor from Udaipur. One senior outreach worker (as an MSM community representative) was also interviewed in Ganganagar district. Interview guides were prepared based on the type of respondent to be interviewed and nature of information required. Guidelines for KIIs can be seen in **Appendix II.**

3. **In depth interviews (IDIs):** Six IDIs were conducted to find out the HIV/ AIDS and sexual health knowledge and attitudes towards sex and sexuality among MSM, Hijras and other TG people in Rajasthan from different social, economic and cultural settings. Sexual behaviours prevalent among these populations and prevalence of STI and HIV infection were also investigated, as were issues like first sexual experience, safer sex practices, number of sexual partners, hurdles in accessing health services and experience of stigma, discrimination and violence. The respondents were asked about livelihood, general health and social security needs that directly impact on sexual health but hardly find a place in most HIV/AIDS programmes. The respondents were MSM, Hijra or other TG individuals from Bharatpur, Bikaner, Jaipur and Tonk districts. Some were affiliated to NGOs or CBOs as outreach workers or peer educators. Interview guides were made to suit the type of respondent and nature of information needed. See **Appendix III** for IDI guidelines.

4. **Institutional assessment:** This activity was built into the literature review and interview processes. The subject of study was what kind of agencies were already working with MSM, Hijras or other male populations in Rajasthan. An assessment was made about what health and related services were available to these populations, and whether the services were being accessed. If not, which other services were preferred and reasons why. Both government and non-government agencies were considered. **Table II, pg. 18** provides a district wise population profile summary and key institutional information.

5. **Group discussions (GDs); non-participatory observations (NPO):** were undertaken to supplement (triangulate) the information gathered through the literature review, KIIs and IDIs. One GD was conducted in Jaipur to validate information obtained from KIIs on the sexual behaviours and networks of MSM and Hijras in Jaipur and other districts. NPO was carried out at public socializing and sex sites in Jaipur and Tonk to understand the networking processes and gain an idea about number of individuals accessing these sites on peak days and peak hours of the day.

1.4b: Consultative Process

The first step in the month-long (July-August 2007) consultative process that followed the situational analysis was holding two Primary Stakeholder (Local) Consultations in Jaipur and Udaipur. These consultations were used to validate findings of the situational analysis and elicit additional information from representatives of MSM, Hijra and TG communities, and individual resource

persons and NGOs working with these communities. Among other issues, population sizes mentioned by KII and IDI respondents were cross-checked and HIV response strategies listed. Reports of the two consultations can be referred to in **Appendices IV and V.** Inputs received from these consultations were added to the situational analysis data to prepare a presentation for a final State Level Consultation in Jaipur. The presentation made by SAATHII at the State Level Consultation can be referred to in **Appendix VII.**

Apart from MSM, Hijra and TG community representatives and officials of NGOs working with these communities, the state level meeting involved representatives from RSACS, UNICEF and other agencies working on issues of gender and health. The meeting deliberated on strategies for rapport building with the communities in question, further (action or operations) research, comprehensive mapping and sexual health needs assessments. These research activities would provide a detailed evidence-base for scaling up TI programmes for MSM, Hijras and other TG populations in Rajasthan in an ethical and participatory manner, and ensure that capacities of the communities concerned were built so that they played a central role in the HIV response. The meeting also discussed building greater trust and coordination between civil society and government agencies involved in the HIV response in the state.

The consultations were conducted jointly by Oxfam GB and SAATHII. Mr. Rajiv Dua of Oxfam GB made key presentations at the Primary Stakeholder (Local) Consultations, while the State Level Consultation was addressed by Dr. Moti Lal Jain, the-then Project Director of RSACS. The agenda for the State Level Consultation can be seen in **Appendix VI** and the list of participants in **Appendix VIII.**

Section II

Findings of the Situational Analysis and Consultations

The findings of the situational analysis and all three consultations have been summarized in the following table. Please also refer to Literature Review Report in **Appendix I**, and reports of the Local Level Consultations in Jaipur and Udaipur in **Appendix IV** and **Appendix V,** respectively.

Table I: Situational Analysis and Consultations Summary

No.	Issues	Findings
2.1	History of male-to-male sexual behaviours and relationships in India and Rajasthan	▪ Same sex sexuality (male-to-male, female-to-female) and TG identity part of Indian culture since ages ▪ References in Vatsayan's "Kama Sutra", other ancient and medieval epics and mythological lore of India ▪ Tonk and Rampur Nawab reported to have maintained harems of young males for sexual pursuits. But these days *laundaybaazi,* practice of maintaining harems of youthful and good looking young males by kings, landlords and other powerful gentry, has waned out ▪ Sufi poets: Preferences for male lovers evident from their poetry, some had strong links in Rajasthan ▪ Though detailed historical references to male-to-male sex in Rajasthan are difficult to come by, the findings above indicate scope for more in-depth research into Rajasthani literature and its oral traditions
2.2	General profile of MSM, Hijras and other TG people in Rajasthan. See **Table II** for more district wise data	▪ Diverse in terms of social, economic, cultural parameters ▪ Representation in all age groups (14-60 years). Not restricted to any single socio-economic class, occupation, educational status or religion ▪ Representation is also there among migrants, refugees, tourists and prison inmates[1] ▪ Some of the occupational groups that include most-at risk MSM, Hijras or other TG people because of prevalence of unprotected and mutli-partner penetrative sex (often both male-to-male and male-to-female): Dancers (entertainers), tourist guides (*lapkas*), camel riders, waiters in hotels and *dhabas*, *pehlwans* (professional wrestlers) ▪ Commercial sex prevalent among some of these occupational groups ▪ Residence not just urban, but also rural. Highly mobile populations ▪ Many are married, or will get married ▪ Diverse preferences for leisure activities

No.	Issues	Findings
2.2a	Profile of gender / sexual identities and sexual behaviours. See **Table II** for more district wise data	▪ Variety of gender / sexual identities and labels prevail: ➤ *Baiji*, *Bilia*, *Chhakka*, Hijra, *Kinner* (among Hijras) ➤ Bisexual, *Chikna*, Gay, *Giriya*, Helicopter, *Janani*, *Kothi*, *Launda*, *Macchar*, *Machis* (among MSM and other TG people) ➤ Many MSM do not have any specific gender or sexual identity at all. Particularly in rural areas, MSM do not form a separate sexual network unlike some of their urban counterparts. Instead, they link to both circuits of high-risk sexual activities (with other males) and the general female population ▪ While pan-Indian male-to-female TG identities like *Kothi* are prevalent in Rajasthan, male-to-male sexual relations in some districts of the state seem to be less gendered than in other parts of India. Machismo in one's sexual partner is much preferred by those who consider themselves masculine, and public visibility for Hijras or other TG people seems fraught with greater risk of violence than in some of the other states ▪ Single men (20-30 years old) most preferred sexual partners. No. of sexual partners: Ranges from single to around 20 in a month (both regular and casual) ▪ Lowest age of first sexual encounter: 12-14 years ▪ First sexual partners – Friends, class mates, older males in the neighbourhood, relatives (cousins, uncles) ▪ Socializing sites – Parks, gardens, cinema halls, discos, pubs, restaurants, outside college canteens, roadsides, railway stations, bus stands, *anaaj mandis*, massage parlours, army camps, public toilets and urinals, country liquor shops in slums. Internet and mobile phone based dating common in urban areas ▪ Sex sites – Own homes, abandoned railway quarters, train toilets, public toilets, train car sheds, hotels, tourist sites, farms and fields ▪ Preference for oral sex among many married MSM ▪ Hijras often preferred by MSM to female sex workers as they are willing to provide oral sex ▪ Payments for commercial sex can be in cash, gifts, food or alcohol. Male sex worker cash charge per client: Rs.20-2,000/-. Among Hijras who sell sex the charge ranges from Rs.20-200/- per client ▪ Many TG people desire to get "married" to their regular male sexual partners

No.	Issues	Findings
2.3	Enumeration data on MSM, Hijras and other TG populations in Rajasthan (to cross verify RSACS and EPOS Health India data). See **Table II** for more district wise data	▪ Stigma, lack of visibility of populations concerned have always made estimation difficult ▪ NACP – III Working Group (2006) estimated 6.50 lakh MSM in Rajasthan. This included 1,30,036 most-at risk MSM (> 5 male sexual partners for anal sex) and 13,004 male sex workers ▪ Participants at the Jaipur Local Level Consultation estimated an overall MSM population of 9-10 lakh, including 1.50-2 lakh most-at risk individuals. These figures were guesstimates and extrapolations made by the participants based on their field knowledge ▪ Mapping exercise undertaken by RSACS in 2005 had estimated 1,400 MSM and 635 Hijras in the state. In some districts like Bikaner, Chittaurgarh, Jaisalmer and Tonk the number of MSM was shown as zero, clearly indicating data collection problems. Besides, one key informant in Ajmer district indicated 500 Hijras in that district itself ▪ Another mapping exercise conducted by New Delhi-based EPOS Health India in 2006 estimated 2,720 MSM and 630 Hijras in Rajasthan. This study had similar problems as the RSACS study ▪ Data from key NGOs: ⅄ Needs assessment conducted by Gram Vikash Seva Sansthan, Jodhpur, 2006: 1,172 MSM in Jodhpur district alone, another 785 in Jaisalmer district ⅄ Coverage of TI programme run by Indian Institute of Development and Communication, Jaipur, 2006: 20,248 MSM at 114 sites in Jaipur district ▪ Study conducted in 2004 on sexual behaviours among rural Indian men (18-40 years, N = 2,910) in five districts in five states (Jalore in Rajasthan) showed 9.50% of single and 3.10% of married respondents had anal intercourse with a man in the past year (Verma and Collumbien – **Appendix I**) [2] If this data were extrapolated to the entire rural male population in the given age bracket in just Jalore district, the number of MSM would far exceed the numbers estimated by RSACS and EPOS Health India for the whole state ▪ No clear finding on enumeration data emerges, but juxtaposing data from different sources indicates that the number of MSM and Hijras in Rajasthan is much higher than what the earlier mapping studies have shown. A comprehensive mapping approach **(Section III)** can provide more accurate estimations

No.	Issues	Findings
2.4	Extent of vulnerability of MSM, Hijras and other TG people to STI/HIV/AIDS and epidemiological information	▪ Low awareness about STI/HIV transmission, testing and treatment among the populations concerned. Awareness about risk of STI/HIV infection in male-to-male sex much lower and anal STI awareness particularly lacking ▪ Poor use of condoms in both male-to-male and male-to-female penetrative sexual acts ▪ The study on sexual behaviours among rural men in Rajasthan and elsewhere in India (Verma and Collumbien – **Appendix I**) showed that only 70% of the respondents had ever heard about HIV/AIDS and only 41% were aware that condom use prevented HIV infection. Only 5% of the respondents were aware about the possibility of getting STI/HIV infection from their male sexual partners (N = 2,910) ▪ This study also showed that respondents with male sexual partners also had more female sexual partners. Around 11% of the respondents reporting male-to-male sex practiced anal sex with their female sexual partners in the past year. Both male-to-male and male-to-female sexual acts were largely unprotected, providing conditions for an accelerated spread of HIV among rural MSM and their sexual partners ▪ In Ajmer, Hijras who sell sex perceive it as providing service to devotees – no association with health risk ▪ Leading to poor health seeking behaviour and unsafe self-medication ▪ 61 out of 115 (more than 50%) prison inmates in Jaipur who had male-to-male sex reported STI infections[3] ▪ Coercion, aggression in sex – anal ruptures reported ▪ Other sexual health problems reported: ⅄ Pyscho-social problems around failure to accept one's gender or sexual orientation. Religious issues may also act as a barrier to self-acceptance and larger social acceptance ⅄ Coercive sex, blackmail, torture (physical, mental) by local goons and other men in the neighbourhood ⅄ Police harassment in cruising areas in cities ⅄ Panchayat leaders act as guardians of morality ⅄ Poor scope for livelihood and education for Hijras
	Note: No Behaviour Surveillance data among MSM / Hijras or HIV Sentinel Surveillance data on HIV prevalence among MSM or Hijras exist in Rajasthan. These are strategic information gaps that need to be addressed urgently. See also **Section III** of this document and the **End Notes.**[4]	

No.	Issues	Findings
2.5	Current extent of HIV/AIDS intervention among MSM, Hijra and other TG populations	▪ RSACS and partner NGOs cover 1,083 MSM and Hijras (less than 1% of number estimated by NACO for the state) through 2 exclusive and 9 composite TI programmes (RSACS State PIP information, 2006)[5] ▪ RSACS aims to reach out to 3,700 MSM by 2012 (the end of NACP – III). Another 4 exclusive TI programmes envisaged for the purpose. But given much higher population figures than estimated by RSACS, many more programmes are needed ▪ NACP – III plan document also estimates need for 32 exclusive and composite TI programmes for MSM and Hijras in Rajasthan ▪ Oxfam GB supports CBOs of MSM and TG people in Bharatpur district to run HIV/AIDS programmes. They also support youth sexual health programmes in Chittaurgarh district that cover youth among the MSM and TG populations ▪ India Health Action Trust supports one CBO of MSM / TG people in Kishengarh in Ajmer district, which provides HIV/AIDS services ▪ All HIV/AIDS programmes serving the populations concerned in urgent need of capacity building
2.6	Current access to sexual health and other general health services	▪ There is no evidence of exclusive community-based sexual health services for MSM, Hijras and other TG populations in Rajasthan. Only a few NGOs provide services that may be sensitive to the needs of these populations. Example: Indian Institute of Development and Communication, Jaipur; Astitva Sansthan, Udaipur; Apollo Hospital, Udaipur; Indian Institute of Human Help, Ajmer. However, a quality audit and capacity enhancement of these services is a likely need ▪ A majority of MSM, Hijras and other TG people in the state – in both rural and urban areas – rely on self-medication or *haakims* (traditional medical practitioners) for STI treatment ▪ There is reluctance to access sexual health services from government and private hospitals because of fear of harassment and lack of sensitivity among health care staff and counsellors. Attitude of the doctors treating anal STIs and ruptures is a concern. This reluctance extends to general health seeking behaviour as well ▪ Information and services on SRS and breast enlargement not readily available. Most Hijras rely on *dais* or doctors in Indore and Ujjain for castration / emasculation. The quality of these services is uncertain

HIV response strategy issues were also investigated through the situational analysis and the three consultations. But all strategy issues have been detailed in **Section III** in a single flow or sequence.

Section 2.7: District Wise Population Profile Features

While **Table I** provides an overall insight into the profile of MSM, Hijra and other TG populations in Rajasthan, the following table provides a district wise summary of profiles, partial populations sizes, key population access points and NGO health services available. **Note:** Government STI/HIV/AIDS services available include 42 VCCTCs, 47 STI clinics, 36 OI treatment facilities, 2 ART Centres and 2 Community Care Centres supported by RSACS. Some of the VCCTCs are run through Community Health Centres in the state.

The population figures mentioned in **Table II** are based on situational analysis data collected mainly through key informant and in-depth interviews, and do not relate to RSACS or EPOS Health India data. The data presented here relates to 9 of the 11 districts covered by the situational analysis.

Table II: District wise population profile summary

No.	District	Key profile features	Population Sizes	Access points	NGO resources
1	Ajmer	• Sizable migrant population present, wherein male-to-male sex is prevalent • Commercial Sex work by Hijras perceived as a spiritual pursuit • Many Sufi saints also known to practice male-to-male sex	• 500 Hijras estimated, 150 of them sell sex • Around 200 *Kothis,* 1,000 *Giriyas* estimated in Kishengarh block • 2,000 strong permanent Sufi population estimated	• Neighbour-hood of religious sites, parks, railway stations	• Indian Institute of Human Help (NGO) • As yet unregistered CBO supported by India Health Action Trust
2	Bharatpur	• Considerable migration of male populations into the district from other districts of Rajasthan for livelihood reasons • On an average, each MSM in the district has 3-4 male sexual partners a month • Bird sanctuary attracts many tourists	• No estimates available	• Railway stations, market places, vicinity of bird sanctuary in the late evenings	• Lupin Human Welfare & Research Foundation • As yet not registered youth / MSM CBO supported by Oxfam GB (Vihaan)

No.	District	Key profile features	Population Sizes	Access points	GO, NGO resources
3	Bikaner	• Considerable migration of male populations into the district from other districts of Rajasthan for livelihood reasons • District has several small, medium and large businesses • Many *Kothis* get paid after dancing in weddings and religious ceremonies by their Gurus	• 200-250 *Kothis* or *Jananis* estimated	• Railway stations, parks and gardens	• Manav Pragati Sansthan
4	Ganganagar	• Considerable migrant population	• Around 70 MSM estimated in Ganganagar city	• Parks, other public net-working sites	• Maharshi Dayanand Vikas Samiti
5	Jaipur	• Mix of higher, middle and lower socio-economic income classes • Hijra, *Kothi* networks co-exist with gay and bisexual men's networks • Internet, mobile phone-based dating common • Considerable tourist, migrant populations	• More than 20,000 MSM estimated in and around Jaipur city, including bridge populations like truck drivers, migrant workers and prison inmates • One interview respondent reported 15-20 commercial sexual partners per month	• Railway stations, bus terminals, parks and gardens, other tourist sites, gymnasiums, gents saloons, e-forums	• Indian Institute of Development & Communication • Vihaan
6	Jaisalmer	• Camel riders and tourist guides believed to have multiple sexual relations with foreign tourists of both sexes • Several thousand male tourists visit the district every year, nearly half of them have sex with camel riders and tourist guides	• 700-800 MSM and 150-200 Hijras estimated	• Hotels, bars, bus stands, tourist sites	• Gram Vikash Seva Sansthan

No.	District	Key profile features	Population Sizes	Access points	NGO resources
7	Jodhpur	• Inward migrant populations are on the rise • Most Hijras in the district are migrants	• More than 1,100 MSM and 500 Hijras estimated	• Railway Station, cinema halls, tourist sites	Gram Vikash Seva Sansthan
8	Tonk	• District has an historical record of kings, courtiers maintaining harems of young males for sexual pursuits. But these days, this practice of *laudaybaazi* is on the wane • Another district with large migrant populations	• No estimates available • 50-60 people identified at a cruising site through NPO in about 30 minutes	• Main bus terminal • Personal contacts play major role in enabling access	• None / Not known
9	Udaipur	• Similar to Jaipur in terms of socio-economic features, including large tourist population and co-existence of various gender / sexual identity–based networks • Internet, mobile phone-based dating common • Sex between tourists and tourist guides (*lapkas*) common	•600-700 effeminate (*Baijis, Bilias*) and other MSM (including *Giriyas*) from lower income groups estimated • 50-60 Helicopters estimated • 100-150 Hijras estimated, 25% of whom sell sex	• Parks, tourist sites, public toilets in evenings, e-forums	• Astitva Sansthan, STI clinic run by Apollo Tyres
10	Chittaurgarh	• Significant youth populations among MSM and TG populations • Districts has several tribal populations	• Estimates not available	• Through youth networks • Personal contacts play role in access	• Oxfam GB – supported youth sexual health projects that also cater to MSM

Enumeration data in **Tables I** and **II** on MSM, Hijra and other TG populations from all sources, including the situational analysis conducted by SAATHII, are largely indicative and partial. As said earlier, most efforts at mapping MSM, Hijra and other TG populations in Rajasthan (as in most other parts of the country)

have run into data collection hurdles. Stigma and discrimination leading to invisibility, denial and silencing has often lead to confusing information, which is impossible to verify in a short rapid assessment.

The solution clearly lies in more time and financial resources being allocated to mapping exercises that initially focus on strong rapport building with the populations to be studied. In that sense, the strength of the study conducted by SAATHII and Oxfam GB lies in having been conducted by trained individuals from MSM and TG communities, who were able to build a quick rapport with the respondents and empathize with their social situation. Enumeration data estimated during the Local Level Consultations through group work also involved community representatives with considerable field knowledge and experience.

Section III of this document elaborates on comprehensive mapping strategies that place greater premium on developing long term rapport building with the populations to be studied.

Section III

Recommended Action Points for HIV Response Strategy

Findings of the initial situational analysis and proceedings of the two Local Level Consultations have been assimilated with the State Level Consultation inputs to inform the strategy sequence presented in this section. Group work among the participants at the State Level Consultation yielded many of the inputs. Major action points mentioned by Dr. Moti Lal Jain, the then Project Director, RSACS (currently Director of Public Health, Directorate of Medical and Health Services, Rajasthan) have also been included. Key inputs were provided by Mr. Rajiv Dua of Oxfam GB during Local Level Consultations on strategies for mapping, TI programme design and principles of transfer of TI management from NGOs to CBOs (as envisaged under NACP - III).

Section 3.1: Fundamental Principles for the Response Strategy

1. Involvement and leadership of MSM, Hijra and other TG communities and their capacity building should be central to the response.
2. The response should include multi-stakeholder involvement based on careful primary and secondary stakeholder analysis, and should facilitate mutual rapport and trust among all stakeholders.
3. The response should not shy away from debate, discussion and information dissemination on gender, sex and sexuality, and practice of all kinds of sexual behaviours, attendant risks involved in terms of STI/HIV infection and possible means of risk reduction. The role played by cultural norms around these issues in increasing or decreasing the risks of STI/HIV infection should be discussed and factored into the response. This would allow for clearer understanding and empathy with issues involved, including issues of stigma and discrimination.
4. There should be wide sharing and dissemination of the response strategy to invite suggestions for further improvements, and for providing precedents to other states of India where similar strategies are needed.
5. Maximum and optimal utilization of resources available should be ensured, with every effort made to divert resources from surplus to deficit areas.

Section 3.2: Structural Recommendations for the Response Strategy

1. **Key recommendation:** Establishment of a State Resource Centre (SRC) on MSM, Hijra and other TG issues. Such a centre would include state and national level experts among its staff, consultants and panel of advisors. It would have representation of leadership from the communities concerned and PLHIV networks in the state. The SRC could be a dedicated unit within the Technical Support Unit (TSU) to be set up under NACP - III as a technical assistance partner to RSACS. Clear terms of reference would have to be developed for the SRC's functioning.

2. **Potential responsibilities of the proposed SRC:**

a) First step: Building capacity of RSACS officials on gender, sexuality, human rights, sexual health, STI/HIV/AIDS and key enabling environment issues that concern MSM, Hijras and other TG people in Rajasthan. This process would also improve links between RSACS and the communities concerned.

b) Preparation of a continuously evolving list of informal networks and CBOs of MSM, Hijras and other TG people in Rajasthan, and NGOs working with or planning to work with these populations in the state. Data provided in this document would be helpful in starting such a list. The main purpose of preparing the list would be to undertake leadership development in the networks, CBOs and NGOs identified.

c) Comprehensive mapping of MSM, Hijra, other TG populations in the state in preparation of scaling up existing TI programmes for these populations or starting new ones: As said earlier, such an exercise would include but not limit itself to enumeration, and also cover (i) Demographic, socio-economic and cultural profiling of the populations, (ii) Site mapping (listing the places, institutions, community forums and media through which the populations can be accessed), and (iii) Mapping information, health, legal, social support and related resources currently accessible to the populations concerned. Data in this document could provide a base for such a mapping exercise.

This exercise should ideally be carried out by the SRC team itself, though it might need to hire the services of a research agency. In either case, the research design, data collection, analysis and dissemination activities must involve trained representatives of MSM, Hijra and other TG communities. The personnel involved in the study detailed in this document were almost all from MSM and TG communities with considerable experience in social research on the communities concerned.

Strategy for mapping: Instead of the mapping strategies adopted so far by NACO, it was recommended that an **action research approach** be adopted for both mapping and subsequent TI programmes. CBOs and NGOs listed and provided leadership training by the SRC should be guided to undertake small scale action research projects. Rapport building with populations concerned and data generated through these projects would provide the groundwork needed for comprehensive mapping and full-fledged TI programmes. The action research approach is detailed in **Section 3.3:** "Methodology for Starting TI Programmes for MSM, Hijra and Other TG Populations".

d) Provision of technical assistance to RSACS, NGOs, CBOs for post-mapping implementation of full-fledged TI programmes.

e) Other key functions proposed for the SRC:

(i) Sensitization of medical and paramedical personnel in government and non-government sectors on gender-sexuality issues concerning MSM, Hijras and other TG people, and their right to non-discriminatory health services.[6]

(ii) In-depth training of medical and paramedical personnel on STI/HIV and other sexual health issues of particular concern to MSM, Hijras and other TG populations. Information provided by MSM and Hijras, **and** health personnel also indicates need for training the health personnel on diagnosis procedures that are gender, sexuality and socio-economic sensitive (asking the right questions in the right way).

(iii) Advocacy for improvement of medical curriculum in terms of the health issues mentioned in the previous point with state and national level ministries and other forums like medical associations. The SRC could also be a prime mover for a change in the national STI treatment guidelines, which are yet to adequately address oral and anal STIs that result from unprotected penile-oral and penile-anal sex, both male-to-male and male-to-female. However, since policy advocacy efforts of this kind take a long time to bear fruit, the SRC should also facilitate more immediate collaborations between individual government health services and civil society on STI/HIV and other health and development needs of the populations concerned.

(iv) Advocacy to ensure sensitive media coverage of gender and sexuality issues, and that progressive visibility of MSM, Hijras or other TG people takes off in the media in Rajasthan. The SRC would need to prepare the ground for regular advocacy efforts at a later stage by NGOs and CBOs.

Section 3.3: Methodology for Starting TI Programmes for MSM, Hijra and Other TG populations

1. In the absence of very many well established CBOs, most TI programmes for MSM, Hijras and other TG populations in Rajasthan are likely to be started by NGOs. But the programmes should always be community lead, and eventually implemented by CBOs.
2. CBOs and NGOs, whether new or old, must undergo leadership training by the SRC before being entrusted with the task of starting and implementing TI programmes – refer to **point 2 (b)** in **Section 3.2.** This requirement should apply also to NGOs and CBOs already implementing TI programmes, and expecting an extension of funding support from RSACS under NACP - III.
3. Agencies implementing TI programmes should determine their working areas based on field knowledge derived from programme or research experience. The working areas should not be limited to urban centres. If relevant, they should extend to the block and village levels as well.[7] All working areas should be decided on in consultation with RSACS, the SRC and other agencies implementing TI programmes based on mutual coordination.
4. After determination of working areas, detailed stakeholder analysis should be undertaken by the agencies concerned. They should also undergo initial training in areas crucial for implementing TI programmes. Training should enhance their knowledge about key thematic issues – gender, sexuality, human rights, sexual health and HIV/AIDS, as well as skills like outreach, counselling, managing referral systems, documentation and basic programme

and organizational management (including financial management). The SRC should take the lead in providing training and stakeholder analysis support.

5. Completion of initial training and stakeholder analysis would indicate an agency's readiness to implement a TI programme. The SRC should now guide the agencies concerned to initiate small scale **action research projects** or pilot TI programmes, each **six months** long in duration.

6. An action research or pilot TI programme should emphasize on **community support services** as follows**:**

   a) One-to-one and one-to-many inter-personal **outreach** among MSM, Hijra and other TG populations towards:

   - **Community mobilization** (befriending, gradually spreading information on the TI programme, encouraging individuals to network and keep in touch with each other, and identifying individuals with potential to become peer educators, outreach workers or even community leaders)

   - **Awareness generation** on key thematic issues and friendly counselling to address simple queries, doubts and myths. Educational literature, if any is distributed, should have minimal text and informative though culturally acceptable illustrations on issues like safer sex

   - Distribution of **condoms and lubes** (free distribution) and providing tips for proper usage

   - **Making referrals** for STI/HIV/AIDS counselling, testing and treatment

   - Making referrals for psycho-social counselling, legal aid, livelihood options

   b) Drop-in centres for meetings; group discussions; interactive sexual health infotainment activities like screening of films, role playing and use of material like flip charts that can afford to have more detailed illustrations compared to material distributed through inter-personal outreach; friendly counselling; making referrals; and running a library. Distribution of condoms and lubes, and demonstration of proper usage on penis models can also be undertaken.

   c) Organizing **community networking events** like cultural performances, film screenings and excursions, initially mainly for the MSM, Hijra and other TG communities, gradually involving other friendly stakeholders as well.

   d) Rapport building with immediate secondary stakeholders: Counsellors, doctors, lawyers, supportive media persons, social workers, PLHIV networks and local police stations. If possible, rapport should be built with the police, guards of parks, tourist guides, Hijra Gurus and MSM with leadership potential to ensure street level security against homophobic or transphobic violence, snatchers, harassers and prevent intra-community violence.

7. A small scale TI programme designed as above would help develop a strong rapport with the populations concerned. It would also generate significant **quantitative data** on services provided, and **qualitative data** on successes and failures during the action research phase. All such data should be

meticulously documented. These factors together would enable richer data collection in subsequent comprehensive mapping studies.

8. For the next step – **comprehensive mapping studies** – the SRC would short list NGOs and CBOs on the basis of their performance during the action research. Thus not all NGOs and CBOs that undertake action research, would be involved in the subsequent steps. Agencies left out might need further training, and the SRC and RSACS would decide how and when they should be involved further in the response process discussed here.

   Other key aspects of comprehensive and participatory mapping have been detailed in **Section 3.2, point 2 (c).** Additionally, the duration of mapping work should be at least two to three months. The rapport built with the populations concerned during the action research phase would help in speedier data collection. Yet, adequate time and human resources should be devoted for both data collection and data validation (cross-verification).

9. After comprehensive mapping conducted by the SRC, it would be the turn of the NGOs and CBOs involved in the mapping to undertake rapid **baseline sexual health needs assessments** (KABP studies) specific to their working areas. The SRC would provide technical oversight for these studies. Data from these studies, the action research and the mapping exercise would be collated for designing full-fledged TI programmes, determining their potential coverage and estimating the financial resources needed for the programmes.

10. The stage would now be set for scaling up the small scale action research projects or pilot programmes into **full-fledged TI programmes**. All NGOs and CBOs that have been through the mapping study and sexual health needs assessment would be provided refresher training by the SRC on issues and skills needed for implementing scaled up TI programmes for MSM, Hijras and other TG populations. This training would include a second round of stakeholder analysis for multi-pronged advocacy.[8]

    Such advocacy should include interaction with secondary stakeholders at the highest levels (leadership of government, political parties, bilateral and multilateral bodies, and national / international foundations that provide funding) for greater allocation of financial and technical resources to health programmes meant for MSM, Hijras and other TG populations.

11. **Prioritization of populations:** It was recommended that Hijras, male and TG sex workers, and other MSM or TG people practicing multi-partner un-protected penetrative sex were the most vulnerable to STI/HIV infection and in need of priority coverage through full-fledged TI programmes.

12. **Key requirements of full-fledged TI programmes:** Under NACP - II, most TI programmes for MSM and TG people focussed on a limited set of activities. Typically, maximum emphasis was put on outreach for community mobilization, awareness generation (IEC material), condom distribution and STI/HIV/AIDS counselling, testing, treatment referrals. Advocacy for creation of an enabling environment usually meant only sensitization workshops with a few stakeholders. Documentation, monitoring and evaluation activities were

given limited emphasis. Most TI programmes failed to reach out to Hijras. But the HIV response strategy recommended for MSM and Hijras in Rajasthan emphasizes on the following **additional features:**

a) Creation of enabling environment must cover issues of mental and general health, livelihood, education, legal reforms (revision of Sections 292 and 377, Indian Penal Code)[9], short stay homes or shelters and other social security aspects. In the case of Hijras or other TG people, issues of informed SRS and hormonal intake for breast enlargement must be addressed. Evidence-based advocacy would be needed on these issues with key secondary stakeholders.

b) Establishment of a mix of community-based (exclusive) STI clinics and VCCTCs **and** referral linkages with government and private agencies for STI/HIV/AIDS related services.[10]

c) The community-based STI clinics and VCCTCs can be housed within drop-in centres as described in point **Section 3.3, point 6 (b).** These drop-in centres can also function as hubs for coordinating the outreach, community mobilization, networking, general health, psycho-social counselling, advocacy and training activities, and provide a physical infrastructure base for the TI programmes.[11] The NACP – III plan document also considers drop-in centres as a standard feature of TI programmes for most vulnerable populations.

d) Capacity must be built in the TI programmes for provision of home based care, support and treatment to MSM, Hijras and other TG people living with HIV. Referral linkages with community care centres, short stay homes and government ART centres must also be developed.

e) Process documentation, financial management, monitoring and evaluation work should be rigorous. Monitoring and evaluation must involve meaningful community participation, and include regular midline sexual health needs assessments to measure progress vis-à-vis the baseline data.

f) BCC should be seen as the bedrock of the entire TI programme. Whether it is encouraging safer sex among the primary stakeholders or reducing stigma and discrimination among secondary stakeholders, what is being attempted is behaviour change. Therefore BCC or IEC material should be well-researched and pre-tested thoroughly before production and dissemination. Besides, such material should not be only in printed media. There would be significant scope also for development of audio-visual and theatre-based material.

Please refer to **Appendix IX: SAATHII TI Programme Model** for a graphic illustration of what an ideal TI programme for MSM, Hijras and other TG populations (or other vulnerable populations) should consist of.[12]

13. **Four issues of caution** were raised by participants in the consultations:

a) Separate TI programmes might be needed and viable for MSM and Hijras. There might also be a case for certain TI facilities to be provided exclusively to MSM and Hijras living with HIV. But separate programmes for male or Hijra sex workers are unlikely to be feasible as it would be very difficult to segregate

MSM and Hijras who practice commercial sex from those who do not. The two sub-populations usually display considerable fluidity in their practices and do not seem to have clear demarcations.

b) Funds for TI programmes for MSM, Hijras or other TG populations should ideally be provided only to NGOs and CBOs that would implement exclusive TI programmes for these populations. Agencies working with other male populations like street children, truckers and migrants should not have access to these funds. They should access funds that are more specific to their activities. However, there should be referral and information / experience sharing linkages between the two sets of agencies.

c) Rajasthan lacks HIV Sentinel Surveillance sites that would measure HIV prevalence among MSM, Hijras and other TG populations. **Baseline data on HIV prevalence** among these populations is needed urgently to set targets for prevalence reduction and proportional allocation of financial resources to TI programmes for the populations in question. The SRC should assist RSACS in identifying the sites and NGOs / CBOs who would partner RSACS in the surveillance, which should take place parallel to the sexual health needs assessments prior to the start of full-fledged TI programmes.

d) Good practices with regard to data collection based on informed consent, data confidentiality and ethical use of data should be identified and applied rigorously in all research undertaken as part of the HIV response strategy.

Section 3.4: Principles for Transfer of TI Programme Management from NGOs to CBOs

In keeping with NACP – III plans to provide a central role for CBOs of vulnerable populations in the national HIV response, it was recommended that even if a TI programme is initiated by an NGO, the implementation must always involve community representatives in key positions in the programme staff. In addition, the NGO must nurture and support the growth of a CBO that would take over the management of the programme in two years time. After two years, the role of the NGOs would change to that of capacity builders for the partner CBO, and possibly developing more CBOs. The time of two years would be calculated from the start of a full-fledged TI programme.

The consultations for the HIV response strategy also yielded a **set of indicators** to be used by RSACS and SRC to determine programme management transfer:

1. **Indicators for checking NGO performance to decide on programme management transfer in two years time:**

   a) Agenda or purpose of the partner CBO and the TI programme is articulated clearly by key CBO members

   b) There is visible, aware and motivated leadership for the partner CBO

   c) Number of active CBO members is at least 20, who are able to reach out to more than 500 individuals. The reach of the CBO is spread across both urban

and rural areas and covers at least a few blocks. The reach has proportional representation, that is, it is not biased towards any one or two areas

d) Drop-in centre for the TI programme is functional with key information, friendly counselling and health services, and is centrally located. It is close to or is part of an office space that has facilities for administrative, financial and programmatic management, and for conducting training activities

e) The partner CBO is registered as a Society or Trust

2. **Indicators for assessing CBO readiness to take over programme management in two years time:**

   a) All active CBO members are aware and articulate about their group's goal or purpose, objectives and activities, as well as that of the TI programme

   b) Documentation assessment reveals proper MIS maintenance and financial management of the TI programme. Documents to be checked for financial management: Vouchers, ledger, cash book, bank book, bank reconciliation statement, balance sheet, audit report, annual report and assets register

   c) Documentation assessment also shows that TI programme targets are being achieved as per agenda and timelines

   d) There is positive beneficiary response to the services of the TI programme (to be determined through a feedback survey)

3. If the NGO and CBO concerned are unable to show a credible performance as per the indicators mentioned, funding support to their TI programme should be withdrawn by RSACS. Such a course of action would be justified given that the agencies concerned would have failed even after being through two rounds of training and stakeholder analysis, an action research, a comprehensive mapping exercise, a sexual health needs assessment and two years of running a full-fledged TI programme.[13] The funding support withdrawn by RSACS should be diverted to other NGOs / CBOs running better TI programmes.

4. A related issue would be repetition of the strategy sequence described in this section. The SRC and RSACS would need to decide on a timeframe within which the strategy sequence would be repeated with a new set of NGOs and CBOs to cover geographical areas and population sub-sections not addressed by existing TI programmes. Agencies left out after the action research phase or at the stage of determining programme management transfer from NGOs to CBOs can also be considered for inclusion in the new sequence. At the same time, agencies already on the path of successful progamme implementation should be monitored, evaluated and enabled to continue work effectively.

Section 3.5: Alternative or Parallel HIV Response Strategies

Some participants in the consultations felt that a sole focus on a TI approach for highly stigmatized populations like MSM, Hijras and other TG people that are difficult to access, mobilize and organize would not be appropriate. There were recommendations for alternative approaches or strategies that can be adopted

parallel to the traditional TI approach, without sacrificing on the fundamental principles of the response strategy:

1. Many MSM and TG people do not want to set up a formalized structure like a CBO out of fear of visibility and worsening of discrimination faced. As a way out, it might be better to initiate **youth sexual health programmes,** which could also cover youth who practice male-to-male sex. As an example, an Oxfam GB supported youth resource centre in Chittaurgarh district was highlighted. The centre had managed to provide health services to MSM and TG people in the district through services for youth in general.

   Such a "non-targeted" strategy focussed on the youth would also be in keeping with the large youth population in the state, and its vulnerability to STI/HIV infection because of absence of reproductive and sexual health education and socio-cultural factors like early sexual initiation through early marriage.

2. MSM, Hijras and other TG people who are "hidden" and not accessible at or through any known place, institution or forum, can be covered through **mass communication campaigns.** Such campaigns should spread information through various forms of mass media on the risks of STI and HIV infection through unprotected penetrative male-to-male sex[14], and publicize contact information of relevant government and non-government health services. The campaigns should emphasize on the right to life and health of each individual, and ensure that the health services publicized would maintain the highest standards of ethics of consent, confidentiality and non-discrimination.

   Mass communication campaigns for covering "hidden" MSM populations are gaining significance internationally. Within India, the experience of NGOs like Thoughtshop Foundation and SAATHII in successfully reaching out to MSM and TG people through mass media campaigns in West Bengal should be studied for possible replication.

   A mass communication approach that includes male-to-male sex would offer possibilities for wide coverage at considerably lower costs (in comparison with focussed, limited coverage campaigns undertaken in most TI programmes), and enable mainstreaming of issues around male-to-male sex.

Section 3.6: Recommendations for Immediate Next Steps

1. RSACS to examine findings and strategies proposed in the document and decide on their applicability to the Rajasthan State PIP (2006).
2. Presentation of the document to NACO for comments and consideration of recommendations contained herein towards inclusion in NACP – III.
3. Preparation of an operational plan to act on findings and strategies endorsed by RSACS and NACO.
4. Dissemination of this document among government, bilateral / multilateral and civil society stakeholders for potential replication in other parts of India.

Section IV

End Notes

[1] The mining industry in Rajasthan employs a large number of migrants, and should be considered as a key stakeholder in the HIV response strategy for both migrant and MSM, Hijra and other TG populations.

[2] "Homosexual Activity Among Rural Indian Men: Implications for HIV Interventions", Ravi Kumar Verma and Martine Collumbien, "AIDS", 18:1845-1856, International AIDS Society, San Francisco, 2004. Please refer to the Literature Review Report in **Appendix I.**

[3] Indian Institute of Development and Communication baseline study, 2005

[4] RSACS data for 2006-07 from 40 government VCCTCs across the state shows that 21,366 males and 12,793 females were tested for HIV. As many as 2,497 males and 1,430 females tested HIV positive. Only 10 males were reported to have been infected through male-to-male sex. These figures need careful analysis. It is well known that male-to-female HIV sexual transmission takes place more easily than female-to-male sexual transmission. Yet, the number of males testing HIV positive is far higher than females. A partial explanation may lie in the fact that males have much easier access to health services and far more number of males were tested for HIV. However, it is possible that male-to-male sexual transmission is also contributing to high HIV prevalence among males. The situational analysis detailed in this document has clearly shown the high vulnerability of MSM, Hijras and other TG people to STI/HIV infection. Given these factors, it is probable that the figure of 10 cases of male-to-male sexual transmission is a serious under-estimation. Extreme stigma attached to male-to-male sex may be preventing the clients from a frank sharing of their sexual behaviours. Counsellors and technicians at the VCCTCs and NGOs need to be sensitized and trained to ask the "right questions in the right way", to get a more accurate picture of the HIV transmission scenario in Rajasthan. This situation, however, is not unique to Rajasthan and is prevalent in other states also.

[5] As of 2006-07, the two exclusive TI programmes were being run by Indian Institute of Development and Communication, Jaipur and Maharshi Dayanand Vikas Samiti, Ganganagar. But while this document was being prepared, some changes in this regard were imminent. It should also be noted that Indian Institute of Development and Communication provided an estimate of MSM and Hijra populations in Jaipur district that was much higher than the total coverage through all the TI programmes **(Section 2.3).**

[6] In August 2007, the Medical Council of India (MCI) notified the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. These regulations prescribe acts of commission and omission on the part of a physician that are construed as misconduct and unethical. The MCI or appropriate State Medical Councils have been empowered to take disciplinary action against a physician for violation of the regulations. This development would provide an opportunity for the SRC to tackle discrimination faced by MSM and Hijras in health settings in Rajasthan. Refer: http://pib.nic.in/release/release.asp?relid=30760.

[7] In most cases, the relevance is likely to be there as many MSM and Hijras served by TI programmes in urban centres have rural linkages, and may even have permanent residences in rural areas.

[8] The first round of training and stakeholder analysis would have been undertaken prior to the action research phase.

[9] Section 292 penalizes obscenity but defines it in vague terms, which leaves room for sexual health educational literature to be termed as obscene. Section 377 criminalizes male-to-male sex, creating a legal environment that adds to the severe social stigma already attached to sex and sexuality in general, and MSM, Hijras and other TG people in particular.

[10] This recommendation was worked out as a middle ground between supporters of "only community-based services" and "only referral-based services". Interestingly, proponents of both

approaches based their arguments on the grounds of tackling stigma and discrimination. Those emphasizing community-based services argued that both government and private sector health services accessed by general populations were extremely discriminatory, and therefore there was need for exclusive services. The other side felt that exclusive services would run the danger of being singled out as services meant only for "sexual deviants", and thereby worsen the situation of stigma and discrimination. They argued in favour of strong advocacy efforts with all health services to reduce stigma and discrimination.

The middle ground argument was based on the realization that community-based services were needed while advocacy efforts elsewhere continued. At the same time, community-based services alone would not be enough to cater to the entire population in need of STI/HIV/AIDS services in a state as big as Rajasthan. Additional to the development of referral linkages, it was suggested that "community guides" should be based in STI clinics and VCCTCs in at least the government health services – to assist individuals through the counselling, testing and treatment formalities and counter any incidents of discrimination.

[11] Administrative and financial activities of the TI programmes may have to be carried out from different premises, or from rooms clearly demarcated from those meant for programmatic activities in the same premises.

[12] More details on standard features of TI programmes for most-at risk or vulnerable populations can be accessed from the NACP – III plan document and operational guidelines.

[13] This recommendation underlined the significance accorded to community building. If an NGO (or CBO) is not able to ensure a satisfactory performance on the most fundamental aspects of community building and programme management, it should not have the mandate to run a TI programme for the beneficiary communities concerned.

[14] The risk of unprotected anal sex should be highlighted in both male-to-male and male-to-female sexual relations.