Building the Capacity of People Living with HIV and Sexual Minorities in Orissa and West Bengal to Advance their Health and Rights

Policy Brief

Health Policies and Sexual and Reproductive Health Needs of People Living with HIV and Sexual Minorities in Orissa and West Bengal

A SAATHII Project in Partnership with Interact Worldwide, London and Funded by the Department for International Development – Civil Society Challenge Fund, Glasgow

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Report Prepared by Lead Consultant
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# Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADMO</td>
<td>Additional District Medical Officer</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwife</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>ARSH</td>
<td>Adolescent Reproductive and Sexual Health</td>
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<td>ASHA</td>
<td>Accredited Social Health Activist</td>
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<td>AWW</td>
<td>Anganwadi Worker</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>BSS</td>
<td>Behavioural Surveillance Survey</td>
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<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
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<tr>
<td>CCC</td>
<td>Community Care Centre</td>
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<tr>
<td>CDMO</td>
<td>Chief District Medical Officer</td>
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<tr>
<td>CHC</td>
<td>Community Health Centre</td>
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<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>CRBG</td>
<td>Coalition of Rights Based Groups</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
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<tr>
<td>DAPCU</td>
<td>District AIDS Prevention and Control Unit</td>
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<tr>
<td>DFID-CSCF</td>
<td>Department for International Development – Civil Society Challenge Fund</td>
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<tr>
<td>DHM</td>
<td>District Health Mission</td>
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<tr>
<td>DHS</td>
<td>District Health Society</td>
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<tr>
<td>DLN</td>
<td>District Level (PLHIV) Network</td>
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<td>DoHFW</td>
<td>Department of Health and Family Welfare</td>
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<tr>
<td>DOTS</td>
<td>Directly Observed Treatment – Supervised [TB]</td>
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<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
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<tr>
<td>EPC</td>
<td>Empowered Programme Committee</td>
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<tr>
<td>FRUs</td>
<td>First Referral Units</td>
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<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
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<tr>
<td>GFATM</td>
<td>Global Fund for AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>GIPA</td>
<td>Greater Involvement of People Living with HIV/AIDS</td>
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<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
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<tr>
<td>HRG</td>
<td>High Risk Group</td>
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<tr>
<td>ICTC</td>
<td>Integrated Counselling and Testing Centre</td>
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<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
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<td>INP+</td>
<td>Indian Network for People Living with HIV/AIDS</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>IUD</td>
<td>Intra Uterine Device</td>
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<td>JPMC</td>
<td>Joint Planning and Monitoring Committee</td>
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<td>MMR</td>
<td>Maternal Mortality Rate</td>
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<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MPW</td>
<td>Multipurpose Health Worker</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
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<td>MSG</td>
<td>Mission Steering Group</td>
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<td>MTP</td>
<td>Medical Termination of Pregnancy</td>
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<td>NACO</td>
<td>National AIDS Control Organisation</td>
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<td>NACP</td>
<td>National AIDS Control Programme</td>
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<td>NGO</td>
<td>Non-governmental Organisation</td>
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<td>NNCC</td>
<td>NACP-NRHM Coordination Committee</td>
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<tr>
<td>NRHM</td>
<td>National Rural Health Mission</td>
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<tr>
<td>OI</td>
<td>Opportunistic Infection</td>
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<tr>
<td>PHC</td>
<td>Primary Health Centre</td>
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<tr>
<td>PIP</td>
<td>Programme Implementation Plan</td>
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<tr>
<td>Abbreviation</td>
<td>Full Expression</td>
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<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>PPTCT</td>
<td>Prevention of Parent to Child Transmission</td>
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<td>RCH</td>
<td>Reproductive and Child Health</td>
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<tr>
<td>RNTCP</td>
<td>Revised National TB Control Programme</td>
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<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
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<tr>
<td>SACS</td>
<td>State AIDS Control Society</td>
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<tr>
<td>SHM</td>
<td>State Health Mission</td>
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<tr>
<td>SHS</td>
<td>State Health Society</td>
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<tr>
<td>SRS</td>
<td>Sexual Reassignment Surgery</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
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<tr>
<td>TG</td>
<td>Transgender (Abbreviation ‘TG’ has been used where only male-to-female transgender people are implied, otherwise full expression has been used)</td>
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<tr>
<td>TI</td>
<td>(STI/HIV) Targeted Intervention (Programme)</td>
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<td>TSU</td>
<td>Technical Support Unit</td>
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Executive Summary

I. BACKGROUND AND PURPOSE: This policy research was conducted in the context of a collaboration between SAATHII, Interact Worldwide and DFID-CSCF titled ‘Building the Capacity of People Living with HIV and Sexual Minorities in Orissa and West Bengal to Advance their Health and Rights’ (in brief, ‘Coalition Based Advocacy Project’). The project aims to contribute to poverty reduction through improved health equity for sexual minorities and people living with HIV (PLHIV), particularly in relation to sexual and reproductive health (SRH) and HIV.

A key component of the project is creation and strengthening of civil society coalitions that advocate for the rights of sexual minorities and PLHIV in Orissa and West Bengal, and monitor and enforce implementation and development of relevant policies. In March 2009, the project facilitated the start of Sampark coalition in Orissa and the Coalition of Rights Based Groups (CRBG) in West Bengal. This study is intended to provide an evidence base for advocacy efforts of these coalitions to improve the SRH status of PLHIV and sexual minorities and to promote their rights to life and health.

In India, addressing the health needs of PLHIV and sexual minority groups such as men who have sex with men (MSM), Hijras and other male-to-female transgender (TG) people has been the responsibility of primarily the Department of AIDS Control, National AIDS Control Organisation (NACO). In addition to the current third phase of the National AIDS Control Programme (NACP-III), other long-term vertical programmes such as Reproductive and Child Health programme (RCH – Second Phase or RCH-II) that are part of the National Rural Health Mission (NRHM) should also ideally meet the specific needs of these populations.

The purpose of this policy research is to assess to what extent the SRH and HIV needs and rights of PLHIV and sexual minorities are addressed in the current national policies and programmes (NACP-III, RCH-II/NRHM), and to put forward recommendations for advocacy efforts.

II. METHODOLOGY: Three data sources were used: (1) Review of key policy and programme documents (related to NACP-III and RCH-II/NRHM); (2) Qualitative research data from key informant interviews; and (3) Qualitative data from stakeholder consultation meetings.

A. Review of key documents: The key documents that were reviewed include: Government policy documents (NACP-III, RCH-II and NRHM) at the national, state and district levels and mid-term evaluation reports of the national programmes (NACP-III and RCH-II/NRHM); peer-reviewed academic journal articles that focus on HIV, and health policies and health systems in India (past six years); and data and reports from non-governmental organisations (NGOs) and community-based organisations (CBOs). Documents were analysed and synthesised in relation to the following focus areas:

1. To what extent have the SRH and HIV needs of PLHIV and sexual minorities been addressed in NACP-III, and RCH-II/NRHM?
2. What has been mentioned about creating an enabling environment for PLHIV and sexual minorities in the national policies; and what has been done so far?
3. What are the proposed coordination mechanisms between NACP-III, RCH-II and NRHM at the national, state and district levels?
4. What type of support (funding and technical) is proposed and available for sexual minority CBOs and PLHIV networks in NACP-III, RCH-II and NRHM?
5. How are the representatives from PLHIV and sexual minority communities involved in decision-making processes at the national, state, and district levels in the programmes of NACO and RCH-II/NRHM?

B. Qualitative research: Key informant interviews (n=12) were conducted to understand to what extent the existing policies have been implemented on the ground (progress and challenges); identify gaps in the policies; and what changes they would like to see in the policies and implementation process. Key informants included SACS officials of Orissa and West Bengal, officials of Technical Support Units of Orissa and West Benga SACS, PLHIV network leaders, leaders of CBOs working with sexual minorities, and key staff of PLHIV networks and CBOs.
C. Consultation meetings with the coalitions: Key findings of the study were presented in consultation meetings with the two coalitions organised by SAATHII. Comments and suggestions from the meetings were considered as ‘feedback data’ and analysed.

III. KEY FINDINGS

A. CURRENT POLICIES AND PROGRAMMES

1. National AIDS Control Programme (NACP-III): The primary goal is to halt and reverse the epidemic over five years (2007-2012). Two (of the four) key objectives are: (1) Prevention of new HIV infections through saturation of coverage of ‘high risk groups’ (HRGs) with targeted interventions (TIs); and (2) Providing greater HIV care, support and treatment to PLHIV. NACO in Delhi under the Department for AIDS Control, Ministry of Health and Family Welfare, is the authority that manages NACP-III. At the state level, State AIDS Control Societies (SACS) are responsible for implementing the HIV programme.

2. National Rural Health Mission and Reproductive and Child Health Programme: The National Rural Health Mission (NRHM) was launched in April 2005 with a goal to improve the availability of and access to quality health care, especially for those who are residing in rural areas. NRHM covers the entire country, with special focus on 18 states, which have weak public health indicators or weak health infrastructure. NRHM subsumes key national programmes including the second phase of the Reproductive and Child Health programme (RCH-II). RCH-II mainly focuses on reducing the maternal mortality ratio, infant mortality rate and total fertility rate. In addition, it also aims to increase the couple protection rate and the coverage of children through immunization.

B. GAPS IN NACP-III

1. Several gaps exist in programme implementation and programme strategies

   a) PLHIV, including MSM, Hijras and TG people living with HIV, face barriers to ART and ART-related services: Though the scale up of antiretroviral therapy (ART) has been considerable, NACO reports that in 2009 only 45% of adults with advanced HIV were receiving ART. PLHIV from marginalized (or HRG) communities such as sex workers, injecting drug users, MSM, Hijras and TG persons face significant barriers in accessing free ART services. Several barriers for PLHIV who require second-line ART are also reported that include long waiting period, high cost, and lack of free ARV drug resistance testing and viral load testing.

   b) Lack of MSM/TG subgroup-specific approaches: Though NACP-III specifically mentions ‘differentiated outreach based on risk and typology [of MSM/TG]’, there has been no change or modification in the intervention components or approaches to reach out to and provide tailored services for MSM sub-populations like Double Deckers and Panthis, and no specific guidelines for Hijra and TG populations.

   c) Limited distribution of water-based lubricants: Often the budget for water-based lubricants in a TI project meant for MSM, Hijra and TG populations is insufficient to meet the lubricant needs of all individuals covered by that project.

   d) Needs of same-sex attracted and TG adolescents are not addressed: Implementers of TI projects for MSM and TG people are hesitant to provide HIV prevention services to those who are below 18 years old because of legal implications.

   e) Lack of positive prevention programmes for PLHIV: The NACP-III plan does not contain any definition of what is meant by ‘positive prevention’ (HIV prevention among PLHIV) and does not articulate the components of positive prevention.

   f) HIV prevention interventions (TIs) primarily focus on individual level: NACP-III focuses primarily on individual level barriers when addressing sexual risk behaviours and promoting condom use. Interpersonal and structural level barriers are often not optimally addressed.
2. Lack of targets for service coverage for PLHIV and treatment coverage for MSM, Hijras and TG people: The current ‘coverage’ for MSM (and Hijras and TG people) in relation to HIV prevention as reported by the mid-term review of NACP-III was 77% as of October 2009, that is, 2.75 lakh (estimated population size 3.51 lakh). No explanations are available as to why the original plan of targeting 11.50 lakh individuals from these communities (out of a total estimate of 23.50 lakh) was scaled down. Similarly, there is no public information available on the number of PLHIV who are provided various services (other than ART) through NACP-III. Also, other than ART, no targets are set for services provided to PLHIV. Similarly, no targets are set for providing ART to MSM, Hijras or TG persons living with HIV.

3. Government needs to support more PLHIV networks and CBOs of MSM, Hijras and TG communities: At the end of October 2009, a total of 131 NACO-funded TI projects were working exclusively among MSM, Hijras and TG people nationally, but out of these only 37 TIs were managed by CBOs (against the NACP-III target of 300 CBO-lead TIs). NACO’s mid-term review of NACP-III also documented that across 20 states in Category ‘A’ and ‘B’ districts, 208 drop-in centres provided psychosocial support and referral services for PLHIV. Discussions with PLHIV network leaders pointed out that not all the district and state level PLHIV networks were being supported by SACS.

4. Creation of ‘enabling environment’ is yet to be fully realised: In NACP-III, the term ‘enabling environment’ is primarily used in the context of creating an environment to ensure smooth provision of HIV prevention services for key populations. In July 2009, the Delhi High Court ruled that consensual same-sex relations between adults in private cannot be criminalized. It is yet to be seen how far that ruling has improved access to HIV and other services for MSM, Hijras and TG people. For protecting the rights of PLHIV and marginalized communities including MSM and TG people, an HIV/AIDS Bill was drafted by NACO and this Bill is expected to be tabled in the Parliament. In the meantime, a variety of forms of discrimination against PLHIV in diverse settings – home, health care settings and larger society – continue to be reported. MSM, Hijras and TG people also face various forms of stigma and discrimination from the family and society and in health care settings. A comprehensive stigma reduction plan for PLHIV and sexual minorities is still not available.

5. Limited involvement of PLHIV and sexual minorities in decision-making processes: PLHIV are rarely involved meaningfully in the decision-making processes and even if PLHIV are in the decision-making bodies (such as ‘Executive Committees’ of SACS), there is no guarantee that their suggestions would actually be considered in decision-making. Though the universally accepted principle of Greater Involvement of People Living with HIV/AIDS (GIPA) refers to greater involvement of people living with and affected by HIV/AIDS – ‘affected’ referring to marginalised groups such as MSM, TG persons, drug users and sex workers – almost none of the Executive Committees in the SACS have representatives from these marginalised groups.

6. HIV-related issues of lesbian/bisexual women and female-to-male transgender people have been totally ignored: Nowhere in the national HIV policy and HIV strategic plan the terms ‘lesbian or bisexual women, female-to-male transgender people or transmen’ are found. It could be because of the perception among policymakers that these populations are relatively small and are not at risk for HIV.

C. GAPS IN SRH NEEDS

In general, in RCH-II/NRHM, the specific SRH needs of PLHIV and sexual minorities are not articulated.

1. SRH needs of PLHIV

a) Lack of comprehensive services for HIV serodiscordant and concordant couples: For both HIV seroconcordant and serodiscordant couples, there is a lack of pre-conception counselling that might help them in taking decisions about whether or not to have a baby and having a baby without infecting their partner (in case of HIV serodiscordant couples). Many HIV serodiscordant couples may not be aware of post-sexual exposure ARV prophylaxis (to prevent
HIV transmission to their partner) that could be initiated if a condom breaks. Sperm-washing and artificial insemination facilities are not available for free for HIV serodiscordant couples who wish to have their own baby.

b) Limited family planning options are offered to PLHIV: Many PLHIV are unlikely to be aware of the various family planning options available to them. One reason for this could be because of the limited options provided to PLHIV by the health care providers, with the counselling limited to discussion on only condoms – emphasizing prevention of HIV transmission to others, and not much discussion on other contraceptives (non-barrier methods).

c) SRH needs of HIV-positive adolescents are not articulated: As ART prolongs the lives of PLHIV, there is an emerging population of HIV-positive children who are now in their teens. Current adolescent reproductive and sexual Health (ARSH) strategies (including Anwesha clinics for adolescents) do not specifically address the unique challenges that health care providers face in providing appropriate SRH information and services to this population.

d) Limited capacity of health centres (PHCs/CHCs) to meet the SRH needs of PLHIV: The RCH-II programme has proposed to strengthen the capacities of Primary Health Centres (PHCs) and Community Health Centres (CHCs) to enable them to become sites for conducting deliveries and providing obstetric care for all complications. It is not clear whether the staff of PHCs and CHCs would be trained in conducting deliveries for HIV-positive women; and whether HIV testing facilities, ARVs and universal precaution kits would be available in all PHCs and CHCs. Current RCH training modules do not articulate specific SRH needs of PLHIV.

2. SRH needs of sexual minorities

RCH-II and NRHM are silent about the needs of sexual minorities. Nowhere in the RCH-II/NRHM documents and training modules one can find terms related to sexual minorities such as MSM or Hijras or transgender people.

a) Health needs of MSM, Hijra and TG populations are not articulated: These populations may be at risk of STIs and HIV if they have unprotected sex with men and women. While any type of STI can be contracted, certain STIs are more likely to be contracted through certain unprotected sexual practices. For example, the risk of getting hepatitis B virus infection is high with unprotected anal sex and that for hepatitis A virus infection with unprotected oral-anal sex (anilingus). Hepatitis B infection may later evolve into a chronic disease affecting the liver and also may lead to liver cancer. Similarly, some strains of the human papilloma virus that cause anal-genital warts may lead to anal cancer. Also, societal prejudice and discrimination have been linked to increased prevalence of mental health disorders among sexual minorities.

b) Health needs of lesbian/bisexual women and female-to-male transgender people are nowhere addressed: Lesbian and bisexual women face the same health issues as that of other women but also have specific health information and service needs. These include: Information on the health risks associated with certain sexual practices with women and men (STIs and HIV); information on cancer screening such as mammography (breast cancer screening) and pap smear (identification of precancerous lesions in the cervix); support for problematic use of alcohol, drug use, and smoking/tobacco use; support for mental health issues; and support services for intimate partner (same-sex or other-sex partner) violence. Some of the health needs related to female-to-male transgender people include: Information and services in relation to gender transition – masculinising procedures and sex change operation; pre- and post-gender transition counselling and support; and support for mental health issues.

c) SRH needs of same-sex attracted and transgender adolescents are not addressed: As same-sex attracted males grow up, some proportion of them may exhibit mannerisms and behaviours that would be labelled by the society as ‘feminine’. Thus, they face ridicule and teasing from their neighbours, school friends and relatives. Similar issues may be faced by other sexual minorities as they grow up. Currently there is a complete lack of correct and supportive information about same-sex sexuality or transgender issues in popular media or even from health care providers.
d) Need for standards of care for gender transition procedures (including sex change operation) for transgender people: Only one state in India, Tamil Nadu, has initiated free sexual reassignment surgery (SRS) in government hospitals – that too, only for Hijras and male-to-female TG people. No support from the government is available for feminising procedures (such as female hormonal treatment and electrolysis for facial hair removal). The government is silent on providing services such as free SRS and masculinising procedures for female-to-male transgender people.

e) Lack of legal recognition of same-sex marriage and marriage between transgender persons and men/women: All citizens including sexual minorities have the right to marry their partner of choice and to have legal recognition of that marriage. Even in the absence of legal recognition, some same-sex attracted people are getting ‘married’ to same-sex partners and some proportion of Hijras and TG persons get ‘married’ to their regular Panthi partners.

f) Ambiguity in legal recognition of gender identity of transgender people and Hijras and its relation to access to health services: Lack of legal recognition of the gender identity of transgender people (male-to-female and female-to-male) is a key barrier to exercising their rights related to marriage with a man/woman (where their ‘trans’ gender identity and not biological sex is primary), child adoption, inheritance, wills and trusts, employment, and access to public and private health services, and access to and use of social welfare and health insurance schemes.

Studies have documented that the Hijras felt humiliated on having to stand in a queue for males at hospitals and were laughed at by the co-patients in the queue. Also, Hijras have no say in deciding in which ward – male or female – they can stay as in-patients in hospitals. These experiences prevent Hijras from ever visiting government hospitals or repeating visits.

g) Marital counselling issues of couples in mixed sexual orientation marriages are not addressed: There is a huge unmet need for counselling support that should address a range of SRH-related topics of sexual minorities. Sometimes, same-sex or both-sex attracted men and TG persons may get married to women attributing family compulsions and other reasons for getting married to a woman. Some proportion of these married same-sex attracted men and TG persons may complain of sexual dysfunction with their wife and may not know how to deal with the issues they face. Men with a bisexual orientation and MSM or TG persons living with HIV may have a dilemma with regard to whether or not to get married and whether or how to disclose their sexuality and/or HIV status before marriage.

Some proportion of lesbians and bisexual women may be compelled or expected by their family members to get married to a man. Heterosexual spouses of sexual minority individuals may also require support in terms of how to deal with their situation, and take informed decisions.

h) Need to impart adequate knowledge on family planning options for married MSM and TG persons: Many married MSM and TG persons are largely unaware of the wide range of family planning options available for them and their spouses. Similar to heterosexual males, married MSM and TG persons do not want to undergo vasectomy due to a variety of reasons. Thus, it is important to educate married MSM and TG persons, just like heterosexual married men, about the need to take responsibility for family planning as well as remove any misconceptions about vasectomy.

IV. RECOMMENDATIONS

Based on the available evidence from this policy research, following recommendations are made to address the gaps in the current policies/programmes and implementation of current policies.

A. SRH AND HIV POLICIES AND PROGRAMMES

1. Policies

a) Develop a national policy on sexual and reproductive health and rights (SRHR) of PLHIV and sexual minorities, and implement that plan during the period of NACP-III, RCH-II/NRHM and
beyond. All national health-related plans (NACP, RCH, NRHM), in their next phases, need to specifically articulate how they are addressing the variety of health-related needs of all sexual minorities and PLHIV.

b) Recognise civil and legal rights of sexual minorities such as the right to same-sex marriage and the right to found a family - given the integral connection that exists between these rights and SRH.

c) Introduce the HIV/AIDS Bill in the Parliament and pass the Bill as a law to ensure protection of the health and rights of PLHIV and sexual minorities.

d) Ensure GIPA in designing and implementing SRH and HIV policies and programmes for PLHIV and sexual minorities. Involvement in decision-making processes needs to be at the national, state and district levels of the decision-making bodies of NACO and RCH/NRHM.

2. Programmes

a) Quicken the steps to strengthen the convergence of HIV services of NACP-III and SRH services of RCH-II/NRHM and ensure that the convergence addresses the specific needs of PLHIV and sexual minorities.

b) Develop specific outreach and communication strategies and guidelines for the various sub-groups of MSM, Hijras and TG people to ensure ‘differentiated outreach and communication strategy based on the risk and typology’ as articulated in NACP-III plan.

c) Take adequate steps to address the structural (policy and legal) and other contextual factors (societal stigma, community norms and relationship dynamics) that influence HIV vulnerability of MSM, Hijra, TG communities in addition to the behaviour change communication approach at the individual level.

d) Train health care providers on the SRH needs and rights of PLHIV and sexual minorities, and on offering counselling and clinical services in a non-judgemental and unbiased manner.

B. ADDRESS GAPS IN SRH AND HIV SERVICES

1. Provide essential information to PLHIV (including sexual minorities) on: Dual use of condoms (prevention of infection and pregnancy), use of dual methods (condoms and another contraceptive), safety of conception and child birth – sperm washing, artificial insemination, and in vitro fertilization as methods of assisted conception, caesarean section for child birth, unwanted/unintended pregnancy, contraceptive options including emergency contraception, and access to legal and safe abortion.

2. Provide risk reduction counselling and reproductive health services for HIV serodiscordant couples who wish to have their own baby.

3. Provide post-sexual exposure prophylaxis (of ARVs) for sexual minorities who experience sexual assault and for HIV serodiscordant couples in case of condom failure or accidental exposure (non-use of condoms).

4. Provide free gender transition procedures including sex change operation for transgender people – both male-to-female and female-to-male.

5. Promote safer sex behaviours among PLHIV (‘positive prevention’). Safer sex messages for PLHIV (including sexual minorities) need to focus on the benefits of consistent condom use with both infected and un-infected partners – which include prevention of re-infections and HIV super-infections, avoiding infection of drug-resistant strains, and STI prevention.

6. Involve HIV-positive men and married MSM and TG persons in family planning counselling to provide support to their spouse’s decisions on family planning and to offer information about male-specific permanent sterilization methods.

C. SUPPORT PLHIV NETWORKS AND CBOS WORKING WITH SEXUAL MINORITIES

1. Ensure that all the needy PLHIV networks at the district and state level are supported by NACO and SACS – regardless of the HIV prevalence category of the district. Support needs to be both in terms of funding as well as capacity building.

2. Support PLHIV networks and NGOs/CBOs working among marginalized communities to meet the unmet SRH needs of PLHIV and sexual minorities through the initiative in RCH-II/NRHM to engage civil society groups in providing family planning services.
D. RESEARCH GAPS AND PRIORITIES

1. Develop appropriate and sensitive measures to capture information about sexual orientation, behaviour and sexual and gender identities, and use those measures in population-based national health surveys to assess health status and identify health disparities, if any, among sexual minorities.

2. Plan and carry out longitudinal surveys that assess the health status and stigma and discrimination experienced by PLHIV and sexual minorities to inform health policies and programmes.
1. INTRODUCTION

The sexual and reproductive health (SRH) of people living with HIV (PLHIV) and sexual minorities is fundamental to their socio-economic and overall well-being and that of their sexual and romantic partners and children (WHO, 2006). Most women come to know of their HIV status when they become pregnant and access antenatal care (ANC) services, from which they are referred to integrated (HIV) counselling and testing centres for (ICTCs). In the National AIDS Control Programme – Phase III (NACP-III), the National AIDS Control Organisation (NACO) has planned to rapidly scale up prevention of parent-to-child transmission (PPTCT) services in India along with the ICTCs. Thus, more number of HIV-positive women is likely to be identified.

However, since the focus of the PPTCT programme is to prevent HIV transmission to the baby (as the name also suggests), the sexual and reproductive health and rights (SRHR) of HIV-positive women and men are often sidelined, misunderstood, or even not recognized (Guttmacher Institute, 2006; Chakrapani et al, 2007). Studies from other developing countries have documented several barriers for women and men living with HIV in accessing antenatal and family planning services (Baek & Rutenberg, 2005). In addition, as the health and well being of HIV-positive men and women improve due to antiretroviral treatment (ART) and management of opportunistic infections, PLHIV may consider or reconsider decisions regarding their sexual activity and reproduction.

Similarly, in India, interventions among men who have sex with men (MSM), Hijras and other male-to-female transgender (TG) people have focused primarily on HIV prevention and almost no specific interventions or services are available to address their larger SRH needs (Chakrapani et al, 2008a). Also, SRH services for other sexual minorities such as lesbian and bisexual women, and female-to-male transgender people are non-existent in the government programmes.

This policy research study was conducted in the context of a project titled ‘Building the Capacity of People Living with HIV and Sexual Minorities in Orissa and West Bengal to Advance their Health and Rights’ (for brevity, ‘Coalition Based Advocacy Project’). The project is a joint initiative of SAATHII (Kolkata and Bhubaneswar Offices) and Interact Worldwide, London, with funding support from Department for International Development – Civil Society Challenge Fund (DFID-CSCF), Glasgow. It aims to contribute to poverty reduction through improved health equity for sexual minorities and PLHIV, particularly in relation to SRH and HIV.

A key component of the project is creation and strengthening of civil society coalitions that advocate for the rights of sexual minorities and PLHIV in Orissa and West Bengal, and monitor and enforce implementation and development of relevant policies. In March 2009, the project facilitated the start of Sampark coalition in Orissa and the Coalition of Rights Based Groups (CRBG) in West Bengal. This study is intended to provide an evidence base for advocacy efforts of these coalitions to improve the SRH status of PLHIV and sexual minorities and to promote their rights to life and health.

India has a concentrated HIV epidemic – with about 0.3% of HIV prevalence among the general population and high HIV prevalence among certain marginalized populations. An estimated number of 2.31 million people are living with HIV in India. MSM, Hijras and TG people are designated ‘core high risk groups’ by NACO (NACO, 2007a), with HIV prevalence among these populations estimated at 7.3%, more than 20 times the general population rate (NACO, 2010). No government (NACO) data are publicly available on HIV prevalence separately among Hijras. However, two recent studies reported high HIV prevalence among them – 18% in four south Indian states (Brahmam et al, 2008) and 17% in Chennai (Saravanamurthy et al, 2010).
In India, addressing the needs of PLHIV and sexual minority groups such as MSM, Hijras and TG people has been the responsibility of primarily the Department of AIDS Control, NACO. In addition to the current third phase of NACP-III, other long-term vertical programmes such as Reproductive and Child Health Programme – Phase II (RCH-II) that are part of the National Rural Health Mission (NRHM) should also ideally meet the specific needs of these populations.

The Millennium Development Goals (MDGs)\(^\text{11}\) include eradication of extreme poverty, combating HIV/AIDS, promotion of maternal health and promotion of gender equality. Though the MDGs incorporate a target of universal access to SRH within the goal of improving maternal health, combating HIV remains separate – clubbed with combating malaria and tuberculosis. However, there has been an increasing attention towards the connections between SRHR and HIV\(^\text{12, 13}\) both within and outside United Nations agencies – especially in relation to SRHR of PLHIV\(^\text{14}\) and MSM\(^\text{15}\).

In India, a significant proportion of PLHIV belong to lower socioeconomic strata. Many have lost their capacity to earn adequate money due to ill health and/or due to money spent in getting treatment for HIV-related illnesses for themselves and their family members. Similarly, sexual minorities from certain sub-groups such as Kothi-identified MSM and Hijras often belong to lower socioeconomic strata and thus engage in sex work, which increases their vulnerability to HIV and STIs. Engaging in sex work is also consequent to lack of other job opportunities for Hijras due to their poor educational status and lack of support from their biological families. Many Hijras run away from their parents' home at a young age due to stigma and discrimination within their own families or from their neighbours and local communities – which explains the lower educational status of Hijra communities.

Several studies have documented that PLHIV, MSM, Hijras and TG people face several barriers in accessing health care services – including SRH services, a key reason being stigma and discrimination faced by them in the health care settings (Chakrapani et al, 2004\(^\text{16}\); 2007b\(^\text{17}\); 2008b\(^\text{18}\)). Thus, complex interconnections exist between poverty, stigma and discrimination, vulnerability to HIV and SRHR. These highlight the need to focus on promoting the SRHR of PLHIV and sexual minorities.

The purpose of this policy research is to assess to what extent the SRH and HIV needs and rights of PLHIV and sexual minorities are addressed in the current national policies and programmes (NACP-III and RCH-II/NRHM), and to put forward recommendations for advocacy efforts.

Appendix 1 lists the key SRHR needs of PLHIV and sexual minorities as articulated by the members of Sampark and CRBG in a joint meeting at Konark, Orissa, in September 2009. The need for this policy brief was also highlighted in the baseline study of the Coalition Based Advocacy Project\(^\text{19}\).

This document is expected to be of use to policymakers as well as civil society organizations (CSOs) to understand the gaps and unmet needs in the current policies/programmes for PLHIV and sexual minorities, and to develop action plans to fill those gaps and needs.

2. METHODOLOGY

This policy brief was prepared using three data sources:
(1) Review of key policy and programme documents (related to NACP-III and RCH-II/NRHM)
(2) Qualitative research data from key informant interviews; and
(3) Qualitative data from stakeholder consultation meetings
A. Review of Key Documents

The key documents that were reviewed include: Government policy documents (NACP-III, RCH-II and NRHM) at the national, state and district levels and mid-term evaluation reports of the national programmes (NACP-III and RCH-II/NRHM); peer-reviewed academic journal articles that focus on HIV, and health policies and health systems in India (past six years); and data and reports from non-governmental organisations (NGOs) and community-based organisations (CBOs). The documents were gathered both manually and via electronic sources such as websites of the government and academic journal databases. Documents were analysed and synthesised in relation to the following focus areas:

1. To what extent have the SRH needs of PLHIV and sexual minorities been addressed in NACP-III, and RCH-II/NRHM?
2. What has been mentioned about creating an enabling environment for PLHIV and sexual minorities in the national policies; and what has been done so far?
3. What are the proposed coordination mechanisms between NACP-III, RCH-II and NRHM at the national, state and district levels?
4. What type of support (funding and technical) is proposed and available for sexual minority CBOs and PLHIV networks in NACP-III, RCH-II and NRHM?
5. How are the representatives from PLHIV and sexual minority communities involved in decision-making processes at the national, state, and district levels in the programmes of NACO and RCH-II/NRHM?

Box 1. List of Key Government Documents Reviewed

National and State Policies and Programmes
National AIDS Control Programme (Phase-III) – Strategic plan
Reproductive and Child Health Plan (Phase-II)
National Health Policy
National Health Research Policy
National Rural Health Mission (NRHM)
State [HIV] Project Implementation Plans – West Bengal and Orissa SACS

Reports and Training Material
Mid-term evaluation reports of NACP-III

NRHM
- Mid-term evaluation report of NRHM
- Reading materials for ASHA – Book Numbers 1 and 2 (Maternal and Child Health)
- Strategic vision for TB control for the country up to 2015, NRHM

RCH-II

B. Qualitative Research

Key informant interviews (n=12) were conducted to understand to what extent the existing policies have been implemented on the ground (progress and challenges); identify gaps in
the policies; and what changes they would like to see in the policies and implementation process. Key informants included SACS officials of Orissa and West Bengal, officials of Technical Support Units of Orissa and West Bengal SACS, PLHIV network leaders, leaders of CBOs working with sexual minorities, and key project staff of PLHIV networks and CBOs.

Key informant interviews were conducted over phone and face-to-face. Key informants provided verbal informed consent. No names and other identifying information are provided in this document. Most interviews were conducted in English and some in Hindi or local language. Active notes were taken during the interviews and notes were expanded soon after the interviews were over. Close and repeated readings of the notes were done to identify categories and themes that are related to the purpose of this study, and finally these findings were integrated with the findings from the documents reviewed.

C. Consultation meetings with the coalitions

Key findings of the study were presented in consultation meetings with the two coalitions organised by SAATHII in March 2011. Comments and suggestions received included the need to translate the study into Bengali and Oriya, and update it based on developments in implementation of NACP-III and RCH-II/NRHM. There was particular concern about the implications of the convergence of NACP-III and NRHM for availability of SRH and HIV services for sexual minority and PLHIV populations.

Limitations and Delimitations: The focus populations of this policy research were primarily ‘PLHIV in general’ and sexual minorities (irrespective of their HIV status). This does not imply that the SRH and HIV needs of other marginalised groups do not merit a separate analysis. Policy research studies on the SRH and HIV service and policy needs of other marginalised populations such as female sex workers (FSWs) and people who use injecting drugs (IDUs) are definitely needed – especially when only a few reports focus exclusively or primarily on the SRH needs of FSWs or IDUs.

In India, though the states are supposed to be responsible for the health of their citizens, it is the national (federal) policies on HIV (NACP-III) and SRH (RCH-II/NRHM) that define/direct the state policies on SRH and HIV in the two study states as well as in other states. Hence, the major focus of this policy review has been on the national health policies/programmes. For this review, we primarily relied on the national and state policy and programme documents that were prepared a few years ago (for example, NACP-III plan was finalised in 2006/07 and the state HIV project implementation plans too were prepared around 2007/08).

As much progress has been made since the formulation of the last national and state policies and programme plans, civil society needs to have access to and use the annual action plans of the state agencies (such as SACS) that implement the national policies and programmes, as well as review the latest annual and evaluation reports of the national and state SRH and HIV programmes. These documents will especially help the civil society stakeholders to identify and focus on the current policy and programme gaps.
3. KEY FINDINGS

The first sub-section provides a brief overview of the current health policies and programmes and the next sub-section summarizes the key gaps in these policies and programmes.

I. Current Policies and Programmes

A. National AIDS Control Programme – Phase III

The primary goal of NACP-III is to halt and reverse the HIV epidemic over five years (2007-2012) through integration of programmes for HIV prevention, care, support and treatment. The four key objectives are: (1) Prevention of new HIV infections through saturation of coverage of "high risk groups" (HRGs) with targeted interventions (TIs); (2) Providing greater HIV care, support and treatment to PLHIV; (3) Strengthening the infrastructure, systems and human resources for the delivery of services at the district, state and national level; and (4) To strengthen nationwide monitoring and information systems. The stated guiding principles include equity; legal, ethical and human rights; and PLHIV and civil society participation.

NACO, SACS and DAPCU: NACO in Delhi under the Department for AIDS Control, Ministry of Health and Family Welfare, is the authority that manages NACP-III. At the state level, State AIDS Control Societies (SACS) are responsible for implementing the HIV programme and each SACS has a state HIV project implementation plan. As part of decentralisation efforts, District AIDS Prevention and Control Units (DAPCUs) have been proposed that will report to SACS. (More details on DAPCUs are provided in Section 3 (I) C: ‘Convergence between NACP-III and Other Programmes’).

Prevention: Prevention is stated to be the main focus of NACP-III. As much as 77% (Rs.7,786 crore) of the total NACP-III budget is allocated for prevention. NACP-III aims to expand the coverage of HRGs (including MSM – with Hijras and TG people subsumed in this category) to 80%. NACO has proposed to establish 2,100 TI sites to cover 80% of HRGs with prevention services that includes treatment for STIs, condom promotion, behaviour change communication (BCC) and enabling environment.

Prevention strategies include:

a) Saturation of coverage of MSM (and Hijra and TG) populations by SACS in partnership with NGOs and CBOs through the following principles:
   • District level mapping based on the classification of the districts into four broad zones:
     Large urban area (establishment of new CBOs in addition to the already existing TIs);
     peri or semi-urban area (covered by NGO-run TIs), outer periphery area (to be covered
     by the Link Workers Scheme) and outlying parts of the district (covered by mass media
     and government functionaries)
   • Coverage of clients of (male/TG) sex workers and female/other sexual partners of MSM
   • Focus on enabling environment (equitable access to services)
   • Forming CBOs to represent the community
   • Establishing Technical Support Units (TSUs) at the state level to enhance the capacity of
     implementing partner agencies

b) Targeted interventions among MSM (and Hijra and TG) populations: In NACO’s operational guidelines for implementing TIs, the main components of TIs for MSM, Hijras and TG people listed are: BCC through outreach education and counselling; condom promotion; STI treatment referrals; referral for HIV testing and ART; and creation of enabling environment in the area where TIs are implemented.
NACO originally proposed to cover 1.15 million MSM (and Hijra and TG) populations over a period of five years (2007-2012) through 600 exclusive and composite TIs. These were to include 40 TIs in Orissa (eight exclusive and 32 composite) and 73 TIs in West Bengal (18 exclusive and 55 composite).

Box 2. Components of Targeted Interventions for MSM, Hijra and TG Populations (NACP-III Guidelines)

<table>
<thead>
<tr>
<th>Outreach and Communication</th>
<th>Services</th>
<th>Enabling Environment</th>
<th>Community Mobilization</th>
</tr>
</thead>
</table>
| - Peer-led, NGO-supported outreach and BCC | - Promotion/distribution of free condoms and lubricants  
- Provision of basic STI and health services including screening and treatment for oral/anal STIs  
- Linkages: ART centres, DOTS centres, ICTCs  
- Provision of drop-in centres | - Advocacy with key stakeholders, power structures  
- Crisis management systems  
- Legal/rights education | - Collectivization (CBO formation)  
- Creation of safe spaces for community events  
- Building capacity of community groups to assume ownership of the programme |
| - Differentiated outreach based on risk and typology  
- Interpersonal BCC | | | |

Care, Support and Treatment: NACP-III plan mentions that TI-implementing NGOs/CBOs will be linked with care, support and treatment centres: Community Care Centres (CCCs) and ART centres supported by NACO; and TB clinics (DOTS centres) supported by RNTCP (Central TB Division). Nutritional support is to be provided for PLHIV admitted in CCCs. The CCCs, TB clinics and ART centres will focus on prevention activities such as developing risk reduction strategies for PLHIV and their partners; integrating risk reduction counselling into treatment for opportunistic infections and ART care; capacity building of PLHIV networks to participate in prevention programmes; sexual partner referrals through counselling; and screening for TB and STIs among PLHIV. No specific activities are listed for MSM, Hijras or TG persons living with HIV. But the plan points out the need to address the perceived socio-economic needs (micro-credit group formation, vocational training skills) of HRGs through linkages with community development programmes and social entitlement schemes.

As per plan, PPTCT centres are located within the government hospitals and they provide HIV screening for pregnant women. If a pregnant woman is detected to have HIV, options are provided on how to deal with the pregnancy. For those who wish to continue their pregnancy, to prevent HIV transmission to the baby, nevirapine is given to the mother at the time of delivery and to the newborn baby.

NACP-III guarantees the provision of free first-line antiretroviral (ARV) drugs to “all those who need them” and explicitly mentions that PLHIV who are referred from TIs will be provided free ART through government-run ART centres. Key informants to this study mentioned that PLHIV referred by health care providers as well as PLHIV networks – if found to meet certain eligibility criteria (such as lower socioeconomic status) – are also enrolled in ART centres. NACO’s target is to initiate ART for 300,000 PLHIV by the end of 2012. However, there are no specific ART targets for MSM, TG persons or Hijras and other marginalised groups like FSWs and IDUs. NACO has also proposed to appoint PLHIV peer educators in the ART centres.

NACO estimates that each year about 57,000 children are born with HIV in India. Even though the government has not released official estimates of children living with HIV, it is believed that at least 100,000 children are living with HIV and about 700,000 are affected by
HIV (one or both parents living with HIV). Paediatric ARV regimens and formulations are being provided in select government centres. In ART centres, a total of 63,889 children living with HIV are registered, of which 18,763 were receiving ART at the end of January 2010.

The mid-term review of NACP-III notes the following achievements of the Ministry of Woman and Child Development in relation to children living with and affected by HIV:

- Integration of the content on HIV/AIDS prevention and women/children-centric issues (including prevention of mother to child transmission) in all training programmes.
- Incorporation of services for ‘children affected by HIV/AIDS’ in the proposed new Integrated Child Protection Scheme under the ministry.
- Inclusion of nutritional supplements for children and women living with HIV in the Integrated Child Development Services programme of four states (Gujarat, Tamil Nadu, Rajasthan and Orissa).

Communication: NACO has proposed a communication strategy that aims at motivating behaviour change among key populations. For MSM, Hijras and TG persons, communication objectives include: Awareness generation about the importance of protected sex; increased and consistent use of condoms with casual and regular partners; reduction in number of casual partners and creating awareness about the use of the available services (such as ICTCs, STI treatment and ART).

For PLHIV, communication objectives include creating awareness about social mobilization efforts to reduce stigma; need to use condoms to protect sexual partners and oneself from re-infection; using available services; and the need for greater networking and advocacy. In addition, NACO has proposed to train NRHM and RNTCP staff on the importance of strengthening linkages between HIV services and their services, and to integrate HIV-related messages to their target audience and motivate people to use the services.

NACO has proposed to develop specific communication material (called ‘second generation messages’) that will position the benefits of behaviour change through mass media and other forms of communication such as interpersonal communication, group meetings, role models, community leaders and involving grass root workers like the Link Workers, ASHA workers, and other functionaries of the RCH-II/NRHM programmes.

B. National Rural Health Mission and Reproductive and Child Health Programme - Phase II

NRHM: NRHM was launched in April 2005 with a goal to improve the availability of and access to quality health care, especially by people residing in rural areas. NRHM covers the entire country, with special focus on 18 states, which have weak public health indicators or weak health infrastructure. NRHM subsumes key national programmes like the RCH-II, National Disease Control Programmes and Integrated Disease Surveillance Project.

Box 3. Targets and Expected Outcomes of NRHM and RCH-II

<table>
<thead>
<tr>
<th>Broad targets of NRHM are to:</th>
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<tbody>
<tr>
<td>Reduce infant mortality rate (IMR) from 60 to 30 per 1,000 live births by 2012</td>
</tr>
<tr>
<td>Reduce the maternal mortality rate (MMR) from 407 to 100 per 100,000 live births by 2012</td>
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<tr>
<td>Reduce the total fertility rate (TFR) from 3.0 to 2.1 by 2012, and</td>
</tr>
<tr>
<td>Maintain 85% cure rate under RNTCP-2 over the entire Mission period</td>
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</table>
The Mission also aims at population stabilization, and gender and demographic balance.36

Key targets of RCH-II are:

- Reducing the IMR to < 45 per 1,000 live births by 2007 and < 30 per 1,000 live births by 2010
- Reducing the TFR to 2.1 by 2010
- Improving coverage of full antenatal care (ANC) from 44.5% (Rapid Household Survey [RHS] 2002-03) to 89% in 2010
- Improving coverage of institutional deliveries/safe deliveries from 39.8% / 54.07% (RHS 2002-03) to 80% in 2010
- Improving coverage of fully immunized children from 48.2% (RHS 2002-03) to 100% in 2010
- Improving the contraceptive prevalence rate (CPR) from 44.8% (RHS 2002-03) to 65% in 2010
- Expanding essential package of services through universalization of RCH in small and medium towns, as well as introducing a package of essential RCH services for the vulnerable groups (Scheduled Castes, Scheduled Tribes and tribal populations). Note: Sexual minorities are not articulated as a vulnerable group

a) Structure and functions of NRHM: 37

Under NRHM, various ongoing vertical programmes of the Ministry of Health and Family Welfare are to be integrated and health plans prepared at the village, district and state levels. NRHM aims at strengthening the public health systems such as the Primary Health Centres (PHCs), Community Health Centres (CHCs), sub-divisional and district hospitals.

At the national level, the NRHM has a Mission Steering Group (MSG) headed by the Union Minister for Health and Family Welfare and an Empowered Programme Committee (EPC) headed by the Union Secretary for Health and Family Welfare. The EPC implements the NRHM under the overall guidance of the MSG.

At the state level, NRHM functions under the overall guidance of the State Health Mission (SHM) headed by the Chief Minister of the state. The functions under the SHM are carried out through the State Health Society (SHS). The SHM is responsible for overseeing the health system, consideration of policy matters related with the health sector (including determinants of good health), review of progress in implementation of NRHM, inter-sectoral coordination, and advocacy measures required to promote NRHM visibility.

RCH-II Programme: The first phase of the RCH programme was in operation since 1997. The second phase commenced from April 2005 for a period of give years. The programme is being implemented as part of the NRHM. RCH-II mainly focuses on reducing the MMR, IMR and TFR. In addition, it also aims to increase the couple protection (contraceptives) rate and the coverage of children through immunization.

a) Structure and functions of RCH-II:

Based on the experiences and lessons learnt from the first phase, RCH-II was designed with more emphasis on state-specific planning. At the national level, a national programme implementation plan guides the states to prepare their own state project implementation plans (PIPs). The national unit functions under the overall supervision of the Union Secretary for Health and Family Welfare and Additional Secretary or Joint Secretary, who are in-charge of the overall programme.

At the state level, the Principal Secretary, Health and Family Welfare, provides overall leadership to the programme. The states are responsible for developing state-specific PIPs in consultation with the districts. In addition, the states are also responsible for providing an
enabling policy framework for the state PIP and overseeing all aspects of planning and implementation and also assist the districts to develop their plans.

At the district level, the Chairperson of Zilla Parishad/Collector provides overall leadership. Chief District Medical Officer (CDMO) and Additional District Medical Officer (ADMO) of Family Planning/RCH provide direct supervision to the programme. The district unit is responsible for developing district action plans, management of human resources, infrastructure, equipment, supplies and consumables or monitoring and supervision.

b) Programme areas:

The key programme areas of RCH-II are:

1) Population stabilization
2) Maternal health
3) Reproductive tract infections/Sexually transmitted infections
4) Child health
5) Adolescent health
6) Addressing the needs of vulnerable groups
7) Convergence

The programme areas of RCH-II are aimed at addressing the needs of the general population. Though there is a separate section focussed on addressing needs of vulnerable populations, the term ‘vulnerable population’ here denotes only the Scheduled Castes, Scheduled Tribes and tribal populations. Exceptionally, the Orissa government introduced the Madhu Babu Pension Scheme for PLHIV through the Department for Woman and Child Development in February 2008.

C. Convergence between NACP-III and Other Programmes (NRHM, RCH-II and RNTCP)

In the NACP-III plan, NACO has acknowledged that it will synergise all its services with the NRHM, especially with RCH-II and the Revised National TB Control Programme (RNTCP).

a) Convergence between NACP-III and NRHM:

The programme management chapter under NACP-III points out the need for the integration of the national HIV/AIDS programmes into the public health system (NRHM). At the same time, NACO emphasizes that the core activities of NACP-III such as TIs will continue to function as separate entities under NACO and SACS. NACO justifies that TIs are largely focused on ‘outlawed groups’ and the HIV prevention needs of these groups are not usually addressed by the public health system.

For effective coordination between the NACP-III and NRHM, NACO has proposed the establishment of an NACP-NRHM Coordination Committee (NNCC) in the Ministry of Health and Family Welfare with the Health Secretary acting as the chair of the NNCC. The NNCC will be responsible for providing policy direction, functional oversight and ensure coordination between the two important centrally sponsored programmes – RCH and RNTCP. The decisions taken by NNCC will be binding at all levels of implementation.

Similar to the NNCC, at the state level, a Joint Planning and Monitoring Committee (JPMC) has been constituted to ensure effective implementation and coordination of the centrally

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1 Terms like ‘Convergence’, ‘Integration’, ‘Linkages’ and ‘Referrals’ are used sometimes as synonyms and sometimes in different ways by government and other stakeholders. Please see Glossary for more information.
sponsored schemes, particularly in the states where SACS has not merged with the SHS. However in such states, the Project Director of SACS will be a member of the Executive Committee of the SHS, while the Chief Executive Officer of the SHS will be a member of the Executive Committee of SACS.

At the district level, the district HIV Unit (DAPCU) will be a part of the District Health Society (DHS). However, in all Category ‘A’ districts (high HIV prevalence districts), appropriate experts will be provided to assist the HIV Unit.

NACO has noted the need for merging of the action plans prepared by the SHS established under NRHM and the SACS for more effective implementation. In the draft operational guidelines for DAPCU, NACO has proposed a programme structure for integration with the NRHM – merging the DAPCUs with the District Health Mission (DHM) of the NRHM. The proposed committee members of DAPCU include representatives from the programme management units of the various national programmes under NRHM; and representatives from PLHIV networks, TI implementing NGOs and CBOs, and CCCs.

DAPCU is responsible for foreseeing the implementation of NACP-III activities at the district level. This committee is also to oversee the planning, implementation and monitoring of programme and financial activities planned in the district HIV/AIDS action plan. The district HIV/AIDS action plan will be a part of the overall district health action plan of NRHM comprising of the RCH-II programme, immunization and NRHM additionalities.

Box 4 shows the proposed list of activities in relation to the general population, PLHIV and other core groups to be implemented by DAPCUs.

| Box 4. Proposed Activities of District AIDS Prevention and Control Units (DAPCU Operational Guidelines) |
|---|---|---|
| **Service delivery** | **Monitoring and Impact Mitigation** | **Management** |
| **Targeted interventions (TIs):** | Women, children and young adults: | Linking care, support and treatment with prevention: |
| i) Facilitate access to HIV prevention and treatment services, general health services and other entitlements including package of services for HRGs | i) Working with district level departments for prevention, treatment and impact mitigation on women, children and adolescents | i) Monitor integration Impact mitigation: |
| ii) Create a supportive environment for TIs to function in | HIV/AIDS response in the world of work: | i) Set up linkages with district level organisations and departments for support to PLHIV and their families |
| Condom promotion: | i) Facilitate access to treatment and prevention services for referrals from TIs | ii) Facilitate access of PLHIV to social support |
| i) Monitor availability of condoms at service provision points | Communication and social mobilization: | |
| Convergence with RCH, TB and other MoH&FW programmes: | i) Conduct district level IEC campaign | |
| i) Work with concerned programme officers to effectively integrate their functions | ii) Use local channels for demand generation | |
| Improved access to opportunistic infection (OI) treatment, ART and continuum: | iii) Work with Panchayati Raj Institutions and local CSOs for social mobilization for HIV prevention and management | |
| i) Monitor management of OIs, ART Care, support, treatment for children infected or affected by HIV: | | |

2 These include Patient Welfare Societies (Rogi Kalyan Samitis) in PHCs, District Headquarters Hospitals and Taluka/Non-Taluka Hospitals, Village Health and Water Sanitation Committees, Village Health and Nutrition Day, Untied Grants to Health Subcentres and PHCs, School Health Programme, National Disease Control Programme, and Inter-sectoral Convergence.
i) Monitor children born to sero-positive mothers for early signs of the need for ART
ii) Monitor and investigate any instance of denial of rights to HIV infected and affected children
iii) Advocate with district authorities and organisations to protect the rights of children

Management of ART drug adherence:

i) Follow up with patients through home based counselling for ART adherence

Civil society partnership forum at district levels:

i) Support the formation and functioning of district civil society partners forums

Under the NACP-NRHM convergence, NACO envisages mainstreaming HIV/AIDS issues with the general health system at the village level by using the services of NRHM grassroots level workers – auxiliary nurse mid-wives (ANMs), ASHA workers, and Multipurpose Health Workers (MPWs). NACO has proposed promoting cross-learning of activities implemented through NRHM and NACP. Thus all HIV-related issues such as IEC, training curriculum, monitoring/evaluation indicators and reporting formats will be included in the NRHM. Also, NRHM focus areas such as family planning, nutrition, triple protective role of condoms (prevention of pregnancy, STIs and HIV) and referrals will be included in NACP activities at all levels. See Box 5 for the convergence of NACP and NRHM activities at the village level.

**Box 5. Convergence of NACP-III and RCH-II/NRHM Activities at Village Level (DAPCU Operational Guidelines)**

**• Functionaries and Committees**

The Village Health Committees and grassroots level workers (ASHA workers, ANMs, MPWs) will be oriented about the threat of HIV/AIDS and strategies for prevention, treatment and care. The Village Health Committees will be motivated to provide community support to PLHIV for treatment and support. Link Workers will be included as members of Village Health Committees. The Village Health Plan will mainstream issues of HIV prevention, care and support.

**• Activities of Functionaries**

Under the revised NACP-NRHM coordination framework, ASHA workers will be given a two-day orientation on HIV/AIDS. These workers, after orientation, will sensitize villagers (women in particular) on RTIs, STIs and HIV/AIDS, advise them on the use of condoms, and refer patients with RTIs or STIs to PHCs for treatment. ASHA workers will promote ANC and institutional deliveries for the joint mandate of NRHM and NACP. Other functionaries like ANMs, MPWs, nurses, Anganwadi Workers (AWWs) and Link Workers will be similarly sensitized on joint issues. Counselling pregnant women in risk areas to seek PPTCT services, overseeing the nutritional support to HIV-positive mothers and newborns, and referrals for timely testing of newborns to assess their HIV status will also be undertaken. ANMs, along with ASHA workers, will ensure institutional delivery for HIV-positive mothers.

**• PLHIV, MSM, Hijras and TG Populations**

Functionaries at the village level will be sensitized about PLHIV and HRGs in their jurisdiction and will ensure supply of condoms. Simultaneously, patients with STIs and OIs in such high risk zones or groups will be motivated to seek referrals for HIV testing and counselling and further management. The grassroots functionaries will also ensure follow up with PLHIV for ART services and community support.
b) Convergence between NACP-III and RCH-II:

The RCH-II programme emphasises on the need to scale up prevention strategies based on factors of risk, vulnerability and impact, expand delivery of interventions and ensure that populations-at-risk and vulnerable groups are reached. It also acknowledges the significant degree of overlap in the areas of interventions of RCH: Focusing on behaviour change, prevention/management of reproductive tract infections (RTIs) and STIs, condom promotion.

RCH-II has proposed a framework of convergence between the Department of Health and Family Welfare (DoH&FW) and NACP. The broader areas of convergence include: RTIs/STIs, ICTCs, PPTCT, BCC and condom promotion (Appendix 2).

NACP-III also noted that by the end of 2012, SRH and HIV services that should be available at PPTCT centres include: Family planning, ante- and post-natal care, safe institutional delivery, medical termination of pregnancy, IEC on breast feeding and nutrition, RTI/STI treatment, voluntary and confidential HIV counselling and testing, ART, and linkages with HIV community care and support programmes.

c) Convergence between NACP-III and RNTCP:

In relation to TB and HIV, NACO proposes sharing of implementation arrangements such as ICTCs and sputum microscopy centres, including strengthening collaboration with CSOs, demand-generation, training programmes, surveillance and logistics.

Diagram 1: Convergence between NACP-III and RCH-II/NRHM
II. Gaps in Current Policies/Programmes

A. Gaps in National AIDS Control Programme – Phase III

1. Several gaps exist in programme implementation and programme strategies

a) PLHIV, including MSM, Hijras and TG people living with HIV, face barriers to ART and ART-related services:

According to the mid-term evaluation report of NACP-III, by the end of August 2009, there were 261,806 PLHIV receiving free ART from government ART centres (target for 2012 being 300,000). Though the scale-up of ART services has been considerable, NACO reports that in 2009 only 45% of adults with advanced HIV infection were receiving ART (NACO, 2010). The International Treatment Preparedness Coalition reports limited access to ART among marginalized groups, including MSM and Hijras, in India. Recent reports and peer-reviewed publications have documented barriers faced by PLHIV from marginalized communities such as sex workers, IDUs, MSM and TG people in accessing free ART services provided in the government hospitals.

At the end of August 2009, 644 patients were receiving second-line ARVs. PLHIV key informants to this study reported that PLHIV who were started on first-line ART by private practitioners and who now require second-line ART face problems in accessing second-line ART from the government ART centres. There is reportedly a ‘preference’ to initiation of second-line ART among PLHIV for whom first-line ART regimen started in government ART centres failed. Key informants also informed that usually there is a long waiting period for the initiation of the second-line ART (as long as two to three months) because the State Physician Panel needs to review and approve the request from PLHIV for second-line ART. Lack of free ARV drug resistance testing and viral load testing in the government hospitals also pose additional financial burden on PLHIV who need to submit these lab test results to the State Physician Panel.

Early diagnosis of HIV in infants could help in taking important decisions on treatment and vaccinations. Lab tests such as polymerase chain reaction (PCR) are required for early diagnosis. However, these tests are not available in government hospitals except in some tertiary care institutions.

b) Lack of MSM/TG sub-group specific approaches:

A recent evaluation research pointed out that though NACP-III specifically mentions ‘differentiated outreach based on risk and typology [of MSM/TG]’, there has been no change or modification in the intervention components or approaches to reach out to and provide tailored services for MSM sub-populations such as Double Deckers and Panthis. Also, though the NACP-III plan and operational guidelines use the term ‘MSM and transgender’, specific approaches for outreach and provision of services to Hijras, the major visible population under the TG umbrella term, are yet to be identified. Discussions with key informants reiterated that in spite of the differentiation at the label level (‘MSM’ and ‘transgender’), TG persons and Hijras continue to be clubbed with MSM. Key informants noted that there is a need to take into account some of the unique dynamics within the Hijra community for effectively reaching out to them (example, involving Hijra leaders), and to facilitate uptake of HIV information among Hijras by addressing information needs other than

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3 Based on the mid-term evaluation report of NACP-III
HIV (example, regarding sex change and hormonal treatment). So far, these efforts have not been taken up systematically.

c) Limited distribution of water-based lubricants:

In NACP-III, budget is allocated for distributing water-based lubricants to MSM, TG persons and Hijras. However, often the allocated money is insufficient to meet the lubricant needs of all individuals in TI project sites. An evaluation research conducted in nine TI sites in Andhra Pradesh found that none of those sites distributed free water-based lubricants in the past year. Key informants in Orissa and West Bengal stated that water-based lubricants are not distributed in enough quantity for each person and not all individuals in a TI site who require lubricants can get them.

d) Needs of same-sex attracted and TG adolescents are not addressed:

Just like heterosexuals, same-sex attracted males might also become sexually active even before attaining 18 years (which is considered as the legal age to engage in consensual sex). Thus, implementers of TI projects, whether supported by NACO/SACS or other donors, are hesitant to provide services to those who are less than 18 years old. Consequently, these vulnerable adolescents are not able to use the available HIV prevention services from NGOs and CBOs till they become legal adults. Both NACP-III and RCH-II are silent about the HIV prevention needs and SRH needs of same-sex attracted males and TG people who are less than 18 years old.

e) Lack of positive prevention programmes for PLHIV:

In the NACP-III plan, NACO has articulated the need for the promotion of HIV prevention programmes among PLHIV in India. Under the sections ‘Care and Support’ and ‘Enabling Environment’ of NACP-III, NACO has proposed activities that aim at promoting positive prevention programmes among PLHIV. But the NACP-III strategic and implementation plan does not contain any definition of what is meant by ‘positive prevention’ and what are its various components.

Globally, there has been greater momentum in advancing policies and programmes related to positive prevention. For example, Global Network of People living with HIV/AIDS, along with other partners, has organized global and regional consultations on positive prevention. In February 2010, the Indian Network for People Living with HIV/AIDS (INP+) organised a national consultation meeting on positive prevention in which both ‘mainstream’ PLHIV and MSM/TG persons living with HIV were invited. The consultation report that includes the consensus definition and suggested programme components of positive prevention was submitted to NACO.

f) HIV prevention interventions (TIs) primarily focus on individual level:

NACP-III focuses primarily on individual level barriers when addressing sexual risk behaviours and promoting condom use. However, in addition to individual level barriers there is a need to address inter-personal and structural barriers to condom use. Some studies (Chakrapani et al, 2007, 2008a, 2008b) have identified that several contexts pose barriers to condom use for MSM, TG persons and Hijras.

Personal-level barriers include: Perceived low efficacy of condoms and perceived reduction in sexual pleasure. Inter-personal barriers varied according to the type of male sexual partner. With a steady partner (‘husband’ or lover), trust and intimacy, fear of arousing suspicion, and having ‘negotiated safety’ agreement (having unprotected sex if both are HIV-
negative) acted as barriers. With paying partners, the barriers came up when more money was paid, and when condom use was seen as the partner’s responsibility. With known partners the barriers were group sex, ‘heat of the moment’ and unexpected sex opportunities. With casual partners, multiple encounters in cruising sites, not wanting to lose good-looking partners, and perception of difficulty in attaining/sustaining erection with condom use were main barriers.

Structural-level barriers included presence of criminal law against consensual sex between adult males (Section 377, Indian Penal Code till at least July 2009) that was misused by the police and ruffians to blackmail and sexually abuse same-sex attracted males. Typically, an individual faces several levels of barriers concurrently. Similar barriers exist for Hijras and TG persons (Chakrapani et al, 2002, 2007, 2008).

2. Lack of targets for service coverage for PLHIV and treatment coverage for MSM, Hijras and TG people

Table 1: NACP-III: Year-wise Targets for Reaching MSM* (in millions)

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<tr>
<td>Number of MSM to be reached by TIs per year</td>
<td>2.35</td>
<td>1.15</td>
<td>0.12</td>
<td>0.46</td>
<td>0.69</td>
<td>0.92</td>
<td>1.15</td>
<td>1.15</td>
<td>1.15</td>
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(*No separate targets for Hijras, TG people or male/TG sex workers are mentioned)

At the beginning of NACP-III (2007), only 30 exclusive TIs for MSM (and Hijra and TG populations) funded by NACO existed. By the end of October 2009, the number was 131. Currently, the average target population size per TI is about 400 to 600. However, during 2009-10, NACO proposed to make TIs more efficient and to increase coverage per TI to about 800.

NACO originally proposed to cover a target of 1.15 million MSM (and Hijra and TG people) over a period of five years – 2007-2012 (Table 1). The current coverage (again with no break-up in terms of MSM, Hijras and TG persons) as reported by the mid-term review of NACP-III was 77%, that is, 2.75 lakhs (0.27 million) out of an estimated population size of 3.51 lakhs (0.35 million). No explanations from NACO could be found in public documents in relation to the revisions in the estimated population size and coverage target.

The extent of coverage of MSM (again inclusive of Hijras and TG populations) as reported in India’s UNGASS Country Progress Report 2010 is, however, different (Table 2). These coverage data seem to be based on the national Behavioural Surveillance Survey (BSS) studies. India has conducted two national rounds of BSS (the first in 2001 and the second one in 2006).

In BSS 2006, the wide range (17-97%) of MSM across 10 states in India reported to have been reached with HIV prevention programmes indicate extreme variation in the extent and coverage of TIs across states. The UNGASS indicators as reported in India’s 2010 UNGASS progress report are given in Table 2.

No public information is available on the number of PLHIV who are provided various services (other than ART) through NACP-III. Even in the context of ART, recent estimates by UN agencies say that of the number of people in need of ART in India, roughly only 40% have access to it. Also, other than ART, no targets are set for services provided to PLHIV. Similarly, no targets are set for providing ART to MSM, TG persons or Hijras.
<table>
<thead>
<tr>
<th>UNGASS Indicator</th>
<th>% across survey locations [Source: BSS 2006]</th>
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<tr>
<td>Percentage of MSM who received an HIV test in the last 12 months and who know their results</td>
<td>3 to 67</td>
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<tr>
<td>Percentage of MSM reached with HIV prevention programmes</td>
<td>17 to 97</td>
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<tr>
<td>Percentage of men reporting the use of condom the last time they had anal sex with a male partner</td>
<td>13 to 87</td>
</tr>
<tr>
<td>Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</td>
<td>16 to 75</td>
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3. Government needs to support more PLHIV networks and MSM/TG/Hijra CBOs

At the end of October 2009, 131 NACO-funded TI projects were working exclusively among MSM, Hijras and TG populations nationally, but out of these only 37 TIs were managed by CBOs. Each of these exclusive TIs reached out to about 600 individuals. Another 219 composite targeted interventions were providing HIV-related services to MSM, Hijras and TG persons (besides FSWs and IDUs).

In terms of NACP-III targets, a total of 600 exclusive and composite TIs were planned for MSM, Hijras and TG populations by March 2009, 50% (300) of which were to be CBO-lead. Clearly, targets for both ‘total number of TI projects for these populations’ and ‘community ownership and leadership of TIs’ are far from achieved.

In a mapping study in 2008, 152 organisations and networks were found to be working with MSM in India. Of these, 53 were NGOs (including international NGOs) and 99 were CBOs. Similarly, 103 organizations/networks (that include agencies providing services for MSM) were found to be working with TG populations in India. Nearly half (46/103) of these organisations are CBOs. Not all these CBOs get support from NACO.

West Bengal SACS, however, has supported MANAS Bangla, a network of CBOs working with MSM, TG and Hijra populations, with funds from implementing TIs since 2004. This took place even before the NGO-CBO transition guidelines from NACO were formulated. No other state in India has such a unique funding mechanism – funding a network to implement TIs through its member agencies. In general, however, in spite of the emphasis on transition of TIs from NGOs to CBOs, even now there is no clear transition plan on the ground. No figures are available even in the mid-term review report on NACP-III on the number of TIs that have been transferred from NGOs to CBOs. While West Bengal has CBO-led TIs for MSM, TG people, Hijras, FSWs and IDUs, in Orissa, none of the TIs are CBO-led (at the time of finalising this report).

According to an estimate by India HIV/AIDS Alliance for a project on strengthening MSM, Hijra, TG community systems (to be funded by GFATM from October 2010), if TIs funded by all donors (NACO and others like Bill & Melinda Gates Foundation) were to be considered, then a total of 90 CBO-lead TIs were operating in India by March 2009. The proposed project, in which SAATHII is a partner, aims to support all of these 90 CBOs and facilitate setting up of another 110 CBOs to lead TI projects as well as provide larger SRH services.

Under NACP-III the maximum target of TI projects for all HRGs and of any kind (exclusive or composite) was 2,100 by March 2009, 50% (1050) of which were to be CBO-lead.
A similar situation exists in relation to the support available for PLHIV networks from SACS and NACO. NACO’s mid-term review of NACP-III (NACO, 2009) documented that across 20 states in Category ‘A’ and ‘B’ districts, 208 drop-in centres were providing psycho-social support and referral services for PLHIV. Discussions with PLHIV network leaders and staff pointed out that not all the district level PLHIV networks (DLNs) and state level PLHIV networks are supported by SACS. One study documented that in five states, only 15 DLNs out of the 71 DLNs affiliated to INP+ have received funds from SACS for implementing drop-in centre projects, and in 2009, SACS organized only three training programmes for the PLHIV networks.

In that study SACS officials provided several reasons for why not all the PLHIV networks are supported by SACS. Presence of non-INP+ affiliated state and district level PLHIV networks apparently created dilemmas for SACS officials who openly acknowledged the difficulty in arriving at decisions regarding which DLNs should be supported by SACS. Perceived limited capacity of DLNs and NACO’s guidelines that prioritise funding drop-in centres in high HIV prevalence districts (Category ‘A’ and ‘B’ districts) were other factors. Thus, appropriate mechanisms to support existing PLHIV networks are still not available even though these networks have great potential to reach out to more PLHIV and provide them psycho-social support services and tailored counselling.

4. Creation of ‘enabling environment’ is yet to be fully realised

In NACP-III, the term ‘enabling environment’ is primarily used in the context of creating an environment to ensure smooth provision of HIV prevention services for key populations. Under ‘creating enabling environment’, sensitization of the police officials on the issues of marginalized communities such as MSM, Hijras and TG people has been proposed. Though this is necessary and may have helped some agencies to implement interventions without interruptions by the police, sensitizing police alone is not enough to create an enabling environment.

a) Legal issues – MSM, Hijras and other TG people:

Till July 2009, under Section 377 of the Indian Penal Code, a post-colonial British legacy, consensual sex between adult males was criminalised. Though this law was not broadly enforced, the criminality of same-sex sexual behaviour indirectly supported MSM, TG persons and Hijras being subjected to physical and sexual violence, blackmail, and extortion of money by police and ruffians. Several sources documented that peer educators and outreach workers involved in providing HIV services to MSM, TG persons and Hijras were harassed by the police. Though same-sex sexual activity (consensual and non-consensual) within prisons is acknowledged, condoms are not distributed within prisons. The major reason given is the existence of Section 377.

In 2001, Naz Foundation (India) Trust, through the Lawyers Collective – HIV/AIDS Unit, filed a public interest litigation in the Delhi High Court to decriminalize adult consensual same-sex relationships. Relying on constitutional law, the petition asked for a ‘reading down’ of Section 377 (that is, making Section 377 not applicable in the context of consensual sex between same-sex adults) as it posed a structural barrier to outreach among MSM (and Hijras and TG people) for provision of HIV prevention and treatment services.

In July 2009, the Delhi High Court ruled that consensual same-sex relations between adults in private cannot be criminalized. Soon after that judgement, appeals in the Indian Supreme court objecting to the ruling were lodged (along with a few in support of the ruling). Hearing

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6 The original wording in Section 377 criminalized any sexual act other than penile-vaginal sex as criminal between any two consenting adults.
on these appeals is yet to start. It is yet to be seen how far the ruling has improved access to HIV and associated services for MSM, TG persons and Hijras. Of course, Naz Foundation (India) Trust’s petition was not grounded on HIV response alone (it also sought to secure the larger rights to life, equality, dignity, privacy and freedom of expression), and it is arguable that one legal change alone can at best be the first step towards realization of these rights (including improving the response to the HIV epidemic).

b) Legal issues – PLHIV:

The international policy-makers conference on HIV/AIDS held in May 2002 in New Delhi articulated the need for a legislation \(^5^4\) to protect the rights of those infected and affected by HIV in India. Subsequently, in the year 2003 the Lawyers Collective – HIV/AIDS Unit was requested by Shri Kapil Sibal, Member of the Indian Parliament and NACO to prepare a draft legislation on HIV/AIDS.

Lawyers Collective – HIV/AIDS Unit conducted several consultations with PLHIV networks and other CSOs in India on the draft legislation for HIV/AIDS. The final draft of an HIV/AIDS Bill was submitted to NACO in 2006. NACO in turn submitted the Bill to the Ministry of Law and Justice in 2007, where it remained pending for a long time.

In view of supporting and showing solidarity with the Indian government to strengthen its efforts in addressing the HIV/AIDS epidemic, in 2008, INP+ and Lawyers Collective – HIV/AIDS Unit organized several national and state level consultation meetings on the proposed HIV/AIDS Bill. In these meetings, the workshop participants strongly articulated the need to form a broad-based advocacy coalition for the HIV/AIDS Bill, and to establish civil society steering committees both at the national and state levels to take a lead in these advocacy efforts.

As a result, in May 2008, the National Advocacy Coalition for HIV/AIDS Bill was formed. Led by INP+, the coalition has developed a set of advocacy strategies – media sensitization, advocating with members of the Indian Parliament and community mobilization – all aimed at pressurizing the Ministry of Law and Justice to expedite the process of reviewing the draft Bill and to introduce the same in the Indian Parliament. Concerted advocacy by the national and state coalition partners (which include both CRBG and Sampark) have pressed the Ministry of Law and Justice to clear the long-pending Bill in the beginning of the year 2010. Currently the Bill is with the Minister of Health and Family Welfare and is expected to be tabled in the forthcoming parliamentary session.

c) Stigma, discrimination and violence:

A variety of forms of discrimination against PLHIV in diverse settings – home, health care and larger society – continue to be reported \(^5^5\) \(^5^6\) \(^5^7\). MSM and transgender people also face various forms of stigma and discrimination from the family and society and in health care settings \(^5^8\) \(^5^9\) \(^6^0\). Kothis and Hijras, especially those in sex work, face physical and sexual violence from police and ruffians. Legal aid units operated by SAATHII and its coalition partners in Kolkata and Bhubaneswar have been dealing with and documenting several such cases since early 2009 (around 60 cases in both states were recorded as of March 2010). A comprehensive stigma reduction plan for PLHIV and sexual minorities is still not available.

5. Limited involvement of PLHIV and sexual minorities in decision-making processes

In 2005, NACO released the National GiPA Strategy \(^6^1\) – originally drafted by INP+. In NACP-III, which was prepared in 2006, ‘GiPA’ is explicitly mentioned as a guiding principle. NACO has plans to finalise the national GiPA policy and implementation plan before the end of 2010 and recently shared the draft GiPA policy for wider consultation.
A situation assessment of GIPA in five Indian states, conducted by INP+, found that barriers to GIPA include:

a) Limited understanding of GIPA among key stakeholders. 'Involvement' of PLHIV at any level, for example, as service implementer or outreach worker, was wrongly interpreted to mean that GIPA had been implemented.

b) PLHIV were rarely involved meaningfully at the decision-making level and even if in the decision-making bodies (such as the 'Executive Committee' of SACS), there was no guarantee that PLHIV's suggestions would actually be considered in decision-making.

c) Lack of adequate investment by SACS in building capacity of PLHIV networks and leaders.

d) Institutional mechanisms at SACS to implement GIPA are nascent and inadequate.

e) Limited participation of women living with HIV and marginalised groups living with HIV (such as MSM, Hijras, IDUs and sex workers) in the decision-making processes of SACS.

Though GIPA refers to greater involvement of people living with and affected by HIV/AIDS – 'affected' referring to marginalised groups such as MSM, Hijras, TG, IDUs and sex workers – CBO leaders working with these populations do not have much knowledge about GIPA nor do they engage in advocacy activities in relation to promoting GIPA. Often GIPA is seen as an issue specific to 'mainstream' PLHIV and not that of marginalised groups. PLHIV networks and CBOs working with marginalised groups in some areas also had conflicts because of allegations of discrimination against PLHIV from marginalised groups by the 'mainstream' PLHIV network management staff. A CBO leader and PLHIV network leaders pointed out that these conflicts could actually reflect the claim of membership of PLHIV from marginalised groups by both the mainstream PLHIV networks as well as the CBOs.

The GIPA study of INP+ noted that none of the Executive Committees in the five SACS had representatives from the marginalised groups. CBO leaders noted that they are primarily expecting the SACS to fund interventions among their constituents and therefore not pursue any agenda of inclusion of marginalised groups in the decision-making processes. Also, CBOs working with marginalised groups are primarily working through the person in-charge of TIs in SACS and do not have opportunities to discuss programmes or policies with the SACS GIPA Coordinator. Thus, the report summarized that 'lack of strong relationship and collaborations between PLHIV networks and NGOs/CBOs working with marginalised groups; limited understanding of GIPA among CBOs/NGOs working with marginalised groups; and financial dependency of NGOs/CBOs working with marginalised groups on SACS – all mean that involvement of PLHIV from marginalised communities in the SACS policy and programme decision-making processes is very limited'.

That report did not focus on how NACO is involving PLHIV in policy and programme decision-making processes. But it recommended that studies are needed to find out whether and in what ways people affected by HIV/AIDS – such as MSM, TG people, sex workers, and IDUs – are involved in decision-making processes at both the state and national levels.

6. HIV-related issues of lesbian/bisexual women and female-to-male transgender people have been totally ignored.

The terms ‘lesbian’, ‘bisexual women’ or ‘female-to-male transgender people’ are nowhere to be found in the national HIV policy and strategic plan (NACP-III). It could be because of the perception that these populations may be relatively small and they may not be at risk for HIV. However, there is a small but still unspecified risk for HIV infection for women who have sex with women62 63 and may depend upon the type of sexual practices64. Some may
contend that because of the low risk associated with female-to-female transmission one need not focus on lesbian women. However, all individuals irrespective of their sexual identity should receive correct information and tools to protect themselves and everyone has the right to health. Sexual identity as a lesbian woman does not mean not having sex with men. Both lesbian-identified and bisexual-identified women may have sex with men (within or outside heterosexual marriage) that may pose risk to them and their sexual partners.

Like male-to-female transgender people, female-to-male transgender persons are also diverse in terms of their self-identities and health needs in relation to gender transition and sex change operation. Very little information is available on the HIV-related risks and health needs of female-to-male transgender people (transmen) in India or even elsewhere. Since gender identity, sexual orientation and sexual behaviours are distinct issues, just like any other people, transmen may have sex with women, men, both men and women or other transpeople. Thus, unprotected sex, depending on the type of sexual practice, does pose risk of HIV to transmen and their sexual partners.

Lack of research among lesbian and bisexual women, and female-to-male transgender people – both in general and in relation to their health needs – means, they continue to face sexual health risks and lack information to protect themselves and their sexual partners from infections.
### Table 3: SRH and HIV Services for PLHIV and Sexual Minorities in the National Health Policies/Programmes: Availability and Gaps

| + | Available | Should have been included but currently not available |
| (+) | Available but not widely available or properly implemented for that particular population | Not applicable or relevant (either for the particular population or for the particular programme/policy) |

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<thead>
<tr>
<th>Sexual and reproductive health and HIV-related services/interventions</th>
<th>RCH-II/NRHM</th>
<th></th>
<th></th>
<th>NACP-III</th>
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<tr>
<td></td>
<td>PLHIV</td>
<td>MSM, Hijras / TG women (MTF)</td>
<td>Lesbians, Bisexual Women</td>
<td>Transmen (FTM)</td>
<td>PLHIV</td>
<td>MSM, Hijras / TG women (MTF)</td>
<td>Lesbians, Bisexual Women</td>
</tr>
<tr>
<td>Whether the policy documents (RCH-II/NRHM and NACP-III) mention these populations?</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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#### HIV prevention and sexual health services

- **BCC in relation to HIV**
- **Free distribution of condoms**
- **Free distribution of water-based lubricants**
- **Peer/outreach education**
- **Drop-in centres**
- **Structural interventions to decrease stigma, discrimination and violence**
- **Addressing sexual and physical violence (prevention/mitigation)**
- **Post-sexual exposure prophylaxis (PEP)**
- **Pre-sexual exposure prophylaxis (PrEP)**
- **STI diagnosis and treatment**
- **Promotion of human rights**
- **Engagement/mobilization of a community-led response**
- **Tailored interventions for MSM sub-groups**
- **Prevention programmes for PLHIV**
- **Sex change operation for transgender people**
- **Hormonal therapy for transgender people**
- **Training for health care providers on HIV and sexual health issues**
<table>
<thead>
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<td><strong>Reproductive health services</strong></td>
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<tr>
<td>• Pre-conception counselling for HIV seroconcordant couples</td>
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<td>• Pre-conception counselling for HIV serodiscordant couples</td>
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<td>• Sperm-washing technique and artificial insemination (for HIV serodiscordant couples in which wife is HIV-negative)</td>
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<td>• In-vitro fertilization (for HIV serodiscordant couples in which husband is HIV-negative)</td>
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<td>• Emergency contraception</td>
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<td>• Contraceptive choices information for PLHIV</td>
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<td>• Female condoms</td>
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<td>• Assisted reproductive technology for sexual minorities (surrogate mother for child birth)</td>
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<td>• Training for health care providers on reproductive health issues</td>
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<td><strong>HIV treatment, care and support</strong></td>
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<td>• Clinical management of opportunistic infections</td>
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<td>• Cotrimoxazole prophylaxis</td>
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<td>• Treatment of TB</td>
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<td>• Availability of ART for all eligible PLHIV (including sexual minorities living with HIV)</td>
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<td>• Tailored interventions for ART education and adherence</td>
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<td>• Treatment for hepatitis B</td>
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<td>• Treatment for hepatitis C</td>
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<td>• Nutritional care and support</td>
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<tr>
<td>• Mental health (full range of psychosocial, psychotherapeutic interventions)</td>
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<tr>
<td>• Vaccinations (full course of hepatitis B vaccination, hepatitis A vaccination, and human papilloma virus vaccination)</td>
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SAATHII IWW COALITION BASED ADVOCACY PROJECT – HEALTH POLICIES BRIEF MARCH 2011
B. Gaps in RCH-II/NRHM

In general, in RCH-II/NRHM, the specific and unique SRH needs of PLHIV, including those from other marginalized communities, are not articulated.

(i) SRH needs of PLHIV

1. Lack of comprehensive services for HIV serodiscordant and concordant couples

For both HIV seroconcordant and serodiscordant couples, there is a lack of pre-conception counselling that might help them in taking decisions about whether or not to have a baby and having a baby without infecting their partner (in case of HIV serodiscordant couples). Many HIV serodiscordant couples may not be aware of post-sexual exposure ARV prophylaxis (to prevent HIV transmission to their partner) that could be initiated if a condom breaks. Currently, only post-occupational exposure prophylaxis for health care providers is available in the government hospitals. Sperm-washing and artificial insemination facilities are not available for free for HIV serodiscordant couples who wish to have their own baby. Specific guidelines on how to educate and provide counselling to HIV serodiscordant and seroconcordant couples are needed and health care providers need to be trained on the same.

2. Limited family planning options are offered to PLHIV

Often HIV diagnosis among women is made during their antenatal check-up and then they are referred to PPTCT programmes. Outside the PPTCT settings, there is limited discussion with PLHIV about their intentions to have a baby. Available studies have pointed out that many PLHIV may not be aware of the various family planning options available to them\textsuperscript{70, 71}. One reason for this could be because of the limited options provided to PLHIV by the health care providers, with the counselling limited to discussion on only condoms – emphasizing prevention of HIV transmission to others, and not much discussion on other contraceptives (non-barrier methods) (WHO, 2006\textsuperscript{72}). It is essential that health care providers at all levels – sub-centre, PHC/CHC and district hospitals – should have adequate knowledge and provide non-directive counselling in relation to family planning options for PLHIV to ensure prevention of unintended pregnancies and unsafe abortions, and to ensure safer pregnancy.

A variety of contextual factors influence an HIV-positive individual regarding the decision to have a baby, and reproductive choice for PLHIV cannot be seen only as an ethical or medical issue (Cooper et al, 2005\textsuperscript{73}, Guttmacher, 2006\textsuperscript{74}). Irrespective of whether it is a personal choice or not, for various reasons PLHIV find it difficult to openly discuss with their health care providers about their intentions, and consequently, opportunities to provide them adequate information on reproductive choices and help them in taking informed decisions are missed. Even if PLHIV disclose their reproductive intentions, often they receive biased counselling reflecting the moral views of the health care providers. Some providers may even coerce HIV-positive women to undergo an abortion. Also, quality abortion services are not available to those PLHIV who want to discontinue their pregnancy, forcing them to go to unqualified practitioners.

3. SRH needs of HIV-positive adolescents, physically challenged people not articulated

As ART prolongs the life of PLHIV, there is an emerging population of HIV-positive children who are now in their teens. Current adolescent reproductive and sexual health (ARSH) strategies do not specifically address the unique challenges that health care providers face in providing appropriate SRH information and services to this population. Recent experiences from other developing countries such as Africa also point out the emerging needs of HIV-positive adolescents\textsuperscript{75, 76}. Similarly, SRH needs of physically-challenged people – PLHIV or sexual minorities – are not addressed anywhere in NACP-III or RCH-II/NRHM.
4. Limited capacity of health centres (PHCs/CHCs) to meet the SRH needs of PLHIV

RCH-II has proposed to strengthen the capacities of PHCs and CHCs to enable them to become sites for conducting deliveries and providing obstetric care for all complications. It is not clear whether the staff of PHCs and CHCs would be trained on conducting deliveries for HIV-positive women, and whether HIV testing facilities, ARVs and universal precaution kits would be available in all PHCs and CHCs. Under RCH-II, it is proposed that various service providers including ANMs and staff of district hospitals, PHCs and CHCs would be trained on expanding the choice of family planning services. Nevertheless, current RCH training modules do not articulate the specific SRH needs of PLHIV.

(ii) SRH needs of sexual minorities

The RCH-II programme is silent about the needs of sexual minorities as well as PLHIV. Nowhere in the RCH-II/NRHM documents and training modules can one find the terms related to sexual minorities such as MSM, Hijras and transgender people. In general, health care providers and non-governmental SRH service providers are not trained to identify or serve sexual minorities in culturally-sensitive ways or understand their specific risks, and health promotion and treatment needs. Neither the current training modules of RCH-II for health care providers nor the medical curriculum address the health needs of sexual minorities.

1. Health needs of MSM, Hijra and TG populations are not articulated

In addition to the health needs as that of any other men, MSM (as well as Hijras and other TG persons) face some specific physical and mental health needs.

a) Sexual health issues: MSM, Hijras and TG persons may be at risk of STIs and HIV if they have unprotected sex with men and women. While any type of STI can be contracted, certain STIs are more likely to be contracted through certain unprotected sexual practices. For example, the risk of getting hepatitis B virus infection is high with unprotected anal sex and that for hepatitis A virus infection with unprotected oral-anal sex (anilingus). Hepatitis B infection may later evolve into a chronic disease affecting liver and also may lead to liver cancer. Similarly, some strains of the human papilloma virus that cause anal-genital warts may lead to anal cancer. This emphasises the need for anal cancer screening for those who have receptive anal sex.

Besides these health issues, MSM, Hijras and TG persons may face challenges in disclosing their STI or HIV status to their male and female sexual partners (including spouses), and to bring the partners as well for STI/HIV screening and treatment.

b) Mental health issues: Societal prejudice and discrimination have been linked to increased prevalence of mental health disorders among gay men and other sexual minorities. For many sexual minority people, having to conceal one’s gender identity, sexual identity or sexual attraction because of fear of rejection and discrimination may act as stressors that increase their chances of experiencing mental health problems. Thus, consequent to society’s prejudice, same-sex attracted individuals may feel bad about themselves (low self-esteem), depressed, abuse alcohol and drugs, and think of committing suicide.

2. Health needs of lesbian/bisexual women and female-to-male transgender people are nowhere addressed

Lesbian and bisexual women face the same health issues as other women but also have specific health information and service needs. Some of the needs include:

- Information on the health risks associated with certain sexual practices with women and men (STIs and HIV).
• Information on cancer screening such as mammography (breast cancer screening) and pap smear (identification of precancerous lesions in the cervix) – since lesbians may have higher prevalence of cancers compared with heterosexual women;
• Support for problematic use of alcohol, drug use, and smoking/tobacco use
• Support for mental health issues (such as emotional distress and depression)
• Support services for intimate partner (same-sex or other-sex partner) violence

Relatively little has been systematically studied and documented about the health needs of female-to-male transgender people. Some of their health needs include:

• Information and services in relation to gender transition – masculinising procedures and sex change operation
• Pre- and post-gender transition counselling and support
• Support for mental health issues.

3. SRH needs of same-sex attracted and transgender adolescents are not addressed

As same-sex attracted males grow up, some proportion of them may exhibit mannerisms and behaviours that would be labelled by the society as ‘feminine’. Thus, they face ridicule and teasing from their neighbours, school friends and relatives. Similar issues may be faced by other sexual minorities as they grow up. Currently there is a complete lack of correct and supportive information about same-sex sexuality or transgender issues in popular media or even from the health care providers. Even among sexual minorities, a variety of beliefs and misconceptions exist in relation to the ‘cause’ of one’s sexuality pointing out the need to provide accurate and scientific information.

4. Need for standards of care for gender transition procedures (including sex change operation) for transgender people

Only one state in India, Tamil Nadu, has initiated free sexual reassignment surgery (SRS) in government hospitals – that too, only for Hijras and male-to-female TG people. However, it is yet to be widely implemented and health care providers need proper training to be competent in performing SRS. In other states, in the absence of free SRS, Hijras mainly rely on unqualified medical practitioners (quacks) for emasculation. Only a small proportion can afford the qualified medical practitioners. Usually no pre-operative counselling about emasculation is given to the Hijras by the quacks. However, before Hijras decide on emasculation, they usually seek the advice of other Hijras and their Gurus.

These days, before emasculation, HIV testing is done by qualified as well as unqualified medical practitioners but no counselling precedes the HIV testing. If someone is found HIV-positive, the operation is not denied but the test result is revealed without providing counselling and additional money is asked for taking ‘extra precautions’.

No support from the government is available for feminising procedures (such as female hormonal treatment for gender transition and electrolysis for facial hair removal). Often Hijras and TG persons take female hormones on their own with no prescription or follow-up by qualified medical practitioners. If they are HIV positive and taking ART, the co-administration of ART and hormonal therapy may cause serious side effects.

There has been total silence on the government side in relation to the need for providing services such as free or affordable sex change operation and masculinising procedures for female-to-male transgender people. Discussions with activists indicated that only a small proportion are able to pay for SRS and masculinising procedures and these services are available only in select government and private hospitals.
Table 4: Gender Transition-related Needs of Transgender People

<table>
<thead>
<tr>
<th>Gender transition-related needs</th>
<th>Male-to-female transgender people</th>
<th>Female-to-male transgender people</th>
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</thead>
</table>
| Common needs                  | • Proper counselling about options available in relation to gender transition  
|                                | • Proper follow-up counselling and support – after operation               |
| Types of surgical procedures required | • Neovagina creation (construction of a vagina)  
|                                | • Penectomy (removal of the penis)  
|                                | • Orchidectomy (removal of the testes)  
|                                | • Clitoroplasty (construction of a clitoris)  
|                                | • Breast augmentation (breast enlargement)  
|                                | • Rhinoplasty (reshaping the nose)  
|                                | • Hair transplants  
|                                | • Bilateral mastectomy (removal of the breasts)  
|                                | • Hysterectomy (removal of the uterus)  
|                                | • Oophorectomy (removal of the ovaries)  
|                                | • Phalloplasty (construction of penis) |
| Types of non-surgical procedures required | • Female hormonal therapy  
|                                | • Hair removal: Electrolysis and laser therapy  
|                                | • Voice modulation: Vocal therapy  
|                                | • Male hormonal therapy  
|                                | • Voice modulation: Vocal therapy |

5. Lack of legal recognition of same-sex marriage and marriage between transgender persons and men/women

All citizens including sexual minorities have the right to marry their partner of choice and to have legal recognition of that marriage. Even in the absence of legal recognition, some same-sex attracted people are getting ‘married’ to same-sex partners and some proportion of Hijras get ‘married’ to their regular Panthi partners.

6. Ambiguity in legal recognition of gender identity of transgender people and Hijras and its relation to access to health services

Lack of legal recognition of the gender identity of transgender people (male-to-female and female-to-male) is a key barrier to exercising their rights related to marriage with a man/woman (where their ‘trans’ gender identity and not biological sex is primary), child adoption, inheritance, wills and trusts, employment, and access to public and private health services, and access to and use of social welfare and health insurance schemes.

The Indian Ministry of External Affairs has introduced an ‘Others’ box in addition to ‘Male’ and ‘Female’ boxes when asking for an applicant’s sex in the passport application. Similarly, some educational institutions in Tamil Nadu and Karnataka have introduced an ‘Others’ box in the application forms for admission of students. The Election Commission of India has announced that Hijras and TG people now have the option to vote as a ‘woman’ or ‘other’. However, all these orders are at the administrative or bureaucratic levels and legal recognition of the gender identity of Hijras and TG people may still be challenged.

Studies have documented that the Hijras felt humiliated on having to stand in a queue for males at hospitals and were laughed at by the co-patients in the queue. Also, Hijras have no say in deciding in which ward – male or female – they can stay as in-patients in hospitals. These experiences prevent Hijras from ever visiting government hospitals or repeating visits.
7. Marital counselling issues of couples in mixed sexual orientation marriages are not addressed

There is a huge unmet need for counselling support that should address a range of SRH-related topics of sexual minorities. Sometimes, same-sex or both-sex attracted men and TG persons may get married to women attributing family compulsions and other reasons for getting married to a woman. Some proportion of these married same-sex attracted men and TG persons may complain of sexual dysfunction with their wife and may not know how to deal with the issues they face. Men with a bisexual orientation and MSM or TG persons living with HIV may have a dilemma with regard to whether or not to get married and whether or how to disclose their sexuality and/or HIV status before marriage.

Some proportion of lesbians and bisexual women may be compelled or expected by their family members to get married to a man. Heterosexual spouses of sexual minority individuals may also require support in terms of how to deal with their situation, and take informed decisions.

8. Need to impart adequate knowledge on family planning options for married MSM and TG persons

Limited information is available on this topic. A study among Kothis identified the following issues: Married Kothis often do not think much about family planning. Married MSM and even married TG persons are largely unaware of the wide range of family planning options available for them and their spouses. Similar to heterosexual males, married MSM and TG persons do not want to undergo vasectomy due to certain reasons: Loss of income – not only on the ‘operation day’ but also because they would not be able to engage in hard work afterwards, weakness and (unknown) side-effects following vasectomy, fear of undergoing surgery, desire to sustain their generation, and not having adequate information about vasectomy. Thus, it is important to educate married MSM and TG persons, just like heterosexual married men, about the need to take responsibility for family planning as well as remove any misconceptions about vasectomy.
4. RECOMMENDATIONS

Based on the available evidence from this policy research, following recommendations are made to address the gaps in the current health and development policies/programmes as well as to ensure implementation of the current policies. The member agencies of CRBG and Sampark need to take the lead in advocacy on these issues in order to improve the health and promote the rights of PLHIV and sexual minorities.

A. SRH and HIV Policies and Programmes

1. Policies

a) Develop a national policy on SRHR of PLHIV and sexual minorities, and implement that plan during the period of NACP-III, RCH-II/NRHM and beyond. All national health-related plans (NACP, RCH, NRHM), in their next phases, need to specifically articulate how they are addressing the variety of health-related needs of all sexual minorities and PLHIV.

b) Recognise civil and legal rights of sexual minorities such as the right to same-sex marriage and the right to found a family – given the integral connection between these rights and SRH.

c) Introduce the HIV/AIDS Bill in the Parliament and pass the Bill as a law to ensure protection of the health and rights of PLHIV and sexual minorities.

d) Ensure GIPA in designing and implementing SRH and HIV policies and programmes for PLHIV and sexual minorities. Involvement in decision-making processes need to be at the national, state and district levels of the decision-making bodies of NACO and RCH/NRHM.

2. Programmes

a) Quicken the steps to strengthen the convergence of HIV services of NACP-III and SRH services of RCH-II/NRHM and ensure that the convergence addresses the specific needs of PLHIV and sexual minorities.

b) Develop specific outreach and communication strategies and guidelines for the various sub-groups of MSM, Hijras and TG people to ensure ‘differentiated outreach and communication strategy based on the risk and typology’ as articulated in the NACP-III plan.

c) Take adequate steps to address the structural (policy and legal) and other contextual factors (societal stigma, community norms and relationship dynamics) that influence HIV vulnerability of MSM, Hijra, TG communities in addition to the behaviour change communication approach at the individual level.

d) Train health care providers on the SRH needs and rights of PLHIV and sexual minorities, and on offering counselling and clinical services in a non-judgemental, and unbiased manner.

B. Address Gaps in SRH and HIV Services

1. Provide essential information to PLHIV (including sexual minorities) on: Dual use of condoms (prevention of infection and pregnancy), use of dual methods (condoms and another

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7 Other than the policies and programmes reviewed in this study, it is suggested that the following government departments and their policies/programmes be also reviewed in the context of SRH and HIV needs of PLHIV and sexual minorities: Woman and Child Development, Social Justice and Empowerment, Law and Justice, Panchayati Raj and Rural Development, Labour, Youth Services and Finance.
contraceptive); safety of conception and child birth – sperm washing, artificial insemination, and in vitro fertilization as methods of assisted conception, caesarean section for child birth, unwanted/unintended pregnancy, contraceptive options including emergency contraception, and access to legal and safe abortion.

2. Provide risk reduction counselling and reproductive health services for HIV serodiscordant couples who wish to have their own baby.

3. Provide post-sexual exposure prophylaxis (of antiretroviral drugs) for sexual minorities who experience sexual assault and for HIV-serodiscordant couples in case of condom failure or accidental exposure (non-use of condoms).

4. Provide free gender transition procedures including sex change operation for transgender people – both male-to-female and female-to-male.

5. Promote safer sex behaviours among PLHIV (‘positive prevention’). Safer sex messages for PLHIV (including sexual minorities) need to focus on the benefits of consistent condom use with both infected and un-infected partners – which include prevention of re-infections and HIV super-infections, avoiding infection of drug-resistant strains, and STI prevention.

6. Involve HIV-positive men and married MSM and TG persons in family planning counselling to provide support to their spouse’s decisions on family planning and to offer information about male-specific permanent sterilization methods.

7. Address the SRH and HIV related information and service needs of physically-challenged people and HIV-positive adolescents.

8. Ensure that all PLHIV are screened for hepatitis B and C infections, and MSM, Hijras and TG persons are screened for hepatitis B infection. Those found hepatitis B negative should be offered relevant vaccination. Those infected with either of the infections, should be provided free or subsidised treatment.

C. Support PLHIV Networks and CBOs Working with Sexual Minorities

1. Ensure that all the needy PLHIV networks at the district and state level are supported by NACO and SACS – regardless of the HIV prevalence category of the district. Support needs to be both in terms of funding as well as capacity building.

2. Support PLHIV networks and NGOs/CBOs working among marginalized communities to meet the unmet SRH needs of PLHIV and sexual minorities through the initiative in RCH-II/NRHM to engage civil society groups in providing family planning services.

D. Research Gaps and Priorities

1. Develop appropriate and sensitive measures to capture information about sexual orientation, behaviour and sexual and gender identities, and use those measures in population-based national health surveys to assess health status and identify health disparities, if any, among sexual minorities.

2. Plan and carry out longitudinal surveys that assess the health status and stigma and discrimination experienced by PLHIV and sexual minorities to inform health policies and programmes.
5. GLOSSARY

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

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

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

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

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

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

Lesbian Woman (here ‘lesbian’ as a self-identity)
A lesbian woman may be understood as someone who has significant (to oneself) sexual or romantic attractions primarily to women, or who identifies as a member of the lesbian community.

Bisexual Woman (here ‘bisexual’ as a self-identity)
A bisexual woman may be understood as someone who has significant (to oneself) sexual or romantic attractions to members of the same gender and/or sex and another gender and/or sex.

Hijra
Hijras are biological males who identify either as women, or “not-men”, or “in-between man and woman”, or “neither man nor woman”. Hijras can be considered as the western equivalent of
transsexual (male-to-female) persons but Hijras have a long tradition and culture, and have
strong social ties formalized through a ritual called “reet” (becoming a member of the Hijra
community). There are regional variations in the use of terms referred to Hijras. For example:
‘Kinner’ in Delhi) and ‘Aravani’ in Tamil Nadu.

Hijras may earn through their traditional work: ‘Challa’ (clapping their hands and asking for alms),
or ‘Badhai’ (blessing new-born babies, or dancing in wedding ceremonies). Some proportion of
Hijras engage in sex work for lack of other job opportunities, while a small number may be self-
employed or work for NGOs.

Transgender People
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.

In contemporary usage, ‘transgender’ has become an umbrella term that is used to describe a
wide range of identities and experiences, including but not limited to pre-operative, post-
operative and non-operative transsexual people (who strongly identify with the gender opposite
to their biological sex); male and female ‘cross-dressers’ (sometimes referred to as
“transvestites”, “drag queens”, or “drag kings”); and men and women, regardless of sexual
orientation, whose appearance or characteristics are perceived to be gender-atypical. A male-to-
female transgender person is referred to as 'transgender woman' and a female-to-male
transgender person, as 'transgender man'.

Sex
1. A term used historically and within the medical field to identify genetic/biological/hormonal/
physical characteristics, including genitalia, which are used to classify an individual as female,
male or inter-sexed person. 2. A person's biological or anatomical identity as male, female or
inter-sexed person. 3. Activity engaged in by oneself, with another, or more than one other
person to express attractions and/or arousal.

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

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

Sexual Minorities or Sexual Minority Community
These terms refer to lesbian, gay, bisexual and transgender/transsexual persons as well as
persons with other identities (such as Kothis and Hijras) as a minority group in a predominantly
heterosexual population (sometimes referred to as 'sexuality minorities'). These days, the terms
'sexual minority communities' or 'sexual minority populations' are used to stress that, like the
people they comprise, these communities or populations are diverse.
Most of the above definitions are adapted from:
Chakrapani, V; Kavi, A R; Ramakrishnan, R L; Gupta, R; Rappoport, C; and Raghavan, S S (2002). HIV prevention among men who have sex with men (MSM) in India: Review of current scenario and recommendations. SAATHII, Chennai, India. Available at www.indianLGBThealth.info

Convergence
In many countries, the HIV/AIDS pandemic has compelled the fields of sexual and reproductive health (SRH) and HIV to better leverage their strengths and address missed opportunities. Convergence of HIV and SRH services can mean just mutual referrals. It can also mean providing HIV related BCC within an SRH setting, and vice versa, or sharing training and training resources. At the facility level, SRH and HIV services can be converged with one another, providing a greater range of service components offered by health facilities. As well as convergence of activities or interventions, convergence of management, administrative, and support functions may result in more efficient infrastructure.


Integration and Linkages
Following the 1994 International Conference on Population and Development, ‘integration’ was interpreted primarily to mean offering a range of services that could meet several needs simultaneously, usually at the same time, same venue, and through the same provider (with relevant data also being recorded in a single database). This interpretation of the term has dominated the literature until recently. These days, the term ‘linkage’ has been used more widely for two main reasons: 1) Many government programmes have separate delivery mechanisms for HIV prevention and treatment services, and family planning and reproductive health services, and the need to link SRH and HIV services reflects the ground reality that, nationally and internationally, policies, funding and health systems for these services remain separate and may remain so in the foreseeable future; thereby necessitating a linked rather than integrated delivery approach. 2) The term ‘linkage’ is also being used to highlight that people’s vulnerabilities to HIV and to SRH ill-health are usually linked through structural determinants such as poverty, gender inequality, marginalisation and inequitable access to information and services.

APPENDICES

Appendix 1: Key SRHR Issues Related to PLHIV and Sexual Minorities

- Gender identity, expression, role and gender discrimination
- Sex and sexuality
- Sexual health
- Stigma and discrimination
- Adolescent sexual and reproductive health
- Adolescent body changes (including menstruation and hygiene)
- Reproductive organs and their functions
- Sexual abuse and harassment
- Child sexual abuse
- Early marriage
- Infertility treatment
- Conception
- Pregnancy care
- Contraceptives
- Safe abortion practices
- Post-partum services
- Immunization
- Nutrition
- RTI/STI prevention and treatment
- HIV/AIDS prevention, care, support and treatment
- HIV/AIDS friendly services
- Safer sexual practices
- Male involvement
- Sexual reassignment surgery
- Safe hormonal therapy
- People with disabilities
- Information, education and services
- Referrals, networks and linkages
- Counselling
- Crisis intervention
Appendix 2: Details of Key Programme Areas of RCH-II

Population stabilization: This section focuses on discussing the issues surrounding the use of contraception and the specific programmes/strategies designed through RCH-II to address those issues. The currently available spacing methods are oral contraceptive pills (OCPs), condoms, intra-uterine devices (IUDs), sterilization (both male and female) and emergency contraception (pills and IUD). Under RCH-II, the government has proposed to expand contraceptive choices and by doing so it aims at increasing access to services through providing a range of options. The additional methods offered include: 1) Injectable contraceptives; 2) Promoting natural family planning methods such as Lactational Amenorrhea Method (LAM) and Standard Days Method (SDM); 3) Other new forms of OCPs; and 4) Female condoms. RCH-II acknowledges condom (male and female) as the only contraceptive method that provides dual protection from pregnancy as well as from STI and HIV.

In order to expand the range of available family planning services, RCH-II has proposed a set of key strategies that include: 1) Training of district hospital, PHC and CHC staff to offer an expanded choice of family planning services; 2) Strengthening the infrastructure facilities of district hospitals, PHCs and CHCs for providing family planning services; 3) Engaging the private (corporate) sector to provide quality family planning services; 4) Stimulating demand for quality family planning services through increasing compensation for undergoing family planning; 5) Using media as a tool to propagate family planning messages; 6) Social marketing of contraceptives in rural areas; and 7) Engaging NGOs in providing family planning services.

Maternal health: RCH-II has proposed strategies that aim at reducing maternal mortality rate. Under RCH-II, expansion and strengthening of facilities for institutional deliveries and emergency obstetric and child care (EmOC) will be given the highest priority.

PHCs will be strengthened to become sites for conducting deliveries and providing obstetric care for all complications. It is expected that by 2010, all CHCs and at least 50% of the PHCs should be providing 24-hour delivery services including the management of common obstetric complications and emergency care of sick children. In addition, these centres will also provide services for family planning, safe medical termination of pregnancies (MTPs), and RTIs/STIs. Guidelines to operationalize the above mentioned services have already been developed.

Under the training component, all doctors (MBBS degree holders) will be trained on basic obstetric care including handling caesarean deliveries. At the community level all the ANMs will be trained to provide obstetric first-aid services including strengthening their ANC care-related counselling skills. RCH-II also talks about the need to improve the quality of ANC care. It aims at raising the proportion of pregnant women receiving ANC care from 44% to 88%.

RTIs and STIs: RCH-II notes the importance of giving major thrust to control RTIs and STIs, and acknowledges the gap in the need for upgrading the skills of health care personnel. At the district level, NACO provides the input for diagnosis and management of RTIs/STIs. However, at the sub-district level the services need to be strengthened. RCH-II proposes strategies that aim at promoting recognition and referral of women (and their sexual partners) with suspected RTIs or STIs; strengthening services for the diagnosis and treatment of RTIs/STIs at PHCs, CHCs, FRUs and district hospitals (including strengthening synergy with NACO activities). Through RCH-II a national consultation has been organized to develop guidelines for dealing with RTIs/STIs at different levels of the health system. The guidelines have been released.

Adolescent health: A two-fold strategy has been proposed under RCH-II to address the adolescent reproductive and sexual health (ARSH) needs. One strategy aims at the overall scale-up and coverage of the RCH-II programme by incorporating the issues of adolescents in all the training programs and IEC materials on RCH. A set of key activities has been proposed to
reach out to adolescents and that includes interventions addressing unmet needs for contraception and pregnancy care, and prevention of STIs and HIV.

Under RCH-II a framework is proposed for operationalizing ASRH services within the context of public health systems. A set of activities focusing on promoting ASRH has been proposed at various levels – sub-centre, PHC, CHC and district hospital.

At the sub-centre level the following services will be available: Provision of spacing methods; routine ANC care and institutional delivery; referrals for early and safe abortion; STI/HIV/AIDS prevention education and nutrition counselling (including anaemia prevention). At the PHC/CHC level, the services will include: Contraceptives; management of menstrual disorders; RTI/STI preventive education and management; counselling and services for pregnancy termination; nutritional counselling and counselling for sexual problems.

In order to facilitate the provision of above mentioned services – through RCH-II – capacities of the health care providers will be strengthened. A self-learning training module covering the core contents – vulnerabilities of adolescents, need for services, and how to make existing services adolescent-friendly – will be developed and used for training the health care providers. In addition, BCC materials that focus on the vulnerabilities of adolescents and the need for ASRH will be developed in local languages.
## Appendix 3: Proposed Framework for Convergence between DoH&FW and NACP

<table>
<thead>
<tr>
<th>Area of Convergence</th>
<th>Role and Functions of DoH&amp;FW</th>
<th>Role and Functions of NACP</th>
<th>Convergence mechanisms/aspects</th>
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</table>
| RTI/STI             | - Primary Responsibility - Integrate RTI/STI management at all levels in public sector system.  
                     - Increase private sector involvement in high quality RTI/STI treatment  
                     - IMA and FOGLI  
                     - Broadly RCH Phase II strategies should be followed  
                     - At PHC level, first line drugs to be offered, district, CHC and FRU to offer comprehensive etiological and lab based treatment. At district level, linkages with STD referral labs to be strengthened. | - Support to HRG-NGOs to continue. Service delivery whether directly through NGOs or referral to public or private sector.  
                     - Ensure that all STI service data and special studies are provided to Joint Consultative Working Group (JCWG) to enable reporting at the convergence committee level. | - At National level, NACP and DoH&FW to set up a JCWG group to monitor access of RTI/STI services for general population and for HRG. Report to HIV/AIDS Convergence Committee.  
                     - Training of providers (public, private and NGO) and lab techs. within purview of DoH&FW.  
                     - DDG-MH/NACO |
| VCTC                | - Infrastructure space to be provided in facilities where VCTC are located.  
                     - Support to ensure referral from other departments  
                     - Overall supervision by head of facility, in collaboration with Ob/Gyn, STD, Paed, and other depts.  
                     - Frontline providers to motivate community at risk for VCTC. | - Primary responsibility :  
                     - Increase VCTC sites.  
                     - Expansion in phased manner.  
                     - NACP support for staff and supplies.  
                     - Include Youth Friendly Information Centers at CHC and PHC.  
                     - VCTC to serve other counseling needs.  
                     - Cadre of counselors to staff the sites. | - JCWG to review functioning of VCTC through periodic State reports. Report to HIV/AIDS Convergence Committee  
                     - Training of providers of DoH&FW at all levels to include elements of risk protection, motivation for testing through DoH&FW  
                     - NGO training facilitated by NACP, but modules jointly developed.  
                     - NACO/DDG-MH |
| PPTCT               | - Overall supervision by head of facility.  
                     - Located in Ob/Gyn department, managed by HOD.  
                     - Ensure non-discriminatory practices.  
                     - Ensure universal precautions.  
                     - At the community level, ANM/ASHA follow up of VCTC clients testing positive for ANC, and motivate for PPTCT. | - Primary Responsibility to ensure functioning PPTCT  
                     - Expand PPTCT sites in a phased manner.  
                     - NACP to support once counselor and lab. Tech. and supplies for PPTCT. | - JCWG to obtain data on functioning of PPTCT and review performance  
                     - Training for all providers to include attitudinal as well technical skills, and universal precautions.  
                     - DoH&FW  
                     - Private sector through IMA and FOGLI  
                     - DoH&FW/NACO/DDG-MH |
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>BCC</td>
<td>All messages for HFW to include HIV/AIDS prevention and care and support as appropriate.</td>
<td>Messages for HIV/AIDS highlight appropriate service provision through public and private health system.</td>
<td>BCC strategy/division for NACP and DoH&amp;FW under single management.</td>
</tr>
<tr>
<td></td>
<td>Ensure that NGO programs also use message content as defined.</td>
<td>Ensure that NGOs highlight service access in addition to prevention messages.</td>
<td>Condom procurement and distribution for FW and NACO under single entity.</td>
</tr>
<tr>
<td>Condom Promotion</td>
<td>Enhance condom use for dual protection.</td>
<td>Condom promotion key to prevention.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female condoms to be promoted as a contraceptive/barrier method.</td>
<td>Female condoms to be promoted as a contraceptive/barrier method.</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>Primary Responsibility for training of all service interventions (except VCTC/ PPTCT) to be within DoH&amp;FW.</td>
<td>Support training in terms of content and technical support.</td>
<td>NACP to coordinate with groups working on RCH Phase II modules to ensure HIV/AIDS content for all workers.</td>
</tr>
<tr>
<td></td>
<td>Support training content and technical support for VCTC and PPTCT training.</td>
<td>Primary responsibility for training VCTC counselors in a range of issues including HIV/AIDS, which include safe motherhood, family planning and childcare. PPTCT staff training also to be conducted by NACO/SACS.</td>
<td>Joint Working Group to be instituted to review and ensure that HIV/AIDS messages and content for training are tailored to each level of provider.</td>
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<td></td>
<td>Ensure that training modules are shared with NGO partners of DoH&amp;FW and NACP.</td>
<td>Ensure that training modules are shared with NGO partners of DoH&amp;FW and NACP.</td>
<td>Ensure dissemination of protocols and guidelines to NGOs and private sector.</td>
</tr>
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Appendix 4: NACP-III: NACO and SACS Organograms²⁹
NACP III: SACS Organogram - Category II States

Project

Addl. Project Director - 1

Joint Director

Joint Director

Joint Director

Joint Director

Joint Director

Joint Director

Asst. Director, ICTC, STI
Asst. Director, B6
Asst. Director, Civil Socy.
Asst. Director, Condom
Asst. Director, Surveillance
Asst. Director, M & E
Asst. Director, ART
Asst. Director, Of
Asst. Director, Finance/ Aid
Asst. Director, Admin. & Proc.

NGO Coordinator

DPO, 1 Stat. Officer

Manager/Supply Logistics

Accountant

Asst. (Gr/Eqpt)
Asst. (Serv/HBC)
Asst. (GM)

12 Programme Assistants for all the above positions

NACP III: SACS Organogram - Category III States

Project Director - 1

Joint Director - 1

Joint Director - 1

Joint Director - 1

Asst. Director - 1

Asst. Director - 1

Asst. Director - 1

(Epidemiologist)

(EVP/CoM)

(Prevention, SIMS, Care, ICTC)

(EO/Civil)

(Fin., Proc., & Accounts)

Accountant - 1

7 Programme Assistants for all the above positions
NACP-III Organogram at the District

NACO

SACS

DHS

RCH NRHM Immunization Committee

TB Committee

DAPCC District Control Officer

Malaria Committee

Blindness Control Committee

DPMU

DACO

DAPCO

DAPCU

DPM

M&E Asst.

Accountant

Prog. Supervisor
Appendix 5: NRHM and RCH-II Institutional Arrangements

NRHM Institutional Arrangement

RCH-II Institutional Arrangement at the National and State Level
Appendix 6: Topic Guides for Key Informant Interviews

Note: These were not the exact wordings that were used in the interviews

3-a. Topic guide for conducting KIIs with SACS and TSU officials

Thanks for agreeing to participate in this interview. Through this interview, we would like to get information from you regarding the SACS-supported interventions among MSM/TG. We also want to know your experiences and perspectives in supporting these interventions; intervention components; and any challenges you have faced.

1. Can you tell us about the support of SACS in relation to interventions among MSM in [state]?
   Probes (examples):
   - What do you think about the coverage of MSM/TG in [state]? Do the SACS have any written plan for scaling up of MSM/TG TIs to increase coverage?
   - Are there any plans to provide free water-based lubricants or to increase the budget for lubes?
   - NACO guidelines usually prevent a single agency being supported for more than 6 TIs. Whether this posed (or pose) a problem in supporting [agency/network]?

2. What is the plan of SACS in relation to supporting Hijras/transgender people? Do you envisage a need for separate TIs or do you want to just ensure Hijras/TG also receive tailored services in ‘MSM TIs’ or you are planning for both?

3. What have been your experiences of working with CBOs/networks? What have you liked and what are the things you wish could have been handled in a different manner?

4. Technical support for CBOs/networks: What kind of technical assistance is provided to networks/CBOs in implementing and managing TIs? Whether CBOs that are not currently receiving SACS funds are eligible to get technical support to build their capacity to implement interventions in the near future?

5. In relation to MSM/TG interventions, what changes you would like to see in NACP-III guidelines?

6. How do SACS collaborate/coordinate with the state RCH department and NRHM? Can you explain in detail – especially in relation to issues of MSM/TG people?

7. Do you have any other things to say before we close this interview?

Thank you very much for your time.

3-b. Topic guide for conducting KIIs with PLHIV network leaders

Thanks for agreeing to participate in this interview. I will be asking you some questions in relation to PLHIV networks and how SACS support PLHIV networks. Please feel free to answer in detail. Your name will not be mentioned in the report and we will keep any names you mention in this interview as confidential and will not include those names in the final report.

1. Can you tell me about yourself briefly and your association with the network?

2. Can you tell me about your interactions with the SACS? (Explore how he/she has been involved: As a positive speaker, consultant, executive board member, speaking in key events of SACS, training programs of SACS, etc.)

3. Funding support from SACS: Whether SACS funds the state and district level PLHIV networks? Do you or did you face any problems in getting funding support from SACS? What are the challenges faced by the state and district level PLHIV networks in getting funding from SACS?

4. If managing drop-in centres: Explore whether there are any challenges faced in properly running the drop-in centre related activities. How are these overcome?

5. Capacity building programs: Explore: What kind of capacity building programmes have been attended by PLHIV network representatives? Who conducted them (SACS, INP+, international NGOs, etc.)? What are their capacity building needs in relation to organizational and personal development?

6. Can you talk about the other PLHIV networks in this state? Explore the relationships with other networks (good/bad/neutral, etc.). Find out how they have interacted so far (get some specific
examples). What is the respondent’s view on the other networks and whether there is a possibility that all the networks can work together to achieve a common cause?

7. Can you talk about your or your network’s relationships with CBOs working with marginalized groups – MSM/TG, IDUs, sex workers? Explore - What kind of relationships exist (get specific examples) and how they have interacted so far.

8. What do you think about the current initiatives by NACO and SACS in relation to GIPA? Explore in relation to the institutional mechanisms such as having SACS GIPA Coordinator. (If they are not aware – briefly mention about these GIPA-related posts and responsibilities to them – to get their informed inputs).

9. Explore: What are the perceived or actual changes that happened as a result of involving PLHIV or their networks in various activities – including any decision making process of SACS? Have they seen any changes? For example, whether stigma and discrimination have decreased after training/sensitization of health care providers (if PLHIV are involved in the training)?

10. What changes you would like to see in the SACS in relation to funding and other support for PLHIV networks?

11. Do you have any other things to say before we close this interview?

Thank you very much for your time.

3-b. Topic guide for conducting KIIIs with MSM/TG/Hijra CBO leaders

Thanks for agreeing to participate in this interview. I will be asking you some questions in relation to MSM/TG programmes in [state]; and how SACS support and involve MSM/TG CBOs. Please feel free to answer in detail. Your name will not be mentioned in the report and we will keep any names you mention in this interview as confidential and will not include those names in the final report.

1. Can you tell me about yourself briefly and your association with your CBO?
2. Can you provide details about the MSM/TG CBOs and MSM networks (if any) in your state?
3. Funding support from SACS: Do SACS fund MSM/TG CBOs in this state? What are the challenges faced by MSM/TG CBOs in getting funding from SACS? What kind of funding support does your CBO get from SACS? Do you or did you face any problems in getting funding support from SACS for running targeted interventions?
4. Funding support from others: Do you currently get funding support from any other sources? Can you explain about that source of funding and what is it available for? Are other MSM/TG CBOs getting funds from anyone else?
5. If you are implementing TIs for MSM/TG: [Explore] What are the challenges you face in implementing the various components of TIs (outreach, BCC, drop-in centre, condom promotion and distribution, and referrals for STI/HIV screening/treatment)? Do you have any suggestions for better implementation of these components?
6. NGOs working with MSM/TG: Are there any NGOs working with MSM/TG in your state? If yes, how many? Have they established any CBOs in their project areas? Are there any plans for transition of TIs from those NGOs to CBOs?
7. Capacity building programs: [Explore] What kind of capacity building programmes have been attended by MSM/TG CBO staff? Who conducted them (SACS, national and international NGOs, others)? What are their capacity building needs in relation to organizational and personal development?
8. Can you talk about how your or your CBO’s relationship is with PLHIV networks? Explore - What kind of relationships exist (get specific examples) and how have they interacted so far?
9. What changes would you like to see in the SACS in relation to funding and other support for MSM/TG CBOs?
10. Do you have any other things to say before we close this interview?

Thank you very much for your time.
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