National AIDS Control Organisation
India's voice against AIDS
Ministry of Health & Family Welfare, Government of India

OPERATIONAL GUIDELINES FOR

Implementing Targeted Interventions among Hijras and Transgender People in India

Guidelines for CBOs/NGOs and SACS/TSU

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Date: 2015

National AIDS Control Organisation
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Maps are taken from OPG for Core Groups (FSW) NACP-III, TG and Hijra interventions need to develop TG and Hijra people specific maps based on TG and Hijra people's needs

Design:
New Concept Information Systems Pvt. Ltd.
email: communication@newconceptinfosys.com

Printed by:
Nikhil Offset
email: nikhil223@yahoo.com

लव वर्मा
सचिव
LOV VERMA
Secretary

सत्यमेव जयते

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण विभाग
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Government of India
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Ministry of Health and Family Welfare

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Foreword

The National AIDS Control Programme Phase IV (NACP IV) of India aims to accelerate the reversal of the epidemic and to further integrate the response by reaching out to the hard-to-reach population groups at high risk with targeted interventions through innovative approaches. One such group which has been recognised as a High Risk Group (HRG) and difficult to reach is Transgender and Hijras. It has been estimated that the HIV prevalence rate in India amongst the transgender community at some places is as high as 18%. Keeping in view the aim of reversal of HIV epidemic in India, it is of utmost importance that the Programme should make intensive efforts to control the spread of HIV infection within this groups on a priority basis.

NACP IV has prioritised TG and Hijras (Trans-women) for HIV preventive interventions scale-up so as to reach all high risk TG/Hijra population. In this endeavour, Operational Guidelines for TG/Hijra will help in building capacity of community led interventions. These Guidelines have been prepared after extensive consultation with experts and community members. The guidelines are beyond 'business as usual' having been developed from a bottom up approach with technical and community inputs which have been compiled and refined over a period of two years. Guidelines are designed for use by national public health officials and managers of HIV/AIDS and STI programmes, Non-Government Organisations (NGOs) including community and civil society organisations and health workers.

As India is poised for upscaling TG and Hijra interventions, these guidelines will help in promoting excellence in TI programme interventions. Since these guidelines are first of its kind, I hope that the international community will also find it beneficial for implementing TG/Hijra interventions.

(Lov Verma)

कमरा नं 156, ए–स्कंध, निर्माण भवन, नई दिल्ली–110011

Acknowledgment

The National AIDS Control Organisation in partnership with UNDP has prepared these Operational Guidelines after a series of consultations with technical and community resource persons, representatives of civil society, Government, core groups, donors and other stakeholders.

The guidelines describe the operational details of how model targeted interventions for TG and Hijras can be operationalised. The guidelines also provide detailed information on issues related to programme management, services required in terms of human resources, infrastructure, linkages and monitoring and evaluation indicators for each programme area.

This draft was written by Dr. Venkatesan Chakrapani, Shankar Silmula, and Ernest Noronha at UNDP and finalised by Manilal Pavitram, and Mridu Markan of the Department of AIDS Control TI division.

I take this opportunity to acknowledge the contribution made by the resource persons, the TI Team of NACO, the DFID technical assistance support team(TAST) project, and the technical team at UNDP in preparing these guidelines. We hope that these guidelines will help State AIDS Control Societies, potential partners (NGOs, CBOs, and networks), programme managers and other staff working in TI projects and TSUs to implement and manage TI projects more effectively.

Dr Neeraj Dhingra
Deputy Director General – Targeted Interventions
National AIDS Control Organisation

Abbreviations and Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CBO	Community Based Organisation
DAPCU	District AIDS Prevention and Control Unit
FSW	Female Sex Worker
GIPA	Greater Involvement of People Living with HIV/AIDS
HCP	Health Care Provider
HIV	Human Immuno-deficiency Virus
HRG	High Risk Group
ICTC	Integrated Counselling and Testing Centre
IEC	Information, Education and Communication
LL	Lower Level
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
OI	Opportunistic Infections
ORW	Outreach Worker
NACP	National AIDS Control Programme
NGO	Non-governmental Organisation
PE	Point Estimate

PLHIV	People Living with HIV
PO	Programme Officer
PPTCT	Prevention of Parent to Child Transmission
RNTCP	Revised National TB Control Programme
SACS	State AIDS Control Society
SAEP	School AIDS Education Programme
SBC	Strategic Behaviour change Communication
STI	Sexually Transmitted Infection
TO	Technical Officer
STRCs	State Training and Resource Centres
TG-H	Transgender – Hijra
TI	(STI/HIV) Targeted Intervention
TSU	Technical Support Unit
UL	Upper level

Contents

Introduction and Background

1. Purpose and Target Audience of the Guidelines

1.1 Need for and Purpose of the Operational Guidelines

There has been growing interest driven by the HIV control programme/efforts in the Transgender community. In NACP-IV Transgender are recognised as a High Risk Group (HRG). It is estimated that the HIV prevalence rate in India among the transgender community is 8.82% (HSS 2010-11), therefore, intensive efforts have been made to control spread of HIV infection within this group. In NACP III (2007 - 2012), the national programme tries to focus attention on routes of transmission among IDU and MSM including Transgender.

NACP III prioritised Hijras for HIV preventive interventions. There have been a few stand-alone intervention for this group in Maharashtra. This may have been due to the difficulty in accessing them, lack of accurate estimation of their population or other factors including discrimination and stigma attached to this group and lack of clarity on their needs and concerns. As the subject group is a high risk group there is a felt need for the national programme to strengthen its reach to the Transgender/Hijra community.

Targeted HIV Interventions for Hijras and Transgender (TG-H) people are relatively new and necessitate conceptual clarity, implementation abilities and enabling environment for them to work. Ensuring performance of the programme and achieving intended outcomes are possible only if adequate mechanisms and quality control and improvement mechanisms are in place and regularly monitored and evaluated, and lessons learnt are used to improve the programme.

In India, the national programme for hijras and transgender populations has to be scaled up with adequate quality so that HIV prevalence can be reduced and prevention and care services are made available to these populations. Thus, these guidelines have been prepared by National AIDS Control Organisation (NACO) and the guidelines define the essential and comprehensive package of services with procedures for implementation, M&E and costing.

1.2 Target users of the operational guidelines

These guidelines are primarily for the CBOs/NGOs implementing the Targeted intervention for Hijras and transgender people in India that are supported by NACO/SACS (both stand-alone and core composite interventions in areas where the Transgender – Hijras populace are not substantive in numbers that necessitate a standalone intervention). The guidelines provide adequate information to CBOs/NGOs and the TI implementation staff viz. PM, ORWs and Peers to plan, implement and monitor high quality prevention and care services to Hijras and transgender people. Thus, programme officers in-charge of targeted interventions will be using these guidelines as a reference point and as a quality check mechanisms for ensuring comprehensive service provision to this target group.

Some guidelines are also directly applicable to NACO SACS and TSU officials regarding what they can support or do to create an enabling environment and building the capacity of various stakeholders, in addition to supporting NGOs/CBOs to implement TIs among Hijras and transgender people.

2. Background

In the third phase of the National AIDS Control Programme (NACP-III; 2007-12), National AIDS Control Organisation/Department of AIDS Control (NACO/DAC[1]) highlighted that 'transgender people' have different HIV prevention and care needs although there are some commonalities between men who have sex with men (MSM) and transgender people. Considering the high HIV prevalence 8.82%[2] among Transgender – Hijras when compared with other high risk groups, it is crucial that HIV interventions among Transgender – Hijras people are scaled up. To assist NACO and SACS in scaling up Transgender – Hijras interventions, operational guidelines for Transgender – Hijras interventions have been developed.

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

NACP-III preparation exercises reconfirmed the importance of focusing efforts on prevention amongst high risk groups (HRGs). While much work has been done in India with female sex workers, it was recognised that the national programme needs to be strengthened among Hijras and transgender people. The national strategy drafted by the NACP-IV working group acknowledges the unique HIV prevention, care, and treatment needs of Hijras and transgender people.

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[1] *More information on NACO at www.nacoonline.org*

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

2.1 Size estimation of Hijra and transgender populations

As per the recently conducted NACO – NIE – UNDP 17 state mapping and size estimation study, point estimate of the TG population from the 5,821 sites was 62,137 (95% CI 53,280,74,297). From this exercise, it is seen that a majority (71%) of TGs were in urban locations and 47% were living as a group under a head TG (Gharana based) Among the TGs who were engaged in sex work (62%), 72% were gharana based. Other main occupations of TGs were begging (28%), blessing others (31%), and dancing (18%). In 9/17 States, more than 60% of TGs were engaged in sex work. In three (Kerala, Manipur and West Bengal) States more than 70% of TGs were living with their own families. Twenty nine districts out of 466 districts in 17 States had more than 400 TGs.

Table 1: Size estimates of Hijras/TG population in study States by location

	Location of the site								
	Total			Rural			Urban		
	Point Estimate	Lower Level	Upper Level	Point Estimate	Lower Level	Upper Level	Point Estimate	Lower Level	Upper Level
Andhra Pradesh	5401	4911	6203	758	704	975	4643	4207	5228
Assam	466	409	472	36	34	40	430	375	432
Bihar	1053	827	1298	160	121	223	893	706	1075
Chhattisgarh	935	817	1051	136	127	155	799	690	896
Gujarat	3058	2669	3439	261	224	294	2797	2445	3145
Jharkhand	385	275	512	25	22	31	360	253	481
Karnataka	2920	1755	4196	300	210	466	2620	1545	3730
Kerala	3208	2658	3452	48	35	50	3160	2623	3402
Manipur	799	697	877	_	_	_	799	697	877
Maharashtra	10057	8727	11588	800	692	994	9257	8035	10594
Nagaland	20	19	21	_	_	_	20	19	21
Odisha	7854	6629	9228	3724	3098	4439	4130	3531	4789
Punjab	4182	3631	4680	438	369	503	3744	3262	4177
Rajasthan	1863	1699	2627	415	379	646	1448	1320	1981
Tamil Nadu	5147	4522	7205	792	726	1092	4355	3796	6113
Uttar Pradesh	8001	6737	9300	3180	2716	3691	4821	4021	5609
West Bengal	6788	6298	8148	2273	2119	2572	4515	4179	5576
Total	62137	53280	74297	13346	11576	16171	48791	41704	58126

2.2 HIV and STI prevalence among Hijra and transgender populations in India

The estimated size of MSM population in India including Hijras and transgender communities is 4.2 lakhs (NACP-IV strategy document). HIV prevalence among MSM populations is 4.43 as against the overall adult HIV prevalence of 0.36%. Until recently, Hijras/transgender people were included under the category of MSM in HIV sentinel serosurveillance. HSS 2010-11, with samples recruited from three sites, shows 8.82% prevalence TG-H population, which is significantly higher than other high risk populations.

STI prevalence among Hijras too is quite high. A study conducted in a Mumbai STI clinic reported very high HIV seroprevalence of 68% and high syphilis prevalence of 57%[3] among Hijras. In South India, a study documented a high HIV seroprevalence (18.1%) and Syphilis prevalence (13.6%) among Hijras[4]. A study conducted in Chennai documented high HIV and STI prevalence among Aravanis: 17.5% diagnosed positive for HIV and 72% had at least one STI (48% tested seropositive for HSV-1; 29% for HSV-2; and 7.8% for HBV)[5].

Published data on sexual risk behaviours of Hijras and transgender are limited but available data indicate high risk sexual behaviours. The available information from the Integrated Biological and Behavioural Assessment (IBBA) survey 2007 conducted in select districts of Tamil Nadu, reported that, nearly three-fourths of them had used condom with them in the last sex act but every time condom usage was 34%. Seventy four percent of Aravanis had paying male partners, and consistent condom usage with them was about 50%. Nearly one-third of the Aravanis had other non commercial male partners and 20% of them used condom for every act.

2.3 About the terminology used – Hijras and Transgender people

Even the umbrella term 'transgender' may hide the complexity and diversity of the various subgroups of gender-variant people in India and may hinder development of

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[3] *Setia, M. S., Lindan, C., Jerajani, H. R., Kumta, S., Ekstrand, M., Mathur, M., Gogate, A., Kavi, A. R., Anand, V., & Klausner, J. D. (2006). Men who have sex with men and transgenders in Mumbai, India: An emerging risk group for STIs and HIV. Indian Journal of Dermatology, Venereology & Leprology, 72(6), 425-431.*

[4] *Brahmam, G.N.V., Kodavalla, V., Rajkamur, H., et al. (2008). Sexual practices, HIV and sexually transmitted infections among self-identified men who have sex with men in four high HIV prevalence states of India. AIDS, 22(5), S45 - S57.*

[5] *Saravanamurthy, P.S., et al. (2010). See above.*

subgroup-specific HIV prevention and care interventions, and policies. Until recently, HIV programmes in India included transgender women under the epidemiological and behavioural term - 'men who have sex with men' (MSM). However, it is increasingly recognised that transgender people have unique needs and concerns, and that it is better to view them as a separate group, that is, not under the rubric of 'MSM'.

After a series of community consultations held in 2010 on the issues faced by Hijras and transgender people, the following working definitions have been agreed upon:

2.3.1 "Hijras" – Consensus definition by Hijra and Transgender – Hijras communities

"Individuals who voluntarily seek initiation into the Hijra community, whose traditional profession is *badhai* (blessings or good wishes by clapping their hands and seeking alms) but due to the prevailing socioeconomic cultural conditions, a significant proportion of them are into begging and sex work for survival. These individuals live in accordance to the community norms, customs and rituals which may vary from region to region."

Explanation: Hijras are biological males who reject their 'masculine' identity in due course of time to 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 transgender/trans-sexual (male-to-female) persons but Hijras have a long tradition/culture and have strong social ties formalised through a ritual called "reet" (becoming a member of Hijra community). There are regional variations in the use of terms referred to Hijras. For example, Kinnars (Delhi) and Aravanis (Tamil Nadu). Hijras may earn through their traditional work: 'Badhai' (clapping their hands and asking for alms), blessing new-born babies, or dancing in ceremonies. Some proportion of Hijras engage in sex work for lack of other job opportunities, while some may be self-employed or work for non-governmental organisations. A significant proportion of hijras are emasculated/nirwan.

2.3.2 "Transgender" – Consensus definition by Hijra and Transgender – Hijras communities

"Transgender persons usually live or prefer to live in the gender role different to the one assigned to them at birth. It is an umbrella term which includes trans-sexuals, cross-dressers, intersex persons, and other gender-variant persons. Transgender people may or may not have undergone sex reassignment surgery or be on hormonal therapy for gender transition".

Explanation: 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 trans-sexual 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*'.

Note: The term 'transgender' or 'transgender populations/people' when used in this document mostly refer to 'male-to-female transgender people'. Sometimes, for brevity, the abbreviation 'Transgender – Hijras ' is used to denote mainly male-to-female transgender people.

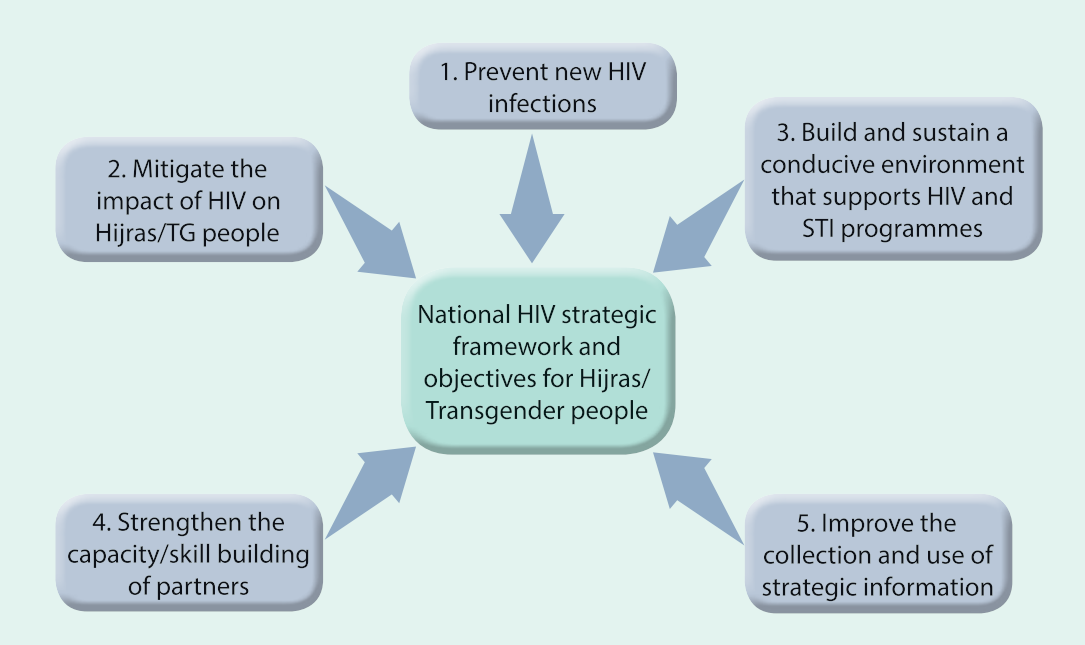
2.4 Key priorities to improve HIV response for Transgender/Hijras

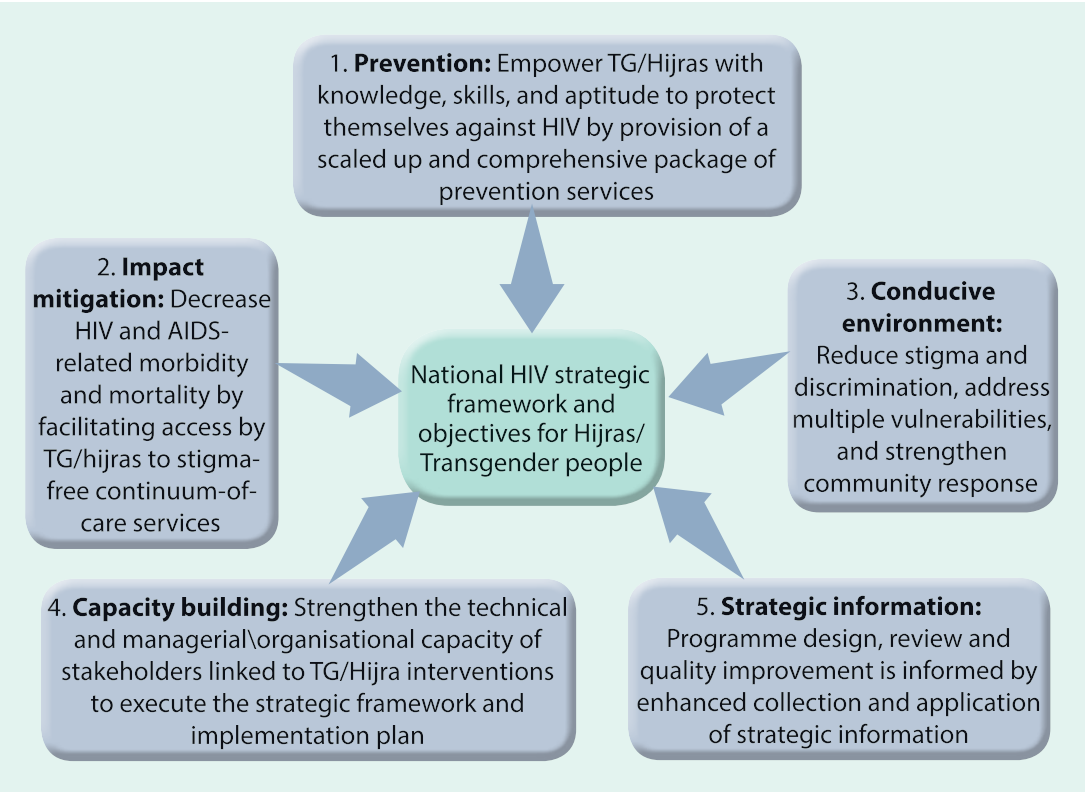
1. Scaling up of **comprehensive prevention package** to achieve significantly increased coverage, particularly where Transgender/Hijras are concentrated and then scale up coverage where Transgender – Hijras populace are sparse or spread out over a larger geographic area
2. Improving the **quality and intensity of transgender – hijra specific prevention services**
3. Building the **technical skills and organisational capacity of CBOs and provide support to effective implementation of prevention activities**
4. Strengthening the **involvement of Transgender/Hijras in HIV/AIDS response** through community development and mobilisation
5. Strengthening the **partnership** between government, CBOs, Transgender/Hijras and technical assistance providers
6. Reducing **stigma and discrimination** against Transgender/Hijras and creation of an enabled environment
7. Vulnerability reduction interventions as well as addressing multiple vulnerabilities
8. Flexibility to design locally responsive interventions

2.5 National HIV strategic framework and objectives for HIV interventions among Transgender/Hijras

In line with the overall strategy and objectives of NACP-IV, the national HIV strategy and objectives for Transgender/Hijras are summarised in the diagrams 1 and 2.

Diagram 1. National HIV strategic framework and objectives for Hijras and Transgender people





Operationalising Targeted Interventions for Hijras and other Transgender People

Guidelines for CBOs/NGOs

1. Introduction

These guidelines are designed for NGOs/CBOs initiating and currently implementing targeted intervention (TI) for TG and Hijras or scaling up an existing intervention to include transgender people, or for strengthening existing TG and Hijras interventions.

The guidelines assume that a desk review and/or broad mapping of existing TIs on the ground has been completed in collaboration with TG and Hijras communities, existing TIs and SACS, and that the number and location of sites and an estimate of Hijras and transgender people are available.

Steps in initiating and Scaling Up Targeted Interventions (TIs)

1. Identification of geographical locations
2. Fixing the target for coverage based on Gharana-based Hijras (who stay together with a leader/guru) and non-Gharana-based TG and Hijras
3. Recruitment and training of staff
4. Site assessment
5. Establishment of basic services
6. Peer Educator (PE) selection and training
7. Scaling up services
8. Outreach planning
9. Community ownership building plan
10. Creating an enabling environment
11. Linkages with other services

2. Phase 1 of Intervention: Start-Up

Phase 1 of the TI comprises of four major steps: site identification/mapping, recruitment and training of staff (except for Peer Educators); site assessment; and provision of basic services.

Step 1: Identification of geographical locations

To initiate TI project for Transgender/Hijras population, intervention sites are to be identified as step 1 with an estimate of the population. A similar approach may be undertaken where the TI is core composite.

Step 2: Fixing the target for coverage (done by SACS) on Gharana-based Hijras and non-Gharana based Transgender/Hijras

Once the sites are identified, population available in each site to be estimated. Transgender/ Hijras population to be categorised based on Gharana or not (Gharana-based and non-Gharana based) to ensure tailored effective intervention packages. Number of Transgender/ Hijras operating under Gurus/Gharanas and non-Gharana based hijras and Transgender – Hijras should be mentioned as target for exclusive TIs and composite TIs.

Step 3. Recruitment and Training of Staff (other than Peer Educators)

A. Hiring staff for the project

The NGO/CBO should conduct the selection of staff based on the organisation's own recruitment policy. In recruitment, Transgender/Hijras should be provided with equitable access to the jobs available if they meet the requirements (e.g., educational and/or other qualifications, reporting skills) for the post.

Project staff should:

- Be non-judgmental and willing to work with transgender and Hijras
- Have good communication and interpersonal skills. Ideally, should have had some in-house counselling and sexual health training and be experienced in community mobilisation
- Preferably have skills and experience in outreach with other high risk groups such as female sex workers and men who have sex with men
- Strong facilitation and community mobilisation skills
- Knowledge of the local language(s) (essential) and transgender – hijra dialects (desirable)
- Strong coordination skills to work and deliver as one team
- Capacity to review the progress and guide the project to achieve the set goals
- Will have to work in the field at least for 5 days in a week (essentially for ORWs).

B. Capacity building of TI staff

On recruitment, all staff should receive an in-house orientation on basic facts of HIV and AIDS and Transgender/Hijras and attend induction training. The induction training should cover the following topics:

- Introduction to HIV/AIDS including basics of transmission, prevention and treatment of HIV and other sexually transmitted infections
- Orientation on TI operational guidelines for Transgender/Hijras
- Sexuality and gender and the dynamics of sex work
- Orientation on prevailing socio-cultural norms within the Hijra – transgender community
- Basic outreach skills including
  - ➔ Active listening and building rapport with marginalised groups
  - ➔ Methodology of site validation
  - ➔ An orientation on the geography of the TI site, for example, which spots are frequented most and how
  - ➔ Community dynamics and entry points for service delivery
  - ➔ Made aware of the range of available services to which clients might require referral
  - ➔ Basics on how to ensure safety for self and clients when carrying out outreach.

Step 4: Site Assessment

Hijras and transgender people have different needs, lifestyles, and concerns than MSM (though in some cases they may visit the same sites as MSM for cruising, sex work, etc.), hence the programmes need to consider their vulnerabilities due to gender identity related issues. Many Trans people may not identify as transgender, live in secrecy, and/or may be afraid to tell people about their gender history. Site assessments which involve trained members of the Transgender – Hijras community help to characterise the community, identify HIV related needs and gaps, and facilitate implementation of the targeted intervention.

The methodology of site assessment is described in detail in **Annexure 1, *Site Assessment*.** The assessment is conducted by trained members of the project staff along with Transgender/ Hijras liaison persons who conduct a series of interactive and participatory exercises with members of their communities, using visual tools (drawings and maps) to solicit information.

The objectives of the site assessment are to determine the site-specific design of TIs through:

- Validation of broad mapping size and location estimates
- Contact with at least 50% of the mapping denominator at least once in three months (as a form of validating the presence of key population)
- Gaining details on risks/vulnerabilities by typology and location for Transgender/Hijras
- initiating interventions, reaching out to populations and scaling up for new sites in existing Tis

Apart from the quantitative information gained in the assessment, there are qualitative outcomes:

- Establish contact with community – the site validation helps the project to meet at least 50% of the estimated population in a given location on a one-to-one or group basis
- Generate community interest about the project and initiation of community building process
- Dispel myths about the intervention before it even begins, and communicate correctly the project's scope and plans, avoiding false promises
- Identify potential peer educators for future hiring
- Identify existing services which can be utilised by HRGs
- Identifying potential gatekeepers and key stakeholders for creation of an enabled environment on the sites.

Tool: Annexure 1 - *Site Assessment – refer annexure for details*

Step 5: Establishment of Basic Services

In order for the community to have faith in the project and see early signs of benefit from it, the NGO/CBO should ensure that staff in the TI –

- Have comprehensive knowledge of health and social needs of transgender clients
- Have the ability to talk to their clients about a range of health and social issues that impact HIV prevention and care and their overall wellbeing. This could also mean addressing issues of hormone therapy, sex reassignment surgery and appearance modification, gender identity disclosure with partners or other individuals in social networks and on issues of social protection.

Knowledgeable members of the Hijra and transgender community recruited as staff are more likely to have these competencies.

A. Initiating activities

The basic services that can be initiated from the outset are:

- Referral systems for HIV related services and treatment of STIs
- Develop and prioritise a list of health service providers for non HIV and general health needs of Transgender/Hijras
- Availability of free condoms and lubricants and identification of community friendly outlets (manned/unmanned)
- A drop-in centre (DIC)/office space which can be easily accessed by the target population group in a non stigmatised manner.

It is important to get the community involved in the planning of these services. Use the following approach:

- Talk to the community in a group setting and make a list of all required/requested services
- Differentiate between services that can be offered on site and those for which linkages/ referrals are needed (include services that can be made available in government health facilities and private centres)
- Ask community to identify barriers to service provision – outreach, condoms, HIV testing, treatment, etc. through participatory approaches
- Explore with the community how project-driven services (condom promotion and STI services) can be maximised.

B. On-site safe spaces: Drop-in Centres (DICs)

Public sites such as streets/parks, gharana/dera and houses of Transgender – Hijras populace do not allow much contact and quality time for outreach workers or peers, so the provision of DICs as "safe spaces" becomes important. "Safe spaces" are critical in the early phase of service provision and throughout the phase of service delivery continuum, especially for highly marginalised populations like TG and Hijras.

- At DICs, community members can interact with each other, rest, discuss and seek advice on high risk behaviours, share information, approach someone in case of a crisis, or pick up condoms
- There can be education material on treatment adherence and mental health issues
- Other popular DIC activities could include community led entertainment programmes, legal information and aid sessions, livelihoods and income generation, social protection, information counselling and/or STI services can be provided at the DIC through counsellor and/or doctor visits on certain days/times
- Referral to satellite services such as crisis response, social welfare schemes and services can also be provided through the DIC.

The DIC should ideally be located close to the hotspots or settlements of hijras and Transgender – Hijras communities. The choice of the centre location should ideally be influence by availability and the preference of the community.

3. Phase 2 of Intervention: From Peer Educator Recruitment to Scale-Up

Step 6: Peer Educator Selection and Training

A. Who is a Peer Educator (PE)?

A peer educator (PE) is a person who can effectively influence attitude and behaviour of others in his or her social group. Peer Educators (PEs) of the Hijra and transgender community voluntarily take responsibility to provide information on HIV/STIs and harm reduction, and promote condom use and lubes amongst peers. PEs should be given supplies of condoms, lubricants, relevant IEC material for distribution. They also help with basic data collection for monitoring the project.

The PE to H/Transgender – Hijras ratio is set at 1:40 -60 (range). One PE for 40 to 60 Hijras and other Transgender people. The ratio of 1: 40 to 60 to be based on the concentration of the Transgender – Hijras - Hijra population in that particular geographical area.

A good peer educator puts a great deal of effort into maintaining her social network. When new hijras and other Transgender people enter her geographic/peer network, a PE should be able to identify them and introduce them to services as soon as possible.

A PE should also be able to identify and segment her portfolio to identify and serve those Hijras and other Transgender people with the highest risk profile (low condom use, new and young Hijras and other transgender people who sell and have high anal sex transactions). A PE also provides the project staff information on key stakeholders, power persons and gatekeepers to the on-site population, they also serve as a key link for ownership of the project with the community.

A PE should be paid an honorarium as per NGO/CBO costing guidelines for her contribution to the TI project. PE is not a full time TI staff member.

B. Why Peer Education?

Most people's attitudes are highly influenced by the perception of what their peers do and think. Younger people are especially highly motivated by the expectations of peers who they respect because of their knowledge and skills. Moreover, PEs can be a bridge between the local Hijra and transgender community and NGO/CBO implementing the TI. This makes Peer Education in TIs a very effective strategy for changing group behaviour.

Peer educators play an important role in TI implementation as they:

- Provide a vital two-way link between the project staff and the community
- Are important role models who help to build trust and establish credibility for the NGO/CBO in the community
- Can effectively represent their community to other stakeholders and the wider community as they are credible opinion leaders within the target group
- Reach a large number of people effectively through everyday social contacts
- Provide a link between the service and the community (for instance, by introducing people or accompanying them to the service facility).

C. Role of the Peer Educator

- Conduct outreach: this includes identifying new Hijras and other transgender people as well as maintaining regular contact with her own social networks in the community. This might entail contacts on a weekly or bi-weekly basis within any given month
- Should meet all registered contacts at least once every fortnight
- Provide dialogue-based IPC as IPC is more familiar with PEs.
- Build skills of the peer group on an on-going basis; for example, the understanding and assessing high risk behaviour, condom and lube use, condom negotiation, identification of STIs, healthy lifestyles, etc.
- Provide training to new PEs in Transgender – Hijras TI projects
- Encourage service and commodity uptake : motivate Hijras and other transgender people to come to DIC, distribute condoms, and make referrals and/or accompany those who are unwell to health clinics
- Advocate for the group with known power structures in the community (police, unofficial gatekeepers, etc.)
- Support project staff in maintaining the DIC up to guideline standards
- Generate demand for existing Social Welfare Programmes and help with identifying the beneficiaries and providing supporting environment

- Regularly visit condom service centres to gather information and to improve service
- Attend project review meetings
- Prepare and present daily reports to ORWs
- Report preparation for activities implemented
- Attend all trainings, workshops and seminars organised by the TI
- Generate community ownership for the project activities through mobilisation of the community members for increased stake in planning and implementation of the project activities.

D. Qualities of a Peer Educator

Peer Educators are critical to the success of a targeted intervention programme. Peer Educators should have the following attributes –

- Is committed to the goals and objectives of the programme
- Is responsible, punctual and available for the programme
- Displays leadership abilities, has confidence, good at decision-making and is respected amongst his or her peers
- Has access to "social networks" in different locations/sites
- Has interest and desire to help members of his/her community
- Feels accountable to the programme and to his/her community
- Is tolerant and respectful of others' ideas and behaviours
- Good listening, communication, and inter-personal skills
- Is willing to learn and experiment in the field
- Can maintain confidentiality
- Has the ability to lead by example and can be a role model and demonstrate the behaviours and attitudes the programme promotes
- Willing to keep abreast of new information and knowledge in the area of HIV/AIDS and related subjects, such as reproductive health and family planning.

A Peer Educator should not be domineering and exacerbate conflict by forcing community members to do things or by putting them down. Neither should a Peer Educator feel compelled to solve all problems and not take guidance from the Out Reach Worker and other TI staff.

E. Recruiting Peer Educators

There are several opportunities for a TI to identify a peer educator from the Hijra and transgender community.

Selection process

- Have a formal selection process which is open and transparent to all hijras and other transgender people in the area.
- The peer selection process should be well publicised in transgender networks so that those interested have the opportunity to apply.
- At the interview, first explain the selection process. Also in brief describe the objectives of the TI and expectations from a PE.
- Conduct basic interviews using a simple but structured questionnaire. Develop a ranking matrix based on the criteria outlined in Section 2 above and rank the candidates accordingly.

The selection of several PEs can take place in a group activity.

- ORWs should conduct a Contact Mapping exercise in the group to determine the size of the different candidates' social network and ascertain whether she is well networked in the community (for details, see Annexure 2, Peer-led Outreach and Planning).
- Consolidate the lists from all peers to assess the overall number of contacts in the community. Explore in the group whether there is duplication of contacts. Through discussion find out which candidate potentially has stronger links and rapport with community/HRGs.
- Through group work and discussion determine which candidates are likely to be accepted as peer leaders.
- Discuss with the group and find out whether they will accept/nominate her as a PE
- In the group take the opportunity to establish systems for monitoring the PE's performance by the community as well. Community members should be given confidence to contact the project if they have any issues related to the PE.
- Following these consultations, select the PEs openly in the group.

F. Capacity building of PEs

As with other staff, PEs will need intensive initial induction training and ongoing follow up training from the NGO/CBO implementing the TI or SACS. The induction training should cover:

- Principles of a TI programme
- Role and responsibilities of PE
- Basics of HIV/AIDS transmission, treatment and care
- Orientation on sexual health and sexually transmitted diseases
- Active listening, conflict resolution, negotiation and other interpersonal skills
- Basic facilitation skills
- Orientation to available referral services and other resources
- Condom promotion and distribution
- Record keeping
- Understanding of when an ORW or other TI staff has to be drawn upon
- Emphasis on the importance of safety and what to do in a crisis situation

For details, see Annexure 3, Peer Educator Training.

G. Review of PEs

The performance of PEs should be reviewed every month against indicators spelled out in guidelines. Since all key components of the TI are led by PEs, this review is critical to keep track of quality of the intervention.

The peer selection process described above may be repeated after 12 for existing TI to 18 months for new TIs to ensure that the PEs in the network are "active" peers and not PEs whose social networks have eroded/changed. This approach also provides opportunities for more Transgender/Hijras to participate in the programme and helps in the development of second-line leadership.

Step 7: Scaling Up Services and Expanding Activities

A. STI and other clinical services

Planning for STI services should be done with the Hijras and Transgender communities. It is important to gather the following information:

- Preferred list of physicians available in the project area
- List of current barriers to accessing STI services
- Ways in which STI services can be made accessible and acceptable to Hijras and Transgender people in terms of location, operating hours, etc.
- Modes of STI service delivery, for example

- Intervention site-based clinic: This ensures confidentiality, less marginalisation and better quality of care. Easy to follow up but difficult to sustain.
- Referral to the public sector: Services can be free but often do not respect confidentiality, and quality of services cannot be predicted. Marginalised groups are often stigmatised in these settings.
- Referral to the private sector: This ensures confidentiality, and services can be sustained, but quality and costs are unpredictable.

Once this information is gathered, health care services can be established through the preferred mode of service delivery. Special attention should be paid to ensuring **community-friendly STI service delivery** options:

- Clinicians with the right attitude towards the community
- Availability of services as per the needs of the community, for example late evening, -night access
- Accessibility of services at optimal location (for example, not too far from the sites where most Hijras and Transgender people reside and operate)
- Basic infrastructure facility (facilities should be maintained at the standards stipulated by the DAC STI guidelines)
- Confidentiality between the clinic team and the community should be maintained.

Effective prevention and treatment of STIs among Hijras and Transgender people require attention to both symptomatic and asymptomatic infections. The prevention and treatment of STIs in Hijras and Transgender people at NGO clinics should have the following two components:

- **Management of symptomatic infections –** using NACO syndromic management flowcharts and laboratory diagnoses where available
- **Screening and management of asymptomatic infections –** quarterly history taking, physical examination and simple laboratory diagnostics (where available):
  - ➔ Treatment for asymptomatic gonococcal and chlamydial infections at the first visit and repeated every six months
  - ➔ Semi-annual serologic screening for syphilis

The **package of HIV/STI services** to be provided is (see *NACO STI Guidelines*):

- Health promotion and STI prevention activities, such as promoting correct and consistent use of male condoms and lubricants and other safer sex practices
- Provision of free male condoms and lubricants
- Immediate diagnosis and clinical management of STIs

- Provision of STI medicines and directly observed therapy for single dose regimens
- Health education and counselling for treatment compliance, correct and consistent use of condoms and regular partner treatment
- Periodic check-ups, syphilis screening and treatment of asymptomatic infections
- Partner management programmes (that is, contact referral)
- Follow-up services
- Counselling support for HIV-seropositive persons
- Prophylaxis and treatment of simple Opportunistic Infections (OIs)
- Referral links to ICTC, HIV care and support and other relevant services
- Strong linkages with outreach activities targeted at Hijras and Transgender people and their regular partners
- STI surveillance as requested.

As per the NACO STI procurement guidelines, all STI drugs are to be procured by SACS/NACO from GMP providers.

Hijras and transgender people have unique health experiences and needs which are often not addressed in mainstream health settings. Usually, they are stigmatised by clinical staff and end up having negative experiences in health care settings. Discrimination leads to delay or avoidance of health interventions, which can put Hijras and other Transgender – Hijras people at greater health risks including transmission of HIV. For better service uptake, **quality of client experience** is key. Care providers and other TI staff –

- Should treat transgender individuals as they would like to be treated themselves
- Have received transgender cultural competency training and that there is a system in the NGO/CBO for addressing inappropriate conduct by staff
- Should focus on care rather than indulging in questions out of curiosity
- Should know that it is inappropriate to ask transgender/hijra patients about their emasculation status if it is unrelated to their care
- Should become knowledgeable about transgender/hijra health care and medical issues and know where to access resources.

B. Condom programming

Ensuring availability, accessibility and correct and consistent usage of free male condoms and lubricants or extra lubricated condoms[6] by Hijras and Transgender people is a core imperative of NACP IV.

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[6] NACP IV lubricant strategy to be relied upon for making derivations. If lubricants have to be socially marketed then the strategy will change accordingly.

Condoms and lubricants should always be available for (1) Free supply through TIs by NGOs/CBOs and (2) via socially marketing strategy via SMOs. If and when demand for socially marketed condoms/lubricants/extra lubricated condoms arises in these groups, appropriate mechanisms must be in place to ensure that the free and socially marketed supplies do not overlap.

The basics of free condom programming for Hijras and Transgender people

- Ensuring availability alone is not enough – distribution does not ensure usage
- Ensuring accessibility is not enough – access does not ensure usage
- **The goal is increased correct and consistent usage of condoms by Hijras and Transgender people**

Address barriers to condom usage: It is important to understand various aspects related to condom usage among **Hijras and Transgender people** at the site level before initiating as well as during condom programming.

Considerations may include:

- The barriers to condom usage, for example, alcohol intake (partner), "difficult clients" of Hijras in sex work
- Misconceptions and myths regarding condom use, for example, not required for anal sex
- Condom availability in the area
- Condom accessibility : are condoms available at the 'pick-up' and/or sex sites (or do they have to travel to buy condoms) and at the time of sex (often in the evening/at night)?
- Creating demand for condoms

Assessing the condom requirement at any given site of intervention is critical in order to ensure condoms are not being "dumped" or stock-outs are not occurring. Ultimately, condom availability depends on the risk profile of the individual site and cannot be averaged/aggregated at the State level.

Calculation of requirement of condoms per month

The following formula can be used to calculate condom requirement for Hijras and transgender people at a given site:

D = (TG-H x I x N) – C where

- **D** is the condom requirement
- **TG-H** is the number of Hijras and Transgender people in the area
- **I** is the number of penetrative sex acts per day
- **N** is the number of days that Hijras and Transgender – Hijras people are sexually active in a given month
- **C** is the number of condoms brought by partners of Hijras and Transgender people from other sources

TG-H, I and N can be determined through the processes of site assessment and outreach planning. **C** can be determined by local SMOs, through special surveys of Hijras and Transgender people. If such surveys have not yet been carried out, the NGO/CBO can estimate the proportion of condoms brought by the clients by polling a random sample of Hijras and Transgender people.

Establish distribution channels – Key channels for ensuring condom distribution to Hijras and Transgender people include:

- **Direct distribution** – Condoms given directly to Hijras and transgender people are more likely to be used and less likely to be wasted
  - ➔ Distribution by PEs and ORWs in the field
  - ➔ At the DIC
  - ➔ At the STI clinics
- **Indirect distribution** – Locations should be chosen carefully to minimise wastage or the chance of the condoms being sold. Condom outlets (for example, sex work sites, petty shops, tea shops, lodges)

Monitoring condoms occurs at three levels:

- **Monitoring distribution/availability** – This can be done at the PE level to ensure that the all penetrative sex acts are being covered by distribution channels. Availability of condoms at hotspots, especially beyond 9:00 p.m., should be ensured by the TI. A regular internal monitoring of condom availability and distribution also needs to be carried out by the TI management team.

The target is to ensure over 100% availability.

- **Monitoring accessibility** – This can be done in a variety of ways, including condom depot monitoring and individual tracking through PEs
- **Monitoring usage** – This can be done through PEs, used condom (counting used condoms at 'pick-up' and sex sites and matching with estimated sex acts in the particular site), peer counsellors at the clinic.

Condom stocking/reporting

- Each implementing NGO/CBO should make sure they have an adequate stock of condoms. Re-ordering is recommended when there is a 3-month stock in hand.
- NGOs/CBOs should have adequate storage space for condoms. Care should be taken that they do not get damaged in storage or during transit to outlets.
- Documentation of condom supplies should be ensured. TI partners should be able to provide data on where, when and how many condoms are supplied.
- When assessing condom requirements, one should factor in the condoms required for condom demonstrations and trainings.

Condom and lubricants use

- Need-based focus group discussions on a periodic basis (bi-annual) can be conducted to assess the changes taking place among hijras and transgender people in knowledge, attitude, and practice with focus on negotiation and communication skills about condom and lubricant use.
- Condom and lube programming should be assessed as part of the annual review/ evaluation and appropriate redesigning done accordingly.

Condom breakage during anal sex and the importance of lubricants

Sometimes, a general complaint by hijras and transgender people is "breakage of condoms". There are several possible reasons for breakage:

1. Poor quality of condoms
2. Condoms used after the expiry date
3. Incorrect use of condoms
4. Poor lubrication
5. Use of incorrect (oil-based) lubricants

It is important to communicate that reasons 3 to 5 can be avoided by emphasising condom demonstrations and education on use of correct lubricants, points 4 and 5 can be corrected through proper education on lubcriations (this is to be part of the outreach SBC conducted).

Lubricants

Available evidence suggests that some proportion of hijras and transgender people may use saliva as a lubricant. This is not optimal since saliva dries rapidly thereby increasing friction, which can results in anal trauma.

Thus, it is important that education on use of lubes is necessary in the project and project should ensure the availability of lubes for the population.

Calculation of requirement of lubricants per month

The following formula can be used to calculate water-based lubricants requirement for Hijras and transgender people at a given site for a month:

L = (Tg-H x I x N) – C where

- **L** is the water-based lubricants requirement
- **TG-H** is the number of Hijras and Transgender people in the area
- **I** is the estimated number of anal sex acts per day
- **N** is the number of days that Hijras and Transgender – Hijras people are sexually active in a given month
- **C** is the number of water-based lubricants brought by partners of Hijras and Transgender people from other sources (usually this proportion is so low that it can be discarded)

Thus, in effect, L = (TG-H x I x N)

TG-H, I and N can be determined through the processes of site assessment and outreach planning.

Note: An important assumption is condoms are used in all these anal sex acts (that is, 100% condom use is assumed). It is proposed that 2 ml of lubricant be used for calculation of demand.

C. Communication for behaviour change

The communication strategies derived from previous NACP plans have contributed to a significant increase in awareness about HIV infection, but this has not been matched by corresponding behaviour changes regarding safe sexual practices and optimal utilisation of services.

Need for a separate BCC strategy for TG - H

Several factors necessitate a separate BCC strategy among TG - H. Their needs are unique, and extend beyond the conventional boundaries of HIV and AIDS prevention programmes. TG - H are not a homogenous group. Cultural and social norms among TG - H vary in different regions of the country and among their various subgroups. Some earn their living through sex work, some beg and some, who live in "Dera", meet their needs only through Badhai. Each of these subgroups has a distinct health need and concern, and requires a different approach for working with them.

TG - H are stigmatised, discriminated and harassed by general community, law enforcement agencies, ruffians, etc. Majority of them experience violence, sexual harassment and rape. Lack of empowerment makes it difficult for them to report such incidents. Even the few who have tried to register cases have experienced non-cooperation from the police who refuse to register their complaints. Hijras and Transgender – Hijras people have low self-esteem, which further erodes their confidence in reporting violence or asserting their rights. Low literacy levels, lack of employment opportunities and high migration and mobility among Transgender – Hijras people further compound their vulnerabilities.

The social hierarchy and community norms among Hijra communities influence their risk behaviours and therefore their vulnerability to HIV infection. Sexual silence is a norm in many Hijra "Gharanas". Gharanas that are dedicated to worship of Goddess are expected to remain celibate. Hijras in such groups do not have access to information and services to engage in safer sex practices.

One of the key gaps identified is in the area of helping Hijras and Transgender people put HIV/STI prevention messages into practice in their own very local or individual contexts. A multi-pronged approach must be adopted to create behaviour change communication (refer to Table 1 in this guideline).

Continue to communicate messages to:

- Create awareness about the importance of using condoms and lubricants for every penetrative anal sexual act, with casual, paying, paid or regular partners
- Create awareness about utilising the services available for STIs, including the importance of regular screening, as well as other services like (ICTC, PPTCT, ART, partner notification)
- Create demand for services, for example, condoms, lubricants, STI services, other health care services.

Move beyond messages to encourage analytical thinking and problem-solving among individual and small groups of Hijras and Transgender people so that they can arrive at and act on locally appropriate solutions to overcome their barriers to HIV/STI risk reduction, through peer facilitated, dialogue-based interpersonal communication (IPC).

TI partner (and SACS) needs to:

- Ensure IEC materials contain clear, concise, simple and short messages that are linked to behaviour change, such as " Use a condom every time you have sex"
- Refer people to only those services that are actually in place
- Collaborate with service providers so that they display and distribute BCC materials for Hijras and Transgender people at their service delivery sites
- Ensure that service providers understand TG - H -specific BCC/IEC materials
- Ensure outreach and peer personnel are trained to deliver behaviour change messages for Hijras and Transgender people in interpersonal, outreach and peer education settings.
- Highlight positive outcomes of behaviour change, that is, improved health, economic and personal outcomes when delivering messages
- Include messages for and images of Hijras and Transgender people in HIV prevention messages/pamphlets prepared for the general population.

Step 8: Outreach Planning

The NGO/CBO should ensure that professional working standards are maintained for its outreach service. When conducting outreach make sure your staff:

- Treat all service users equally and non-judgmentally, recognising and respecting diversity
- Does not give information or advice when uncertain about the facts. It is okay to say that you are unsure and will find out the correct information
- Should set and maintain professional boundaries. It is important to develop good and

friendly working relationships. Overstepping work relationships can compromise a sex worker, the project worker and the service

- Outreach staff should be aware about safety and minimise risk to service users and themselves. A few steps can help:
  - ➔ Prepare thoroughly before each outreach session
  - ➔ Inform and seek support from police about outreach activity. Record any incident that might have taken place and have arrangements for contacting the local police if any incidents occur
  - ➔ Establish clear links with key local stakeholders such as community leaders, police partners and local political councillors
  - ➔ Have understanding between staff on how to communicate and have an exit strategy to terminate sessions or leave situations immediately which are perceived as unsafe
  - ➔ Have debriefing at the end of sessions between colleagues and with supervisors.

Three broad outreach strategies can be adopted:

1. Traditional site-based (hot-spots-based) outreach
2. Through support of Gurus or Gharana/Jammath/Dera leaders
3. Through melas/functions in which Hijras and transgender people gather

Key activities of outreach using any of these strategies include:

- Providing HIV/STI prevention and safer sex education to Hijras and transgender people through peer education and counselling
- Reach sub-groups of both visible and hard-to-reach hijras and transgender people
- Include information and activities on HIV/STI risk assessment and HIV/STI risk reduction skills, and distribute condoms and lubricants
- Incorporate positive prevention messages for HIV-positive Hijras and transgender people
- Provide outreach education and distribute condoms at festivals and melas where Hijras and transgender people gather or come together

Table 1: Intervention areas - key components of outreach communication, counselling and BCC/IEC

Key Areas	Activities	Objectives	Key Messages
Outreach and Peer Education	• Provide HIV/STI prevention and safer sex education to TG - H through outreach and peer education • Reach sub-groups of both visible and hard-to-reach TG - H • Include information and activities on risk assessment and risk-reduction skills • Incorporate positive prevention messages for HIV-positive Hijras and Transgender – Hijras • Provide outreach at popular Transgender – Hijras/Hijra-gathering festivals	• To reach TG - H with accurate information through effective peer education • To ensure outreach and peer education efforts reach at known gathering places of TG - H • To include information for HIV-positive TG - H on HIV prevention (positive prevention) • To improve the understanding of gatekeepers/Gharana leaders/Gurus/Nayaks and other stakeholders on the risks faced by TG - H and their rights	**HIV Prevention** • Preventing sexual transmission of HIV • Condoms and other methods to promote safer sex (access, skills building in condom use, etc.) • Prevention and treatment for STIs • Encouraging treatment - seeking behaviour • Protecting oneself and one's sexual partners from HIV (including condom negotiation skills) • Violence prevention and mitigation • Links between HIV and drug use • Positive prevention • Encourage regular medical check up • Encourage screening for HIV

Key Areas	Activities	Objectives	Key Messages
Psychological support	• Provide psychological support to TG - H in the community and offer counselling for specific challenges faced by them • Include information on HIV/STI prevention and referrals to services • Provide information on hormonal treatment for gender transition • Provide information on sex change operation • To refer to higher level of counselling if required • Counselling to develop self-esteem	• To ensure all TG - H have access to counselling services that are targeted to their specific needs	**Stigma & Discrimination** • How to overcome rejection by partners, families and communities • How to overcome discrimination from employers and service providers • Self recognition • Empower to accept one's own gender identity **Illness** • Coping with STI • Coping with HIV
Behaviour Change Communication/ IEC materials	• Work with TG - H and PEs to create or adapt IEC materials • Collaborate with other partners in sharing relevant and effective IEC materials for TG - H through mass media and other innovative methods	• To ensure all TG - H have access to Transgender – Hijras -specific IEC materials • To improve access and use of effective Transgender – Hijras -specific materials that promote behaviour change and service uptake	• Preventing sexual transmission of HIV • Condoms and other methods to promote safer sex • Prevention and treatment of STIs • Encouraging treatment-seeking behaviour

Key Areas	Activities	Objectives	Key Messages
	• Providing information on accessing HIV/STI testing and treatment, including ICTC • Ensure efficient distribution of IEC materials by developing/improving logistics • Reach all TG - H (and their stakeholders and gatekeepers) by creating IEC materials with balance of text and pictorial information • Hold discussion sessions with TG - H in order to receive feedback on IEC • Ensure mentioning the risks faced by TG - H in IEC materials for the general population • Ensure materials contains clear, concise, simple and short message that are linked to behaviour change, such as "Use a condom every time you have sex"		• Protecting oneself and one's partners from HIV • Positive prevention • Accessing HIV and sexual health services • Symptoms of STS • Need of presumptive treatment and regular medical check-up (RMC) • Use of lubricants

Key Areas	Activities	Objectives	Key Messages
	• Collaboration with service providers so that they display and distribute BCC materials for TG - H at their service delivery sites. • Ensure that service providers understand the BCC materials • Ensure outreach and peer personnel are trained to deliver BCC messages for Hijras and transgender in interpersonal and one-to-group settings • Highlight positive outcomes of behaviour change, i.e., improved health, economic and personal outcomes when delivering messages • Develop mass media messages for TG - H		

Outreach with the support of Gurus or Gharana/Jammath/Dera leaders

- For effective implementation of this model, all Gharanas in the TI site need to be studied and understood. Based on the study an appropriate strategy needs to be developed. At the time of preparing this guideline, two pilot projects on the involvement of Gurus or Gharana/Jammath leaders were being implemented. The results from these projects will help in fine-tuning these guidelines further.
- Peer Educators (PEs) may be recruited with consensus of the Gurus and in some Gharanas Soukens[7] could be identified as potential PEs.
- Existing outreach workers can be used to liaise with Gurus of the gharanas in the TI sites. Where necessary, one or more outreach workers (in addition to the number of ORWs as per guidelines) might need to be hired for this liaison work.
- HIV-related messages need to be understood and approved by the Gurus.
- An approach which clearly shows the benefit to the Gharanas and its members as well as one that does not threaten in any way the authority and power of the Guru(s) has to be developed.

Through melas/functions[8] in which Hijras and transgender people gather

Festivals like Koovagam and Kaliyar Sharif are special festivals/melas/events of where a large numbers of Hijras and transgender people congregate and also practice multi-partner sex and sex work. These gatherings which are periods of intense sexual activity as well as a platform for networking present a rare opportunity to reach out to Transgender – Hijras people who are mostly integrated with the general community but do have periods of intense vulnerability to HIV. To effectively use this opportunity, the interventions have to use different outreach methods to reach out to these Hijra and transgender populations who periodically attend the melas.

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

[8] *Some of the events identified are as follows: Ajmer Sharif, Rajasthan; Haji Malam, Thane; Kaliyar Sharif, Haridwar; Meeraj; Udhavaru – Gujarat; Koovagam; Shahkalp poora ; Mahashivarathri – Orissa, Gujarat; Sambalpur mela; Ghutiary sheriff- 24 Parganas; Surajpur mela – Haryana; Bannarghetta jatra – Karnataka; Kuttikulangara – Kerala; Yellamma jatra – Karnataka; Kothadai – TN; Bannari – TN.*

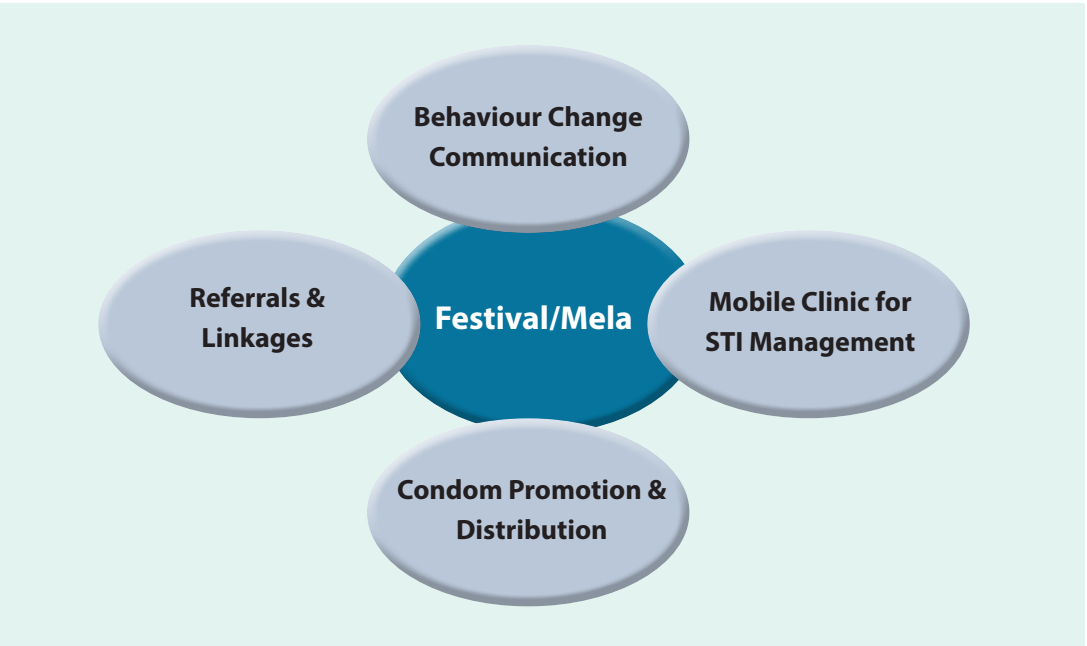
Following activities shall be implemented with the support of IEC and STI divisions in the respective State:

- Develop IEC messages and materials suited to the Mela Outreach approach.
- State AIDS Control Societies can help in mapping all festivals in their States where there is significant participation of Transgender – Hijras people in festival/melas or exclusive events for Transgender – Hijras.
- Understand how these festivals get organised and whether they are managed by particular groups or forces so that entry to these can be appropriately planned.
- It is necessary to use CBOs or NGOs to ensure that peer workers are placed in vantage positions in such melas. These organisations would be better off if they have prior familiarity with such events but since these intense activities may only be for a few days in each place their expertise may be used across many such events.
- To follow up with the HIV prevention work at such Melas, efforts can be made to link willing Transgender – Hijras people with the TI NGOs/CBOs near their place or residence/work.

Why Melas and other congregations?

- TG - Hpeople tend to practice multi-partner sexual relationships at the melas/festivals.

Outreach in Festivals/Melas



- Transgender – Hijras people come from far and near to the melas and for some it takes on a pilgrimage halo. And as such this approach is likely to reach some Transgender – Hijras people who cannot be reached by NGO site interventions and gharana interventions.
- Clients of Transgender – Hijras people who frequent these melas can also be reached. It is likely these clients are not being reached through other HIV core group interventions.

Limitations

- It may be a one-time intervention or sensitisation for some of the Transgender – Hijras people when follow up is not possible.
- Transgender – Hijras people may not be receptive to HIV messages in the environment of a Mela and religious festivities.
- Details of TG - H and MSM TIs in the country to be exhibited

Additional Outreach activities

- Helpline in CBOs/NGOs - providing anonymous services (HIV information and counselling)
- Massage parlours/hamams (for example, in Bangalore) – HIV information/counselling services to Transgender – Hijras masseurs
- Mobilisation points – Transgender – Hijras people to be reached at traffic signals points, bus stops and railway crossings; the outreach need not be limited to solicitation and encounter points only
- Telecommunications — Hijras and transgender mobile users — SACS can develop tele-mobile communications technology; audiovisual messages through telecom mobile services
- Internet-based services – providing information through anonymous chatting (for transgender people from middle and upper socioeconomic class)

In all forms of Hijra and transgender interventions, outreach education and communication will have a focus on Transgender – Hijras -specific BCC when dealing with and involving the Hijras and transgender population as opposed to the generic HIV outreach communication in a composite TI. Therefore, the focussed outreach with Hijras and transgender population in a composite TI should also borrow the same IEC/BCC materials that would be developed for Hijras and transgender community, and use it with the Hijras and transgender population in the composite.

Step 9: Community ownership building plan

It is important to facilitate the formation of Community Groups/CBOs in a systematic manner through a democratic and representative process. It is also necessary to understand and recognise that CBOs are autonomous bodies even though they might have been formed under a NGO-led TI for the sole purpose of transfer of TIs.

Scenarios:

a. **Presence of CBOs**: In case Transgender – Hijras CBOs exist and are functional, these CBOs can be assessed via a systematic process to understand the capacity of the CBO in managing a TI.
b. **Presence of NGOs but not CBOs:** If the TG and Hijras TI is required to be given to an NGO due to the non-existence of a competent CBO, there should be a transition plan along with a clear timeline to see that the management of TI is transferred to the CBO within a time frame of 2-3 years.
c. **Pre-TI Phase**: In an entirely different scenario, where the present TI (by NGO or CBO) not directly working with Transgender – Hijras population, but substantial numbers of TG and Hijras are found and identified in mapping/validation exercise, SACS may take a view that it would be more appropriate to include the population with existing FSW/MSM or IDU TIs and strengthen the community to take over the project within a specified time-period. In order to do so, the TG and Hijras community may be mobilised and facilitated to form a CBO. The capacities of this nascent CBO need to be nurtured to implement TI. NGO/CBO selection for implementing hijra/TG TIs will be on the basis of the NGO/CBO selection guidelines of DAC.

Enable Community Mobilisation processes and Facilitation of Group formation

NGOs should facilitate the process to bring the community together to facilitate the formation of groups from the initial stages of a TI. Similarly the TI should enable the formation and ownership of Core Community Committees in all TIs so that increasing community participation in the TI functioning becomes possible. The process will build and enhance ownership within the community members.

Role of SACS

State AIDS Control Societies should monitor the above activity closely so that when the CBOs are mature and are empowered to take on management responsibilities the TIs could be handed-over to the CBOs after the completion of due process. The community project management of the TI (that is, CBOs to take over the TI management) should be defined in

various stages. SACS can give clear technical inputs on the role of NGOs and CBOs defining the Community Transition function. The STRCs should also have Capacity building on Community Mobilisation as their prime focus in designing training curricula that need to be monitored by SACS. These activities will be coordinated with the Global fund-supported project Pehchan for synergic effect.

Transition Strategy

A clearly defined and articulated Community Transition strategy should be in place right from the inception of the TI. The plan for NGO should be clearly spelt out so that the TI management is transitioned to the CBO in a phased manner and according to a timeline. The Capacity Building plan of TI Community Management through various committees should be clearly worked out based on the phased-out time and activity plan. It is advised that on the inception of the project, the TI implementor draws up a transition strategy with key community persons and peer educators.

This strategy can be validated by TSU/SACS officials and be monitored for effective implementation. The community mobilisation strategy may be reflective of the transition strategy, that is, how the community may be empowered and collectivised over a period of 2 – 3 years and suitable capacity building provided for better community ownership of results and ultimately handover of project to the community at the end of the stipulated transition period.

Capacity Building

Effective usage of funds should be undertaken for community mobilisation and capacity building. Similarly, exposure visits to CBOs and visits to learning sites should be ensured for the nascent CBOs to learn about project management issues.

Development of Community Resource pool

To strengthen the community mobilisation, it is also necessary to build a Community Resource Pool in the districts/states to provide services to the CBOs. The Community Resource Pool should be well-trained on community and TI issues to enable formation of CBOs and their Project management skills.

Community Committees

As envisaged above, the Community Committees should be formed to enable them to involve themselves in Project management as well as enhance their Capacity building skills in managing the community CBO-led TIs.

It would be 4-5 Community Committees within the CBO/NGO – in the suggested functions - Outreach, Clinic services, Condom distribution, Advocacy, Monitoring, etc. The Committees' role would be to effectively shadow the regular functions as well as take part in the supervisory mechanism at a TI level.

Step 10: Creating an Enabling Environment

A supportive or enabling environment that includes policies and legislation that address stigma, discrimination and violence, and psychosocial vulnerabilities, is critical to achieving universal access to HIV prevention, treatment, care and support for hijras/transgender people. Activities to promote enabling environment thus will not only be limited to advocacy with the immediate stakeholders around the TI implementing sites but changing the negative attitude of the general public and healthcare providers towards hijras/transgender people. Both proactive and reactive advocacy strategies will be used by key stakeholders to contribute to creation of an enabling environment. Depending on the nature of the issue, the activities could be training and sensitisation, legal reform, and partnerships with agencies working on human rights issues. Also, some of these advocacy activities will happen at the national level, State level, district level or TI site level.

Table 2. Creating a conducive environment

Key Areas	Activities	Objectives
Rapid Response Team	• Creation of community RRT which is readily accessible to Transgender – Hijras community in times of crises and violence • Contact details are circulated to the entire TI community who will reach out to the RRT • The service is embedded within the CBO/NGO	• To ensure Transgender – Hijras people/Hijras are treated fairly, equally and compassionately by service providers, police and other stakeholders
Stakeholders and employer education	• List of friendly services – lawyers, doctors, police, etc.	• To ensure all gatekeepers are aware of the health needs of Transgender – Hijras people/ Hijras and can support them in seeking services

Key Areas	Activities	Objectives
Involvement of Transgender – Hijras/hijras in SACS's activities	• Create a structure of TG - H community representatives with whom there can be periodic interactions in relation to programme planning, implementation and evaluation of Transgender – Hijras TIs	• To ensure TG - H involvement is integral in programme design and evaluation process • To enable TG - H to contribute to community and national level campaigns on HIV awareness • To enable TG - H to contribute to community efforts to decrease HIV infection and improve community health
Raise positive public awareness of TG - H	• Create IEC materials on social entitlements and Human Rights • Regional seminars on Transgender – Hijras issues – generate solidarity and advocate for the cause • Operational research and studies on the TG - H populations • Transitioning of NGO-CBO • Provide space and hire Transgender – Hijras employees and consultants for conducting advocacy • SACS to respond to any violation of rights or denial of services • Support Community Mobilisation initiatives of Transgender – Hijras Network at State and national level	• To improve understanding and respect for the rights of TG - H among the general population • To participate in BCC/media campaigns and represent TG - H in planning meetings

Key Areas	Activities	Objectives
Documentation	• Collect case studies, best practices and success stories to inform national and international community of the needs of TG - H • Video documentation on positive aspects of life of TG - H people	• To share best practices and lessons learned with other partners and stakeholders working with TG - H
Advocacy with Police	• Training police personnel at all levels (use NACO - approved model for working with police) Note: Each training to have personnel from the same level to ensure a more open discussion and better interaction among the trainees • Orientation/sensitisation of police personnel at the local Police Station level by local TIs	• To improve understanding and respect for the human and legal rights of TG - H among the police

Step 11: Linkages with Other HIV Prevention, treatment, care and support services through TIs and DAPCUs

Referrals to ICTC

Transgender – Hijras populations identified and registered in the TI need to be referred to free HIV testing offered in the ICTCs after assessing their HIV risks. Transgender – Hijras people who are tested HIV-negative are followed up and referred for periodic HIV testing (for example, once in three months). Transgender – Hijras people who are tested HIV-positive are linked up with relevant HIV treatment, care and support services.

Referral to STI services

Transgender – Hijras populations registered in the TI are referred to free STI treatment offered in the government hospitals either separately or with ICTC. TI is to ensure that presumptive treatment is offered in STI clinic to asymptomatic Transgender – Hijras people as per the STI guidelines. Also, TI needs to follow-up Transgender – Hijras people on treatment until they complete the treatment course, and if necessary, assist in partner screening and treatment through referral. TI staff can refer Transgender – Hijras people for periodic (once in three months) STI services to all Transgender – Hijras people at risk of HIV/STI.

Referral to ART services and community care centres

TG – H people tested HIV-positive are referred to ART centres to register in the free ART programme and followed by TI once in three months for checking their CD4 level and eligibility for free ART. Transgender – Hijras people eligible for ART, is followed by TI staff to ensure that they are started on ART and adhere to it. Furthermore, TI staff can provide accompanied referrals to other services such as TB (DOTS centre) and community care centre (CCC). There might be a need for sensitising the staff and co-patients in the general community care centre about the issues faced by Transgender – Hijras.

Referral to DOTS (TB) centres

TG – H people tested positive for HIV testing or Transgender – Hijras people reporting symptoms of TB need to be referred to the government's free TB (RNTCP) programme. Transgender – Hijras people diagnosed with TB are usually treated in the DOTS centre near their residence. In addition to the DOTS centre outreach staff, TI staff can also contribute to the follow-up of TG - H people registered in the free RNTCP programme to ensure that they complete the treatment course.

Referral to/linkages with networks of people living with HIV

Transgender – Hijras TIs need to establish referrals and linkages with the networks of people living with HIV in their districts so that Transgender – Hijras people living with HIV can also access and use the services offered through the PLHIV networks. Transgender – Hijras TIs might also need to sensitise the staff and board of the local PLHIV networks about the issues faced by HIV-positive Transgender – Hijras people/Hijras.

Linkages with RRCs and School AIDS Education Programme (SAEP)

TIs can educate/sensitise school and college students about Transgender – Hijras communities in coordination with SACS through the Red Ribbon Clubs (RRCs), College sexuality education programmes and SAEPs (desirable) that are supported by SACS. Such sessions may also be helpful in identifying Transgender – Hijras adolescents/youth studying in the schools and colleges. This can be done by Transgender – Hijras CBOs themselves.

Linkages with health care providers who offer safe sex change operation ('sex reassignment surgery')

Not all TG - H want or need SRS. But for those who are thinking about having SRS, referrals need to be provided to qualified health care providers who offer quality counselling and then assist TG-/hijras in taking informed decisions on undergoing SRS. Only the government of Tamil Nadu offers free SRS in select government hospitals.

Linkages with social welfare schemes and legal aid

Transgender – Hijras TIs can establish linkages with the district level authorities in-charge of the social welfare schemes for Transgender – Hijras people and help Transgender – Hijras people in getting necessary identity documents and social entitlements. Transgender – Hijras TIs can refer Transgender – Hijras people who require legal support to the State Legal Aid Authority and/or the AIDS legal cells established in select hospitals in some States.

Linkages with State legal authority can be initiated by respective SACS. Trained Transgender – Hijras people can be part of the SACS initiative.

Operationalising Targeted Interventions for Hijra and Transgender populations

Guidelines for SACS and TSU

1. Mapping and Size Estimation

1.1 Size estimation

State-wise mapping/estimation needs to be commissioned to understand the TG and Hijra community's size for NACP-IV. While the overall principles of the mapping of high-risk groups (as detailed in the operational guidelines of NACO for MSM TI) remain the same, care should be taken to completely involve contacted TG and Hijras or TG CBOs in mapping.

Going by the estimate of 2.36 million MSM and male sex workers in the country (NACO, 2006[9]), even if the Hijra and TG population were to be a fraction of this figure, any national response to HIV will merit far higher number of interventions than what is currently being funded. This is particularly relevant given the vast geographical areas and huge populations that have traditionally not been covered by the national programme.

1.2 Prioritisation of Hijra and TG TIs

Based on the mapping and size estimation information and programme data, selection of districts for initiation of HIV interventions among hijras/TG people needs to be based on the concentration of the hijra/TG people.

1.3 General guidelines for mapping of TG and Hijras in the context of HIV intervention

Mapping/estimation in the context of NACP-III TIs (and of this document), refers to the following three exercises:

1. Review of secondary data

[9] *National AIDS Control Organisation (NACO). Strategy and implementation plan – National AIDS Control Programme Phase III (2007–2012). New Delhi, NACO, 2006.*

2. "Broad mapping" to estimate size, identify HRG typology and locations of risk
3. "Site assessment" to derive basic insights into factors that make HRGs particularly vulnerable to HIV and to initiate interventions

TG and Hijras will be "mapped" in each State in two distinct phases:

In the **first phase,** mapping is to be carried out:

- Where TIs addressing TG and Hijras are in operation
- Any other areas where TIs may not be in operation but TG and Hijras are known to be present in significant numbers like gharanas, deras

The **second phase** of mapping is implemented when SACS and TSUs identify major geographic areas in the State which have been left out of TI coverage. This could occur through a review of TI data against State geography. The objective of mapping in the second phase is to ensure that such gaps in coverage are "mopped up" through commissioning of new TIs or reconfiguration of existing TIs. Mapping in the second phase will follow the same methodologies as in the first phase.

This guideline describes mapping in the **first phase**.

Key Terms

- A geographical area demarcated by a definite boundary (for example town, city, village) is referred to as a **"site"**.
- Areas within a site where there is significant concentration of TG - H are referred to as "**hot-spots"**. Within hotspots Hijras and Transgender – Hijras may solicit, cruise, and interact with other HRG members, or have sex or share drugs.

The overarching goal of mapping estimates of TG and Hijras is to **put appropriate and effective interventions in place**. Therefore it is important to remember:

1. Mapping must be **rapid –** based on its results the TIs have to be designed and services have to reach these populations urgently.
2. Those who are mapping TG and Hijras must know **how to find them**; must be **credible** and **acceptable** to them; and most importantly, must be **respectful** towards the norms, practices and rights of TG and Hijras. This is because many of the TG and Hijras members

are hard to reach or are geographically scattered. Stigma, discrimination and violence from the mainstream society often make TG and Hijras even more inaccessible, as they are usually reluctant to share personal information with outsiders.

3. Methods must be Hijra/TG **friendly.**

Identify or confirm locations within the States and Districts where TIs ought to be placed to reach those TG and Hijras who are most vulnerable. Targeted interventions will address the universe of TG and Hijras, most at risk .Therefore, only these subcategories of TG and Hijras should be mapped and not the whole universe of MSM.

1.4 Validate estimates of size

- Generate estimates of the size of TG - H in each site, by different categories
- Provide locations of hotspots where HIV risk activities predominantly take place
- Generate information to help understand the mobility patterns of TG - H within and outside the site
- Explore the HIV/STI risks that TG and Hijras face and the vulnerability factors that exacerbate such risks
- Characterise the TG and Hijras to facilitate subsequent programming
- Identify their HIV related needs, existing HIV interventions and key gaps

1.5 Mobilising HRG groups for HIV/STI prevention

Begin the process of mobilisation:

- Build awareness of HIV
- Increase knowledge about risk reduction strategies
- Increase knowledge about existing HIV/STI prevention interventions for TG and Hijras
- Build social capital and solidarity amongst TG and Hijras a collective voice
- Explore safe and private spaces for TG and Hijras to meet and work together
- Build a core group of Hijra and TG members from the site who will serve as an important resource for project implementation by recruiting and training local HRG members to implement mapping

1.6 Expected Outputs (from mapping)

- List of sites where there are no TIs but obvious and/or reported concentrations of TG and Hijras
- List of reported hotspots
- Size estimation by subcategories of TG and Hijras – hotspot level
- HIV/STI services that could be available for TG and Hijras
- Confirmed list of hotspots in the site
- Fine-tuning of estimated numbers by subcategory in the site
- Report on mobility pattern of TG and Hijras
- Report on availability of TG and Hijras
- Risk profile of TG and Hijras
- Client profile of TG and Hijras population

1.7 Annual validation of at-risk Hijra and TG populations

It is expected that the Hijra and TG size estimated by the TI is annually validated by SNA (Social Network Analysis) and/or PSA (Participatory Site Assessment) exercises so as to add new TG members in the site and also eliminate duplication.

2. Criteria for TI Allocation, TI Unit Size, and Geographic Distribution of TIs

2.1 Size of the TG and Hijras TI and Flexibility in Approach

2.1.1 As the size of the Hijra and TG community in a given area is expected to be small, the size of the Hijra and TG population covered can be standardised to a minimum of 200 per TI to be established. Generally, the Transgender – Hijras population in a combined MSM/Transgender – Hijras TI is expected to be around 15-20%, from which the size of 200 has been arrived at. The 200 size is optimal for TG and Hijras to be covered by a standalone TI, given the difficult, mobile and scattered nature of the population.

2.1.2 If the number of TG and Hijras people is smaller than 200 in a given area, they could still be covered as a part of the core/composite TI.

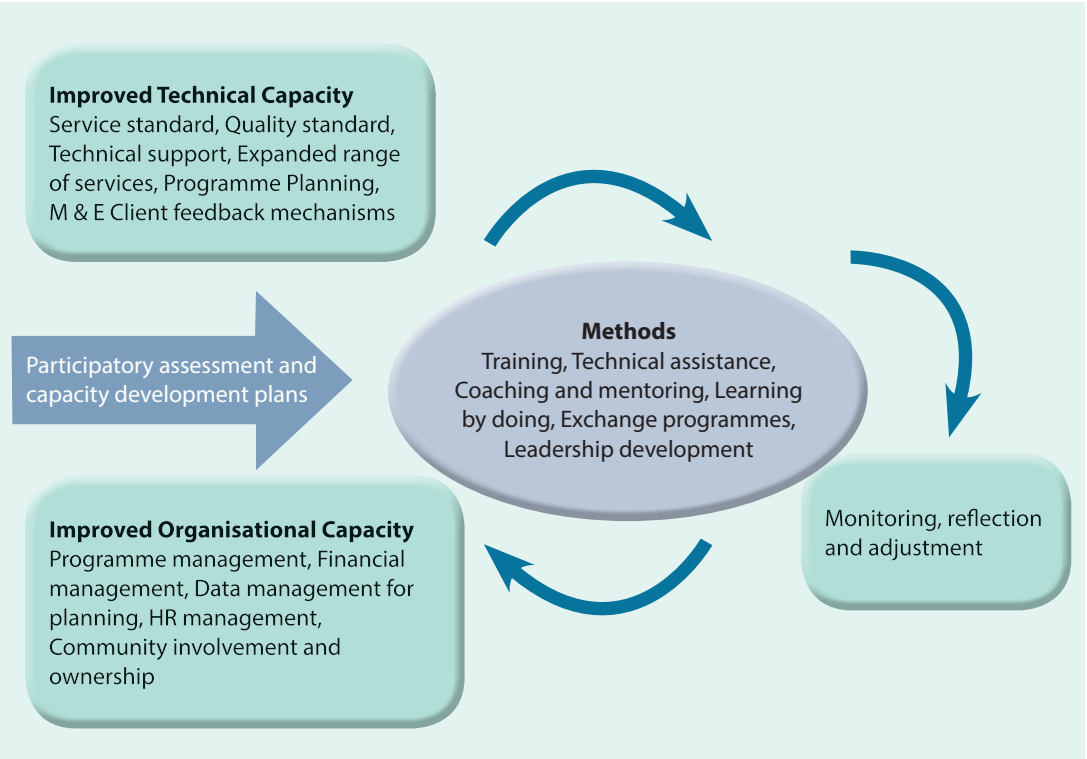
2.1.3 Another viable option is to cover a population of 200 -250 TG and Hijras, the `spread-out' TI can be spread across 3-4 towns within a radius of 30 km. This is a good option to maintain the TG and Hijras exclusivity, and at the same time it can sustain itself as it has the requisite numbers. This model has been tried and tested for several years in composite TIs which are working in rural and semi-urban areas spread across vast distances.

3. Recruitment, Capacity Building and Programme Management

3.1 Recruiting NGOs/CBOs/Networks to Implement TIs

Each SACS is to recruit suitable NGOs, CBOs or networks following the processes laid out in the guidelines to implement the numbers of TI units required to saturate coverage of the Transgender – Hijras populations mapped and estimated in the State. Operational guidelines for selection NGOs/CBOs for implementing targeted intervention.

Diagram 3. Capacity building plan – At a glance



Transgender – Hijras interventions are possible under NACP-IV in the following ways:

- Funding of existing Transgender – Hijras CBOs
- Funding of NGOs with CBO transition plan
- Funding of new Transgender – Hijras CBOs/groups with capacity building plan

3.2 Capacity Building Plan for CBOs/NGOs Implementing TIs

The capacity building needs to address the core and the need-based issues of TG and Hijras communities. The core components of the capacity building issues include:

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

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

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

The core topics of the capacity building for the TG and Hijra community can be as follows:

1. Implementation on the targeted intervention and basic services
2. Behaviour change and interpersonal communication
3. Sexual health, preventive measures and risk management
4. Community mobilisation and community system strengthening
5. Documentation, communication and financial management
6. CBO strengthening and leadership development
7. Mental Health and positive living
8. Care and support
9. Advocacy and crisis management
10. Life skill programmes

Overall outline of the above topics are explained more in detail below.

CBO strengthening and leadership development – This module will have focus on mentoring the community leaders within the community. The effective community leaders will ensure programme ownership at the field level and support the overall programme to buy community involvement and accountability in the long run.

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

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

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

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

Sexual health, preventive measures and risk management – The issues of the TGs and Hijras regarding sexual health will cover sexual risk behaviours, lifestyle, occupation, sex work, substance abuse and emasculation/sex change operation. The capacity building component can talk about the vulnerability factors and the risk management for TG and Hijras.

Mental Health and positive living - Attention to mental health and positive living are extremely poor in TG and Hijras and this inattention makes them vulnerable for substance abuse, risky sexual behaviour, violence and attempting suicides. The mental health and positive living capacity building needs to be given to counsellors, peer educators and the outreach workers to instigate positive living.

Care and support - Care and support component can look in to the issues of the ART registration, ART eligibility, ART follow up, OI management, Community support to PLHIV, nutrition and dealing with the status disclosure issues.

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

Life skill programmes – Employment is the biggest concern of the TG and Hijra population that makes them more vulnerable for the HIV/AIDS. Life skills, education that are community-specific can make the community to become empowered and responsible towards the risk management and healthy living.

The capacity building plans for the TI staff are summarised in Table 2 below.

Table 2. Capacity building of Hijra/TG TI staff

Areas of Capacity Building Programme	Content of Capacity Building	Target Audience	Who is responsible for Capacity Building?	Outcome of Capacity Building
Management of Drop-in centre (DIC)	Concept of DIC and effective use of DIC as: 1) service delivering point, 2) Community Mobilisation, 3) Ownership building to the programme	Community Leaders and TI staff	SACS, TSU and STRC	Effective use of Services
Community Mobilisation and outreach	Concept of community mobilisation, CM and service uptake, strategies for community mobilisation. Outreach planning and monitoring	Community Leaders or Gurus TI staff	SACS, TSU and STRC	Skills in Community Mobilisation and outreach techniques will be improved, service uptake and community involvement in programme planning, implementation and monitoring.

Areas of Capacity Building Programme	Content of Capacity Building	Target Audience	Who is responsible for Capacity Building?	Outcome of Capacity Building
Maintaining books of Accounting	Management of finance system in the project, Cash Book, Bank Book and Cash Receipt, Bank receipt, and ledgers and other books maintenance	TI PD and Accountants	SACS, TSU and STRC	Robust finance management system in place in all the TIs, Strengthened capacities of the community in maintaining transparent books of accounts
Documentation	Importance of documentation, Various types of documentation Best practices documentation etc.	TI staff and community members who are all interested to take part in the programme	SACS, TSU and STRC	Strengthened capacities of the community to document good practices in their respective programmes
Counselling	Pre- and post-test counselling, Counselling techniques	Counsellors or Community Counsellors working In TI	SACS, TSU and STRC	Trained Community counsellors will be available for TI, service uptake

Areas of Capacity Building Programme	Content of Capacity Building	Target Audience	Who is responsible for Capacity Building?	Outcome of Capacity Building
Hormonal treatment among Transgender – Hijras people, Post-surgical complications in Transgender – Hijras, Psycho-social problems of social ostracisation, isolation, complications of drug interactions	Information on SRS, Hormones, medical complications, etc.	Counsellors in TI and ICTC or Community Counsellors working In TI and doctors	SACS, TSU and STRC	Trained Community counsellors and doctors competent to provide services to hijras/TG communities
Advocacy Skills Building	What is advocacy? Importance of advocacy in Transgender – Hijras intervention, Steps in advocacy process Target audience analysis Evidence based advocacy	TI project staff, Advocates, Community Leaders or Gurus	SACS, TSU and STRC	Effective advocacy programme in place, Community leaders will be equipped with advocacy steps in a systematic manner

Areas of Capacity Building Programme	Content of Capacity Building	Target Audience	Who is responsible for Capacity Building?	Outcome of Capacity Building
Accountability, transparency and sustainability	Programme management, SHG development, Sustainability of the programme, etc.	CBO Leaders Programme Leaders	SACS, TSU and STRC	Transparency, Accountability and sustainability will be seen in the programme
Transgender – Hijras TI Induction Programme	Conceptual clarity on the issues of hijras/TG people, TG TI components	TI Programme Staff	SACS, TSU and STRC	TI Project team will get clarity on Transgender – Hijras TIs
Transgender – Hijras TI PE training	Components of TI PE system Role of PEs in TI programme Effectiveness of PE system in TI	Transgender – Hijras TI PE team	SACS, TSU and STRC	PE knowledge level will be improved. Effective PE system in place of all TIs. Saturation of coverage will be improved
Training on Networking	Networking Importance of Networking or coalition State and National level networking for policy formulations	Community Leaders, CBO Presidents and Secretaries	SACS, TSU and STRC	CBO leaders will come to know the importance of networking

Areas of Capacity Building Programme	Content of Capacity Building	Target Audience	Who is responsible for Capacity Building?	Outcome of Capacity Building
Training on legal Literacy for TI team	Legal Issues of MSM/ Transgender – Hijras IPC -377 Human Rights etc.	Community Leaders TI Staff	SACS, TSU and STRC	CBO leaders will get knowledge on Legal Issues
Training on developing linkages with Govt. Departments, and other agencies	Various schemes available from Govt. Agencies Linkages with Govt. Officials	Community Leaders/TI staff	SACS, TSU and STRC	Community will get clarity on Govt. welfare schemes and start using all those resources

4. Programme Management

4.1 Objectives of Programme Management

- To improve quality and management of Transgender – Hijras TI
- To effectively deliver project services to Transgender – Hijras people
- To increase the coverage of, and uptake of services by the Transgender – Hijras populations
- To build the capacities of CBOs by providing training and active support wherever required
- To ensure effective advocacy programme
- To identify and effectively fill gaps in Transgender – Hijras TI implementation
- To set up efficient administrative and management systems to support these operations

4.2 Role of State AIDS Control Society (SACS)

The overall responsibility of implementing NACP-IV in the State belongs to the SACS. SACS plans, monitors and manages TIs through partner organisations and with technical support from TSU. SACS ensures adequate resources to accomplish goals and it will ensure the minimum quality of interventions. SACS provides support and necessary mentoring to achieve its objectives. It reviews and monitors all partner organisations to identify gaps in Transgender – Hijras TIs and address them.

4.3 Role of TSU & DAPCU

The TSU oversees the implementation of TIs in the respective State along with SACS. The TSU follows NACP-IV guidelines developed by NACO and facilitates its implementation along with partner organisations. The TSU facilitates the designing, planning, implementation, handholding and monitoring of targeted interventions in the States along with SACS, and provides management and technical support to the SACS.

DAPCU plays a pivotal role in monitoring and coordination of different facilities in the district. They also focus on mainstreaming, facilitating access to social protection and convergence with NRHM.

Being in the field

The key to successful programme management of TIs is field-level presence: TSU project officers should spend adequate time (on the basis of needs) to provide hands-on capacity building and problem solving support in three key programme areas: outreach/community mobilisation, STI, documentation and M&E.

The TSU makes supportive visits to partner organisations and ensures that coaching and mentoring to CBOs/NGOs and TI staff is available. It participates in periodic reviews of all partner organisations and provides necessary inputs. TSU staff includes project officers who visit TIs on a regular basis to assess quality of outreach, STI services, documentation and M&E.

4.4 Role of CBOs and Non-Governmental Organisations (NGOs)

CBOs and NGOs implement TIs in their respective project areas and achieve objectives laid out by the project plan. The implementation of TIs follows the guidelines of NACP-IV. All CBOs and NGOs report to SACS/TSU and can seek support wherever required. Each CBO and NGO prepares a project implementation plan or proposal along with its respective SACS/TSU. CBOs and NGOs will liaise with DAPCU, local health authorities and other CBOs and NGOs while implementing TI. Additionally, NGOs selected for Transgender – Hijras TI will work towards forming a CBO of Transgender – Hijras people and strengthen it so as to transfer their project to the CBO within a stipulated timeline (at least within two years). A separate NGO-CBO Transgender – Hijras TI transition guideline document (similar to that in NACP-III) can be developed, if necessary.

4.5 Financial Management

Available funds should be used in accordance with plans and proposals approved by SACS. Proper accounting systems should be in place and all the necessary records should be maintained for internal/external auditing. For details, see the NACO's *NGO/CBO Guidelines*.

4.6 Programme Monitoring

The project lifecycle of the Transgender – Hijras TI follows a few phases of scale up, which should be reflected in the monitoring and management of these TIs:

4.7.1 Scaling up coverage

- Coverage scale plan up to be developed with the mapping estimation and to select the locations where interventions need to be launched
- Commissioning TIs to ensure saturated coverage of Transgender – Hijras people at the State level.

4.7.2 Scaling up infrastructure (0 – 3 months)

- Improving infrastructure with respect to clinics (if justified) and DIC (Safe Places)

4.7.3 Scaling up intensity of service delivery (3 - 12 months)

- Ensuring regular outreach contacts with >80% of the population on a monthly basis
- Ensuring regular medical check-up/STI uptake for the population on a quarterly/monthly basis
- Ensuring condom availability and accessibility
- Creation of an enabling environment – crisis response, power structure mapping and analysis
- Strengthening community initiatives – formation of community committees, seeding collectives, etc.
- If NGO-led TI, steps for NGO led –CBO to transition

4.7.4 Scaling up quality of service delivery (9 - 18 months)

Improving service delivery

- Strengthening handholding, monitoring and evaluation of TI
- Improving linkages with DAPCU and other local administration (such as district level committee of the body in charge of Transgender – Hijras welfare)
- Appropriate fund/grant utilisation
- Strengthening referrals to TB units and other OI/ICTC/ART referrals
- Building CBO systems
- If NGO-led TI, steps for transitioning to CBO led interventions, in a phased manner

The process of handholding and monitoring happens at three different levels:

- National level by NACO
- State level by SACS & TSU & STRC
- TI level by CBO implementing the project

Programme monitoring of State performance should assess the performance of the TIs based on the life cycle mentioned above.

- SACS/TSU should be assessed in all four phases
- NGOs/CBOs/TIs should be assessed in phases 2-4

4.8 TI M&E and Documentation

It is widely acknowledged that emphasis on M&E and documentation is not only necessary to keep track of work but also for planning, monitoring and defending the HIV programme in India. While NACP-III has established effective data collection systems with HIV programme, genuine burden on the load of data collection, perceived overemphasis on M&E at the expense of project implementation and lack of feedback loop to improve the project – all means that data collection and reporting in relation to M&E are adequate, relevant and non-burdensome.

4.8.1 Principles of SIMS for TIs

As a result of the scale of TIs and the importance of information gathering, analysis and use by the project, NACO has developed a Computerised Strategic Information and Management System (SIMS). The meaning of SIMS and its uses should be understood clearly by the community, partner NGOs/CBOs and SACS/TSU.

SIMS:

- is not a means to find faults in the implementation process
- is not gathering of information to be used only for research purposes
- is not gathering of quantitative information only
- is diagnostic, that is, to identify opportunity gaps in the project implementation
- is supportive, that is, to help bridge opportunity gaps for optimum implementation of the project
- is participatory, that is, the community, NGOs/CBOs and SACS/TSU are equal partners in monitoring

Common serialised Unique Identity (UID) numbers across the TIs for the Transgender – Hijras community

The UID card can have a check-mark when the hijras and Transgender – Hijras community accesses services from different TIs, possibly in different States as the community is highly

migratory in nature. Tracking and providing flexible mixture of services to the Transgender – Hijras migrant population would thus happen if the approach is flexible and comprehensive.

- Rationalised handholding and monitoring systems from national to State to district levels
  - ➔ Revisiting cost benefit in multiple monitoring systems (National level – TOs and NTSU; State level – TSU, SACS PO, STRC; and District level – DAPCUs).
- Need to reduce redundant and repetitive documentation among PEs, ORWs, counsellors and PCs
- Simplify documentation so that it better reflects the work of PEs
  - ➔ Maintain peer diary and simplify data collection tools and formats
  - ➔ Hot spot analysis every quarter
  - ➔ Develop gap analysis from M&E data analysis twice a year
- Providing specific data analysis software for TI level, State level and National level and ensure a feedback loop as well as build capacity to use the data.
- Assessment through Evaluation of TIs

4.8.2 Community Involvement in Monitoring and Evaluation

Community Social Audit can be carried out for the TI programmes where the HRG community including TG and Hijras community is present and functional in the various evaluations that are conducted by SACS from time to time.

Glossary

Hijras

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

(Note: This definition is based on the consensus definition in a national consultation on hijras/ transgender people held in New Delhi in 2010).

Transgender people

Transgender persons usually live or prefer to live in the gender role different to the one in which they are assigned at birth. The preferred gender role may or may not be related to their sexual preferences. It is an umbrella term that includes transsexuals, cross-dressers, intersexed persons, and gender-variant persons. Transgender people may or may not have undergone gender transition-related surgery or may or may not be on hormonal therapy related to their gender identity. Transgender people can be 'male-to-female' (**MtF**) or 'female-to-male' (**FtM**), and sometimes referred to as '***transgender woman/trans woman'*** and '***transgender man/ trans man***', respectively.

(Note: This definition is based on the consensus definition in a national consultation on hijras/ transgender people held in New Delhi in 2010).

Aravanis and 'Thirunangi'

Hijras in Tamil Nadu identify as "Aravani". Tamil Nadu Aravanigal Welfare Board, a State Government's initiative under the Department of Social Welfare defines Aravanis as biological

males who self-identify themselves as a woman trapped in a male's body. Some Aravani activists want the public and media to use the term 'Thirunangi' to refer to Aravanis.

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. (Note: Self-identified Hijras or male-to-female transgender people are not included under the term 'MSM'.)

Kothi

Kothis are a heterogeneous group that includes both same-sex oriented males as well as male-to-female transgender people. 'Kothis' can be described as biological males who show varying degrees of 'femininity' - which may be situational. Some proportion of Kothis have bisexual behaviour and get married to a woman. Kothis are generally of lower socioeconomic status and some engage in sex work for survival. Some proportion of Hijra-identified people may also identify themselves as 'Kothis'. But not all Kothi-identified people identify themselves as transgender or Hijras.

Jogtas/Jogappa

Jogtas or Jogappas are those persons who are dedicated to and serve as a servant of Goddess Renukha Devi (Yellamma) – whose temples are present in Maharashtra and Karnataka. 'Jogta' refers to male servant of that Goddess and 'Jogti' refers to female servant (who is also sometimes referred to as 'Devadasi'). One can become a 'Jogta' (or Jogti) if it is part of their family tradition or if one finds a 'Guru' (or 'Pujari') who accepts him/her as a 'Chela' or 'Shishya' (disciple). Sometimes, the term 'Jogti Hijras' is used to denote those male-to-female transgender persons who are devotees/servants of Goddess Renukha Devi and who are also in the Hijra communities. This term is used to differentiate them from 'Jogtas' who are heterosexuals and who may or may not dress in woman's attire when they worship the Goddess. Also, that term (jogti hijra) differentiates them from 'Jogtis' who are biological females dedicated to the Goddess. However, 'Jogti Hijras' may refer to themselves as 'Jogti' (female pronoun) or Hijras, and sometimes even as 'Jogtas'.

Shiv-Shaktis

Shiv-Shaktis are considered as males who are possessed by or particularly close to a goddess and who have feminine gender expression. Usually, Shiv-Shaktis are inducted into the Shiv-Shakti community by senior gurus, who teach them the norms, customs, and rituals to be observed by them. In a ceremony, Shiv-Shaktis are married to a sword that represents male power or *Shiva* (deity). Shiv-Shaktis thus become the bride of the sword. Occasionally, Shiv-Shaktis cross-dress and use accessories and ornaments that are generally/socially meant for women. Most people in this community belong to lower socio-economic status and earn their living as astrologers, soothsayers, and spiritual healers; some also seek alms.

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

Sexual minorities or Sexual minority community

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

(Some of the above definitions are adapted from:

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

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

Annexure 1

Site Assessment

1. Exercises for Site Assessment

Number and Trend Map ("How Hot is the Spot"?)

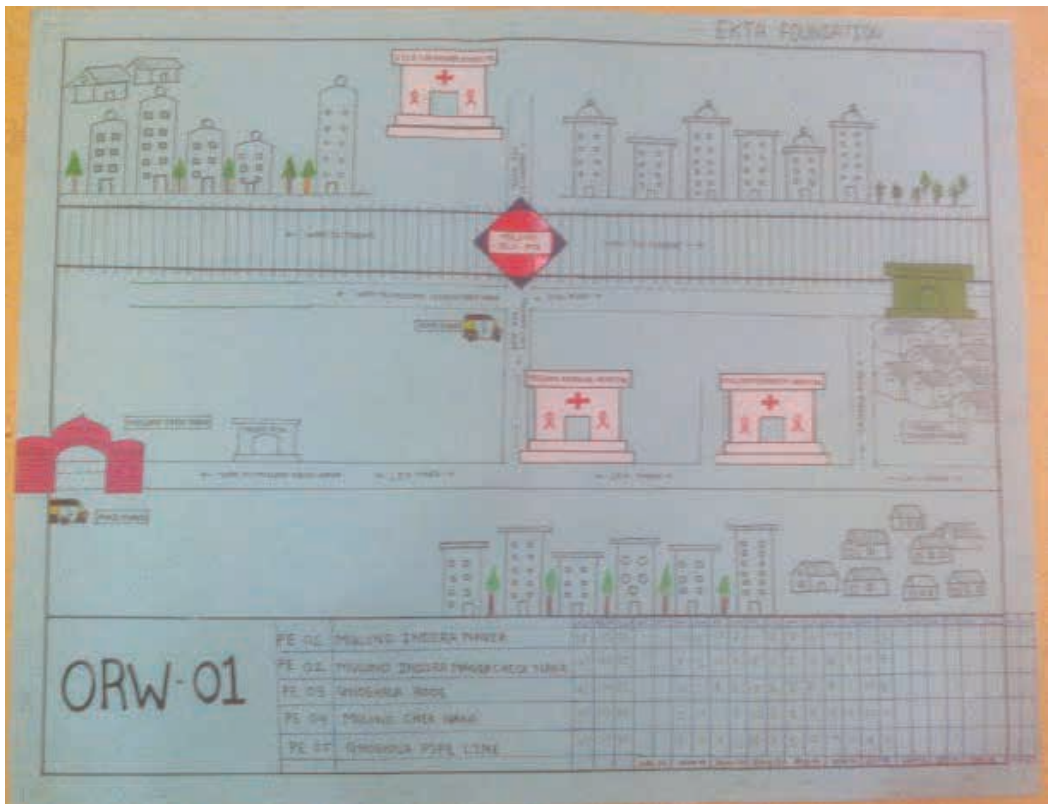
Respondents

Visible and self-identified HRGs (TG and Hijras)

Location

At all hotspots identified through Broad Map, and any other hotspot that might be subsequently identified through the course of the Mapping implementation in the site.

Hotspot Mapping



Requirements: Chart paper, markets, bindis (or any other low cost colourful identification stickers).

Process

1. Settle respondents with an icebreaker
2. Ask the group to draw a map of the local area, including any local landmarks to orient the map.
3. Ask them to mark the hotspots they themselves frequent, in reference to the landmarks (the facilitator may also want to talk about what kind of spots there are generally – for example, truck terminals, bushes, bus stop, parlours, hamams, badhai area, hijra/TG houses, etc this will also help stimulate the discussion in the group).
4. Ask the group to rank the hotspots using symbols for high, medium or low according to the level of risk practice that puts HRGs at risk of HIV/STI infection at different hotspots.
5. Ask the respondents why they have marked different hotspots differently – is it according to numbers of HRGs who frequent that hotspot or the particular risk practice usually carried out at the hotspot which may carry more or less risk of HIV/STI transmission, or the frequency of risk practice, or any other reason? Let the HRGs suggest their own reasons rather than asking them leading questions.
6. Do not contradict unless you have to clear misconceptions and myths.
7. Then ask respondents to look at the hotspots ranked as high. Ask them to discuss what change needs to happen generally to make the location into a medium or low rank. Then ask what individual HRGs or small peer groups could do to reduce risk practice in these locations. Again, do not contradict unless you have to clear misconceptions and myths.
8. Ask respondents to estimate the number of HRGs from different categories who usually frequent each hotspot on an average day. Let respondents debate among themselves to arrive at figures most members of the group are happy with. Against each hotspot on the chart ask respondents to put different symbols for different categories of HRGs and put the corresponding number next to each symbol (numbers can be represented through symbols too).
9. Ask respondents to draw a clock (or a line representing 24 hours of a day) and indicate on the clock (or the line) at what time of the day the numbers they have mentioned is to be found at the hotspot. Ask them to mark (with + and – signs, or with spots or *bindis*) different hours of the day to indicate how that number might fluctuate during the day.
10. Ask participants to draw a line indicating 7 days of a week and ask them to similarly mark the line to indicate fluctuations during a week.
11. Ask them to put symbols against the hotspot to indicate events or festivals in a year when the number might significantly go up or down.

12. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.
13. At the end of the session, note down the date, place, number of respondents (disaggregated by HRG categories) and your mapping team number on the back of the chart paper.

Outputs

1. Estimated numbers of different HRG categories in different hotspots
2. Timings when the HRGs are available at the hotspots (daily, weekly and special annual events or festivals)

Seva Chitram (Services Map)

Purpose

This is a method to assess availability and accessibility of different services in the site to HRGs.

Respondents

Visible and self-identified HRGs.

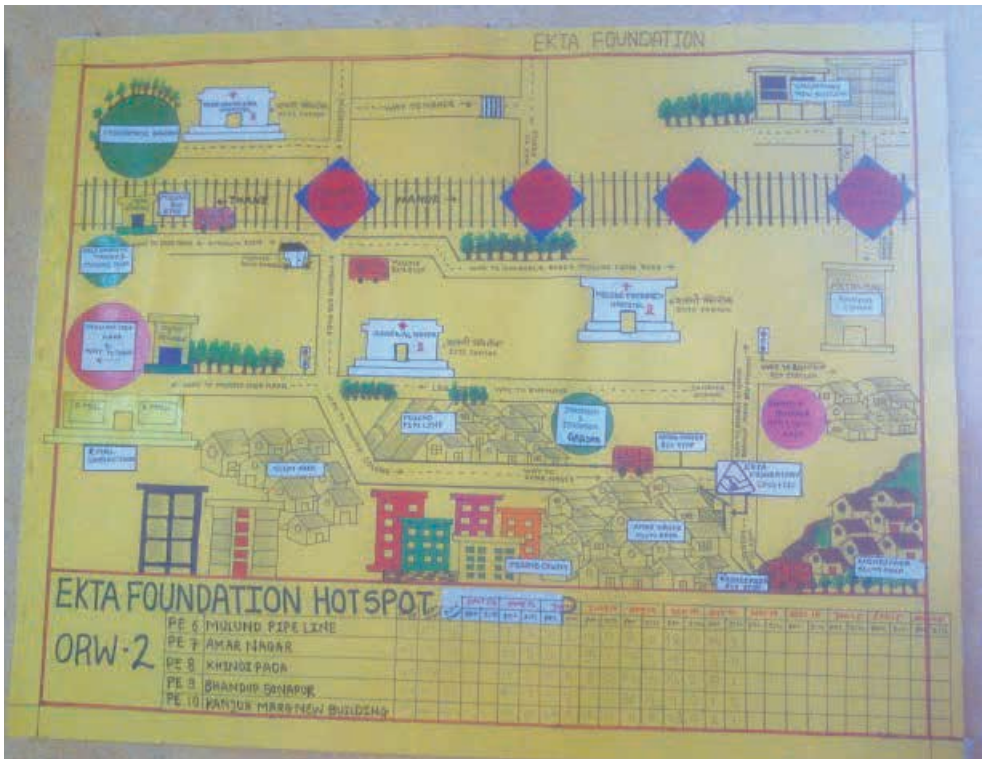
Location

At all hotspots identified through broad mapping, and any other hotspot that might be subsequently identified through the course of the mapping implementation in the site.

Process

1. Ask the participants to draw a map of the site including a few main landmarks and ask them to indicate the hotspot where the HRG mapping team contacted them.
2. Ask the participants to include in the map any places or people that their HRG group could go to get support for HIV/STI prevention and treatment.
3. Ask the participants to put against each intervention:
   - ➔ What each service provides
   - ➔ How each service helps reduce risk of HIV/STI infection(some Transgender – Hijras may also provide SRS/and other service provider details – it may be useful to mark out these with a star or asterisks for strengthening referral, etc)
4. Now ask the participants to rank the services high, medium, or low according to how accessible they are to HRGs like themselves (how often they access or utilise the services – often, sometimes, never).

Service Map (Seva chitram)



5. Ask them to identify factors that make them use the services marked high or medium (such as distance, cost, behaviour of service providers, confidentiality, effectiveness of services provided, availability and timing and so on).
6. Now ask them to discuss the services ranked with low accessibility. What could be done to make these important services more accessible to HRGs like themselves?
7. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.
8. At the end of the session, note down the date, place, number of respondents (disaggregated by HRG categories) and your mapping team number on the back of the chart paper.

Outputs

1. Location of different HIV/STI related services in the site
2. Range of services offered by each service provider
3. Criteria by which HRGs judge a service to be accessible and available
4. Recommendations from HRGs about how to make services accessible and available to them

Why is it so?

Purpose

The method will help HRGs analyse the range of risk and vulnerability factors they experience that increase their susceptibility to HIV/STI transmission. This will help to identify the strategies and intervention components that have to be put in place to enable them to avert the risks.

Respondents

Visible and self-identified HRGs

Location

At all hotspots identified through broad mapping, and any other hotspot that might be subsequently identified through the course of the mapping implementation in the site

Process

1. Ask participants to name the different kinds of behaviours that put people at risk of HIV/STI infection. Correct any misconceptions.
2. Pick one of the risk behaviours.
3. Ask them to draw a symbol of this risk behaviour in the centre of the flipchart inside a circle.
4. Ask "Why is it so?" and ask them to draw and/or write the reasons for the risk behaviour in balloons.
5. Keep asking "Why is it so", adding further reasons in connecting balloons until they can think of no more.
6. Ask the participants what the diagram says about:
   - ➔ What are the most important reasons (vulnerability factors) for risk behaviour?
   - ➔ What are the ways that the HRG group already try and reduce risk behaviour?
   - ➔ What would further help the HRG group avoid the risk behaviour in the diagram?
7. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.
8. At the end of the session, note down the date, place, number of respondents (disaggregated by HRGs and non-HRGs) and your mapping team number on the back of the chart paper.

Outputs

1. The factors that make particular categories of HRGs vulnerable to HIV/STI risks
2. Recommendations from HRGs about how to address some of these factors and risk reduction strategies

Sex Life

Purpose

The range of sexual partners of HRGs can be explored through this method. The method will also indicate the kinds of sex acts usually practiced by a HRG with her sexual partners, helping to estimate the volume of penetrative sex, and therefore project needs for condom and lube requirement.

Respondents

Visible and self-identified HRGs.

Location

At all hotspots identified through broad mapping, and any other hotspot that might be subsequently identified through the course of the mapping implementation in the site.

Process

1. Administer this method on a one-to-one basis with an individual HRG
2. Ask the HRG to put herself at the centre of the chart
3. Ask her to draw pictures of her sexual partners all around her own picture in the middle and describe the partners (without naming them) – who are they, what do they do, how old are they, how are they related to the HRG, how did they meet, etc.
4. Then ask the HRG to indicate against each partner's picture or symbol what kind of sex did she have with the partner in the last one week, and how many times?
5. At the end of the session, note down the date, place and your mapping team number at the back of the chart paper.

Outputs

1. The range of sexual partners HRGs have – clients, *panthis*, boyfriend/husband, wife, other women (please bear in mind some of the transgender persons could be married, have a female spouse or partner – care must be taken not to create any stigmatisation attitude or comments), etc.
2. The proportion and frequency of penetrative sex acts they engage in and with which category of sexual partners.

2. Capacity Standards for Participatory Site Assessment With HRGs

Rather than use site assessment as a one off process to begin a project, many organisations carry out site assessment on a regular basis to review their programmes. For this reason, capacity standards have been developed so that organisations can continually improve their site assessment implementation, outputs and outcomes.

The site assessment capacity standards shown below are not indicators which can be objectively measured: rather they are designed to stimulate discussion in the organisation so that creative ways to optimise the site assessment process can be found. The capacity standards should be used in planning, then checked throughout the site assessment. The scores are intended to indicate where an organisation needs to take action to maximise the impact of their site assessment. The basic capacity standards in this guide are useful only to the extent that users are committed to honest and critical reflection, and they can be used by organisations (with or without an external facilitator) to identify their own capacity building needs, plan technical support and monitor and evaluate their site assessment progress.

Scoring of capacity standards can be carried out using the scores below:

DK= Don't know or not applicable

1= Needs urgent attention

2= Needs major improvement

3= Satisfactory, room for some improvement

4= Satisfactory, room for a little improvement

5= Exemplary, cannot be improved

Although difficult, a frank and critical approach will mean that the final scores are more meaningful and useful to the organisation. In particular, participants should think carefully before assigning a '5' – is there really no room for improvement? Even if the standard is being reached, are there opportunities to improve the quality of the work?.

Capacity Standards for Site Assessment with HRGs	DK	1	2	3	4	5
1. Methods used in site assessment should be dialogue-based, highly participatory and give the opportunity for HRGs in the site to analyse barriers to reducing HIV risk and find solutions. In other words, as well as generating information, site assessment should mobilise HRGs and strengthen their ability to critically reflect on reducing HIV risk.						
2. Reporting formats should be developed which are easy for site assessment team members to use. The team should meet at the end of each day to assess the information generated, look at what gaps still remain and to plan site assessment activities for the following day.						
3. During site assessment, the teams need to be very careful to keep information secure and confidential. They must also take care not to make false promises or raise unrealistic expectations about what will happen after the site assessment.						
4. At the end of site assessment, a feedback and project design or planning meeting needs to be held immediately. All the main stakeholders, including the site assessment team members and HRG representatives from the site should be present. The site assessment team members should have time before this meeting to organise how they will present the findings to make sure that confidentiality is maintained.						
5. If nothing happens or there are no changes in the site after site assessment, the momentum will be lost. Prior to site assessment, funding must be secured for follow up activities. Any activities initiated by the HRGs themselves as a result of site assessment should be applauded and supported.						

Annexure 2

Tool

Peer-Led Outreach and Planning

Tool Type: Exercises and sample materials for outreach planning.

Summary: The rationale for outreach planning is presented with a series of participatory exercises by which Peer Educators (PEs) can plan outreach to their areas. Monitoring of outreach is described and sample formats for PEs and ORWs to record outcomes are provided.

Who can benefit from this resource?

Peer Educators and outreach workers at NGOs/CBOs.

Section I - Overview of Outreach Planning for Peer Educators

Outreach planning is a tool that facilitates a peer educator's individual-level planning and follow-up of prevention service uptake, based on individual risk and vulnerability profiles of Transgender – Hijras and their partners.

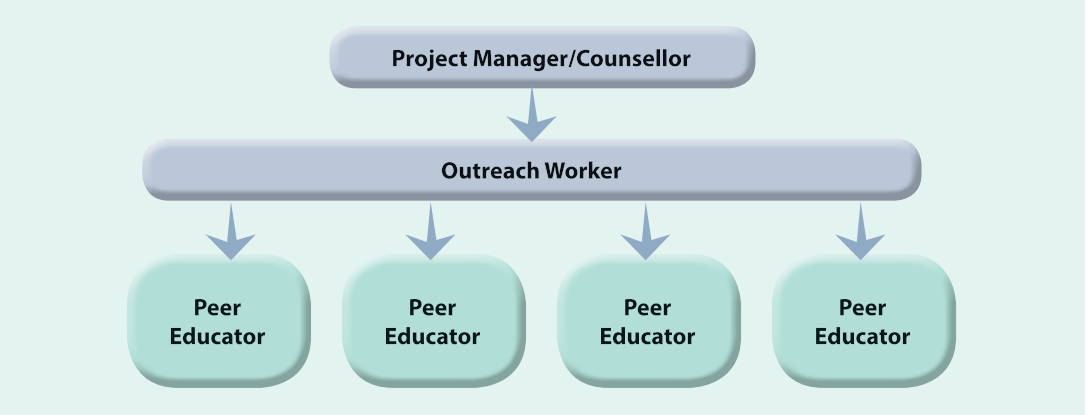
Outreach planning at each site is done by PEs. An outreach plan gives a visual picture of the site that a PE is managing. It helps the PE to understand the extent to which programme services have reached the Transgender – Hijras and to identify and monitor problem areas.

Benefits of Outreach Planning

- **Defined area of operation for PE –** duplication of effort and diffusion of responsibility is avoided when a site is demarcated and responsibility for that site rests with an individual PE.
- **Repeat visits for monthly screening –** The PE is able to monitor clinic visits for monthly screening of the FSWs in the given site.
- **Individual Tracking –** The PE can track how many Transgender – Hijras are being reached during a given month for various services (clinic/camp attendance, one-on-one sessions, contacts, group sessions, and condom distribution).
- **PE able to collect, analyse and act upon data** – Using the PE daily activity report, the PE is able to generate data and use it to provide minimum services to all Transgender – Hijras in her site.
- **PE becomes the site manager –** PEs decide and budget for activities to be conducted in their site and take responsibility to ensure service provision to all Transgender – Hijras in their site.
- **Community ownership –** By addressing felt needs of the community and encouraging active involvement and decision-making by the Transgender – Hijras in all aspects of the programme, a sense of belongingness and ownership is cultivated.
- **Shift from delivering services (push) to meeting community's demand for services (pull)** – Ownership by the community generates demand for services. The project services will be community-driven rather than IP-driven.

Outreach Planning in the Organisational Context

To ensure effective implementation of outreach planning, a particular flow system to manage the outreach activities should be put in place, with defined responsibilities for each member. Following is the structure for a typical outreach worker's area:



Through the outreach planning exercises, PEs plan their outreach services, including health camps, events, communication sessions, condom distribution and crisis management for the Transgender – Hijras in their zone. As managers, these PEs monitor their own performance and the delivery of monthly services in consultation with project staff to ensure that the minimum package of health, communication and HIV prevention services reaches all Transgender – Hijras in their respective zone. This approach has demonstrated that Transgender – Hijras from low literate and economically challenged backgrounds have the capacity to take up various challenging tasks including managing HIV/STI prevention services.

Elements of the Outreach Plan

A PE creates an outreach plan for her own site and updates and analyses it every month. The essential elements of an outreach plan include:

- pictorial depiction of the site
- number of registered Transgender – Hijras in the site
- number of new and dropout Transgender – Hijras
- number of Transgender – Hijras accessing services
- number of Transgender – Hijras who are members of the NGO/CBO
- key stakeholders
- location of condom depots, clinic and health camp areas and location of other relevant local resources

Section II - Outreach Planning Processes

Outreach planning is a participatory and interactive process. Following are a set of processes that can be facilitated by outreach workers to help PEs create their own outreach plan. The processes are presented below in a training format, that is, the tool is designed for outreach workers to train a group of PEs, who will then be able to repeat the processes for themselves as they update and revise their outreach plans.

Process 1 Spot Analysis

Aim: To help participants compile information collected during urban situation and needs assessment related to each high-risk spot/site in their respective project areas to facilitate planning.

Description: Participants, through group work, will compile spot-wise information for planning.

***Suggested Teaching Method*:** Large group discussion.

Materials/Preparation Required: Spot-wise information collected in urban SNA, chart paper, pens, and Handout I (*Planning Outreach for Sex Work Interventions*).

Duration: 120 minutes

Process:

1. Begin the session by asking participants what they learned during the urban situation and needs assessment process. Allot time to share key findings.
2. Clarify the importance and need for outreach planning with respect to HIV prevention programmes. Use the following reasoning:

In a programme such as ours, a spot is the smallest geographic location for intervention, and it is important to plan for each and every spot at the town level. Therefore, outreach plans are developed for the following reasons:

- ➔ Each spot is different, therefore plans have to be spot specific
- ➔ Other characteristics such as client volume and typology of sex work have to be factored into planning
- ➔ Spot-wise planning should facilitate outreach to maximum number of Transgender – Hijras

3. Ask participants what information they require about Transgender – Hijras operating in a spot that would help them develop a plan for that spot. Make sure the following is included:
   - ➔ Volume of client - high volume (more than 10 clients/week), medium volume (5-9 clients/week), low volume (less than 4 clients/week)
   - ➔ Typology of TG and Hijras - Gharana based, non Gharana based, other transgenders (who are not part of any gharana system)
   - ➔ Age of TG and Hijras below 20 years, 20-30 years, 30-40 years, above 40 years
   - ➔ Time of operation - morning (6 a.m. - 10 a.m.), afternoon (10 a.m. - 2 p.m.), evening (2 p.m. -8 p.m.) and night (8 p.m. - 6 a.m.)
   - ➔ Frequency of operation - daily, weekly, monthly, seasonal
4. Ask participants to divide themselves into groups; group size should reflect the sites they represent in number. Ask each group to identify a well-known spot in their sites and to do the Exercise 1, Spot Analysis.
5. Give participants 45 minutes to do Exercise 1. Make sure peers in the group participate actively.
6. After everyone completes the exercise ask each group to present their spot analysis. Encourage peers to make this presentation.
7. After each group presents its spot analysis, ask the following questions:
   - ➔ What was the process that each group adopted to do this exercise?
   - ➔ What is the analysis for the spot?
   - ➔ As a result of the analysis, what is the spot plan?

8. Before concluding, stress the following:
   - ➔ Volume of clients - Planning should ensure that Transgender – Hijras with higher volume of clients are reached as a priority.
   - ➔ Typology - Planning should include typology of sex work and needs to be specific to each type. Non Ghrana based can be reached at solicitation points as well as points of service. Outreach workers can work with them directly or can reach them through network operators. On the other hand, for Ghrana based Transgender – Hijras outreach workers have to advocate with Gurus and work through Gurus and nayaks. Gharana based Transgender – Hijras - Hijras can also be reached at the points of service, that is, in the soliciting points.
   - ➔ Age - Transgender – Hijras' needs differ with respect to age, therefore planning should address that.
   - ➔ Time/day of operation - Understanding the time and day of operation will help plan outreach with respect to those times. For example, there are certain days in a month, like festival days, when more Transgender – Hijras come to a particular spot such as a market. During those days of the month, outreach needs to be strengthened. Similarly, evenings and nights may be very busy in certain spots. Hence, the project needs to ensure that outreach is planned during those times of the day.
9. Distribute Handout I, *Planning Outreach for Sex Work Interventions,* to the participants.
10. Inform participants that spot analysis should be done every six months since ground realities may change.
11. Conclude by reminding the participants the importance of including peers and Transgender – Hijras in planning.

Note: During this workshop, analysis of only one spot/group can be done due to time constraints. Make sure that, by end of the day, participants plan and develop a time line to complete this exercise for all spots. This analysis can be adapted for understanding characteristics of each location, each town, each site as well as each district.

Exercise 1 – Spot Analysis

District : , Taluk : , Location : , Spot : , Date of analysis :

High Volume	Typology																							
	Street																							
	Age																							
	>20								20-30								30-40							
	Daily				Weekly				Daily				Weekly				Daily				Weekly			
	Time								Time								Time							
	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N

High Volume	Home																							
	Age																							
	>20								20-30								30-40							
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High Volume	Brothel																							
	Age																							
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High Volume	Lodge																							
	Age																							
	>20								20-30								30-40							
	Daily				Weekly				Daily				Weekly				Daily				Weekly			
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	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N

Medium Volume	Typology																							
	Street																							
	Age																							
	>20								20-30								30-40							
	Daily				Weekly				Daily				Weekly				Daily				Weekly			
	Time								Time								Time							
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Medium Volume	Home																							
	Age																							
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Medium Volume	Brothel																							
	Age																							
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Medium Volume	Lodge																							
	Age																							
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	Time								Time								Time							
	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N

Low Volume	Typology																							
	Street																							
	Age																							
	>20								20-30								30-40							
	Daily				Weekly				Daily				Weekly				Daily				Weekly			
	Time								Time								Time							
	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N

Low Volume	Home																							
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Low Volume	Brothel																							
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	Time								Time								Time							
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Low Volume	Lodge																							
	Age																							
	>20								20-30								30-40							
	Daily				Weekly				Daily				Weekly				Daily				Weekly			
	Time								Time								Time							
	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N	M	A	E	N

Handout I: Planning Outreach for Sex Work Interventions

The main objective of outreach, in the HIV intervention context, is to impart behaviour change in targeted populations. The project is attempting to do the following:

- Encourage timely and complete treatment of STIs
- Encourage correct and consistent condom use

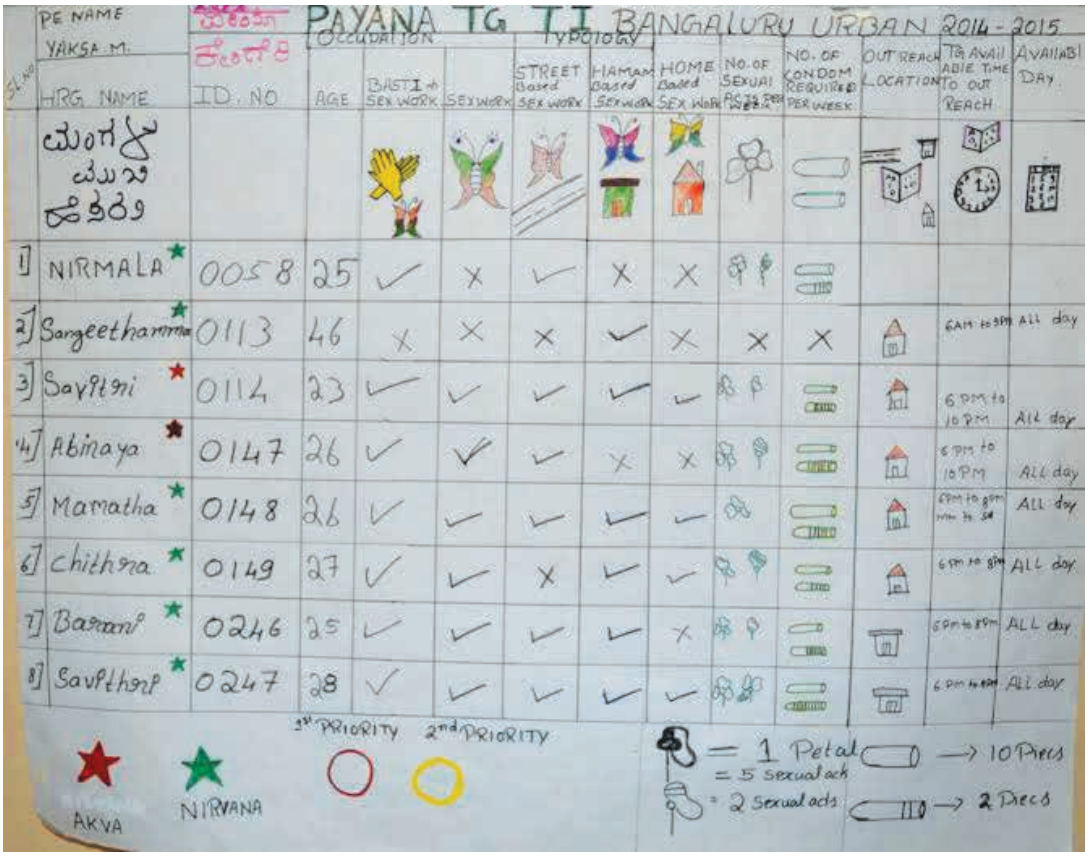
The project will work with Transgender – Hijras and their clients as well as regular partners of Transgender – Hijras. However, the outreach strategy will differ with respect to TG and hijras. The objectives of outreach to Transgender – Hijras are to provide knowledge about STIs/ HIV, develop better health seeking behaviour, build skills to negotiate condom use, provide condoms and referrals for services. The objective of outreach to clients is to facilitate safer sexual relationships.

Key elements of outreach with Transgender – Hijras are as follows:

- **Geographical Coverage** – Outreach needs to be planned for each location/site at which sex work takes place. Each location has its own characteristics/needs, therefore an outreach strategy must address these.
- **Client Volume** – Understanding client volume of sex work is important to develop a good outreach strategy. Outreach strategy should ensure that high volume Transgender – Hijras (high volume = more than 10 clients/week, medium volume = 5-9 clients/week, low volume = 4 or fewer clients a week) are reached with specific purpose and at specific periods. This is important because, in the context of HIV, Transgender – Hijras with more clients are most vulnerable and at most risk.
- **Type of Sex** – Type of sex influences risk and vulnerability of Transgender – Hijras. Anal sex is more risky than oral sex. Therefore, the outreach strategy would also have to address those who are involved in higher risk activities.
- **Typology of Transgender – Hijras -** This is very important to understand because outreach strategies differ based on typology of sex work. The outreach strategies for street based sex work would need to include an intensive peer network in order to reach Transgender – Hijras both at points of solicitation and points of service. The programme would have to work with gurus, nayaks to reach the gharana. Gharana based Transgender – Hijras may be difficult to reach and would require different strategies. Outreach strategies need to reflect the typologies within the location with a focus on high volume of Transgender – Hijras.
- **Age** – Age of Transgender – Hijras is also crucial for designing outreach strategies. Interests and needs of Transgender – Hijras differ depending on age. Vulnerability to risk will differ as a result of age.

- **Time** – It is important to understand time of sex work in the location so that outreach strategies reflect this understanding. For example, Transgender – Hijras may normally work in the evening in a specific location Hence outreach to Transgender – Hijras needs to be planned during that time in those locations. Sex work interventions cannot work on a specific timetable. They have to adapt to field realities.

Planning Outreach for Sex Work Intervention



Process 2.1 Contact Mapping (Part 1)

Aim: To help participants map contacts they have with Transgender – Hijras in each spot and plan for outreach based on these contacts.

Description: The participants, through group work, map the contacts they have in each of the spots and analyse needs.

Suggested Teaching Method: Large group discussion.

Materials/Preparation Required: Maps of each town in the site, chart paper and pens.

Duration: 105 minutes

Process:

1. Begin the session by asking the participants to divide themselves again into site wise groups.
2. Ask each group to draw a map of the town and mark all the locations and spots in the map. Write the estimated number of Transgender – Hijras in each spot.
3. Ask the participants to give a colour code to each of the outreach workers and peers.
4. Then using the different colour codes, mark the number of Transgender – Hijras each outreach worker and peer knows in the spot. For example, assign the colour red to Laxmi, a PE, and mark all her Transgender – Hijras contacts in each spot using red.
5. Allot 30 minutes to complete mapping. Ask each group to present their maps. Encourage the peers to make presentations.
6. After each peer presents, ask the following questions:
   - ➔ What does the map show?
   - ➔ In which spots are the contacts limited? Why?
   - ➔ Where is the outreach not happening?
   - ➔ What should be done in those specific locations where Transgender – Hijras are not reached?
7. Conclude by asking participants if all the contacts that they marked are mutually exclusive, emphasising the fact that contacts could overlap. For example, PEs may know the same member but count her as two contacts.

Note: Colour-coded maps are easy to understand by all participants, independent of literacy level.

EXAMPLE: CONTACT MAPPING OF DODDABALLAPURA (SURAKSHA- NGO)

Process 2.2 Contact Mapping (Part 2)

Aim: To help participants understand who the contacts are after mapping them in each spot.

Description: The participants, through group work, list out contacts that they mapped in the previous exercise.

Suggested Teaching Method: Large group discussion.

Materials/Preparation Required: Chart paper and pens.

Duration: 90 minutes

Process:

1. Ask the groups to get together and look at their map again.
2. Ask each group to select 3 spots in the map that have the maximum number of contacts.
3. Give the groups 30 minutes and ask them to list names of the contacts in each of the spots as stated in Exercises 2 & 3 (Contact Mapping)
4. Ask each group to answer and record the following:
   - ➔ Which contacts does each outreach worker know very well?
   - ➔ How many and who are the contacts that are known by more than one outreach worker?
5. After 30 minutes, ask each of the groups to present their group work. Again encourage the peers to make the presentations.
6. Ask participants what they learned and how it will help them in planning outreach. Ensure that the following points are covered:
   - ➔ It is important to understand how many contacts we have in each spot and how to increase the number of contacts so that maximum Transgender – Hijras can be reached.
   - ➔ It is important to understand who the contacts are so that we understand whom we are not reaching. That way, we can plan to reach those not yet reached.
   - ➔ It is important to understand that outreach workers, especially peers, have contacts in more than one spot.
   - ➔ It is important to understand that peers have their own social network, certain Transgender – Hijras who they are friends with and have influence over.
7. Conclude by informing the groups that both geographic networks and social networks of peers play an important role in planning outreach to Transgender – Hijras.

8. Also inform the group that mobility is a factor, therefore it is important to conduct Exercise 2 and Exercise 3 every six months. This way the project can ensure that both new and continuing TG - H in each spot are being reached.

Note: Due to workshop time constraints, it may not be possible to conduct this exercise for all the spots. Hence a time line needs to be planned to complete this exercise for all the spots.

Exercise 2: Contact Mapping

District: Taluk: Name of Town: Date of exercise:

Estimated number of Transgender – Hijras in the town:

Contacted Number of Transgender – Hijras in the town:

Sl. No	Name of Spot	Peer 1 No. of contacts	Peer 2 No. of contacts	Peer 3 No. of contacts	Peer 4 No. of contacts
1					
2					
3					
4					
5					
6					
7					
8					
Total					

Exercise 3: Contact Mapping

District: Taluk: Location: Spot:

Date of exercise:

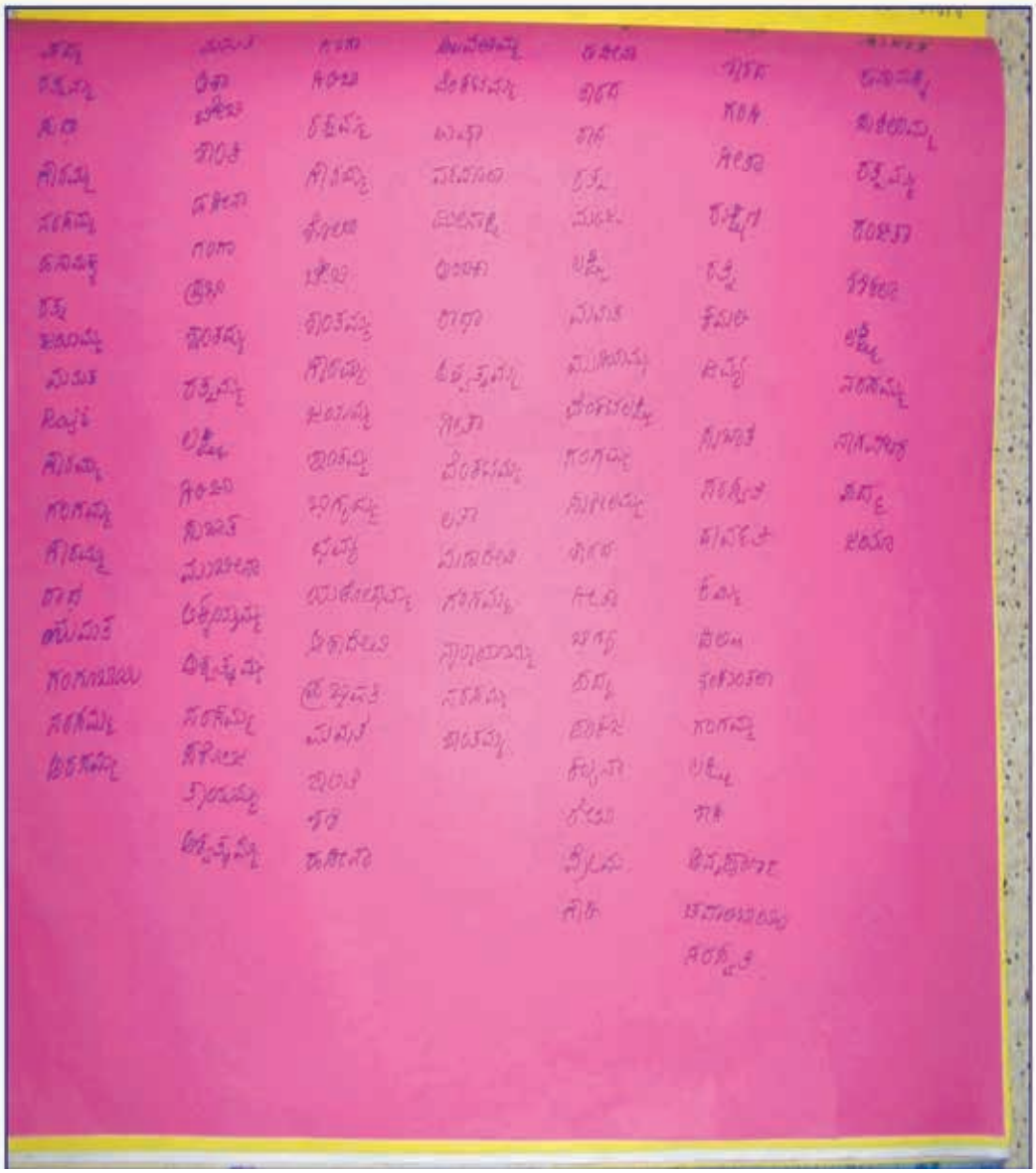
Estimated number of Transgender – Hijras in the town:

Contacted Number of Transgender – Hijras in the town:

Sl. no	Peer 1 Name of contact	Peer 2 Name of contact	Peer 2 Name of contact	Outreach staff 1 Name of contact	Outreach staff 2 Name of contact
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
11					
13					
14					
15					
No. of contacts that are known very well					
	# of contacts	# of contacts	# of contacts	# of contacts	# of contacts

Colour-code the contacts that are common to more than one list.

EXAMPLE: CONTACT MAPPING DODDABHALAPUR (SURAKSHA-NGO)



Process 3 Networks

Aim: To help participants understand geographic and social networks of Transgender – Hijras and advantages and disadvantages associated with both.

Description: The participants, through a debate, discuss the advantages and disadvantages of geographic and social networks and include the same in planning outreach.

Suggested Teaching Method: Debate and discussion.

Materials/Preparation Required: Chart paper and pens, Handout II (*Geographical and Social Networking*).

Duration: 90 minutes

Process:

1. Deliver a mini-lecture on Transgender – Hijras networks – gharana and non gharana based, etc. Clarify that Transgender – Hijras can have contacts in a particular geographical location, a particular social circuit, and also with network operators. It is important to understand the networks because both "frequency of meeting" and "peer influence" have a great impact on the Transgender – Hijras. Hence while selecting peers it is important to ensure that peers are selected from all networks so that the project can maximise reach.
2. Distribute Handout II (*Geographical and Social Networking*). Ask one participant to read the case study out loud to the group. Ask them to stop where the case study ends. Make sure that they do not read the definitions.
3. Once you ensure that every participant has understood the case study, divide the participants into two groups using a group forming energiser.
4. Ask the groups to discuss the following:
   - ➔ Group 1 - Advantages of selecting peers from a particular geographical location and disadvantages of selecting peers from social circuit.
   - ➔ Group 2 - Advantages of selecting peers from social circuit and disadvantages of selecting peers from within a particular geographical location.
5. Give the participants 30 minutes to prepare for the debate.
6. Appoint a referee for the debate and allot 10 minutes to each of the group to share their view-points.

7. Highlight the key advantages and disadvantages of each network and conclude that both networks are important to consider in selecting peers. Peer selection depends on the situation, and a combination of both strategies may need to be used. In the early stage of the project a social network may be more efficient even though it is time consuming. Once all the social contacts of each peer/volunteer are introduced to the project and rapport is built by each peer with others in her group, the project should move to geographic networks. At times, depending on the situation, the project may have to use geo-social networks in order to ensure effective outreach. The project should decide which one to adapt and determine this based on the project needs and reach at that time.
8. Conclude by reading out the definitions of geographic networking and social networking from the handouts.
9. Announce that both teams have worked hard and both the teams have won. Distribute small prizes (if possible) to all the team members.

Handout II: Geographical and Social Networks

Case Study of Renni

1. Renni is a Hijra who has been operating in 'X' City for past 7 years. She is 26 years old. In her early years, she used to operate from the bus stand with her friend Santi. Over a period of time she developed a friendship with 15 other Transgender – Hijras who operate from the same area. She comes from her village every day. She arrives at 11 a.m. and work until 6 p.m.
2. She knows that there are around 100 to 150 Transgender – Hijras who operate at the bus stand. Some of them operate in the morning hours (6 a.m. to 10 a.m.), some in the evening (6 p.m. to 10 p.m.) and some in the night (10 p.m. to 5 a.m.). Renni has seen many of them but not all are her close friends. She knows about 70 Transgender – Hijras who operate at the bus stand at the same time as her (11 a.m. to 6 p.m.). Of the women who operate at the same time as her, 15 are her close friends and 30 are her acquaintances. In last 7 years of working in City 'X', Renni has moved to different locations in the city, such as the railway station and the market, to solicit clients due to various reasons. Over the years, Renni has operated in the top 10 locations within the city. She has developed close friendship with 80 Transgender – Hijras in those locations (including 30 in the bus stand). She also knows 140 other Transgender – Hijras who operate in those locations regularly.
3. The SNA and spot analysis estimates 500 Transgender – Hijras in those 8 locations. These Transgender – Hijras are known to operate at different times. The project has developed a good rapport with Renni. Furthermore, Renni is willing to work as a PE since she understands that STI/HIV is a serious threat to her community, especially to her friends who she loves and is concerned about. The project staff recognises that Rani is an asset to

the project. They are interested in involving her in the project. The staff has to decide on how to incorporate Renni into the project.

4. The project has two options:

   Option One:

   Renni can be given a particular geographical area (1 or more locations) and she has to reach all the Transgender – Hijras who operate in that area and also identify new Transgender – Hijras. This would mean that she will have to build rapport with all the Transgender – Hijras in the assigned location, give them information and condoms and bring them to the clinic.

   Option Two:

   Renni can be given the responsibility of reaching her close 80 friends on a regular basis whom she knows very well and has good rapport with in 10 different locations within the city.

5. **The Questions:**
   1. Which option is the most effective and efficient?
   2. What are the advantages and disadvantages of each option?

Definitions

Geo-Networking Concept (Option One)

Geo-networking is defined as networking/reaching Transgender – Hijras within a fixed geography. Using this concept, a peer educator/community volunteer is given the responsibility of reaching all the Transgender – Hijras-Hijras that are operating in a particular geography irrespective of her rapport or relationship with them.

This in practical terms means that the peer has to go and make friends with all the Transgender – Hijras in the particular spot (geography) irrespective of age, time of operation, etc. For this she may have to work beyond her normal sex work times, make an effort to meet the women or get introduced another way.

Social Networking Concept (Option Two)

Social networking is defined as networking/reaching TGs-hijras within a social circuit. Using this concept, the peer educator/community volunteer is given the responsibility of reaching out to her friends irrespective of a defined geographical area.

This in practical terms may mean that the peer may have to travel to a few spots, do her work and also work for the project. The project may have to appoint more than one peer in one spot/ geography.

Handout III: Opportunity Gaps

Opportunity Gaps are obstacles that disable an individual/community from moving from one level to the next level in the behaviour change processes.

The Transgender – Hijras has to undergo different stages/level of the outreach cycle for effective behaviour change to occur. The project should work on removing the obstacles and on creating an environment at every stage/level so that the individual/community can move from one level to the next level easily.

The factors/reasons that cause opportunity gaps may vary from individual to individual in a community. The project should develop systems to assess opportunity gaps at every level by using qualitative/quantitative information.

Example of Opportunity Gaps

(A spot-wise analysis must be done and an overall analysis for the town must be completed to gain both a spot-wise understanding and overall understanding, since the opportunity gaps may vary from spot to spot.)

Level 1 Estimated Transgender – Hijras in the project area Opportunity gap (Level 2 - Level 1)	– –	0	218
Level 2 Transgender – Hijras who have been contacted at least once by the project Opportunity gap (Level 3 - Level 2)	– –	79	218
Level 3 Transgender – Hijras who have been registered Opportunity gap (Level 4 - Level 3)	– –	34	139
Level 4 Transgender – Hijras who are in regular contact with the project Opportunity gap (Level 5 - Level 4)	– –	47	105
Level 5 Transgender – Hijras who visited the clinic for STI treatment Opportunity gaps (Level 6 - Level 5)	– –	12	58
Level 6 Transgender – Hijras who completed the treatment Opportunity gaps (Level 7 - Level 6)	– –	46	46
Level 7 Transgender – Hijras who had regular health check-up	-		0

See example for details. The reason for opportunity gaps at each level has to be identified and an action plan needs to be developed to overcome these opportunity gaps. The reasons for gaps may be internal factors (where the project has direct control, as in work timing of ORWs and PEs) or external factors (for example, high mobility of FSWs on a daily basis.) The internal factors can be solved immediately so that the quality of input from the project can be strengthened. Proper networking and advocacy with other government and not government organisations can solve most external factors.

Definitions

Contact	Identification of Transgender – Hijras. Purposeful interaction with the HRG
Registration with the project	After building rapport with the Transgender – Hijras, the Transgender – Hijras is registered by filling the registration form. This provides his/her a number and makes it easy for the project to track outreach provided to her. Registration can happen after 1-8 contacts in the field.
Regular contact	A Transgender – Hijras is receiving education regularly (once every 15 days), over a period of one year or until the Transgender – Hijras is no longer in that location (total 24 interactions a year). Transgender – Hijras is receiving condoms for 90% of her estimated/reported client interaction. Condom distribution is accompanied by demonstration and training in negotiation skills if needed.
Referral to clinic for STI related services	Referral is done by outreach workers or peer. Referral should include STI information, condom information and demonstration and distribution of at least four condoms. Address of a clinic should also be shared. The doctor provides syndromic case treatment for STIs. STI treatment includes understanding the symptoms of the Transgender – Hijras, clinical examination, prescription/distribution of drugs to Transgender – Hijras and partner notification/treatment. STI treatment also includes risk assessment and risk reduction counselling, condom demonstration and distribution. Either the doctor or the counsellor can provide counselling. Referral to the clinic needs to be done whenever a Transgender – Hijras has a symptom. Every 6 months, the Transgender – Hijras is referred for presumptive treatment.
Follow up	Transgender – Hijras who have been treated in the clinic need to be followed
	up at home or clinic within one week.
Regular health check-up	Transgender – Hijras receiving STI/health care services every three months from the programme clinic or through referral doctors (aiming for four check-ups in a year).
	The objective is to promote regular health seeking behaviour among Transgender – Hijras. She should be referred every quarter even if she does not have symptoms.

Example: Opportunity Gaps Analysis

Activities	Status	Opportunity Gaps	Reasons		What should we do?
			Internal	External	
Estimate	218				
Contact	218				
Registration	139	79	Lack of rapport with the 79 Transgender – Hijras	Low volume Transgender – Hijras Fear of identification HRG come to town only once in 15 days	Understand the time when these TG come and plan accordingly Build their trust by contacting them through other ex-workers or stakeholders
Regular Contact	105	34	Have not been able to generate interest	Higher mobility of Transgender – Hijras Few Transgender – Hijras come only once in a month	Link up with other services in the taluk so that women can be offered varied services Reach Transgender – Hijras through their social networks
STI Treatment	47	58	Referral clinic is new Clinic is available only on fixed days Lack of trust in the project	No symptoms Transgender – Hijras drink alcohol	Build trust through peers Inform the Transgender – Hijras about advantages of check-ups

Follow-Up	12	46	Importance of follow-up not communicated properly Staff did not have clear guidance on follow-up	Transgender – Hijras are mobile	Provide counselling about follow-up to Transgender – Hijras along with treatment Motivate doctors to advise follow-up Continuously remind Transgender – Hijras about clinic day
Regular Health Check-Up	0	46	Communication gap with NGO. This service has not been started		

Process 5 - Participatory Site Load Mapping

Aim: To help us to understand the gap between estimates of TGs - Hijras, the number of unique contacts and the number of regular contacts by studying the TG -H load in a day, a week and a month in different sites. Participatory site load maps also give information on potential regular contacts: the potential number of Transgender – Hijras s a site team can contact in a month.

Description: The participants develop site maps to understand the turnover of Transgender – Hijras at a given site in a day, week and month and compare the same with the number of unique contacts and the number of regular contacts at these sites.

Materials Required: Charts, pens

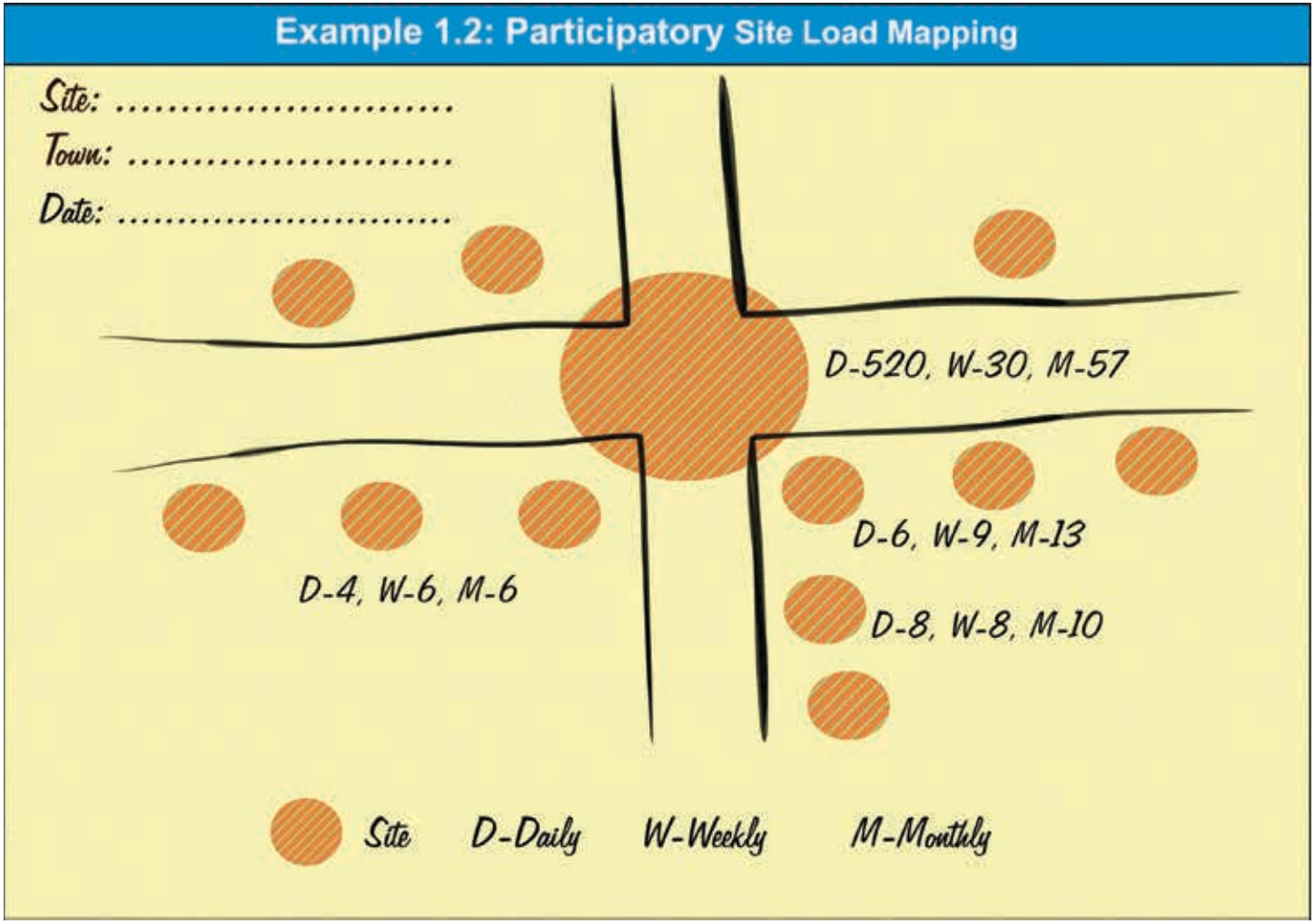
Duration: 120 minutes

Process:

1. Discuss with the participants that in order to reach out to the TGs-hijras it is important to know where, and how many are available on a given day, week and month.
2. Divide the participants, site - wise and ask them to draw a map of the site clearly depicting the sex work sites (the sites at which Transgender – Hijras pick up/solicit their clients) in the site. Ask the participants to colour-code the sites based on sex work typology such as non-gharana based sites, gharana based sites, etc.
3. Check with the participants if they have marked all the sites based on typology. Once all the sites are marked, ask the participants to write down beside the site the number of Transgender – Hijras who are always available on a normal day.
4. Next, ask the participants to write the number of Transgender – Hijras available at these sites in a week. Check with the participants if there are any specific days in a week when the number of Transgender – Hijras peaks and reasons for the same, for example, more Transgender – Hijras are available on a particular day.
5. Once the above exercise is done, ask the participants to mark the number of Transgender – Hijras available in these sites on a monthly basis and also ask if there are specific days in a month where the turnover is high and the reasons for the same, for example more Transgender – Hijras are available on payday.
6. Then ask the participants to add the daily, weekly and monthly turnover in all the sites and draw up a picture of Transgender – Hijras turnover in a site.
7. Now again ask the participants to compare these figures with their estimate, unique contact and regular contact figures for these sites and analyse in the following way:
   - ➔ Are the total Transgender – Hijras available in these sites more or less than the unique contact and regular contact? Why?
   - ➔ Is high weekly and monthly turnover linked with any specific typology of sex work, fir example, is there high turnover seen in mostly Gharana based sex work? Why?
   - ➔ Are there specific sites where unique contact and regular contact is less than monthly turnover? Why?
   - ➔ Which are the sites and typology of sex work that need focused outreach in the site? Which (outreach team) is responsible for these specific sites? What should they do to improve outreach to ensure higher contacts?

Note: Participatory site load mapping is a visual exercise done along with outreach workers, peers and volunteers. This exercise requires a thorough understanding of the geography of the town.

Example 1.2: Participatory Site Load Mapping



Sample Site Load Map

Process 6 Seasonality Diagramming

Aim: To understand peaks and troughs of sex work at a given place in a year and its impact on outreach planning.

Description: The participants, through a seasonality map, attempt to understand the peaks and troughs in sex work based on typology in a taluk and reasons for the same. They learn to plan outreach based on this seasonal variation.

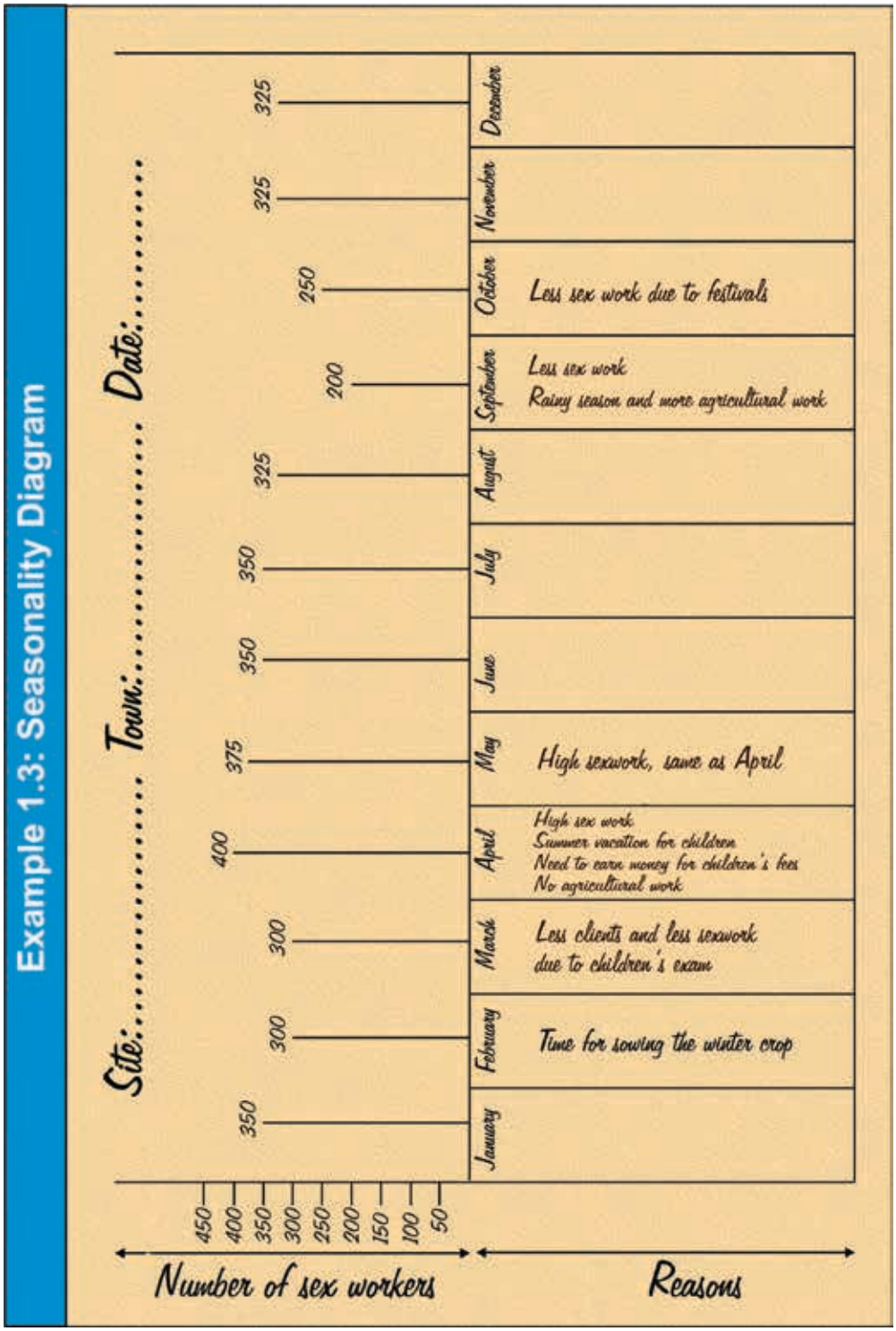
Materials Required: Pens, chart paper

Duration: 120 minutes

Process:

1. Inform the participants that in this exercise we will attempt to understand how the sex work scene changes in a year in their town.
2. Divide the participants into site-wise group and start by asking them which month of the year maximum number of Transgender – Hijras operate in the town. Ask the participants to have a group discussion and finalise the month/s.
3. Next ask them to write the approximate number of Transgender – Hijras in those high and low months and the reasons for the same.
4. Then identify the next busiest or peak month, the number of Transgender – Hijras and the reasons. Document results. Similarly continue doing this exercise for all the months in a year.
5. Make sure that the discussions are intensive and all the participants are involved. Make the exercise visual by using chart paper, colour pens, etc.
6. Finally, when the seasonal calendar is complete, verify the results with the participants to ensure that everybody agrees with what the calendar depicts.
7. Ask the group the following questions:
   - ➔ During peak months do we find Transgender – Hijras from other towns coming to our town?
   - ➔ Is the peak season specific to our site or is it valid in other sites also?
   - ➔ In the low season, do the Transgender – Hijras stop sex work or do they migrate to other towns?
   - ➔ How does our outreach plan change based on these seasonal variations?

Note: The seasonal calendar can also be done for a month or even a week to understand the peaks and troughs in a given period. Pay close attention to how the participants understand the different months in a year. Sometimes the participants may be more familiar with seasons in a year or different festivals in a year. In that case ask them to follow that calendar. Ensure that you check the peaks and troughs based on festivals, specific events, etc. A seasonality diagram can be also done to understand seasonal variations in other factors such as, STIs or police violence.


Example 1.3: Seasonality Diagram
Site:..... Town:..... Date:.....
January
February
March
April
May
June
July
August
September
October
November
December
350
300
300
400
375
350
350
325
200
250
325
325
High sex work
Summer vacation for children
Need to earn money for children's fees
No agricultural work
High sexwork, same as April
Less sex work due to festivals
Less sex work
Rainy season and more agricultural work
Time for sowing the winter crop
Less clients and less sexwork
due to children's exam
450
400
350
300
250
200
150
100
50
Number of sex workers
Reasons

Process 7 Force Field Analysis

Aim: To understand the reasons for gaps in contact and regular contact, and plan outreach to reduce the gap.

Description: The participants through this exercise analyse the reasons for gaps in contact and regular contact, and develop plans to address these reasons.

Materials Required: Pens and Chart paper

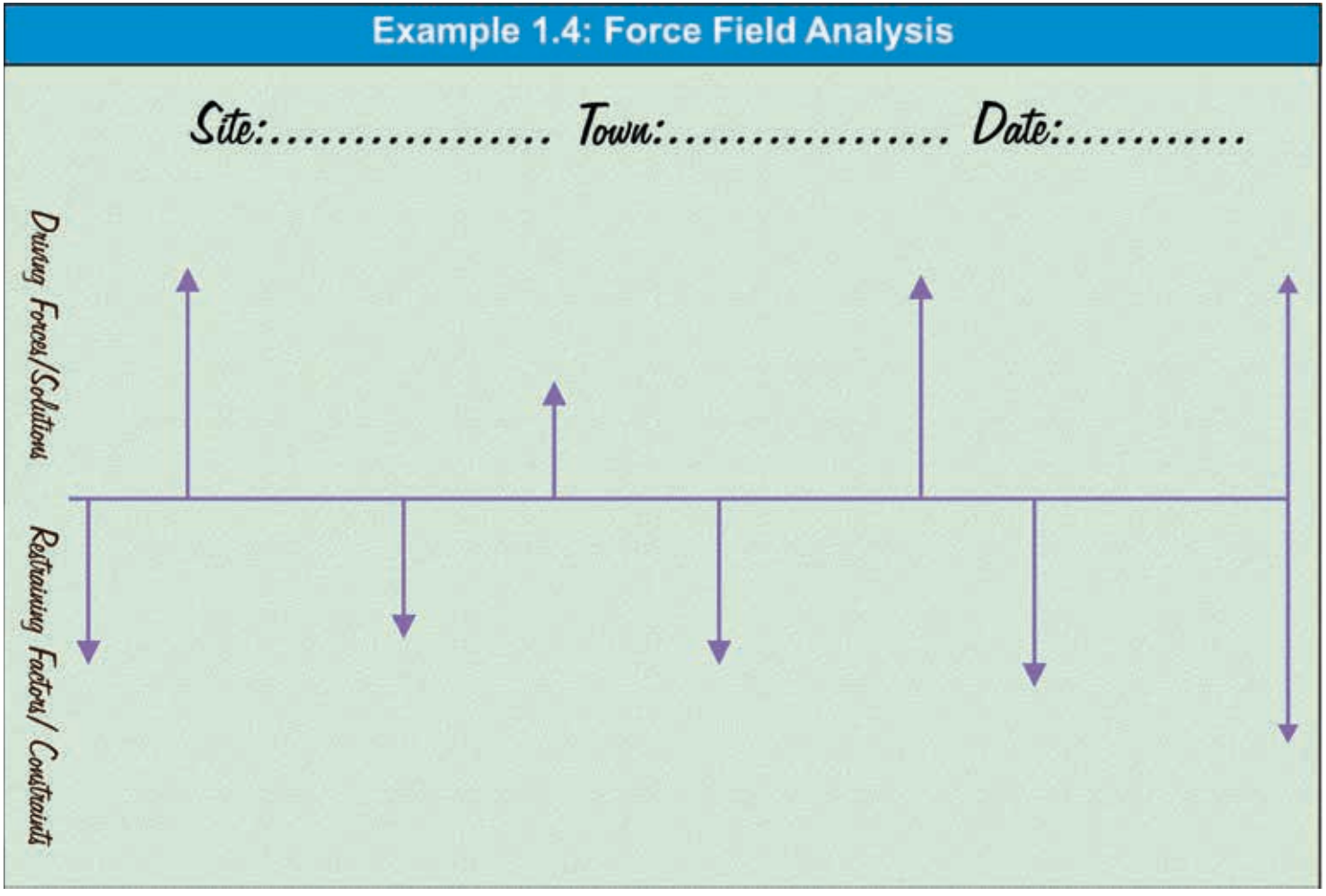
Duration: 120 minutes

Process:

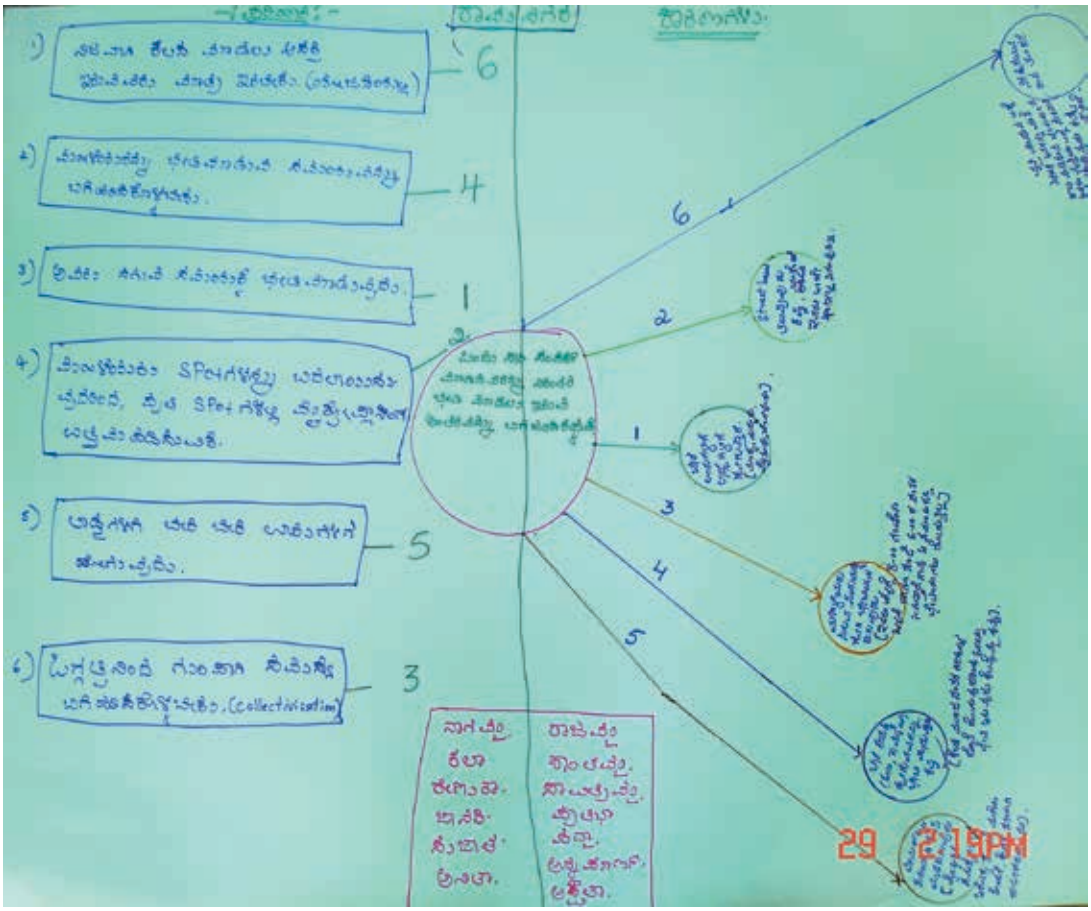
1. Divide the participants into taluk-wise groups and ask each group to identify the reasons for the difference between the unique contacts and regular contacts.
2. Ask each group to pictorially depict these reasons in small charts.
3. Ask the participants to rank the reasons in order of priority. Ensure that the participants enter into a lively debate and everyone participates.
4. Once these reasons or constraints are identified ask the participants for ways in which these constraints can be overcome. Ask them to go through each constraining factor and ask the participants to list down ways to overcome each of the constraints. Discuss with the participants the various ways listed out to overcome constraints and the ways that are easily do-able.
5. Finally compile all results on a chart paper and check with the group for any disagreements.
6. Ask the groups to present their discussions and ask the following questions:
   - ➔ Were they aware of these constraints and the ways to overcome them?
   - ➔ How will this knowledge help them in planning outreach?

Note: This is a technique to identify and analyse the forces that restrain and facilitate a particular situation, process or outcomes. The assumption is that for a given situation, there will be restraining factors and similarly there will also be factors that help improve the situation. When it comes to finding reasons for opportunity gaps, this exercise can be used at all levels of gaps.

Example 1.4: Force Field Analysis



Sample Force Field Analysis



Process 8 Preference Ranking

Aim: To identify the reasons for gaps in regular contact and clinic attendance and prioritise the same.

Description: The participants by using the preference ranking tool analyse the reasons for gaps in regular contact and clinic attendance, prioritise the same and make plans to address them.

Materials Required: Chart paper and pens

Duration: 120 minutes

Process:

1. Begin by discussing the general reasons why Transgender – Hijras do not come to access clinical services.
2. After the initial discussions, ask the participants to list out the reasons why Transgender – Hijras in their town do not access clinical services. Give each of the participants a flash card and ask them to pictorially depict the reasons on the card.
3. Ask the participants to now discuss the reasons in groups, prioritise the same and select the five most important reasons for low clinic attendance.
4. Then ask the participants to do a preference ranking of each of these five reasons and prioritise the most important reason.
5. Ask the participants to make presentations and ask them the following questions:
   - ➔ What are the most important reasons for Transgender – Hijras not coming to the clinic?
   - ➔ What are the plans to address these reasons?
   - ➔ How would outreach or services change based on this exercise?
6. Conclude by developing an outreach plan to address these priorities.

Note: This exercise can be also done to develop a community/Transgender – Hijras understanding of a good service. We can ask the community/Transgender – Hijras to list the elements of a good service and do a preference ranking to understand their priorities. Compare whether the existing services meet these priorities. If not, then develop a plan to make the existing services better.

Example 1.5: Preference Ranking

Sample Preference Ranking

Process 9 Condom Accessibility and Availability Mapping

Aim: To map the condom availability points and to understand if they are easily accessible to Transgender – Hijras population.

Description: The participants by using maps identify the condom availability points and analyse its accessibility to Transgender – Hijras population.

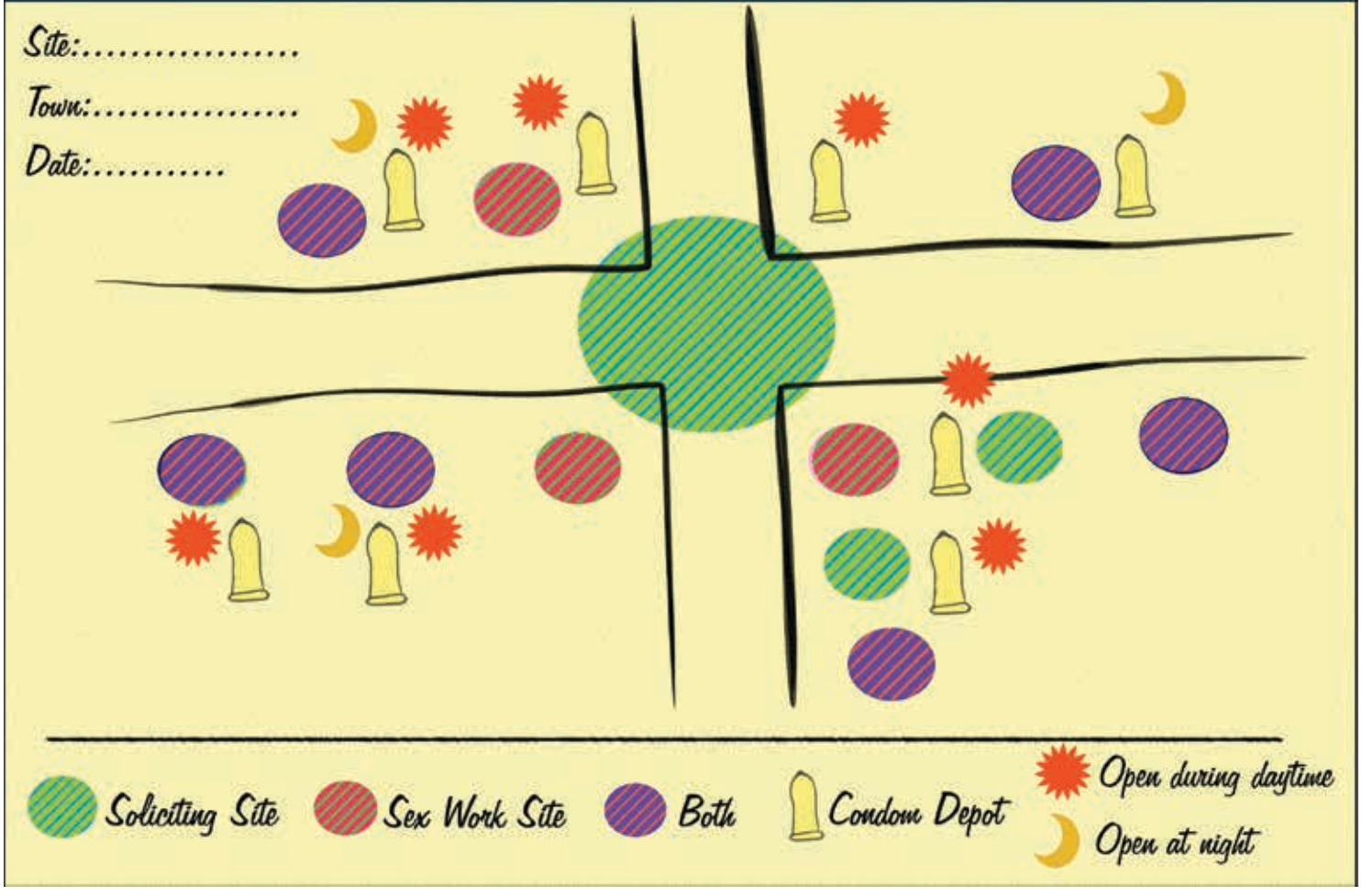
Materials Required: Maps and pens

Duration: 120 minutes

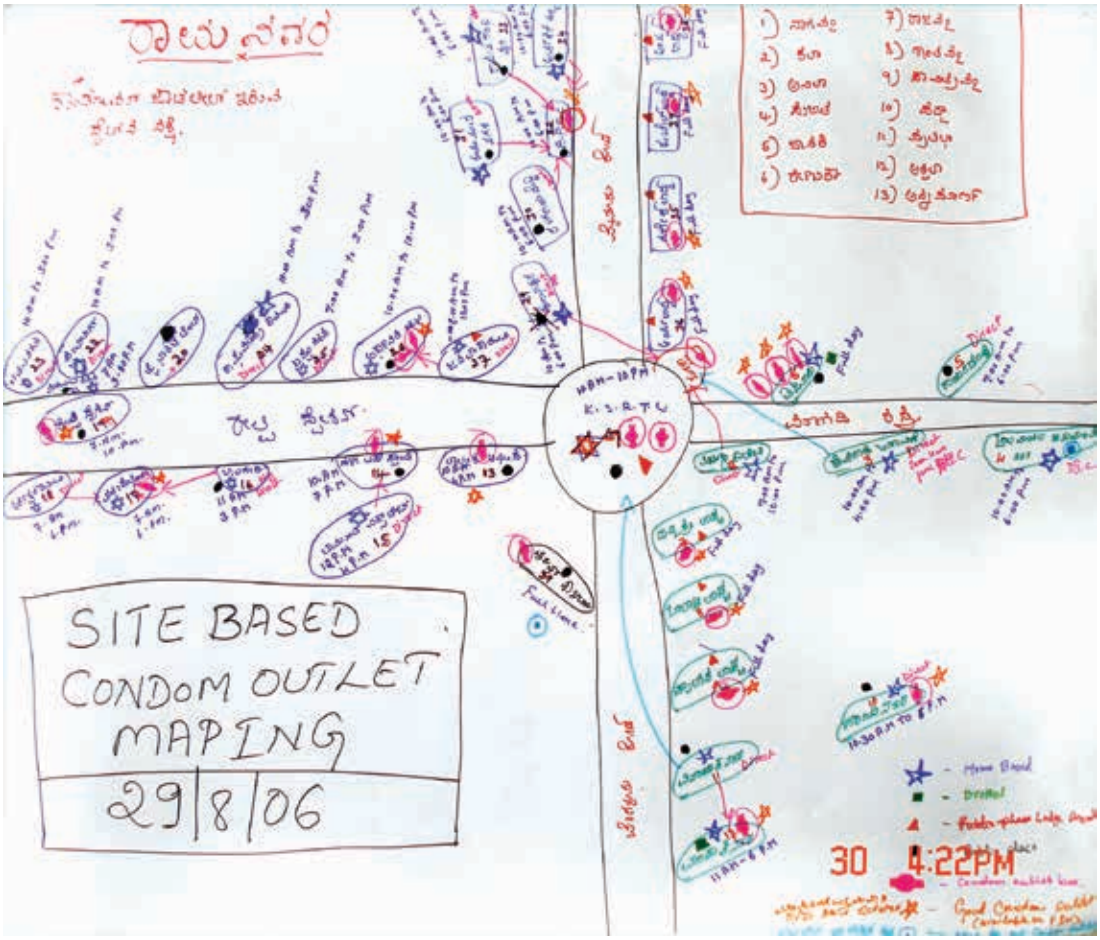
Process:

1. Begin by discussing with the participants the importance of condoms to prevent HIV. Also discuss that in condom programming the first priority is to make condoms accessible and available and that this exercise is meant to do so.
2. Ask the participants to draw a map of their town or use an existing map of the town.
3. Ask the participants to mark all the places where Transgender – Hijras solicit clients. Also ask the participants where the sexual act takes place. Mark all these places on the map using *bindis* of two different colours: one to indicate sites where solicitation takes place and the other to indicate sites where the actual sexual act takes place.
4. Then ask the participants to discuss and understand each site to see when it is active (soliciting and sex work) and at what time of the day. Mark with colour depicting the site as active either only in the day or at night or both the times.
5. Then ask the participants to mark the condom depots in the map symbolically to indicate whether the depots are function during the day or at night or round the clock.
6. Once the map is complete ask the following questions:
   - ➔ Are there condoms depots in all the sites where soliciting or sex work takes place? If not what are the reasons? Do the sites, for example home based sites, which do not have depots prefer direct distribution?
   - ➔ Do all the sites that are active during the day or night or round the clock have condom depots that are open at the same time as the sites are active?
   - ➔ Are condom depots accessible to the Transgender – Hijras?
7. Conclude by stating the importance of access to condoms at the right time and place. Draw up a plan to fill the gaps if any.

Example 1.6: Condom Accessibility and Availability Map



Sample Condom Accessibility and Availability Map



Process 10 Peer Maps

Aim: To understand the nature of outreach done by PEs with the Transgender – Hijras they work with.

Description: The participants by using maps understand and analyse the outreach with Transgender – Hijras that they are accountable for.

Materials Required: Charts and pens

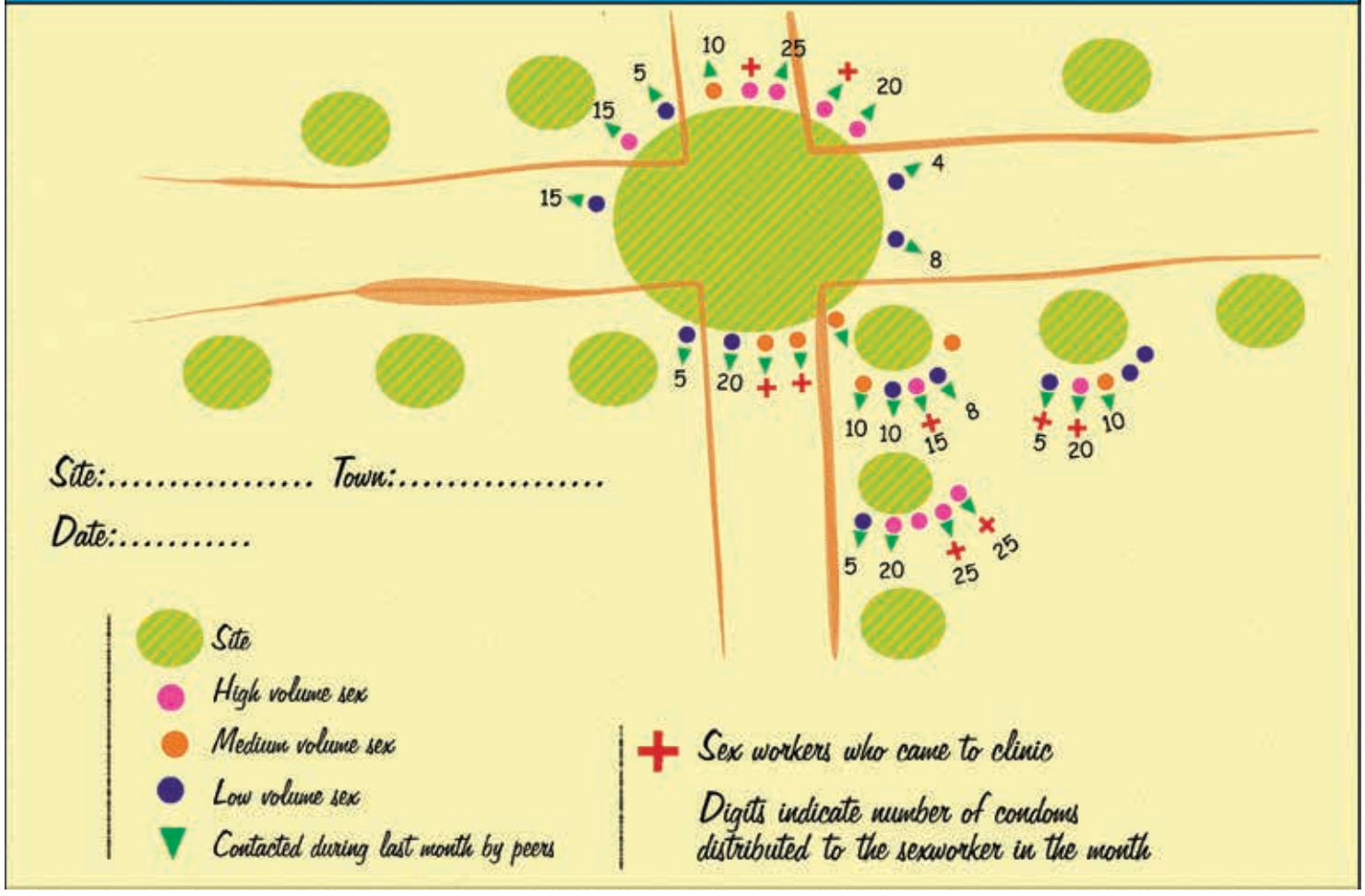
Duration: 120 minutes

Process:

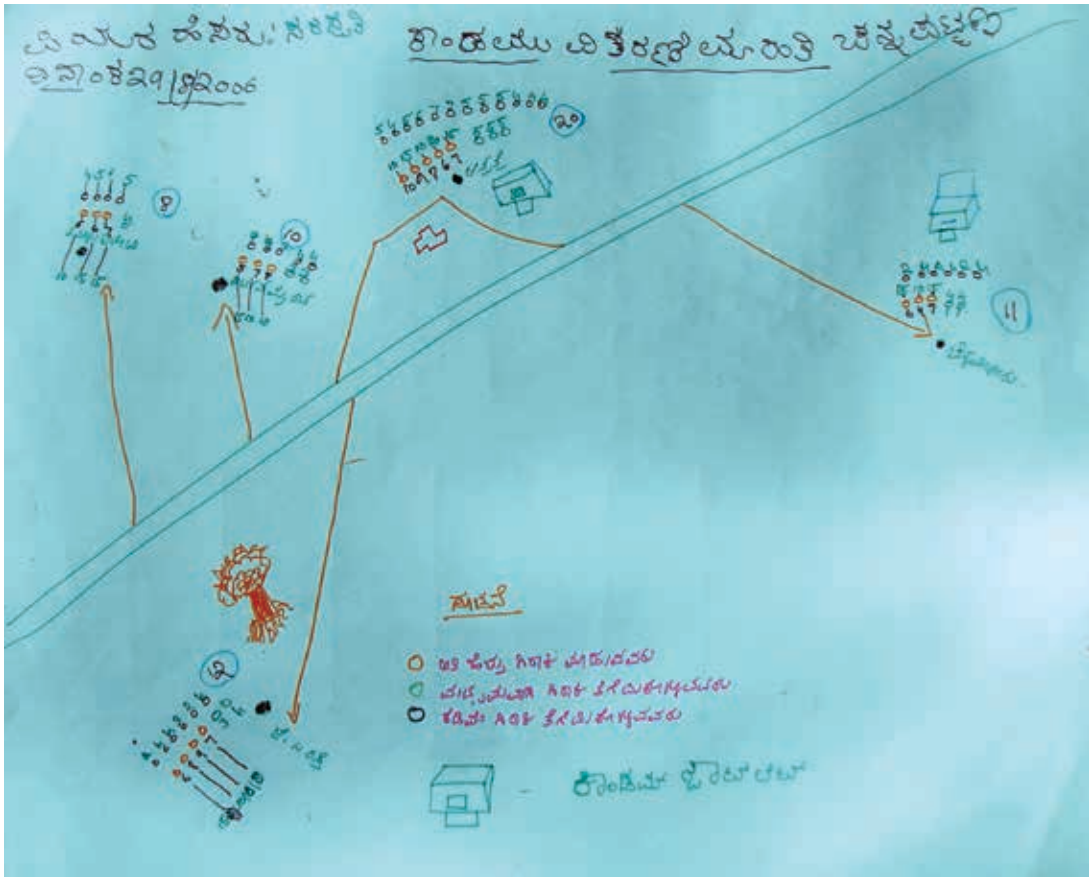
1. Ask the peers to map the sites in the town where they work and meet their community members.
2. In these sites ask the PEs to map the Transgender – Hijras that they are accountable for. Ask them to depict the high volume, medium volume and low volume Transgender – Hijras population in these sites using different colour codes.
3. Now ask the PEs to indicate the number of times each of them met the Transgender – Hijras they are working with, in the last month.
4. Then ask each of them how many condoms were distributed to each of the Transgender – Hijras contacted.
5. Also ask each PE to mark the condom outlet boxes in these sites.
6. Now ask each of the PEs to analyse the map by answering the following questions:
   - ➔ In the previous month, did the peer meet all Transgender – Hijras that she is working with? If not, why?
   - ➔ Based on the volume of sex work, was there any difference in kind of outreach done by the peer? Did she meet high volume Transgender – Hijras more often and the low volume Transgender – Hijras less often?
   - ➔ Were the condoms distributed based on the volume of sex work? Were enough condoms distributed to cover all the sexual acts of each of the Transgender – Hijras? Is there a shortfall? How is this shortfall in condom distribution being filled? Is it through the depots? Are the clients bringing condoms?
7. Conclude by saying that it is important to understand the need of each of the Transgender – Hijras, that a peer is accountable for planning regular contact and condom distribution accordingly. This will ensure that condoms are available with Transgender – Hijras whenever they are needed and at the same time will avoid dumping of condoms where there is no need.

Note: These maps can be adapted to include other indicators like clinic attendance, access to crisis support, access to entitlements, etc.

Example 1.7: Peer Maps



Sample Peer Map



Process 11 - Typology-Wise Outreach Planning

Aim: To understand the link between typology of population and outreach

Description: The participants through discussion and analysis of peer outreach understand the link between outreach and typology of sex work.

Materials Required: None

Duration: 120 minutes

Process:

1. Explain to the participants that it is important to recognise and understand the link between outreach, typology of population and timing of sex work and cruising.
2. Ask the participants to list the Transgender – Hijras that they are accountable for but have not met in the last two months. This information can be generated from the peer calendars.
3. For each of the TGs listed above, ask the peers to provide the following information:
   - ➔ Place of residence
   - ➔ Place of soliciting
   - ➔ Place of sex work
   - ➔ Ideal timing for outreach (morning, afternoon, evening, night)
4. When the participants complete this information, ask them to identify commonalities in typology and timing of outreach in those mentioned in the list. Bring out the characteristics of these.
5. Then ask the following questions:
   - ➔ Is there a link between the number of Transgender – Hijras who are not contacted and typology of sex work? Which typology of Transgender – Hijras population is left out from outreach most often?
   - ➔ Is there link between those who are left out and timing of outreach? Are Transgender – Hijras practicing sex work at night or at a specific time of the day left out from outreach?
6. Now ask the participants to develop a strategy for outreach to a typology of Transgender – Hijras population who are left out from outreach. Ask the participants to plan how to contact, provide services and give condoms to Transgender – Hijras who are often or always left out from outreach services.
7. Conclude by asking if there are any questions.

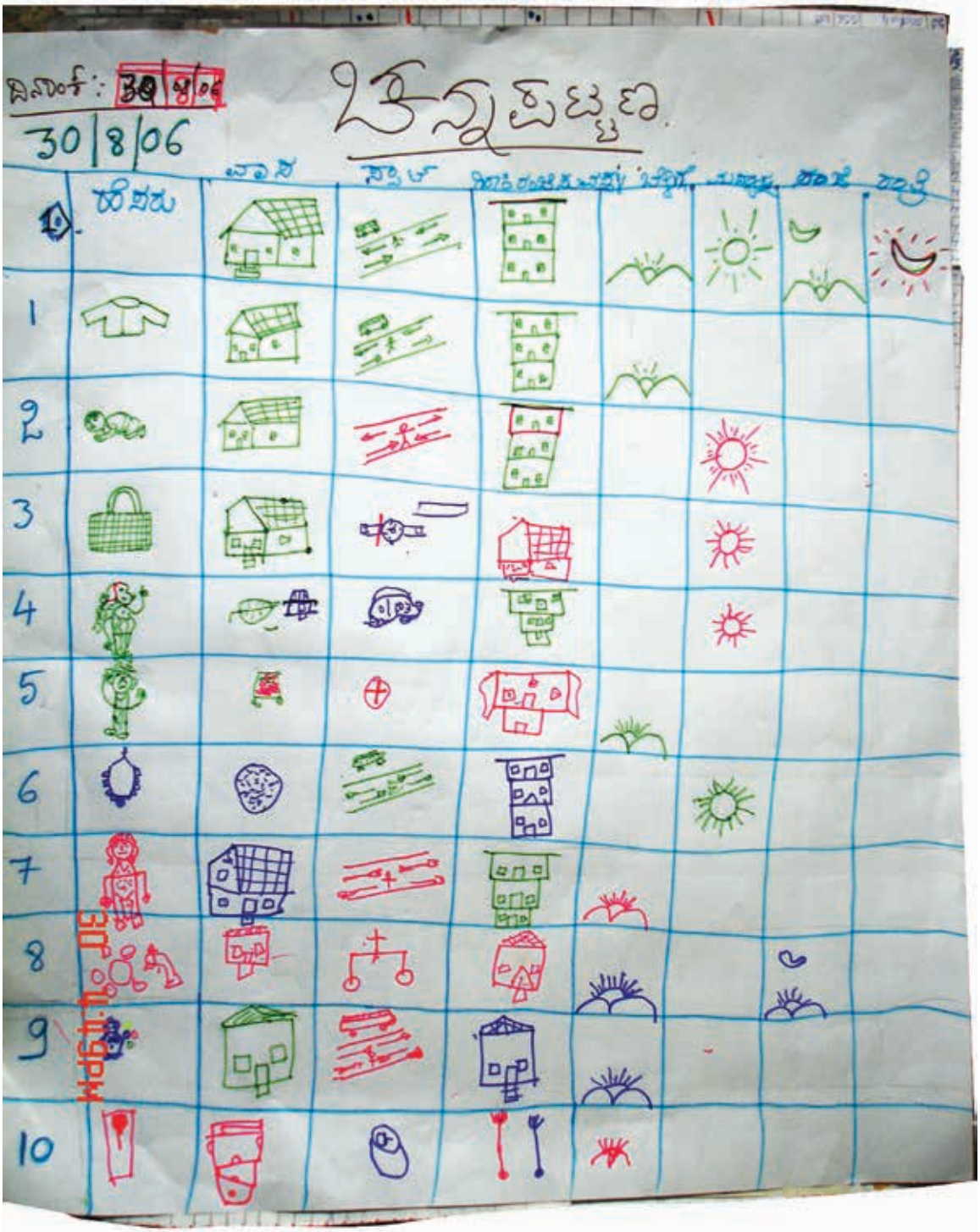
Note: The participants can use pictures.

Example 1.8: STOP

Site:..... Town:..... Date:.....

Name of sex worker/Symbol denoting sex worker	Place of residence	Place of soliciting	Place of sex	Time when available			
				Morning	Afternoon	Evening	Night
	Home/Street Brothel/Lodge	Home/Street Brothel/Lodge	Home/Street Brothel/Lodge				
Gowramma							
Eshwaramma							
Gangamma							
Kalamma							

Sample Stop List



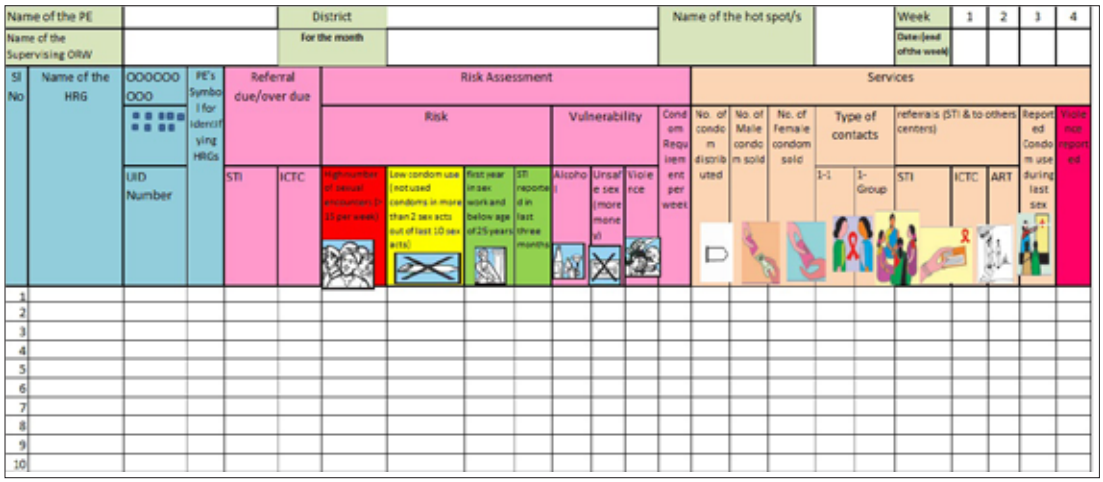
Section III - Tools for Monitoring Project Outreach Planning

The following tools can be used by PEs and ORWs to evaluate progress in outreach and delivery of a minimum package of services to Transgender – Hijras in their area.

PE Daily Activity Report

A PE records new and repeats contacts, one-to-one sessions, one-to-group sessions, referrals to clinic, condom demonstrations, condom distribution and one-to-ones with a regular partner in the daily diary. This is pictorial to be user-friendly to low-literate PEs. The data in the PE daily diary is used by the ORW to update the individual tracking sheet.

Sample PE Daily Activity Report



Individual Tracking Sheet

The individual tracking sheet provides the list of all the Transgender – Hijras in a given site managed by a given PE/ORW. The services provided to each Transgender – Hijras every week are marked against her name. It helps to monitor the number of Transgender – Hijras who were provided with the minimum packet of services during the month. Every month the ORW fills up the individual tracking sheet and analyses it along with the PE. The ORW discusses with the PE any difficulties in providing services to the Transgender – Hijras and makes a plan for the future.

Sample Individual Tracking Sheet

Name of the ORW		District		Name of the PE		For the Month		Monthly Tracking on core parameters

Sl No	Name of the HRG	UID Number	Referral due/over due		Risk Assessment								Services									Reported condom use during last sex	Violence reported	Monthly individual met	Regular monthly contacts (yes / No)	Condoms distributed as per requirement	referred to ICTC and tested
					Risk				Vulnerability			Condom requirement per month (condom pp analysis)	No. of condom distributed	No. of male condom sold	No. of female condom sold	Type of contacts		referrals (STI & others centers)									
			STI	ICTC	High number of clients per week	Low condom use (wet and oral condoms in last 2 sex acts out of last 10 sex acts)	First year in sex work and below age 25 years	STI reported in last three months	Alcohol	Unsafe sex (more money)	Violence					1-1	1-Group	STI	ICTC	ART						
1																											
2																											
3																											
4																											
5																											
6																											
7																											
8																											
9																											

Outcomes of Outreach: The "Minimum Package"

Each Transgender – Hijras covered by a TI is entitled to a "Minimum Package". An effective outreach strategy should ensure that she gets them. The package includes the following services:

- One quality IPC session provided
- Clinical services offered
- Membership in NGO/CBO
- Quality condoms provided every week
- At least one project-related service (clinic, counselling, IPC session, condoms, regular meeting, etc.)

Delivery of Minimum Packages can be summarised using information from the PE Daily Activity Report and the Individual Tracking Sheet.

Sample Site-Wise Tracking Sheet for Delivery of Minimum Package, Completed (With use of colour-coding to flag areas for attention)

FORM C_1: Monthly summary sheet for FSW, MSM, TG and IDU (filled in by ORW)																				
Name of the ORW									For Month						Tracking on core parameters					
Sl No	Name of the PE	Week		Services											No. of individuals reported not sharing needles/syringes during last injecting episode	No. of individuals reported condom use during last sex	No. of individual met each week	No. of regular contacts	No. of individuals provided needle/ Syringe as per requirement	No. of individuals distributed condoms as per demand	No. of individuals referred to ICTC and tested
			Condom requirement per week (as per condom gap analysis)	No. of condom distributed	Type of contacts		Needles/Syringes requirement per week	No. of syringes distributed	No. of syringes returned	Referrals (STI & others centers)											
					1-1	1-Group				STI	Absc ess treat ment	ICTC	ART							
1	PE 1	Week 1																		
		Week 2																		
		Week 3																		
		Week 4																		
		Total																		
2	PE 2	Week 1																		
		Week 2																		
		Week 3																		
		Week 4																		
		Total																		
3	PE 3	Week 1																		
		Week 2																		
		Week 3																		
		Week 4																		
		Total																		

Annexure 3

Peer Educator Training

Section I - Sex and Sexuality

Every human being is a sexual entity. Feelings about the body and sensual pleasures are all part of the human personality and sexuality. Sex is one of the basic physiological needs of human beings, and people engage in sexual activity primarily for intense pleasure. In many societies, popular norms limit sex to the purpose of reproduction. But, in fact, people enjoy sex for reasons of physical and emotional pleasure and gratification.

Procreation can be one of the results of heterosexual intercourse. But there is a wide range of sexual activities which are not related to procreation. This is clear from the ratio of how many times a married couple engage in sex to how many children they have during the span of their conjugal life. As another example, homosexual males and females do not reproduce through their sex acts. And women are not fertile throughout the whole period of their menstrual cycle, but they may be sexually active all the time. Hence it is imperative to separate the two issues of sex and reproduction.

Sex and sexuality has remained a secret subject for many years but with the emergence of HIV it has become an area of prime concern. The concept is deeply entrenched in the social, cultural and historical construct of a given society and far exceeds the biological arena. In Indian society, sex is generally seen as a necessary evil, and it has no social sanction beyond its function for reproduction within the marital bounds of a man and woman. Society does not acknowledge the aspects of pleasure, comfort, happiness and intimacy which are intrinsic to sexuality. Any sexual practice other than sex for reproduction is perceived as a moral sin. In this context, sex work is considered a sinful profession.

This session on sex and sexuality addresses this conceptual framework. It is necessary to differentiate and discuss on the meaning of the terms "sex" and "sexuality".

Step 1 Participatory Exercise

The purpose of this exercise is to make participants consider differing moral perspectives on sexuality. In particular, it helps Transgender – Hijras to analyse and clarify their understanding of how moral judgments are associated with sex acts in situations where they have no bargaining power, are completely exploited and are highly vulnerable, as against situations where they can engage in sex for mutual benefit. The discussion following this exercise can also enable them to reflect on the psychological attitudes behind such moral judgments. This exercise is expected to bring clarity to their thinking about their self-image.

A story is told that depicts three mutually exclusive options for a Transgender – Hijras to cross over to the other side of a river, where her panthi/husband is waiting. In all three situations, she must negotiate with others who are creating obstacles for her. The Transgender – Hijras must put herself in the place of the person and choose one of the following three options which she thinks she could morally stand by:

1. She crosses the river by walking over a bridge, but she will unavoidably encounter a man on the bridge who is a habitual and brutal rapist.
2 She crosses the river by boat, but the boatman will ask to have sex with her in return for rowing her over to the other side of the river.
3. She swims across the river, but she risks her life as the crocodiles in the river might eat her.

The participants take the role of the girl in the story and individually choose one of the options. Having chosen, they divide into three groups, one for each option. In their groups, they discuss the moral reasons for their choice. Each group has a facilitator who allows the Transgender – Hijras to freely imagine and derive the consequences of their choice. No one's views should be undervalued. Each group is asked to make a presentation to the other groups at the end.

The attitudes derived from each of these options may be summarised as follows:

1. Despite brutal physical abuse by the rapist, the moral response is that she was a victim of the situation.
2. An atmosphere of mutual benefit where the girl too has an equal bargaining power and an opportunity to voice her priorities.
3. Moral chastity placed over physical survival.

Discussions on moral judgments after the presentations should be guided by the facilitators in order to apply them to the contexts of "sexuality" and the "sex trade".

Step 2

Participants brainstorm the terms they know which are somehow related to sex. List also all the local terminologies they know, including slang.

For example:

- Sexual encounter
- Menstruation
- Man and woman
- Woman gives birth to child
- Penis
- Vagina
- Anus
- Pubic hair
- Vaginal sex
- Anal sex
- Breast
- Homosexual
- Male who has sex with males
- Persons who like to have sex both with male and female partners
- Masturbation
- Sex worker
- Clients of Transgender – Hijras and FSWs

Group discussion on how transgender - hijras perceive their sexuality and the sex work profession. Encourage them to raise questions and myths regarding sex and sexuality. Group presentation and listing of all the issues raised.

Issues that may be raised include:

- Clients are sinners and we have to engage ourselves to meet their sinful desires
- Clients visit us to fulfill their sexual desire; there is nothing wrong about it
- Masturbation is abnormal, and transgender persons especially should not do this act
- Sex is unclean and genitals are dirty
- Sexual urge is a biological and emotional need
- We, the Transgender – Hijras, are giving sexual services and we should be considered as professionals.

Step 3

Discuss the dominant discourse on sexuality. How does society perceive sexuality?

Possible responses:

Sex is a sin

One should not discuss sex

One should not learn about sex

Sex is necessary only for procreation

Any sexual activity not intended for reproduction is morally unacceptable

Sex outside a marital relationship should be banned

People who visit Transgender – Hijras are doing wrong as this behaviour contravenes socially sanctioned sexual rules If there is any acknowledgment at all of sexual needs beyond procreation, it is only for men.

Social practices strictly prohibit the expression of Transgender – Hijras sexuality.

Transgender – Hijras are morally corrupt as their sexual behaviour is different from the socially accepted sexual rules.

Step 4

Discuss and define the concepts of sexual desire, sex and sexuality.

- **Sexual desire** is a fundamental need of human beings as biological creatures. Sexual desire has components of mutual pleasure, comfort, and satisfaction. Fulfillment of sexual desire makes a person healthy. One of the results of sexual intercourse between a man and woman may be the birth of a baby.

- **Sex** refers to the **biological attributes** that identify a person as male, female or in rare cases where a person is born intersexed or with ambiguous genitals. Terms such as man and woman, pregnancy and childbirth, menstruation, and terms denoting sexual organs all come under the concept of sex.
- **Sexuality** refers to **manifestations of sexual preferences and behaviours**. Terms such as vaginal sex, anal sex, homosexual, males who have sex with males and persons who like to have sex both with male and female partners all come under the concept of sexuality.

Understandings of sex and sexuality are deeply rooted in the social, cultural, and historical construct of a given society. In Indian society, sex and sexuality are seen as sinful and only necessary for reproduction. Any sexual activity beyond the boundaries of reproduction is not sanctioned by society. The aspects of mutual pleasure, comfort and happiness are not acknowledged by society. But these are a very basic biological and psychological need of human beings.

Discuss appropriate and inappropriate notions of sex and sexuality.

Step 5

Participatory discussion on different types of sexual activities.

Different kinds of sexual activities - Penetrative, non-penetrative and safer sex

Time: 1.30 hrs

Expected Outcomes

- Participants identify different local terminologies related to sex and sexuality
- Participants understand society's perceptions of sex and sexuality; participants understand the broad concepts of sex and sexuality, and an empowering attitude towards sex, sexuality and sex work profession.

Section II - Understanding Sexual and Reproductive Health

Social marginalisation and economic status impede TG and Hijras access to information, including health-related knowledge. Their opportunities to learn about reproductive health are very limited. Poor basic knowledge and misconceptions about the body, its different parts and their functioning, hygiene and disease processes, etc. increase their vulnerability to ill health, and especially infection with STIs and other reproductive health hazards. Health education can help Transgender – Hijras understand their bodies, the importance of self-examination and the need for health check-ups, and increases their control over their bodies and their health.

Step 1

Discuss PEs' perceptions about their bodies.

Some of the opinions may be:

- We work with our bodies to give services to our clients
- The body is like a machine, having different parts for specific functions
- Those different parts and components work as a whole and in coordination with each other
- Like a machine, the body needs food, cleaning, maintenance and caring.

Based on the perceptions expressed, the discussion can cover what the body is and why every person should respect her body to remain healthy. Transgender – Hijras in sex work, or those who indulge in non – commercial/casual sex with their clients/husbands/panthis/partners do not need to consider their bodies as dirty or shameful. They should keep their bodies healthy and well cared for like anybody else.

Time: 20 minutes

Step 2

- Discuss health and hygiene, including the necessity of maintaining personal and environmental hygiene, and its relevance to controlling diseases.
- Discuss common communicable and non-communicable diseases
- **Communicable diseases:** air-borne, water-borne, contamination through body fluids, etc. (for example, TB, malaria, cholera, diphtheria, STIs, AIDS)
- **Non-communicable diseases:** diabetes, arthritis, cancer, etc.

Time: 20 minutes

Step 3

Brief discussion on various parts of the body and its systems.

For example:

- Digestive, circulatory, skeletal, nervous, reproductive systems, etc.
- Different organs and sensory organs associated with the systems

Time: 10 minutes

Step 4

In this session, major elements of the male and female reproductive systems, their anatomy and physiology are discussed. A simple diagram showing the male and reproductive organs can be used to explain the anatomy.

Female reproductive anatomy: External organs – vulva, labia and clitoris. Internal organs – vagina, uterus, cervix, ovaries, fallopian tubes

Female reproductive physiology: menstruation, menarche, menopause, ovulation, fertilisation, conception, pregnancy, childbirth, etc.

Male reproductive anatomy: External organs – penis, scrotum, testes. Internal organs – vas deferens, seminal vesicles, prostate gland, urethra

Male reproductive physiology: puberty, formation of sperm and semen, storage of semen, erection and ejaculation

The discussion should emphasise that reproductive organs are like any other part of the body and we should not neglect them if problems occur.

Time: 1 hour

Step 5

Discuss common reproductive health concerns.

STIs

Problems caused due to improper castration, misuse of hormones, etc.

Time: 15 minutes

Step 6

Discussion of RTIs.

Reproductive Tract Infections (RTIs): Infections that affect the reproductive tract of males and females. RTIs are of three types:

1. Sexually transmitted infections (STIs). Caused by virus, bacteria, or fungal microorganisms which are passed through unprotected sexual intercourse with an infected partner.
2. Microorganisms that are normally present in the vagina multiply and cause infection. This type of RTI is mostly caused due to inadequate maintenance of personal, sexual and menstrual hygiene.
3. Infections caused due to inappropriate medical procedures, such as unsafe abortions.

Time: 15 minutes

Step 7

Discuss sexual/reproductive health rights of TG and Hijras

Availability of reproductive health information and services

Right of transgenders to take decisions about their sexual health

Time: 10 minutes

Expected Outcomes

Participants understand the basics of the body, its different parts, systems and functions

Participants understand why every person should respect his/her body

Participants understand the basics of health and hygiene

Participants know about common communicable and non-communicable diseases

Participants know the basics of reproductive functions and reproductive health concerns.

Section III - STIs and the Role of PEs in STI Management

In community mobilisation among Transgender – Hijras, the significant issues regarding STI management are:

- Community must identify the core issues and generate options for solutions
- Solutions must be tailor-made and integrated with adaptability, and services must be provided with active participation of the community
- The community members must be in a position to monitor the delivery mechanism and quality of services
- Clinic setting must not be seen merely as a place for treatment but must be positioned as a space for social interaction and for nurturing relationships. The structure and processes of the STI service delivery mechanism must be largely designed and controlled by the FSW community.

These are the basics to establish control over access and utilisation of the services by the community. The STI management approach in community mobilisation calls for the Four "D"s:

1. De-stigmatisation of sex and sexual illness

The fundamental prerequisite is to remove the stigma attached to the profession of sex work and develop a non-judgmental attitude towards sex and sexuality. One should have respect for her body and its different parts, including the genitals. There is nothing sinful in acquiring an STI, and she has the right to quality treatment.

2. Demystification of technical aspects of STI services

Conscious efforts must be made to demystify STI management services. Treatment procedure must be made very clear to the community members. Clinic attendees have the right to be informed about their illness and the treatment procedure.

3. Decentralisation of STI management services

Decentralise the STI management procedure from clinic to community level. Prescription is not the only component of treatment: PEs and ORWs are responsible for counselling, communication, ensuring compliance with treatment and condom promotion.

4 Democratisation of STI management services

From a governance perspective, the Transgender – Hijras community's control over STI management must be ensured. An STI management team should be built up, comprising representatives from PEs, doctors, counsellors, paramedical staff, etc. An information-sharing mechanism between clinic and outreach staff should be established for efficient service delivery.

Step 1

Keeping this conceptual framework in mind, discuss STIs and their management. Ask PEs what they know about STIs.

Different opinions may be:

STIs are sinful diseases

Symptoms should not be disclosed

If we disclose that we have STIs, customers won't visit us

We are in the sex work profession, and STIs are a professional hazard

STIs are like any other infection and should be treated properly

Discussion continues based on the understanding of PEs. Explain clearly what sexually transmitted diseases are. Emphasise non-discriminatory attitude of projects towards STIs. STIs are viewed as an occupational disease; explain vulnerability of Transgender – Hijras to these diseases.

Time: 30 minutes

Step 2

Ask the participants to discuss their knowledge regarding the symptoms of STIs, including local terms used to denote symptoms of STIs. Record all the known symptoms on chart paper.

Start the discussion on STI symptoms according to participants' understanding. Make necessary clarifications where their knowledge on symptoms and the diseases is inappropriate or incomplete. Encourage the participants to raise questions where they feel uncomfortable. Avoid using too many medical terms and use local language.

This session can be arranged with a slide show demonstrating the symptoms to give PEs a clearer idea.

Symptoms

- Genital ulcers: single painless, multiple painful
- Urethral discharge
- Burning sensation while passing urine
- Scrotal swelling
- Vulval swelling (neo-vagina in case of TG and Hijras who have undergone nirwan/SRS)
- Swelling of inguinal glands
- Warts: pearly and cauliflower

STIs

- Syphilis
- Gonorrhea
- Chancroid
- Lympho Granuloma Venereum (LGV)
- Bartholonotis
- Trichomoniasis
- Candidiasis
- Chlamydia
- PID
- Herpes simplex
- Warts: Condyloma accuminata, Moluscum contagiosum

- Scabies
- Hepatitis B & C
- AIDS

Time: 1.5 hrs

Step 3

- Discuss the risks from STIs if they remain untreated
- Can cause serious illness
- Enhance the chance of contracting HIV (ulcerative STIs)
- Untreated syphilis can lead to mental inertia
- Some STIs can be passed through to the next generation if a pregnant mother is infected (for example, syphilis/gonorrhoea). Longstanding gonorrhea can constrict or even block urinary tract
- Chronic cervicitis can cause infertility.

Encourage participants to ask questions, and give clarifications accordingly.

Time: 20 minutes

Step 4

Discuss the ways STIs are transmitted. Presentation of pictures or animations on the issues can be arranged.

Transmission Routes

- Unprotected penetrative sexual encounter with infected person
- From infected mother to child, for example, HIV, syphilis
- Use of infected blood for transfusion, for example, HIV, hepatitis B and C
- Through infected needle/syringe.

Talk about why Transgender – Hijras are more prone to get infected by STIs/HIV.

Physiological factors

- Anal sex can lead to anal trauma
- Lack of natural lubrication in the anal cavity

Social factors

- Low socio-economic status families ignore or overlook health issues, including reproductive health. Even Transgender – Hijras themselves give little attention to their health
- Lack of information regarding the diseases
- STIs have linkage with sexual behaviour and thus it is not socially acceptable for some conservative TG and Hijras
- Participatory discussion on why Transgender – Hijras are the most vulnerable in the sex profession.

Time: 30 minutes

Step 5

Discuss management of STIs. With few exceptions, STIs are fully curable. One should get treated as early as possible and complete the treatment cycle as per the advice given by the doctors.

Treatment aspects

- Self-examination of genitalia
- Need for regular health check-ups since STIs often remain asymptomatic especially in high risk MSM and TG–H: opportunistic screening through proctoscopic examination and blood test for VDRL
- Get treated immediately after occurrence of symptoms
- Compliance with treatment and consequences if treatment is not completed
- Follow-up of treatment
- Treatment of partner
- Referral to higher institution if the symptoms recur or persist

Prevention aspects

Use of safer sex measures, consistent use of condoms

Time: 20 minutes

Step 6

- Discuss PEs' role in STI management.
- Disseminate information to transgender - hijras and their clients regarding STIs, counsel and motivate them to come to the clinic for health check up, and be alongside clinic attendees to give them confidence
- Ask and counsel them about compliance with treatment
- Put effort into bringing the partners to clinic for health screening
- Provide counselling on consistent condom use. Monitor quality of services: maintenance of confidentiality, privacy, pay attention to whether non-judgmental attitude and friendly behaviour is extended by the project staff
- As active members of clinic management team, PEs should stay familiar with clinical procedures
- Participate actively in clinic meetings and provide feedback that will help in triangulating data gathered by the clinic team and outreach team as well. For comprehensive management of STIs, PEs are the link between clinic and outreach team.

Time: 1hr

Expected Outcomes

Participants understand that STIs are occupational hazards of the sex work profession.

Participants know the common symptoms of STI and their local terminologies

Participants know the name of some common STIs

Participants know the risks from STIs if they remain untreated, mode of transmission of STIs and prevention of transmission

Participants understand why Transgender – Hijras are more vulnerable to STIs

Participants know how to control STIs (prevention and treatment)

Participants understand the role of peer educators in STI management

Section IV - HIV and AIDS

Step 1

Ask the participants whether they have any knowledge about HIV/AIDS. Begin discussion about definitions.

The term AIDS stands for:
A = Acquired – not born with
I = Immuno – body's defence system
D = Deficiency – not working properly
S = Syndrome – a group of signs and symptoms

AIDS is not a single disease but a syndrome, a group of signs and symptoms resulting from weakening of the body's defence system, which is caused by a virus. HIV is the name of the virus that causes AIDS.

- HIV stands for Human Immunodeficiency Virus
- Being HIV positive does not mean that a person has developed AIDS
- Once a person gets HIV infection, he/she remains infected and infectious throughout his/her life
- Treatment can extend the lifespan of an AIDS patient, but it is expensive
- No curative treatment for AIDS has been discovered so far and thus AIDS is fatal

Step 2

Discuss signs and symptoms of HIV.

When a person first becomes infected with HIV there may be some signs of illness or no signs at all, but the virus is multiplying in the body (window period)

In the second stage of infection, HIV infected person has no symptoms In the third stage, AIDS-related symptoms occur. These include severe weight loss, persistent diarrhoea, night sweating, persistent fever, etc.

In the fourth stage the person suffers recurrent opportunistic infections, cancers, severe weight loss, fatigue, etc. This is the stage known as AIDS.

The infected person can transmit HIV to another person during **all** stages of infection through sexual contacts or blood.

Step 3

Ask participants whether they know the mode of transmission of HIV. List all their conceptions, and discuss any misconceptions.

How HIV can be transmitted

- Unprotected sex
- Blood and blood products
- Sharing of infected needle/syringe
- Infected mother to child

Misconceptions (myths) about modes of HIV transmission

- Insect bite
- Sharing common toilet, bed, common clothing
- Casual contact for example handshake, hugging, kissing
- Eating together
- Air-borne or water-borne
- Using common toilet
- While taking care of HIV infected persons.

Step 4

How to prevent HIV transmission:

- Practice non-penetrative sex and use condom for every penetrative sex act. This is understood as "safe sex"
- Use of screened blood and blood products
- Use of sterilised needle and syringe
- Getting treatment of STIs as early as possible.

Step 5

Discuss the social dimensions of HIV. Ask PEs what their attitude and behaviour would be if they learned that any of their colleagues was HIV positive. Role play a supportive attitude towards an HIV positive person.

Individuals with HIV or AIDS are kept isolated from society and alienated even by their family members. This creates tremendous emotional and psychological stress, which may lead to extreme depression and feelings of fear and guilt.

Time: 2 hrs

Expected Outcomes

Participants know what HIV and AIDS are

Participants know the signs and symptoms of HIV infection

Participants know the mode of transmission and prevention of HIV

Participants understand the desired attitude towards HIV positive persons

Section V - Identifying Risk and Vulnerability Factors

Step 1

Divide the participants into groups. Assign each group a particular category of sex work, for example hammam/Gharana based, highway, street based, brothels, etc.

Ask each group to prepare a role play depicting a situation or behaviour that puts them at risk of STI or HIV transmission.

After each role play ask participants to identify the risk behaviour and vulnerability factors depicted in the act. List the risk behaviour and vulnerability factors in relation to each group.

Risk behaviour is behaviour that puts someone directly at risk of HIV/STI infection, such as unprotected anal or oral sex.

Vulnerability factors are factors that make risk behaviour more likely and which therefore put someone indirectly at risk of HIV/STI infection. For example, having group sex, being poor or being transgender - hijra.

Step 2

Facilitate a discussion to encourage the participants from all groups to enhance the list. Ensure that the participants clearly understand the difference between risk and vulnerability and also the link between the two.

Risk behaviours are made more likely by vulnerability factors, but vulnerability factors in themselves do not lead to HIV infection.

Ask the group if risk and vulnerability are mutually exclusive and if any programme would be successful if we work on only one element, either risk or vulnerability. Discuss a few risk reduction and vulnerability reduction strategies in the context of sex work.

Risk reduction addresses the immediate factors of sexual transmission which is mainly because of sex work as an occupation. Risk reduction strategies include:

- Ensuring correct knowledge about STIs/HIV
- Ensuring access to treatment of STIs and other health problems
- Access to male condoms
- Improving condom negotiation and decision-making skills in sexual encounters
- Working with clients/partners of sex workers.

Vulnerability reduction addresses underlying factors affecting transmission: poverty, lack of human rights, gender relations, stigma and discrimination, and legal framework. Vulnerability reduction strategies include:

- Providing economic alternatives to TG and Hijras
- Basic amenities like ration cards
- Children's education
- Promoting legal reforms
- Sensitising/educating clients and police against violence against Transgender – Hijras
- Promoting participation and decision-making of Transgender – Hijras in sex work programmes.

Be sure to emphasise that without understanding and addressing vulnerability factors, behaviour change is not possible. Most of the time changing behaviour is not easy. Only when vulnerabilities are addressed do people respond favourably to knowledge and information. If we are willing to address and accept the vulnerability factors, the HRG is more likely to be willing to find effective and lasting solutions.

Time: 1.5 hrs

Expected Outcomes

Participants understand the risk and vulnerability factors involved in sex work, and can distinguish between the two.

Participants know several risk and vulnerability strategies.

Section VI - Negotiation Skills

This section addresses how peer educators can help Transgender – Hijras to improve their negotiation skills. Providing information on safer sex practices to Transgender – Hijras is not enough to ensure safe behaviour. It is not a question of the attitude and behaviour of the Transgender – Hijras, but rather of the power of her clients. Even being fully aware of the necessity of using condoms, a Transgender – Hijras may be compelled to jeopardise her health out of fear of losing her customers.

In the case of Transgender – Hijras controlled by gurus or pimps, a significant share of the Transgender – Hijras income usually goes to these people, leaving the Transgender – Hijras with meagre resources. In this situation a Transgender – Hijras cannot easily refuse her clients. These power relations often determine the outcome of negotiations between Transgender – Hijras and their clients. Improvement of self-esteem along with the attainment of technical negotiation skill is imperative for Transgender – Hijras to negotiate better with their clients and other power brokers. Discussion of negotiation skills must be carried out keeping in mind the context in which Transgender – Hijras have to negotiate.

Step 1

Discuss the issues that hinder safer sex practices by Transgender – Hijras - List all the issues raised by the PEs.

- Clients are not willing to use condoms
- Pimps/gharwali/gurus force the Transgender – Hijras to practice unprotected sex
- Transgender – Hijras don't know how to negotiate condom use with their clients
- Some Transgender – Hijras are extremely depressed and see little difference between living and dying
- Transgender – Hijras' inability to make decisions about their life
- Clients or power brokers force Transgender – Hijras to have sex without a condom
- Transgender – Hijras have limited income opportunities and are afraid of losing customers

Discuss how to resolve these situations. Take the points one after another, determine the stakeholders with whom Transgender – Hijras have to negotiate and identify possible solutions. Most of the issues may not have any immediate solutions. Issues that may come up include

collective bargaining, empowerment of Transgender – Hijras, improving their self-esteem, advocacy, the need for more economic options, etc.

Step 2

Discuss approaches to negotiation with different groups.

Clients	Exploring their business acumen and packaging of services to motivate clients in safer sex practice. For example: • Showing keenness to ensure pleasure through a variety of sexual activities • Showing caring and loving attitude towards the clients • Adequate foreplay for the maximum pleasure depending on client's desire • First, stimulate the client and when the client gets aroused explain that a condom will not reduce the pleasure but enhance the enjoyment and protect client's health • Transgender – Hijras puts the condom on client as a loving gesture.
Madams/ Pimps	Convincing the Madams/pimps by raising the issue of mutual benefit from their business perspective. For example, if the Transgender – Hijras remains healthy she can earn more and ensure income for Madam/pimp. Emphasising their positive role such as setting norms for condom use by the clients that can help their girls to convince the clients.
Police/ Administration	Sensitising judiciary and its administrators on the technical socio clinical issues that the TI strives to address and how the judicial attitudes and legal provisions intersect. The sense of absolute authority, moral guardianship, and power with which the police deal with the Transgender – Hijras often leads to harassment and violence. Such abuses directly increase the vulnerability of Transgender – Hijras, who lack a legal remedy.
Persons belonging to mainstream society	Raising the issues pertaining to their social and legal status and its consequences. Expressing how this situation restricts the Transgender – Hijras enjoyment of their human and citizens' rights. Emphasising the role of people other than Transgender – Hijras in challenging the exploitative situation and in establishing Transgender – Hijras rights to self-determination. Creating broader alliance and support base by involving people from various spheres of society.

- Role-play how Transgender – Hijras could negotiate on condom use with a client, and with exploitative police personnel.

Time: 1.30 hrs

Expected Outcomes

- Participants identify the factors that hinder Transgender – Hijras from negotiating with their clients on safer sex practices.
- Participants identify some of the issues to improve Transgender – Hijras negotiation skills.
- Participants learn basic negotiation skills.

Section VII - Condom Promotion

Step 1

- Ask the participants to talk about what they know about condoms. List terminology they use for condoms. Ask them to explain what condom is:
  - ➔ It is a rubber sheath. It is a long thin tube when rolled out. At the lower end it is closed and has a teat, which collects the semen. The condom acts as a wall and prevents the sperm and STI- causing germs and HIV from entering the anus, and from transgender genital parts to the penis.
  - ➔ It acts as a barrier against STI and HIV transmission.
  - ➔ It acts as a contraceptive device.
- Display a condom and give a condom to each participant so that they can see and feel it.

Step 2

- This session teaches PEs about the correct use of condoms. Ask PEs to demonstrate putting a condom on a dildo. Then demonstrate correct condom use with the dildo:
  - ➔ Put on the condom only after the penis becomes fully erect. Open the packet carefully without damaging the condom.
  - ➔ Hold the tip of the condom ensuring no air bubbles form inside and slowly unroll it to full length so that the penis is completely covered.
  - ➔ Ensure that the condom is in the correct position before beginning sexual intercourse.
  - ➔ Immediately after ejaculation withdraw the penis from the anus/chapti/neo-vagina.
  - ➔ Remove the condom carefully without spilling the semen.
  - ➔ Tie a knot so that the semen can not spill out and then dispose of in a dustbin.
  - ➔ Do not reuse a condom.
  - ➔ Improper use of condom can damage it, resulting in tearing of condom, which could lead to HIV/STIs or unwanted pregnancy. Care should be taken while using condom.
  - ➔ While giving the condoms to the FSWs, PEs should check the expiry date.

Step 3

- Ask participants why people do not use condoms and the misconceptions about using condoms:
  - ➔ Using condom during sex is irritating.
  - ➔ Condom will tear during intercourse.
  - ➔ Condoms reduce sexual pleasure.
  - ➔ Condom is sticky and oily.
  - ➔ Erection goes before using condom.
  - ➔ Problem of buying.
  - ➔ Double condoms will provide better protection.
  - ➔ Use of condom implies lack of emotional feeling of her love for the partner.
  - ➔ Condom is barrier of "mistrust"between two partners.

Clarify misconceptions:

- ➔ Condoms are soft and lubricated, and proper use of a condom does not cause irritation.
- ➔ The process of wearing a condom is pleasurable, as the Transgender – Hijras puts the condom on her/his client as a loving gesture.
- ➔ TG –H must convince the client that if he uses condom he will enjoy himself more, without any tension or apprehension about getting infected by STIs/HIV.

- As an exercise, ask a PE to put a condom on one finger. Tell her to touch various materials with the finger, and ask whether she can differentiate between them. Explain that the condom does not create any barrier of feeling.
- Ask PEs to share practical experience of what they do in these situations.

Step 4

- Discuss availability of condoms. Ask PEs where condoms are available. List all locations/ channels:
  - ➔ With PEs
  - ➔ Medicine shops
  - ➔ Other shops
  - ➔ Clinic

Step 5

Condoms should be stored in a cool dry place. Discuss how and where the FSWs can store their condoms.

Time: 2 hours

Expected Outcomes

- Participants understand what condom is and why it should be used.
- Participants know proper use of condoms.
- Participants know some of the methods for convincing clients use condoms.
- Participants know about the availability of condoms and condom storage.

Section VIII - Self-Esteem

Transgender – Hijras in the sex work profession are rarely seen as an occupational group. Rather they are categorised as a group of persons that poses a threat to sexual morality and social stability. Although sex work and transgender/hijras identified is an age-old profession and part of the Indian culture, Transgender – Hijras are an invisible part of society. Their class, caste, gender, and occupation relegate them to a most marginalised position. Most Transgender – Hijras have a low social class and economic background, and being in this socially unaccepted position have very low self-esteem.

These are critical concerns while dealing with the lives of Transgender – Hijras. Only if they learn to value themselves will they think to protect their life and health. It is thus imperative to help Transgender – Hijras to value themselves as human beings and establish a positive sense of their identity. This section aims to boost the morale and self-worth of Transgender – Hijras.

Step 1

Discuss what PEs think of themselves. Address different aspects of self-esteem following the matrix.

Aspects of self-esteem	What we think of ourselves	What we must do to enhance our self-esteem
TG - H engaged in sex work • Do we consider our work like other livelihood options or is it something else? • Do we think of ourselves as sinners or as workers who earn our own subsistence? • Are we ashamed of being in this profession? • Are we able to disclose our occupational identity to our families and children?		
As human beings • Do we think that our lives are valuable? • Do we also have dreams and aspirations for our future and can we express these feelings? • Do we think that we should have the right to live with dignity?		
Ability to make decisions about our mental and physical well-being • Do we think that we can take decisions about entertaining customers/being with panthi/regular partners when we feel sick? • Do we take decisions about seeking treatment? • Do we think that we should get equal and non-discriminatory health services from health service providers? • Do we think that we should have the right to information?		
Social identity beyond our occupation • Do we think of ourselves only as transgender – hijra persons? Or do we have other material and emotional needs? • Do we think of ourselves as having responsibility for other social causes?		

Our legal status • Do we think that we can ask police about the cause of an arrest or raid? • Do we think police should not harass us during raids?		
Our political status • Do we think we should have a ration card, voter identity card? • Do we think we should enjoy our rights as citizens and voters of this country?		
Our civic amenities • Do we think we should get the same basic civic amenities as any other citizen?		
As peer educator • Can we be respectful health educators? • Can we be community representatives? • Can we be community organisers? • Can we be responsible social beings?		