INNOVATIONS
&
PILOT MODELS – PROCESS DOCUMENT

(An experience of reaching the unreached TG/H people through various innovative models like Dera / Gharana – led networks, making the invisible - visible through events-based, connect link networks, ICT application techniques, focusing young TG/H people)

Save the Children | M8A Multi Country South Asia HIV Program | NACO | VHS Voluntary Health Services – We Serve the People Who Serve You

Year of publication
2018

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Disclaimer
This document is prepared under the Global Fund – Round 9: Multi-Country South Asia HIV Program grant in India as part of the Innovations and Learning Site project. The content expressed will not directly reflect the intention of the Global Fund.

The content expressed captures the learnings during the piloting of the programme, with the support of the respective Community Based Organization (CBOs) and State AIDS Prevention and Control Societies (SACS). The lessons learnt will be shared with National AIDS Control Organization (NACO), Ministry of Health and Family Welfare, Government of India, New Delhi.

Foreword

The National AIDS Control Programme (NACP) has always taken proactive and progressive steps to control the HIV epidemic and strived to address the unmet needs of key populations. India is committed to the 2016 Political Declaration on 'Ending AIDS: On the Fast-Trackto accelerate the fight against HIV and to end the AIDS epidemic by 2030' and the same is reflected in the National Strategic Plan for HIV/AIDS and STIwith the goal to reduce 80% of new infections by 2024. In the ongoing extended NACP IV phase, intensive efforts are undertaken to control the spread of HIV infection within the TG-H groups. However, the community remains one of the most at risk for HIV, with a national average HIV prevalence of 7.5% (2014-15, Source: IBBS, NACO).

The gap areas mentioned in the National Strategic Plan for HIV and STI, clearly indicates that flexible and innovative models need to be introduced to reach the unreached KPs and to redo the size estimations for fresh targets. Additionally NACP-IV Mid-Term Assessment Report 2016 emphasised the need to revise the existing HIV prevention guidelines matching changes in social and sexual dynamics of key populations and based on typology and coverage area.

VHS under the Multi-country South Asia (MSA) DIVA Projectunder the guidance of NACO has piloted various innovations under the DIVA – Innovation and Learning Site project. This report details the processinvolved in implementing the various pilot models with the support of the respective CBOs and in partnership with SACS.

I hope the learnings will be helpful in scaling up the innovations for improving the HIV service delivery among TG/H people.

With best wishes,

Dr.Joseph D Williams,

Director - Projects,
Voluntary Health Services

Preface

The "Innovations & pilot models – process document" consolidates the experiences, lessons learned, innovations piloted and challenges encountered through the "Innovations and Learning Site" project implemented by the Community Based Organisations (CBOs) in the states of Andhra Pradesh, New Delhi, Karnataka and Odisha in partnership with the respective State AIDS Control Societies (SACS).

During the experimentation phase, there were many learnings that helps to prove that fast-track models would help in reaching the unreached young TG/H people on time and minimize the gap between reach – test – treat. Thus, such fast-track models helps to strengthen the overall HIV prevention and treatment cascade.

Despite being a brief period of experimentation, it has thrown out opportunities to explore new ways to penetrate into the TG/H population and differentiated approaches and service delivery mechanism need to be planned accordingly based on this innovative learning site programme.

As highlighted in the MTA, and one of the key recommendations from innovation programme, the needs of the TG-H people are beyond HIV/STI hence a holistic health model needs to be introduced taking care of all other needs including the gender transition and sex reassignment, giving provisions for education, employment, professional training and social protection schemes.

VHS takes this opportunity to acknowledge the support provided by the NACO, SACS of Andhra Pradesh, Odisha, New Delhi and Karnataka. They have been supportive and provided valuable inputs in decision making, policy level advocacy and capacity building of various cadres of personnel.

VHS thank the active participation of Transgender and Hijra population, key community members & leaders, stakeholders like respective ICTC, ART, STI centers and its staff, Consultants, Field Mentors, etc. Special gratitude and thanks to the Project Directors, Additional Project Directors, Joint Directors, Team Leaders of respective SACS and their team for extending their full support and monitoring the progress of DIVA innovation and learning site program.

VHS acknowledges the significant contributions of the Lead Consultant - Mr.KannanMariyappan, Field Mentors – Mr.Prashant Kumar Patra, Mr.DavidBodapatti, Mr.Rakesh Kumar and MrJagdish Kumar for their technical expertise in guiding the CBOs and implementing the pilot project. VHS place on record the developing these guidelines with inputs from VHS-MSA DIVA team.

We place on record the significant support received from the CBOs – Kinnar Bharati, SAKHA, KYSS in coordination with SGSS and PAYANA for taking their utmost efforts in implementing the innovation programme towards reaching the unreached TG/H people with proven results in their respective States.

Voluntary Health Services extend its gratitude to the entire MSA-DIVA team for their sincere commitment and facilitation in the whole initiative.

We acknowledge the efforts of Shankari for leading the learning site activities, Mr.Johnson and Girish Kumar for facilitating with the CBOs and SACS towards the conduct of the activities at the grass root level.

I owe my sincere thanks to the Director – Projects, VHS Management and the PR agency – Save the Children International, Nepal for encouraging us to have this innovations as part of the MSA initiative and for their continuous support and motivation.

Dr.A.Vijayaraman

Deputy Director, VHS-MSA DIVA Project,
Voluntary Health Services

Contents

Abbreviations

AIDS	-	Acquired Immuno Deficiency Syndrome
AP	-	Andhra Pradesh
APAC	-	AIDS Prevention And Control project
APSACS	-	Andhra Pradesh State AIDS Control Society
ART	-	Anti-Retroviral Therapy
BCC	-	Behaviour change communication
BMGF	-	Bill and Melinda Gates Foundation
CBO	-	Community Based Organization
CBS	-	Community Based Self-testing
CBT	-	Community Based Testing
CCLNM	-	Connect, Community, Link, Network Model
CLA	-	Community Link Agents
CM	-	Community Mobilizers
CSO	-	Civil Society Organization
CSS	-	Community Systems Strengthening
DA	-	Data Analyst
DAPCU	-	District AIDS Prevention and Control Unit
DIC	-	Drop-In-Centre
DIVA	-	Diversity in Action
DRP	-	District Resource Person
DSACS	-	Delhi State AIDS Control Society
EQAS	-	External Quality Assurance Service
GFATM	-	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	-	Human Immunodeficiency Virus
HRG	-	High Risk Group
IBBS	-	Integrated Biological and Behavioural Survey
ICT	-	Information, Communication and Technology
ICTC	-	Integrated Counselling and Testing Centre
IEC	-	Information, Education and Communication
KSAPS	-	Karnataka State AIDS Prevention Society
MoHFW	-	Ministry of Healthand Family Welfare
MSA	-	Multi-country South Asia
MSM	-	Men who have Sex with Men
MTA	-	Mid-Term Appraisal
NACO	-	National AIDS Control Organization
NACP	-	National AIDS Control Program
NALSA	-	National Legal Service Authority
NGO	-	Non-Government Organization
NSP	-	National Strategic Plan
OSACS	-	Odisha State AIDS Control Society
PC	-	Project Coordinator
PD	-	Project Director
PE	-	Peer Educator
PLHIV	-	People Living with HIV
PR	-	Principal Recipient
RPR	-	Rapid Plasma Regimen
SACS	-	State AIDS Control Society
SIMS	-	Strategic Information Management System
SNA	-	Situational Need Assessment
SR	-	Sub Recipient
SRH	-	Sexual and Reproductive Health
STD	-	Sexually Transmitted Diseases

STI	-	Sexually Transmitted Infections
TAI	-	Tamilnadu AIDS Initiative
TB	-	Tuberculosis
TG	-	Transgender
TG/H	-	Transgender/Hijra
TI	-	Targeted Intervention
TSU	-	Technical Support Unit
UHC	-	Universal Health Coverage
UNAIDS	-	United Nations Agency for HIV/AIDS
USAID	-	United States Agency for International Development
VHS	-	Voluntary Health Services
WHO	-	World Health Organization

Background

Transgender is an umbrella term applied to a variety of individuals, behaviours, and groups involving tendencies that diverge from the normative gender roles. In India, they are often known as “Hijras” also referred as ‘Kinnars’ in the ancient times. Today, the transgender and the hijra (TG/H) communitiesare forced to live in poverty, denied access to equal opportunities such as education, family property inheritance, employment and other basic social entitlements and thus, their legal and social rights too. This population is one of the most vulnerable to HIV, with a prevalence rate of 7.5% (2014-15, Source: NACO) with the latest report revealing a 3.1% (HSS 2016-17) which is thirty times higher when compared with the national adult prevalence rate. The IBBS Report 2014-2015 shows that (70%) of TG-H people are primarily engaged in sex work, one in five experiences sexual and physical violence, 71% face stigma in health-care settings, and 50% are discriminated and rejected by their families and friends.

This document consolidates the experience, lessons learned, innovations piloted and challenges encountered through the “innovations & learning site” project implemented by the CBOs in the states of Andhra Pradesh, Delhi, Karnataka and Odisha. Despite it being a briefperiod of experimentation, it has thrown out opportunities to explore new ways to penetrate into the TG/H population and differentiated approaches and service delivery mechanism need to be planned accordingly based on this innovative learning site program under the MSA DIVA – Supported by Global Fund.

About Voluntary Health Services

Voluntary Health Services (VHS) hospital, established in 1958, is a 465 bedded multi-speciality tertiary teaching hospital. VHSis based in Chennai, Tamil Nadu, India and is registered as a non-profit society under the Registration of Societies Act, 1860. The hospital was inaugurated by the first Prime Minister of India – Pandit Jawaharlal Nehru. Dr. M SSwaminathan, renowned Agricultural Scientist, is the President of VHS. It is pride that the organization has crossed 60 years of selfless and dedicated service to the community. VHS offers affordable medical care services to people belonging to poorer backgrounds and low-income groups based on their health care needs rather than their ability to pay. VHS approaches health care from a holistic perspective, laying emphasis on disease prevention, health promotion, fostering and serving the family as a unit, actively promoting community participation and providing affordable care.

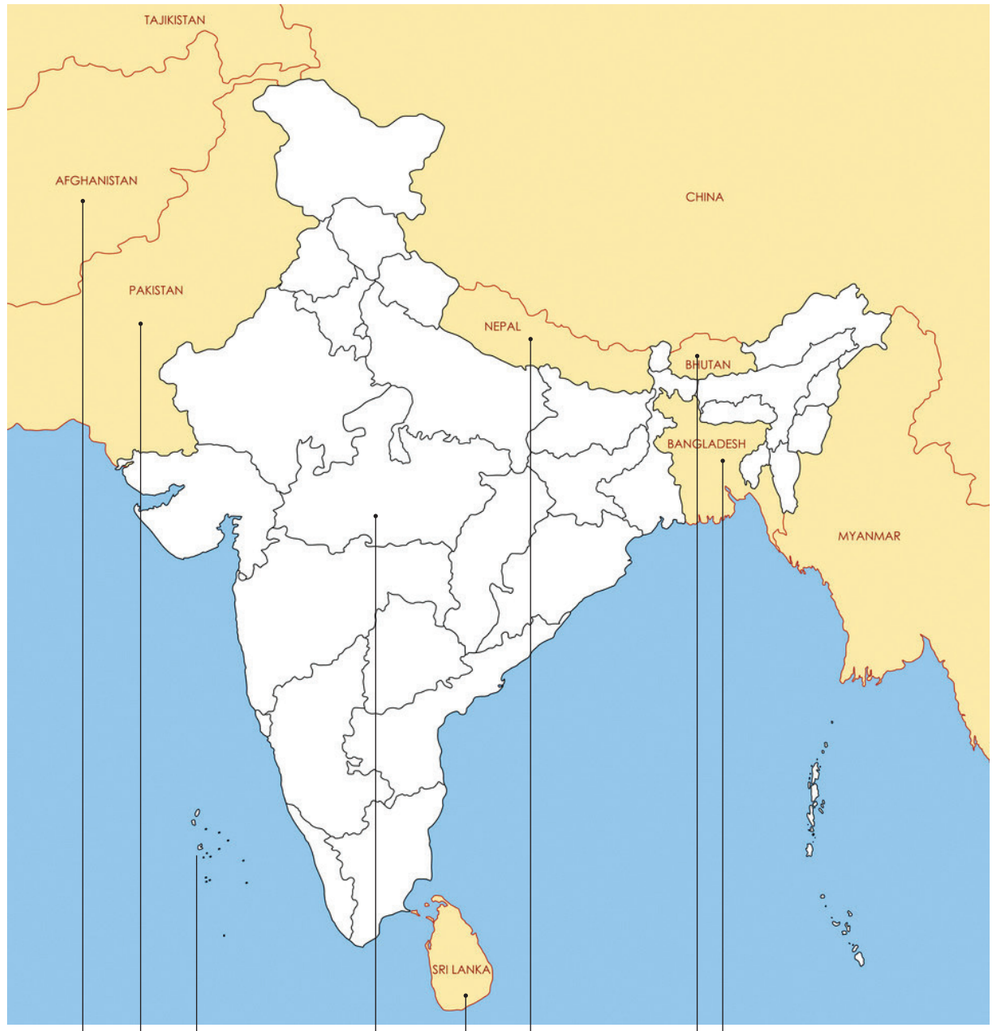
VHS also pioneered the model of Mini Health Centres with the aim of providing primary health care services to the poor near their place of residence and promoting community health through trained health workers from within the community.

VHS has been at the forefront of managing comprehensive community health and STI/HIV prevention programmes for marginalised populations, sexual minorities, and deprived groups. Backed by nearly 20 years of wide ranging experiences in implementing HIV/AIDS prevention, care and support programmes, building the capacity of Civil Society Organizations (CSOs) and training health care providers. VHS has since built a reputation for understanding and addressing the needs of disadvantaged communities.

About MSA-DIVA
GF ATM Round 9 Grant

Voluntary Health Services (VHS) is implementing the Multi-Country South Asia Grant in India and is the Sub-Recipient wherein Save the Children International, Nepal is the Primary Recipient. VHS MSA-DIVA project strives to improve the health and human rights issues of TG-H people through capacity building, policy advocacy, and research initiatives. Given the need from the NACP and in line with MSA-DIVA programme objectives, VHS proposes to implement four innovative, community-driven ideas to improve the overall HIV service delivery programme by incorporating newer strategies within the existing intervention framework and encourage community-led advocacy. The project,under the guidance of National AIDS Control Organization (NACO) and in partnership with the respective State AIDS Control Societies (SACS), aims to reduce the impact of HIV on the hijra (H)/transgender (TG) population.

The Global Fund Round 9 South Asia HIV Programme is a Community Systems Strengthening (CSS) Grant, and Phase 1 (Start Date 1 January 2011) was implemented in seven countries: Afghanistan, Bangladesh, Bhutan, India, Nepal, Pakistan, and Sri Lanka. Phase 2 began in November 2014 and ends in September 2018. The second phase of the programme hadstarted with an official communication and clearance from National AIDS Control Organization (NACO), Ministry of Health and Family Welfare (MoHFW), New Delhi. Initially, NACO had requested to build the capacity of 6 states and late in 2016, this had been extended to the entire country except for the north eastern states, based on the need and the existing results.



PAKISTAN
Naz Male Health Alliance

AFGHANISTAN
Youth Health and development organization

MALADIVES

SRI LANKA
Family Planning Association Of Sri Lanka

INDIA
Humsafar Trust
Voluntary Health Services

NEPAL
Blue Diamond society

BHUTAN
National STI and HIV/ AIDS Prevention and Control Programme
Lhak-Sam, bhutan Network of People Living with HIV (BNP+)

BANGLADESH
Bandhu Social welfare Society

Global Prevention Agenda

In 2016, UNAIDS, in its "Prevention Gap Report[1]", elucidated the detailed consultations held in countries to address the agenda behind the Key Population. This report says that two-thirds of young people do not have correct and comprehensive knowledge on HIV; condom use is much low across all population groups at higher risk of infection; transgender people are 49 times more likely to be living with HIV than adults in the general population and these populations continue to be left behind. Further, the report stated that;

- Key populations face specific challenges and barriers, including violence and violations of their human rights, with women in key populations particularly affected by the same.
- Criminalisation and stigmatisation of same-sex relationships, cross-dressing, sex work, and drug use block access to the HIV prevention services and increase risky behaviours.
- Stigma and discrimination related to HIV towards key populations inhealth-care settings undermine access to HIV prevention and other healthservices.

To close the prevention gap, it proposes to build on the momentum established at the 2016 United Nations General Assembly High-Level Meeting on Ending AIDS and this requires translating the commitments within the Political Declaration into action. Global targets and milestones need to be translated first into national and sub-national targets; implementation plans that focus on the populations and locations to reach the targets are required to address the legal, social and economic barriers that prevent service access and uptake. At the local level, stakeholders need to analyze and understand their local prevention needs and elicit an appropriate combination prevention response.

1. **UNAIDS: Prevention Gap Report, 2016**

UNAIDS greatly emphasizes on the urgency to meetthe 90:90:90 target on the completion of which, the attention could shift towards the saturation of key population with overall prevention and treatment services. Efforts have especially been accelerated in countries that top the priority list and working closely with the respective national governments has been done to ensure the same. One such country high on priority in the South East Asia region is India, which needs to consolidate the gains in the last two decades and invest the available resource envelope to the high priority states and districts, populations and sub-populations that are in need of detailed analysis and right interpretation to be able to achieve the target of 90:90:90. The major challenge behind reaching the first 90 is mobilising the unreached population and their networks. Reaching them with the HIV screening service is on top priority, so that countries will have a clear denominator to work on the other two 90s. It is very important to focus on partnerships and resource mobilisation to cater to the services, as the available resource envelope is already shrinking in the region.

Agenda on Key population under UHC

The concept of UHC is rooted in the right to health, as set out in the International Covenant on Economic, Social, and Cultural Rights. Its guiding principle is health equity: Everyone, irrespective of their race, gender or social status, deserve to receive the health services they need without suffering any financial hardship.

UHC encompasses all components of the health system: Financing mechanisms, service delivery systems, the workforce, health facilities, information systems, access to technologies, quality assurance, governance and more. UHC, therefore, provides a framework for strengthening disease prevention and control, and also improving health outcomes in an equitable manner. It also offers a framework for pragmatically linking together, resources and interventions, to eliminate major public health threats such as the overlapping epidemics of HIV, TB and hepatitis B and C. Improving people's access to health services requires the removal of other barriers as well, such as human rights violations, stigma and discrimination, and laws that criminalise sex work, drug use or same-sex relations[2] .

With the above context in mind, the Key population agenda needs to take priority under the overall umbrella of UHC, if we are aiming for elimination of HIV. For decades, HIV programmes have exemplified core UHC principles, for example, by:

- emphasising rights-based and people-centred strategies;
- demanding universal, free-of-charge access to essential interventions, particularly HIV testing and antiretroviral therapy (ART);
- challenging stigma and discrimination to enhance equal access to health services;
- campaigning for reduced prices of HIV medicines and other commodities;
- integrating the knowledge and work of community organisations in HIV programmes;
- extending the reach and scope of the services in marginalised or remote communities; and
- linking access to services for comorbidities such as TB, viral hepatitis and substance dependence.

HIV programmes therefore support and slot into broader efforts to make essential health services accessible and affordable to all and to realise the universal right to health.

Challenges of NACP through MTA

The Mid-Term Appraisal[3] (MTA) of NACP-IV undertaken by NACO has been an unique and a large exercise which witnessed participation of all the Development Partners, representatives from community and civil society organizations, technical & subject-matter experts, and representatives of the states. It involved numerous consultations by the MTA Steering Committee, Technical Sub-Committees, desk reviews, field visits and report compilation.

The recently concluded Mid-Term Appraisal (MTA) of National AIDS Control Programme (NACP) has clearly outlined the gap in the details of the programme, which needs attention of policy makers and program implementers with the active community engagement at all levels. Some of the major gap, as mentioned in MTA, are as follows:

PRIORITY 1: Accelerating HIV Prevention in 'At Risk Group' and Key Population

PRIORITY 2: Expanding Quality Assured HIV Testing With Universal Access to Comprehensive HIV Care

PRIORITY 3: Elimnation Of Mother to Child Transmission of HIV and Syphilis

PRIORITY 4: Addressing the Critical Enablers in HIV Programming

PRIORITY 5: Restructuring the Strategic Information System to Veeffcient and Patient - Centric

FAST TRACK APPROCH

- Mobile-based and internet-based intervention among the TG/H communities have not been achieved.
- Providing water-based jelly to MSM & TG/H people still needs to be achieved.
- 100% HIV testing needs to be promoted.
- Building community ownership has been on a slow-track mode.
- Lack of specific IEC/BCC efforts to work with TG/H people, especially on “Feminisation process and HIV/AIDS”.

Key recommendations include encouraging adaptation of interventions to local context through systematically monitoring and reflecting on their data; address financial uncertainties and fund flow issues; commission an options paper on the design and future of TIs; upgrade the guidelines for population size estimation and validation; strengthen the interventions to improve the coverage of KP; strengthen community and civil society partnerships.

2. **Are key populations really the “KEY” to ending AIDS in Asia? Putting Asia’s HIV response back on track. New Delhi:World Health Organization, Regional Office for South-East Asia; 2018.**

3. **Mid-Term Assessment of National AIDS Control Program Phase IV, National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India, August 2016**

Reading through the lens of NSP 2017 - 24

With the detailed deliberations and consultations, the NACP come with a clearly articulated vision document, National Strategic Plan (NSP) for HIV and STI 2017-24[4] . This seven-year plan document is replete with strategies, indicators, monitoring and proposed financial requirements to succeed in implementation of the targeted intervention programme among the Key population in the country. The NSP has five priorities and outlined all components under NACP in the country. The NSP suggested some of the innovations for future pilots and their implementation, and based on the results, it will be scaled up across the country. The innovations mentionedin the document are as follows;

PREVENT	TEST	TREAT
• Increased Coverage for improved prevention, testing and care linkages. • Systematic evidence generation to reach ''at risk'' population • Retain KP with adequate and appropriate services	• Geo-prioritise differential approach • Use Graded approach to increase HIV testing • Pilot and scale up newer modalities of testing (e.g. CBT, Self Testing, etc.) • Active use of IEC to increase demand for HIV testing	• Accelerate uptake of ART • Improve ART retention by engaging community / NGOs/ private sector. • Ensure supportive environment for achieving universal access to ART • Address co-morbidities of HIV infection to lower mortality and morbidity

- Community-based testing/self-testing
- Community-led monitoring for adherence
- Low mass coverage communication
- Develop hand-held device-based reporting and adherence monitoring systems
- Various means to assess treatment adherence: Use of dedicated telecom network for health applications
- Comprehensive integrated care centre model in few identified facilities
- Differentiated and de-centralised care service delivery models
- Community-led comprehensive care model
- Innovative eLearning approaches

In conjunction with the UNAIDS agenda, the NSP has also set a target to reach 95:95:95 by 2024, which would be the end of the NSP period and so, a lot of work and partnership needs to go hand in hand. With the above direction, focusedprimarily on capacity building, the targeted intervention projects seek to work amongst the transgender and hijra populationand this shall be looked at as an emergence to pilot certain models at the grass root level.

4. National Strategic Plan for HIV/ AIDS and STI 2017-24; Paving Way for an AIDS Free India: December 1, 2017.

Rationale of innovation and pilot model

Historically, VHS has been the pioneer in innovating and piloting many ideas in the state of Tamil Nadu. It is evident from the fact that many of the activities, and processes implemented by VHS have been later translated into national programmes and VHS has facilitated the development of that as well. The USAID-supportedAIDS Prevention and Control (APAC) project, and the BMGF-supportedTamilnadu AIDS Initiative (TAI) projectsareremarkable contributions in the field of HIV in India. With that memory and well-wishers guidance, VHS always finds a way to support and facilitate the national programme needs in the context of Key population in the country.

The MTA has come up with clear gaps and NSP has provided a way for innovation to address the gaps with clear strategies. VHS has been implementing successful Key population programmes for more than a decade and has worked extensively with the transgender population. Based on its existence in the various states under the MSA DIVA programme, VHS aimed to pilot few models in the implementing states. The results will be useful to contribute to the national agenda by generating evidence, findings and recommendations.

Based on the core meeting with the respective State AIDS Control Society (SACS), four models and states have been selected to pilot some of the innovative models. The selected states are Andhra Pradesh, Delhi, Karnataka and Odisha. The innovative models are as follows;

Name of the State	Innovation Piloted
Andhra Pradesh	Connect, Link and Network – CLN Model
Delhi	Dera Led Network Model
Karnataka	Reaching the young TG-H through ICT
Odisha	Making the Invisible Visible

In the state of Andhra Pradesh, the TG/H population mostly resides in the rural area and their accessibility to urban-based targeted intervention program was limited. This population needs a networking setup to make them understand the programme. So, Connect, Link and Network – CLN Model.

The state of Delhi is one of the major TG/H populated states in the country, and has around 6 Jamaths and around 80 Deras, based on the discussion from Delhi SACS. Most of the TG/H population stays and lives under the system, which means the leaders' participation in the HIV service delivery program is important to reach out to the TG/H population. This was aimed to reach out to the leaders of TG/H population to take part in the prevention and treatment of HIV. So, Dera Led Network Model.

Bengaluru, Karnataka is a high-tech city with the availability of all kinds of information technologies. The mobile and the use of social media had been taken as the priority and to reach the TG/H people with the HIV-related services. This will provide an idea of virtual intervention possibility among the TG/H population. So, Reaching the young TG-H through ICT.

One of the emerging prevalence states and one that has increasing numbers of the TG/H population is Odisha. Very recently, due to various partners' work and the Odisha SACS' involvement, these communities started coming out and started accessing the services. The focus was majorly on advocacy and rights-related aspects. The Odisha SACS requested very clearly that there is a need to form an estimate of available TG/H population in the state and plan the intervention program for them. As decided, Making the Invisible Visible.

VHS also aimed to reach the agenda of reaching out to the "YOUTH" and focused on the young TG/H population during this pilot project. The implementing agencies were oriented on the importance of reaching the young Key population and priority age category set as below 24 years. Even those the project identified above the age of 24 years, were referred to the existing targeted intervention system for HIV related services. It highlights the vision of these innovations and the learning site activity was clear, focused, and targeted, to reach the young population with the HIV-related services.

Preparation Towards the Direction

The necessary communication has been sent to the respective SACS; the implementing agency (CBO) selection processes were started in coordination with SACS. The SACS has nominated the respective CBOs to implement the pilot project as part of the MSA programme. The initial discussions were held by the MSA DIVA project team with their respective state teams for the implementation and SACS has been oriented on it.

Name of the State	CBO Engaged	Location of Innovation and Learning Site
Andhra Pradesh	KYSS in colloboration with SGSS CBO	West Godavari District
Delhi	Kinnar Bharathi CBO	Delhi
Karnataka	PAYANA CBO	Bangalore
Odisha	SAKHA CBO	Bhubaneswar and Sambalpur district

Discussion with stakeholders

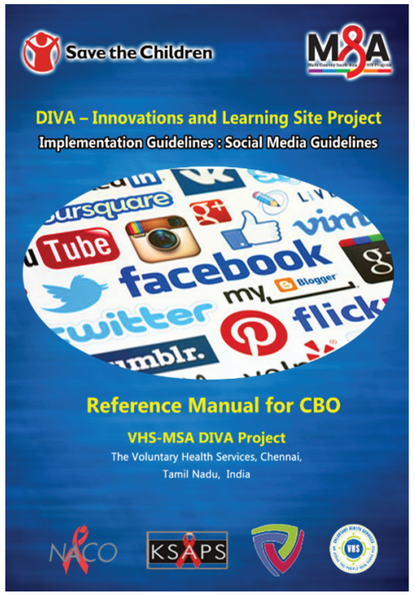
This particular innovation and learning site activity has stakeholders as SACS, District AIDS Prevention and Control Units[5] (DAPCU), implementing agencies, health care providers and leaders of the TG/H population in the respective states. This innovation programme has a component of initial orientation to the above cadres at the beginning of the project. The project team and consultants have spent due time to orient and take their partnership and direction at all the stages of the implementation. It is also ensured that an update has been made available with them, on a monthly basis, to understand the progress and the challenges, and sought direction to overcome the challenges for better and improved implementation.

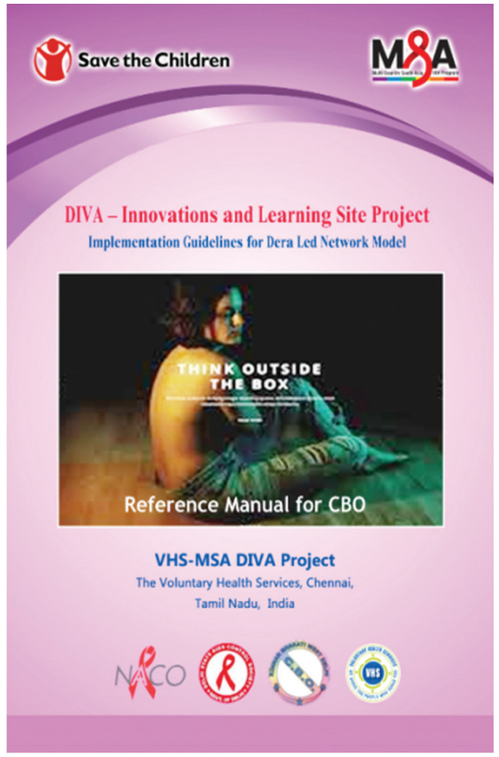
5. In India, the DAPCU plays a major role in implementing the national guideline at the grass root level and sends feedback back to the policy makers with the implementation achievements and challenges. It is vital to coordinate with DAPCU at the grass root level for any support and direction.

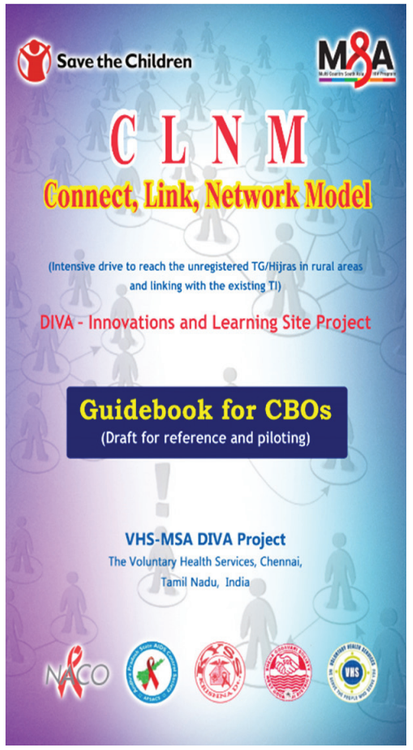
Development of Guidelines

VHS believes in planning and the plan should have all modalities that will be discussed during the course of the innovation implementation. The clearly-defined draft guidelines have been prepared for all innovation and learning site activity, separately with rationale, the kind of preparedness for innovation, step-by-step approaches (role of leadership, smartness in outreach, community-based HIV testing, events, stakeholder engagement, capacity building, how proper communication plays an important role, knowledge products, how to conduct the mega event, strategy checkpoints, and steps for messaging in Whatsapp), monitoring indicators, time management and foreseen risks.

The developed draft guidelines have been reviewed and shared with the respective SACS for their information. This guideline was useful in understanding the direction of the activity and the role of each player in the tasks. It is important to have these guidelines in advance, so that while transferring the information, knowledge, findings, and recommendations that emerge from the innovation and learning activity can be translated into a national programme by sharing this well-planned guideline, which is again helpful in designing the national policy level guidelines for the TG/H population in the country. This is also a contribution to the national programme and VHS believes in it, based on their past experience in working with NACP.







Orientation programme to the Field Mentors and Project Coordinators

It is proved strategy that imparting the capacity building to the workforce recruited before initiating the implementation process is very important and easy to mentor and guide the team during the later period of the project.

MSA DIVA Innovations & Learning Site Orientation Program for the Field Mentors and Project Coordinators from Andhra Pradesh, Delhi, Karnataka and Odisha wasorganised at Hotel Courtyard, Chennai along with the entire project team. It was a two-day workshop from 24 to 25 May, 2018. Around 20 members participated, benefited and were oriented about the innovation activity and provided an overview of draft guidelines developed as part of the activity.

Dr. Vijayaraman, VHS welcomed the participants on behalf of VHS and crisply presented an overview of Voluntary Health Services to the participants. He was explaining that NACO commissioned for NACP IV found many gaps and wanted to prioritize them for the next phase, say, IEC materials are sufficient but unsuitable right now for existing communities, strategies applied are: Prevent Test and Treat, however, there are new gaps in which the VHS has come forward to give importance in relation to the TG/H community. New models have to be generated and evolved for better and qualitative service to the poor/unreached and unregistered TG/H people. This program would help us to come out with an innovative model with which we go ahead to fill gaps in this field.

The first day focused on the brief overview about VHS, introduction of MSA DIVA programme, introducing the learning site concept by providing rationale, unpacking the agenda by explaining the objectives of the innovation and learning site programme and clarifying the roles and responsibilities, presentation and discussion of all four guidelines and feedback of the day; day two, mainly, had a discussion on the revision needed in the draft guidelines, challenges and opportunities state-wise, work plan presentation and action plan development, explaining the administrative and financial guidelines and instruction as a mandate part of the grant, reporting structure and final feedback with closing remarks. So, the two-day packed agenda and energized discussion was useful to the participants to understand the expected results from the innovation activity.

Followed with an introduction part, the respective consultants presented the draft guidelines to the field mentors and project coordinators of the CBOs from the states. The draft guidelines gave an idea, what, when, how and why to implement the innovation model and sought inputs. All strategies and guidelines listed in the document were discussed, in detail, by the participants. There was feedback from the participants to include some of the aspects and target setting agenda.

It is highlighted that the implementing doesn't need to worry about the target achievement as the innovation only looks for processes and lessons learnt by implementing new strategies and the participation from the communities from the field. Further, clear emphasis was laid on reaching the youth and young population under this innovation activity. It is also highlighted that it was going to be four-month activity and VHS has been working in these states since the last three years for various activities, which is greatly helpful to start from the core activity as the base is already set. This has helped in accelerating innovation activity and the ability to articulate all the guidelines and results.

Lead and Field Mentors

The fact is that the innovation project, from the beginning, planned to have experienced workforceand include those who have implementation knowledge among the TG/H population, so that this rapid implementation and process will be followed at all stages. It is also envisaged to have the consultants who have already worked in the state and national program along with the experienced MSA DIVA team. Accordingly, the consultants' team have been selected and employed in the innovation and learning site programme. The consultants were working on the national programme, state level technical support unit, written guidelines and modules for the Key population programme. These experiences are very important to coordinate with the respective SACS, which was crucial. Even then, in one place, we had to wait some time for the approval to go ahead.

The innovation activity has the structure of Lead Consultant and Field Mentors in each state to coordinate, facilitate, monitor and ensure this innovation activity implemented as visualized. The lead consultants monitored the field mentors and their reports. The field mentors are directed by the lead consultant for all activities and the challenges were overcome during the course of the implementation.

Reverted the Implementation Science

The mixed results were encouraging and motivating, especially, considering that this is a pilot initiative. The innovation and learning site activity had good achievements as a model and had some disadvantages too. This learning will be very useful in designing the future programme, especially on community engagement.

The overall results from Karnataka and Delhi showed that we can contribute to the UNAIDS target of fast tracking 90:90:90 and can achieve the target of NSP 95:95:95 by 2024. However, there are items to be kept in mind while implementing the programme and engagement of communities and the need for intensive communication for health seeking behaviour, which is of the challenges in the current programme.

The implementation science matters a lot among the partners with clear intention to reach the unreached. This innovation and learning site activity says that active involvement of communities and their leaders along with community-based organisation is crucial in reaching the 90:90:90 target. This will revert the epidemic among the TG/H population. A standard approach to all the areas will not work as the ethnicity, culture, community dynamics, stakeholder engagement, availability of commodities, timely reach of financial support, commitment in reaching the population rather than a target driven approach, community mobilisation and advocacy varies from place to place, community to community, district to district and state to state. Especially, when you see the high positivity, the system should act rigorously but in many a case, it has become just another routine monitoring process. The evidences generated are not replaced with flexible strategies to address the emerging needs at the grass root level.

Key Indicators	Andhra Pradesh	Delhi	Karnataka	Odisha	Total	%
Target	75	80	75	250	480	100%
New TG/H enrolled	80	93	87	258	518	108%
Young TG/H (18-25 Yrs)	70	93	87	211	461	89%

The programme focused on reaching the young TG/H population and was able to reach 89% of the targeted population. In some places, they focused only on the young population and in some places, it was difficult to manage the identification and enroll them. As expected, the outreach team registered a mix of young population from rural areas, those who are under Dera system, with the use of social media and invisible population through festival/event-based identification process.

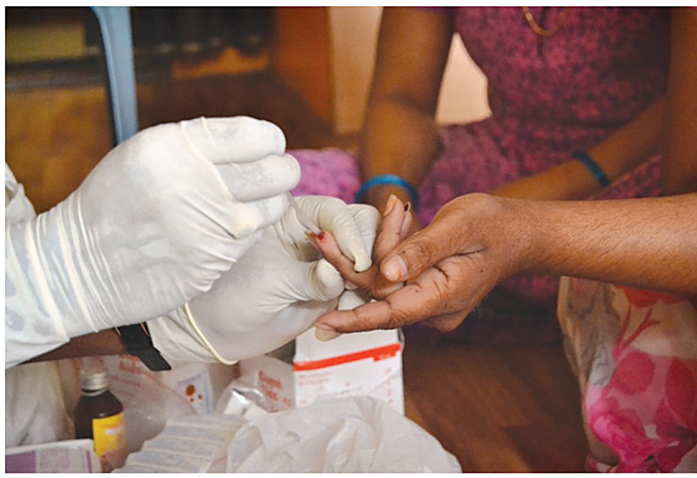
Reaching the Young TG/HPopulation through ICT – Karnataka

"Reaching the young TG-H through ICT", the Learning Site Pilot Project was given to Payana CBO is working with the Transgender community in Karnataka, to reach out to Transgender and Hijra community who are between 18 years and 26 years and who are not on the radar of the existing targeted intervention program. The goal of the project is to `Innovative HIV response to reach the unreached TG-H people stepping towards 90-90-90 targets in India'.

The current generation of transgender uses mobile phones/smartphones to solicit and pick-up clients and the number is as high as 86 percent and out of them 25 per cent use internet. However, in the existing intervention structure, there is no provision for virtual outreach. NACO's Mid-Term Assessment Report 2016 outlined that the single approach throughout the country will not work, it must be a combination of locally tailored strategies for alternative outreach models and reasonable investment in community-driven mobilization and advocacy initiatives.

The main objectives of the Pilot Project are:

1. To reach the young TG-H people using social media and events linking them with the HIV services.
2. To mainstream the TG-H issues among relevant stakeholders thereby reducing stigma and creating equal opportunities.
3. To provide mentoring support, resources and tools to strengthen the CBO capacity.



The staff of the project met over three hundred transgender and hijra (TG-H) people in the course of two months; the focus was only on the youngsters in the community as per the project and only those in the age-

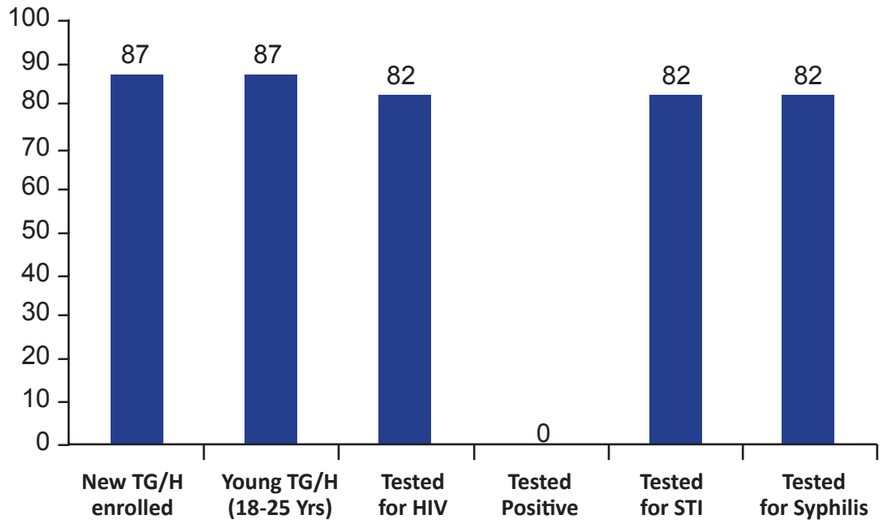
group were reached out to and registered. These are the young community members who have either recently migrated to Bengaluru or have been living in the city for a few years, but have not shown interest in joining the existing programme.

To achieve the first objective, the project was designed to mainly use two methods; one is to use the events andHamamhome-based meetings to reach out to the target population and the second way is to use social media and mobile, online or virtual outreach to reach out to the community who are 1. Unreached and unregistered in the existing TI programme; 2. In the age group of 18 to 26 years. Deep inroads were made into the online outreach which is new to both the CBO and the new Community Mobilisers, who are a mix of both young and experienced transgender people. The Project Coordinator is experienced in the actual activity-based knowledge of websites like Grindr and Planet Romeo, and along with the mentor, has studied and analyzed the websites to chalk out a plan and strategy for the Virtual Outreach. The other activity was creating a Facebook page and Twitter handle. Community Mobilisers (CMs) have created short videos with messages on safe-sex that were circulated at regular intervals as per the project mandate and made shareable. This has been a big hit with, at least, few of the young transgender people who are active social media users and they have started posting positive story videos of transgender community. The community-based testing has been effective in reaching the first 90 and the communities had actively participated.

The project identified two websites - Planet Romeo and Grindr, and three members, including the mentor were active in monitoring and understanding how these dating websites for sexual minorities work. On the other hand, the project staff and CMs were vigilant during our event-based outreach to find out, among young community members, if anyone was using these sites.

These findings were then shared with the staff, including CMs during the review meetings. The project had undertaken key activities like an orientation meeting in Chennai for Project Coordinators and Mentors, assessment of the Field Mentor's needs of Payana and discussion with Coordinator, VHS Regional Manager and project staff meet KSAPS PD and staff, Regional Manager, Mentor meet Payana Board members and Coordinator. Mentor analyzes the online websites, social media pages, prepared messages and detailed plan for activities including video sharing, Orientation for Staff of Learning Site, Staff Meeting to develop and revise the work plan, Sub-DiC events, Meeting with DAPCU, First Thematic Training, Review meeting for staff, Review meeting, Mega event – dissemination, Closure meeting - Consolidating data and Report writing.

By conducting the above activities, the innovation project reached out to 87 young transgender people and all of them were taken into HIV and STI services. This particular project is an example of how to implement the community-based intervention and the entire organisation was actively involved in it, due to only which the achievement of target of young population has been made possible. The achievement also shows an evidence of the unreached population and we



would be able to achieve the first 90 within a span of one or two months, with active outreach and community engagement. This needs to be translated into the national programme as the team showed that they were capable of performing better in their reaching out to the unreached population. This is very important in the context that 2/3 of new infections occur only from Key population and in their allied networks. This would lead to achieving coverage and reaching the target of 90:90:90 and as well as the UHC agenda of 'no one left behind'.

The necessary stakeholders and DAPCU meetings were held and they have been informed about the subsequent development. The testing kits and other commodities had also been supplied by this unit. The CBO felt that there are many challenges working with the transgender people, especially the young ones. They said that despite repeated reminders over the phone and continuous WhatsApp messages, mobilising the community for regular meetings continues to be a regular challenge. All the community mobilisers have made a strong commitment,and they were explained, in detail, that identifying and testing is not the only goal, and that one needs to follow the process and to be focused while also documenting the experiences side by side. Towards the end of the project, they felt that there is a lot of opportunity to penetrate into the virtual media like Planet Romeo, Facebook, Grindr etc. The immediate availability of mobile facility and technology to the workers becomes a necessity here, in it the lack of which could lead to delay in action. Further, the staff should be knowledgeable in technology and its usage, and minimum protocols and decorum must be strictly maintained.

The systematic implementation of the project was carried out since its inception. A discussion took place with the Karnataka State AIDS Prevention Society (KSAPS); they appreciated the piloting of this activity. KSAPS had also express their desire to pilot similar programme in the state. Since many HRGs, including the transgender population, are using smartphones to pick up their clients, the learnings from this project will also help them to design innovations. We had a joint meeting with PAYANA, Program Officer from TSU, VHS and Mentor, to discuss and develop action on how to go about the plan. PAYANA identified experienced staff for the project (all from Community only); induction training was given to them and they work was begun. Mr. David, Mentor for this project, who also has a good rapport with KSAPS and PAYANA, was closely monitoring the project to meet the goals.

Positive feedbacks are as follows:

- KSAPS encouraged the project to be implemented in the project location, and deputed their Program Officer to mentor the learning site programme, and also as their routine visit to the CBO.
- CBO has a good rapport with Hamam Leaders, which help them to identify young transgender people within the limited timeframe.
- Whatsapp video messages helped the programme to introduce new innovations in the outreach.
- The CBO board members took up the programme seriously and completed it as per the target.
- Support supervision from the Mentor (Mr. David) helped in the plan, design and execution of the programme as per the target.
- CBO adopted various methods to reach the young TG-Hs using social media, online platforms, through Hamam leaders, melas and functions, community gatherings, bars and clubs and that yielded results.
- Support from the Political leader of the program was worthy of appreciation too.

Reaching the young TG-H through ICT is a good initiative. In a city like Bengaluru, which is also known as electronic city, transgender people, who live on their own, do use smart phones whereas those who are under the shadows of Hamam Leaders, do not use them.Whatsappvideo messages carrying health-related messages were successful modelled, as they reach all the members using smart phones. This channel could further be used to share phased messages on information related to HIV and other services.

Dera-led Intervention – Delhi

The Dera-led learning site activity had the major support of Delhi SACS. The objectives of the Dera led intervention were as follows;

- To assess the feasibility of different community-led intervention models addressing the unreached TG-H people with HIV services.
- To mainstream the TG-H people's issues among relevant stakeholders, thereby reducing stigma and creating equal opportunities.
- To provide mentoring support, resources and tools to strengthen the CBO capacity.

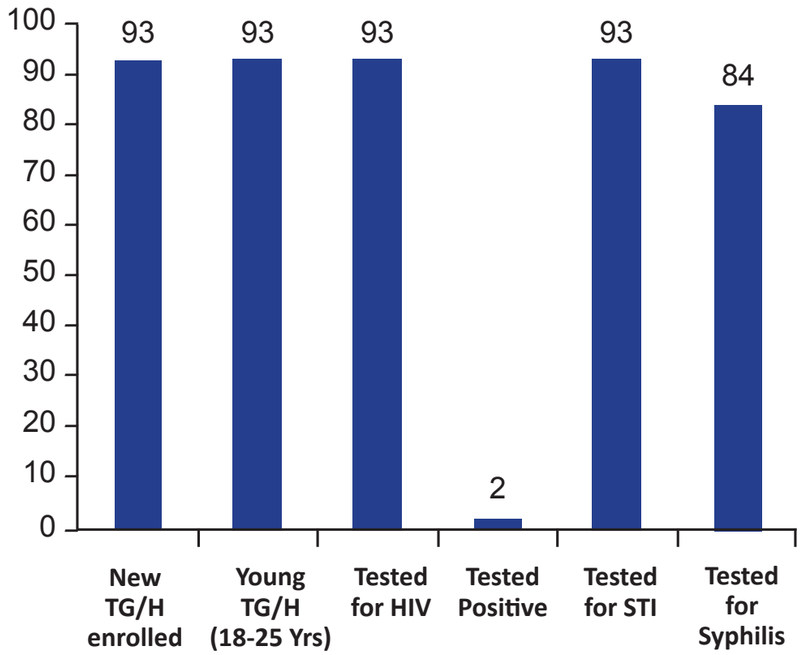
The Project Director of CBO was skillful in mobilising and organising the programme. Orientation of SACS, TSU, DAPCU and ICTC is completed, but since it also involves them in day-to-day activities, progress about the same needs to be updated periodically. Additionally, involvement of district government officials is vital, and since orientation of these officials is pending, it remains as a hindrance in the provisioning of social entitlements to TG-Hs.

As per the plan, all 4 Whatsapp groups were created, and theDera leaders participated in the discussion. Staff review meetings were being conducted, but needed to be more specific, in it the CMs should be present to share the challenges they face and seek support for. Similarly, PD and Mentors should also be a part of the review meetings to provide their valuable inputs for the gaps, if any. 80 new TG people/Hs have been identified from four deras; Deepa Guru, Madhu Guru, Sonam Guru and Neelam Guru, out of which, 50 have already been registered, after provisioning them for HIV and RPR screening services.

The Dera Leader Meeting was organised by Kinnar Bharati CBO in collaboration with the Voluntary Health Services (VHS), and Delhi State AIDS Control Society (DSACS) to share the concept of Dera-led Learning Site intervention with Dera Leaders/ Gurus. The meeting was held at thePanchayati Sada Shiv Mandir during the month of July, 2018. The meeting aimed to introduce the learning site plan with theDera Leaders/Gurus to actively involve them in the programme and to discuss the expectations of the same. During the orientation, the basics of HIV/AIDS and STI, outreach strategies adopted in the HIV programme, how the Dera leaders can be helpful in reaching the unreached TG/hijra population, the situation and vulnerability, prevention methods, orientation about the MSA programme, innovation and learning site activities were clearly explained to them. This programme had a good impact among the Dera leaders who were, at the end of which, willing to support the HIV-related services.

Thislearningsiteactivitybeganwiththegovernment stakeholder orientation and gathered adequate support for the implementation. However, the active engagement was continuouslychallenged during the implementation, and some of the activities could not be executed due to various interferences of community systems. The CBO is experienced in implementing programmes. The staff engagement and commitment with the senior levels were compromised a bit.However, the target has been successfully achieved.

The staff orientation, recruitment, Dera leaders meet, sensitization program, mega event and messages were part of the activities actively implemented. Initially, there were apprehensions in developing the video messages, as the community felt that it may create problems.



This project showed high potential of scaling up the activities into all Deras in the state. The Delhi SACS had even requested to organise a Deraleaders consultation at the state level. But, this could not be materialized due to lack of commitment by the community itself and a lack of interest to intervene in the Dera system. Therefore, it is highly essential to facilitate the participation of the Dera leaders in the HIV-related services.

The CBT was initiated at the DIC, where the TG people/Hs were screened and of them, two were further referred for confirmatory screening at ICTC. The state has adequate testing facility at the government facilities. However, the CBT is helpful in reaching into the Deras and to provide the HIV screening services. The acceptance level is appreciable as the state level policy is also under progress in the state.

Video clips by the DeraLeaders for the community mobilisation was completed, after an initial refusal. Sensitisation of the government stakeholders was conducted by the Regional Manager – VHS. Repeated visits to the Social Welfare department was made and coordination was done for issuing of the Aadhar Card with the transgender identity. After repeated visits and request to the officer concerned, camp for Aadhar Card was held at the DIC and TG/Hs availed their TG Aadhar card. Similarly, few TG/H people expressed their interest to have a PAN card. A mega event was organisedalong with the DSACS and TSU officials and the local leaders also attended the event. Totally, 97 participants from the community, in addition to the invited guests, attended the mega event held at Karol Bagh, Delhi.

Some of the challengesduring the implementation of the project were:

- Frequent change of CMs and PC hampered the programme's active pace. Involvement of the cream of the management in other community activities also resulted in their limited involvement in this pilot project.
- Technical support provided by the non-community members was also another reason behind the subdued response of the community. Hence, apprehension of PD about the role of Mentor was made a big challenge.
- As per a hijra tradition, chelas have to maintain discipline and decorum at Dera;PC and DA, hence, had to pay limited visits to Dera. All ativities at Dera totally depend upon the discretion of the Dera leaders/community mobilisers and the top management of CBO.

Connect, Community Link Network Model – Andhra Pradesh

In the ongoing NACP IV phase, intensive efforts have been made to control the spread of HIV infection within the TG-H group. However, the current HIV intervention strategy focuses more on the prevention using the blanket approach of “one size fits all”.There is enough evidence to support the idea, but the service delivery program needs to identify alternative means to deliver the outreach and clinical services.

CCLNM

Primarily focus:	Has not focused on:
TG/Hijras living or operating in the same area, but not enrolled in TI program.	TG/Hijras not at all enrolled or availed services from TI.
TG/Hijras indulging in high risk activities.	TG/Hijras enrolled in TI and left the TI on interim basis due to seasonal migration.
TG/Hijras either operating in the newly emerged hotspots, operating through mobile network, social media networks, etc.	TG/Hijras enrolled in other TIs within the same district or other districts and moved for seasonal migration.
TG/Hijras indulged in high risk activities either on part time or full-time basis (but not reached through TI).	TG/Hijras not involved in high risk activities and primarily involved in badhai.
Any other TG/ Hijras who are at high risk but not enrolled so far in TI.	

During the initial stages of the project design, it was proposed that the KYSS CBO willimplement the same. In consultation with the respective KYSS CBO and APSACS officials, it was agreed to invest efforts and resources to reach the unreached TG-H population around the TI programme and create a database and link them to the services. On February 22-23, a two-day planning meeting was organized for all 4 CBOs to identify issues and brainstorm appropriate innovation strategies to bridge the gaps in the new enrollment, testing and treatment services and social protection opportunities. Later, in order to avoid duplication among the partners, in accordance with the SACS instructions, the project was subsequently shifted to Westgodavari District and decided to roll out by KYSS, in collaboration with SGSS CBO of Westgodavari District.

A series of planning meetings were then organised with different levels of stakeholders: the first meeting was with the State AIDS Control Society officials, i.e. the Additional Project Director, Joint Director [TIs] and Team Leader TSU on the concept of the project, its time frame and geographical coverage and the staff structure. This was followed by a planning meeting each with both the CBOs and a joint meeting on building common understanding about the project and the different stages of project implementation as well as finance management. At project level planning meetings, there were discussions oncoverage of area, selection of CLAs, dos and don’ts, action plan, timeline and accomplishments.

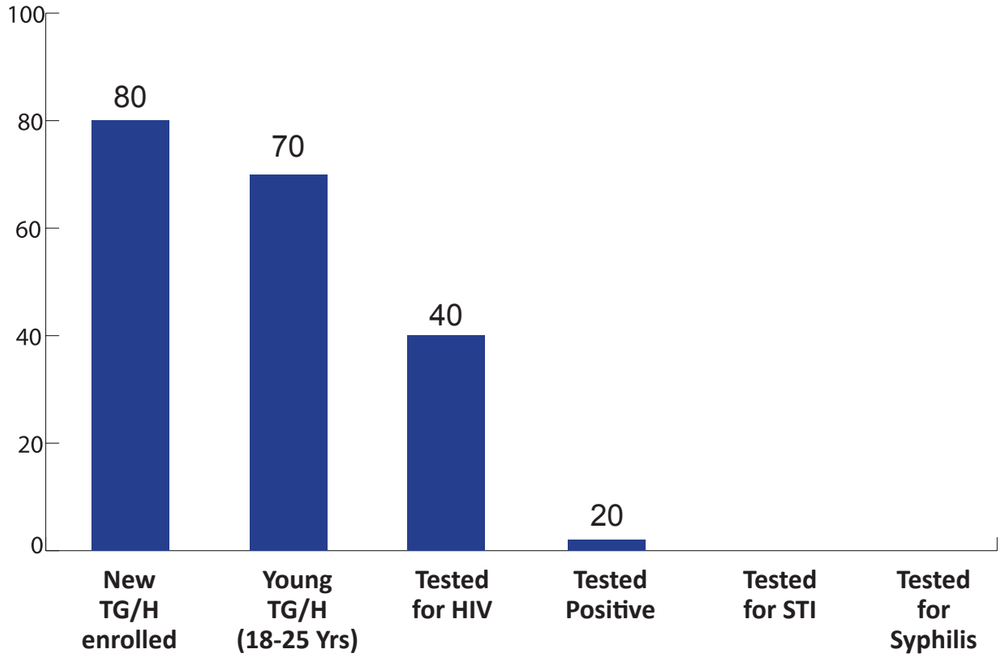
According to the project design, 4 active community members were selected as community mobilisers covering different areas and they, in turn, identified 8 community link agents, who were mostly Gurus of those communities and it was ensured that they have understood the concept and possess capacities to motivate and link themselves to the project, and willingness to dedicate their time to support community mobilisers, it had also been important to assess their basic understanding on HIV/AIDS, possess a positive attitude and familiarity with their social cultural frames. Preference was given to people from the same community or those who were influential with the community members and are possibly living or operating in the same area.

Total project staff included one project coordinator, one M&E cum accountant and four community mobilisers, who were then oriented on the project Introduction of CCLNM in HIV/AIDS prevention programme among the TG people/ hijras, the Goal, “Innovative HIV responses to reach the unreached TG-H people stepping towards 90-90-90 targets in India”. Individual roles and responsibilities with the help of a PPT [presented in Chennai Training] and group interactions. Roles and responsibilities of mentor in this program and Regional Manager as overall in charge were also explained along with the implementation structure flow in detail.

Apart from reaching out to the unreached community, the project staff organisedsensitis ationprogrammes for Panchayat president and ward members on their role in supporting the community and support in minimising the stigma, discrimination and violence at different levels by the community.


ROJECT
2018


NACO
THE VOLUNTARY HEALTH SERVICES-MSA- DIVA-PROJECT


100
80
60
40
20
0
80
70
40
20
New TG/H enrolled
Young TG/H (18-25 Yrs)
Tested for HIV
Tested Positive
Tested for STI
Tested for Syphilis

Promotion and supporting voluntary testing and accessing different services provided by government are one of the major areas and prioritization of the TG/H Community in various social welfare schemes at Panchayat level.

Strengthening the linkages and networking with social welfare departments like SC Corporation, BC Corporation, MEPMA, Skill Development Schemes, and housing corporations were one of the key areas of field level activities. As there were no targeted interventions going on in the district, the CCLNM developed a relationship and coordination mechanism to link the newly registered population with the Link Workers Scheme, which is focusing on the rural areas/villages covering the high risk and the most vulnerable population for further follow-up and linkages.

A gathering of 100 TGs - both new and old - demanding for social protection and welfare in a stigma & discrimination free environment and sensitisingthe media and government officials as well as politicians, on issues of TGs was the main activity of the day, besides the different cultural and community events. The presence of the Mayor and Dy. Mayor, Ward Presidents, DAPCU officials, Social Welfare Department officers, the DRP Link workers project, community elders, launching of the CBS were some of the highlights of the day.

With the above activities, the project had a major impact among the community, though not in a number-wise account, in a qualitative response from the field. Since the project activity started, they have had been able to reach the target of reaching the unreached population but have not been able to reach the 90% HIV related services; it only stands at 50% now. The main item to be noticed is that all the projects were able to reach the unreached population from the field for the first time and that they (communities) need the services and support beyond HIV, has been identified.

There were, indeed, challenges due to theshort duration of the project, and reaching the unreached at village level through cross dressing; self-stigma & discrimination levels are high amongst the rural TGs and hence, building rapport with new members needsmore time and frequent visits; motivating and sensitising the Gurus on services made available by the govt., and cultural variations and them accepting the CMs proved to be a bit difficult, which are, in general, reasons for poor acceptance and integration amongst the MSM, TGs and Hijras group.

Invisible Visible – Odisha

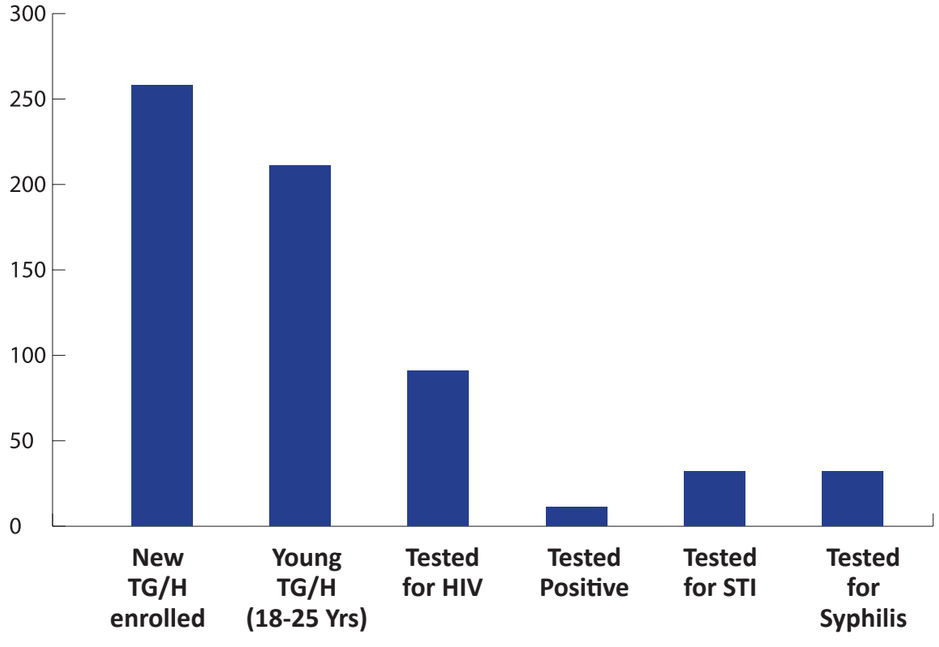
The Odisha project was implemented by SAKHA CBO, which is based in Bhubaneswar. This project had a target to identify 250 new TG/H people. The Odisha SACS had requested to estimate the available TG/H population in the state for further programming. Here, the event/festival-based approach was adopted to pilot the activities, as the Sitalasthi Festival has a reach of around 2000 TG/H population during the festival days. The project was aimed to identify new TG/H population those who are not part of the existing intervention.

As there was another set target to do 10 sub-event activities in SAKHA learning site project, SAKHA had completed the same by putting in their sincere efforts through all the challenges. So, this approach is an innovative approach to reach out to the unreached TG/H communities available in Odisha.By adopting an event-based approach, SAKHA has reached a total number of 258 new unreached TG/H community people, who were then identified and registered (including Mega event) for providing TI services.192 new TG/H population enrolled during the 10 sub-events held. 34, out of 192, underwent HIV testing and 10, out of those, were found to be HIV positive, and 1, out of that 10 confirmed as HIV positive,had been registered at Pre-ART. The remaining HIV positive TG/his could not be linked to Pre-ART due to the timeline.

The event-based approach is an effective approach in which SAKHA can easily reach the unreached TG/H population.Involvement of local community mobilisers increased the identification in project activity. Staff at ICTC and ART centers have also beensensitised on TG/H issues and were being community-friendly.

Some of the challenges were: a) Because of high levels of local stigma and discrimination, the TG/Hpopulations hide their identification and so, the sub-event approach was not able to reach the 100 percent TG/H community in their locality. b) These communities keep frequently migrating to other districts of Odisha as well as other states of India for their livelihood. c) The young TG/H people migrating thus from the various interior districts of Odisha, do not have appropriate knowledge on the importance of undergoing the STI examination and HIV testing is a major challenge for SAKHA hence. d) Fear-factor associated with the transgender community, myths and misconceptions related to HIV among the TG/H people continue to keep them away from proper access to the health services.

Initially, there were issues in the recruitment and understanding of the process of implementation. As the leadership remains to be dependent on the CBO head, decisions were, in turn, delayed, lead the project to sink into a lack of expected target achievement. The project could only reach 43% of its first 90 targets. They have been provided with the flexibility of adopting community-based testing services. This has not been used at the cost of benefit to the communities. This particular innovation has provided lots of insight into the programme managers and designers. Mainly, the way CBO, staff and head



coordinated for the innovation project needs thorough understanding. This is one of the emerging epidemics settings in the region and this particular innovation project's HIV testing showed a 5.2% positivity, which is on the higher side when compared with the national average.

The project oriented the staff team, conducted government and stakeholder sensitisation for real partnership, periodic sub-events, a mega event and listed activities, as per the budget. The doctors' training could not get materialized. The project team is oriented by the Regional Manager about the project. The project has been given adequate sub-events to reach as much population as possible. The sub-event concept helped the team reach out to many TG/H populations. However, the process of reaching them with services was challenge. The community-based testing services had not been mobilized enough to reach every door step of the communities for their HIV screening.

There was a lot of discussion between the field mentor and the project head over the phone. Despite being in the same town, the CBO head was totally engaged in other local activities. This has major affected

the implementation of the project and they were focusing only on the activities that has been budgeted. The project team was not available to dispense the services to the communities and because it was looked at only as extra work, even the social entitlement services area was not fully covered. The lessons learnt would help in better programme implementation, active community engagement and mobilising the resources for the communities. The HIV programme will concentrate only on HIV-related services and the other services demanded by the communities, therefore, need to be fastened from the line departments.

This table reflects the impact of the project. Even though it shows a high positivity rate, there is a need for big advocacy efforts to ensure treatment care to the population. The young population needs to be reached with immediate services. Efforts have been taken to provide STI related services as well. However, this has emphasized that even though the project period is closed, the services to the identified population has to be provided and the same has been shared with the Odisha SACS. The SACS and DAPCU meetings were held to discuss the project later.

The festival of Sitalasthi: The marriage of Shiva and Parvati is celebrated as Sitalsasthi, a major festivalof Utkal Brahmins since ages. It was started 400 odd years ago in Sambalpurafter the king of Sambalpur brought UtkalSrotriyaVaidika Brahmins fromBrahmin sasana villages of Puri district.Sakha has been doing a fashion show in Sambalpur in collaboration with the SitalasasthiJatra Committee, Sambalpur. So, this year, not only the fashion show but also, health service to the transgender and the hijra communities, who are gathering at Sambalpur for attending in SitalsasthiJatra have been arranged. Since the last five years, Sakha have been doing this event in collaboration with theSitalsasthiJatra Committee. In Sambalpur, the transgender and the hijra communities continue being a high-risk and vulnerable group.

A mega dance programme had also been organised and there was a gathering of 400-500 of general population. It was an opportunity to share the issues of the TG/H population for the CBO head toemphasise on the programmatic approaches. The renowned TG/H population, who are working for the cause, was also rewarded during the dance programme. The fashion show demonstrated the skills of TG/H people in continuation of the dance programme.

During this festival, there was a mass gathering of the TG/H population and there is a superstition that if the general public has sex with TG/H population during one of these days, it brings good fortune for them. So, the movement of especially male and youth population is high during this festival and this was the main focus of the project. The mega event organised during the initial days by SAKHA, reached out to around 70 people with HIV testing services through health camps. But, if this could have been organised during the last two days of the festival, there would have been a potential to reach, at least, 500-1000 of the TG/H population and we should have involved all the existing targeted intervention in the district for mobilisation and district authority involvement also could have increased the reach of the programme.

There were dynamics and it is better to accept. The community dynamics and politics, sometimes, tend to disturb the real purpose of the programme and it ended in not reaching the expected results and a rough line listed estimation of the TG/H population in the state through this festival. But this festival has lots of opportunity to penetrate into TG/H population in the state of Odisha and the Odisha SACS should focus on this festival and other such similar events, as they are interested in doing programmes with the TG/H populationwith the involvement of their district authorities.

Expectation from Stakeholders

There are lots of expectations from the respective SACS and constant funding support from CBOs. Nowadays, the SACS doesn't have adequate technical support and piloting innovation, as they are busy in looking after administrative and handling achievement of targets. They look forward to gaining active and genuine stakeholders and partner engagement in all spheres of the KP programme, for the reduction of HIV and new infections. The innovative projects and programmes with right intentions are welcomed with an open-door approach by the SACS.

Tracing the Implementers and Beneficiaries

Tracing the real implementers is the need of the hour. The commitment should always be laid on implementers with less monitoring and supervision. The needs emerge from the field and this has to be realised by the implementer. The current programmes are leveraging most of the resources on the project management, risk mitigation and monitoring. The active community engagement is crucial and this needs change. The second part is that beneficiaries should be educated, enhanced, empowered and should ask these projects/implementers to work for their communities, rather than achieving the targets on their own. These quality targets should be a part of the implementation programme, which is learnt through these pilots.

Community Empowerment and Dynamics

Community Empowerment refers to the process of enabling communities to increase control over their lives. "Communities" are groups of people that may or may not be spatially connected, but who share common interests, concerns or identities. These communities could be local, national or international, with specific or broad interests. 'Empowerment' refers to the process by which people gain control over the factors and decisions that shape their lives. It is the process by which they increase their assets and attributes and build capacities to gain access, partners, networks and/or a voice, in order to gain control. "Enabling" implies that people cannot "be empowered" by others; they can only empower themselves by acquiring more of power's different forms (Laverack, 2008). It assumes that people are their own assets, and the role of the external agent is to catalyze, facilitate or "accompany" the community in acquiring power[6] .

Community Dynamics is the process of change and development in communities. This needs detailed elaboration in this section, as the evidence and experience under this pilot initiative has played a major role in contemplating the development and progress of each activity and strengthening the community towards “Empowerment” vs “Dynamics”.

Community empowerment necessarily addresses the social, cultural, political and economic determinants that underpin health, and seeks to build partnerships with other sectors in finding solutions. The increased risk and vulnerability need to be understood in a polished manner where communities have to be oriented and empowered with the right information and knowledge.

Even with the available resource envelope under the programme, the demotivated reactions

6. **http://www.who.int/healthpromotion/conferences/7gchp/track1/en/**

from the communities standing as the major challenge in the implementation of the HIV-related prevention and treatment services to the intended population. The existing empowered communities have been so for as long as possible; no new generation in the last half decade in the country. The theory of second line leadership in any setup is absolutely right and it is need of the hour; in some places the empowered communities are striving for financial emancipation and political power rather grooming the second line leadership of communities.This has disturbed the implementation of program including reaching the unreached population. These are becoming the challenging dimensions of the programme and understanding the situation is much more complicated. The personal satisfaction, pleasure, power and relationship plays a vital role, nowadays, in community dynamics. The community is responsible for it, which increases delayed response and will lead to new infections.

The target and activity oriented programme monitoring affects the upcoming communities and garners less interest to participate in the entire journey. In this, the footpath finds lacunae in thelack of leadership, participation, interest, access to services, satisfaction and gained the impression that empowered community can have access to good services. This is the major challenge behind the community-led and or community-driven programme.

There is a need for a paradigm shift in the thinking of the entire process and to gain the motivation and trust from the real beneficiaries of the programme, which is the mandate of the hour in the country. The process has witnessed the direction, which everybody agrees; the situation is not equal and same in all regions. However, the emerging epidemics and the emergence of these kinds of responses will never compliment the target behind us (i.e) Ending AIDS by 2030.

Missing Opportunities

- The festival-based identification process could not yield the expected results due to the lack of preparation towards the programme and hence, no active engagement. Purposefully, the administrative bodies were not involved, which further resulted in the lack of penetration into the same.

- As expected by Delhi SACS, there was a plan to conduct a Gharana/Dera Leaders Consultation at the state level, which could have helped in planning the differentiated service delivery model among the leaders of the TG/H population in the state, but that which had to be foregone due to the lack of attention from the implementing agency and community ownership.

- There are, indeed, missed opportunities in the programme, implementation and lack financial resources leading to complications; the concerns of the communities looking for winning daily bread, for opportunities, for respect and dignity, for active engagement and change in their lives,for pro-active education engagement etc., could not be addressed properly, given the context of roles, divided departments and programmes.

- In Andhra Pradesh, we could have reached out to the rural based TG/H population. But, due to the delay in approval and owing to another project operating simultaneously in the same district, another intervention district had to be chosen and that took its own process time. There is still ample amount of opportunities to penetrate into the district and plan a proper targeted intervention programme; since the district does not have a targeted intervention program for the TG/H population, the same could have been materialized by mobilising and witnessing more rural-based population in the district.

Way Forward
Recommendations

Recommendations are restricted to the transgender/hijra population and the relatedlearning experience from the states of Delhi, AP, Karnataka, and Odisha since it will be useful for larger consideration.

1. Potential in penetrating virtual outreach among the TG/H population; may not be in complete agreement yet, but the scope has certainly been identified. There was a certain degree of reluctance initially due to the lack of prior knowledge on the subject. A precisely written, comprehensive process of using trained staff on social media management and people who can adhere to ethics of social media guidelines needs to be framed. The information related to the identities of communities needs to be protected based on the feedback; ensuring the same will further the number of those willing to take part in the HIV service delivery programme.

2. There is a lot of scope to gain access to the unapproachable population in the rural areas of India. The pilot showed that the majority of the population never reached out for HIV services as they are bound to the local culture and context. The national programme needs to resolve about addressing the rural TG/H population because the existing targeted intervention does not extend beyond the urban population.

3. The national programme is at the right stage now to think about the possible approaches to the different sub-populations of the TG/H population; using “one size fits all” approach may not yield the expected results, as there is a need to strengthen the ideals of the programme this time owing to the emerging epidemics in the newer pockets. One such approach could be the intervention among the Gharana/Deras; their participation in the HIV service delivery program is crucial as they handle the hijra system and manage at least 20-40 TG/H people in each of their houses.

4. The national programme would also need to put their efforts on event-based identification or/and festival-based identification and other testing programmes since such events, observed by huge gatherings of the TG/H population, hold an emotional association. Here, the respective SACS have to play a major role and provide all the support. The community-based testing services also need to be introduced. The programme, in addition, needs to adopt flexibility to fund the provisions for these efforts and reach the first 90.

5. The service unreached areas have a huge potential of taking or accessing the community-based HIV testing services and this should be acknowledged. A proper plan, competent staff, availability of commodities and adhering to the protocols of testing procedure will improve the quality of national programme. This becomesvery important during the time of financial constraints as investing the resources in an appropriate domain will yield results and thus, sustain the continuous engagement of the communities.

6. It is learnt from the pilot intervention that the community-based HIV testing needs adequate orientation, skill building, few technical items that should not be missed (for e.g.respectful treatment, carrying the kits ONLY in a cool box as prescribed by NACO to the field, point-to-point monitoring of the community, and the supply of kits and confirmatory tests (even this indicator could become a part of EQAS), etc.), planning the testing camps in advance, mobilizing the transgender and the hijra population and an overall positive approach towards the new dimension of HIV test will, in turn, ensure reaching the first 90 of 90:90:90 target in India.

7. There should be a mechanism of accreditation to the implementing agencies. A strategic plan needs to be in place to have good implementing agencies reach and teach some basic ethics to the communities and contributing to the national cause. The community engagement, mobilization and empowerment are highly crucial rather than having a target-driven drive by these agencies and moderated by the monitoring indicators and expectation.

8. Establishing shelter homes to the destitute transgender people and those who don’t want to be a part of any hijra system is very essential and it will significantly reduce the stigma, discrimination, violence faced by them on a regular basis and improve their lifestyle by getting educated on the sense of proud ownership of their bodies and their earnings, learning the employability skills, decision making, realising and maintaining their individuality,and finally, mainstreaming them with the rest of the society.

9. Identifying the potential of the emerging areas to address the issue of transmen in the country. The environment pillars that enable them to live their lives with dignity and complete the transition process need to be strengthened. Incompletion of the same would make them vulnerable to sexually transmitted infections, violence, discrimination and highly prone to HIV infections.

10. The concept of a Community Link Agent will be very effective in strengthening and sustaining the networking model. The Peer Educators concept thus can be replaced with CLAs, as PEs have become employers of the CBO/NGO, thereby questioning the original ideas like a concern for the community, motivational efforts, thinking beyond sexual behaviors and self-dignity. The CBOs are also in project mode and financial demands.

11. Most of the concepts and programs designed by the centre hardly match the demands and concerns of the different grass root levels. Hence, there is a need to design and develop programmes as area-specific, and necessitating the community involvement in all stages of the programme/project design. The situational need assessment (SNA) and enrollment campaigns should be led rather by the people in the community since there have been instances of outsiders, though highly educated, misguiding the community owing to little or no exposure.

12. A constructive coordination amongst SACS, TSU and DAPCU could address the identification/ enrollment and service delivery mechanism. Building a work force with required skills becomes crucial because despite being given preliminary training, many communities are ignorant about the why, what and how behind the implementation of the programme and the benefits; therefore, engaging the people post a clear articulation of the same will be more successful.

13. Many people, despite an exposure to the social media and technology usage, are still concerned by the basic principles of the communities they belong to and so, though they participate in the interaction and community mobilization, their involvement in the HIV related services access is decided by either system of the Gurus; their focus needs to extend beyond seeing only sex work and begging as priority, as it is high time, the risk and vulnerability to HIV infection needs to be emphasized. Their participation in the HIV program is very important as bringing them as goodwill ambassadors of the programme will power and lead the advocacy of the same among the TG/H population.

14. Developing concern for a co-community by the CM/CLA, roping in the Gurus to aid in the programme, mapping of the community by the community itself, DAPCU involvement at all stages, introducing CBS for HIV testing, building a partnership amongst CBOs and implementation of single project and a sensitization programme for Heath Care Providers on stigma and discriminationas progressive measures of the plan.

Learnings

1) As mentioned in the NACO's NationalStrategic Plan, different local based intervention models should be experimented based on the needs of the TG-H people and existing social and sexual dynamics. The fast-track models will help in reaching the unreached young TG-H people on time, and minimise the gap between reach – test – treat. The fast track models will strengthen the overall HIV prevention and treatment cascade.

2) The safe space concept for the TG-H people is not limited to DIC's anymore there are other non-traditional spaces where community collectivisation occurs. Hence has reiterated in the MTA report and from the key strategies implemented in the innovation programme, physical and virtual safe spaces should be targeted to reach the untapped TG-H people and provide services.

3) Physical spaces such as Dera's, religious and cultural events, community gatherings, hamaams and village panchayats and virtual spaces like Facebook, PlanetRomeo, Grinder and WhatsApp can be used for interventions to identify the unreached TG-H people and link with services.

4) As highlighted in the MTA, and one of the key recommendations from innovation programme, the needs of the TG-H people are beyond HIV/STI hence a holistic health model needs to be introduced taking care of all other needs including the gender transition and sex reassignment. Other provisions for education, employment, professional training and social protection schemes are available.

5) Investment in operational researchis required for evidence-based programming, due to the changing dynamics of the community and HIV transmission the data will inform the interventions to change and revamp strategies timely to increase the efficacy of the outreach models.

Conclusion

The welfare of the community should be always given priority over any target-driven approach as the latter tends to be monotonous in implementation owing to a lack of innovation in general and because the changes/provisions are usually made according to the beneficiaries' real interests. The challenges seen by the implementers and financial constraints, in addition, only generates a lot of conflicting situations.

Addressing the need is absolutely necessary to contain the spread of HIV infection. The real change comes from within and not just with funds and this has to be explained well. The BCC needs to pay more attention on creating an adequate and a consistently healthy environment that is especially devoid of stigma, discrimination, and violence among the transgender population.

Although put together in a short period with multiple project timeline restrictions and designed as per the demands of the hour, this project should certainly be seen as an opportunity to pilot certain creative and productive models among the TG/H population.This,therefore, needs further deliberations and duration-specific piloting in some of the states for large scale-up and reaching to the communities. The recommendations can be considered for further discussion and planning and development of national level programme design, consultation and in development of policies for the TG/H population.

By this document and some of the recommendations put forth, VHS believes that this will definitely contribute to the tasks and expectations of the National Strategic Plan for HIV/AIDS and STI 2017-24 and also address some of the challenges mentioned in the MTA of NACP IV.

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