A Report

Improving the service delivery among Transgender/Hijra people

Operational Research

Draft report
For Internal Circulation only

Supported by
SAVE THE CHILDREN (GFATM)

Conducted by
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Foreword

Dear Readers,

This report on operation research for improving the service delivery among Hijra / Transgender people talks about the findings and the recommendations with regard to the existing challenges faced by H/TG people in accessing services, the current emerging trends in outreach, the need for capacity building, the innovations that can be piloted in the ongoing interventions, steps to strengthen the existing TIs.

The report also quotes reference on the country scenario with regard to strategies in implementing TIs among H/TG people, the findings from IBBS study and mid-term appraisal conducted at the national level.

I am sure, the operation research findings done under the VHS-MSA-DIVA Project will be helpful for the entire team involved in implementing TIs among H/TG people.

Happy reading!

Best regards,

Dr.Joseph D Williams,
Director – Projects,
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SACS / TSU	:	Joint Director (TI), State AIDS Control Societies & team Team Leader & Program Managers, TSU team
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Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante-Natal Care
ART	Anti-Retroviral Therapy
BCC	Behaviour Change Communication
BMGF	Bill and Melinda Gates Foundation
BSS	Behaviour Surveillance Survey
CBO	Community Based Organization
CBT	Community Based Testing
CC	Core Composite
CDC	Centers for Disease Control and Prevention
CSM	Condom Social Marketing
CSO	Civil Society Organization
CST	Care, Support and Treatment
DAPCU	District AIDS Prevention and Control Unit
DNRT	DAPCU National Resource Team
DIC	Drop-In-Centre
FGD	Focus Group Discussion
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
IBBS	Integrated Biological and Behavioural Surveillance
ICTC	Integrated Counseling and Testing Centre
IDI	In-Depth Interview
IDU	Injecting Drug User
IEC	Information, Education and Communication
IPC	Inter Personal Communication
INFORCEM	Indian Network for Sexual Minority
M&E	Monitoring and Evaluation
MHC	Master Health Check up
MSA DIVA	Multi-country South Asia - Diversity in Action
MSM	Men who have Sex with Men
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
NRHM	National Rural Health Mission
N/S	Needles / Syringes
NTSU	National Technical Support Unit
OI	Opportunistic Infections
ORW	Outreach Worker
OST	Oral /Opioid Substitution Therapy
PBS	Polling Booth Survey
PE	Peer Educator

PHC	Primary Health Centre
PLHIV	People Living with HIV/AIDS
PPP	Preferred Private Provider
PPP	Private Public Partnership
PPTCT	Prevention of Parent to Child Transmission
PT	Presumptive Treatment
RAT	Research Advisory Team
RMC	Regular Medical Check-up
RNTCP	Revised National TB Control Program
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SAEP	School AIDS Education Program
SLP	State Lead Partner
SRS	Sex Reassignment Surgery
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TANSACS	Tamil Nadu State AIDS Control Society
TA	Technical Assistance
TB	Tuberculosis
TExSHARe	TSU Experience Sharing
TG	Transgender
TI	Targeted Intervention
TSU	Technical Support Unit
UNICEF	United Nations Children's Education Fund
USAID	United States Agency for International Development
VHS	Voluntary Health Services (Chennai)

1. Introduction:

1.1. About The Voluntary Health Services (VHS):

The Voluntary Health Services (VHS) is registered as a non-profit society under the Societies' Registration Act, 1860. VHS was founded in 1958 by Dr. K.S. Sanjivi, an eminent physician and visionary leader who drew inspiration from Gandhian thought and was guided by the philosophy of "*unto the last*". VHS is governed by a Board of Trustees comprising distinguished persons from diverse fields. The Central Committee and Sub Committees are represented by senior Government officials, renowned medical professionals, prominent patrons and philanthropists, respected community leaders and experienced social workers. The institutional strength of VHS is encapsulated in its visionary governing body, strong management team, experienced professionals, enduring partnerships with key stakeholders, well defined organizational policies, effective project management systems and efficient financial management processes.

The ethos of VHS embodies the continuum of care model providing preventive, promotive, curative and rehabilitative care to patients through a central tertiary care hospital networked with 10 peripheral Mini Health Centres offering basic clinical care and outreach services to surrounding communities. The community health program of VHS has been widely acclaimed as a pioneering model for delivering essential medical services at a proximal point from people's residence. Eminent doctors, dedicated nurses, skilled paramedical personnel and committed staff have made valuable contributions to nurture and strengthen the institution and ensured continued access to affordable and quality health care for the poor and disadvantaged people.

Over the past 59 years, VHS has evolved into three divisions: (1) Clinical and Academic Affairs; (2) Hospital; and (3) Projects. Today, VHS is a 465 bedded multi-speciality tertiary teaching hospital with 23 clinical departments delivering affordable and modern medical services to the poor and lower income groups. A range of basic medical services are available at VHS including Medicine, Surgery, Obstetrics, Gynaecology and Paediatrics, specialities such as, Cardiology and Orthopaedics and super-specialities namely, Neurosurgery, Neurology and Rehabilitation. Other medical departments comprise of Diabetology, Ear, Nose and Throat (ENT), Community Health, Ultrasound and Psychiatry. The hospital has a well-equipped Intensive Care Unit (ICU) and a non-commercial Blood Bank.

VHS plays an important role in building the capacity of the country's human resources. VHS is a nationally recognized Post Graduate training institution accredited by the National Board of Examinations (NBE), Ministry of Health and Family Welfare, Government of India (GoI) for courses in the branches of General Surgery, Gynaecology, Obstetrics and Neurosurgery. The Medical Council of India (MCI) has recognized VHS for Senior Housemanship in General Medicine and General Surgery. VHS organizes a number of Continuing Medical Education (CME) programs, panel discussions, lectures, symposia and workshops to expose students to current knowledge and latest scientific developments. Formal and non-formal training programs in Community Health are offered at the VHS Model Health cum Training Centre.

The Department of Clinical Research has been recognized as a Scientific and Industrial Research Organization by the Department of Scientific and Industrial Research (DSIR), Ministry of Science and Technology, Government of India. VHS manages several scientific research projects through research

units attached to the respective departments, with papers published in leading scientific indexed journals. The Y.R. Gaitonde Centre for AIDS Research & Education (YRG CARE) was established by VHS to provide HIV counselling, testing and treatment services including Anti Retro-viral Therapy (ART) and management of Opportunistic Infections (OIs), conduct research and generate community awareness.

Experience in HIV/AIDS Programs: Since 1995, VHS has spearheaded comprehensive, multi-layered and high impact community centered programs on STI/HIV/AIDS prevention, treatment, care and support for vulnerable and key affected populations in India and select countries in sub-Saharan Africa. Over the past 20 years, VHS has administered projects valued at nearly US$100 million, which includes HIV/AIDS focused projects worth nearly US$80 million. VHS has established and institutionalized robust project management systems and processes to ensure that grants awarded by donors are effectively managed and utilized for the purpose received.

As one of the principal nodal agencies implementing STI/HIV/AIDS programs, VHS has fostered productive collaborations and resilient partnerships with Government of India's National AIDS Control Organization (NACO) as well as national level line ministries, state level departments, district administration, State AIDS Control Societies (SACS), Technical Support Units (TSUs), District AIDS Prevention and Control Units (DAPCUs), service delivery units, Civil Society Organizations (CSOs), Key Populations (KPs), positive people's networks and private sector.

VHS has been providing Technical Assistance (TA) to the National AIDS Control Program (NACP) for more than 10 years, most recently for the Mid Term Assessment of the National AIDS Control Program. As part of the Mid Term Assessment, VHS supported the review of assessment tools, data collection, analysis, dissemination and coordination of field visits. VHS has played a strategic role in HIV policy formulation at the national level by serving as Chair of the Technical Resource Group (TRG) on Targeted Intervention (TI).

VHS has been a member of Technical Sub Committees and Working Groups on prevention, care, support, treatment and communication constituted by NACO for planning NACP phases II, III and IV. VHS contributed to the formulation of NACP IV as a member of the national team led by NACO in discussions with the Planning Commission, Government of India.

Collaborating with national, state and district level governments, civil society organizations, key populations, positive people's networks, international donors, sub-Saharan African country governments and private sector, VHS programs have reached nearly 1,25,000 key affected populations over the past two decades.

Approach: VHS has invested in a key population owned and led model that positions key populations at the centre of programming and empowers them to lead, design, deliver, monitor and evaluate their own interventions. This replicable and scalable model is grounded in participatory approaches, nurtures autonomy, promotes community engagement and strengthens institutional capacity. VHS has implemented several innovative and high impact prevention programs for key populations, fostered close partnerships with Civil Society Organizations and key stakeholders and built institutional capacity of partner organizations for improved service delivery.

VHS has made important contributions towards reducing structural barriers faced by key populations and people living with HIV, expanding their access to quality health services, sensitizing key

stakeholders, building capacities of CSOs/CBOs, addressing stigma, discrimination and violence, advocating for human rights, enhancing linkages to social protection programs and enabling sustained key population led responses to the HIV/AIDS epidemic.

1.2. Brief about Multi-country South Asia - Diversity in Action (MSA-DIVA) Program:

Vulnerability to HIV among Transgender/Hijra people remains high compared to other high risk groups. High prevalence and incidence of HIV among TG/Hijra people has increased their socio-economic vulnerability. With funding support from the United Nations Development Program - Asia Pacific Regional Centre (UNDP-APRC), Voluntary Health Services (VHS) initiated the MSA-DIVA project to address the vulnerability of TG/Hijra people and improve their quality of life. The program is supported by The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM).

The three main areas of focus of this project are: (i) Creating an enabling environment through sensitization programs; (ii) Building capacities of TG/Hijra people intervention teams; and (iii) Advocating for policy level changes.

MSA-DIVA project is providing technical support for effective implementation of the TG/Hijra Targeted Intervention (TG-TI) program in selected states under NACP IV, with guidance from the National AIDS Control Organization (NACO) and in partnership with State AIDS Control Societies (SACS). The project also advocates for the promotion and protection of rights of TG/Hijra people.

The **goal** of the project is to reduce the impact of HIV on Men who have Sex with Men (MSM) and TG/Hijra people in South Asia.

The **objectives** of the project are: to improve the delivery of HIV prevention, care and treatment services for TG/Hijra people, to improve the policy environment for TG/Hijra people and HIV related issues and to improve strategic knowledge about the impact of HIV on TG/Hijra people.

1.3. Terminologies used – TG/Hijra people[1]:

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 subgroup-specific HIV prevention and care interventions, and policies. Until recently, HIV programs in India included transgender women under the epidemiological and behavioural term - 'Men who have Sex with Men' (MSM). However, it is increasingly recognized 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:

***"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

[1] *Operational Guidelines for Implementing Targeted Interventions among Hijras and Transgender People in India, National AIDS Control Organization.*

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 formalized 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.

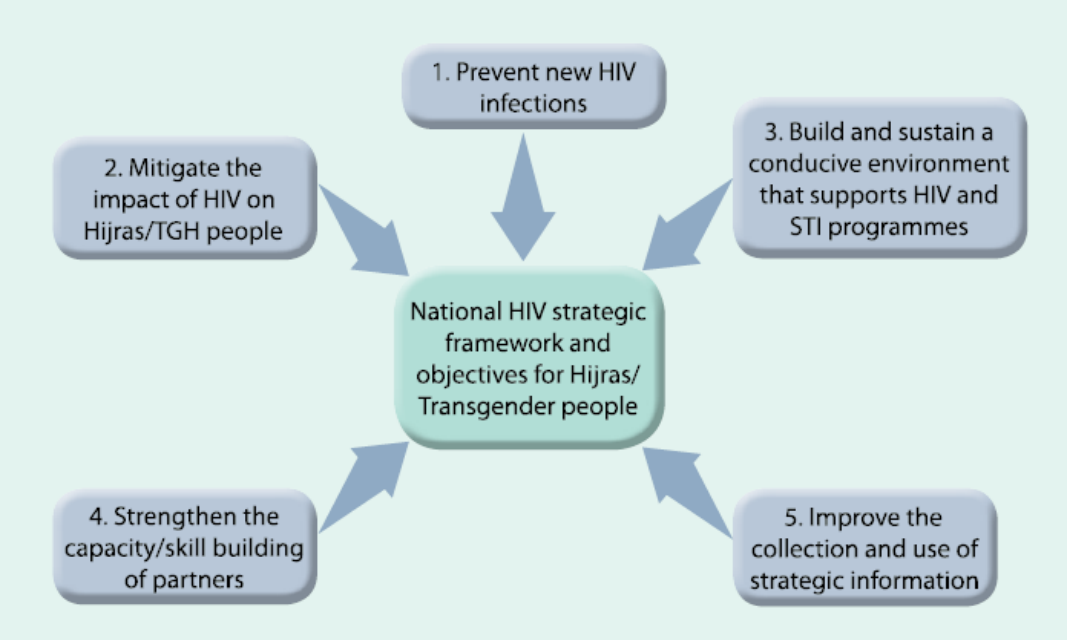
"Transgender" – Consensus definition by Hijra and Transgender – Hijras communities**:** "Transgender persons usually live or prefer to live in the gender role different to the one assigned to them at birth. It is an umbrella term which includes trans-sexuals, cross-dressers, intersex persons, and other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

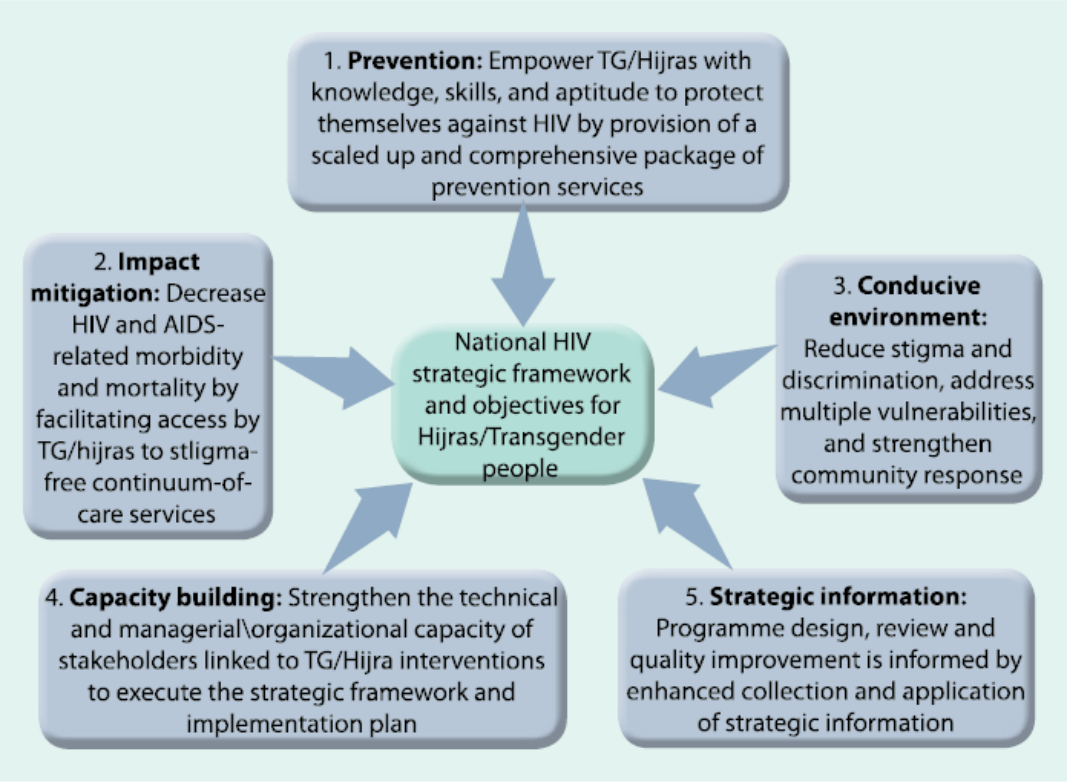
> ***Explanation:*** The term 'transgender people' is generally used to describe those who transgress social gender norms. Transgender is often used as an umbrella term to signify individuals who defy rigid binary gender constructions, and who express or present a breaking and/or blurring of culturally 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, postoperative 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 maleto-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.

1.4. Intervention programs for TG/Hijra people – An overview:

1.4.1. NACO strategies[2]:





[2] *Operational Guidelines for Implementing Targeted Interventions among Hijras and Transgender People in India, National AIDS Control Organization.*

1.4.2. Mapping[3]:

As per the recently conducted DAC- 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). 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.

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

	Location of the site								
	Total			Rural			Urban		
	PE	LL	UL	PE	LL	UL	PE	LL	UL
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

[3] *Operational Guidelines for Implementing Targeted Interventions among Hijras and Transgender People in India, National AIDS Control Organization.*

1.4.3. 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 4 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 sero-surveillance. HSS 2010-11, with samples recruited from three sites, shows 8.82% prevalence among Transgender – Hijras/Hijra 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%[4] among Hijras. In South India, a study documented a high HIV seroprevalence (18.1%) and Syphilis prevalence (13.6%) among Hijras[5]. A study conducted in Chennai documented high HIV and STI prevalence among Aravanis: 17.5% diagnosed positive for HIV and 72% had at least one STI (48% tested seropositive for HSV-1; 29% for HSV-2; and 7.8% for HBV)[6].

Published data on sexual risk behaviours of Hijras 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, among Hijras/Transgender – Hijras, the condom use during last anal sex with commercial male partners and with non-commercial male partners is 85% and 81% respectively. Also, the survey documented low levels of consistent condom use among Hijras/Transgender – Hijras: 6% with commercial male partners and 20% with non-commercial male partners.

1.4.4. Targeted Intervention program for TG/Hijra people[7]:

Targeted Intervention (TI) program is one of the most important prevention strategies under NACP. TIs comprise of preventive interventions working with focused client populations in a defined geographic area where there is a concentration of one or more High Risk Groups (HRGs). The key high risk groups covered through Targeted Interventions (TI) program include: Core HRGs such as Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgender/Hijra (TGs), Injecting Drug Users (IDU) and Bridge Populations such as Migrants and Long Distance Truckers. People from high risk communities are engaged to deliver services and act as agents of change, linking services with commodities provision. TI projects provide a package of prevention, support and linkage services to HRGs through outreach-based services delivery model which includes screening for and treatment of Sexually Transmitted Infections (STI), free condom and lubricant distribution among core groups, Social Marketing of condoms, Behaviour Change Communication (BCC), creating an enabling environment with community involvement and participation, linkages to integrated counseling and testing centers for HIV testing, linkages with care and support services for HIV positive HRGs, community mobilization and ownership building and specifically for IDUs, distribution of clean needles and syringes, abscess prevention and

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[4] 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.

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

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

[7] Annual Report 2016-2017, National AIDS Control Organization.

management, Opioid Substitution Therapy (OST) and linkages with detoxification / rehabilitation services.

The national program continues to provide program services at the "doorsteps" of the HRGs adopting the peer led approach through partnering with NGOs/CBOs along with State AIDS Control Societies (SACS) and Technical Support Unit (TSU) taking the role of mentoring and supervising the TIs.

Performance of TI Program during 2016-17:

Coverage of core HRG group: The data for coverage is derived from monthly performance indicator reports received by NACO. The coverage has decreased as compared to the last year (2015-16). This is because of delayed or no reporting from some states. The FSW and MSM coverage is the highest among all groups at 65% exclusive TIs for TG was initiated in 2014 and hence the coverage is lower than other core groups. New strategies, guidelines and modules have been developed and are being rolled out to increase the coverage of TGs.

The number of clinic visits made by HRGs during 2016-17 along with the proportion of STI clinic attendees diagnosed and treated for STI/RTI during 2016-17. The bridge population is showing higher number of STI/RTI episodes vis-à-vis FSW/MSM/TG/Hijra and IDU population. This is due to the fact that the NACO guidelines suggest that HRGs from core groups should visit STI clinics every quarter, especially for regular medical check-up and for treatment of Sexually Transmitted Infection (STI) / Reproductive Tract Infection (RTI). However, there has been a decrease in the STI detection among Bridge Population from last year.

HIV testing and ART linkages among HRGs: As per the NACO guidelines all core HRGs should be tested for HIV once every six months. Amongst IDUs, TGs and Truckers, the HIV positivity is higher. The positive detection among all the typologies is consistent with the previous year.

However, among Bridge Population, the treatment cascade is a challenge owing to their mobility. Discussions are being undertaken through Technical Working Groups to re-design interventions what will be able to address the gaps.

More than 80% of the PLHIV identified among core group are linked to ART centers. Community based testing might be able to increase the linkages among bridge population.

Condom distribution among HRGs: As part of the National Program, a lot of emphasis is provided on keeping all sexual encounters protected by consistent and correct usage of condoms. To ensure this, condoms are distributed to HRGs as per their requirement.

Capacity building of TIs: Under NACP-IV, State Training & Resource Centers were envisioned to provide sustained support and enhance quality of interventions through training and developing the capacity of TI projects staff. Since the STRCs were discontinued, NACO identified development partners capable of undertaking capacity building of all typology of TIs and conducting training programs. As a part of it, the Voluntary Health Services (VHS) has been identified as a training institution for conducting training programs for TG/Hijra people in Pan-India except North-East.

State wise distribution of TIs on TG intervention supported by NACO:

S. No.	State	No. of intervention	Coverage
1	Ahmedabad*	1	306
2	Andhra Pradesh		1141
3	Arunachal Pradesh		0
4	Assam		264
5	Bihar	0	0
6	Chandigarh	0	105
7	Chhattisgarh	0	627
8	D & N Haveli		0
9	Daman & Diu	0	0
10	Delhi	6	6003
11	Goa	0	0
12	Gujarat	1	1222
13	Haryana	0	0
14	Himachal Pradesh		0
15	Jammu & Kashmir		0
16	Jharkhand		127
17	Karnataka	2	2043
18	Kerala	7	2343
19	Madhya Pradesh	0	0
20	Maharashtra	5	3847
21	Manipur	0	0
22	Meghalaya		0
23	Mizoram	0	0
24	Mumbai*	4	3529
25	Nagaland	0	0
26	Odisha	1	2056
27	Puducherry	0	102
28	Punjab	0	0
29	Rajasthan	2	584
30	Sikkim		0
31	Tamil Nadu	2	3115
32	Telangana		311
33	Tripura	0	0
34	Uttar Pradesh	2	2514
35	Uttarakhand		104
36	West Bengal	1	235
	Total	**34**	**29325**

1.4.5. Key observations from MTA[8]:

Targeted Interventions for Key & Bridge Populations – Progress and gaps against targets, recommendations & priorities identified in NACP IV: Targeted Interventions (TI) for key and bridge populations has been the core prevention strategy under National AIDS Control Program in India. Key population includes Female Sex Workers, Men who have Sex with Men, Transgenders & Injecting Drug Users, while bridge population includes migrants & truckers. TIs are implemented as NGO/CBO-led peer outreach model to provide a package of prevention services including behavioural change communication, condom promotion, prevention and management of STI, community mobilization and enabling environment, and linkages to HIV testing, care, support & treatment. Needle syringe exchange program and Opioid Substitution Therapy are provided for prevention of HIV among IDU.

The Targeted Intervention (TI) program under NACP-IV proposed intensification of strategies by building synergies and strengthening service delivery systems based on local evidence. Overall, the goal of NACP IV was to reach out to 90% of key population through 2703 TIs. Setting up TIs in the Northern States was identified as a challenge, as the current model required an NGO or CBO to be available in the district who was interested in and capable of taking on the TI. Where this had not been possible, saturation remained a challenge.

The overall coverage of TI program is summarized in the table below:

Thematic Group	Mapping Estimates (2009)	Program Targets (NACP IV)	Covered under TIs (2015-16)	Percentage Coverage
FSW	8,68,000	9,00,000	6,78,423	75.38
MSM +TG/Hijras	4,27,000	4,40,000	2,72,322	61.89
IDUs	1,77,000	1,62,000	1,30,800	80.74
Migrants	72,00,000	56,00,000	32,97,748	58.88
Truckers	20,00,000	16,00,000	10,95,400	68.46
TG+Hijra (separate since 2013)	75000		25486	33

Year wise number of Targeted Intervention programs (2012-2016) implemented are as below.

Years	2012-13	2013-14	2014-15	2015-16
FSW	515	547	498	472
MSM	184	189	158	141
IDU	277	295	271	247
TG /Hijra	21	21	33	37
CC	407	440	455	424
Migrants (Transit)	64			
Migrants Destination	251	289	307	272
Truckers	87	92	96	84
Total	1806	1873	1818	1677

[8] *Mid-Term Appraisal of National AIDS Control Program Phase IV – Aug 2016.*

The coverage of total number of HRG population has declined from 1,199,305 in 2012-13 to 1,081,585 as of March 2016. The number of TIs was reduced from 1873 in 2014 to 1677 in March 2016. This reduction in TI coverage is due to a reduction in the number of TIs and in reduction of the coverage of the remaining TIs in few States. A number of TIs that were terminated because of unsatisfactory performance were not replaced in 2014-15 due to decreased funds available to NACO and SACS. The coverage of TIs, calculated out of set annual targets, varies by the type of HRG. In the year 2015-16, it was highest for IDU (81%), followed by FSWs (75%) and then high risk MSM and transgender (TG) (62%). There was an increase in distribution of condoms for FSW, MSM and IDUs. Against the footfalls, the number of episodes of STI treated has declined over the period of last five years. Progress has been made in increasing HIV testing among HRGs with testing rates of over 70% by March 2016. Positivity rates among those tested have decreased over time. In the last seven years, the program has identified around 50,000 PLHIV (cumulative) from among key populations out of which more than 90% were linked to ART.

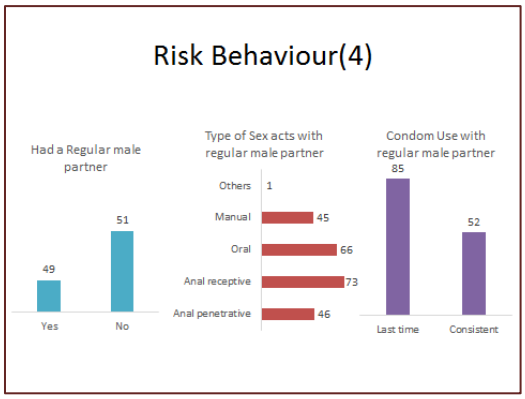
Some TIs carry out interventions for spouses and partners of HRGs although there is no clear policy or guidelines on how to reach this group and what services should be provided. Strategies, activities & targets need to be formalised by issuing clear policies and guidelines to the TIs. Also, indicators and targets needed to be developed for monitoring these interventions. A special focus is needed on prevention among sero-discordant couples.

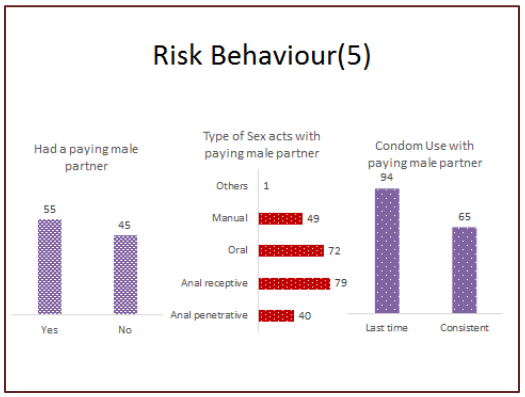
***Transgenders/Hijra*:** NACP IV identified Transgender/ Hijras as a group that requires special focus and separate prevention strategies. The following key priorities were identified for TG/Hijra interventions.

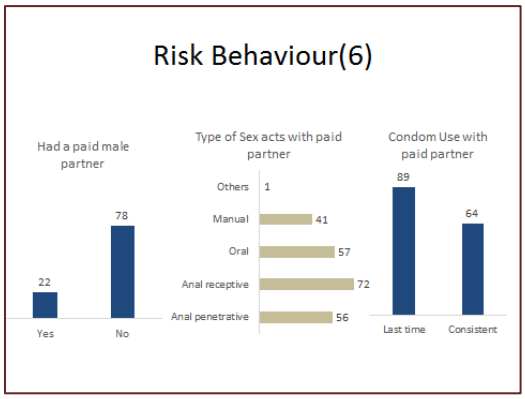
- Separating intervention strategies for TG/Hijras and initiating exclusive TIs for TG/Hijra community.
- Scaling up of comprehensive prevention package (including sexual health, risk management, mental health & positive living, advocacy and crisis response & life skills program) to achieve significantly increased coverage, particularly where TG – Hijras are concentrated.
- Building the technical skills and organizational capacity of NGOs/CBOs to manage TG/Hijra interventions; to build TG/ Hijra resource pool.
- Strengthening the involvement of TG - Hijras in HIV/AIDS response through community development and mobilization.
- Strengthening the partnership between government, NGOs, CBOs, TG- Hijras and technical assistance providers for an improved program management capacity at all levels for TG/Hijra interventions.
- Reducing stigma and discrimination against TG – Hijras.

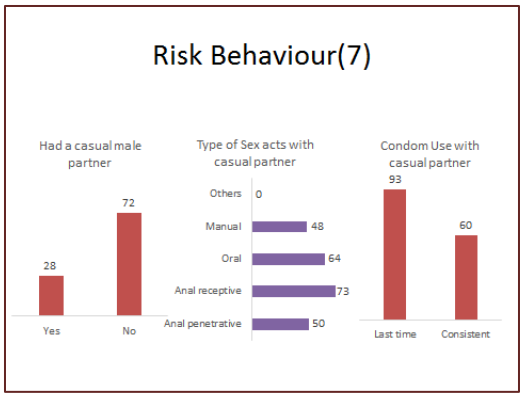
It was estimated that 1 lakh TGs will be covered during the NACP IV period. Mapping of TGs in 17 States has resulted in a population estimate of approximately 70,000. Current coverage through 37 exclusive and 70 core composite TIs is estimated at 25,483(36%), which represents an increase from 14,080 and 21 TIs in 2012-13. Condom distribution against demand has declined from 79% in 2012-13 to 62% in the year 2015-16.

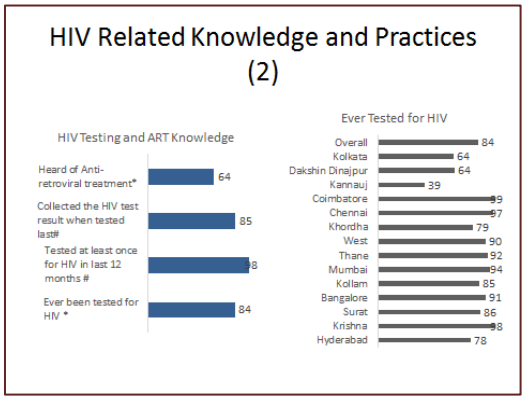
1.4.6. IBBS study findings on TG/Hijra people:







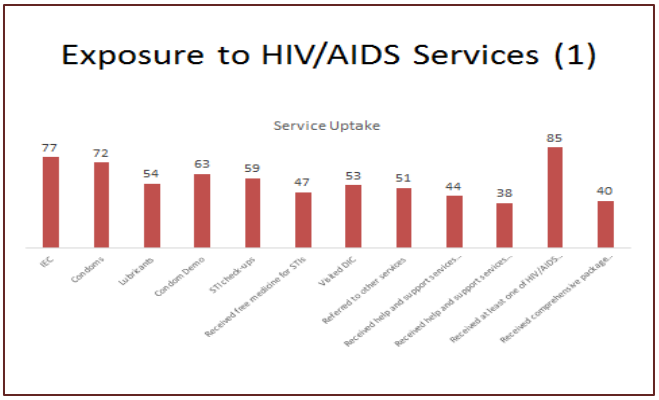




HIV Related Knowledge & Practices (3)

Table 9.1 Stigma and Discrimination, H/TG National IBBS, 2014-15

State	Domain	N	Treated disrespectfully by family/friends/neighbors because of being a H/TGs	Felt that treated differently than other persons in hospitals because of being a H/TGs
Telangana	Hyderabad	301	76.8	59.6
Andhra Pradesh	Krishna	348	83.7	61.9
Gujarat	Surat	398	29.6	21.6
Karnataka	Bangalore	391	40.9	27.3
Kerala	Kollam	246	35.5	19.8
Maharashtra	Mumbai	385	54.3	48.1
	Thane	374	39.2	32.1
Delhi	West	396	62.9	58.8
Orissa	Khordha	395	73.4	41.3
Tamil Nadu	Chennai	362	49.5	29.0
	Coimbatore	385	51.1	33.4
Uttar Pradesh	Kannauj	356	49.7	58.1
West Bengal	DakshinDinajpur	256	22.3	14.8
	Kolkata	373	27.0	11.0
Overall		4966	49.8	36.7



2. Research methodology:

2.1. Introduction:

Transgender/Hijra people are one of the most at risk, vulnerable and affected populations among marginalized groups practicing high risk behaviours. Given their tendency to engage in unprotected oral and anal sex with multiple sexual partners (regular, casual and paying), alcohol use before and during sex and poor health seeking behaviours, TG/Hijra persons are highly susceptible to STI and HIV infections.[9,10] Mainstream society considers expression of one's true gender identity as deviant behavior and shackles such persons to endure a lifetime of multi-dimensional deprivations. From a health systems perspective, TG/Hijra persons experience considerable social, cultural and structural barriers that prevent them from accessing HIV related services or availing social protection schemes. Barriers include social stigma, systemic discrimination, bad attitudes of health care providers and law enforcers, shortage of drugs, poor understanding about TG/Hijra persons, criminalizing legal provisions and absence of safe public spaces.

Staff and counsellors at Targeted Intervention (TI) projects and STI clinics may not have adequate knowledge and skills to address the unique life experiences and behaviours of TG/Hijra persons. Consequently, even those who come to TI Drop-In-Centres (DIC) or access health facilities for screening and regular medical check-ups view the visit as an imposition, inconvenience and burden rather than an opportunity to improve their quality of life. Being disowned by family, dispossessed of property rights, shunned by society and facing systemic barriers, TG/Hijra persons are drawn towards the Gharana/Jamath and owe primary allegiance to their Guru. During a time of intense distress and impoverishment, the Gharana/Jamath offers solace, protection and a sense of belongingness.

Anecdotal evidence from the Multi-Country South Asia - Diversity In Action (MSA DIVA) program, being implemented by VHS with support from Save the Children, indicates that up to 70% of TG/Hijra persons belong to a Gharana/Jamath. Sex work is the primary occupation for two-thirds of all TG/Hijra persons and three-fourths of Gharana/Jamath based TG/Hijra persons.[15] Against this backdrop, identifying TG/Hijra persons, reaching out with critical HIV related information, distributing condoms, promoting safer sexual practices, linking them with HIV and sexual health services, social entitlements and sensitizing health care providers remain formidable challenges.

2.2. Problem Statement:

Reaching out to TG/Hijra persons and linking them with HIV related health services and social protections have been important thrust areas under the fourth phase of the National AIDS Control Program (NACP-IV). Recognizing the necessity of a differential approach, the national program envisaged establishment and scale-up of exclusive targeted interventions for TG/Hijra persons through community participation and focused strategies to address their vulnerabilities.[9]

Since 2012-13, a separate TI program for TG/Hijra persons has been structured and implemented across India by the National AIDS Control Organization (NACO). Starting with 21 exclusive TG/Hijra TIs, the

[9] National Integrated Biological and Behavioural Surveillance (IBBS) 2014-15: High Risk Groups. December 2015. National AIDS Control Organization.
[10] National AIDS Control Program Phase-IV (2012-2017): Strategy Document. Department of AIDS Control.

program has scaled-up to 34 TIs in 2015-16. The 34 exclusive TG/Hijra TIs, along with 209 core composite TIs, cover around 29,000 TG/Hijra persons in 18 states. A comprehensive package of services is being provided including, sexual health, risk management, mental health, positive living, advocacy, crisis response and life skills program.[11]

Despite concerted efforts from multiple stakeholders, the program has managed to reach only 40% (29,000) of the total mapped population (70,000) of TG/Hijra persons.[12] Consistent condom use is low and service uptake is sporadic. The Gharana/Jamath is a powerful influence and overwhelming presence in the lives of TG/Hijra persons. Without consent from the Gharana/Jamath, TG/Hijra persons cannot take independent decisions about their well-being, practice safer sex or access health services.

There is a need to inquire into and understand what the critical enablers are that would powerfully reach out to the hidden population, address the ground realities and needs of TG/Hijra persons, bring them to the service facilities and end the cycle of HIV infections. Given the widespread use of mobile phones for contacting and picking up clients, which conventional outreach strategies are unable to capture and address, there is a need to look into a technology driven solution. Efforts must be intensified to address specific needs of the community, increase enrollment in the program, promote consistent condom usage, improve service uptake and facilitate access to social entitlements.

A deeper and nuanced understanding of the sexual dynamics, practices and behaviours of TG/Hijra persons across varying geographies and local contexts, influence of social network (Gharana/Jamath) on sexual health decisions and evolving modes of soliciting clients would help develop practical strategies for strengthening outreach, tailor programs based on need, empower the community to consistently access HIV and STI services, inform policy decisions and contribute to the reduction in new infections.

National Integrated Biological and Behavioural Surveillance (IBBS)[11] - HIV Prevalence: The TG/Hijra community has emerged as a high risk group, contributing significantly to the overall HIV prevalence in India. At the beginning of NACP-IV, a rising epidemic among TG/Hijra persons was identified as a key concern and challenge for the national program.[9] The National Integrated Biological and Behavioural Surveillance (IBBS) carried out in 2014-15 among groups practicing high risk behaviours attempts to understand and analyze the HIV related risk behaviours and prevalence among TG/Hijra people. The study estimates that 70,000 TG/Hijra people are living across 18 states in India, with a national HIV prevalence of 7.5%. There are regional variations in prevalence rates with pockets of high prevalence observed in Maharashtra (Mumbai 12.1%, Thane 23%), Odisha (Khordha 9.2%) and Tamil Nadu (Chennai 8.2%).

HIV prevalence for TG/Hijra people has remained at unacceptably high levels for a number of years, with only a marginal decline from the 8.8% rate recorded by HIV Sentinel Surveillance conducted in 2010-11.[13] Among high risk groups, HIV prevalence for TG/Hijra people is second only to Injecting Drug Users (9.9%). HIV prevalence recorded among Female Sex Workers (FSW 2.2%) and Men who have Sex with Men (MSM 4.3%) are much lower.

[11] Mid-Term Appraisal of National AIDS Control Program Phase-IV: Technical Report. August 2016. National AIDS Control Organization.
[12] National IBBS Among Hijras/Transgender People: Key Findings. Power Point Presentation. December 2016. National AIDS Control Organization.
[13] HIV Sentinel Surveillance: A Technical Brief 2014-15. National AIDS Control Organization.

In 2015, the national adult (15-49 years) HIV prevalence was estimated at 0.26% (0.30% among males and 0.22% among females). The trend nationally has steadily declined from an estimated peak of 0.38% in 2001-03 with similar consistent declines observed among men and women.[14]

- **Demographic Characteristics**[11]: The IBBS study found that HIV prevalence rates tend to rise with age, peaking for TG/Hijra people who are 35 years of age and above (9.9%). Among 15-19 years old adolescents, HIV prevalence is comparatively low (3.2%). Non-literates (11.2%), currently married (10%) and those involved in sex work/masseur (10%) are also at greater risk. TG/Hijra persons who are married and engage in unprotected sex with others are not only putting themselves at risk but also exposing their spouse and babies to HIV infection. In such instances, they form a bridge for HIV transmission from a high risk group to the general population.

  Sexual encounters in lodge / hotel appears to present a higher risk for contracting HIV (14.2%) compared to other locations, such as home / rented home (5.8%) and public place (7.4%). In a surprising finding, HIV prevalence among TG/Hijra people consistently using condoms is higher (8.1%) than those who reported inconsistent condom use (5.5%).

  Despite high literacy levels (close to 90% can read and write), relatively high educational attainment (nearly 50% have 10 or more years of schooling) and forming the employable life stage (nearly 50% fall in the 25-34 years age group), only a small proportion of TG/Hijra people reported to be in formal service (3.5%). More than two-thirds (70%) of TG/Hijra people are primarily engaged in sex work, badhai, begging and manual labour.

- **Risk Behaviour**[11]: Early initiation of sexual activity is common among TG/Hijra people with a quarter reporting having sex by 14 years of age and a majority (56%) engaging in sex before they turn 18. For every three out of 10 TG/Hijra people, their first sexual encounter is forced. Although a large proportion (more than two-thirds) of TG/Hijra people are practicing oral and anal sex with either regular, paying or casual partners, consistent condom use is relatively low (65%). Engaging in unprotected sex places them at high risk for acquiring HIV. The Targeted Intervention project and their staff are the primary sources for obtaining condoms followed by chemists, partners and health facilities. More than 50% of TG/Hijra people consume alcohol before or during sex. Drug use is quite low (3.7%), however, among those who do inject drugs one third share needles and syringes exposing them to HIV risk.

- **Technology**[11]: Contemporary telecommunication channels are being increasing preferred by TG/Hijra people for contacting and picking up clients for sexual activity. Nearly nine out of 10 TG/Hijra people use mobile phones and one in four use the internet to solicit clients.

- **Exposure to Violence**[11]: Physical and sexual violence are commonly experienced by one in five TG/Hijra people. The perpetrators include goondas, law enforcers, strangers, family members and clients. However, only a small number (about 20%) approached either the NGO staff or law enforcement officers for assistance. Predominantly, victims chose to remain silent or confided

[14] India HIV Estimations 2015: Technical Report. National AIDS Control Organization and National Institute of Medical Statistics, Indian Council of Medical Research.

within their community, to a friend or family member. Injury sustained from sexual violence increases the chances of STI and HIV infections.

- **HIV Related Knowledge and Practices**[11]: A substantial majority (80%+) of TG/Hijra persons have heard about HIV/AIDS, have tested for HIV, understand the major routes of transmission and know about key prevention methods. Despite high levels of awareness among TG/Hijra people, only half have comprehensive knowledge of HIV/AIDS. Nearly 50% are not familiar with mother to child transmission of HIV and a third have not heard about anti-retro viral treatment.

- **Stigma and Discrimination**[11]: Stigma and discrimination is widely prevalent in society adversely affecting the lives of TG/Hijra persons. Being treated disrespectfully by family, friends, neighbours (50%) and health care providers (37%) is a common occurrence. Family rejection, stigma and discrimination by mainstream communities, difficulties finding and keeping jobs and challenges in adapting to work places drives TG/Hijra persons into the margins of society and forces them to engage in sex work and begging. Stigma and discrimination are important factors that restrict access to health services for TG/Hijra persons and increase their risk and vulnerability to HIV.

- **Exposure to HIV/AIDS Services**[11]: Most (85%) TG/Hijra persons have received at least one HIV/AIDS related service through the TI program. The number of TG/Hijra persons covered by the TI program has increased in the past few years (18,000 in 2014-15 to 29,000 in 2015-16).[3,15] However, many at risk and vulnerable (60%) are still failing to receive the comprehensive package of services. Less than half receive help and support services when faced with violence or come in conflict with the law. Nearly 50% have not visited the Drop In Centre or been referred to other services. The most common service provided to TG/Hijra persons include IEC and condoms. Early detection of HIV through screening at Integrated Counselling and Testing Centres (ICTCs) have fallen short of expected levels. Nearly one-third of Men who have Sex with Men (MSM) and TG/Hijra persons have neither registered with a TI nor tested for HIV.[10]

2.3. Title:

Operational Research on improving the service delivery among TG/Hijra people.

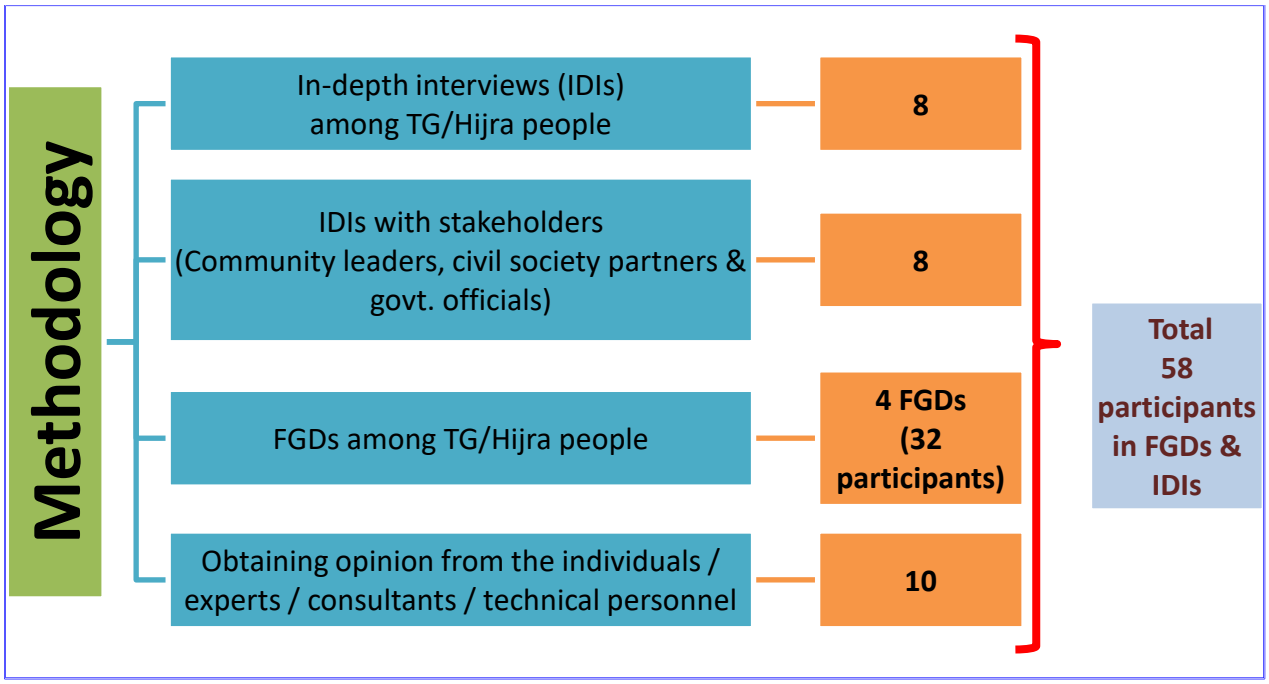
2.4. Objectives:

- To identify the current challenges faced in implementing the existing package of TI services for TG/Hijra people;
- To develop appropriate practical strategies for reaching out to 'hard-to-reach' TG/Hijra people; and
- To offer recommendations for improving the service delivery, consistent condom usage, application of information technology.

[15] Annual Report. 2015-16. National AIDS Control Organization.
[15] Mapping and Size Estimation of Hijras and other Transgender Populations in 17 States of India. Technical Report. A study conducted under the aegis of NIE-ICMR, UNDP and National AIDS Control Organization. 2014.

2.5. Methodology and Sampling:

The methodologies adopted for the qualitative study will include: Focus Group Discussions, In-Depth Interviews with community members, secondary review, etc. The following pictorial representation clearly demonstrates the details on the sampling on each methodology along with the number:



Study sites from different regions / states	In-depth Interviews		FGDs among TG/Hijra people	Obtaining opinion from the individuals / experts / consultants / technical personnel
	In-depth interviews (IDIs) among TG/Hijra people	IDIs with stakeholders (Community leaders, civil society partners & govt. officials)		
Site-1	2	2	1	
Site-2	2	2	1	
Site-3	2	2	1	
Site-4	2	2	1	
Total	**~ 8**	**~ 8**	**~ 4 FGDs (32 participants)**	**10**
Thus, a total of about 58 participants in FGDs and IDIs				

2.5.1. Profile of the sites identified for FGD and data collected:

Region	Name, address & contact details of the site	Type of organi-zation	Years of experience in implementing intervention among TG/Hijra people	Category of districts based on Prevalence	Type of intervention (composite / standalone)	Target and reach			Gaps in the service uptake	
						Target	Reach	% of reach	STD	HIV test
North (MODERATE)	Darpan Foundation, Ray road Mumbai, Maharashtra	CBO	8 years	B	Standalone	721	650	95%	52%	90%
Central (BEST)	Kinnar Bharati, Patel Nagar, Delhi	CBO	12 years	B	Standalone	800	1200	150%	100%	100%
East (MOEDRATE)	Mitwa Sankalo Samhiti, Chattisgarh	CBO	5 years	C	Composite	1200	986	82%	40%	70%
South (BEST)	KYSS, D. No. 2-63, 13th ward, Matam veedhi, Pedana, Krishna district, AP	CBO	7 years	B	Composite	1539	1578	102%	100%	98%

2.5.2. Details on the In-Depth Interviews (IDI) conducted:

Category proposed	# of IDI	Site 1	Site 2	Site 3	Site 4
In-Depth Interviews (IDI) among TG/Hijra people		**Mumbai**	**Delhi**	**Chhattisgarh**	**Andhra Pradesh**
Jamath based community member	1				✓
Gharana based community member	1	✓			
Mobile based (moving to different locations) Hijras / TGs	1			✓	
Community member operating through technology (mobile phone)	1		✓		
Community member operating through social media (web)	1				✓
Peer educators	1		✓		
Community member who has availed services from the intervention for more than 2 years	1			✓	
Community member who has recently joined in the intervention (undertaken services for less than 1 year)	1	✓			
Sub total	**8**	**2**	**2**	**2**	**2**
plans for conducting eight in-depth interviews among stakeholders (Community leaders, civil society partners & govt. officials):					
Community Leaders	2	✓			✓
Civil Society partners	2		✓		✓
Technical experts	2		✓	✓	
Stakeholders	2	✓		✓	
Sub total	**8**	**2**	**2**	**2**	**2**
Grand total	**16**	**4**	**4**	**4**	**4**

2.6. Data Collection tools, data collection, analysis and development of report:

2.6.1. Description of the tool:

The developed following two different tools and the details on each tool are also narrated below:

- ***Guidelines for conducting FGD***: Developed guidelines for conducting FGD for facilitating uniform administration and ensuring coordination. The guidelines for facilitators and documenters included the following:

  - Invitation, registration and consent
  - Guiding principles in conducting FGD
  - Overall plan for conducting FGD
  - Role of recorder
  - Role of facilitator
  - Facilities and aspects to be taken care of while conducting FGD
  - And other details

- ***Profile Format***: Developed a profile format and collected information from each of the participant participating in the FGD. This format had provision for collecting information such as: date, place, name (if willing), sex, age group, category (experience in years associating with intervention), typology, availability of mobile phones and other details.

- ***Questions for conducting FGD:*** Developed FGD guidelines for facilitating the Focus Group Discussion to elicit the qualitative information for understanding the aspects such as:

  - Emerging sexual behaviours, networking and dynamics among TG/Hijra people.
  - Effectiveness of current strategies in reaching out & delivering services to target groups.
  - Existing challenges in access to services such as: STI, HIV testing and condom.
  - Efforts need to be undertaken to overcome the challenges and enable the TG/Hijra people to access services.
  - Suggest any of the experimental models which has worked in enhancing the service uptake with similar target groups.
  - Recommended strategies / approaches for addressing the existing gaps including refining the intervention approaches, service delivery strategies and any new intervention components that need to be incorporated.

  The tools has been developed in English and translated into the respective languages for effective conduct of Focus Group Discussions.

- ***Tool for In-Depth Interview:*** Developed a tool for conducting In-Depth Interviews with appropriate modifications for each category of the community / stakeholders, etc. Broadly, IDI has nine questions including: personal profile, association with the intervention, existing challenges in the ongoing intervention program, emerging sexual behaviours and networking dynamics, effectiveness of current strategies and intervention, existing challenges and efforts need to be undertaken to overcome challenges.

This has helped in collecting common information and specific information considering the nature of the association with the intervention and providing strategic suggestions. The tools has been developed in English and translated into the respective languages for effective conduct of In-Depth Interviews.

- ***Pre-testing of tools:*** The FGD guidelines and IDI tools were pre-tested by conducting a mock exercise. This has helped in standardizing the questions, avoiding unwanted questions, considering the time limits for eliciting information through FGD, avoiding stigmatized questions, etc.

2.6.2. Data collection:

- ***Identification of investigators and training***: The study identified facilitators for conducting FGDs, recorders for documenting and recording the FGD findings. These facilitators and documenters have also been oriented on the importance of the study, purpose, methodology, guidelines on conducting FGD, briefing on the questions, how to elicit answers / responses, do's and don'ts, guiding principles, reporting mechanism, etc. This has helped in making the team to understand the importance of the study, their role and ensuring uniformity.

- ***Selection of respondents for ID and FGD***: Based on the sampling methodology, by adopting random sampling, the participants for FGD was selected and involved in the FGD.

  The facilitators and documenters has collected consent forms from each participant participated in the data collection process.

- Focus Group Discussions (FGD): Administered the FGDs in each site by engaging a dedicated team trained for this purpose. The aspects such as: privacy, enabling environment, comfortable situation, enough spacing, provision of drinking water and tea & snacks and other aspects have been taken care of. In each FGD, eight members have participated. In Mumbai site, 10 members have participated with the overwhelming response. The FGD was conducted for about 75-90 minutes without affecting the flow of information and interactions.

  The recorder cum documenter has undertaken efforts to record the proceedings and interactions with the permission of the community members. In addition, played an observer role and documented the key suggestions emerged during the process of FGDs.

- ***In-depth Interviews (IDI)***: Trained team supported with questions for conducting IDIs was involved in conducting IDIs and collecting qualitative data. Each IDI was conducted between 20-40 minutes by using the questions. The respondent for IDI has also been briefed on the purpose of the study and builds rapport through informal interactions to enable him/her to share the challenges, issues and suggestions without any inhibitions.

  Overall, 16 IDI was conducted considering the time and resource constraints. Information collected from IDI has helped in validating the information collected through FGD.

2.6.3. Data consolidation and analysis:

The information collected through the FGDs have been documented by the documenter. Each FGD report has also been transcribed based on the recordings conducted in the respective sites. The team reviewed the information collected through FGD in each site. Also, consolidated the suggestions emerged under each question for easy review and analysis.

Similarly, the reports on IDI were also reviewed. After a review, consolidated the key suggestions emerged from the IDI in a format for consolidation and review.

2.6.4. Preparation of report:

The research team developed the report on "Operational Research on improving the service delivery among Transgender/Hijra people". This report is summarized under the following chapters:

- Introduction
- Research methodology
- Findings
- Recommendations
- Annexures

2.7. Limitations of the study:

- This study is considered as a rapid assessment in the form of Operational Research focusing on qualitative study.
- This study is limited only to the interventions being implemented among the TG/Hijra people both by NGOs & CBOs.
- This study more focused only on community perspectives and minimal on key stakeholders' perspectives.
- This study is limited to intervention among TG/Hijra people, but not made efforts to compare the different interventions (MSM, FSW, etc.).
- This study has not been undertaken in all the interventions being implemented in the country only sample of sites has been identified and collected data – considering the resource constraints.
- The suggestions emerged as a part of the study may need to be further explored for understanding the intensity associated with the suggestions for addressing the gaps.
- The study has not considered the administrative aspects, budget aspects, etc. This study has focused primarily on possible suggestions for addressing the gaps in uptake of services by further strengthening the ongoing interventions and systems.
- Unable to collect the required number of In-Depth Interviews from Mumbai considering the unexpected heavy rains, limitations in mobility, non-availability of network and communication system, etc.
- This study has not undertaken analysis and review on the state wise data and gaps in the service uptake due to focus was on qualitative study and evolving factors.

2.8. Data collection and findings:

2.8.1. Consolidated summary of Focus Group Discussion findings:

Part 1 – Administrative details:

Name of the site	Mumbai	Delhi	Kurnool (Nandyal) – Andhra Pradesh	Chattisgarh
Date	28/08/2017	26/08/2017	26/08/17	26/08/17
Name of the facilitator	Mr. Manoj Jani	Mr. Manoj Benjwal	Mr. Lenin Shyam	Ms. Akanksha Dubey
Name of the documenter	Dr. Attar Quereshi	Mx. Deepak Thakur	Mr. Srinivas	Mx. Yasha
Name of the CBO coordinated the FGD	Aarju Foundation	Kinnar Bharati	Suraksha Sangham (KNL)	Mitwa Sankalp Samiti
Total number of participants in the FGD	10	8	8	8
Language in which FGD conducted	Hindi-Marathi	Hindi & English	Telugu	
Time	5:45 pm to 7:30 pm	5:00 pm to 6:20 pm	2:40 pm to 4:15 pm	

Part 2 – Profile of the participants:

Age group	Site wise age group profile in %				Average
	Mumbai	Delhi	Andhra Pradesh	Chattisgarh	
18 – 25	30%	25%	50%	20%	31.25%
25 – 35	30%	62.5%	10%	30%	33.12%
36 – 45	20%	12.5%	30%	30%	23.12%
46 and above	20%	-	10%	20%	12.5%

Category of participant attended the FGD:

Association with HIV/AIDS Intervention	Total no. of persons	Typology	No. of persons
Less than 1 year	2	Hotspot based	18
1-2 years	7	Non-hotspot based	10
2-3 years	11	Jamath based	6
3-4 years	6		
Above 4 years	8		

Availability of mobile phone with the participants attended the FGD:

Availability of phone	No. of participants having mobile phone				Total (%)
	Mumbai	Delhi	Kurnool (Nandyal) – Andhra Pradesh	Chattisgarh	
Using ordinary phone without internet facility	1		2	1	**4 (12%)**
Using ordinary phone with internet facility	8	3		7	**18 (53%)**
Using high-end phone without internet facility		5	5		**10 (29%)**
Using high-end phone with internet facility	1		1		**2 (6%)**
Using tab					
Any other, specify					

Part 3 – FGD details:

3.1. Emerging sexual behaviours, networking and dynamics among TG/Hijra people:

Typologies:

→ The intervention addresses the following **typologies** in Hijras;
- Nirvan Hijra
- Akwa Hijra
- Transsexual
- Daagi/Behrupia or Dandel Hijra
- She-Males
- Inter-sexed
- Kothi
- Cross-dresser (CD)/ Drag Queens
- Hijras based on their Vocation/Profession: (1) Sex Workers (2) Mangti Hijras (3) Dhol/Badhai Hijras (4) Hijras who are working in Dance Bars

→ People are using internet facility for cruising site, some of the people are operating sex work from their home because home based client are paying more money. Road based people are doing sex work because they do not have any other source of cruising for earning.

→ Guru chela dynamics and Jamath system dynamics and aqua and Nirvaan dynamics.

Reaching out the typologies:

- → The Intervention is able to reach the Hijras that stay as part of a congregation (with their Guru or with their chelas or with their guru-bhais) or in groups or at identified sex work sites (red light areas). The Kothi typologies that are mostly occasionally available are often catered by the MSM Interventions. The She-Males, Inter-sexed and Cross-dressers are mostly found online (via social media) and are not that easily accessible. There are some Hijras who stay independently (and not in their traditional congregation, who are sparsely accessible by the intervention. Most of them are accessible at the time of a major event or function within the community.
- → We are reaching to the people through contact number for mobilization and conversation, some of the people are living in group so that outreach in very easy for us. We are using WhatsApp group for us to spread our massage.
- → Two big hurdles due to different typologies to access the services are the fear of disclosure of their sexual identify, non-availability of doctors who understand their sexuality and most important point is that the community does not like to show their private parts to the doctors or other health providers.

Emerging new networking & sexual operations and possible approaches:

- → Though the community has been able to maintain their traditional and cultural identity (The Guru-Chela Parampara and the Gharana Systems), there are some changes seen in the modern times. The community in the past was more concentrated in terms of their living but these days it is found to be mobile and floating. With the advent of technology and social media platforms the population is migrating to its use. This newer networking avenues are especially seen amongst the younger or the newer members of the community or with the more affluent or education sections within the community.
- → The newer/younger generation of the community is Tech-savvy and is well connected through various WhatsApp Groups (Formal or Informal). Interpersonal Physical Communication and Collection at sites has gone down (though not stopped completely). The communication channels have shifted to the Mobile Phone. Access to Internet is also reported by the participants. Social Media also is playing an important role as the networking platform for the community. Many of the groups are regular attendees of the party circles (both within the MSM and the TG Communities). Events like Birthday Parties and Social Get-togethers are also organized within the community these days. Some of the typologies (like the She-Male, CDs and Drag Queens) are accessible through Social Networking sites like Grinder and Planet Romeo (PR). Some Hijras who cannot write (type) messages in English use 'Hinglish' or regional language text or simply send a voice recording.
- → People are using WhatsApp, Facebook, planet Romeo, Grindr TS (a new site), Vchat, YouTube, Instagram, ManZam, etc., because they are educated but still uneducated people are.
- → We are reaching to the people through contact number for mobilization and conversation. Some of the people are living in group so that outreach in very easy for us. We are using WhatsApp group for us to spread our massage. Now transgender people are much more trained and aware but they are not getting any job in any organization or any company. Some of the community members are providing spa and massage from their home any they are getting much more money from the client.

- → Rural to urban networking – Suraksha Sangham, Samatha Hijra Sangham, Indian Network for Sexual Minority (INFORCEM).
- → Gurus must be consulted, Jamath culture has been adopted.
- → Community members move from district to district within the state & move from state to state:
    - For long and short period
    - The period varies from two months to six months during seasons (e.g.,) in north India, in the form of "Launda dancers" as a group of 20-25 members, moved to many states for performing dance programs. Similarly, in Kerala, January to June, TGs move to different districts for participating and performing in the Hindu religious festivals.
    - For SRS, the community member may need to be away from the headquarters and stationed in other state / district for more than 45 days.
    - Average cost for SRS will be between 30,000 to 1.5 lakhs.
    - For GTRS (voice, breast, body hair, etc.), average cost will be 5-6 lakhs and they also need money for managing the consequences associated with that. Considering this, they are more focused on earning money and compromising on other aspects.
    - Need for comprehensive communication kit for TGs in the form of resource kit including flip book, flash cards, condom demo kit, etc.
    - This reason also shows as not reported or poor in seeking services. Hence, NGOs, SACS & NACO should identify these realistic gaps & develop systems for addressing the same.

Access and use of technologies:

- → The team members are access and usage of technologies (mobile phone, internet, Facebook, WhatsApp group, YouTube, Instagram, etc.) with the following technologies:

Type of phone	Average % of usage by community members			
	Mumbai	**Delhi**	**Andhra Pradesh**	**Chattisgarh**
Using ordinary phones without internet	30%	30-40%	25%	35%
Using phones with internet (Android)	60-70%	70-80%	75%	60%
Using tab	Rarely	2%		
Using laptop	10%	5%		
Other devices	Ipod etc…	Visiting card		5%

Considering the high level of usage of mobile phones with internet facilities, the community members suggested to introduce technology in the communication for comprehensive coverage, reaching the non-hotspot based community members and enhancing the service uptake.

The suggested methods may include but not limited to:

- → Sending voice based SMSing on specific day without any stigmatization primarily focusing on promoting service uptake/adherence.
- → Use of mobile phones as a communication device for screening video clippings on HIV/AIDS to communicate effectively as a part of IPC.
- → Sharing IT enabled video films / short films / audio messages to the outreach team for integrating and communicating effectively.
- → Using TV or tab for providing group education and effective communication.
- → The use of technology will also help in providing graded messages and overcoming the message fatigue and monotony.
- → These devices can also be used for advocacy and sensitizing the key stakeholders in the area.

"The younger Hijras and newer community members are available and have access through various social media channels.
There is an increase in use of social media and modern tools to access them"

Hindering the non-hotspot based community members to visit hotspot and seek services:

- → The hot-spots are used by community members but the newer/younger generation who is Tech-savvy and has access to technology uses social media, mobile phones and internet to connect with their clients. Moreover there are avenues available to such populations to service or entertain their clients. The traditional hotspots have de-merits which are a deterrent for the newer/younger groups, such as sharing the space with older members of the community, competition, bhilpan (trouble from various secondary stakeholders such as police or goons or the clients).
- → Another important issue highlighted was the inter-community dynamics. The participants reported of in-fighting/professional rivalry that exists between the individuals or groups (mostly in terms of earning a living through sex work). Some of the community members are perceived to be vocally abusive and pull legs of the others and that is a big turn off for many to access the hotspots. Independent Hijras are working in sex work on a flexible basis and restricted service timings are also a great barrier in access to service.
- → Around 30 to 35 percent community members are visiting our hotspot and they are getting our services.
- → They are always in the hidden population, due to their personal stigma and fear discloses.

3.2. How effective are current strategies in reaching out and delivering services to the target groups?

Opinion on the existing package of services:

- → The existing service packages are more HIV/STI focused. There is a need to provide a more Community specific package of services along with the HIV/STI services. The approach should be holistic rather than stand alone or just health focused. Though health is an important determinant to be factored in tailor making the service delivery package, it should not be the ONLY focus.
- → We are providing, Condom, Counselling, DIC, VDRL, HIV testing, STI testing.
- → They are satisfied with the existing services for target groups which are clubbed with the MSM community.

Additional core package of services suggested:

- → The respondents felt that following services should be added with the HIV/STI services;
  - Social Schemes such as access and linkage to Aadhar, PAN and Voter ID, Ration Card (PDS) etc.
  - Trauma Center for crisis Management
  - Income generation Avenues and Training
  - Sex Reassignment Surgery (SRS) Information Dissemination, Access to Safer and Cheaper avenues to avail such services. Either partial or complete SRS (including Laser Treatment for hair removal, breast implant surgeries, castration, emasculation and vagino-plasty, hormonal therapy, mental health)
  - Information and Education on the issues related to SRS
  - Funding Pattern of the NACO/MDACS/MSACS programs was a big concern. The shortage of funds in the overall program, especially the cut down in the Community Based Human Resources was a concern raised by the members.
  - Better Advocacy & Sensitization at Public Health & with various Govt., departments.
  - Formal or Informal Education for un-educate or illiterate members of the community
  - Better Housing and Living Conditions.
- → Will add hormones services, mental health & SRS related counselling, General checkup & medication, legal information about Transformation of gender need to provide by NGO.
- → Need to add specific Transgender Health related problems like Urinary Tract Infections and providing Mental Health Services from the TI.

Opinion on Prevention Plus services and package on Prevention Plus:

- → The respondents as mentioned earlier were asking again and again for social benefits that the citizen is entitled to. The respondents also wanted the 'Transgender Welfare Boards' in the States (as initiated under the directives of the Hon. Supreme Court under the NALSA Judgment) to be more active and carryout rigorous sensitization and advocacy programs. The Maharashtra TG Welfare Board should take example from the Tamil Nadu

> ***"We need more information on Sex Reassignment Surgery (SRS) and hormone therapy"***

and Andhra Pradesh (united AP) counterparts and show some better results.

→ As per community response they want mental health counselling, SRS related counselling, General checkup and medication, legal information about Transformation of gender need to provide by NGO.

→ According to the participants' opinion, the necessity to educate the Health Care Providers about the mental status of the Transgenders and expert counsellors to counsel on need basis services.

Effectiveness of peer educators program in promoting BCC and seek services:

→ The peer led model of outreach is effective and is working for the community. There is a strong networking within various groups through this sort of formal and informal peer based networks. The information about HIV, Condoms, STIs, etc., has percolated deep down within the community. There was a time when the Guru needed to be sensitized but today both the Guru and the community as a whole is very receptive of the information and aware about the services available.

→ Peer need to have separate area Peer is providing information about Aadhaar card and PAN card because this is very important to have ID's.

→ They need young Transgenders as peer educators involving in the health services and importance of the STI and condom usage must be imparted to the community through them.

→ Peer educators unable to reach the community members at the hotspot due to diversified geographical area.

→ There is no opportunity for the community members to seek services beyond the public facility both during the stay in the intervention are and while moving to other districts / other intervention areas.

> ***"Some of the peer educators are good old, working for more than three years of experience as peer educators. Not having understanding on the emerging dynamics…. Hence, they are unable to understand the emerging typologies and reaching this group".***

Opinion on the existing communication materials and IPC activities:

→ The participants feel that the existing communication materials and IPC activities should be more specific to the needs of the community (and not generic). There is a sense that these materials and activities should be in local/regional languages, include words and lingo used by the community. The Community based Human Resource is crucial to the dissemination of information. Community get-togethers and events needs to be reviewed (there is a cut down in the budgets from NACO). Newer communication materials and strategies need to be looked into. Information regarding SRS, hormone therapy etc., should also be included.

→ Technically we are able to provide information about HIV and STI, we required transgender specific IEC for the community.
→ Need to develop the IPC materials regarding Transgender lifestyle and their risk behaviour, develop the IEC Materials with the help of Transgender leaders on need basis. Specific meeting with the Transgender community to improve and avail the services, suggestions, case studies have to be discussed on individual lifestyles.

→ ***Gradation of messages***: Currently, the community members expressed that, the target groups may be classified into following categories:

Association with HIV/AIDS intervention	Average %
Less than 1 year	5-10%
1-2 years	10-20%
2-3 years	30%
3-4 years	25%
Above 4 years	15-20%

Considering this, the messages need to be graded into 2 (or) 3 phases for effective communication. For new entrance and people with less than one year of association may need to be provided with intensive communication. Similarly, if intervention does not capitalize the behavior change among these groups, it is very difficult to motivate them for behavior change and seeking services during subsequent years.

Reaching the new entrance, young groups and hidden groups through the intervention:

→ The existing interventions are unable to tap the new entrants, younger groups or hidden groups as effectively as the previous groups. There is a need to build capacity of the existing TIs and its staff to upgrade and reach out to such groups.
→ We are inviting people through Transgender networking group and Planet Romeo and Grindr and we are inviting to new and hidden population those are 18 year above and if under age person is coming to us we are treating them but out of office premises.
→ Intervention is not able to reach the Transgender community because it is a mixed group, uniform guidelines apply in this regard Transgender community is not able to avail the services. Anusri Transgender demanded separate Transgender Project for Transgenders where the focus is about Transgender issues and requirement.

Helpfulness of existing mentoring support:

→ The existing mentoring needs to be more focused and community driven. There are educated sections of the community that need to be roped in and given proper avenues to help the community.

Support of the SACS and TSUs in identification of CBOs, partnership development, providing financial support, technical guidance, mentoring support, capacity building, experience sharing opportunities, collection of reports and providing feedbacks, annual assessments, ongoing guidance, etc., are very much supportive and helps in improving the quality of the program and achieving the targets.

3.3. What are all the existing challenges in access to services such as: STI, HIV testing, condom, ART, HIV/TB, etc.?

- → Mostly people are using condom to prevent their self and they are using condom consistently some of people are using condom through private shop.
- → Mostly client are getting information by our NGO clinic but if someone comes detected with STI we are referring him/her at hospital.
- → People are having trust on our NGO so if we will provide service to them that would be good.
- → For HIV testing, Transgenders communities are not getting tested at ICTC due to self-stigma and disclosure.
- → For Transgender community, among 8 participants, only 3 are using condoms for intercourse.
- → No specific STI treatment has been done for the participants though STI services are available in the TI.
- → HIV and TB test is a process which the community are not able to avail due to stigma and discrimination from the general population. The community is not ready to get tests done along with the general population. They are demanding for a separate HIV and TB testing centre at least at the district Headquarters.

Services	Existing challenges / hindering factors	
	At the intervention level including community perspectives	At the service facility level
Condom usage	▪ Lubrication, Quality, Size, Flavors (for oral sex not available), the Community does not buy Social Marketing Condoms (need to explore the cases). ▪ Majority of them avails condom from NGO office / ORWs. ▪ Few of them purchased condom from private shops – it is not being taken into account. ▪ Clients also bring condoms. ▪ Some of the community members are enrolled in the program – however they are not practicing or engaged in sex trade, hence, they don't use condoms. ▪ Demo kits are not available. ▪ Introducing social marketed condoms as a part of the interventions. ▪ The staff members are not able to counter emerging myth and misconceptions in the context of TG/Hijra people. ▪ Condom outlets are not available in the new areas (beyond hotspots) – considering the emerging non-hotspot based approaches. ▪ The TG/Hijra people operating through mobile phones will never visit hotspot and not accessing condoms. ▪ Introducing new condom outlets / vending machines at free of cost for TG/Hijra people.	▪ Availability
STI	▪ Medical Providers Apathy, Medical or Service Providers Attitude, Service Providers are not Sensitized. ▪ Mostly, target oriented approach. ▪ Peer educators incentivizing few members and few members not incentivized. ▪ The intervention team not communicating the date and time in advance. ▪ While not indulging in sexual activities (engaged in begging, become senior members, living with one partner / lover), having a feeling not	▪ Accessibility of services and Apathy and Attitude of the Providers ▪ Non-availability of trained doctors. ▪ Inconvenient timings. ▪ Stigma and discrimination. ▪ No specific day for TG/Hijra people. ▪ Awaiting for long time and over crowd in the STD clinics and undue delay in providing services.

Services	Existing challenges / hindering factors	
	At the intervention level including community perspectives	**At the service facility level**
	to go for treatment. ▪ Distance and non-convenient timing. ▪ About 20% of community members are either retired, not indulging in sex, living with one partner / lover, engaged in begging – hence, this group will not avail any of the services. ▪ Doctors negative approach in handling the community members. ▪ Taking treatment with the preferred HCPs but not accounted by NGO (self-reporting – requesting for evidences). ▪ More health conscious but not accounting to the NGO (being personal care). ▪ More compulsion from the CBO to avail treatment than voluntarily seeking services. ▪ More focused on earning and saving money for SRS and GTRS – necessitated to compromise on many aspects. ▪ Able to practice safe sexual practices which is not risk. Hence, not interested in availing services. ▪ More compulsion from the CBO to avail treatment than voluntarily seeking services. ▪ Peer educators reminding only when see the target community for testing and treatment (if not seen in the hotspot, no efforts undertaken to contact over the phone or other mechanisms to communicate). ***"Some of the community members are unable to access services due to various factors such as: inconvenient timing, untrained doctors, stigma, undue delay, overcrowding, non-availability of doctors, etc. Hence, how the service facility / team move towards the community to provide services at DICs".***	▪ Some days the doctor is not available – necessitates for double visits. ▪ Non availability of trained doctors. ▪ The TG/Hijra people are not visiting the facilities on different days – the NGOs/CBOs promotes accompanied referral in a day as a crowd. ▪ Frequent changes of doctors. ▪ Treatment provided by the training doctors than the trained qualified doctors. ▪ No dedicated day for TG/Hijra people to provide community friendly services.

Services	Existing challenges / hindering factors	
	At the intervention level including community perspectives	At the service facility level
HIV testing	▪ Community is well sensitized and willing, no-more a taboo or fears testing. Overall acceptance to testing and its results is prevailing in the community. Gurus are also promoting their chelas to get tested. ▪ Not indulging in sex – no necessity to go to testing. ▪ Names entered in the register but not reached by the outreach team. ▪ Need to visit two days – one day for testing and another day for collecting results. ▪ Self-stigma. ▪ About 20% of them are not indulging in sex with multiple partners – they are not realizing the importance of testing - if we re-classify these groups, we can achieve 100% of service uptake. ▪ Difficult to reach non-hotspot based team members. ▪ People migrate or moving from hotspot to non-hotspot. ▪ Some percentage of community members are migrating to other intervention areas for various reasons including seasonality, cultural programs, festivals, etc. ▪ Not involved in high risk behaviours (moved away from the trade) ▪ More compulsion from the CBO to avail treatment than voluntarily seeking services.	▪ There is Stigma and Discrimination faced by sections of the community. The Public Health Hospitals (Sion Hospital) discriminates the community on basis of their HIV status and refuses to provide SRs or other treatments. ▪ Some days over crowded. ▪ Counseling is focusing more on HIV – need more information beyond HIV. ▪ Stigma. ▪ Overcrowded. ▪ Non-availability of color coded kits. ▪ Non-availability of community preferred HCPs in the intervention area to seek services. ▪ Not accounting the testing taken outside the public facility. ▪ Not accepting the self-reporting on the tests undertaken at private labs.
ART	▪ There is a sense of normalcy within the community towards the ART. There is no stigma attached to the person who is HIV positive, but there is support within the community. There is a feeling that the medication can enhance life and quality of life. ▪ Community members are registered with ART center. ▪ There is no systematic mechanism to motivate and follow-up on the adherence. ▪ Need intensive counseling to motivate on drug adherence (mobility pattern, non-hotspot operations, no residence, not taking food properly, etc.).	▪ Availability and Apathy and Attitude of the Providers (in Government Hospitals- especially 2nd line ART and special mention of the discriminatory behavior of the Nuns of the Niramaya Niketan Care and Support Center in Navi Mumbai. ▪ ICTC takes up the responsibility in referring the tested positive. ▪ Due to mobility patterns. Some of them are not accessing nearby ART centers eventhough provisions are available.

Services	Existing challenges / hindering factors	
	At the intervention level including community perspectives	At the service facility level
HIV/TB	▪ Scared. Special mention of MDR TB. The Community is petrified to access services at the DOTS/TB centers (special mention of the Sewri TB Hospital). There is greater awareness of the RNTCP program and there is normalcy around the disease. ▪ Difficult to administer the medicines at regular intervals because of mobility patterns. ▪ The intervention is not giving much focus on HIV/TB. ▪ The peer educators and outreach team not trained on HIV/TB.	▪ Accessibility of services and Apathy and Attitude of the Providers. Cleanliness and hygiene of the centers is a big concern. ▪ ICTC and ART centers motivates tested positives to enroll and avail services.

→ Registering as targets of all TGs, but not all TGs are involved in sex trade (some of them do blessings, begging, participating in ritual performances / dance performances, serving as Jamath and guide people, etc.).
→ Consider the other benefits more very important than STD and HIV.
→ Discourage by Jamath leaders.
→ Needs to be away from interventions for SRS and GTRS for long time. Hence unable to access services at regular intervals. There is no provision to account such type of gaps.
→ Monotonous messages in IPC and follow-up communications. This factor also does not encourage the community members to get motivated to seek services. In addition, the peer educators and outreach workers generally speaks always only 2 (or) 3 messages, but, not communicating effectively in the context of community members.

"There is discrimination faced by HIV positive Hijras in the Government Hospitals (especially Sion Hospital). They refuse to operate and provide SRS to the HIV positive Hijra. The Hijras then have to go to private providers which are expensive"

→ Fewer opportunities for exchange of experiences and best practices related to achievements in access to services. No much interactions between the CBOs working for TG/Hijra people in exchanging innovations and ideas.
→ Mentorship from TSUs is regular, but not providing handholding and mentoring to overcome the challenges (requires newer job description and exposures for the TSU team).

3.4. In your opinion, what are all the efforts need to be undertaken to overcome the challenges and enable the TG/Hijra people to access services?

At CBO level	✓ Capacity Building and Training of the Staff, Attitude of some of the Community Staff is an issue that needs to be addressed (seeing and treating all the members equally), Professionalism in handling the community. ✓ Counseling profile need to change specially on legal process and sex change. ✓ Video audio facility, Game facility. ✓ HIV testing facility need to be done in NGO or CB roof. ✓ Mental health counselling need to be done at CBO level. ✓ TGs are more comfortable with Suraksha Sangham CBO where they get legal and social protection like house schemes, Aadhaar Card, Bank Account. ✓ Strengthening outreach team by capacity building of the peer educators and outreach workers on the emerging typologies and innovative approaches. ✓ Undertaking a study on the emerging dynamics and sexual behaviours for improving and re-strategizing the outreach plan. ✓ Classifying the enrolled community members into: o Hotspot o Moved away from hotspot o Living in intervention area but not indulging in sexual activities, etc. ✓ Coordinating with Jamaths available in intervention area for reaching both hotspot and non-hotspot based community members. ✓ Engaging Jamath leaders as peer educators for effectively reaching 60-80 community leaders.
At community level	✓ Peer & Community Leaders should take the most vulnerable and weakest along with them. ✓ Hijra conflict is coming at our center and some of the time they behaving very bad with our team that should be resolve. ✓ Community need to focus on equality. ✓ Community need to resolve each topic together. ✓ Community is not interested in health issue but they are not considering our self. ✓ Internal politics in Transgenders are more challenging, only one person (Nayak) will lead the entire group whether it is good or bad. This is the main obstacle to the Transgender community to overcome. ✓ Communication need to focus on increasing risk perception. ✓ Peer educators needs to adopt community friendly and not target friendly.
At SACS and TSU level	✓ Funding, Capacity Building of the CBOs, Advocacy and Mainstreaming efforts with Government Departments and CBO focused Human Resource ✓ Condom quality needs to be change because we required flavored condom for oral sex. ✓ TG specific IEC material required. ✓ General medicine also needs to be distributed. ✓ TSU staff should be from community so that he or she can understand us. ✓ All existing services are availed by the community but specific Transgender issues like health and legal services has to be focused in SACS and TSU levels.

	✓ The TSU team may help CBOs to overcome the gaps in service uptake. ✓ STI doctor may undertake visits to intervention sites in bike to provide services (adopting calendar of activities).
At NACO level	✓ Funding and CBO focused Human Resource & timely funding for the office. ✓ Documents load need to be lesser then current situation. ✓ The TRG members may also undertake visits to interventions. ✓ Developing new training manuals for counselors and doctors. ✓ Emphasize on provide counseling beyond HIV/AIDS including SRS, etc. ✓ Developing approaches & guidelines including on the mechanisms to reach non-hotspot based operating team, use of mobile phones, technology, etc. ✓ Develop systems for re-enrollment / Adhoc service uptake in the other interventions while community members move from one intervention to other intervention (currently the services availed in other areas are not taken into account).
At other stakeholders level	✓ Special mention of the Police (the community members face harassment and sexual abuse at the hands of the police). More Advocacy needs to be done. TG Welfare Board to be pro-active. ✓ NGO or SACS need to have a consultation with police with letter. ✓ We required support of Aadhaar card, PAN card so we need to have advocacy with them. ✓ In each district need to establish one legal cell exclusively for Transgenders to address their legal issues and problems. More focus must be given to rural level transgender issues.
Any other suggestions	✓ Income Generation Training and Vocations to be introduced for the community. ✓ SACS need to spread letter to send our stakeholder so that they can support us during project. ✓ Need to focus on young Transgenders lifestyles & opportunities and working in the mainstream. ✓ Continue to undertake national level and state level communication campaign on eliminating stigma and discrimination, increasing risk perception, condom usage, treatment for STI, positive living, etc., to create a demand and motivate people to seek services. ✓ Efforts may be undertaken to provide information on services available through SMS by using the existing helpline services.

"Request SACS and TSUs to organize series of experience sharing meets, workshops for identifying field level issues and evolving suggestions, introduce provision for undertaking pilots / innovations for identifying new approaches, etc."

"Use of mobile phones, technology devices, social media is the need of the hour for reaching, reinforcing and motivating to seek services – in line with this a road map for intervention among TG/Hijra people will be of more useful."

"Developing community friendly models such as: Satellite clinics, mobile STI clinics, collecting bloods from the field and testing at the labs, mobile ICTCs for promoting community testing, etc., will be of more useful to motivate community members to avail services without fail."

3.5. Suggest possible ways and means to overcome the current gaps in service uptake (what efforts will help in improving the service uptake at the intervention level) – discussions may be in general. The information may be collected and grouped into these categories.

Capacity building and technical update:

- → There is a need for building the Capacity of the CBO members, especially related to the communication and use of technology. Strategies need to be evolved to reach out to the newer and younger sections of the community which is accessible on social media and modern technology tools.
- → Training on HIV prevention, Training of each component to each staff, HIV testing from office means single prick from finger.
- → Developing updated training manuals covering beyond HIV/AIDS to counselors.
- → Need to have Cascaded Training to Transgenders on their specific issues like computer training, personality development and life skills.
- → Develop new technology enabled training materials to train the doctors both through onsite and offsite for enhancing their knowledge and skills and provide community friendly treatments.
- → Improve training system through:
  - Technical update series for NGOs/CBOs
  - Periodical training
  - Video materials to enable the outreach team to view and benefit on their roles and effective outreach.
  - Establishing demo sites for hands-on training
  - Develop mobile Apps for obtaining basic information on HIV/AIDS and services available.
  - Developing a network or e-groups or any other platform for facilitating experience sharing among all CBOs and NGOs working for TG/Hijra people.
- → Revising the roles and responsibilities of the Program Officers of TSU to provide mentorship on overcoming challenges, guiding on use of technology, etc.
- → Currently training program is being conducted for the project team including peer educators on program perspectives. Based on this, peer educator promotes IPC activities on one to one and one to group basis. Efforts may be tried out to introduce the group training for promoting behaviour change and health seeking behaviour.

"The TSUs and DAPCUs may need to play a vital role in addressing the field level challenges including improving the service facilities".

Package of services:

- → Need to be expanded to include more social benefits, SRS (as discussed above), Income Generation Avenues and Vocational Training, More Focused Advocacy.
- → SRS counseling to attract our community.
- → General medicine for community members.
- → Legal advice required for community because our community is on risk.
- → Prevention Plus services through other organizations.
- → Existing package of services may be continued.
- → System for prevention plus.
- → Emphasize on community friendly than target oriented.
- → The testing for people not indulging in multi-partner sex – may be once in a year not once in six months.
- → The guidelines on linelisting may be revisited and updated considering the field level challenges and realities.
- → Engaging part time experience counselor with good exposure to Reproductive Sexual Health (RSH), mental health services, etc., (providing counseling beyond HIV).
- → Currently, VHS-MSA DIVA project is providing services on Prevention Plus. Such services may need to be continued for all the CBOs for providing comprehensive package of services both through ongoing intervention and additional support from the key stakeholders.

Reaching the unreached (hotspot based and non-hotspot based):

- → Re-strategizing the Outreach approach and activities. Use of Technology and making the 'user friendly' services available. Multi-pronged approach to be adopted to reach the unreached sections of the community. Peer-KP ratio to be decreased.
- → WhatsApp group and social media based approach for mobilizing people.
- → Peer educator will visit to new and hidden population for uptake our services.
- → Engaging technology enabled person as M&E & using his expertise in using social media.
- → At each intervention, the NGO with the support of TSU and consultants may take efforts to study the mobility patterns and emerging trends in a detailed manner. Accordingly, the strategic efforts and approaches may be customized.
- → The outreach workers may be provided with mobile phones or internet facilities.
- → Transgender groups need to provide attractive schemes on their need based vis-a-vis talk about their risk behaviour, livelihood apart from sex work and begging.
- → Introduce technology & provision to use social media by CBO – internet, training, etc.
- → Undertaking a study to identify the mechanism to reach the unreached.
- → Appoint peer educators those who are community but operating through mobile network.
- → Introduce SMS based reporting from the peer educators and community members operating through mobile networks (beyond hotspot).
- → Introduce voice based SMSing for reminder on service uptake.
- → Identifying and engage the non-hotspot based peer educators with the experience in mobile networking models to reach their own groups through mobile, WhatsApp, and other networks.

"The traditional Guru-Chela parampara is alive and will never die, though there have been changes in the community dynamics and professions" – the Jamath based interventions may be of more useful."

"The list of names registered with the NGO may need to be validated by classifying into hotspot, non-hotspot, persons not indulging in sexual activities, but living in the intervention area, etc. This will help in who needs services and the gaps may be addressed easily".

"We are surviving for our livelihood…. We wish to avail services on HIV, but, we don't want regular disturbances from outreach team communicating only on HIV/AIDS…. It is sometimes irritating".

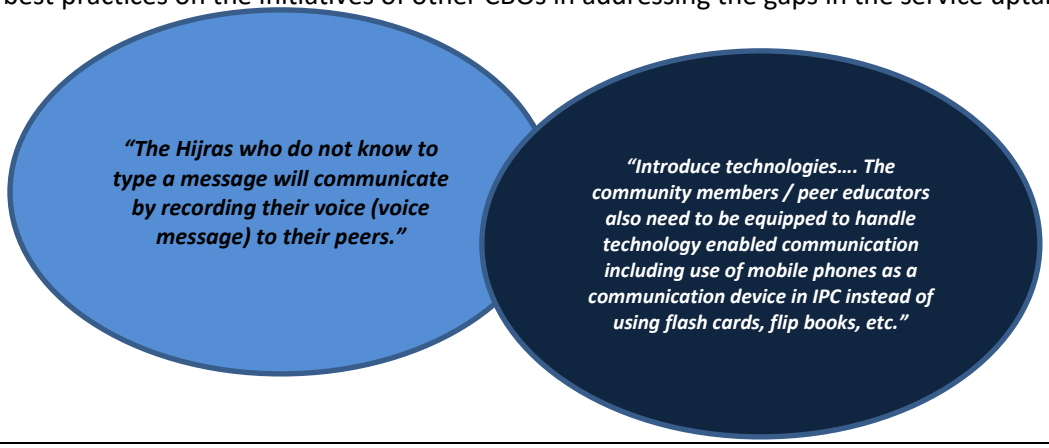
Service uptake (STI, HIV testing, linkage with ART, HIV/TB and condom usage):

- → The community appears more streamlined, but, service delivery system from Public Health Department needs to be streamlined and made more Accessible and Community Friendly.
- → HIV testing should be from CBO.
- → We will discuss with SACS for provide more services to the community members.
- → Introducing the blood collection system for HIV testing at regular intervals either at hotspot or at DICs by engaging trained technician or community volunteer. This will help in timely testing. The community members will be able to collect results in person.
- → Introducing community preferred HCPs.
- → Introducing cash voucher system to access services at the time convenient without affecting our regular activities.
- → Introducing mobile team to visit intervention area.
- → Self-reporting by the non-hotspot based operating team.
- → Introducing cash voucher system for community members to access services from recognized / authorized private clinics (time saving, no crowd, friendly approach, availability of services at community convenience, etc.).
- → Evolving mechanism for introducing extended timings in STD clinics for TG/Hijra people to seek services. This may be piloted in an intervention and scaled up.
- → Use the mobile STI clinics for intervention areas to promote testing through satellite clinics.

"The uptake of services needs much attention as a coordinated effort of outreach team and community members. Presently, the complacence and monotony is in existence. This needs to be addressed and new approaches may need to be undertaken".

Communication materials required to support the intervention (print, non-print including technology enabled if any):

- → More materials in connection with SRS and overall Social Schemes.
- → Transgender specific IEC material and flip book on SRS related services.
- → Softcopy IEC needs to be post on Facebook and WhatsApp.
- → Producing video / clippings to use by the outreach workers, peer educators in IPC activiites and sending us WhatsApp messages.
- → NACO can develop standardized messages for sending through WhatsApp. This will help respective NGOs/CBOs to share the messages at regular intervals through social media.
- → Need to focus on Transgender lifestyle on print and electronic media about their biological and mental status to get mainstreaming them.
- → Develop multi-media packages.
- → Provide instruments / systems to use videos, clippings, etc., effective communication.
- → Develop communication materials covering: a) on HIV/AIDS; and b) beyond HIV/AIDS, focusing on prevention plus, holistic care of TG/Hijra people.
- → The outreach team or M&E officer need to be trained on effective use of social media for introducing technology in the ongoing intervention and to reach the unreached including non-hotspot based operating team.
- → Introduce internet facility or provision or internet in the mobile phones of the outreach team for using social media to send reminder messages, share video clippings, etc.
- → The TG/Hijra people are maintaining different WhatsApp groups such as Angel group, Sweety group, Marina group, Rose group, etc. Each group is having about 100-200 members and these team members regularly shares information on general awareness, human rights, safety tips for protecting from the rowdies and other benefits.
- → However, community members expressed that, these groups will be used for promoting HIV/AIDS only during World AIDS Day. Suggested to use this platform for effective communication without disturbing the existing network mechanism and social networking.
- → To reach the unreached / hidden groups / non-hotspot based groups / high-end groups – self risk assessment Apps may be developed to enable the technology friendly community members to know the risk factors on their own and seek services.
- → Develop series of books for enhancing knowledge among the outreach workers with the best practices on the initiatives of other CBOs in addressing the gaps in the service uptake.



Innovations / pilot initiatives for improving the overall reach and service uptake:

- → WhatsApp based Outreach and Income Generation Activities.
- → Parlor and makeup training to the people, life skill education to the community people so that service will be uptake. Community event has to be done at our office.
- → Extended outreach work for ICTC team for introducing HIV testing in the intervention area.
- → Introducing community volunteers for blood collection.
- → Using mobile clinics for providing treatment for STI.
- → Specific TG Intervention on Health and Legal Services and also occupational skills.
- → Introducing web based system for self-risk assessment to enable the non-hotspot based team to undergo self-risk assessment process and go for testing (possibly new apps may be developed and introduced).
- → Piloting of new strategies and approaches to reach the un-reached including:
    - Jamath based interventions
    - Use of technology
    - Mobile HIV testing and STI clinic (both services on the same day) / extended clinics, use of two-wheeler for providing STI services.
    - Training the community member for blood collection and handing over at the facilities for blood test and HIV testing.
    - Voice based SMSing
    - Client based approach

Enabling environment for TG/Hijra people for reaching and service uptake:

- → More focused Advocacy with the Police and Doctors (Health Care Providers). Community Human Resources needs to be funded.
- → Dance, Masti, we can have session on general discussion and life style sharing.
- → Dedicated day for TG/Hijra people and dedicated time to provide treatment.
- → Sensitized doctors to handle TG/Hijra people.
- → Developing and sharing a book on understanding TG/Hijra people to all HCPs.
- → Special training to the counselors in STI clinic and ICTCs to provide specific counseling to TG/Hijra people than providing general counseling being provided to everyone.
- → Need to have a specific DIC for TGs, Queer Queen Competitions, Debate on Knowledge.
- → The services of DIC may be revisited.
- → Identifying 4/5 core team members & trained to undertake efforts for creating an enabling environment in the intervention area by undertaking advocacy, lobbying, networking, etc.
- → Some researches need to be undertaken to understand the needs and requirements of service facilities for providing community friendly services, strengthening infrastructure, enhancing human resources, etc.

Social protection and mainstreaming:
→ State Level Advocacy & Sensitization Programs and Community Mobilization Activities. → Aadhar & Pan card, rent agreement, bank account health insurance, etc., need to be done. → Undertaking efforts to improve the livelihood and risk reduction practices. → Shelter home, Old Age Pensions, Aadhar Card, PAN Card, Bank Account with 'TG' column, Loans for TG Community, Political Existence, TGs must get reservation Ward Wise, Mandal, MLA and MP wise. 
Any other:
→ Community based (TG) welfare board to get the Line Department Services and all Social Protection Schemes based on caste, reservation in competitive examinations to get jobs in all domains. → Undertake short-term researches including secondary review, mid-term review, etc. → Encourage field visits by the TRG team members for understanding the field realities and provide guidance to the CBOs to overcome the challenges. → Evolve strategies and guidelines to move from hotspot based intervention to non-hotspot interventions considering the emerging networks, sexual behavior, etc.

3.6. For overall enhancing the quality of intervention program and improving the service uptake among the community members at regular intervals, please share any other suggestions.

→ Testing need to be done at office, legal and SRS counseling, ART medication at office with support of ART and our doctor.
→ The CBO team needs to be trained on 90-90-90 to enhance their knowledge, skills and improve the commitment.
→ Greater engagement of DAPCU for addressing the problems at the facilities in providing services to the community members.
→ Piloting innovations in the demo sites and the learnings may be replicated.
→ The learnings gained from previous donor driven models may be reviewed and best practices may be considered.
→ New methodologies / approaches / behavior modifications may be evolved (beyond IPC and counseling) – may be team training, training on self-esteem, soft skill training, etc.
→ Provision of Toilet in the Intervention was a major issue that was prompted by the participants of the FGD.

Part 4: Personal observations and summary of the discussions based on the FGD:

- → There is a transformational shift in the attitude and behavior of the community. Back in the late 80's when the HIV program was initiated there was lot of taboo and fear about the virus. There is an overall sense of normalcy that has developed over the period of time. There is discrimination and stigma faced by the community from various sections of the society, but life goes on. The community is empowered but not in the way it should have been. Often they are shy and still fearful of the fact that the 'other side' is not openly accommodating and accepting. There is lot of apathy from the Medical fraternity and the health care providers. There is a need to reach out and engage the younger and newer members of the community who are accessing technology and social media. The strategist and program developers also need to consider the major focus areas and areas of concern of the community from the prospect of the community. Health should be focused but there needs to be a greater emphasis on MENTAL HEALTH AND SRS (including Laser Treatment for hair removal, breast implant surgeries, castration, emasculation and vagino-plasty, hormonal therapy).
- → As per our observation community members are demanding for some additional services under Targeted intervention program especially for this transgender community they want more counseling on mental health issue because they are in more risk as compare with heterosexual community.
- → More than 50% required Hormonal and Sex reassignment related services at least we need to trained our counsellor and outreach staff on SRS related services so that transgender community can show their interest to visit our targeted intervention site.
- → Transgender community involve in oral sex behavior so they demanding for flavored condom.
- → Community people are not so much interested in HIV services I think that is why we are lacking to reach in our project target so we need to provide some services with this Targeted intervention service package.
- → We all have to take decision for such kind of additional services with our TI project SACS and civil society need to add this component in our projects.

2.8.2. Consolidated summary of In-Depth Interview findings:

Part 1 – Category of persons from whom data collected through IDI:

The details on the category of persons interviewed as a part of In-Depth Interview and sampling details are given below:

Category proposed	# of IDI	Site 1	Site 2	Site 3	Site 4
In-Depth Interviews (IDI) among TG/Hijra people		Mumbai	Delhi	Chhattisgarh	AP
Jamath based community member	1				✓
Gharana based community member	1	✓			
Mobile based (moving to different locations) Hijras / TGs	1			✓	
Community member operating through technology (mobile phone)	1		✓		
Community member operating through social media (web)	1				✓
Peer educators	1		✓		
Community member who has availed services from the intervention for more than 2 years	1			✓	
Community member who has recently joined in the intervention (undertaken services for less than 1 year)	1	✓			
Sub total	**8**	**2**	**2**	**2**	**2**
plans for conducting eight in-depth interviews among stakeholders (Community leaders, civil society partners & govt. officials):					
Community Leaders	2	✓			✓
Civil Society partners	2		✓		✓
Technical experts	2		✓	✓	
Stakeholders	2	✓		✓	
Sub total	**8**	2	2	2	2
Grand total	**16**	**4**	**4**	**4**	**4**

Overall, 16 IDIs has been conducted representing from four sites based on the sample selection.

Part 2 – Personal Profile:

Age group of participants:

Age group	No. of respondents		%
	Community	Stakeholder	
18-25 years	1		6.25%
26-35 years	4	5	56.25%
36-45 years	3	2	31.25%
Above 45 years		1	6.25%
Total	**8**	**8**	**100%**

Gender of participants:

Gender	No. of respondents		%
	Community	Stakeholder	
Male		2	12.50%
Female		2	12.50%
Transgender	8	4	75%
Total	**8**	**8**	**100%**

Experience and association with intervention among TG/Hijra people:

No. of years	No. of respondents		%
	Community	Stakeholder	
< 1 year	1		6.25%
> 1 year & < 2 years	2	2	25%
> 2 years & < 4 years	4	3	43.75%
> 4 years	1	3	25%
Total	**8**	**8**	**100%**

Part 3 – Findings of the In-Depth Interview:

3.1. Association with the intervention:

- **Community members:** Overall, 16 members participated in the In-Depth Interview (IDI). Amongst the 16, eight (50%) community members have participated in the IDI. Amongst these community members, 1 member (6.25%) with less than one year of association with the intervention (new entrance) 2 members (12.50%) are more than one year and less than 2 years of association, 4 members (25%) are more than two years and less than 4 years of association. 1 member (6.25%) are more than 4 years of association. Overall, 43.75% of members have associated with the intervention for more than one year.

- **Stakeholders:** Overall, 16 members participated in the In-Depth Interview (IDI). Amongst the 16, eight (50%) members representing from stakeholders including SACS, TSU, HCPs, CBOs and other stakeholders have participated in the IDI. Amongst these stakeholders, 2 members (12.50%) are more than one year and less than 2 years of association, 3 members (18.75%) are more than two years and less than 4 years of association. 3 members (18.75%) are more than 4 years of association. Overall, 43.75% of members have associated with the intervention for more than one year.

- **Role of stakeholders:** The respective key stakeholders shared the responsibilities associated with the intervention among TG/Hijra people are:

  SACS: Overall, state level organization in coordinating prevention to care continuum. Implements and monitors all the HIV/AIDS program in the state. Manages prevention program, basic services, care, support & treatment services and other strategic support. Also, coordinates with TSU and other stakeholders.

  TSU: Providing technical support for effective implementation of the TI program in the state in coordination with SACS. Provides mentorship and monitoring to the CBOs.

  HCPs: Provides treatment for STI by adopting the guidelines.

  ICTC: Provides basic counseling, HIV testing, post-counseling, linkage with ART, HIV/TB programs, etc.

3.2. Existing challenges in the ongoing intervention and uptake of services:

a) Community members:

- Participating in the intervention program managed by CBO with the support of SACS. Operating in a hotspot and availing services from the peer educators. The services availed will include: one to one, counseling, condom, motivation for testing and treatment, providing clarity, meeting regularly and promoting good habits.
- Overall, I like the services of counselor in promoting behavior change.
- I am also associated with HIV program… In addition, undertake advocacy initiatives with local police, political leaders, police officers, also serves as a member of the district level service authority.
- There are many dynamics in the Hijra community – which must be addressed and bring them under TI program.

- We are facing a big problem due to non-distribution of condoms… Condoms are not available regularly, at all times, in our hotspots, etc.
- The community members need to stand in a queue along with other members… this creates many problems including stigmatizing by fellow patients… Separate queue or priority may be provided in treating TGs.
- The exclusive TI for TGs managed by CBO may be of helpful in addressing comprehensive needs of the TG/Hijra people and complete the service package.
- Gharana based system requires permission from the head or group. Hence, there is a need for advocacy with Gharana leaders, advocacy greater engagement and using them as peer educators.
- Intervention may need to take possible efforts to provide positive image building to the TG community members to develop self-esteem. This will help in considering the life value and adopt positive behavior change and health seeking behavior change.
- Salaries are not paid in time in certain occasions…. This also discourages the motivation and encouraging community to seek services.
- Delay in recruitment of peer educators both during the commencement of the project and during the changes in the peer educators. This delay contributes for lack of rapport, disturbances in providing continuity of services and necessitates to commence the activities from the basic.
- Introduce innovations and new approaches in promoting behavior change and health seeking behavior by using technology, innovative communication materials, game based materials, community prepared IEC materials, etc. This will help in strengthening the effective communication and motivating community to seek services.
- Social acceptability is very important, as long as the family will not keep a member of the community with him, it is difficult to keep it safe. Giving government schemes benefits to the members of the community, providing them employment, preventing them from walking on the wrong path.
- Still community people are hidden just because of social discrimination.

"Most TGs are not educated. In my opinion, if we can facilitate for providing basic education to the TG/Hijra people…. This will help in improving understanding, increasing knowledge level, overcoming myth and misconceptions, improving negotiating power and availing services…. Efforts need to be made to improve the literacy level or basic literacy by linking with ongoing Govt., programs."

"We are still facing stigma and discrimination at the hospital. The general public does not give respect to us, if event the service providers do not treat like other human beings, where will we go. That's why some of the TGs do not show interest to go to Govt., hospitals and ART centre to avail services."

"I do not involve much in the dynamics and networking among the community. I always interact with community people with whom I am comfortable."

"There are HIV services to TG community, but there are some hindrances to go for HIV test, people suspect that we have HIV. They also doubt if our family members also must be infected with HIV. They fear to talk and also are scared to touch us. With this fear most of us are not going for HIV test. The stigma and discrimination regarding STI/HIV tests and makes the community and the general public that it is normal to go for regular check-up to keep them in good health and take treatment for STI or

HIV if infected."

"We want the government to take up measures to educate and sensitize the healthcare providers so that they do not treat transgenders with discrimination and give proper services to them."

"As per my opinion, still TG/Hijra people are not ready for HIV testing because, lots of people have seen who answered me that, why we should get tested for HIV as it is our life is like hell."

"They do not get specific chance from their busy schedule to approach intervention to take services as they have to act as their guru tell them. They have to go to Badhai / Basti."

"We have very backward area to work with TG and Hijra population and some of the people are start behaving as transgender and start doing sex work at site and after this our local society start blaming on our self that these organization is not good for our child and family."
"Transgender and Hijra Guru is also creating problem or conflict between community and some of Hijra Guru is start beating to the transgender person with blaming them usually they use work or artificial or Fake hijra for transgender community that is why our some or hidden or new community member are losing their interest to involve in our Targeted project."

"Dera based Hijra's chela is not open in family to come at DIC and hospital just because of Nayak and guru's (head of the family) pressor and they are teasing to each other like you are doing anal sex that is why you want to test yourself that very bad for our community you have to leave this anal sex but no one is trying to understand what they want in reality."

"Transgender people are doing sex work in night time for sustainability in the morning g time they are sleeping after sex work so till 11 am they are sleeping at hospital and ICTC and STI center staff is not much aware and sensitized about community issues and timing is not friendly as per the community."

"Transgender community is hesitating to show their sexual organ at hospital because they are not friendly with STI clinic staff at the hospital because they are non-community members…. ART counselors may also need to provide counseling beyond HIV…. Considering the needs of TG/Hijra people."

"Peer educators need to dedicate more time in providing services…. We found that, while we visit the hotspot, the peer educators are not available…. Or else, peer educators are not undertaking visits, while we are in the hotspot…. This requires series planning and strengthening coordination."

"We need to resolve the matter of crisis with in the community and outside the community specifically in Dera based outreach and police crisis just because Dera guru is not like this kind of intervention."

"Social awareness need to be strong because local Gunda's and police are creating issues with us and NGO have limitation to support us if other government project and community will support us that would be great for us if government taken initiate to advocate about TG and hijra community within general community that would be good."

"Sometime doctor were missing from the center and we need those medicine from this center."

b) Stakeholders:

- Associated with TSU and providing mentorship, monitoring, data management, capacity building of TIs, managed by both NGO/CBO which includes intervention among TG/Hijra people.
- Peer led program needs motivation and systems for rotation of community members for ensuring interest and sustainability.
- High age group based community members are accepting the suggestions and guidance provided by the outreach team. Peer educators found very difficult in canvasing and convincing the young age group and middle age group…. This may require selection of peer educators in different age groups…. Also, the peer educators may also need to be accountable to reach their own age group members instead of reaching out everybody irrespective of the age…. Piloting will be of useful.
- The community members are not accessing further services which may be due to: inconvenient timing, tests and results requires two mandays, too crowd, stigma, untrained doctors, ineffective counseling due to overcrowd / unforeseen rush, need more coordination between NGO and service facilities.
- The NGOs should undertake continuous efforts to motivate the community members to seek services and undertake accompanied referrals.
- Computerized software may be developed to track the people those who have not undertaken services, generate pop-ups / preparation of reminder list and automatic sending reminders.
- Orienting the CBO team on the emerging networks and possible approaches to reach… organize experience sharing meeting.
- Recognize best CBO and staff at state level during World AIDS Day for achieving the service uptake by using new approaches.

"The community members, as part of accompanied referral, undertakes visits to ICTC or STI clinics and avails the services with the supervision or guidance of outreach….. But, the same community member is not convenient or hesitant to come to the same facility for the second time…. This may be due to complacence, dissatisfied with the first time services, negative approaches, not provided effective counseling, etc… These factors need to be studied and addressed."

3.3. Emerging sexual behaviours, networking and dynamics among TG/Hijra people:

a) Community members:

- There are many new groups emerging among TG/Hijra people. This requires intensive study. However, the Jamath leaders will be able to share the details on the same.
- The intervention may need to more closely work with Jamath leaders to understand the emerging dynamics networks, sexual practices, etc.
- The community members in the intervention area are found to be mobile and move from place to place within the distance, within the state and to other states.
- Use of mobile phone and social media among the community members…. The dependency on brokers or hotspot becoming less significant.

- Community members are having hesitance in participating in the TI program or availing services considering the not much encouragement from the Gurus / Jamath leaders.
- The NGO/CBOs using the good old conventional methods in communication… considering the use of social media and emerging trends…. It requires induction of new approaches in the ongoing TI.
- In some interventions, the hotspot based TG/Hijra people move to mobile based operations or operates both at hotspots and through mobile based. Hence, it is difficult to meet and provide services.

"TG/Hijra people are involved in the sexual activities very much as it is easy way of earning handsome money. Now-a-days they are using social media like facebook, whatsapp and other applications."

"We have done some work under the leadership of "Mitwa". In which we had six goals set out. Doing a splash in every 6 months or giving a package of money in every 3 months. Opening of account in social facilities such as bank, making Aadhaar card, creating identity card, etc. Organizing programs in different stages, creating friendly environment, interacting with people of the society, providing treatment to patients with sexually transmitted diseases… Also, undertake interventions to address the gaps."

"Young MSM community people are following process of Transgender and Hijra community to open or expose their identity and people are demanding about young sex worker so they are ready to provide more money to the transgender people so after that MSM start behaving like transgender."

"Some of Manly looking guys are behaving like transgender for earning only so some of non-operated transgender."

b) Stakeholders:

- Community members expect tests and results on the same day.
- Frequently, the middle aged and the aged community members are visiting and undertaking services. The new entrance or young age members are not visiting the facilities to avail services.
- Some of the community members more knowledgeable, informative and aware. This requires advanced level of communication.
- DAPCUs, during the district level review meetings, can facilitate experience sharing and coordination to identify the emerging trends.
- Some of the community members, prefer to avail services in the private hospitals. The NGOs may need to undertake tracking system on the same.

3.4. Effectiveness of current strategies:

a) Community members:

- Appreciate the efforts undertaken by NACO & SACS for supporting dedicated intervention for TG/Hijra people.

- The package of services focusing on prevention to care continuum such as: behaviour change communication, condom promotion, treatment for STI, HIV testing, counseling, linkage with other services, positive prevention, etc. This package is a common minimum package for us. These services are provided by CBOs to the community members.
- First time mapping of TG population has been done in India.
- The present intervention program, services, systems, linkages are really good. The focus on prevention package for TG/Hijra people is really acceptable. The support of SACS & NACO and CBO is more meaningful.
- The intervention program has been working to create awareness and prevention…. It is doing well.

"The Zapp program is very effective. In order to make people aware of health, use of security related equipment, community consciousness has come. It is difficult to understand the elderly kinaro, but the young sheer has become very aware of us."

"So as of now they are providing HIV and STI services at their center and after every 6 month they are providing HIV testing service and after 3 month they are providing STI services to the community members… This system is good."

b) Stakeholders:

- Operational guidelines for implementing TI, provides uniform guidelines for all the organizations working on prevention.
- Standalone model of implementing TI for TG/Hijra people than composite intervention is found useful.
- NACO engages the community and its networks in the process of developing NACP III and other documents.
- TSU support in providing continuous mentoring support by a designated program officer is also much appreciated.

"NACO adopts prevention to care continuum by providing financial support, training, mentoring, needed operational guidelines, linkage with the services and support from different stakeholders."

"The branding of STI clinics, ART centre, ICTC is found to be more effective and non-stigmatized… This system should continue… Similarly, the NGO project officers or TI programs may also be branded to enable the community members to avail prevention services."

3.5. Suggestions to overcome challenges in accessing services:

a) Community members:

- Expecting recognition from the Govt., for the TG/Hijra people. This will help in getting more recognition, avoiding stigma & discrimination, improved self-respect, thereby adopt risk-reduction practices, etc.

- The intervention should provide more information on TG health issues at regular intervals both at intervention level and health facility level. These services should be beyond HIV/AIDS.
- SACS and TSU may need to undertake holistic efforts to build the capacity of the outreach team in providing comprehensive counseling and services to the TG/Hijra people. However, the team can focus more on prevention. In addition, they should also provide other services as a part of their regular communication and counseling.
- Undertake efforts or initiate research study to find out the reasons / inability factors in not accessing services by the community members. Study the aspects such as in the perspectives of program managers, HCPs, community members, outreach team, etc.
- As a TG community, expecting a standalone intervention for TG/Hijra people to make it more TG friendly and run by TG/Hijra people – the existing composite interventions may need to be converted in standalone interventions for TG/hijra people, this will help in focused services and uptake of services.
- Separate day may be introduced for the TGs to avail services without any stigma. This will help in enhancing the motivation of the community members to seek services, along with the other TG members as a team.
- Separate TG-TI program for TG/Hijra people will be of useful than NGO model.
- Efforts need to be undertaken to reach the dropouts and motivate them to re-enroll into the interventions and encourage for services. In case, if they are not found, delete them from the master list. This will help in arriving at correct beneficiaries and understand the linkage system for services.
- Develop training manuals, use vide clippings, use technology and train the doctors to understand the TG people and provide community friendly services without any stigma and avoiding asking probing questions.
- Networking of all CBOs and NGOs working for TG/Hijras including involved in TI and non-TI under one umbrella… this will help in uniform understanding, enlist their support, working with the common agenda, work towards achieving targets and addressing field level challenges.
- Counseling to TG/Hijra people need to be provided in HIV and beyond HIV including Psycho-Social, mental health, family counseling, partner counseling and other aspect to provide community friendly counseling.
- HIV testing may be undertaken in the event based programs organized at Jamath or Gharana – non-stigmatized and group approach.
- Prepare their comfort zone for their community members.
- Need to develop new strategies to make it community accessing services… this requires intensive review and coordination.
- Use social networking models for effective reach of unreached population including whatsapp, facebook, etc.
- Piloting client based approach to identify the non-hotspot based sex workers operation, new trends, sending messages, etc.
- Shelter home for positive people for TG/Hijra people may also be of useful.
- Engage TG/Hijra positive persons as outreach team in ART centre to reach the positive persons for follow-up on drug adherence.
- The structures in the ART program may slightly decentralized…. The TG/Hijra people may be encouraged to initiate ART and collect drugs from link ART centres to avoid travel time, save time and ensuring continuity.

- Request to consider introducing SRS at low cost in nearby areas…. This will help in preventing the community members in compromising in use of condoms, running behind earning money, etc. If SRS services provided at low cost, people may sustain behavior change, adopt risk reduction practices and avail services.
- Need for flavoured condom, because, indulging in oral sex… due to non-availability compromising in using condoms.
- Increase and improve condom outlets considering the emerging networking and dynamics… This will help in addressing the gaps and increasing use of condom.
- NGOs more focus on prevention efforts in TI program… There is a need for improvement in the efforts in promoting positive prevention among the people found positive.

"All the transgenders must be educated about the infections which they might acquire if they do not indulge in safe sex practices in a very enabling environment where they feel comfortable discussing their health issues."

"Transgenders who have good rapport in the community must be taken into the project in the positions of Peer Educators and Outreach Workers."

"The strategies which are currently using in the intervention to reach out people and deliver their services available in the intervention are better… but, still we have to develop much better and new strategies like we can make a whatsapp group and add community in the group. We can share information and stories about the services in the whatsapp where by the community members who are hidden, not approached may be able to avail services."

"I think, we want our own community testing centre or our own CBO testing centre… this may be of helpful in addressing the existing challenges."

"The project should be restarted and it would be better if the project was run by the government. Because, permanent members are needed to maintain continuity. The problem of community members considers the community person better. Therefore it should be operated with the main selected educated people of the community and in cooperation."

"After few months Community Based Tested (CBT) guideline is also going to start in our organization we are hoping that in future we will get more involvement of the community people because they don't want to go at hospital ICTC so State AIDS Control has taken very good initiative for us."

"Better quality condom required in community more lubrication with condom and we required attractive condom from this organization transgender is doing oral sex so they required flavored condom."

"We need to work for teen age community members for education we need to involve with other NGO or organization so that we can get more support from the other organization."

"Some of the community members are demanding for SRS related counselling and services and government hospital team also need to aware about this project and community need."

"Sex worker are much aware about health issues and they are doing 15 or 20 sexual encounter in a day so they are aware about health we don't have any issues with these population…. This requires effective IPC and behavior change communication."

"Clinic doctor is providing STI checkup only if he will provide general medication or treatment to us that would be a great for us because community is not comfortable to visit local private doctors…. Efforts may be undertaken to provide STI and general health check-up services."

"If government or SACS can do some consultation to spread information about Transgender community related issue within society that would be appreciable."

"Create group at social networking site to support each other that would be great for our community."

b) Stakeholders:

"The Jamath and Gharana influence in encouraging the community member to participate in the TI program and availing services are found at high level. This requires strong advocacy networking and greater engagement."

"The skills among the NGO team and outreach team need to be further enhanced through training for improving the documentation skills."

"Exploring on the possibilities to provide Psycho-Social support and effective counseling on risk reduction practices will be of more effective."

"Our CBO has helped the TG/Hijra people to avail around 300 social entitlement services as like Bank account, PAN card, Voter ID card, Aadhaar card, Pension scheme and Ration card…. This type of linkages and recognition will also help in seeking services…. This needs some investigation and study."

"Create a visibility for the project including intervention, ICTC, STI clinic, ART center and other services."

"Some of the community member has fear of HIV result so we have face SNR (sample not received) cases many time at our ICTC."

In-Depth Interviews has helped in eliciting information in the perspectives of community and key stakeholders. Some of the suggestions emerged in the IDIs are complementing the suggestions emerged in the FGDs. The community has shared the information more during the IDIs than the key stakeholders.

3. Recommendations:

The Operational Research (OR) finding has been analyzed. Based on the findings and suggestions emerged from the Focus Group Discussions (FGD), In-Depth Interviews (IDI), stakeholders meeting & other related methodologies, evolved the following recommendations for introducing, reviewing & improving and modifying. Overall, the study reveals that, the community members and key stakeholders are appreciating the NACP III initiatives, package of services being provided, monitoring and mentoring support being extended through the TSUs, SACS, DNRT, DAPCUs and other systems. These recommendations will be of useful for further strengthening the ongoing TI program among TG/Hijra people and will help in reaching the unreached, improving the uptake of services and enhancing the quality of the TI program.

The recommendations emerged from FGD and IDIs are grouped in the following 13 sub headings:

3.1. Existing challenges:

NACO through SACS, DAPCU, TSU, DNRT, NTSU and other mechanisms developed a standardized national level system including strategies, mapping, operational guidelines, training materials, monitoring tools, mentoring support system, tracking of indicators, coordination of prevention and other services at district level, supply chain management system, service provision and many more. This system is continued to be successful in reaching the intended target community and ensuring the required package of services. This study identifies the key challenges in reaching the "difficult to reach group" due to various dynamics and motivating them to seek services. Almost, the ongoing intervention is able to reach 90-95% of the target groups and provide services to 70-80% of the target population.

The study revealed that, the following are some of the challenges found in the ongoing interventions. However, this requires much attention for ensuring effective reach and services:

- Reaching the unreached
- Poor service uptake
- Difficult to reach young and high-end
- Inconsistency in service uptake
- Stigma in providing services (at facilities)
- Mobility pattern of the TGs / Hijras
- Poor condom usage / negotiating power
- CBOs / governing team unable to extract work from the project team
- Messages are not interesting / poor positioning
- Moving from hotspot approach to mobile based

The community members are not accessing the services from the STI clinics considering the reasons:

- Non suitable timings
- Doctor's negative approach
- Frequent changes of doctors in the clinic and need to educate each time
- Taking treatment with the preferred HCPs but not accounted by NGO
- More health conscious but not accounting to the NGO (being personal care)
- Not involved in high risk behaviours (moved away from the trade)
- Registering as targets of all TGs, but not all TGs are involved in sex trade (some of them do blessings, begging, participating in ritual performances / dance performances, serving as Jamath and guide people, etc.).
- More compulsion from the CBO to avail treatment than voluntarily seeking services.
- Some of the peer educators incentivizing the community members for achieving the targets…. This demotivates other members in seeking services.
- Over crowd in the STD clinics and undue delay in providing services.
- Consider the other benefits more very important than STD and HIV.

The TGs considers the housing, livelihood options, income, recognition, eliminating stigma, etc., are primary important than the HIV/AIDS. It is not the utmost priority for the TGs.

3.2. Reasons for not accessing services:

Facility Level:

- Non suitable timings.
- Doctor's negative approach.
- Frequent changes of doctors in the clinic and need to educate each time.
- Over crowd in the STD clinics and undue delay in providing services.
- No dedicated date for TG/Hijra people to seek services.

Individual Level:

- More health conscious but not accounting to the NGO (being personal care).
- Not involved in high risk behaviours (moved away from the trade).
- Consider the other benefits more very important than STD and HIV.
- Discourage by Jamath leaders.
- Needs to be away from interventions for SRS and GTRS for long time.
- More focused on earning and saving money for SRS and GTRS – necessitated to compromise on many aspects.
- Able to practice safe sexual practices which is not risk. Hence, not interested in availing services.

Intervention Level:

- Taking treatment with the preferred HCPs but not accounted by NGO.
- Registering as targets of all TGs, but not all TGs are involved in sex trade (some of them do blessings, begging, participating in ritual performances / dance performances, serving as Jamath and guide people, etc.).
- More compulsion from the CBO to avail treatment than voluntarily seeking services.
- Some of the peer educators incentivizing the community members for achieving the targets…. This demotivates other members in seeking services.
- Peer educators unable to reach the community members at the hotspot due to diversified geographical area.
- Engaging other community members as peer educators leads to non-effective communication and motivating people.
- There is no opportunity for the community members to seek services beyond the public facility both during the stay in the intervention are and while moving to other districts / other intervention areas.
- Encouraging the senior community members who are in access to the peer educators to seek services than encouraging the new entrance and young TG/Hijra people to seek services.
- Monotonous messages in IPC and follow-up communications. This factor also does not encourage the community members to get motivated to seek services. In addition, the peer educators and outreach workers generally speaks always only 2 (or) 3 messages, but, not communicating effectively in the context of community members.
- Non-availability of community friendly updated communication materials.
- Peer educators reminding only when see the target community for testing and treatment (if not seen in the hotspot, no efforts undertaken to contact over the phone or other mechanisms to communicate).

Others:

- Existence of stigma and discrimination.
- Fewer opportunities for exchange of experiences and best practices related to achievements in access to services. No much interactions between the CBOs working for TG/Hijra people in exchanging innovations and ideas.
- Mentorship from TSUs is regular, but not providing handholding and mentoring to overcome the challenges (requires newer job description and exposures for the TSU team).

3.3. Emerging trends:

- ***Gradation of messages***: Currently, it is observed that, the classification of the community members associated with the targeted interventions will include:

Association with HIV/AIDS intervention	Average %
Less than 1 year	5-10%
1-2 years	10-20%
2-3 years	30%
3-4 years	25%
Above 4 years	15-20%

Considering the above years of experience / association with the TI interventions, it is necessary to provide messages in a gradation way. May be the gradation can be grouped into two forms:

→ Basic Bahaviour Change Communication messages: Upto 2 years.
→ Advanced Bahaviour Change Communication messages for sustaining health seeking behavior more than 2 years.

- ***Typologies of TG/Hijra people in the intervention areas / mainly from hotspot to non-hotspot based***: The community members expressed that:

Typology	Average estimates
Hotspot based	30-40%
Non-hotspot based	50-60%
Jamath based community members	35%
Non-Jamath based community members	65%

Considering the above emerging dynamics, it is suggested to take possible strategies and approaches to address and reach the non-hotspot based community members operating in the intervention or neighbouring areas through mobile phones and by using technologies.

- ***Availability of mobile phone***: The community members, NGO/CBOs and stakeholders expressed that, the community members are using likely the following category of mobile phones:

Using ordinary phone without internet facility	28%
Using ordinary phone with internet facility	60%
Using high-end phone without internet facility	2%
Using high-end phone with internet facility	5%
Using tab & other devices	5%

Currently, The TG/Hijra people are maintaining different WhatsApp groups such as Angel group, Sweety group, Marina group, Rose group, etc. Each group is having about 100-200 members and these team members regularly shares information on general awareness, human rights, safety tips for protecting from the rowdies and other benefits. However, community members expressed that, these groups will be used for promoting HIV/AIDS only during World AIDS Day.

Suggested to use this platform for effective communication without disturbing the existing network mechanism and social networking.

Considering the high level of usage of mobile phones with internet facilities, the community members suggested to introduce technology in the communication for comprehensive coverage, reaching the non-hotspot based community members and enhancing the service uptake. The suggested methods may include but not limited to:

→ Sending voice based SMSing on specific day without any stigmatization primarily focusing on promoting service uptake/adherence.
→ Use of mobile phones as a communication device for screening video clippings on HIV/AIDS to communicate effectively as a part of IPC.
→ Sharing IT enabled video films / short films / audio messages to the outreach team for integrating and communicating effectively.
→ Using TV or tab for providing group education and effective communication.
→ The use of technology will also help in providing graded messages and overcoming the message fatigue and monotony.
→ These devices can also be used for advocacy and sensitizing the key stakeholders in the area.

- ***Mobility Pattern*****:** Community members move from district to district within the state and move from state to state:

→ For short period
→ For long period
→ The period varies from two months to six months during seasons (e.g.,) in north India, in the form of “Launda dancers” as a group of 20-25 members, moved to many states for performing dance programs. Similarly, in Kerala, January to June, TGs move to different districts for participating and performing in the Hindu religious festivals.

→ For SRS, the community member may need to be away from the headquarters and stationed in other state / district for more than 45 days.
→ Average cost for SRS will be between 30,000 to 1.5 lakhs.
→ For GTRS (voice, breast, body hair, etc.), average cost will be 5-6 lakhs and they also need money for managing the consequences associated with that. Considering this, they are more focused on earning money and compromising on other aspects.
→ Need for comprehensive communication kit for TGs in the form of resource kit including flip book, flash cards, condom demo kit, etc.
→ This reason also shows as not reported or poor in seeking services. Hence, the NGOs, SACS and NACO should identify these realistic gaps and develop systems for addressing the same.

3.4. Communication & technology:

- ***Training on effective use of social media for the TI team***: The community members opined that, the use of social media including facebook, internet, whatsApp, instagram and other groups for canvasing the clients by using different approaches. The existing outreach team and peer educators are not having such experience in handling social media effectively. The project team members and outreach team has opined that:

    - The project may provide internet facility to the team members for accessing and using social media.
    - The allowances may be provided for using high-end telephones to use these phones for effective communication and effective use of social media.
    - The training on use of social media may also be provided.
    - Opportunities may also be explored to use part / full time IT persons to use the social media to reach the existing hotspot based social media users and non-hotspot based social media users.

- ***Use of technology***: The study reveals that, the efforts may need to be undertaken to use the technology considering the reasons such as: emerging technology, high usage of mobile phones, use of social media, moving towards technology enabled communication (instead of conventional communication), reaching non-hotspot based community members and ensuring services uptake. Considering this, some of the technology driven approach may be piloted, introduced and scaled up:

    - Develop websites with information on state / location wise service provision.
    - Self-learning package including self-risk assessment and accessing services: Develop a website or online system to enable any individuals to understand HIV/AIDS, undergo self-risk assessment tool, analyze the risk associated, identify the nearest service facilities and undergo HIV testing. This will help in providing one stop shop communication to all non-hotspot based TG/Hijra people, clients and other general population.
    - Develop IPC kits in video formats for sending through whatsapp / uploading in the YouTube and display it during one-to-one interactions by using high-end mobile phones or multi-media devices. The staff members may also be trained to produce local specific

video clippings in their own languages for effective communication. This type of effective communication may help in sustaining behavior change and health seeking behavior.

- Utilizing the mobile phone for communicating effectively including using social media: The internet facility for the staff may be provided. Also, the staff members may be trained to use the mobile phones as a communication device. In addition, the reminder messages, reinforcement messages, etc., may also be send through whatsapp and other network platforms.

- ***Formation of Advisory Committee for enhancing the service uptake at intervention level*****:** The community members expressed that, the advisory committee at intervention level may be formed to share challenges, evolve local specific plans for addressing the challenges, providing strategic suggestions to improve the uptake of services and addressing the gaps. This advisory group committee may be formed with 8-10 members and the meetings may be conducted once in three months or as and when required.

- ***Document the case studies / experiences of interventions demonstrated the service uptakes (may be India experiences or experiences from other countries and share)***: Many CBOs may undertaken innovative efforts to enhance the service uptake. The best practices associated with service uptake in the ongoing interventions, in the interventions managed by the other stakeholders / donors and facilities may also be collected and shared for technical update, knowledge enhancement and adoption.

- ***Develop a repository of IEC materials produced by SACS and various stakeholders for TG/Hijra people with digitalization***: The community members felt that, there is a need for using new communication materials at regular intervals for effective communication. It also suggested to develop a repository of IEC materials by updating at regular intervals (with the provision of type of materials, language, theme, etc.). In addition, the members also suggested that, there is a need to develop new IEC materials by SACS by engaging community members, by incorporating the emerging myth and misconceptions, etc.

- ***Strengthening the infrastructure facilities in the service facilities***: A rapid assessment may be conducted to understand the needs and requirements of the service facilities such as:

    - Infrastructural needs
    - Human resource needs
    - Capacity building needs
    - Communication material needs
    - And other needs

    The above assessment will help in identifying the infrastructure needs and requirements. Based on this, the DAPCU, TSU, SACS and other key stakeholders may undertake advocacy and networking with NRHM, health system strengthening and department of health and family welfare for ensuring such provisions through mainstreaming initiatives. Addressing these gaps will also motivate the community members in accessing the services without any hindrance, stigma and fear.

- ***Capacity building of HCPs***: The community preferred HCPs in the intervention areas and the HCPs available in the STI clinics may also be trained by using the advance training manuals developed based on the training need assessment. This will help in motivating the HCPs to use scientific approaches and provide treatment without any stigma. The technology enabled devices may also be used in training programs.

- ***Extended timings in STD clinics***: The DAPCU TSU SACS may explore the possibilities of providing dedicated time and extending the clinic hours to provide specialized services for TG/Hijra people. This will help in the issues expressed by the community that, the service facilities are not functioning to their convenience.

- ***Ensuring the availability of trained doctors in STI clinic***: The community members also opined that, engaging and ensuring the availability of trained doctors to provide STI treatment in a community friendly manner. The DAPCU may be requested to coordinate with the health system for replacing the vacancies and availability of doctors during the clinic hours. This will help in motivating the community members to seek services.

- ***Use of existing mobile ICTCs for testing the community members at NGO office / DIC / hotspots***: The existing mobile ICTCs may be encouraged to visit the NGO intervention area for conducting testing for the community members. In case, mobile ICTCs are not available, the existing ICTC team may undertake outreach on a specific day and specific time to the intervention sites and conduct HIV testing. This will help in enhancing the uptake of services and addressing the gaps.

- Engaging **part time experienced counselor** with good exposure to Reproductive Sexual Health (RSH), mental health services, etc., (providing counseling beyond HIV).

- Identifying and **engage the non-hotspot based peer educators** with the experience in mobile networking models to reach their own groups through mobile, WhatsApp, and other networks.

- ***Demand generation through communication campaigns***: NACO and SACS has undertaken and continue to undertake national level and state level communication campaign on eliminating stigma and discrimination, increasing risk perception, condom usage, treatment for STI, positive living, etc. Such campaigns and communication initiatives may need to be continued to create a demand and motivate people to seek services.

- ***Helpline:*** Currently, national level helpline is offering services to both HRGs and general population. This also helps in countering myth and misconceptions, increasing risk perception and availing information on services available for STI treatment and HIV testing. The efforts may be undertaken to provide information on services available through SMS (if it is not available).

3.5. Capacity Building:

- ***Capacity building***: As a part of the study, the following suggestions emerged for strengthening capacity building for initiatives to enhance knowledge and skills of the outreach team for effective communication, demonstration, motivating the community members, adopting new techniques / innovations, how to mobilise the community for uptake of services, etc. Some of the suggestions emerged will include:

    - Training for CBOs on governance and resource mobilization
    - Periodical in service training for the outreach team including peer educators (developing training manuals, incorporating modules with case studies and problem solving approaches, exposure visits, sharing of experiences, etc.).
    - Organizing Technical update series for NGOs/CBOs involved in intervention among TG/Hijra people on quarterly basis. This will help in addressing the field based queries and provides additional information for effective performance.
    - A book on common issues and challenges in intervention among TG/Hijra people and effective ways and means to overcome. This book may be developed by collecting common issues and challenges faced by the interventions. For each issue and challenges, multiple experiences adopted by NGOs/CBOs within India and outside India may be provided for each category of challenges. This book will be of useful to use as a ready reckoner – problem solving tool for the NGO/CBO outreach team, etc.
      The same content may also be produced in a video format for screening during the training sessions for the outreach team.
    - Demo sites for piloting innovations and exposure visits / hands-on training to the intervention team. The demo sites may be developed in each state for facilitating exposure visits and providing hands-on training to the project team members including outreach team. The demo sites may be identified through a process by adopting specific criteria. These demo sites may also be encouraged to pilot innovations for identifying new learnings for adoption / scaling up.
    - Develop mobile apps for high-end TG/Hijra people to access and learn – self learning package and self-risk assessment.
    - E-newsletter with best practices and experiences for sharing it with CBOs and other stakeholders. This may be developed either by NTSU or designated consultant or by the CBOs on turn basis. The content may be reviewed and shared among all NGOs/CBOs and outreach team involved in intervention among TG/Hijra people.
    - Forming e-groups at national level for periodical sharing and learning: An e-group may be formed:

        - Networking all NGOs/CBOs involved in intervention among TG/Hijra people in the entire country (may be state wise groups and national groups).
        - Forming a e-group of outreach team for sharing case studies, best practices, experience sharing, etc.
        - Forming e-groups for counselors involved in intervention among TG/Hijra people.
        - In addition to e-groups, whatsApp group may also be formed for sharing uniform messages, motivating messages, reminder messages, etc.

The above e-groups may be administered by NTSU or the technical officer in-charge of intervention among TG/Hijra people (or) an agency may be engaged for this purpose.

- National summit for sharing best practices: The national summit may be organized specifically on sharing experiences to reach the unreached experiences and achieving 90-90-90 in intervention among TG/Hijra people. This summit may be organized annually or biennial. This will help in identifying best practices, sharing experiences, integrating new learnings into the intervention for achieving the desired results.

3.6. TSU / SACS:

Overall, the community members, CBOs and all stakeholders endorses that, the support of the SACS and TSUs in identification of CBO, partnership development, financial support, technical guidance, mentoring support, capacity building, experience sharing opportunities, collection of reports and providing feedbacks, annual assessments, ongoing guidance, etc., are very much supportive and helps in improving the quality of the program and achieving the targets. TSU support in providing continuous mentoring support by a designated program officer is also much appreciated.

"NACO adopts prevention to care continuum by providing financial support, training, mentoring, needed operational guidelines, linkage with the services and support from different stakeholders."

- ***Training program for the TSU team members mentoring the interventions among TG/Hijra people for improved mentoring and support***: TSU members provide mentoring support and guidance in a systematic manner at regular intervals to all NGOs/CBOs. The Program Managers managing interventions among TG/Hijra people may be provided with:
  - Additional in-service training
  - Developing e-group among these Program Managers working in different states for experience sharing (e-group for Program Managers mentoring interventions for TG/Hijra people).
  - Developing WhatsApp groups for exchange of experiences and clarifying their doubts.
  - Facilitate webinar for technical update once in three months.

- ***Team training for SACS officials to enable them to understand the MSM and TG/Hijra people***: NACO has taken utmost efforts to orient, train and prepare the officials in SACS for efficient program management, documentation, monitoring, etc. The community members suggest that, a team training in SACS may be organized on orientation about TG/Hijra people to enable them to understand the TG/Hijra people and provide needed strategic support as and when required (both technical and financial team).

3.7. NGOs / CBOs:

- ***Improving the capacities of the counselor and enhancing the scope of counseling*:** The community members expressed that, the existing counselors in NGO/CBO, ICTC and other service facilities are providing the basic counseling on HIV/AIDS. These counselors are not concentrating in providing counseling on SRS & GTRS, etc., to provide counseling beyond HIV/AIDS or to provide comprehensive counseling to address the needs and priorities of the TG/Hijra people, recommended to develop tool kits on counseling and conducting in special training program to counselors for providing counseling beyond HIV/AIDS to TG/Hijra people.

3.8. Health Care Providers (HCPs):

- NACO/SACS may undertake the Training Needs Assessment (TNA) of HCPs in public health facility and in private sector (community preferred HCPs). Based on this, the existing training manual may be updated or refresher training manual may be developed with the case studies related to TG/Hijra people.
- The training may be conducted for HCPs for two days in an intensive way. The community members / CBO representatives may also be engaged in this training program for facilitating interactions, to enable doctors to understand the needs & priorities of the TG/Hijra people, etc.
- In addition to the formal training program, technical update distance learning series may also be conducted. Further, e-groups and whatsapp groups of HCPs involved in providing STI services may be formed and technical updates are shared at regular intervals.
- The existing newsletters and magazines being produced by Indian Medical Association and other doctors association may effectively be used for technical update and networking of doctors.

3.9. Piloting new initiatives & innovations:

- ***Model intervention sites to reach the unreached for 6-9 months for documenting the experiences and evolving strategies***: The community members expressed that:

    - Piloting of new strategies and approaches to reach the un-reached including:
        - Jamath based interventions
        - Social media & Use of technology
        - Mobile HIV testing & STI clinic (both services on the same day) / extended clinics
        - Capacity building of outreach team on use of social media
        - Use of mobile phones as communication device for communicating effectively with community members (addressing monotony, message fatigue and providing comprehensive messages effectively).
        - Voice based SMSing
        - Client based approach (collecting information from the clients on the current trends, newly emerged hotspots, community members available in the newer areas, etc.).
        - And other approaches.

This will help in identifying the effectiveness of each of the approaches and help in evolving strategies, guidelines, integration into the training manual, budget, etc.

3.10. Innovations for piloting in the ongoing interventions:

- Voice based SMSing to promote service uptake
- Use of technology in IPC activities (mobile phone, tab, etc.)
- Client based identification of unreached HRGs
- Reaching young and new entrance
- Mobile based STI clinic to enhance uptake of services
- Community preferred HCPs, visiting hotspots to provide services
- New systems for individual tracking and developing a reminder mechanism to motivate to seek services
- Re-strategizing BCC for HRGs – more than 3 years vs. new (messaging, materials, communication plan, etc.)
- Jamath based intervention
- Goodwill Ambassadors to reach the unreached
- Re-strategizing the proportionate of peer educators in the hard to reach population areas / hotspots
- Linking livelihood options and uptake of services
- Increasing self-esteem and contribution in risk reduction practices
- Exploring the new engagement of community members beyond peer educators
- Community led IEC material development / package
- Strategies to reach the emerging technology enabled mobile groups in the intervention area / within the district / between the districts
- Extended STI clinic model – Medical Officers from STD clinics visiting NGO office / hotspots on specific days
- Camp approach for STI screening / treatment
- Nurse model for providing treatment for STI
- Community testing
- Alternative strategies for reaching the TGs/Hijras non-willing to enrol in intervention and interested in maintaining identity
- A study on whether the person availed benefits through social protection, improved income has resulted in reducing the risk behavior / partner reduction / access to services, etc.
- Needs and expectations of hard to reach HRGs for access and avail services
- Study on factors contributing for mobility patterns of TGs/Hijras in accessing services / non-tracking, etc.

3.11. Strengthening interventions:

- ***Coordination between interventions of MSM and TG for exchange of information***: Some of the hotspots are similar in nature for both MSM and TG/Hijra people. Hence, it is very much ideal to work hand-in-hand between the NGO/CBOs for effective exchange of ideas and carrying out common activities. This will also help in identifying new entrance, young TG/Hijra people entering into the trade, etc.

- ***Developing community friendly / convenient clinics***: Currently, the community members have their own reservations and limitations in accessing services from public health facilities. The

community members opined that, the following types of clinics will be of more useful to access services and this will help in overcoming the existing limitations and challenges:

- *Extended clinics*: The existing STD clinics and ICTC centres may develop a plan for undertaking extended clinics to visit NGO office / DIC / hotspots or any other strategic locations on specific day and specific time to enable the community members to avail the needed benefits.

- *NGO based STI clinics*: Establishing NGO based STI clinics by engaging part time doctors to provide static services at the DIC and encouraging the same team to undertake visits on scheduled basis to different regions to provide services in the community available areas. This may also help in enhancing the services.

- *Community preferred Health Care Providers (HCPs)*: The community preferred HCPs may be mapped and capacitated. These HCPs may also be provided with needed communication materials on STI for effective communication and providing services in line with the NACO guidelines for STI.

- *Cash voucher system*: Based on the previous experiences, the NGO may be encouraged to provide referral slips to the private HCPs. The community members will avail the services for STD and the doctor will collect the fees from the NGO based on the referral slips / cash vouchers. This will help in addressing the issues such as stigma, convenient timing, easy access, understanding by the doctor and comprehensive services.

- *Dedicated day for TG/Hijra people*: The PHC and other facilities may dedicate a specific day for the TG/Hijra people to access services. This will help in providing services without undue delay and non-stigmatized. This dedicated day and time may be piloted and modified according to the intervention areas and preferences of the community members.

- *Accounting the treatment undertaken by the community members outside the public facility*: Systems may need to be evolved for collecting referral slips / reported information from the private HCPs and accounting as a part of the services. This will help in recording of all the reported data.

- ***Non-availability of ID cards leads to registration issues in ART***: Many of the TGs does not have ID cards or they struggle hard to receive ID cards. This hinders in registering for ART if a person found positive from TG/Hijra people. The systems may be introduced to avoid such requirements.

- ***Mobile TG/Hijra people***: The community members expressed that, in the intervention area, there are various types of mobile population which hinders in contacting, providing regular package of services, taking services such as STI, testing and condom.

    - Moving from one intervention to other intervention area – within the district
    - Moving between the districts and within the state

- Moving between the states
- Moving for short-term or on long-term basis / seasonal migration
- Unique ID / smart card for accessing services during the migrating period (similar to RNTCP)

Considering this, a system may need to be evolved:

- For developing and issuing smart card with unique IDs
- Develop systems for availing services in other intervention areas and reported to the parent TI
- Introducing systems for reporting as "self-reported data" (or)
- Any other similar mechanisms for capturing the services undertaken in other intervention areas.

- ***TRG for TG – members may undertake often field visits and interactions with the field team for identifying field level issues and developing policies***: The TRG for TG members contributes in policy formulation and contributing to the large extent for addressing TG/Hijra people issues in coordination with NACO. The TRG members may also be encouraged to participate in the field level programs, undertake field visits, interact with the community members, undertake rapid assessments, etc. This will help in understanding the field realities, identifying the gaps and initiating efforts for addressing the same.

- ***Re-visiting the facilities in the DIC and expanding the functions beyond safe space (introduce more activities to invite more community members than engaging the regular visitors)***: Currently, the DICs are being used as a safe space for the community members supported with TV program, recreation facilities, IPC activities, STI services, etc. However, the communities may be considered and identified for effective usage of DICs with additional facilities and services. These facilities may also be used as extension clinic on branded days to enable the community members to seek services.

- ***Exploring on the possibilities to introduce a cluster volunteer / network volunteer / community dhosth or any other nomenclature***:

  - 1:10 ratio
  - Adopting multi-level marketing
  - Under peer educators
  - Voluntary

- ***Primary emphasize on reaching the new entrance and young***: The community members and stakeholders expressed that, the outreach team and peer educators may need to be oriented on how to identify new entrance and young TG/Hijra people for enrolling and providing services. The needed case studies, best practices may also be shared with the outreach team for understanding various methods, innovations, new approaches adopted by other organizations for knowledge sharing and adoption. The TSUs may also provide the needed support as a part of mentoring process.

- ***Balancing the time allocation between the outreach and the report preparation (more focus on outreach, simplifying the reporting formats)*:** The outreach team member feels that, the team members invest lot of time in developing reports and documentation pertaining to the project activities. Suggesting to review the existing records & registers, minimizing the formats and developing a comprehensive format to capture the core indicators. This will help in encouraging the outreach team in concentrating on the outreach activities thereby motivating the members to seek services and reach the un-reached.

- ***Factors motivating TG/Hijra people in compromising the condom usage for money – need to explore and address*:** From the Operational Research, it is revealed that, there are various factors that, motivates the TG/Hijra people for compromising in condom usage may include but not limited to.

    - Average cost for SRS will be between Rs. 30,000/- to Rs. 1.5 lakhs.
    - For GTRS (voice, breast, body hair, etc.), average cost will be Rs. 5-6 lakhs and they also need money for managing the consequences associated with that. Considering this, they are more focused on earning money and compromising on other aspects.
    - Considering the above, the TG/Hijra people compromise on unsafe sexual practices, relapse in behavior change practices and not showing interest in seeking services from the service facilities. This requires intensive review and thus necessitates a modified inter-personal communication activities to focus on behavior change and health seeking behavior.

- ***Encourage and improve community testing*:** Community testing may be encouraged in the intervention areas of TG/Hijra people to enhance the service uptake including HIV testing. This community testing model will also address the achieving the coverage, enhancing the service uptake and promotes periodical medical check-up. In this regard, attempt may be made to promote testing at Jamath/Gharana, hotspots, DICs, etc. The same may be piloted by introducing: mobile testing centre, outreach by ICTC team, conducting health camps, etc.

- ***Enhance accompanied referral*:** Currently, the peer educators are showing keen interest in achieving the monthly target to obtain the honorarium / incentivisation. Considering the target based approach, the peer educators accompanies the community members only selectively. The promotion of accompanied referral may help in reducing the gaps between referral and testing, gaps in availing services, etc. The accompanied referral / visits will also help in addressing the apprehensions in seeking services.

- ***Reaching the high end, mobile based and technology enabled TG/Hijra people*:** From the study, it is observed that, the TG/Hijra people are operating through non-hotspot based approach by using mobile phones, social media, networks, etc. They operate in the form of: Massage provider, home visits to bachelors, working in bars & engaging clients, call boys/girls, etc. It is also revealed that:

    - The TG/Hijra people reach out to new groups through social media / networks;
    - Referral by one client to the other client; etc.

Operating through high end / technology enabled client identification and engagement is helping in: direct income without any commission to the middle man or brokers, no mischieving clients, no rowdies and getting higher income. This motivates the young entrance, operates through non-hotspot based approaches. The intervention does not have very strategic provision to reach these groups considering the various reasons.

- ***Move from hotspot based to non-hotspot based – need to pilot:***

    - From the study, it reveals that, in an average 30-60% of the TG/Hijra people are operating in hotspots. However, this number varies from intervention to intervention, based on the typology of the TG/Hijra people, seasonality, mobility pattern, etc.

    - Remaining 40-50% are not operating through hotspot. The study reveals that, about 40% of the community members either partly visits hotspot or not at all visiting the hotspot. Some of these community members initially, operated through hotspots now moved from hotspot to non-hotspot. This also to an extend hinders in reaching the community members, motivating them seek services and reasons for not achieving the required amount of targets in accessing services including testing and treatment for STD.

- ***Develop mechanisms for Jamath based and non-Jamath based interventions to reach out more TG/Hijra people***:

    - Capitalize the Jamath based events conducted at regular intervals. The Jamaths conducts different activities in the entire year. The community members (Chellas) comes together and celebrate the occasions. This platform provides opportunity for large gathering (from 40-80 Chellas at a time in a day in a place). These Chellas includes community members operating in hotspot and non-hotspot. The outreach team may be encourage or new strategies emerged to reach the Jamath based approaches for reaching the unreached, ensuring services for the already reached groups and for effective interventions.

    - Efforts may also be undertaken to provide basic services at Jamath such as: distribution of condoms, HIV testing through extended testing team / mobile units and health camps for STD treatments. Initially, Jamath based interventions may be introduced. Slowly, all the community members may be encouraged to access services from public health facilities and designated clinics.

- ***Emphasize on engaging TG/Hijra people representative as peer educators / outreach workers in the composite interventions***: From the in-depth interview and FGDs, it is observed that:

    - The NGOs involved in implementing core composite intervention, appoints the non-community members as peer educators to reach the TG/Hijra people. This also one of the reasons in reaching the target groups and ensuring services.

- Considering the need for engaging community based peer educators, the respective implementing agency (NGO/CBO) need to be emphasized to engage community based peer educators. The TSUs and SACS may need to take utmost care in ensuring the community based peer educators in all interventions in the entire country.

- ***Piloting extended clinics / mobile clinics and providing services through satellite clinics***: Efforts may be made to pilot on the possibilities of using mobile STI clinic / two-wheeler based mobile STI clinic, to undertake visits to DICs, NGO office and other satellite clinics identified in the intervention areas to enable the community members to access and seek services. Satellite clinics may be of any community centre, sub-centre of the PHC, peer educators' residence, school building or any other premises which ensures privacy and easy access.

- ***Promoting community level blood collection by engaging trained technicians for HIV testing***: The blood collection for HIV testing may be undertaken by training a peer educator or volunteer to collect blood samples at the field level and transport to the testing centers for HIV testing by adopting basic guiding principles. The HIV test results may be provided to the individual by adopting post-counselling at the facility level. This will help in addressing the current gaps. Also will help in undertaking blood collection at the convenience of the community members by addressing the challenges such as: stigma, non-convenient timing, distance and other factors.

- ***Continuing Prevention Plus services:*** Currently, VHS-MSA DIVA project is providing services on Prevention Plus. Such services may need to be continued for all the CBOs for providing comprehensive package of services both through ongoing intervention and additional support from the key stakeholders.

3.12. Mainstreaming:

- ***Strong advocacy and greater engagement of SALSA and NALSA for addressing issues pertaining to the TG/Hijra people***: Community members praised the engagement of SALSA and NALSA for their support. It is suggested that, these organizations may be effectively engaged in a consistent manner for addressing field level challenges and community members' needs, priorities and rights.

- ***TG Welfare board***: This board was initially established in Tamilnadu. This board is being established in many other states. This board provides opportunity for enhancing Govt., support for the welfare of the TG/Hijra people. The welfare facilities introduced, political commitment, recognition and other aspects will create an enabling environment for TG/Hijra people to lead a normal life. This will also help in eliminating stigma and discrimination. This will contribute for TG/Hijra people to participate in the intervention, avail services and partner in the CBO initiatives.

3.13. Research:

- ***Compare the advantages / effectiveness of composite model vs. standalone model***: A study on the advantages of composite model, standalone model may be undertaken to explore the real effectiveness for reaching the unreached, enhancing the uptake of services and achieving 90-90-90.

The study is intended to identify the existing challenges, identifying possible suggestions to improve the service delivery among Transgender/Hijra people. The recommendations listed out above are inter-related and complementing each other towards improving the service delivery. Some of the recommendations are directly related in improving service delivery. Some of the recommendations are indirect contributory factors for improving service delivery by further developing systems, addressing the gaps, improving further capacity building, developing linkages, undertaking researches, improving coordination & linkage systems, etc. The suggestions and recommendations emerged meant for further review, discussions and evolving need based strategies to address the existing gaps and move towards achieving 90-90-90.

4. Annexures:

4.1. FGD tools:

1. Emerging sexual behaviours, networking and dynamics among TG/Hijra people:
   - Different typologies currently being addressed through the intervention
   - Whether the intervention is able to reach out all the typologies as a part of the ongoing intervention?
   - What are all the new networking and sexual operations emerging?
   - Suggest possible approaches will help in reaching out the newly emerging groups / typologies / networks.
   - How much the team members are access and usage of technologies (mobile phone, internet, facebook, WhatsApp group, YouTube, Instagram, etc.)?

Type of phone	Average % of usage by community members
Using ordinary phones without internet	
Using phones with internet (Android)	
Using tab	
Using laptop	
Other devices	

   - What hinders the non-hotspot based community members to visit hotspot and seek services?

2. How effective are current strategies in reaching out and delivering services to the target groups?
   - Opinion on the existing package of services is being provided to the community members.
   - What are all additional core package of services need to be provided for strengthening prevention program?
   - Your opinion on providing prevention plus services, if so, what are all prevention plus services need to be provided?
   - Effectiveness of peer educators program in promoting behavior change and motivating the community to seek services.
   - Opinion on the existing communication materials and IPC activities supporting the ongoing interventions.
   - Whether the intervention is able to reach the new entrance, young groups and hidden groups?
   - How the existing mentoring support is helpful in overcoming the challenges?

3. What are all the existing challenges in access to services such as: STI, HIV testing, condom, ART, HIV/TB, etc.?

Services	Existing challenges / hindering factors	
	At the intervention level including community perspectives	At the service facility level
Condom usage		
STI		
HIV testing		
ART		
HIV/TB		

4. In your opinion, what are all the efforts need to be undertaken to overcome the challenges and enable the TG/Hijra people to access services?

At CBO level	
At community level	
At SACS and TSU level	
At NACO level	
At other stakeholders level	
Any other suggestions	

5. Suggest possible ways and means to overcome the current gaps in service uptake (what efforts will help in improving the service uptake at the intervention level) – discussions may be in general. The information may be collected and grouped into these categories.

Capacity building and technical update:
Package of services:
Reaching the unreached (hotspot based and non-hotspot based):
Service uptake (STI, HIV testing, linkage with ART, HIV/TB and condom usage):
Communication materials required to support the intervention (print, non-print including technology enabled if any):
Innovations / pilot initiatives for improving the overall reach and service uptake:
Enabling environment for TG/Hijra people for reaching and service uptake:
Social protection and mainstreaming:
Any other:

6. For overall enhancing the quality of intervention program and improving the service uptake among the community members at regular intervals, please share any other suggestions.

4.2. In-depth interview tools:

1. Personal profile:

Name	
Designation	
Age	
Sex	
Overall experience in HIV/AIDS program	
Experience and association with intervention among TG/Hijra people	
Category of community members / stakeholders (please refer the sample selection table)	
Representing from (please select the appropriate)	• SACS • TSU • STRC • Condom social marketing • Health care provider • Counselor • Outreach worker • Peer educator • Community member • Community based organization • Any other, specify

2. Kindly share your association with intervention among TG/Hijra people (specific roles / contributions, support being extended, type of support / contribution, etc.).
3. In your opinion, what are all the existing challenges in the ongoing intervention program among TG/Hijra people?
4. What are all the emerging sexual behaviours, networking and dynamics among TG/Hijra people?
5. How effective are current strategies in reaching out and delivering services to the target groups (package of services, information on prevention plus services, effectiveness of peer educators, opinion on the existing communication materials, whether the intervention is able to reach the new entrance, young groups and hidden groups and opinion on the existing mentoring support)?
6. What are all the existing challenges in access to services such as: STI, HIV testing, condom, ART, HIV/TB, etc.?
7. In your opinion, what are all the efforts need to be undertaken to overcome the challenges and enable the TG/Hijra people to access services?

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