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Facilitator's Manual

For building capacities on the Operational Guidelines for implementing Targeted Intervention among hijras and transgender people in India

FACILITATOR'S MANUAL

FOR BUILDING CAPACITIES ON THE OPERATIONAL GUIDELINES FOR IMPLEMENTING TARGETED INTERVENTION AMONG HIJRAS AND TRANSGENDER (H/TG) PEOPLE IN INDIA

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Foreword

Acknowledgement

Acronym

AIDS	Acquired Immuno-Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CBO	Community Based Organisation
DAPCU	District AIDS Prevention and Control Unit
FSW	Female Sex Worker
GIPA	Greater Involvement of People Living with HIV/AIDS
HCP	Health Care Provider
HIV	Human Immuno-deficiency Virus
HRG	High Risk Group
H/TG	Hijra/Transgender people
ICTC	Integrated Counselling and Testing Centre
IEC	Information, Education and Communication
LL	Lower Level
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
OI	Opportunistic Infections
ORW	Outreach Worker
NACP	National AIDS Control Programme
NGO	Non-governmental Organisation
PE	Point Estimate
PLHIV	People Living with HIV
PO	Programme Officer
PPTCT	Prevention of Parent to Child Transmission
RNTCP	Revised National TB Control Programme
SACS	State AIDS Control Society
SAEP	School AIDS Education Programme
SBC	Strategic Behaviour change Communication
STI	Sexually Transmitted Infection
TO	Technical Officer
STRCs	State Training and Resource Centres

TG-H	Transgender – Hijra
TI	(STI/HIV) Targeted Intervention
TSU	Technical Support Unit
UL	Upper level

Introduction

In NACP-IV, one such group which has been recognized as a High Risk Group (HRG) and difficult to reach is the Hijras and Transgender People (H/TG). It is estimated that the HIV prevalence rate in India amongst the transgender community is 8.82% (HSS 2010-11), and therefore, intensive efforts have been made to control the spread of HIV infection within this group. In India, the national programme for hijras and transgender populations has been scaled up with adequate quality on a priority basis so as to make the prevention and care services available with the aim to reduce the HIV prevalence among these high risk H/TG populations.

Targeted HIV Interventions for Hijras and Transgender (H/TG) people are relatively new and thus, necessitate conceptual clarity, implementation abilities and enabling environment to work efficiently. Ensuring performance of the programme and achieving intended outcomes are possible only if adequate improvement mechanisms and quality control are in place along with support structure. Besides, it is immensely important to provide continuous capacity building, intensive technical support, mentoring on the ground, regular monitoring, and capturing/sharing of lessons learnt/good practices that gives inputs to the programme for reaching the desired results.

In view of that, National AIDS Control Organisation (NACO) developed separate operational guidelines (OG) for H/TG in 2015 and it defines the essential and comprehensive package of services with procedures in a step by step approach for start-up, scale-up, implementation, management, and M&E accompanied with the tools and instruments.

The OG for H/TG is primarily meant for the CBOs/NGOs implementing the Targeted intervention for Hijras and transgender people in India that are supported by NACO/SACS (both stand-alone and core composite interventions). It provides adequate information to CBOs/NGOs and the TI implementation staff viz., PM, ORWs and Peers to plan, implement and provide high quality prevention and care services to Hijras and transgender people.

With the aim to implement the OG and to scale-up intervention along with the quality services among H/TG, this facilitator's manual has been developed. This manual will assist the facilitators/mentors to build the capacities of the TI staff to scale-up and reach the H/TG with quality services. This facilitator's manual will also be of great help to the SACS/TSU officials to use it as a tool for continuous capacity building, technical and mentoring support to the Tis of H/TG. It can as well be used as a self-learning material by the NGO/CBOs.

Need for facilitator's manual

Successful scale-up of targeted intervention with the aim to deliver quality HIV related services to H/TG demands adequate skills and capabilities at the field level. It is also part of the mandate to develop the capacities of field-level TI staff and peer-educators to achieve one of the objectives of the National HIV strategic framework for H/TG. This facilitator's manual provides requisite knowledge, skills and appropriate perspective to assist the facilitators and other mentors to enhance

the field capacities for effective scale-up of quality prevention and care services to H/TG. Tremendous efforts have been taken by NACO/SACS/TSU and all other stakeholders to build the capacities at the field. It is also felt that there is a recognized need for a comprehensive capacity building toolkit, particularly on the operational guidelines, that can be handy in the field for the on-site support for NGO/CBOs.

The Objectives of the Facilitator's Manual:

The main objective of the facilitator's manual is to translate the operational guidelines for implementing the targeted intervention for H/TG in India as a capacity building tool.

The specific objectives are as given below:

1. To equip the facilitators and other technical support providers with adequate expertise on H/TG intervention.
2. To assist the facilitators and other technical support providers deliver the capacity building activities in a systematic way.
3. To help to train the field level TI staff with the critical knowledge and skills to effectively scale-up and implement targeted interventions for H/TG; and to impart the programme as well as technical perspectives of the HIV intervention and service delivery for H/TG.
4. To aid the facilitators with appropriate methods and techniques to transfer the know-how that is related to H/TG Intervention
5. To design this manual in such a fashion that it can as well be used as a tool for self-learning and technical/mentoring support and not alone a mere training material.

This manual has been developed keeping in mind the field level requirement of the TI staff & peer educators. The requisite knowledge, skill and attitude on the ground to implement targeted intervention among H/TG have been thought through in the planning process of development of this facilitator's manual.

Who can use this Facilitator's Manual?

The facilitator's manual are meant to be used by the trained facilitators, TOTs, POs of TSUs and other officials of NACO/SACS/DAPCU & TSU whose activities may include providing technical and mentoring support to the NGO/CBOs implementing TI for H/TG.

Who is the target audience to be capacitated / provided with technical on-site support?

The main target audiences to be provided with capacity building / technical on-site support for which this facilitator's manual was developed are NGO/CBOs and all the staff implementing TI for H/TG. The staff includes:

- Project Head / Management official of NGO/CBO
- Programme Manager
- Counselor

- M&E Officer
- ORWs
- Peer Educators

Training / Capacity Building Strategy

All sessions that are arranged in sequence can be delivered as a complete training workshop at one time stretched over four-five days. As in the case of providing technical/mentoring support, the activity at the field level can be extended over a period systematically in accordance with the plan.

For effective outcome, it is recommended to take a maximum of 30 participants for one workshop. The number of trained facilitators needed will depend on the availability of the subject experts and the officials from NACO/SACS/TSU and other thematic technical assistance agencies.

Sessions Plan

The capacity building programme has sixteen key sessions covering core components and areas of targeted HIV intervention among H/TG. Besides, it has an opening session as well as a closing session. Every session is designed in the same way keeping in mind to address the three key aspects, viz., knowledge, skill and attitude, wherever it is necessary. The knowledge, skill and attitude that are most essential at the field level to scale up / implement the H/TG Intervention have been highly considered. Few complementary sessions on the topics related to mental health, gender affirmative surgery, etc. that were not covered in the operational guidelines which later found to be relevant have been included in this manual. Besides, in the context to the emerging advancement and the demand for establishing class and innovation, a session on Knowledge Capturing/Sharing is added as well.

The outline of the capacity building plan and/or the structure of the workshop are given below.

SN	SESSION	EXPECTED TIME
1.	Opening Session	75 Minutes
2.	Introduction to Sex & Sexuality & Understanding Sexual and Reproductive Health	100 Minutes
3.	Basics about HIV & AIDS and Identifying Risk & Vulnerability Factors	90 Minutes
4.	Background - The need for scale-up of HIV response for H/TG	40 Minutes
5.	National HIV strategic framework and objectives for H/TG	20 Minutes
6.	Start-up - Phase 1 of the Intervention	90 Minutes
7.	Phase 2 of the Intervention - Strengthening Peer Education system	60 Minutes
8.	Outreach Planning	120 Minutes
9.	Communication for behaviour change & counselling	90 Minutes

10.	STI & other clinical services	90 Minutes
11.	Condom programming	90 Minutes
12.	Community ownership	90 Minutes
13.	Creating an Enabling Environment	90 Minutes
14.	Linkages with other HIV Prevention, treatment, care and support services	90 Minutes
15.	Access to Healthcare: General Health Services (Physical / Mental), and Gender Transition Services (including gender-affirmative surgeries)	90 Minutes
16.	Mental Health Issues in H/TG	30 Minutes
17.	Programme Management	90 Minutes
18.	Introduction to the capturing of experiential knowledge, good practices, innovations & systematic knowledge sharing	
19.	Closing Session	60 Minutes

About the Facilitator's Manual

This Manual comprises of materials that the facilitator/mentor requires to lead the participants through the capacity building exercise. It is easy to follow and contains the following:

- Session plan including time frame, methods, content, etc., for each;
- Guidelines/instructions on how to conduct each session;
- Information to present through Slides/Chart along with discussion guides and key Q&A sessions;
- Ice-breakers, learning exercises, etc.; and
- Role-plays, group exercises and demonstrations.

Methods and techniques adopted for the Capacity Building

In order to overcome the unwieldy processes and for effective knowledge transfer, skill enhancement and perspective building for the field level implementers, a variety of participatory methods that were time tested have been appropriately identified and meticulously employed in the design of this capacity building activity. It includes interactive presentations, role-plays, group work, demonstrations, Q&A sessions, games, and brainstorming sessions to facilitate exchange of ideas and encourage participants to apply knowledge and skills from the sessions. Many new role-plays and other innovative exercises have been introduced here for the first time.

The methods adopted will aid not only the easy knowledge transfer, but also employs hands-on exercises to learn and familiarize the tools that are required for planning and implementation of TI among H/TG. The participants are encouraged to actively engage in all the discussions and the exercises and seize this opportunity to enhance one's knowledge and skills to augment the efficiency of individuals and teams in the work.

This capacity building tool/facilitator's manual uses the technique - key points to emphasize information. The key points covered in each session are clearly outlined

(throughout this Facilitator's Manual) and are expected to be reinforced throughout the workshop (by facilitators and participants), by repeatedly writing them, putting them on display and reiterating them verbally in a strategic way. Key points from preceding sessions need to be reemphasized and reinforced in each subsequent session and other relevant sessions. Key points will be summed up by the facilitator at the closing of each session in the form of 'take home messages'. It is recommended to encourage one of the participants each day to volunteer for recording those 'take home messages'.

Follow-up activities and on-site support

It is important to plan for follow-up activities and technical/mentoring support while the participants attempt to apply the skills that they have learnt in the workshop. The POs of TSU and other officials of SACS/TSU and also the officials of DIVA Project are required to provide the technical and mentoring support to the TI staff by using this facilitator's manual as a tool.

Towards the end of the workshop, facilitators (with the assistance of the SACS/TSU officials) help each participant or a team from same TI to write a plan or list of actions that they will undertake to apply the skills learnt.

How a facilitator/on-site support provider can be effective and proficient?

The effective facilitator should:

- Be enthusiastic about the subject and have a capacity to deliver it in an interesting way.
- Have a warm and welcoming manner and an ability to show approval and acceptance of participants.
- Be able to build a good rapport with the group.
- Be able to lead without constraining participation.
- Be able to create an interactive environment, i.e. by asking questions, moving around the room, always addressing the whole group, and avoiding focusing on a small group or individual.
- Always speak clearly and in understandable language, addressing all participants.

The effective facilitator needs to:

- Ensure that the appropriate visual materials, such as flipcharts or laptop / /PPTs are available and ready.
- Keep visual aids simple and legible.
- Use the room and visual aids as required without creating interference in the process.
- Regularly check that participants understand the information being presented and keep them interested and engaged.
- Use interactive techniques, such as asking open-ended questions which require participants to explain and give detailed answers that demonstrate their comprehension.
- Give participants a genuine chance to arrive at the answers to the questions included in each session themselves. Questions are asked in such a way that

participants should be able to find the appropriate answer by looking at the relevant figures displayed or by drawing from their own experience, or from material that has been covered previously in the workshop.

- Sometimes, participants may need additional help in finding the answer; in such cases, you may opt to give them a hint. In other instances, you may find that asking the question again in a different way can help.

In line with the key principles of adult learning, facilitators should also aim to:

- Encourage discussion and sharing of ideas and experience. Learning is more effective and faster when it builds on what learners already know or have experienced.
- Ensure to have a non-judgmental attitude to participants (even if he or she does not share their views).
- Create conditions so that the participants will learn in an atmosphere of acceptance, respect and encouragement, one in which they will feel free to ask questions and contribute to discussions.
- Communicate clear messages to learners; this minimizes confusion and facilitates learning.
- Present information in a logically ordered and structured way.
- Facilitate learning by using a variety of training methods and techniques.
- Build trust with learners by demonstrating that he or she is equally committed to the training and is willing to share his or her own experience.
- Provide opportunities for learners to practise what they are learning and to address feelings and ideas as they arise.
- Encourage team work and a sense of belonging through active participation.

Tips and techniques for facilitation skills

Time management

- Emphasize important points; try to avoid repetition unless really useful.
- Do give a few local examples; avoid introducing too much extra material.
- If it is necessary to read from the guide, look at the audience regularly.
- Keep to time: pace yourself; gauge the group regularly to ensure that you are not moving too fast or too slow; do not take too long with the early parts of the session.

Use of materials

- Follow the session plan accurately and completely; use your guide.
- Prepare thoroughly; read and obtain any materials that you need beforehand.
- Prepare your helpers (e.g., for role-plays) before the session; practise if possible.
- Do not learn the session by heart; follow the guide but talk in your own way.

Visual aids

- Have the required aids and equipment ready; check and arrange them before the session.
- Make sure that everyone can see clearly; arrange the room so they can
- Point to what you are talking about on the projector or on the screen as appropriate.
- If using a flipchart or a board, write in large, clear letters.
- Cover, turn off, or remove visual aids that are not in use any more.

Speech

- Speak clearly, slowly and loudly enough for everyone to hear; be natural and lively; vary the tone of your voice as appropriate.
- Write difficult new words on the flipchart; pronounce and explain them.

Interaction

- Interact with and engage all participants; address them by name as appropriate.
- Ask the questions suggested in the text; ask different participants; encourage quiet participants to speak.
- Allow time for participants to answer; do not give the answers too quickly; drop hints if needed.
- Respond encouragingly and positively to all answers; correct errors with tact and sensitivity.
- Avoid discussions which are off the point or distracting; postpone them if necessary. Try to give satisfactory answers to questions from participants.

Movements

- Take centre stage; avoid standing in a corner or behind a desk.
- Face the audience; do not face the board or screen when speaking.
- Avoid blocking the audience's view.
- Make eye-contact with people in all sections of the audience.
- Use natural gestures and facial expressions.
- Move around the room; approach people to get their attention and encourage their participation.

Onsite support Skills: to be included

What are the materials and equipment required?

MATERIALS	EQUIPMENT

- Copy of the facilitator's Manual
- PowerPoint Slides
- Pre-test & Post-test Questionnaire
- Markers & sketch pencils
- Notebook and Pens for Participants
- Feedback questionnaire
- Logistics note

- Flip charts & stand
- Laptop
- LCD Projector
- Chart papers
- Tape to stick

Instruction Notes to use the Facilitator's Manual

In order to guide the facilitator effectively to lead the session, the following styles and format have been followed.

Script for the facilitator to SAY is written like this. (In Italics, black)

Instructions for the facilitator to DO are written like this. (In Italics, dark red)

The key points are underlined in small dots in dark red like this.

All the information to be presented is written like this. (Normal font, black)

Details of method and the subtopic are written like this (normal, bold, blue) along with icons.

Pointers for preparing the session is written like this as a right side alignment text

ICON GLOSSARY:

PowerPoint Presentation

Use flipchart

Interaction

Role Play

Group work

Summing up

Key point

Q & A Session

Workshop Preparation Checklist

Task	✓
Obtain and test the LCD projector and the Laptop	
Obtain and test the Laptop	
Obtain flip charts and markers	

Obtain copies of the facilitator's manual for all the Facilitators	
Stationeries	
Prepare flip charts	

REMEMBER!

HIV/AIDS, Sex/Sexuality, STI, Hijra/Transgender is a very sensitive topic. Be aware that participants may have strong feelings and may have certain apprehensions about this topic. It is also likely that some participants are themselves from the community and/or living with HIV or have close family or friends who are living with the disease. Help participants to understand and accept each other's experiences and perspectives and to show mutual respect without passing judgment. Avoid and rectify any comments that can sound critical of community and of those infected or affected.

Opening session

Learning objectives:

By the end of the session, the participants will be able to:

- understand the objective and purpose of this workshop/on-site support, the agenda and its details
- familiar between participants (get to know each other)
- complete the pre-test
- share the expectations from the workshop/ on-site support and get the clarity about the workshop without any apprehensions

Session outline

SN	Content	Time
1.	Introduce the objectives, purpose of the workshop/ on-site support and sharing the workshop agenda/ on-site support plan	10 minutes
2.	Introduction of participants	20 minutes
3.	Pre-test	20 minutes
4.	Ground Rules / Expectations & Apprehensions	15 minutes
5.	Summary of the session and transition	10 minutes
	Total	**75 minutes**

Pointers for preparing the session

Prepare a slide on the learning objectives of this session.
Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.
Prepare slides on the introduction to the workshop; combine all the slides as one presentation.
Develop questionnaire for the pre-test.
Arrange all the equipment and materials including LCD projector, laptop, flip-charts along with the stand, markers/sketches, etc.

Presentation: Details of the workshop/capacity building activity

Introduce the objectives, purpose of the workshop/ on-site support and sharing the workshop agenda/ on-site support plan (10 minutes)

At the outset, commence the session with suitable greetings and by introducing yourself, and subsequently introduce the other facilitators and their brief profile (achievements).
(Important note: It is always good if someone introduce you first with appropriate introduction with your brief bio sketch particularly about all your credentials and achievements)

After introducing yourself, ask the participants if all of them have a copy of an agenda (Annex 1). If someone is not having a copy of the agenda, please provide one.

Indicate the objectives of the session.

Present the objectives and purpose of the workshop/capacity building activity. If needed, you can use PPT slides. Display the PPT slides and outline the aims and objectives. Use the following information for further explanation:

The objectives of the Workshop/On-site support:

The objectives of this workshop/on-site mentoring are to support the NGO/CBOs and its staff & PEs to:

1. Learn and understand the key activities and the tools outlined in the operational guidelines for implementing targeted intervention for H/TG in India
2. Learn the critical knowledge and skills for effectively implement and scale-up targeted HIV intervention for H/TG
3. Gain appropriate perspectives on the technical/programme aspects of the HIV intervention and service delivery for H/TG

The Purpose of the Workshop:

- In India, the national programme for H/TG has been scaled up with adequate quality, so that care services are made available to these populations and HIV prevalence among H/TGs will be reduced.

- Targeted HIV Intervention for H/TG are relatively new and necessitate conceptual clarity, implementation abilities and enabling environment for them to work.

- Ensuring performance of the programme and achieving intended outcomes are possible only if adequate mechanisms and quality control and improvement mechanisms are in place and regularly monitored and evaluated and lessons learnt are used improve the programme.

- Thus, NACO prepared separate operational guidelines for implementing targeted intervention among H/TG in India in the year 2015.

- These guidelines define the essential and comprehensive package of services with procedures for implementing, M&E and costing.

- These guidelines provide adequate information to CBO/NGOs and TI implementation staffs, that is, PM, Counselor, ORWs, Peers and every other staff, to plan, implement and monitor high quality prevention and care services to H/TG.

- The purpose of this workshop/on-site support is to fulfill the fourth objective of the National HIV strategic framework for H/TG, that is, 'strengthen the capacity/skill building of partners'. It is intended to address the field demand for adequate skills and capabilities for effective scale-up of targeted intervention for H/TG. This workshop will also provide requisite knowledge, skills and appropriate perspective to strengthen the field capacities in order to deliver quality prevention and care services for H/TG.

Give an overview of the workshop/on-site support methodology

Methods and techniques adopted

In order to overcome the unwieldy processes and for effective knowledge transfer, skill enhancement and perspective building for the field level implementers, a variety of participatory methods that were time tested have been appropriately identified and meticulously employed in the design of this workshop/capacity building activity. It includes interactive presentations, role-plays, group work, demonstrations, Q&A sessions, games, and brainstorming sessions to facilitate exchange of ideas and encourage participants to apply knowledge and skills from the sessions. The methodology adopted will aid not only the easy knowledge transfer, but also employs hands-on exercises to learn and familiarize the tools that are required for planning and implementation of TI among H/TG. The participants are encouraged to actively engage in all the discussions and the exercises and seize this opportunity to enhance one's knowledge and skills to augment the efficiency of individuals and teams in the work.

Give information on administrative matters (e.g. stay, food, other facilities, point persons details, etc.)

Ask the participants if they have any queries on the above and answer those questions that come-up.

Icebreaker: 'Get to know each other'

Introduction of Participants (20 minutes)

First, ask the participants to get to know the person next to them and extract as much information about them as possible, in order to present them later on to the rest of the group (their name, organization, education qualification, experience, any talents, etc.) – give five minutes time.

Once everyone is done, now ask participants to present their neighbours (briefly) to the rest of the participants.

Exercise: Pre-test

Pre-test (20 minutes)

Distribute copies of the Pre-test and inform participants that they have 15 minutes to complete it.

Ask participants to write down their names to help with the analysis of the test results.

Explain about the pre-test process and the details.

Once it is done, please collect back the filled in pre-test papers.

Exercise: a) Ground Rules b) Expectations & apprehensions

Establishing Rules for this Workshop (5 minutes)

Ask the participants to come up with their own rules for the duration of the workshop. What should we all adhere to in order to make the workshop a success?

What are the rules we want to set for ourselves to get the most out of this workshop?

Examples: be on time, turn off mobile phones/laptops, listen to your peers, respect different opinions, be concise in your answers/statements, stay throughout the entire duration of the workshop, speak up, don't take any comments personal, dare to ask questions, etc.

Ask your co-facilitator or any volunteer from the participants to capture the rules on a flipchart and then post it for all to see.

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Identifying the expectations & apprehensions of participants (10 minutes)

Explain about the exercise and the details. Make the participants to feel comfortable and share their expectations and apprehensions, if any.

Ask the participants to tell or share (one by one) about their expectation about the workshop.

Ask your co-facilitator or any volunteer from the participants to help you write down participants' expectation from the workshop on the flipchart and post the complete list on the wall.

Once it is done, similarly, ask the participants to tell about their apprehensions about the workshop, if any.

Ask your co-facilitator or any volunteer from the participants to help you write down participants' apprehensions about the workshop on the flipchart.

If any apprehensions are shared, please acknowledge and appreciate them and then attempt to explain it.

Interaction: Summing-up, Key points and Q & A

Summary of the session and transition (10 minutes)

At the end, summarize the key points and ask the co-facilitator or participant (volunteer) to write on a flipchart.

The key points to be remembered:

The objectives of this workshop/capacity building activity are to support the NGO/CBOs and its staff & PEs to:

1. Learn and understand the key activities and the tools outlined in the operational guidelines for implementing targeted intervention for H/TG in India
2. Learn the critical knowledge and skills for effectively implement and scale-up targeted HIV intervention for H/TG
3. Gain appropriate perspectives on the technical/programme aspects of the HIV intervention and service delivery for H/TG

The Purpose of the Workshop:

- In India, the national programme for H/TG has been scaled up with adequate quality, so that care services are made available to these populations and HIV prevalence among H/TGs will be reduced.
- Targeted HIV Intervention for H/TG are relatively new and necessitate conceptual clarity, implementation abilities and enabling environment for them to work.
- Thus, NACO prepared separate operational guidelines for implementing targeted intervention among H/TG in India in the year 2015.
- These guidelines provide adequate information to CBO/NGOs and TI implementation staffs, that is, PM, Counselor, ORWs, Peers and every other staff, to plan, implement and monitor high quality prevention and care services to H/TG.
- The purpose of this workshop/capacity building activity is to fulfill the fourth objective of the National HIV strategic framework for H/TG, that is, 'strengthen the capacity/skill building of partners'. It is intended to address the field demand for adequate skills and capabilities for effective scale-up of targeted intervention for H/TG. This activity will also provide requisite knowledge, skills and appropriate perspective to strengthen the field capacities in order to deliver quality prevention and care services for H/TG.
- The methodology adopted will aid not only the easy knowledge transfer, but also employs hands-on exercises to learn and familiarize with the tools that are required for planning and implementation of TI among H/TG. The participants are encouraged to actively engage in all the discussions and the exercises and seize this opportunity to enhance one's knowledge and skills to augment the efficiencies of individuals and teams in the work.

Select one participant who can volunteer for recording the 'take home messages'. This will be presented on the morning of the 2nd day as part of recap of the previous day (1st day) before going to the scheduled session of day two.

Ask if there is anything that requires clarification, or if there are any doubts/questions.

Clarify all the doubts and queries, if any, that have come up.

Now we are moving to the interesting part, that is, to the core sessions, technical sessions. As per the agenda, we will cover the topic - Introduction to Sex & Sexuality and Understanding Sexual and Reproductive Health in the next session. So and so (please,

name/introduce the facilitator for the next session) will present/facilitate the next session who is an expert on the subject and has extensive experience in the sector/field.

Session 1: Introduction to Sex & Sexuality and Understanding Sexual and Reproductive Health

Learning objectives:

By the end of the session, the participants will be able to:

- understand the meaning of the key terms used in the area of sex & sexuality
- understand moral perspective on sexuality
- understand sexual & reproductive health
- get the clarity on certain myths & misconceptions about Hijra & Transgender people (H/TG)

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	Meaning of the key terms used in the area of 'sex & sexuality'	30 minutes
3.	Social perspective on sexuality	20 minutes
4.	Sexual and Reproductive Health	20 minutes
5.	Demystifying misconceptions about H/TG	15 minutes
6.	Summary of the session and transition	10 minutes
	Total	**100 minutes**

Pointers for preparing the session

Prepare slides as one presentation on the learning objectives of this session, key terms used in the areas of 'sex & sexuality', and the interactive session on social perspective on sexuality, sexual/reproductive health and key terms of H/TG.
Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until needed.
Find out appropriate terms in the native languages of the participants. Often, there may not be appropriate equivalent terms in the native language. For example, there is no term in most (if not all) of the Indian languages for 'heterosexual' or 'bisexual'.
(Note: There may be recently coined technical terms for 'homosexual' or 'homosexuality' in the native languages.)
Prepare for the 'Card Exercise' on common queries.

Presentation: Learning Objectives

Review the learning objectives of the session (5 minutes)

Show the slide and discuss the learning objectives.

Talk about the structure of the session and inform that this session will take little longer, i.e. over one hour. Suggest the participants that in between there will energizer exercises which will keep everyone alert.

Request the participants to actively participate and encourage them to ask questions and clarify the doubts if it arises since this session is deals with such a sensitive topic. However, give confidence that at the end of the session, the participants will get good clarity.

Introduce the session

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

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

Meaning of the key terms used in the area of 'sex & sexuality' (30 minutes)

Proceed from simple terms to complex

Please note that not all the key terms in the field of sexuality need to be taught – only those terms that are relevant for the discussion in this course need to be given importance.

Interaction with the participants in this session is very crucial since they need to be very clear in the basic and key terminology that will be used throughout this capacity building activity as well as in their everyday work.

Presentation: Key terms of Sex & Sexuality

Brief the audience on the importance of understanding the basic terminology and concepts in sexuality for better understanding and appreciation.

The definitions of the following can be then shown and explained:

1. **Sex**
2. **Sexuality**
3. **Gender**
4. **Sexual orientation (homosexual, heterosexual, bisexual)**
5. **Sexual behavior (homosexual, heterosexual, bisexual)**
6. **Sexual identity (gay, bisexual, lesbian)**
7. **Gender expression**
8. **Gender identity**
9. **Transsexualism**
10. **Transsexual (male-to-female transsexual, female-to-male transsexual)**
11. **Transgender**

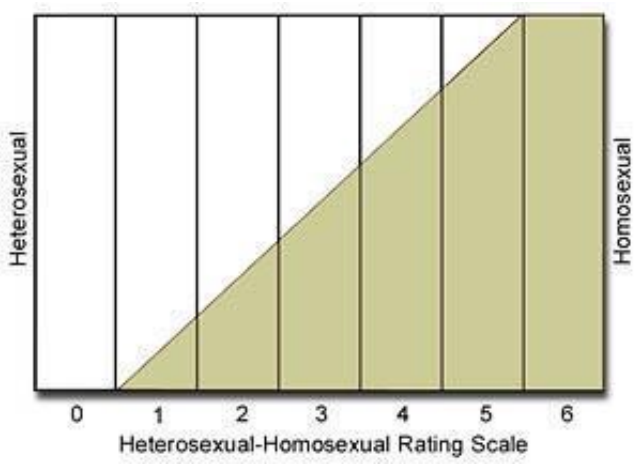
Give examples to the participants to understand the difference between the following:

1. **Sex and gender**
2. **Sex and sexuality**
3. **Sexual orientation and sexual behavior**
4. **Sexual identity and gender identity**

Give examples and provide explanations to show that:

1. Feminine gender expression may or may not be associated with homosexual orientation (a male can be feminine and still have heterosexual orientation/behavior, a male can be masculine but still have a homosexual orientation/behavior).
2. Sexual identity and sexual behavior may or may not correlate (a gay-identified male may get married to a woman and have bisexual behavior, a person without a gay identity might have had same-sex behavior).
3. Point out that masculine and feminine are not dichotomous notions, but rather a continuum and very much based in the culture and era in which one lives.

A modified Kinsey's sexual attraction/behavior scale is given below[1].



0- Exclusively heterosexual with no homosexual [attraction/behavior]

1- Predominantly heterosexual, only incidentally homosexual

2- Predominantly heterosexual, but more than incidentally homosexual

3- Equally heterosexual and homosexual

4- Predominantly homosexual, but more than incidentally heterosexual

5- Predominantly homosexual, only incidentally heterosexual

6- Exclusively homosexual

Once the participants understand the above, tell the participants that gender expression and sexual orientation can be viewed as continuum rather than polar categories of masculine and feminine or heterosexual and homosexual, respectively.

Definitions of Sexuality-related Terms

(From diverse sources: www.indianLGBThealth.info; WPATH SOC 7th edition – www.wpath.org; IPPF online glossary: www.ippf.org/resources/media-press/glossary)

Sex refers to biological status as male or female. It includes physical attributes such as sex chromosomes, gonads, sex hormones, internal reproductive structures, and external genitalia.

Gender is a term that is often used to refer to ways that people act, interact, or feel about themselves, which are associated with boys/men and girls/women. While aspects of biological sex are the same across different cultures, aspects of gender may not be.

Sexual orientation refers to attractions, behaviours, fantasies, and emotional attachments toward men, women, or both. Transgender people may be sexually attracted to man, woman or both.

Identity

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

Gender identity refers to a person's internal, deeply felt sense of being either man or woman, or something other or in between. Because gender identity is internal and personally defined, it is not visible to others.

Sexual identity refers to an inner sense of oneself as a sexual being, including how one identifies in terms of gender identity and sexual orientation. That is, whether one identifies as a heterosexual, homosexual or bisexual person.

A person's ***'gender expression'***, in contrast to gender identity, is external and socially perceived. Gender expression refers to all of the external characteristics and behaviours that are socially defined as either masculine or feminine, such as dress, mannerisms, speech patterns and social interactions.

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011).

Social perspective on sexuality (20 minutes)

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

Exercise: How does society perceive sexuality? - Interaction

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

Possible responses:

Sex is a sin

One should not discuss sex

One should not learn about sex

Sex is necessary only for procreation

Any sexual activity not intended for reproduction is morally unacceptable

Sex outside a marital relationship should be banned

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

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

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

Exercise: 'Card Exercise' to clarify common queries

The facilitator has many cards each containing one statement (true or false) about homosexuality. He/she reads out what is written in each card and asks what the participants think about that statement. The participants are encouraged to tell their opinion. Interactions among the participants are encouraged rather than the facilitator trying to answer or respond to the comments from each participant. After a reasonable period of discussion on a particular statement, the facilitator intervenes and summarizes the discussions and gives the rationale behind why a particular statement is a myth or fact.

Below is a list of statements (false or true) that can be used for this exercise.

- Homosexuality is abnormal
- Homosexuality is unnatural
- Homosexuality is not a mental illness
- Homosexuality can be cured by appropriate therapy
- Homosexual people can be identified by their mannerisms, or appearance.
- Gay people could be cured if they have sex with a person of the opposite sex.

Note:

The trainer is strongly recommended to read the handout from the American Psychological Association (APA) and available as a pdf document at:
http://www.apa.org/topics/lgbt/orientation.pdf

Handout can be distributed to the participants or they can be asked to download and read this handout.

Instructions for the facilitators

Note that some participants may not be satisfied with your 'rationale' behind why a particular statement is a myth or fact. Acknowledge that it may not be possible for everyone to agree or disagree with certain statements and at least make them understand it might have definitely challenged the way they might have thought about that initially. And then move forward to other statements or next session.

Variants of this exercise

Each of the participants can be given one card containing a statement (false or true) and asked to comment on that statement. Later the other participants are asked to talk about their views on that statement. Finally the facilitator intervenes and gives the rationale behind why a particular statement is false or true.

Sexual and Reproductive Health (20 minutes)

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

Exercise

Step 1: Discuss community's perceptions about their bodies:

Ask few participants who are from the H/TG community to share their perceptions about their bodies.

Some of the opinions may be:

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

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

Step 2: Discuss health & hygiene:

Discuss health and hygiene, including the necessity of maintaining personal and environmental hygiene, and its relevance to controlling diseases.

Discuss common communicable and non-communicable diseases

- Communicable diseases: air-borne, water-borne, contamination through body fluids, etc. (for example, TB, malaria, cholera, diphtheria, STIs, AIDS)
- Non-communicable diseases: diabetes, arthritis, cancer, etc.

Step 3: Discuss various parts of the body and its systems:

Discuss about various parts of the body and its systems.

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

Step 4: Discuss male and female reproductive systems:

Discuss major elements of the male and female reproductive systems, their anatomy and physiology.

Use a simple diagram showing the male and reproductive organs to explain the anatomy.

- Female reproductive anatomy: External organs – vulva, labia and clitoris. Internal organs – vagina, uterus, cervix, ovaries, fallopian tubes
- Female reproductive physiology: menstruation, menarche, menopause, ovulation, fertilization, conception, pregnancy, childbirth, etc.
- Male reproductive anatomy: External organs – penis, scrotum, testes. Internal organs – vas deferens, seminal vesicles, prostate gland, urethra
- Male reproductive physiology: puberty, formation of sperm and semen, storage of semen, erection and ejaculation

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

Step 5: Discuss common reproductive health concerns:

Discuss common reproductive health concerns.

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

Step 6: Discuss RTI:

Discuss RTIs.

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

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

Step 7: Discuss sexual/reproductive health rights of TG and Hijras:

Discuss sexual/reproductive health rights of TG and Hijras

- Availability of reproductive health information and services
- Right of transgender to take decisions about their sexual health

Demystifying misconceptions about H/TG (15 minutes)

Transgender-related terms

Transgender person is an individual who does not identify with the gender assigned to them at birth and their experienced gender (self-assigned or self-identified gender) may be opposite to that of the birth assigned gender. Transgender person may also identify as a gender that is in between man and woman or neither man or woman.

Male-to-female (MtF) transgender person is an individual who is born as a natal male (male sex by birth) but whose gender identity is woman (or in between man and woman). Also known as transgender woman or trans woman.

Female-to-male (FtM) transgender person is an individual who is born as a natal female (female sex by birth) but whose gender identity is man (or in between man and woman).Also known as transgender man or trans man.

Transsexual is an adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

Gender-affirmative surgeries (Sex reassignment surgery) refer to surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Gender-affirmative surgeries can be an important part of medically necessary treatment to alleviate gender dysphoria.

Intersex or Intersexuality refers to congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some medical professionals prefer the term 'disorders of sexual development' instead of 'intersex'.

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

Interaction: Summing-up, Key points and Q & A

Summary of the session and transition (10 minutes)

Once again summarize the key points.

The key points to be remembered:

- Every human being is a sexual entity. Feelings about the body and sensual pleasures are all part of the human personality and sexuality. Sex is one of the basic physiological needs of human beings, and people engage in sexual activity primarily for intense pleasure. In many societies, popular norms limit sex to the purpose of reproduction.
- The definitions of the following were learned:
  - Sex
  - Sexuality
  - Gender
  - Sexual orientation (homosexual, heterosexual, bisexual)
  - Sexual behavior (homosexual, heterosexual, bisexual)
  - Sexual identity (gay, bisexual, lesbian)
  - Gender expression
  - Gender identity
  - Transsexualism
  - Transsexual (male-to-female transsexual, female-to-male transsexual)
  - Transgender
- Learned the difference between the following:
  - Sex and gender
  - Sex and sexuality
  - Sexual orientation and sexual behavior
  - Sexual identity and gender identity
- Important points related to sexual orientations:
  - Feminine gender expression may or may not be associated with homosexual orientation (a male can be feminine and still have heterosexual orientation/behavior, a male can be masculine but still have a homosexual orientation/behavior).
  - Sexual identity and sexual behavior may or may not correlate (a gay-identified male may get married to a woman and have bisexual behavior, a person without a gay identity might have had same-sex behavior).

- Point out that masculine and feminine are not dichotomous notions, but rather a continuum and very much based in the culture and era in which one lives.

- **Sexual and Reproductive Health:** Social marginalization and economic status impede TG and Hijras access to information, including health-related knowledge. Their opportunities to learn about reproductive health are very limited. Poor basic knowledge and misconceptions about the body, its different parts and their functioning, hygiene and disease processes, etc. increase their vulnerability to ill health, and especially infection with STIs and other reproductive health hazards. Health education can help Transgender – Hijras understand their bodies, the importance of self-examination and the need for health check-ups, and increases their control over their bodies and their health.
- **Transgender-related terms**
  - Transgender person is an individual who does not identify with the gender assigned to them at birth and their experienced gender (self-assigned or self-identified gender) may be opposite to that of the birth assigned gender. Transgender person may also identify as a gender that is in between man and woman or neither man or woman.
  - Male-to-female (MtF) transgender person is an individual who is born as a natal male (male sex by birth) but whose gender identity is woman (or in between man and woman). Also known as transgender woman or trans woman.
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  - Transsexual is an adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through feminizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.
  - Gender-affirmative surgeries (Sex reassignment surgery) refer to surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Gender-affirmative surgeries can be an important part of medically necessary treatment to alleviate gender dysphoria.
  - Intersex or Intersexuality refers to congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some medical professionals prefer the term 'disorders of sexual development' instead of 'intersex'.
  - Hijras: Individuals who voluntarily seek initiation into the Hijra community, whose traditional profession is badhai but due to the prevailing socioeconomic and cultural conditions, a significant proportion of them are into begging and sex work for survival. These individuals live in accordance to the community norms, customs and rituals which may vary from region to region.

Ask if there is anything that requires clarification, or if there are any doubts/questions.

Let us move on to the next session. We will cover the topic - Basics about HIV & AIDS and Identifying Risk & Vulnerability Factors in the next session. So and so (please, name/introduce the facilitator for the next session) will present/facilitate the next session who is an expert on the subject and has extensive experience in the sector/field.

Session 2: Basics about HIV & AIDS and Identifying Risk & Vulnerability Factors

Learning objectives:

By the end of the session, the participants will be able to:

- understand the basics about HIV & AIDS
- understand and identify the risk & vulnerability factors

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	Basics about HIV & AIDS	25 minutes
3.	Role play on Supportive Attitude towards PLHIV	20 Minutes
4.	Identifying risk & vulnerability factors	45 minutes
5.	Summary of the session and transition	05 minutes
	Total	**100 minutes**

Pointers for preparing the session

Prepare a slide on the learning objectives of this session and also the other slides on basics about HIV/AIDS and identifying risk & vulnerability factors.
Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.
Find out appropriate technical terms in the native (vernacular) languages of the participants.
Prepare for the group exercise and the plan how to conduct it.
Identify potential participants for the role play and train and support them to rehearsal it during the break time.

Presentation: Learning Objectives

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Explain the structure of the session and the expected time of each subsection; inform the methods that will be adopted in imparting the subtopics.

Discussion: Basics about HIV & AIDS

Basics about HIV & AIDS (30 minutes)

Find out appropriate technical terms in the native (vernacular) languages of the participants.

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

Begin discussion about definitions.

Step 1

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

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

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

Step 2

Discuss signs and symptoms of HIV.

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

In the second stage of infection, HIV infected person has no symptoms.

In the third stage, AIDS-related symptoms occur. These include severe weight loss, persistent diarrhoea, night sweating, persistent fever, etc.

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

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

Step 3

Ask participants whether they know the mode of transmission of HIV.

List all their conceptions, and discuss any misconceptions.

How HIV can be transmitted

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

Misconceptions (myths) about modes of HIV transmission

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

Step 4

How to prevent HIV transmission:

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

Step 5

Discuss the social dimensions of HIV.

Ask the participants that what their attitude and behaviour would be if they learned that any of their colleagues was HIV positive.

Role-play a supportive attitude towards an HIV positive person.

Role-play: Why supportive role is important to the HIV positive person?

ROLEPLAY SETTING: In an OFFICE where FOUR PEOPLE WORK as a team in one section.

SCENE1: THE SCENE OPENS WITH FOUR PEOPLE HAVING LUNCH TOGETHER ON SOME DAY AT THE OFFICE AT THE LUNCH HOUR: IT IS A ROUTINE THAT ALL THESE FOUR COLLEAGUES EAT TOGETHER. (*The scene description can be given by someone in the background.*)

The four colleagues are now eating together, sharing their food with each other, and having an informal conversation about the whole world, sharing jokes, gossiping, etc., just like a family. IT IS THEIR REGULAR THING. *(While acting, humorous actions to be made and even some jokes to be shared to make it more fun.)*

SCENE 2: IN THE FOLLOWING WEEK IN ONE OF THE WEEK DAYS

THE SCENE OPENS WITH ONLY THREE PEOPLE, HAVING LUNCH TOGETHER AT THE OFFICE DURING THE LUNCH HOUR

Today, three of them are having lunch as usual. While they are sharing & eating together (*actions like sharing food to be made*), and discussing, someone is casually mentioning that our friend who is not here is on leave and he is not well for the last two, three days. When listening, the other two people express sadness.

SCENE 3: TEN DAYS LATER

THE SCENE OPENS WITH THREE PEOPLE, HAVING TEA TOGETHER AT THE OFFICE DURING THE TEA TIME IN THE MORNING HOURS

The three colleagues other than the person who were on leave meet and having tea. During the conversation, suddenly in a hush voice like a secret one person tells them that our friend who was sick last week is found to be HIV positive. Hearing this, all of them are feeling shocked with disbelief… but among them, one person, even though feeling sad, tells to the other two that in a very casual way that it may not be an issue. He continues, I think he can live a health life. Listening to him, the other two give a surprised look but confused and not able speak anything… they appear to be perplexed, forehead frowned, staring at him briefly and walking away from the place in a confused state.

SCENE 4: ON THE SAME DAY DURING THE LUNCH HOUR.

THE SCENE OPENS WITH FOUR PEOPLE HAVING LUNCH TOGETHER AS USUAL...

The same day during the lunch hour, as usual all four colleagues assembled together to have lunch. But this day the HIV positive person unusually senses some differences in the colleagues' behaviour (except one person). They are not looking at the HIV positive person on his face and avoiding him and behaving unusually, keeping themselves in a little distance, etc. – *this is required to be role-played properly*). However, the HIV positive person even though feeling very bad but not showing it openly instead he is trying behave normal. Today usually all of them immediately start eating without much of any discussion and not enquiring about the other person's food. Suddenly, with much excitement, the positive person shares some sweets which he has but the other two persons hesitate to take and

informing that they don't feel like eating. But the person, who was behaving normal, takes one and thanks him by patting his shoulder. The other two without much conversation completes their food and abruptly leaves the place. So now the person who was supportive to the positive person, again patting in his shoulder says that not to worry about anything and the things will change…, again assuring him that he will be always with him and will speak the other colleagues regarding about their misconceptions about the disease.

Individuals with HIV or AIDS are kept isolated from society and alienated even by their family members. This creates tremendous emotional and psychological stress, which may lead to extreme depression and feelings of fear and guilt. Hence, showing supportive attitude towards PLHIV is the first step to encourage PLHIV to live a positive life.

Identifying risk & vulnerability factors (30 minutes)

Step 1: Group Work (Exercise)

Divide the participants into groups.

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

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

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

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

Vulnerability factors will make risk behaviour more likely and which therefore put someone indirectly at risk of HIV/STI infection. Take for example the following: having group sex, being poor, or being transgender – hijra, etc.

Step 2: Discussion

Facilitate a discussion to encourage the participants from all groups to enhance the list.

Ensure that the participants clearly understand the difference between risk and vulnerability and also the link between the two.

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

Ask the group if risk and vulnerability are mutually exclusive and if any programme would be successful if we work on only one element, either risk or vulnerability.

Discuss a few risk reduction and vulnerability reduction strategies in the context of sex work.

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

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

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

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

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

Interaction: Summing-up, Key points and Q & A

Summary of the session and transition (10 minutes)

Summarize the key points of this session.

The key points to be remembered:

- The term AIDS stands for:
  - A = Acquired – not born with
  - I = Immuno – body's defence system
  - D = Deficiency – not working properly
  - S = Syndrome – a group of signs and symptoms
- AIDS is not a single disease but a syndrome, a group of signs and symptoms resulting from weakening of the body's defence system, which is caused by a virus. HIV is the name of the virus that causes AIDS.
  - HIV stands for Human Immunodeficiency Virus

  - Being HIV positive does not mean that a person has developed AIDS
  - Once a person gets HIV infection, he/she remains infected and infectious throughout his/ her life
  - Treatment can extend the lifespan of an AIDS patient, but it is expensive
  - No curative treatment for AIDS has been discovered so far and thus AIDS is fatal
- HIV can be transmitted through Unprotected sex, Blood and blood products, Sharing of infected needle/syringe, and Infected mother to child.
- Misconceptions (myths) about modes of HIV transmission are Insect bite, Sharing common toilet, bed, common clothing, Casual contact for example handshake, hugging, kissing, Eating together, Air-borne or water-borne, Using common toilet and While taking care of HIV infected persons.
- HIV transmission can be prevented by practicing non-penetrative sex and use condom for every penetrative sex act, use of screened blood and blood products, use of sterilized needle and syringe, and getting treatment of STIs as early as possible.
- Risk behaviour will put someone directly at risk of HIV/STI infection, such as unprotected anal or oral sex.
- Vulnerability factors will make risk behaviour more likely and which therefore put someone indirectly at risk of HIV/STI infection. Take for example the following: having group sex, being poor, or being transgender – hijra, etc.
- Risk reduction addresses the immediate factors of sexual transmission which is mainly because of sex work as an occupation. Risk reduction strategies include Ensuring correct knowledge about STIs/HIV, Ensuring access to treatment of STIs and other health problems, Access to male condoms, Improving condom negotiation and decision-making skills in sexual encounters and Working with clients/partners of sex workers.
- Vulnerability reduction addresses underlying factors affecting transmission: poverty, lack of human rights, gender relations, stigma and discrimination, and legal framework. Vulnerability reduction strategies include Providing economic alternatives to TG and Hijras, Basic amenities like ration cards, Children's education, Promoting legal reforms, Sensitizing/educating clients and police against violence against Transgender – Hijras and Promoting participation and decision-making of Transgender – Hijras in sex work programmes.
- It is emphasized that without understanding and addressing vulnerability factors, behaviour change is not possible. Most of the time changing behaviour is not easy. Only when vulnerabilities are addressed do people respond favourably to knowledge and information. If we are willing to address and accept the vulnerability factors, the HRG is more likely to be willing to find effective and lasting solutions.

Ask if there is anything that requires clarification, or if there are any doubts/questions.

As per the agenda, we will cover the topic - Basics about HIV & AIDS and Identifying Risk & Vulnerability Factors in the next session. So and so (please, name/introduce the facilitator for the next session) will present/facilitate the next session who is an expert in the field and has extensive experience in the sector.

Session 3: Background - The need for scale-up of HIV response for H/TG

Learning objectives:

By the end of the session, the participants will be able to learn about:

- H/TG Intervention in NACP
- Size estimation of H/TG
- HIV & STI Prevalence among H/TG in India
- terminology used - H/TG

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	H/TG Intervention in NACP	10 minutes
3.	Size estimation of H/TG	10 minutes
4.	HIV & STI Prevalence among H/TG in India	10 minutes
5.	Terminology used - H/TG	10 minutes
6.	Summary of the session and transition	05 minutes
	Total	**80 minutes**

Pointers for preparing the session

Prepare a slide on the learning objectives of this session.
Prepare slides on H/TG intervention in NACP, Size estimation, HIV & STI prevalence among H/TG in India & Terminology used
Keep all the slides as one presentation for this session
Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.
Find out appropriate technical and programmatic terms, viz., size estimation, prevalence, mapping, and so on, in the native (vernacular) languages of the participants. Note down those relevant 'words' in the vernacular language to use to during the presentation/discussion.

Presentation: Learning Objectives

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Explain the participants how the session is structured; inform why this session is important as we learn about the national programme for H/TG.

Introduce the session

Explain why it is relevant to understand the need for H/TG Intervention in NACP

Please note that only the broad idea of National AIDS Control Programme (NACP) to be introduced in order to provide the country context and how each intervention contributes to the achievement of overall objectives of the national programme.

Presentation: Details of Intervention among H/TG in NACP

H/TG Intervention in NACP (10 minutes)

Present the following information as a PowerPoint presentation and discuss with the participants.

- In the third phase of the National AIDS Control Programme (NACP-III; 2007-12), National AIDS Control Organisation (NACO) highlighted that 'hijras' & 'transgender people' (H/TG) have different HIV prevention and care needs although there are some commonalities between men who have sex with men (MSM) and transgender people.
- Considering the high HIV prevalence 8.82% among H/TG when compared with other high risk groups, it is crucial that HIV interventions among H/TG are scaled up. To assist NACO, SACS and TI NGO/CBOs (who are implementing H/TG Intervention) in scaling up H/TG interventions, operational guidelines for H/TG interventions have been developed**.**
- The estimated number of new annual HIV infections has declined by more than 50% over the past decade. One of the biggest and most immediate challenges in effectively responding to HIV in India is confronting the truly high rates of HIV infection among Hijras and transgender people**.**
- NACP-III preparation exercises reconfirmed the importance of focusing efforts on prevention amongst high risk groups (HRGs). While much work has been done in India with female sex workers, it was recognized that the national programme needs to be strengthened among Hijras and transgender people**.**
- The national strategy drafted by the NACP-IV working group acknowledges the unique HIV prevention, care, and treatment needs of Hijras and transgender people.

Presentation: Details of Size Estimation of H/TG

Size estimation of H/TG (10 minutes)

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

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

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

Presentation: Details of Size Estimation of H/TG

HIV & STI Prevalence among H/TG in India (10 minutes)

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

STI prevalence among Hijras too is quite high. A study conducted in a Mumbai STI clinic reported very high HIV seroprevalence of 68% and high syphilis prevalence of 57%3 among Hijras. In South India, a study documented a high HIV seroprevalence (18.1%) and Syphilis prevalence (13.6%) among Hijras4. A study conducted in Chennai documented high HIV and STI prevalence among Aravanis: 17.5% diagnosed positive for HIV and 72% had at least one STI (48% tested seropositive for HSV-1; 29% for HSV-2; and 7.8% for HBV)5.

Published data on sexual risk behaviours of Hijras and transgender are limited but available data indicate high risk sexual behaviours. The available information from the Integrated

Biological and Behavioural Assessment (IBBA) survey 2007 conducted in select districts of Tamil Nadu, reported that, nearly three-fourths of them had used condom with them in the last sex act but every time condom usage was 34%. Seventy four percent of Aravanis had paying male partners, and consistent condom usage with them was about 50%. Nearly one-third of the Aravanis had other non commercial male partners and 20% of them used condom for every act.

Presentation: Details of Size Estimation of H/TG

Terminology used - H/TG (10 minutes)

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 programmes 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:

A. "Hijras" – Consensus definition by Hijra and Transgender – Hijras communities

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

Explanation: Hijras are biological males who reject their 'masculine' identity in due course of time to identify either as women, or "not-men", or "in-between man and woman", or "neither man nor woman". Hijras can be considered as the western equivalent of transgender/trans-sexual (male-to-female) persons but Hijras have a long tradition/culture and have strong social ties formalised through a ritual called "reet" (becoming a member of Hijra community). There are regional variations in the use of terms referred to Hijras. For example, Kinnars (Delhi) and Aravanis (Tamil Nadu). Hijras may earn through their traditional work: 'Badhai' (clapping their hands and asking for alms), blessing new-born babies, or dancing in ceremonies. Some proportion of Hijras engage in sex work for lack of other job opportunities, while some may be self-employed or work for non-governmental organisations. A significant proportion of hijras are emasculated/nirwan.

B. **"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 gender-affirmative surgeries (sex reassignment surgery) or be on hormonal therapy for gender transition".

Explanation: The term 'transgender people' is generally used to describe those who transgress social gender norms. Transgender is often used as an umbrella term to signify individuals who defy rigid binary gender constructions, and who express or present a breaking and/or blurring of culturally prevalent stereotypical gender roles. Transgender people may live full- or part-time in the gender role 'opposite' to their biological sex.

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

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

Interaction: Summing-up, Key points and Q & A

Summary of the session and transition (05 minutes)

Summarize the key points.

The key points to be remembered:

Ask if there is anything that requires clarification, or if there are any doubts/questions.

As per the agenda, we will cover the __ topic (please mention the next topic) in the next session. So and so (please, name/introduce the facilitator for the next session) will present/facilitate the next session who is an expert in the field and has extensive experience in the sector.

Session 4: National HIV strategic framework and objectives for H/TG

Learning objectives:

By the end of the session, the participants will be able to learn about:

- National HIV strategic framework and objectives for H/TG
- Key priorities to improve HIV response for H/TG

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	National HIV strategic framework and objectives for H/TG	10 minutes
3.	Key priorities to improve HIV response for H/TG	10 minutes
4.	Summary of the session and transition	05 minutes
	Total	**30 minutes**

Pointers for preparing the session

Prepare slides on the learning objectives of this session and also the national HIV strategic framework for H/TG and the key priorities to improve the response for H/TG. Combine all the slides together as one presentation.

Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.

Presentation: Learning Objectives

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Discuss the structure of the session as well.

Presentation: The diagram of the National strategic framework & objectives for H/TG

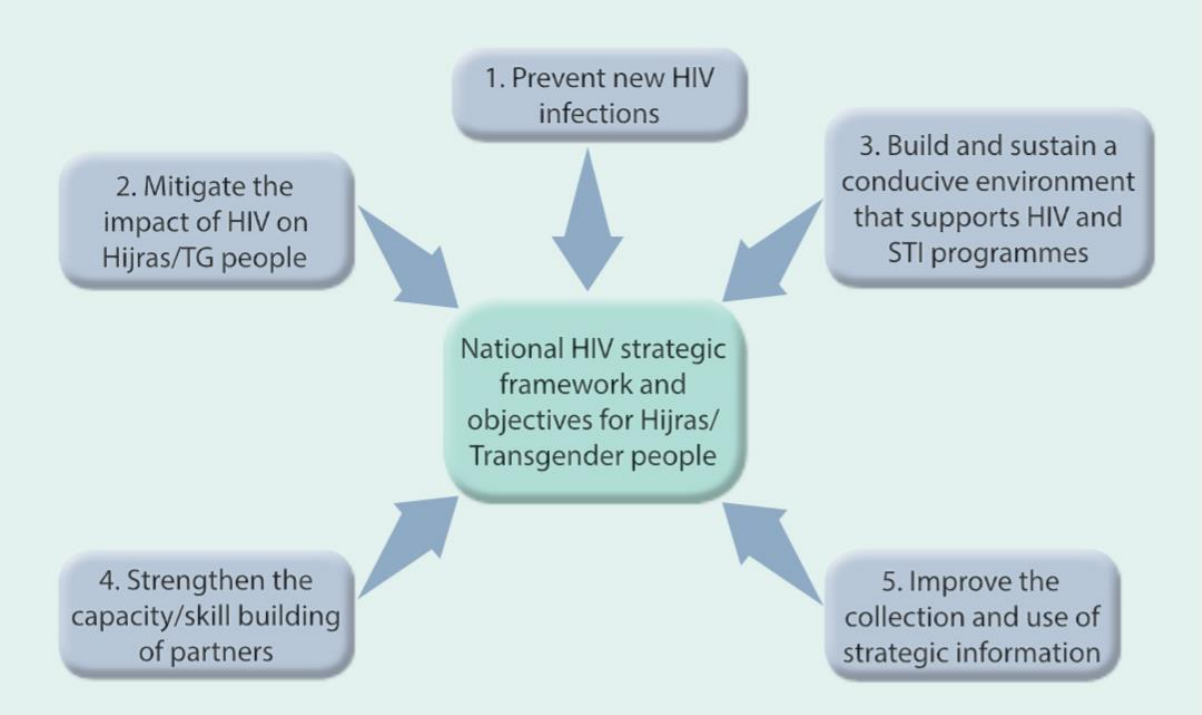
National HIV strategic framework and objectives for H/TG (10 minutes)

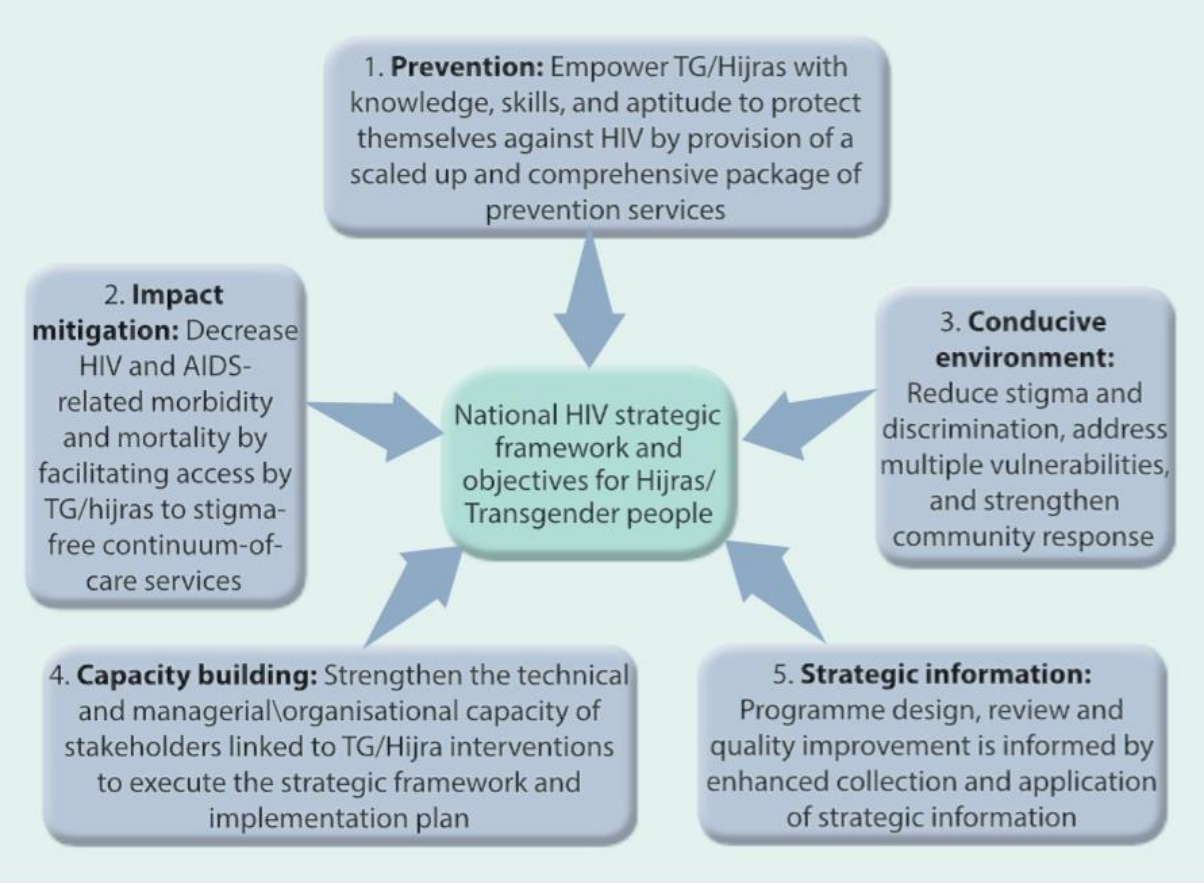
Present the following information as a PowerPoint presentation and discuss with the participants.

Explain the following:

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

Show Slides: National HIV strategic framework and objectives for Hijras and Transgender people.





Presentation: The diagram of the National strategic framework & objectives for H/TG

Key priorities to improve HIV response for H/TG (10 minutes)

Present the following information as a PowerPoint presentation and discuss with the participants.

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

Interaction: Summing-up, Key points and Q & A

Summary of the session and transition (05 minutes)

Summarize the key points.

The key points to be remembered:

Ask if there is anything that requires clarification, or if there are any doubts/questions.

As per the agenda, we will cover the __ topic (please mention the next topic) in the next session. So and so (please, name/introduce the facilitator for the next session) will present/facilitate the next session who is an expert in the field and has extensive experience in the sector.

Overview of the sessions focusing on operationalizing the TI:

With the objective to translate the operational guidelines (OG) as a TOOL for self-learning, capacity building and technical support, this facilitator's manual has been developed. The OG was designed primarily for NGO/CBOs initiating and currently implementing targeted intervention (TI) for H/TG or scaling up an existing intervention to include H/TG, or for strengthening existing H/TG intervention.

The OG delineated the following steps for initiating and scaling up TI among H/TG:

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

The OG grouped these steps into two phases as start-up (phase 1) and scale-up (phase 2) activities. The first five steps are part of the start-up activities and the remaining six steps are included as scale-up activities.

However, the facilitator's manual has elaborated some of the phase 2 steps as a single session in order to impart the technical details along with the skill building activities. Nevertheless, sincere efforts have been taken to present the overall information in a sequential manner.

Session 5: Start-up - Phase 1 of the Intervention

Learning objectives:

By the end of the session, the participants will be able to understand/familiar with:

- the geographical locations (sites / hotspots)
- the fixed target for coverage
- site assessment
- establishment of services & linkages system

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	The geographical locations (sites / hotspots)	10 minutes
3.	The fixed target for coverage	10 minutes
4.	Site assessment including Group Work (Hotspot Mapping)	40 minutes
5.	Establishment of services & linkages system including Group Work (Seva Chitram)	40 minutes
6.	Summary of the session and transition	05 minutes
	Total	**110 minutes**

Pointers for preparing the session

Prepare a slide on the learning objectives of this session.
Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.
Prepare slides on the subsections, viz., the geographical locations, the fixed target for coverage, and the guidelines for the group work.
Combine all the slides together in a way to guide the entire session.
Prepare for the group work exercises and the strategies to carry out; collect the tools, appropriate data, and materials that will be used during the exercise.
Collect beforehand one or two geographical locations including the sites/hotspot details, target coverage of the TI, etc., from different states to be used as an example (dummy) during the session, one for stand-alone model and one for core composite intervention.

Presentation: Learning Objectives

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Inform how the session is structured as it will have two important group activities; encourage the participants to actively involve, particularly in the group work.

Presentation: Five major steps of the start-up activities

Introduce the session

Phase 1 of the TI comprises of five (5) major steps:

1. Site identification/mapping,
2. Fixing the target for coverage
3. Recruitment and training of staff (except for Peer Educators);
4. Site assessment; and
5. Provision of basic services.

With regard to the third step - recruitment and training of staff, the following assumptions have been taken:

a. At this point of time, it is presumed that the recruitment of staff has been completed by now for the intervention that is already in place. It is likewise believed that all the startup activities have been carried out or partially accomplished. However, this manual will assist the participants to learn to carry out and/or complete the startup activities in a systematic way.
b. It is presumed that various capacity building and technical support activities have been undertaken at the field level by the NGO/CBO, TSU PO, etc. and at the regional/state level by NACO/SACS/TSU and other agencies working in this thematic area. Nevertheless, this capacity building tool will provide and build the requisite knowledge, skills and the appropriate perspective for implementing the intervention for H/TG.

Explain the participants elaborately about the above mentioned five steps of the startup activities by using PowerPoint presentation along with few group work activities:

Presentation: Intervention sites / hotspots

The geographical locations (sites / hotspots) (10 minutes)

Present the following information as a PowerPoint presentation and discuss with the participants.

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

Ask the participants if they have one such list is available at the intervention.

If the participants are not familiar, provide the details of the same including the hotspots, estimated size of population in the hotspot, etc.

Meanwhile, show the dummy TI Intervention sites and the estimated population and explain how to finalize the intervention site and the population estimate.

Presentation: Target for coverage

The fixed target for coverage (10 minutes)

Explain the following and discuss with the participants:

Once the sites are identified, population available in each site to be estimated. Transgender/ Hijras population to be categorized based on Gharana or not (Gharana-based and non-Gharana based) to ensure tailored effective intervention packages.

Number of Transgender/ Hijras operating under Gurus/Gharanas and non-Gharana based hijras and Transgender – Hijras should be mentioned as target for exclusive TIs and composite TIs.

Presentation: Recruitment and capacity

Recruitment and Training of Staff (other than Peer Educators) (10 minutes)

Present and discuss with the participants on the following.

A. Hiring staff for the project

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

Project staff should:

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

B. Capacity building of TI staff

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

- Introduction to HIV/AIDS including basics of transmission, prevention and treatment of HIV and other sexually transmitted infections
- Orientation on TI operational guidelines for Transgender/Hijras
- Sexuality and gender and the dynamics of sex work
- Orientation on prevailing socio-cultural norms within the Hijra – transgender community

- Basic outreach skills including:
  - Active listening and building rapport with marginalized groups
  - Methodology of site validation
  - An orientation on the geography of the TI site, for example, which spots are frequented most and how
  - Community dynamics and entry points for service delivery
  - Made aware of the range of available services to which clients might require referral
  - Basics on how to ensure safety for self and clients when carrying out outreach.

This facilitator's manual was developed with the objective to translate the operational guidelines as a capacity building tool for the NGO/CBOs and its staff implementing targeted intervention among H/TG by the officials of SACS/TSU including the NGO/CBO and other relevant agencies/teams/individuals who will be involved in capacity building activities and providing technical/mentoring support. Similarly, all the participants are encouraged use this manual as a guide for further improvement of your capacities to effectively scale-up the H/TG Interventions.

Presentation: About site assessment

Site assessment (10 minutes)

Present the following information as a PowerPoint presentation and discuss with the participants.

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

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

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

- Validation of broad mapping size and location estimates
- Contact with at least 50% of the mapping denominator at least once in three months (as a form of validating the presence of key population)

- Gaining details on risks/vulnerabilities by typology and location for Transgender/Hijras initiating interventions, reaching out to populations and scaling up for new sites in existing Tis

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

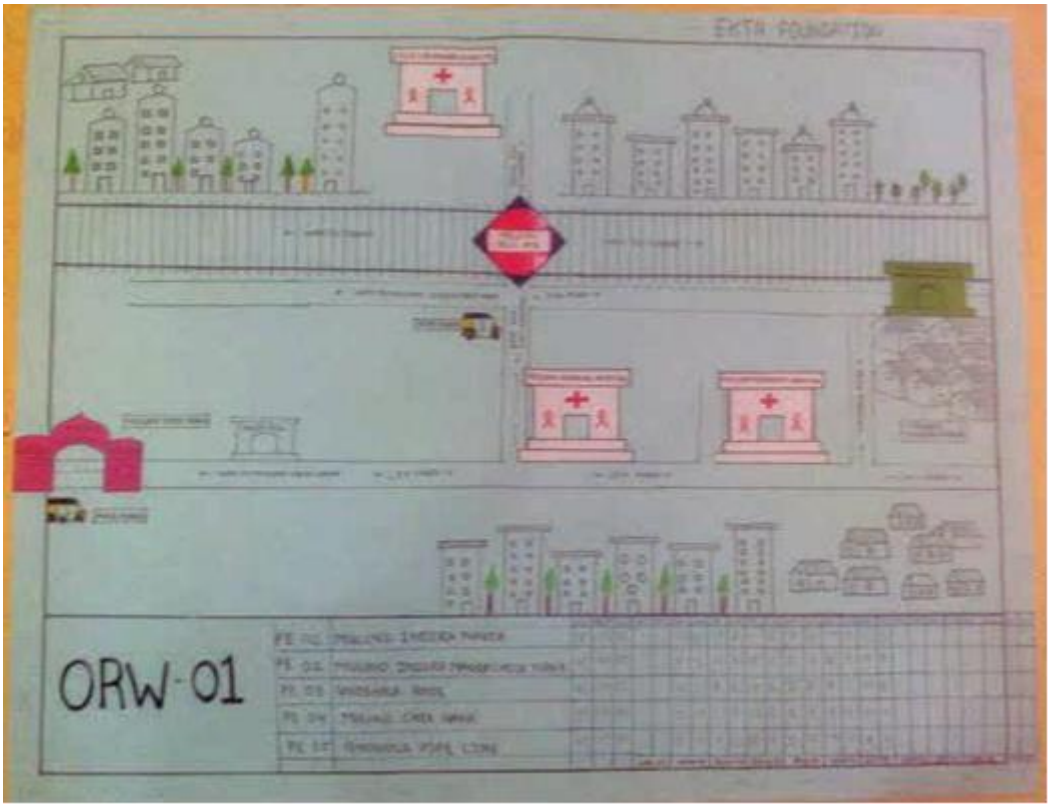
- Establish contact with community – the site validation helps the project to meet at least 50% of the estimated population in a given location on a one-to-one or group basis
- Generate community interest about the project and initiation of community building process
- Dispel myths about the intervention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

Exercises 1 (Group Work) for Site Assessment: Number and Trend Map ("How Hot is the Spot"?)

Collect one or two geographical locations including the sites/hotspot details, target coverage of the TI, etc., from different states to be used as an example (dummy) during the session, one for stand-alone model and one for core composite intervention.

This exercise that the participants are going to learn will be done in the field with the help of visible and self-identified HRGs (TG and Hijras) at the hotspots. At all hotspots identified through Broad Map, and any other hotspot that might be subsequently identified through the course of the Mapping implementation in the site.

Hotspot Mapping



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

Process

(Options: This exercise can be executed in one of the local TI hotspots with the help of the NGO/CBO along with the community members or perhaps at the training venue by gathering the participants into two-three groups of 8-10 members each using a dummy map with fictional numbers)

1. *Ask the group to draw a map of the local area, including any local landmarks to orient the map.*
2. *Ask them to mark the hotspots in reference to the landmarks (the facilitator may also want to talk about what kind of spots there are generally – for example, truck terminals, bushes, bus stop, parlours, hamams, badhai area, hijra/TG houses, etc., this will also help stimulate the discussion in the group).*
3. *Ask the group to rank the hotspots using symbols for high, medium or low according to the level of risk practice that puts HRGs at risk of HIV/STI infection at different hotspots.*
4. *Ask the participants why they have marked different hotspots differently – is it according to numbers of HRGs who frequent that hotspot or the particular risk practice usually carried out at the hotspot which may carry more or less risk of HIV/STI transmission, or the frequency of risk practice, or any other reason?*
5. *Do not contradict unless you have to clear misconceptions and myths.*
6. *Then ask participants to look at the hotspots ranked as high. Ask them to discuss what change needs to happen generally to make the location into a medium or low rank. Then ask what individual HRGs or small peer groups could do to reduce risk practice*

in these locations. Again, do not contradict unless you have to clear misconceptions and myths.

7. *Ask participants to estimate the number of HRGs from different categories who usually frequent each hotspot on an average day. Let participants debate among themselves to arrive at figures most members of the group are happy with. Against each hotspot on the chart ask participants to put different symbols for different categories of HRGs and put the corresponding number next to each symbol (numbers can be represented through symbols too).*
8. *Ask participants to draw a clock (or a line representing 24 hours of a day) and indicate on the clock (or the line) at what time of the day the numbers they have mentioned is to be found at the hotspot. Ask them to mark (with + and – signs, or with spots or bindis) different hours of the day to indicate how that number might fluctuate during the day.*
9. *Ask participants to draw a line indicating 7 days of a week and ask them to similarly mark the line to indicate fluctuations during a week.*
10. *Ask them to put symbols against the hotspot to indicate events or festivals in a year when the number might significantly go up or down.*
11. *Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.*
12. *At the end of the session, note down the date, place, number of participants (disaggregated by HRG categories) and your mapping team number on the back of the chart paper.*

By doing this exercise, it will help the participants to learn how to do the hotspot mapping which in turn helps the participants to understand the dynamics of the hotspots as given below:

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

Establishment of services & linkages system (10 minutes)

Present the following information as a PowerPoint presentation and discuss with the participants.

A. Initiating activities

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

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

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

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

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

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

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

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

Exercises (Group Work) for Site Assessment: Seva Chitram (Services Map)

This is a method to assess availability and accessibility of different services in the site to HRGs. At all hotspots identified through broad mapping, and any other hotspot that might be subsequently identified through the course of the mapping implementation in the site.

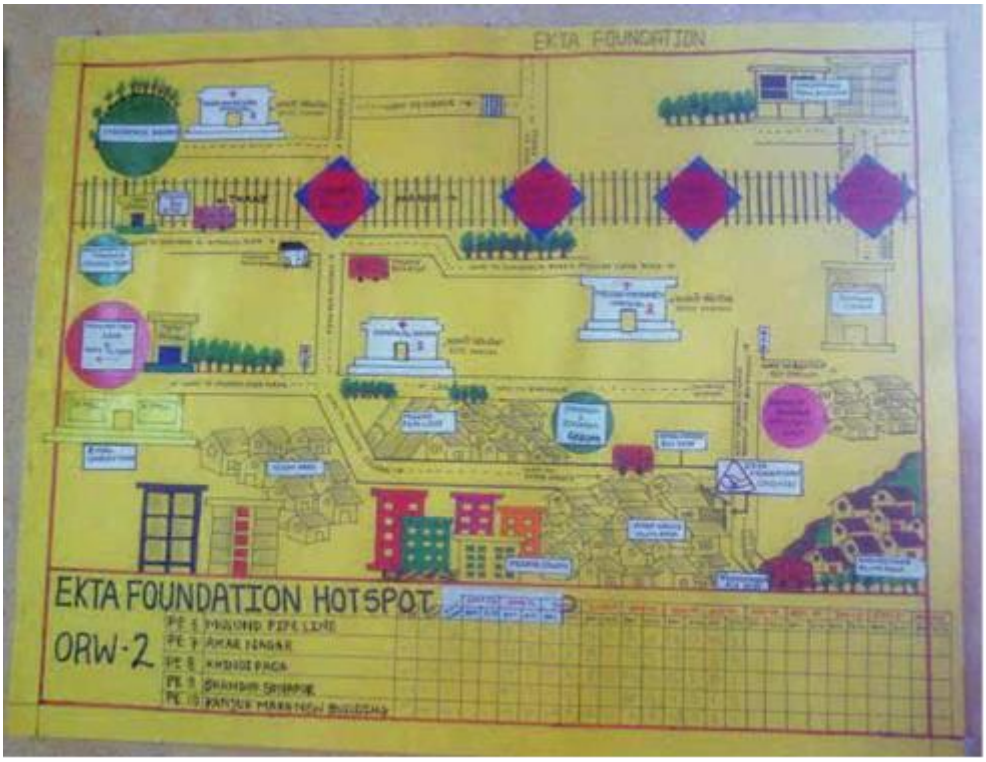
Process

1. *Ask the participants to draw a map of the site including a few main landmarks and ask them to indicate the hotspot where the HRG mapping team contacted them.*
2. *Ask the participants to include in the map any places or people that their HRG group could go to get support for HIV/STI prevention and treatment.*
3. *Ask the participants to put against each intervention:*
    a. *What each service provides*

b. *How each service helps reduce risk of HIV/STI infection(some Transgender – Hijras may also provide SRS/and other service provider details – it may be useful to mark out these with a star or asterisks for strengthening referral, etc)*

4. *Now ask the participants to rank the services high, medium, or low according to how accessible they are to HRGs like themselves (how often they access or utilize the services – often, sometimes, never).*
5. *Ask them to identify factors that make them use the services marked high or medium (such as distance, cost, behaviour of service providers, confidentiality, effectiveness of services provided, availability and timing and so on).*
6. *Now ask them to discuss the services ranked with low accessibility. What could be done to make these important services more accessible to HRGs like themselves?*
7. *Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.*
8. *At the end of the session, note down the date, place, number of respondents (disaggregated by HRG categories) and also the mapping team number on the back of the chart paper.*

Service Map (Seva chitram)



By doing this group work exercise, it will help the participants to learn how to do the service mapping which in turn helps the participants to understand the details of the availability of the various services as given below:

- Location of different HIV/STI related services in the site
- Range of services offered by each service provider
- Criteria by which HRGs judge a service to be accessible and available

- Take recommendations from HRGs about how to make services accessible and available to them

Summary of the session and transition (05 minutes)

Once again summarize the key points.

Ask if there is anything that requires clarification, or if there are any doubts/questions.

As per the agenda, we will cover the __ topic (please mention the next topic) in the next session. So and so (please, name/introduce the facilitator for the next session) will present/facilitate the next session who is an expert in the field and has extensive experience in the sector.

Session 6: Phase 2 of the Intervention - Strengthening Peer Education system

Learning objectives:

- By the end of the session, the participants will be able to understand about peer education approach to reach H/TG

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	Peer education approach to reach H/TG	20 minutes
3.	Peer map – group work	30 minutes
4.	Summary of the session and transition	05 minutes
	Total	**60 minutes**

Preparing for the session

Prepare a slide on the learning objectives of this session.

Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Introduce the session

As it was mentioned earlier in the overview of the sessions on operationalizing the TI, the Phase 2 tasks include six more major steps for the scale-up activities.

However, in order to impart the technical details along with the skill building activities, some of the phase 2 steps have been elaborated and presented as a single session.

This session only talks about Peer Education.

Peer education approach to reach H/TG (20 minutes)

Present the following information as a PowerPoint presentation and discuss with the participants.

Explain the following:

A. Who is a Peer Educator (PE)?

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

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

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

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

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

B. Why Peer Education?

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

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

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

C. Role of the Peer Educator

Conduct outreach: this includes identifying new Hijras and other transgender people as well as maintaining regular contact with her own social networks in the community. This might entail contacts on a weekly or bi-weekly basis within any given month

- Should meet all registered contacts at least once every fortnight
- Provide dialogue-based IPC as IPC is more familiar with PEs.
- Build skills of the peer group on an on-going basis; for example, the understanding and assessing high risk behaviour, condom and lube use, condom negotiation, identification of STIs, healthy lifestyles, etc.
- Provide training to new PEs in Transgender – Hijras TI projects
- Encourage service and commodity uptake: motivate Hijras and other transgender people to come to DIC, distribute condoms, and make referrals and/or accompany those who are unwell to health clinics
- Advocate for the group with known power structures in the community (police, unofficial gatekeepers, etc.)
- Support project staff in maintaining the DIC up to guideline standards
- Generate demand for existing Social Welfare Programmes and help with identifying the beneficiaries and providing supporting environment
- Regularly visit condom service centres to gather information and to improve service
- Attend project review meetings
- Prepare and present daily reports to ORWs
- Report preparation for activities implemented
- Attend all trainings, workshops and seminars organised by the TI
- Generate community ownership for the project activities through mobilisation of the community members for increased stake in planning and implementation of the project activities.

D. Qualities of a Peer Educator

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

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

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

E. Recruiting Peer Educators

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

Selection process

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

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

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

F. Capacity building of PEs

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

- Principles of a TI programme
- Role and responsibilities of PE
- Basics of HIV/AIDS transmission, treatment and care

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

(For details, see Annexure 3, Peer Educator Training in the OG)

G. Review of PEs

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

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

Understand and analysis the peer outreach by using peer maps (30 minutes) – Group work

Exercises: Peer Maps (Group Work)

This exercise is conducted in order to understand the nature of outreach done by PEs with the Transgender – Hijras they work with. The participants by using maps understand and analyse the outreach with Transgender – Hijras that they are accountable for.

Materials Required: Charts and pens

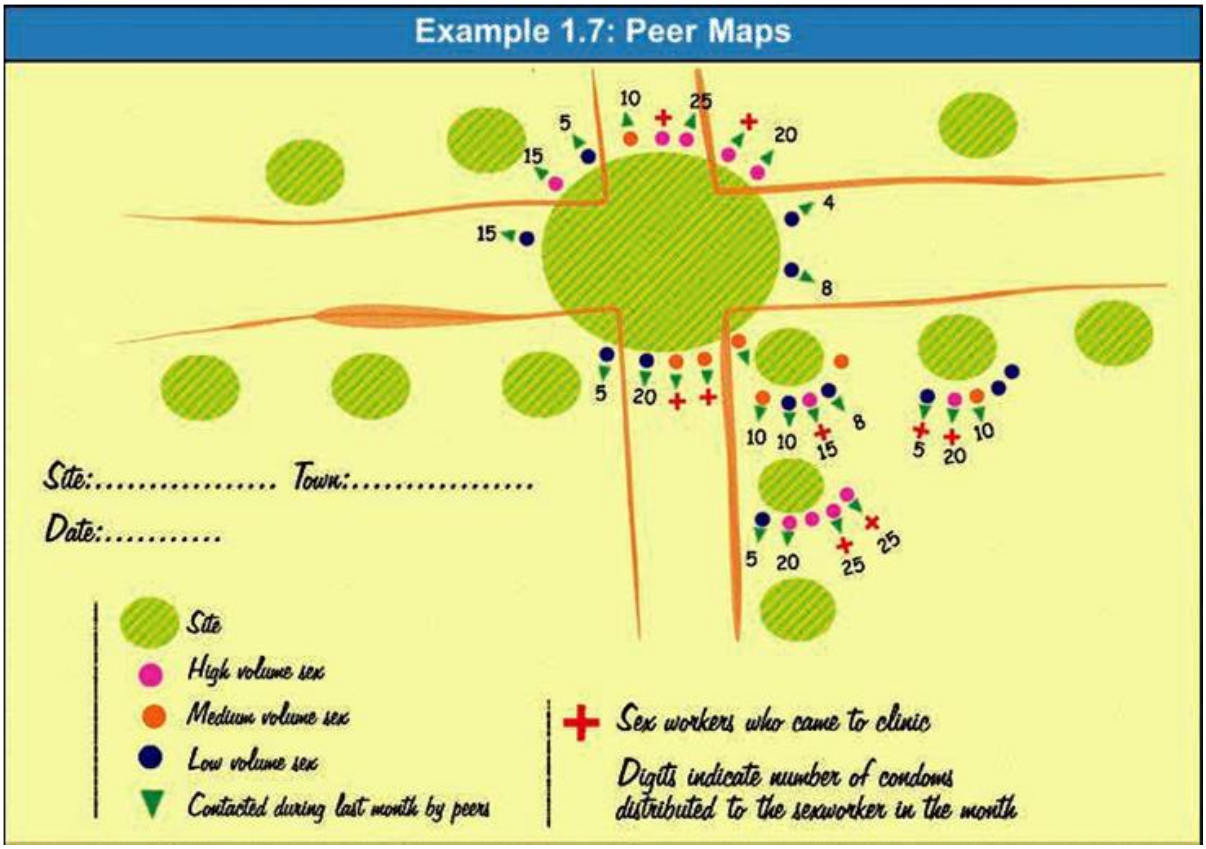
Process:

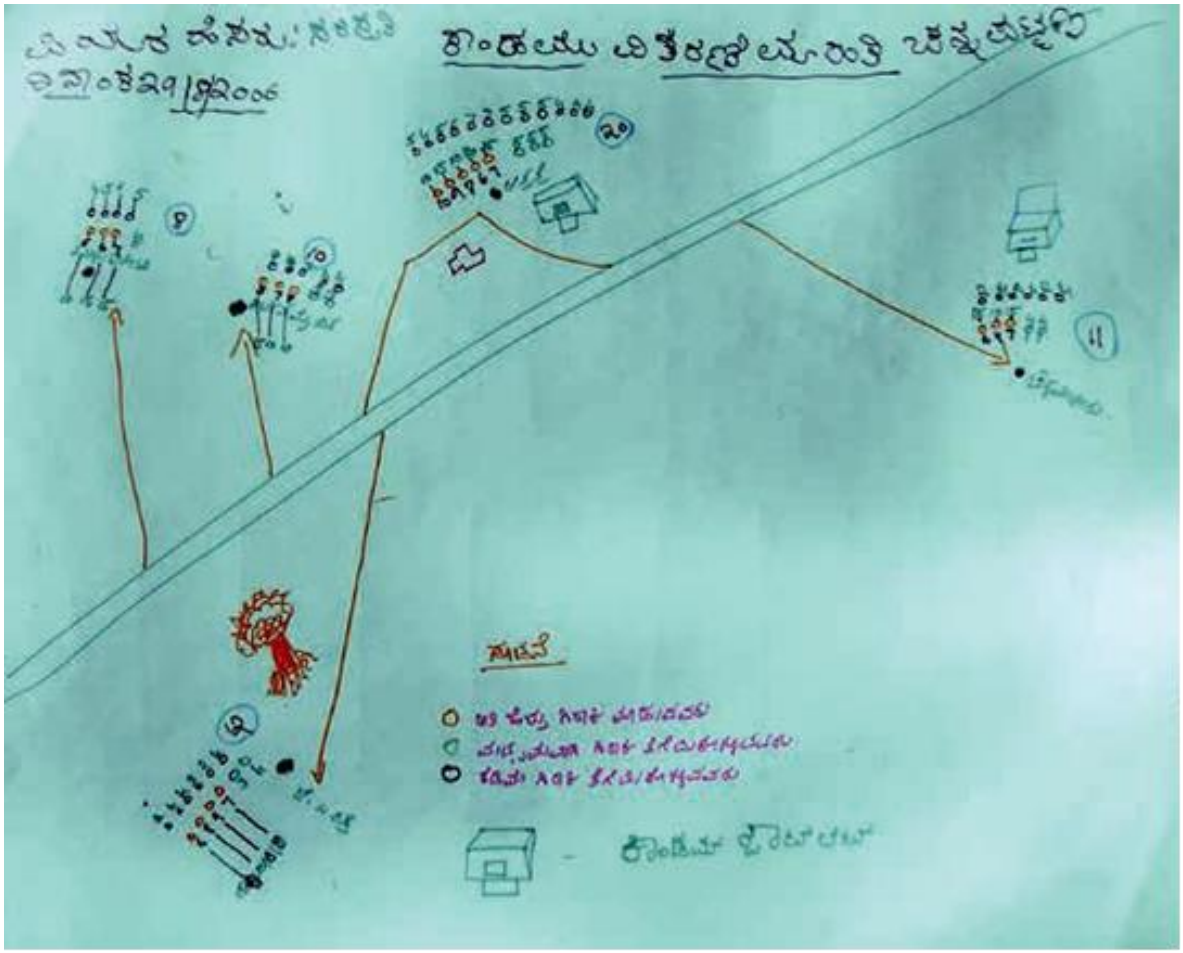
1. *Ask the peers to map the sites in the town where they work and meet their community members.*
2. *In these sites ask the PEs to map the Transgender – Hijras that they are accountable for. Ask them to depict the high volume, medium volume and low volume Transgender – Hijras population in these sites using different colour codes.*
3. *Now ask the PEs to indicate the number of times each of them met the Transgender – Hijras they are working with, in the last month.*
4. *Then ask each of them how many condoms were distributed to each of the Transgender – Hijras contacted.*
5. *Also ask each PE to mark the condom outlet boxes in these sites.*
6. *Now ask each of the PEs to analyse the map by answering the following questions:*

7. *In the previous month, did the peer meet all Transgender – Hijras that she is working with? If not, why?*
8. *Based on the volume of sex work, was there any difference in kind of outreach done by the peer? Did she meet high volume Transgender – Hijras more often and the low volume Transgender – Hijras less often?*
9. *Were the condoms distributed based on the volume of sex work? Were enough condoms distributed to cover all the sexual acts of each of the Transgender – Hijras? Is there a shortfall? How is this shortfall in condom distribution being filled? Is it through the depots? Are the clients bringing condoms?*
10. *Conclude by saying that it is important to understand the need of each of the Transgender – Hijras, that a peer is accountable for planning regular contact and condom distribution accordingly. This will ensure that condoms are available with Transgender – Hijras whenever they are needed and at the same time will avoid dumping of condoms where there is no need.*

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

Sample Peer Maps





Summary of the session and transition (05 minutes)

Once again summarize the key points.

Ask if there is anything that requires clarification, or if there are any doubts/questions.

As per the agenda, we will cover the __ topic (please mention the next topic) in the next session. So and so (please, name/introduce the facilitator for the next session) will present/facilitate the next session who is an expert in the field and has extensive experience in the sector.

Session 7: Outreach Planning

Learning objectives:

- By the end of the session, the participants will be able to understand about outreach planning and learn the know-how of outreach planning exercises

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	Outreach – Broad Strategies	20 minutes
3.	Outreach Planning Processes	60 minutes
4.	Summary of the session and transition	05 minutes
	Total	**90 minutes**

Preparing for the session

Prepare a slide on the learning objectives of this session.

Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Introduce the session

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

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

Benefits of Outreach Planning

- ***Defined area of operation for PE*** – duplication of effort and diffusion of responsibility is avoided when a site is demarcated and responsibility for that site rests with an individual PE.
- ***Repeat visits for monthly screening*** – The PE is able to monitor clinic visits for monthly screening of the FSWs in the given site.

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

Outreach Planning in the Organizational Context

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

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

Elements of the Outreach Plan

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

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

Outreach – Broad Strategies (20 minutes)

Present the following information as a PowerPoint presentation and discuss with the participants.

Explain the following:

Three broad outreach strategies can be adopted:

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

Key activities of outreach using any of these strategies include:

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

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

- Treat all service users equally and non-judgmentally, recognizing and respecting diversity
- Does not give information or advice when uncertain about the facts. It is okay to say that you are unsure and will find out the correct information
- Should set and maintain professional boundaries. It is important to develop good and friendly working relationships. Overstepping work relationships can compromise a sex worker, the project worker and the service
- Outreach staff should be aware about safety and minimize risk to service users and themselves. A few steps can help:
    - Prepare thoroughly before each outreach session

- Inform and seek support from police about outreach activity. Record any incident that might have taken place and have arrangements for contacting the local police if any incidents occur
- Establish clear links with key local stakeholders such as community leaders, police partners and local political councillors
- Have understanding between staff on how to communicate and have an exit strategy to terminate sessions or leave situations immediately which are perceived as unsafe
- Have debriefing at the end of sessions between colleagues and with supervisors.

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

- For effective implementation of this model, all Gharanas in the TI site need to be studied and understood. Based on the study an appropriate strategy needs to be developed. At the time of preparing this guideline, two pilot projects on the involvement of Gurus or Gharana/Jammath leaders were being implemented. The results from these projects will help in fine-tuning these guidelines further.
- Peer Educators (PEs) may be recruited with consensus of the Gurus and in some Gharanas Soukens7 could be identified as potential PEs.
- Existing outreach workers can be used to liaise with Gurus of the gharanas in the TI sites. Where necessary, one or more outreach workers (in addition to the number of ORWs as per guidelines) might need to be hired for this liaison work.
- HIV-related messages need to be understood and approved by the Gurus.
- An approach which clearly shows the benefit to the Gharanas and its members as well as one that does not threaten in any way the authority and power of the Guru(s) has to be developed.

Through melas/functions in which Hijras and transgender people gather

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

Why Melas and other congregations?

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

Limitations

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

Additional Outreach activities

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

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

Outreach Planning Processes (60 minutes) – Group Work

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

Process 1 - Group Exercise: Spot Analysis

The Group Exercise - Spot Analysis is conducted in order to help participants compile information collected during urban situation and needs assessment related to each high-risk spot/site in their respective project areas to facilitate planning. Participants, through group work, will compile spot-wise information for planning.

Suggested Teaching Method: Large group discussion

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

Process:

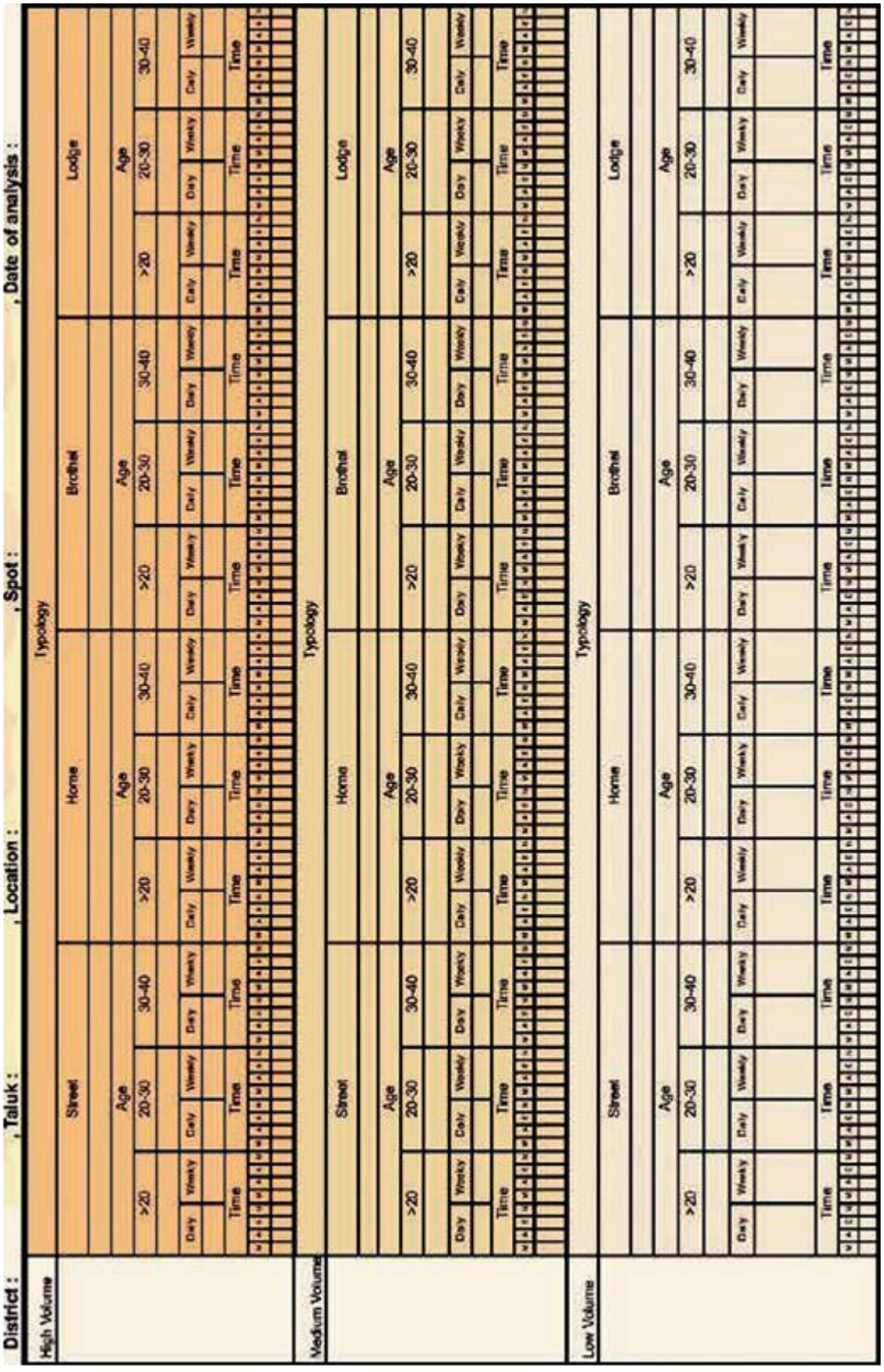
1. *Begin the session by asking participants what they learned during the urban situation and needs assessment process. Allot time to share key findings.*
2. *Clarify the importance and need for outreach planning with respect to HIV prevention programmes. Use the following reasoning:*
   In a programme such as ours, a spot is the smallest geographic location for intervention, and it is important to plan for each and every spot at the town level. Therefore, outreach plans are developed for the following reasons:
   - *Each spot is different, therefore plans have to be spot specific*
   - *Other characteristics such as client volume and typology of sex work have to be factored into planning*
   - *Spot-wise planning should facilitate outreach to maximum number of Transgender – Hijras*
3. *Ask participants what information they require about Transgender – Hijras operating in a spot that would help them develop a plan for that spot. Make sure the following is included:*
   - *Volume of client - high volume (more than 10 clients/week), medium volume (5-9 clients/week), low volume (less than 4 clients/week)*
   - *Typology of TG and Hijras - Gharana based, non Gharana based, other transgenders (who are not part of any gharana system)*
   - *Age of TG and Hijras below 20 years, 20-30 years, 30-40 years, above 40 years*
   - *Time of operation - morning (6 a.m. - 10 a.m.), afternoon (10 a.m. - 2 p.m.), evening (2 p.m. -8 p.m.) and night (8 p.m. - 6 a.m.)*
   - *Frequency of operation - daily, weekly, monthly, seasonal*
4. *Ask participants to divide themselves into groups; group size should reflect the sites they represent in number. Ask each group to identify a well-known spot in their sites and to do the Exercise 1, Spot Analysis.*
5. *Give participants 45 minutes to do Exercise 1. Make sure peers in the group participate actively.*
6. *After everyone completes the exercise ask each group to present their spot analysis. Encourage peers to make this presentation.*
7. *After each group presents its spot analysis, ask the following questions:*
   - *What was the process that each group adopted to do this exercise?*
   - *What is the analysis for the spot?*
   - *As a result of the analysis, what is the spot plan?*
8. *Before concluding, stress the following:*
   - *Volume of clients - Planning should ensure that Transgender – Hijras with higher volume of clients are reached as a priority.*
   - *Typology - Planning should include typology of sex work and needs to be specific to each type. Non Ghrana based can be reached at solicitation points as well as points of service. Outreach workers can work with them directly or can reach them through network operators. On the other hand, for Ghrana based Transgender – Hijras outreach workers have to advocate with Gurus and work through Gurus and nayaks. Gharana based Transgender – Hijras - Hijras can also be reached at the points of service, that is, in the soliciting points.*

- *Age - Transgender – Hijras' needs differ with respect to age, therefore planning should address that.*
- *Time/day of operation - Understanding the time and day of operation will help plan outreach with respect to those times. For example, there are certain days in a month, like festival days, when more Transgender – Hijras come to a particular spot such as a market. During those days of the month, outreach needs to be strengthened. Similarly, evenings and nights may be very busy in certain spots. Hence, the project needs to ensure that outreach is planned during those times of the day.*

9. *Distribute Handout I, Planning Outreach for Sex Work Interventions, to the participants.*
10. *Inform participants that spot analysis should be done every six months since ground realities may change.*
11. *Conclude by reminding the participants the importance of including peers and Transgender – Hijras in planning.*

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

Exercise 1 – Spot Analysis



Handout I: Planning Outreach for Sex Work Interventions

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

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

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

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

- ***Geographical Coverage*** – Outreach needs to be planned for each location/site at which sex work takes place. Each location has its own characteristics/needs, therefore an outreach strategy must address these.
- ***Client Volume*** – Understanding client volume of sex work is important to develop a good outreach strategy. Outreach strategy should ensure that high volume Transgender - Hijras (high volume = more than 10 clients/week, medium volume = 5-9 clients/week, low volume = 4 or fewer clients a week) are reached with specific purpose and at specific periods. This is important because, in the context of HIV, Transgender – Hijras with more clients are most vulnerable and at most risk.
- ***Type of Sex*** – Type of sex influences risk and vulnerability of Transgender – Hijras. Anal sex is more risky than oral sex. Therefore, the outreach strategy would also have to address those who are involved in higher risk activities.
- ***Typology of Transgender – Hijras*** - This is very important to understand because outreach strategies differ based on typology of sex work. The outreach strategies for street based sex work would need to include an intensive peer network in order to reach Transgender Hijras both at points of solicitation and points of service. The programme would have to work with gurus, nayaks to reach the gharana. Gharana based Transgender – Hijras may be difficult to reach and would require different strategies. Outreach strategies need to reflect the typologies within the location with a focus on high volume of Transgender – Hijras.
- ***Age*** – Age of Transgender – Hijras is also crucial for designing outreach strategies. Interests and needs of Transgender – Hijras differ depending on age. Vulnerability to risk will differ as a result of age.
- ***Time –*** It is important to understand time of sex work in the location so that outreach strategies reflect this understanding. For example, Transgender – Hijras may normally work in the evening in a specific location Hence outreach to Transgender – Hijras needs to be planned during that time in those locations. Sex work interventions cannot work on a specific timetable. They have to adapt to field realities.

Planning Outreach for Sex Work Intervention

Process 2 - Group Exercise: Contact Mapping (Part 1)

The Contact Mapping (Part 1) is conducted to help participants map contacts they have with Transgender – Hijras in each spot and plan for outreach based on these contacts. The participants, through group work, map the contacts they have in each of the spots and analyze needs.

Suggested Teaching Method: Large group discussion

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

Process:

1. *Begin the session by asking the participants to divide themselves again into site wise groups.*
2. *Ask each group to draw a map of the town and mark all the locations and spots in the map. Write the estimated number of Transgender – Hijras in each spot.*
3. *Ask the participants to give a colour code to each of the outreach workers and peers.*
4. *Then using the different colour codes, mark the number of Transgender – Hijras each outreach worker and peer knows in the spot. For example, assign the colour red to Laxmi, a PE, and mark all her Transgender – Hijras contacts in each spot using red.*
5. *Allot 30 minutes to complete mapping. Ask each group to present their maps. Encourage the peers to make presentations.*
6. *After each peer presents, ask the following questions:*
   - *What does the map show?*

- *In which spots are the contacts limited? Why?*
- *Where is the outreach not happening?*
- *What should be done in those specific locations where Transgender – Hijras are not reached?*

7. *Conclude by asking participants if all the contacts that they marked are mutually exclusive, emphasising the fact that contacts could overlap. For example, PEs may know the same member but count her as two contacts.*

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

EXAMPLE: CONTACT MAPPING OF DODDABALLAPURA (SURAKSHA- NGO)

Process 3 - Group Exercise: Contact Mapping (Part 2)

The Contact Mapping (Part 2) is conducted to help participants understand who the contacts are after mapping them in each spot. The participants, through group work, list out contacts that they mapped in the previous exercise.

Suggested Teaching Method: Large group discussion

Materials/Preparation Required: Chart paper and pens.

Process:

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

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

Exercise 2: Contact Mapping

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

Estimated number of Transgender – Hijras in the town:

Contacted Number of Transgender – Hijras in the town:

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

Exercise 3: Contact Mapping

District: Taluk: Location: Spot:

Date of exercise:

Estimated number of Transgender – Hijras in the town:

Contacted Number of Transgender – Hijras in the town:

District: Taluk: Location: Spot:

Date of exercise:

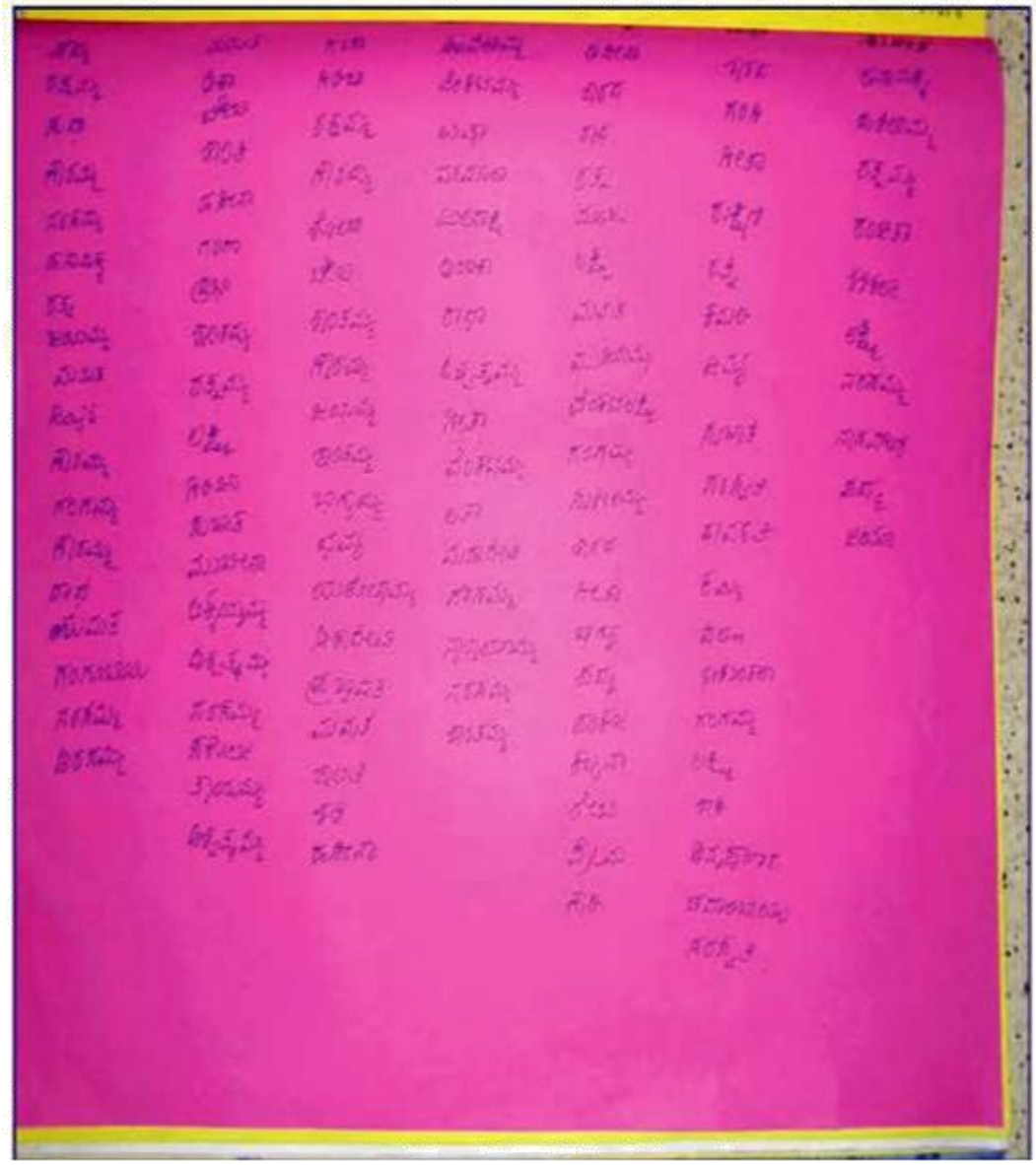
Estimated number of Transgender – Hijras in the town:

Contacted Number of Transgender – Hijras in the town:

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

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

EXAMPLE: CONTACT MAPPING DODDABHALAPUR
(SURAKSHA-NGO)



Process 4 - Group Exercise: Networks

The Group Work – Networks is conducted to help participants understand geographic and social networks of Transgender – Hijras and advantages and disadvantages associated with both. The participants, through a debate, discuss the advantages and disadvantages of geographic and social networks and include the same in planning outreach.

Suggested Teaching Method: Debate and discussion

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

Process:

1. *Deliver a mini-lecture on Transgender – Hijras networks – gharana and non gharana based, etc. Clarify that Transgender – Hijras can have contacts in a particular geographical location, a particular social circuit, and also with network operators. It is important to understand the networks because both "frequency of meeting" and "peer influence" have a great impact on the Transgender – Hijras. Hence while selecting peers it is important to ensure that peers are selected from all networks so that the project can maximize reach.*
2. *Distribute Handout II (Geographical and Social Networking). Ask one participant to read the case study out loud to the group. Ask them to stop where the case study ends. Make sure that they do not read the definitions.*
3. *Once you ensure that every participant has understood the case study, divide the participants into two groups using a group forming energizer.*
4. *Ask the groups to discuss the following:*
   - *Group 1 - Advantages of selecting peers from a particular geographical location and disadvantages of selecting peers from social circuit.*
   - *Group 2 - Advantages of selecting peers from social circuit and disadvantages of selecting peers from within a particular geographical location.*
5. *Give the participants 30 minutes to prepare for the debate.*
6. *Appoint a referee for the debate and allot 10 minutes to each of the group to share their view-points.*
7. *Highlight the key advantages and disadvantages of each network and conclude that both networks are important to consider in selecting peers. Peer selection depends on the situation, and a combination of both strategies may need to be used. In the early stage of the project a social network may be more efficient even though it is time consuming. Once all the social contacts of each peer/volunteer are introduced to the project and rapport is built by each peer with others in her group, the project should move to geographic networks. At times, depending on the situation, the project may have to use geo-social networks in order to ensure effective outreach. The project should decide which one to adapt and determine this based on the project needs and reach at that time.*
8. *Conclude by reading out the definitions of geographic networking and social networking from the handouts.*
9. *Announce that both teams have worked hard and both the teams have won. Distribute small prizes (if possible) to all the team members.*

Handout II: Geographical and Social Networks

Case Study of Renni

1. Renni is a Hijra who has been operating in 'X' City for past 7 years. She is 26 years old. In her early years, she used to operate from the bus stand with her friend Santi. Over a period of time she developed a friendship with 15 other Transgender – Hijras who

operate from the same area. She comes from her village every day. She arrives at 11 a.m. and work until 6 p.m.

2. She knows that there are around 100 to 150 Transgender – Hijras who operate at the bus stand. Some of them operate in the morning hours (6 a.m. to 10 a.m.), some in the evening (6 p.m. to 10 p.m.) and some in the night (10 p.m. to 5 a.m.). Renni has seen many of them but not all are her close friends. She knows about 70 Transgender – Hijras who operate at the bus stand at the same time as her (11 a.m. to 6 p.m.). Of the women who operate at the same time as her, 15 are her close friends and 30 are her acquaintances. In last 7 years of working in City 'X', Renni has moved to different locations in the city, such as the railway station and the market, to solicit clients due to various reasons. Over the years, Renni has operated in the top 10 locations within the city. She has developed close friendship with 80 Transgender – Hijras in those locations (including 30 in the bus stand). She also knows 140 other Transgender – Hijras who operate in those locations regularly.
3. The SNA and spot analysis estimates 500 Transgender – Hijras in those 8 locations. These Transgender – Hijras are known to operate at different times. The project has developed a good rapport with Renni. Furthermore, Renni is willing to work as a PE since she understands that STI/HIV is a serious threat to her community, especially to her friends who she loves and is concerned about. The project staff recognises that Rani is an asset to the project. They are interested in involving her in the project. The staff has to decide on how to incorporate Renni into the project.
4. The project has two options:

   Option One:

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

   Option Two:

   Renni can be given the responsibility of reaching her close 80 friends on a regular basis whom she knows very well and has good rapport with in 10 different locations within the city.
5. The Questions:
   1. Which option is the most effective and efficient?
   2. What are the advantages and disadvantages of each option?

Definitions

Geo-Networking Concept (Option One)

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

This in practical terms means that the peer has to go and make friends with all the Transgender – Hijras in the particular spot (geography) irrespective of age, time of operation,

etc. For this she may have to work beyond her normal sex work times, make an effort to meet the women or get introduced another way.

Social Networking Concept (Option Two)

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

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

Handout III: Opportunity Gaps

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

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

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

Example of Opportunity Gaps

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

Level 1 Estimated Transgender – Hijras in the project area Opportunity gap (Level 2 - Level 1)	- -	0	218
Level 2 Transgender – Hijras who have been contacted at least once by the project Opportunity gap (Level 3 - Level 2)	- -	79	218
Level 3 Transgender – Hijras who have been registered Opportunity gap (Level 4 - Level 3)	- -	34	139
Level 4 Transgender – Hijras who are in regular contact with the project Opportunity gap (Level 5 - Level 4)	- -	47	105

Level 5 Transgender – Hijras who visited the clinic for STI treatment Opportunity gaps (Level 6 - Level 5)	- -	12	58
Level 6 Transgender – Hijras who completed the treatment Opportunity gaps (Level 7 - Level 6)	- -	46	46
Level 7 Transgender – Hijras who had regular health check-up	-		0

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

Definitions

Contact	Identification of Transgender – Hijras. Purposeful interaction with the HRG
Registration with the project	After building rapport with the Transgender – Hijras, the Transgender – Hijras is registered by filling the registration form. This provides his/her a number and makes it easy for the project to track outreach provided to her. Registration can happen after 1-8 contacts in the field.
Regular contact	A Transgender – Hijras is receiving education regularly (once every 15 days), over a period of one year or until the Transgender – Hijras is no longer in that location (total 24 interactions a year). Transgender – Hijras is receiving condoms for 90% of her estimated/reported client interaction. Condom distribution is accompanied by demonstration and training in negotiation skills if needed.
Referral to clinic for STI related services	Referral is done by outreach workers or peer. Referral should include STI information, condom information and demonstration and distribution of at least four condoms. Address of a clinic should also be shared. The doctor provides syndromic case treatment for STIs. STI treatment includes understanding the symptoms of the Transgender – Hijras, clinical examination, prescription/distribution of drugs to Transgender – Hijras and partner notification/treatment. STI treatment also includes risk assessment and risk reduction counselling, condom demonstration and distribution. Either the doctor or the counsellor can provide counselling. Referral to the clinic needs to be done whenever a Transgender – Hijras has a symptom. Every 6 months, the Transgender – Hijras is referred for presumptive treatment.
Follow up	Transgender – Hijras who have been treated in the clinic need to be followed

	up at home or clinic within one week.
Regular health check-up	Transgender – Hijras receiving STI/health care services every three months from the programme clinic or through referral doctors (aiming for four check-ups in a year).
	The objective is to promote regular health seeking behaviour among Transgender – Hijras. She should be referred every quarter even if she does not have symptoms.

Example: Opportunity Gaps Analysis

Activities	**Status**	**Opportunity Gaps**	**Reasons**		**What should we do?**
			Internal	**External**	
Estimate	218				
Contact	218				
Registration	139	79	Lack of rapport with the 79 Transgender – Hijras	Low volume Transgender – Hijras Fear of identification HRG come to town only once in 15 Days	Understand the time when these TG come and plan accordingly Build their trust by contacting them through other ex-workers or stakeholders
Regular Contact	105	34	Have not been able to generate Interest	Higher mobility of Transgender – Hijras Few Transgender – Hijras come only once in a Month	Link up with other services in the taluk so that women can be offered varied services Reach Transgender – Hijras through their social Networks
STI Treatment	47	58	Referral clinic is New Clinic is available only on fixed days Lack of trust in the project	No symptoms Transgender – Hijras drink Alcohol	Build trust through Peers Inform the Transgender – Hijras about advantages of check-ups
Follow-Up	12	46	Importance of follow-up not	Transgender – Hijras are	Provide counselling about follow-up

			communicated Properly Staff did not have clear guidance on follow-up	mobile	to Transgender – Hijras along with treatment Motivate doctors to advise follow-up Continuously remind Transgender – Hijras about clinic Day
Regular Health Check-Up	0	46	Communication gap with NGO. This service has not been Started		

Process 5 - Group Exercise: Participatory Site Load Mapping

The Group Work – Participatory Site Load Mapping is conducted to help us to understand the gap between estimates of TGs - Hijras, the number of unique contacts and the number of regular contacts by studying the TG -H load in a day, a week and a month in different sites. Participatory site load maps also give information on potential regular contacts: the potential number of Transgender – Hijras s a site team can contact in a month. The participants develop site maps to understand the turnover of Transgender – Hijras at a given site in a day, week and month and compare the same with the number of unique contacts and the number of regular contacts at these sites.

Materials Required: Charts, pens

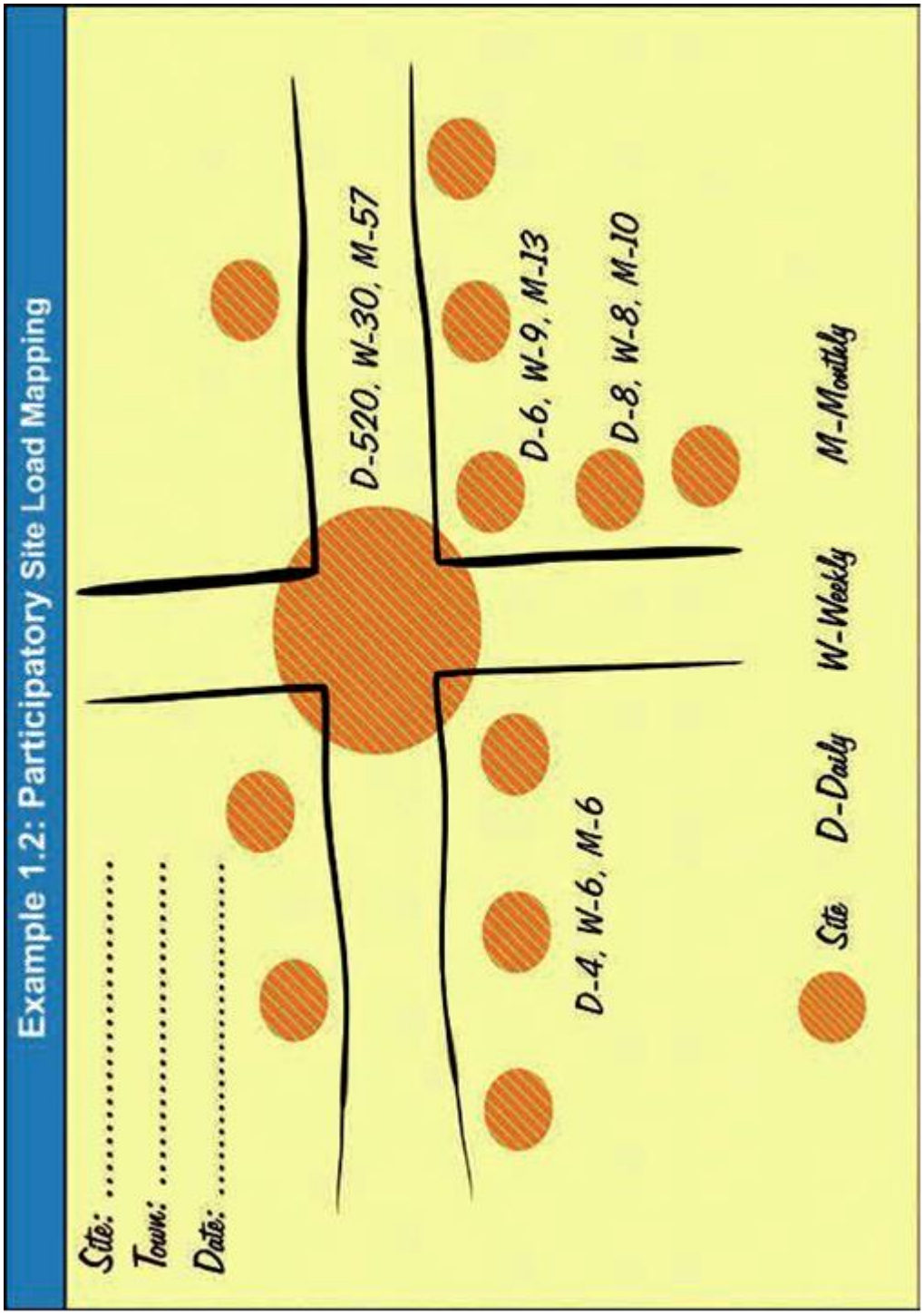
Process:

1. *Discuss with the participants that in order to reach out to the TGs-hijras it is important to know where, and how many are available on a given day, week and month.*
2. *Divide the participants, site - wise and ask them to draw a map of the site clearly depicting the sex work sites (the sites at which Transgender – Hijras pick up/solicit their clients) in the site. Ask the participants to colour-code the sites based on sex work typology such as non-gharana based sites, gharana based sites, etc.*
3. *Check with the participants if they have marked all the sites based on typology. Once all the sites are marked, ask the participants to write down beside the site the number of Transgender – Hijras who are always available on a normal day.*
4. *Next, ask the participants to write the number of Transgender – Hijras available at these sites in a week. Check with the participants if there are any specific days in a week when the number of Transgender – Hijras peaks and reasons for the same, for example, more Transgender – Hijras are available on a particular day.*
5. *Once the above exercise is done, ask the participants to mark the number of Transgender– Hijras available in these sites on a monthly basis and also ask if there are*

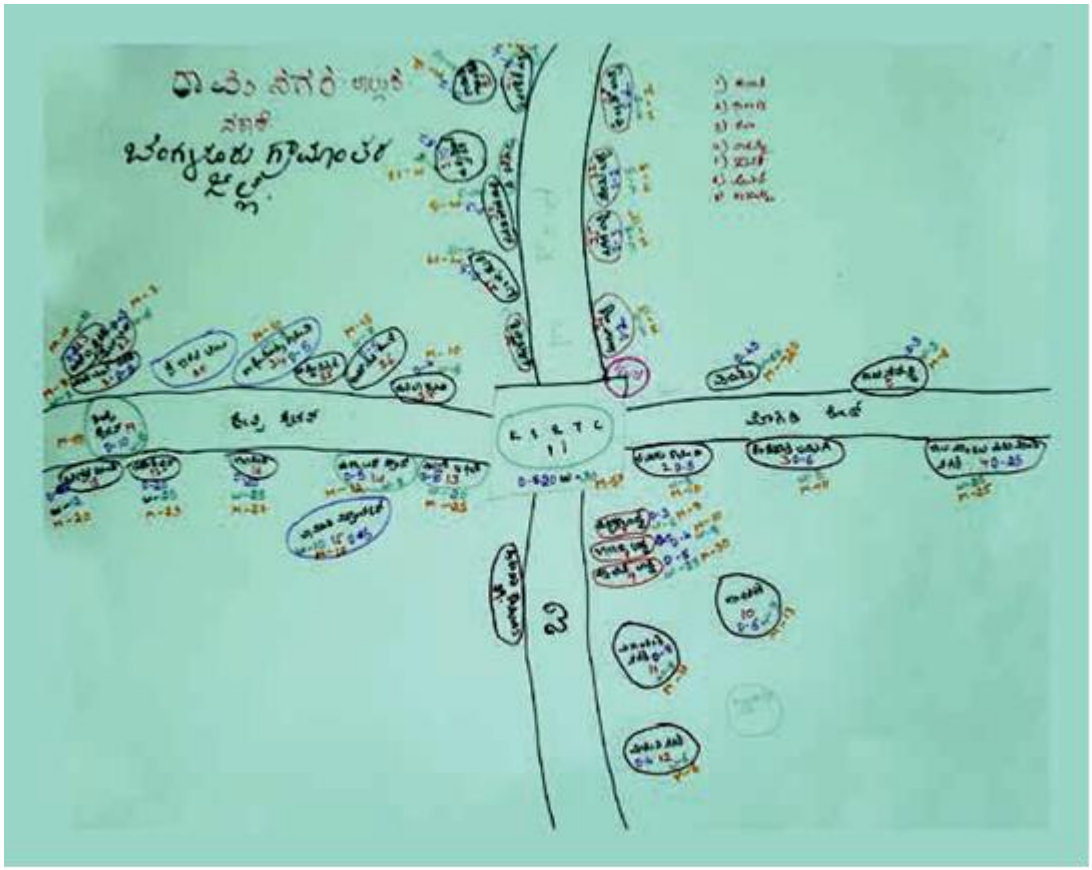
specific days in a month where the turnover is high and the reasons for the same, for example more Transgender – Hijras are available on payday.

6. *Then ask the participants to add the daily, weekly and monthly turnover in all the sites and draw up a picture of Transgender – Hijras turnover in a site.*
7. *Now again ask the participants to compare these figures with their estimate, unique contact and regular contact figures for these sites and analyse in the following way:*
   - *Are the total Transgender – Hijras available in these sites more or less than the unique contact and regular contact? Why?*
   - *Is high weekly and monthly turnover linked with any specific typology of sex work, fir example, is there high turnover seen in mostly Gharana based sex work? Why?*
   - *Are there specific sites where unique contact and regular contact is less than monthly turnover? Why?*
   - *Which are the sites and typology of sex work that need focused outreach in the site? Which (outreach team) is responsible for these specific sites? What should they do to improve outreach to ensure higher contacts?*

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



Sample Site Load Map



Process 6 - Group Exercise: Seasonality Diagramming

The Seasonality Diagramming Exercise is conducted to understand peaks and troughs of sex work at a given place in a year and its impact on outreach planning. The participants, through a seasonality map, attempt to understand the peaks and troughs in sex work based on typology in a taluk and reasons for the same. They learn to plan outreach based on this seasonal variation.

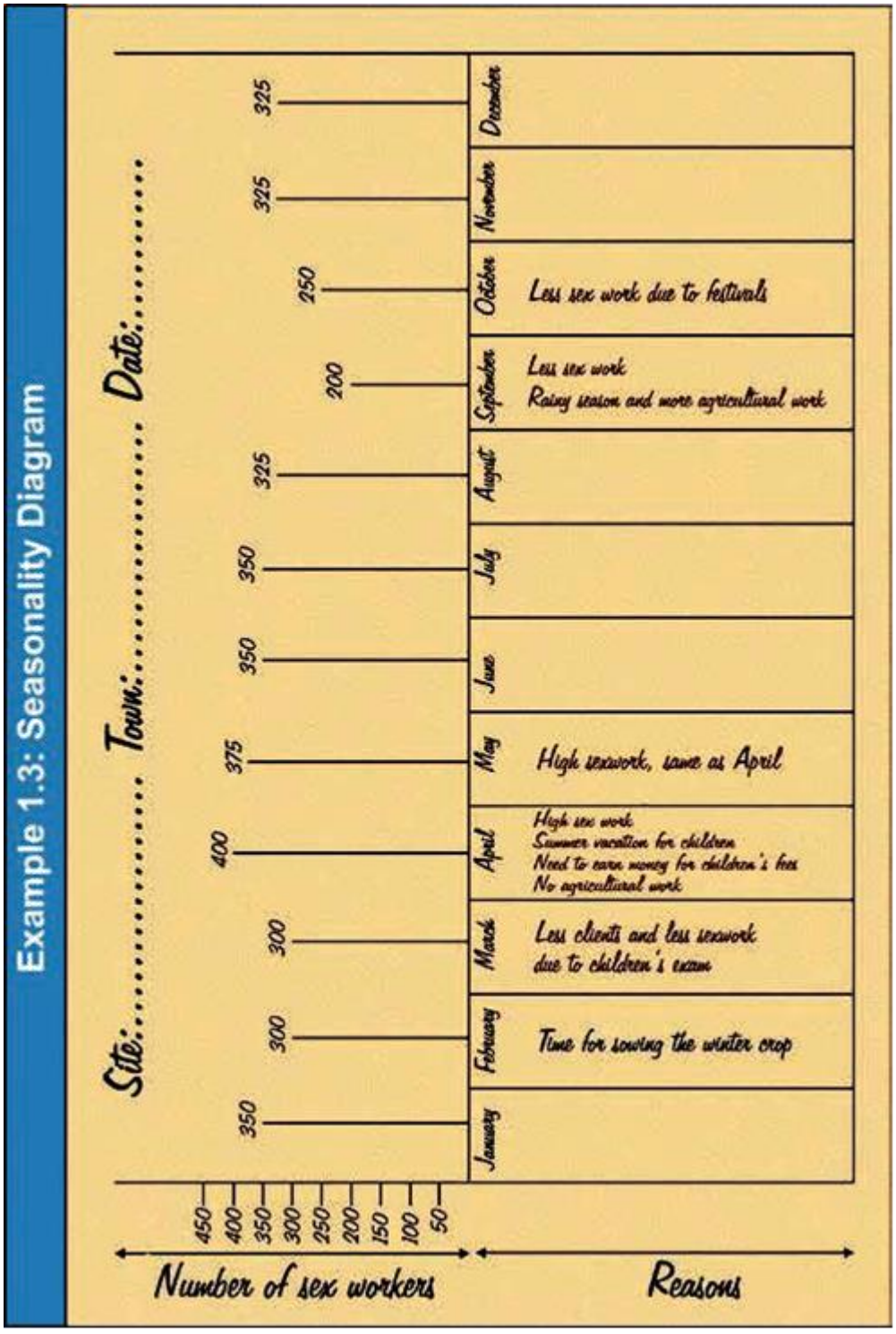
Materials Required: Pens, chart paper

Process:

1. *Inform the participants that in this exercise we will attempt to understand how the sex work scene changes in a year in their town.*
2. *Divide the participants into site-wise group and start by asking them which month of the year maximum number of Transgender – Hijras operate in the town. Ask the participants to have a group discussion and finalise the month/s.*
3. *Next ask them to write the approximate number of Transgender – Hijras in those high and low months and the reasons for the same.*
4. *Then identify the next busiest or peak month, the number of Transgender – Hijras and the reasons. Document results. Similarly continue doing this exercise for all the months in a year.*
5. *Make sure that the discussions are intensive and all the participants are involved. Make the exercise visual by using chart paper, colour pens, etc.*

6. *Finally, when the seasonal calendar is complete, verify the results with the participants to ensure that everybody agrees with what the calendar depicts.*
7. *Ask the group the following questions:*
   - *During peak months do we find Transgender – Hijras from other towns coming to our town?*
   - *Is the peak season specific to our site or is it valid in other sites also?*
   - *In the low season, do the Transgender – Hijras stop sex work or do they migrate to other towns?*
   - *How does our outreach plan change based on these seasonal variations?*

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



Process 7 - Group Exercise: Force Field Analysis

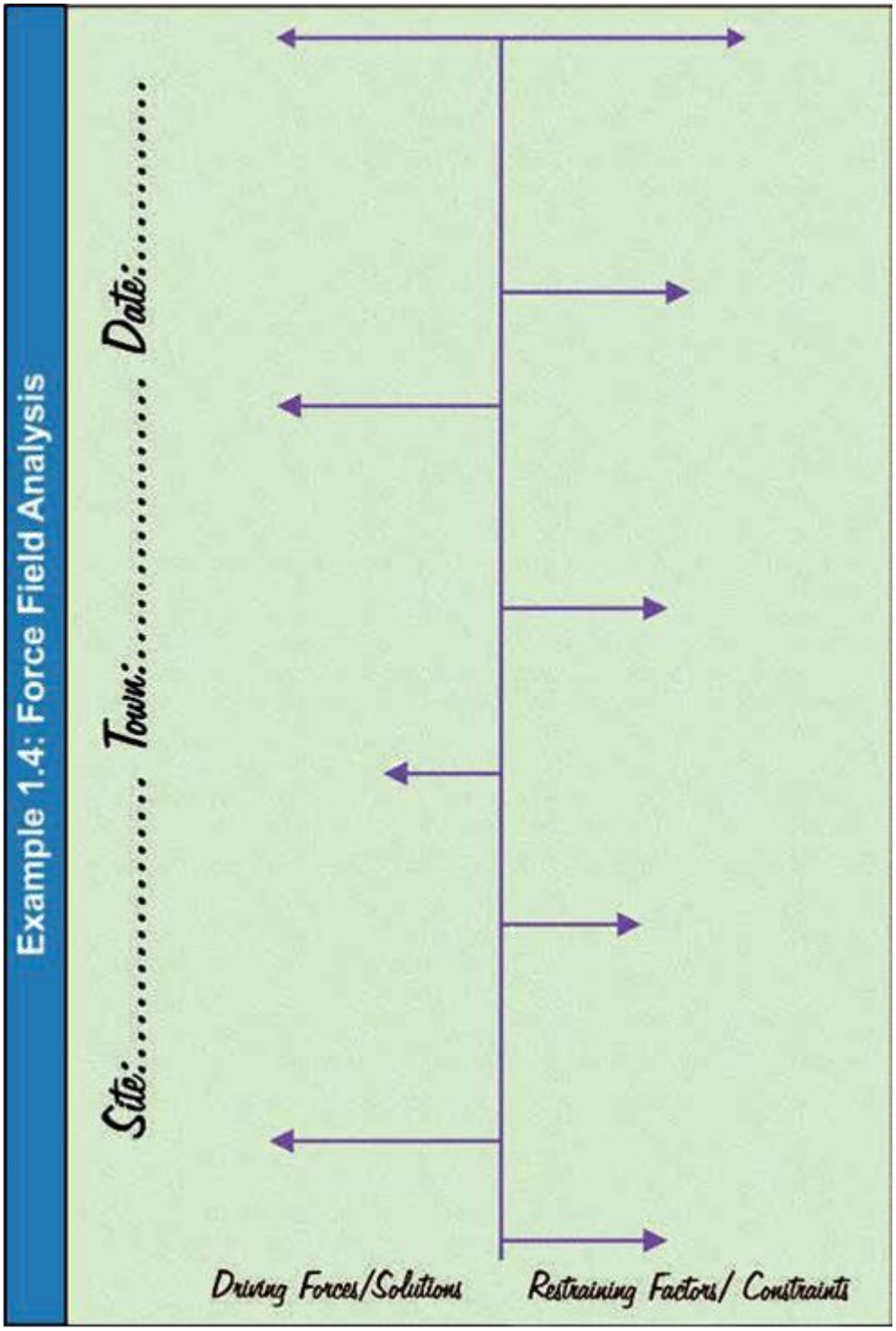
The Force Field Analysis is conducted to understand the reasons for gaps in contact and regular contact, and plan outreach to reduce the gap. The participants through this exercise analyze the reasons for gaps in contact and regular contact, and develop plans to address these reasons.

Materials Required: Pens and Chart paper

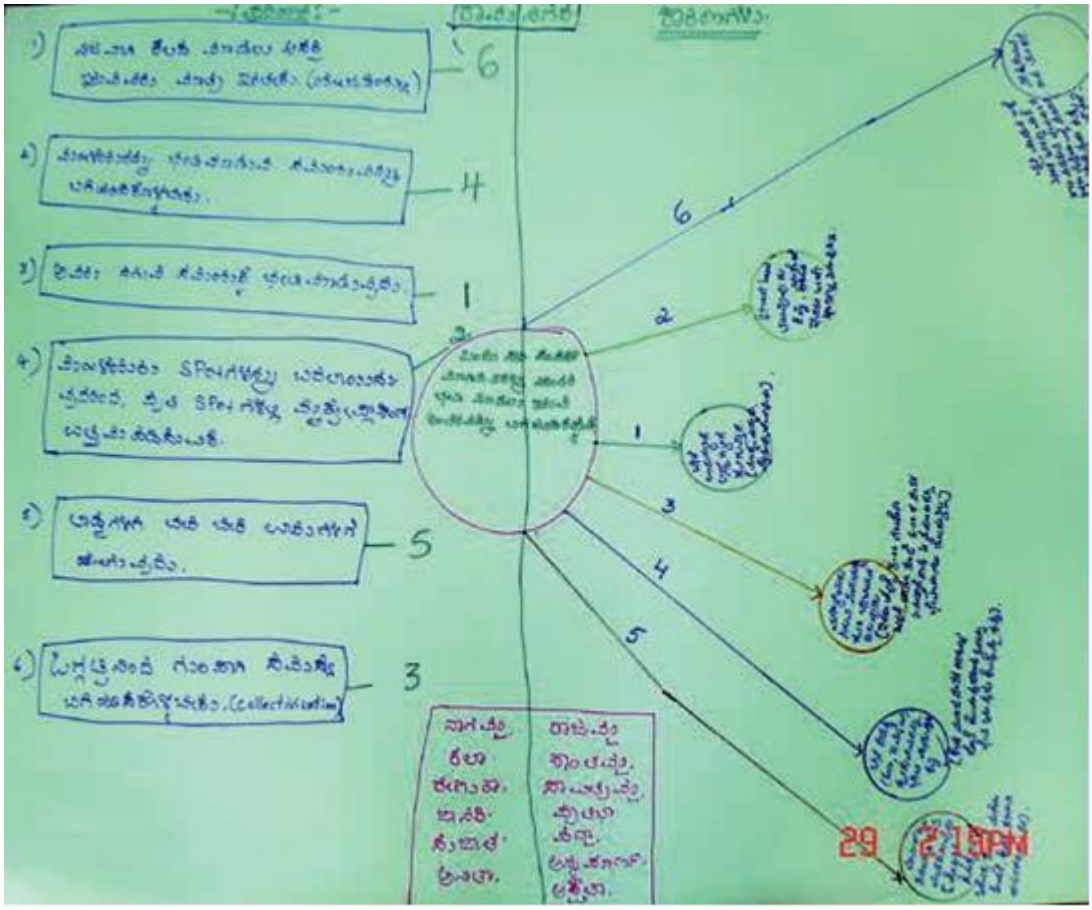
Process:

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

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



Sample Force Field Analysis



Process 8 - Group Exercise: Typology-Wise Outreach Planning

Typology-Wise Outreach Planning is conducted to understand the link between typology of population and outreach. The participants through discussion and analysis of peer outreach understand the link between outreach and typology of sex work.

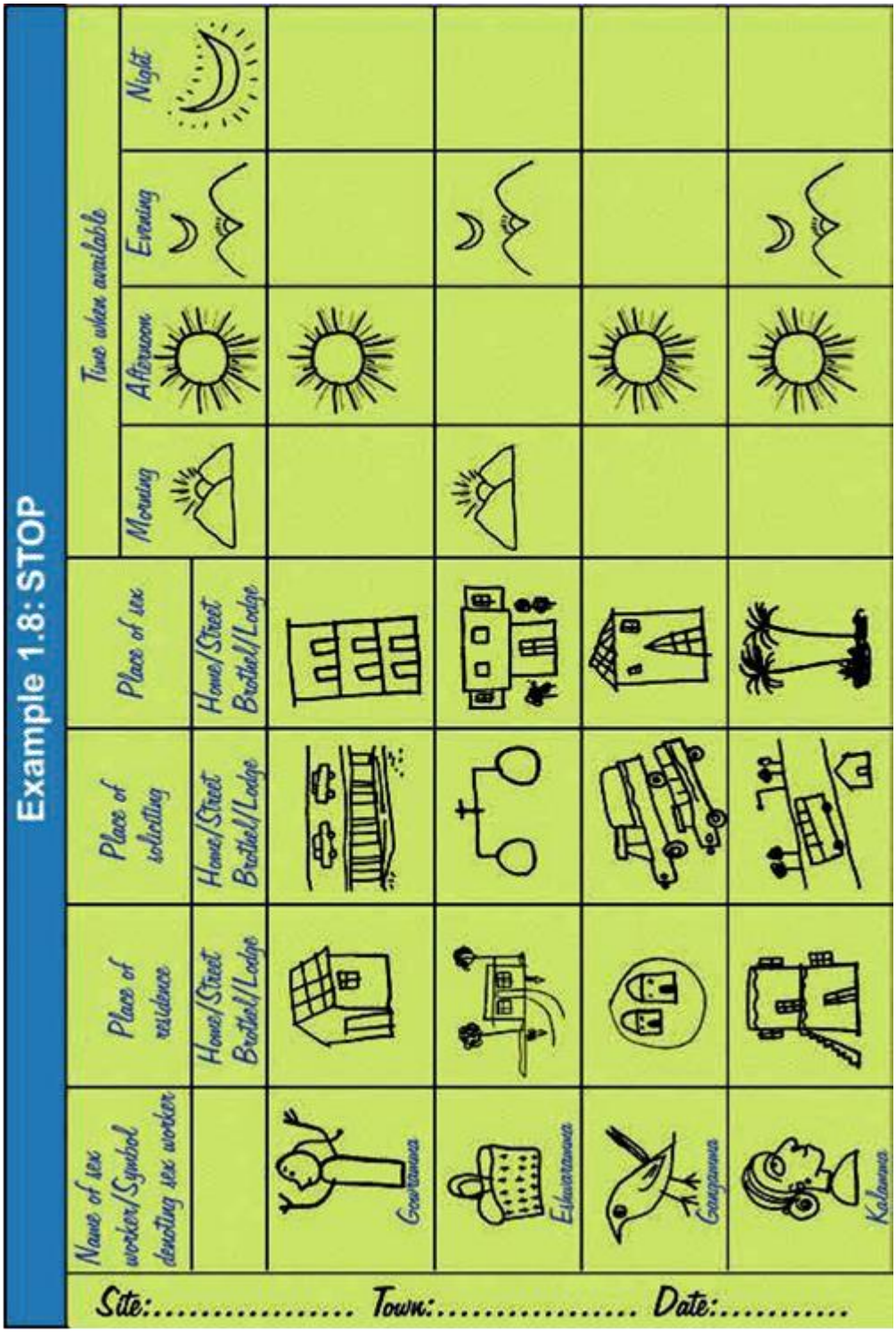
Process:

1. *Explain to the participants that it is important to recognise and understand the link between outreach, typology of population and timing of sex work and cruising.*
2. *Ask the participants to list the Transgender – Hijras that they are accountable for but have not met in the last two months. This information can be generated from the peer calendars.*
3. *For each of the TGs listed above, ask the peers to provide the following information:*
   - *Place of residence*
   - *Place of soliciting*
   - *Place of sex work*
   - *Ideal timing for outreach (morning, afternoon, evening, night)*
4. *When the participants complete this information, ask them to identify commonalities in typology and timing of outreach in those mentioned in the list. Bring out the characteristics of these.*
5. *Then ask the following questions:*

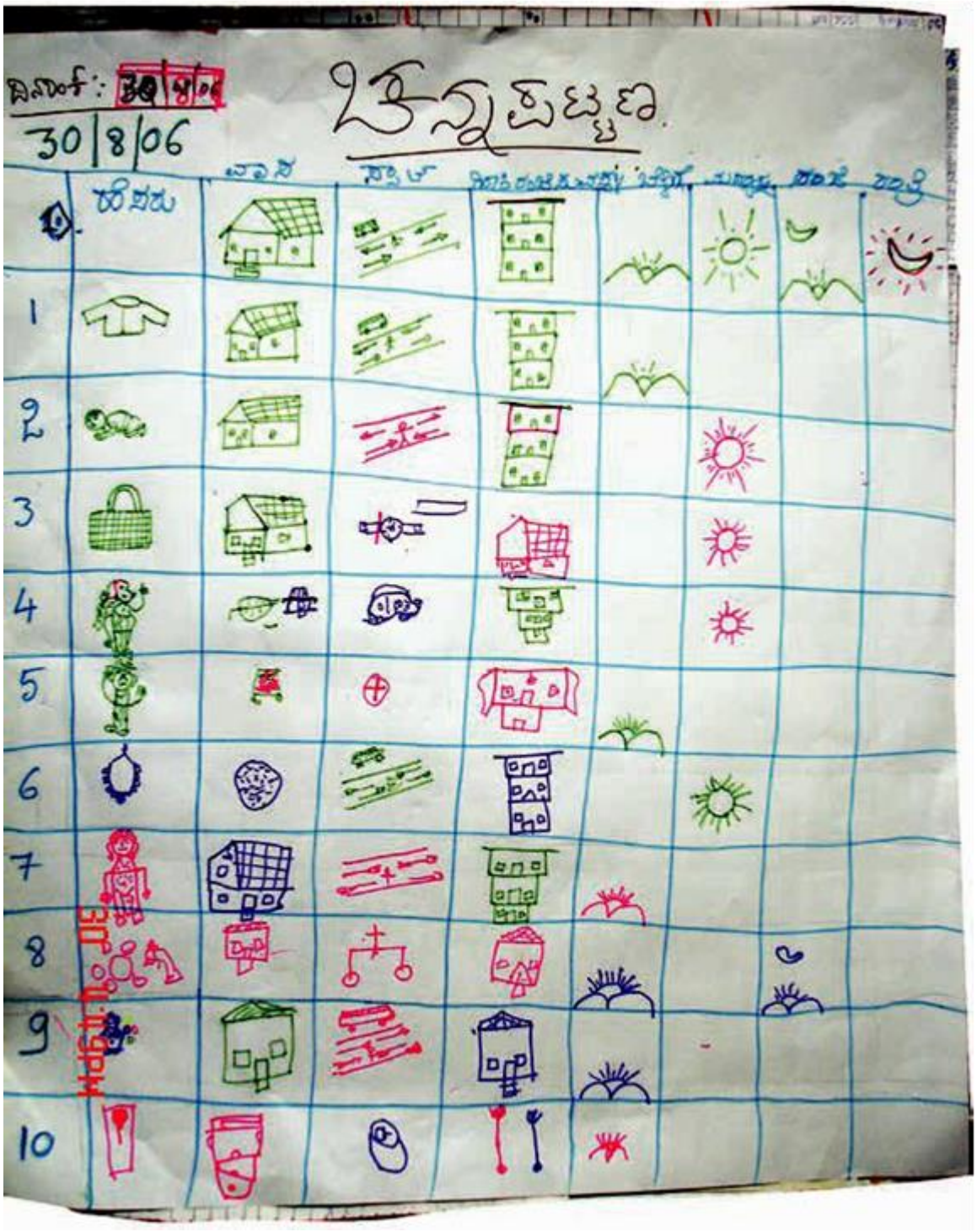
- *Is there a link between the number of Transgender – Hijras who are not contacted and typology of sex work? Which typology of Transgender – Hijras population is left out from outreach most often?*
- *Is there link between those who are left out and timing of outreach? Are Transgender – Hijras practicing sex work at night or at a specific time of the day left out from outreach?*

6. *Now ask the participants to develop a strategy for outreach to a typology of Transgender-Hijras population who are left out from outreach. Ask the participants to plan how to contact, provide services and give condoms to Transgender – Hijras who are often or always left out from outreach services.*
7. *Conclude by asking if there are any questions.*

Note: The participants can use pictures.



Sample Stop List



Summary of the session and transition (05 minutes)

Once again summarize the key points.

Ask if there is anything that requires clarification, or if there are any doubts/questions.

As per the agenda, we will cover the __ topic (please mention the next topic) in the next session. So and so (please, name/introduce the facilitator for the next session) will

present/facilitate the next session who is an expert in the field and has extensive experience in the sector.

Session 8: Communication for behaviour change & counselling

Learning objectives:

- By the end of the session, the participants will be able to understand the role of BCC and counselling in HIV prevention.

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	Communication for behaviour change	15 minutes
3.	Key components of communication, counselling and BCC/IEC	15 minutes
4.	Summary of the session and transition	05 minutes
	Total	**40 minutes**

Preparing for the session

Prepare a slide on the learning objectives of this session.

Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Communication for behaviour change (15 minutes)

Present the following information as a PowerPoint presentation and discuss with the participants.

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

Need for a separate BCC strategy for TG - H

Several factors necessitate a separate BCC strategy among TG - H. Their needs are unique, and extend beyond the conventional boundaries of HIV and AIDS prevention programmes. TG - H are not a homogenous group. Cultural and social norms among TG -

H vary in different regions of the country and among their various subgroups. Some earn their living through sex work, some beg and some, who live in "Dera", meet their needs only through Badhai. Each of these subgroups has a distinct health need and concern, and requires a different approach for working with them.

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

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

One of the key gaps identified is in the area of helping Hijras and Transgender people put HIV/STI prevention messages into practice in their own very local or individual contexts. A multi-pronged approach must be adopted to create behaviour change communication *(This will be discussed later at the end of this session)*.

Continue to communicate messages to:

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

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

TI partner needs to:

- Ensure IEC materials contain clear, concise, simple and short messages that are linked to behaviour change, such as " Use a condom every time you have sex"
- Refer people to only those services that are actually in place
- Collaborate with service providers so that they display and distribute BCC materials for Hijras and Transgender people at their service delivery sites
- Ensure that service providers understand TG - H -specific BCC/IEC materials

- Ensure outreach and peer personnel are trained to deliver behaviour change messages for Hijras and Transgender people in interpersonal, outreach and peer education settings.
- Highlight positive outcomes of behaviour change, that is, improved health, economic and personal outcomes when delivering messages
- Include messages for and images of Hijras and Transgender people in HIV prevention messages/pamphlets prepared for the general population.

Key components of communication, counselling and BCC/IEC (15 minutes)

Present the following information as a PowerPoint presentation and discuss with the participants.

Explain the following:

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

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

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

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

Summary of the session and transition (05 minutes)

Once again summarize the key points.

Ask if there is anything that requires clarification, or if there are any doubts/questions.

As per the agenda, we will cover the __ topic (please mention the next topic) in the next session. So and so (please, name/introduce the facilitator for the next session) will present/facilitate the next session who is an expert in the field and has extensive experience in the sector.

Session 9: STI & other clinical services

Learning objectives:

- By the end of the session, the participants will be able to know about basics of STI, and the package of STI services

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	Interactive Session on Basics of STI	20 minutes
3.	Package of STI Services	20 minutes
4.	Preference Ranking – Group Work	30 minutes
5.	Summary of the session and transition	05 minutes
	Total	**80 minutes**

Preparing for the session

Prepare a slide on the learning objectives of this session.

Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Basics of STI (20 minutes) – Interactive Session

Interact with the participants on the following:

Ask the participants to discuss their knowledge regarding the symptoms of STIs, including local terms used to denote symptoms of STIs.

Record all the known symptoms on chart paper.

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

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

Symptoms

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

STIs

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

Further discuss with the participants on the following:

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

Encourage participants to ask questions, and give clarifications accordingly.

After Q & A session, move on to discuss on the transmission dynamics…

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

Transmission Routes

- Unprotected penetrative sexual encounter with infected person
- From infected mother to child, for example, HIV, syphilis

- Use of infected blood for transfusion, for example, HIV, hepatitis B and C
- Through infected needle/syringe.

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

Physiological factors

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

Social factors

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

Further continue the discussion on treatment aspects

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

Treatment aspects

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

<u>Prevention aspects</u>

Use of safer sex measures, consistent use of condoms

Take the discussion further with the participants on the following:

- Discuss PEs' role in STI management.
- Disseminate information to transgender - hijras and their clients regarding STIs, counsel and motivate them to come to the clinic for health checkup, and be alongside clinic attendees to give them confidence
- Ask and counsel them about compliance with treatment
- Put effort into bringing the partners to clinic for health screening

- Provide counselling on consistent condom use. Monitor quality of services: maintenance of confidentiality, privacy, pay attention to whether non-judgmental attitude and friendly behaviour is extended by the project staff
- As active members of clinic management team, PEs should stay familiar with clinical procedures
- Participate actively in clinic meetings and provide feedback that will help in triangulating data gathered by the clinic team and outreach team as well. For comprehensive management of STIs, PEs are the link between clinic and outreach team.

This interactive session on the STI will help the participants to learn on the basics of STI as given below:

- the common symptoms of STI and their local terminologies
- the name of some common STIs
- the risks from STIs if they remain untreated, mode of transmission of STIs and prevention of transmission
- understand why Transgender – Hijras are more vulnerable to STIs
- how to control STIs (prevention and treatment)
- understand the role of peer educators in STI management

Package of STI Services (20 minutes)

Present the following information as a PowerPoint presentation and discuss with the participants.

Explain the following:

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

- Preferred list of physicians available in the project area
- List of current barriers to accessing STI services
- Ways in which STI services can be made accessible and acceptable to Hijras and Transgender people in terms of location, operating hours, etc.
- Modes of STI service delivery, for example
- Intervention site-based clinic: This ensures confidentiality, less marginalization and better quality of care. Easy to follow up but difficult to sustain.
- Referral to the public sector: Services can be free but often do not respect confidentiality, and quality of services cannot be predicted. Marginalized groups are often stigmatized in these settings.
- Referral to the private sector: This ensures confidentiality, and services can be sustained, but quality and costs are unpredictable.

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

- Clinicians with the right attitude towards the community
- Availability of services as per the needs of the community, for example late evening, -night access

- Accessibility of services at optimal location (for example, not too far from the sites where most Hijras and Transgender people reside and operate)
- Basic infrastructure facility (facilities should be maintained at the standards stipulated by the DAC STI guidelines)
- Confidentiality between the clinic team and the community should be maintained.

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

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

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

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

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

- Should treat transgender individuals as they would like to be treated themselves
- Have received transgender cultural competency training and that there is a system in the NGO/CBO for addressing inappropriate conduct by staff
- Should focus on care rather than indulging in questions out of curiosity

- Should know that it is inappropriate to ask transgender/hijra patients about their emasculation status if it is unrelated to their care
- Should become knowledgeable about transgender/hijra health care and medical issues and know where to access resources.

Preference Ranking – Group Work (20 minutes)

The exercise Preference Ranking is conducted to identify the reasons for gaps in regular contact and clinic attendance and prioritize the same. The participants by using the preference ranking tool analyze the reasons for gaps in regular contact and clinic attendance, prioritize the same and make plans to address them.

Materials Required: Chart paper and pens

Process:

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

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

Sample Preference Ranking

Summary of the session and transition (05 minutes)

Once again summarize the key points.

Ask if there is anything that requires clarification, or if there are any doubts/questions.

As per the agenda, we will cover the __ topic (please mention the next topic) in the next session. So and so (please, name/introduce the facilitator for the next session) will present/facilitate the next session who is an expert in the field and has extensive experience in the sector.

Session 10: Condom programming

Learning objectives:

By the end of the session, the participants will be able to know the following:

- Condom Promotion,
- The basics of free condom programming for H/TG
- Condom Accessibility and Availability Mapping
- Negotiation skills

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	Condom promotion	30 minutes
3.	The basics of free condom programming for H/TG	30 minutes
4.	Condom Accessibility and Availability Mapping	30 minutes
5.	Negotiation skills	20 Minutes
6.	Summary of the session and transition	05 minutes
	Total	**120 minutes**

Preparing for the session

Prepare a slide on the learning objectives of this session.

Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Condom Promotion (20 minutes) – Interactive session

Interact with the participants on the following:

This session can be arranged with a PPT on the key points.

First, ask the participants to talk about what they know about condoms.

List terminology they use for condoms.

Ask them to explain what condom is:

- It is a rubber sheath. It is a long thin tube when rolled out. At the lower end it is closed and has a teat, which collects the semen. The condom acts as a wall and prevents the sperm and STI- causing germs and HIV from entering the anus, and from transgender genital parts to the penis.
- It acts as a barrier against STI and HIV transmission.
- It acts as a contraceptive device.

Display a condom and give a condom to each participant so that they can see and feel it.

Secondly, talk about the correct use of condoms (condom demo).

Ask a participant (any volunteer) to demonstrate putting a condom on a dildo (penis model). Then demonstrate correct condom use with the dildo (penis model):

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

Further, discuss with the participants about why people do not use condoms and the common misconceptions about using condoms are:

Write those misconceptions that emerge during the discussion from the participants on a flipchart paper. The following common misconceptions may be prepared as a slide to present to the participants:

- Using condom during sex is irritating.
- Condom will tear during intercourse.
- Condoms reduce sexual pleasure.
- Condom is sticky and oily.
- Erection goes before using condom.
- Problem of buying.
- Double condoms will provide better protection.
- Use of condom implies lack of emotional feeling of her love for the partner.
- Condom is barrier of "mistrust" between two partners.

Once the all the common misconceptions were listed down, clarify misconceptions as given below:

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

As an exercise, ask a participant to put a condom on one finger.

Tell the participant to touch various materials with the finger, and ask whether the person can differentiate between them.

Explain that the condom does not create any barrier of feeling.

*If any community is part of the exercise or if this exercise is conducted at a TI site, ask one or two community members to share their practical experience of what they do in these situations. (**Optional**)*

Further, take the discussion on the availability of condoms at the field.

Discuss availability of condoms. Ask the participants where condoms are available.

List all locations/ channels:

- With PEs
- Medicine shops
- Other shops
- Clinic

Finally, discuss on how and where the H/TG can store their condoms.

Condoms should be stored in a cool dry place.

This interaction session on condom promotion will help the participants to understand and know the following:

- What condom is and why it should be used
- Proper use of condoms
- Some of the methods for convincing clients use condoms
- Availability of condoms and condom storage

The basics of condom programming for Hijras and Transgender people (30 minutes)

Present the following information as a PowerPoint presentation and discuss with the participants.

Ensuring availability, accessibility and correct and consistent usage of free male condoms and lubricants or extra lubricated condoms6 by Hijras and Transgender people is a core imperative of NACP IV.

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

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

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

Considerations may include:

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

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

Calculation of requirement of condoms per month

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

D = (H/TG x I x N) – C where

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

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

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

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

Monitoring condoms occurs at three levels:

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

The target is to ensure over 100% availability.

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

Condom stocking/reporting

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

Condom and lubricants use

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

Condom breakage during anal sex and the importance of lubricants

Sometimes, a general complaint by hijras and transgender people is "breakage of condoms".

There are several possible reasons for breakage:

- Poor quality of condoms
- Condoms used after the expiry date
- Incorrect use of condoms
- Poor lubrication
- Use of incorrect (oil-based) lubricants

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

Lubricants

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

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

Calculation of requirement of lubricants per month

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

L = (H/TG x I x N) – C where

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

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

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

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

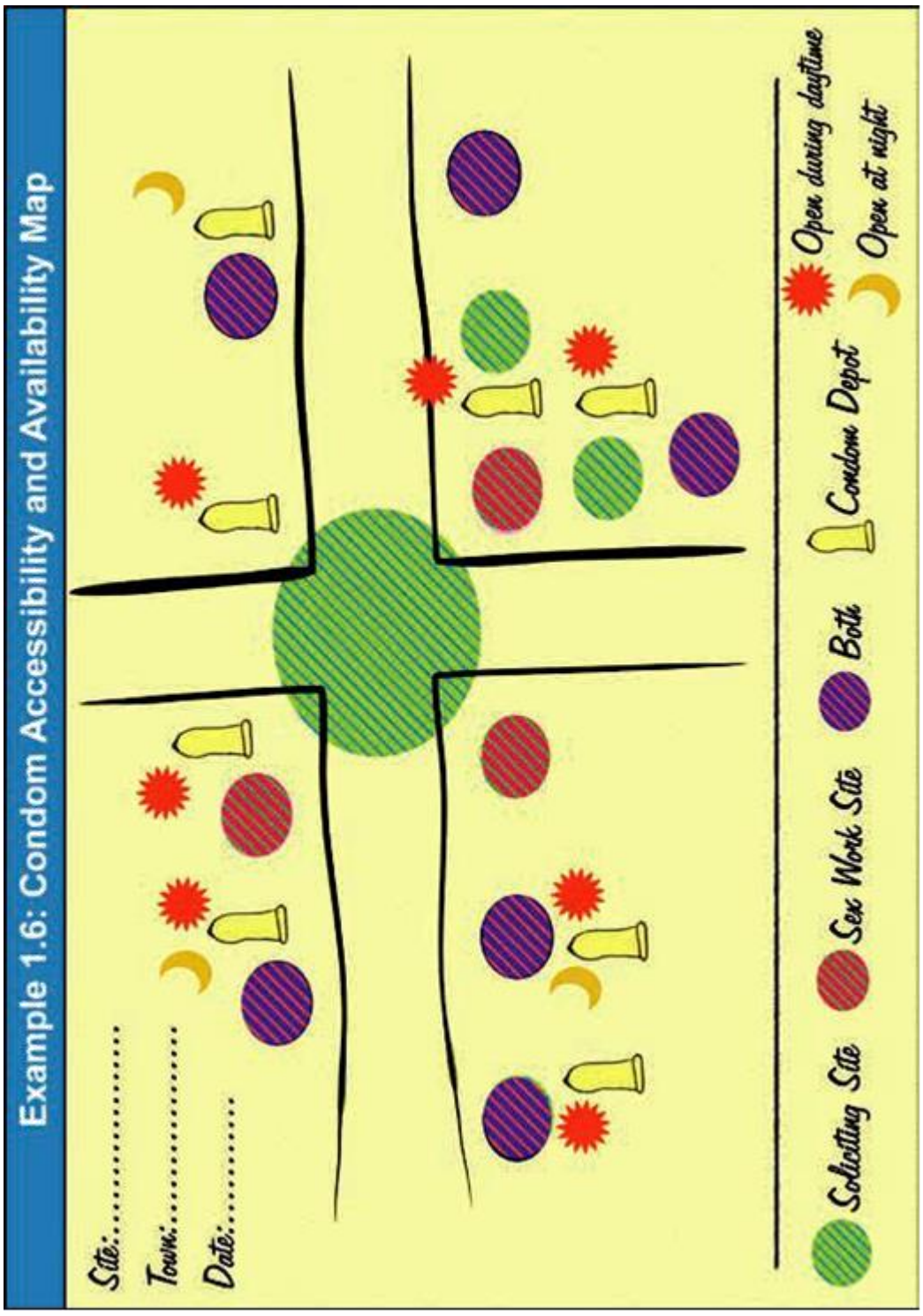
Condom Accessibility and Availability Mapping (30 minutes) – Group Work Exercise

This group work exercise is conducted in order to help the participants to map the condom availability points and to understand if they are easily accessible to H/TG population. The participants by using maps identify the condom availability points and analyze its accessibility to H/TG population.

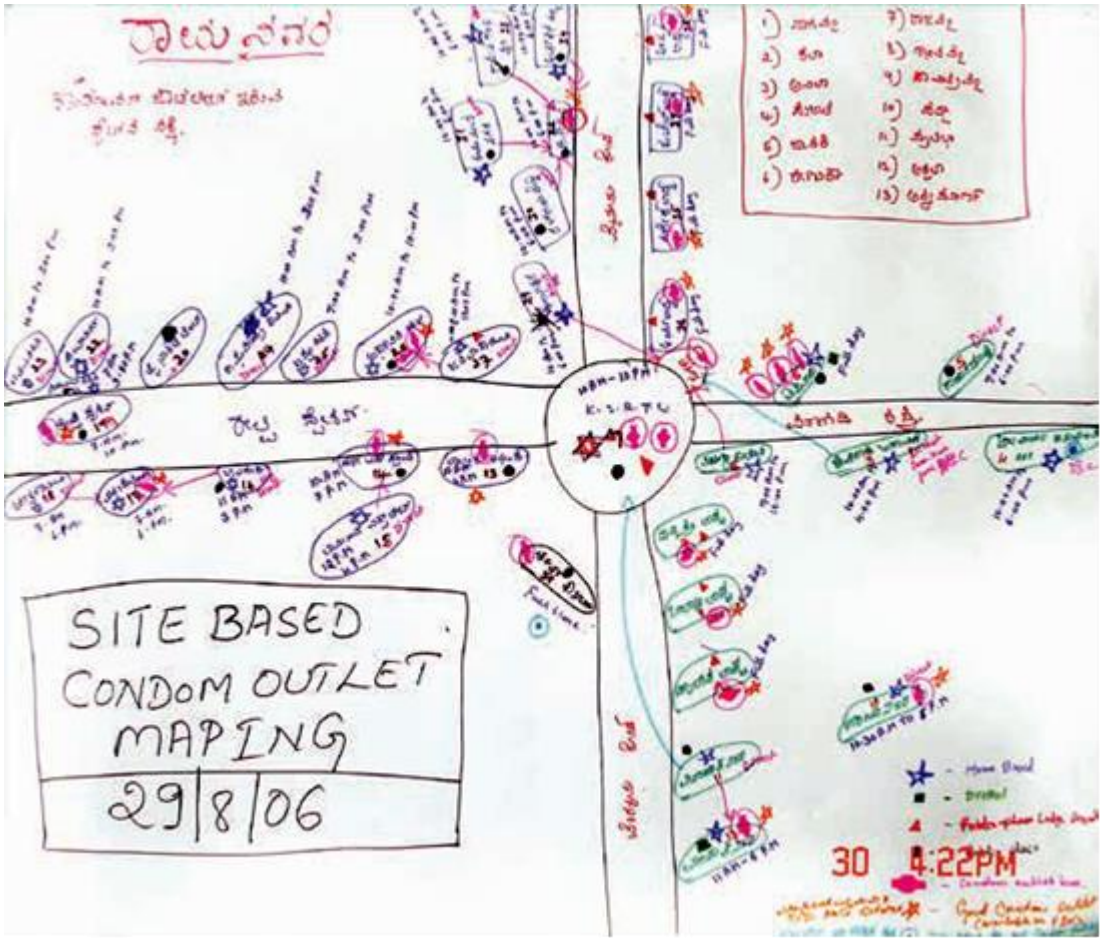
Materials Required: Maps and pens

Process:

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



Sample Condom Accessibility and Availability Map



Negotiation Skills (30 minutes) – Interaction and role play

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

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

First, discuss the issues that hinder safer sex practices by H/TG.

List all the issues raised by the participants (or PEs if this exercise is conducted at the TI Site.)

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

Then, discuss how to resolve these situations.

Take the points one after another, determine the stakeholders with whom H/TG have to negotiate and identify possible solutions.

Most of the issues may not have any immediate solutions. Issues that may come up include collective bargaining, empowerment of H/TG, improving their self-esteem, advocacy, the need for more economic options, etc.

Secondly, discuss approaches to negotiation with different groups as given below in a table:

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

Further, role-play how H/TG could negotiate on condom use with a client, and with exploitative police personnel.

This interactive session will help the participants to learn to identify the factors that hinder H/TG from negotiating with their clients on safer sex practices, identify some of the issues to improve H/TG negotiation skills, and the basic negotiation skills.

Summary of the session and transition (05 minutes)

Once again summarize the key points.

Ask if there is anything that requires clarification, or if there are any doubts/questions.

As per the agenda, we will cover the __ topic (please mention the next topic) in the next session. So and so (please, name/introduce the facilitator for the next session) will present/facilitate the next session who is an expert in the field and has extensive experience in the sector.

Session 11: Community ownership

Learning objectives:

- By the end of the session, the participants will be able to understand and know about community mobilization & ownership

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	Basics of Community Mobilization	20 minutes
3.	Community Mobilization and Facilitation of Group Formation	30 minutes
4.	Summary of the session and transition	05 minutes
	Total	**60 minutes**

Preparing for the session

Prepare a slide on the learning objectives of this session.

Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Community Mobilization (20 minutes)

Present the following information as a PowerPoint presentation and discuss with the participants.

Explain the following:

Community Mobilization under NACP IV:

- Targeted Intervention (TI) is part of NACP's strategy for containing the spread of HIV among marginalized and vulnerable high risk populations
- Emphasis on prevention approach to attain scale, coverage and quality through the involvement and ownership of the at-risk/vulnerable communities themselves.
- Transformation from service provision to demand generation leading to greater utilization of services and commodities
- Emphasis on community mobilization, enabling community leadership development and community self-organizing and for the community to take the lead.
- Community owned initiatives enable the HRG to play the role of a pressure group as consumer to maintain and reinforce quality services.

- The empowered community thereby plays the role of a 'gatekeeper of services' and not merely that of recipients or beneficiaries.

Community Mobilization under NACP IV

Principles of Community Mobilization:

- Aim to achieve the dual outcomes of community – immediate and future challenges
- Encourage meaningful community participation
- Encourage meaningful community participation at every stage of the mobilization process
- Work together
- Build trust and social capital
- A relaxed process –based on the community capacity
- Maximize the use of available resources

Stages of Community Mobilization:

1. Starting together
2. Assessing together
3. Planning together
4. Acting together
5. Monitoring and evaluation together
6. Scaling up together

Community Ownership Building Plan (20 minutes)

Discuss with the participants using PPT on the following:

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

Scenarios:

1. ***Presence of CBOs:*** In case H/TG CBOs exist and are functional, these CBOs can be

assessed via a systematic process to understand the capacity of the CBO in managing a TI.

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

Enable Community Mobilisation processes and Facilitation of Group formation

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

Transition Strategy

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

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

Capacity Building

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

Development of Community Resource pool

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

Community Committees

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

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

Summary of the session and transition (05 minutes)

Summarize the key points of this session.

Ask the participants if there are any doubts/questions or if there is anything that requires clarification.

As per the agenda, ____ topic (please mention the next topic) will be covered in the next session. It will be presented/facilitated by so and so (please, name/introduce the facilitator for the next session). The facilitator is an expert on the subject and has a lot of experience in the field.

Session 12: Creating an Enabling Environment

Learning objectives:

- By the end of the session, the participants will be able to learn about the component of enabling environment

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	Creating Enabling Environment	20 minutes
3.	Rapid Response Team for crisis intervention	30 minutes
4.	Summary of the session and transition	05 minutes
	Total	**60 minutes**

Preparing for the session

Prepare a slide on the learning objectives of this session.

Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Creating Enabling Environment (20 minutes)

Introduce the session:

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

Present the following information as a PowerPoint presentation and discuss with the participants.

Explain the following activities that are presented in a table:

Key Areas	Activities	Objectives
Rapid Response Team for Crisis Intervention	▪ Creation of community RRT which is readily accessible to H/TG community in times of crises and violence ▪ Contact details are circulated to the entire TI community who will reach out to the RRT ▪ The service is embedded within the CBO/NGO	▪ To ensure H/TG are treated fairly, equally and compassionately by service providers, police and other stakeholders
Stakeholders and employer education	▪ List of friendly services – lawyers, doctors, police, etc.	▪ To ensure all gatekeepers are aware of the health needs of H/TG can support them in seeking services
Involvement of H/TG in SAC's activities	▪ Create a structure of H/TG community representatives with whom there can be periodic interactions in relation to programme planning, implementation and evaluation of H/TG TIs.	▪ To ensure H/TG involvement is integral in programme design and evaluation process ▪ To enable H/TG to contribute to community and national level campaigns on HIV awareness ▪ To enable H/TG to contribute to community efforts to decrease HIV infection and improve community health
Raise positive public awareness of H/TG	▪ Create IEC materials on social entitlements and Human Rights ▪ Regional seminars on H/TG issues – generate solidarity and advocate for the cause ▪ Operational research and studies on the H/TG populations ▪ Transitioning of NGO-CBO ▪ Provide space and hire H/TG employees and consultants for conducting advocacy ▪ SACS to respond to any violation of rights or denial of services ▪ Support Community Mobilization initiatives of H/TG Network at State and national level	▪ To improve understanding and respect for the rights H/TG among the general population ▪ To participate in BCC/media campaigns and represent H/TG in planning meetings
Documentation	▪ Collect case studies, best practices and success stories to inform national and international community of the needs of H/TG ▪ Video documentation on positive aspects of life of H/TG people	▪ To share best practices and lessons learned with other partners and stakeholders working with H/TG

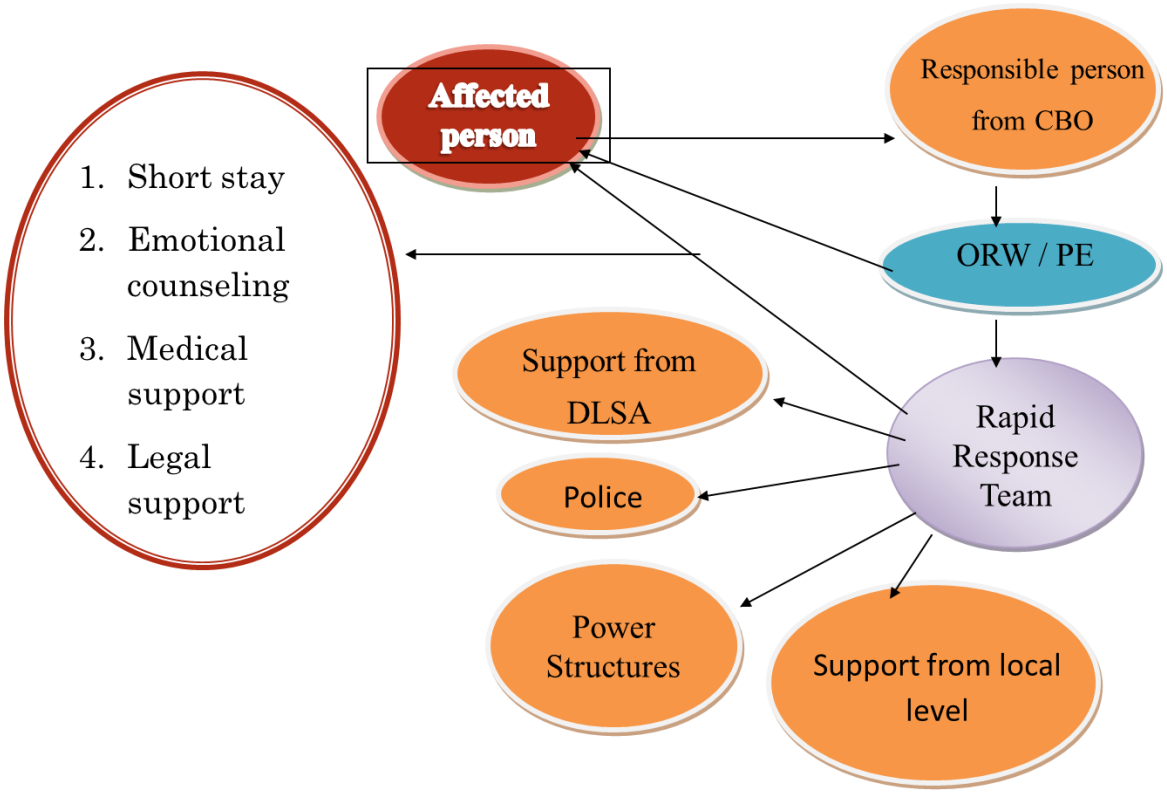
Key Areas	Activities	Objectives
Advocacy with Police	▪ Training police personnel at all levels (use NACO – approved model for working with police) Note: Each training to have personnel from the same level to ensure a more open discussion and better interaction among the trainees ▪ Orientation/sensitization of police personnel at the local Police Station level by local TIs	▪ To improve understanding and respect for the human and legal rights of H/TG among the police

Rapid Response Team for Crisis Intervention (20 minutes)

Discuss with the participants using PPT on the following:

H/TG populations continue to face innumerable incidents of violence due to their identity and non-confirmative gender expressions. To address such cases of violence and harassment it is imperative to formally set up Rapid Response Team (RRT) for Crisis Intervention.

Rapid Response System for Crisis Intervention:



Effective RRT for Crisis Intervention:

The effective RRT for crisis intervention is required to have the following:

- Trained and committed staff members 'on call' 24 hours responding immediately when a crisis happens
- Effective communication mechanisms
- Availability of information about crisis response to community members
- Experienced committed lawyers and HCPS willing to provide 24 hours assistance
- Networking, alliance-building, and sensitization work with local stakeholders through regular meetings and education as appropriate. This includes community-level legal literacy sessions.
- Close alliances with other civil society organisations, activists and local media contacts who can advocate on behalf of the community when necessary.
- Reflections on crisis management cases to improve and build internal capacities.
- RRT can get support through networking from local NGOs, community volunteers, CAB members, human rights organizations and bar associations.
- The RRT must have one member from H/TG hijra and led by either community PM or PD of the CBO.

RRT in Action: What needs to be done during the crisis situation?

- When a community member informs on one's behalf or on behalf of another member who gets harassed or abused, the member of the crisis team responding to the information gets in touch with other crisis team members to apprise them of the situation.
- The team ensures that at least one person from the crisis response team goes to the spot where the crisis has happened and meets the person concerned. It is important to provide immediate moral support and give the message that the person is not alone in this situation and the person has support from the programme.
- If a police report needs to be filed or it the situation any kind of police action, a team member and a lawyer should reach the police station immediately.
- If a person reports any physical injuries health care provider should be immediately contacted to provide first-aid and/or hospitalization.
- Every crisis is documented to record as per the M&E register. This information can be used both to strategize for improving crisis response and for public advocacy. Also when this data is analysed over a period of time, it can reveal trends in the nature and frequency of these incidents.
- Immediate meeting for all the crisis team members should happen within 24 hours.

A role-play may be conducted with an imaginary situation by forming a RRT by volunteer participants with various roles.

Summary of the session and transition (05 minutes)

Summarize the key points of this session.

Ask the participants if there are any doubts/questions or if there is anything that requires clarification.

As per the agenda, ____ topic (please mention the next topic) will be covered in the next session. It will be presented/facilitated by so and so (please, name/introduce the facilitator

for the next session). The facilitator is an expert on the subject and has a lot of experience in the field.

Session 13: Linkages with other HIV Prevention, treatment, care and support services

Learning objectives:

- By the end of the session, the participants will be able to understand the importance of referral linkages of various services to H/TG

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	Linkages with Prevention & CST Services	30 minutes
3.	Summary of the session and transition	05 minutes
	Total	**40 minutes**

Preparing for the session

Prepare a slide on the learning objectives of this session.

Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Linkages with Prevention & CST Services (30 minutes)

Present as a PowerPoint presentation and discuss with the participants.

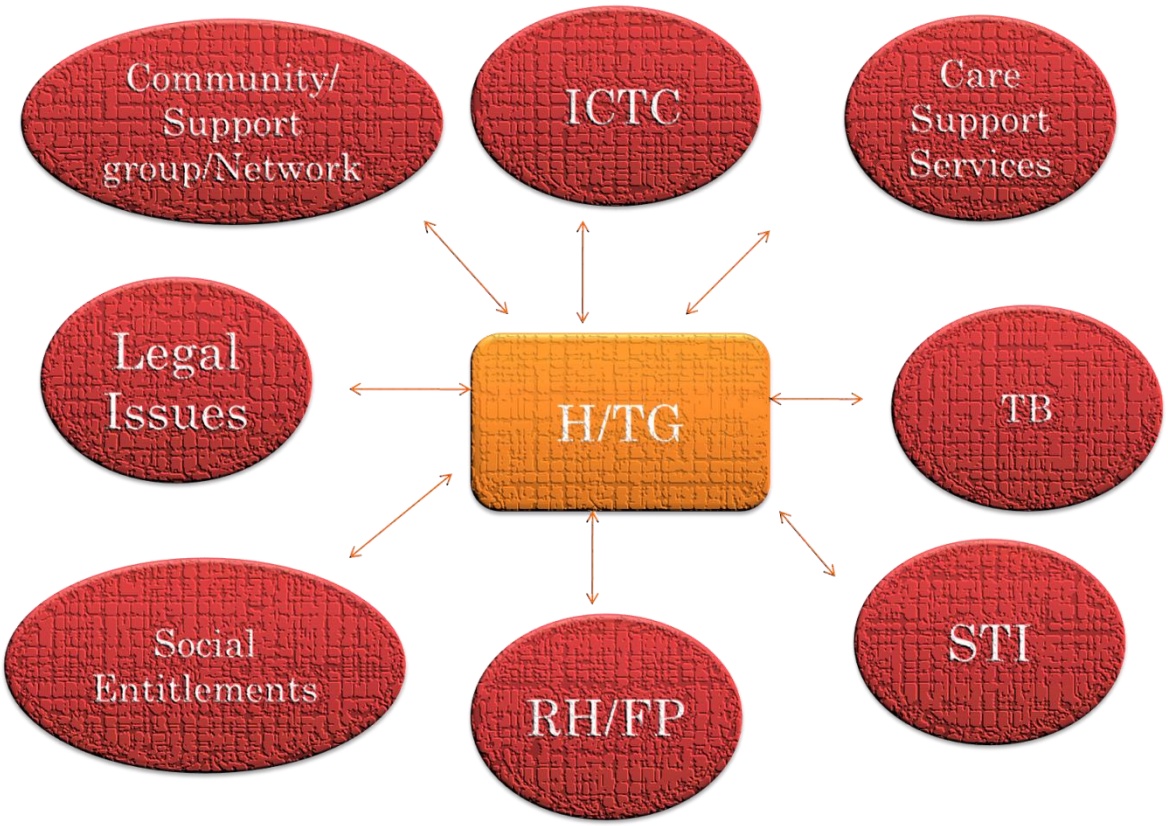
Explain the following activities of referral and linkages:

What & Why – Referral and Linkages?

H/TGs have multiple needs. All those needs cannot be satisfactorily met by TI project with limited staff and service provision.

- Increases community confidence on TI services
- Fills up gaps in TI services.
- Makes TI work more effective.

TI needs to establish network of referral linkages with other service providers like government hospitals (ICTC/DMC/ART) DLN, legal services, etc.



Referrals to ICTC

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

Referral to STI services

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

Referral to ART services and community care centres

H/TG people tested HIV-positive are referred to ART centres to register in the free ART programme and followed by TI once in three months for checking their CD4 level and eligibility for free ART. Transgender – Hijras people eligible for ART, is followed by TI staff to ensure that they are started on ART and adhere to it. Furthermore, TI staff can provide accompanied referrals to other services such as TB (DOTS centre) and Care and Support

Centre (CSC). There might be a need for sensitizing the staff and co-patients in the general community care centre about the issues faced by Transgender – Hijras.

Referral to DOTS (TB) centres

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

Referral to/linkages with networks of people living with HIV

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

Linkages with health care providers who offer 'Gender-affirmative surgery', ('sex reassignment surgery' [SRS])

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

Linkages with mental health care providers and institutes

Most H/TG experience depression and it may vary from mild to severe forms. H/TG experience stigma and discrimination in the society. They lack family support. Promoting positive living and providing mental health service is essential for the healthy living of H/TG. Referral to nearby government hospitals and recruiting trained professionals by the CBOs are ways to access the mental services.

Linkages with social welfare schemes and legal aid

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

Linkages with State legal authority can be initiated by respective SACS. Trained H/TG people can be part of the SACS initiative.

Reverse Referral and Linkages to TI:

RRCs and School AIDS Education Programme (SAEP) link and refer to TI

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

Referral Mechanism

- Assess needs
- List priorities
- Identify, link and compile details with the facilities/providers
- Make a referral plan
- Refer- referral slip/note/ letter
- Document referral
- Ensure referral maturity
- Follow-up

Referral Guide:

- Name of the provider or agency
- Range of services provided - educate each agency about H/TGs, methods of access, etc.
- Contact details - Directions, transportation information, and accessibility to public transportation
- Record the agencies and services in a simple database.
- Competence in providing services
- Eligibility, admission policies and procedures
- Referral slips /other documents that the H/TG people need to carry
- Community satisfaction

How can referrals be done better?

1. Accompanied referrals
2. Use of PE and/or local ORW
3. Formalized linkages with institutions

After referral:

- Follow up of Clients.
- Regular touch With Service Providers.
- Partner Counseling. (Disease Aspects)
- Care Giver Training. (If Positive)

Summary of the session and transition (05 minutes)

Summarize the key points of this session.

Ask the participants if there are any doubts/questions or if there is anything that requires clarification.

As per the agenda, ____ topic (please mention the next topic) will be covered in the next session. It will be presented/facilitated by so and so (please, name/introduce the facilitator for the next session). The facilitator is an expert on the subject and has a lot of experience in the field.

Session 14: Gender Transition Services (including gender-affirmative surgeries)

Learning objectives:

- By the end of the session, the participants will be able to understand/know gender transition-related health services for transgender people

Session outline

SN	Content	Time
4.	Learning objectives and introduction to the session	05 minutes
5.	Gender transition-related health services for transgender people	30 minutes
6.	Summary of the session and transition	05 minutes
	Total	**40 minutes**

Preparing for the session

Prepare a slide on the learning objectives of this session.

Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Introduce the session:

The World Health Organisation (WHO) has defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Transgender people too, like any other people, have the right to enjoy physical and mental health and contribute to their families and the society.

The Intervention requires to attempt to assist the H/TG for improving access to and use of gender transition-related health services for transgender people. The TI needs to establish a network of referral and linkages with the health care providers who offer 'Gender-affirmative surgery' ('sex reassignment surgery' [SRS]).

Gender transition-related health services for transgender people (30 minutes)

Present as a PowerPoint presentation and discuss with the participants.

Explain the following:

Not all transgender people desire surgery or hormone therapy. Some proportion of transgender people would like to undergo surgery and/or hormonal therapy to align their bodies with their gender identity.

Except in a few government hospitals, gender affirmative surgery (sex reassignment surgery) and other gender transition-related services are not available for free in tertiary level government hospitals in different parts of India. A study conducted in 2013 to assess the situation of gender transition-related health services for MtF transgender people reported that:

- Lack of free sex reassignment surgery (SRS) in public hospitals and the prohibitive cost of SRS in private hospitals seem to be the key reasons behind why some hijras and other MtF trans people go to unqualified medical practitioners for surgery – resulting in post-operative complications that could have been avoided had the surgery been provided by qualified medical practitioners in public hospitals.
- Unwillingness among qualified medical practitioners to prescribe hormone therapy (for feminization), and self-administration of female hormonal tablets among hijras and other MtF transgender people.
- Lack of national guidelines on gender transition services and ambiguous legal status of SRS mean even qualified medical practitioners are hesitant to perform SRS.

The common gender transition-related service needs of transgender people are summarized in the Table below:

Gender transition-related needs	MtF transgender people	FtM transgender people
Common needs	• Proper counselling about options available in relation to gender Transition • Proper post-operative follow-up counselling and support	
Types of surgical procedures required	• Neovagina creation (construction of a vagina) • Penectomy (removal of the penis) • Orchidectomy (removal of the testes) • Clitoroplasty (construction of a clitoris) • Breast augmentation (breast enlargement) • Rhinoplasty (reshaping the nose) • Hair transplants	• Bilateral mastectomy (removal of the breasts) • Hysterectomy (removal of the uterus) • Oophorectomy (removal of the ovaries) • Phalloplasty (construction of penis)
Types of non-surgical procedures required	• Female hormone therapy • Hair removal: Electrolysis and laser Therapy • Voice modulation: Vocal therapy	• Male hormone therapy • Voice modulation: Vocal therapy

Challenges:

The services related to gender transition for FTM transgender population are ubiquitously not available in India. Even though many changes have happened particularly for H/TG population, yet there are many challenges regarding the provision of gender transition services for H/TG. These are the broad challenges that require multi-pronged approach at the policy level. Some of the general challenges are given below:

- Very little academic or grey literature is available on access to gender transition services for FTM transgender people in India.
  - Limited expertise in India on SRS (especially penile construction or metaidioplasty4) for FtM people: This means many FtM transgender persons wait for years before they undergo penile construction (phalloplasty). Note: Expertise for other surgical procedures such as hysterectomy, oophorectomy, and mastectomy already exist in India, as these surgeries are commonly performed among cis-women with certain medical/surgical conditions.
  - Limited knowledge among health care providers on the range of surgical and non-surgical options available for FtM transgender people. Examples:
    - Lack of awareness about devices used by FtM transgender people such as binders, packers, urinating devices, and penile prosthesis (with air pumps to facilitate erection)

- Limited knowledge about male hormone therapy (for FtM transgender people) among HCPs. This means many FtM transgender people self-administer male hormones.

Summary of the session and transition (05 minutes)

Summarize the key points of this session.

Ask the participants if there are any doubts/questions or if there is anything that requires clarification.

As per the agenda, ____ topic (please mention the next topic) will be covered in the next session. It will be presented/facilitated by so and so (please, name/introduce the facilitator for the next session). The facilitator is an expert on the subject and has a lot of experience in the field.

Session 15: Mental Health Issues among H/TG

Learning objectives:

- By the end of the session, the participants will be able to understand/know the mental health needs of H/TG

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	Mental Health Issues among H/TG	30 minutes
3.	Enhancing the Self Esteem of the PEs - Self- Questionnaire	20 minutes
4.	Summary of the session and transition	05 minutes
	Total	**60 minutes**

Preparing for the session

Prepare a slide on the learning objectives of this session.

Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Introduce the session:

Mental health is an integral and essential component of health. The WHO constitution states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities.

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.

Mental health and well-being are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. On this basis, the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world.

Determinants of mental health

Multiple social, psychological, and biological factors determine the level of mental health of a person at any point of time. For example, persistent socio-economic pressures are recognized risks to mental health for individuals and communities. The clearest evidence is associated with indicators of poverty, including low levels of education.

Poor mental health is also associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, risks of violence, physical ill-health and human rights violations.

There are also specific psychological and personality factors that make people vulnerable to mental disorders. Lastly, there are some biological causes of mental disorders including genetic factors which contribute to imbalances in chemicals in the brain.

Mental Health Issues among H/TG (30 minutes)

Present as a PowerPoint presentation.

Discuss with the participants about the social issues that affects the mental health of H/TG people.

Transgender people too, like any other people, have the right to enjoy physical and mental health and contribute to their families and the society.

Mental health is intrinsically connected to cultural, physical, sexual, psychosocial, and spiritual aspects of health. Complete mental health care for the transgender community must similarly be considered in the context of a holistic approach to transgender health that includes comprehensive primary care as well as psychosocial care (Keatley, Nemoto, Sevelius, & Ventura, 2004; Raj, 2002).

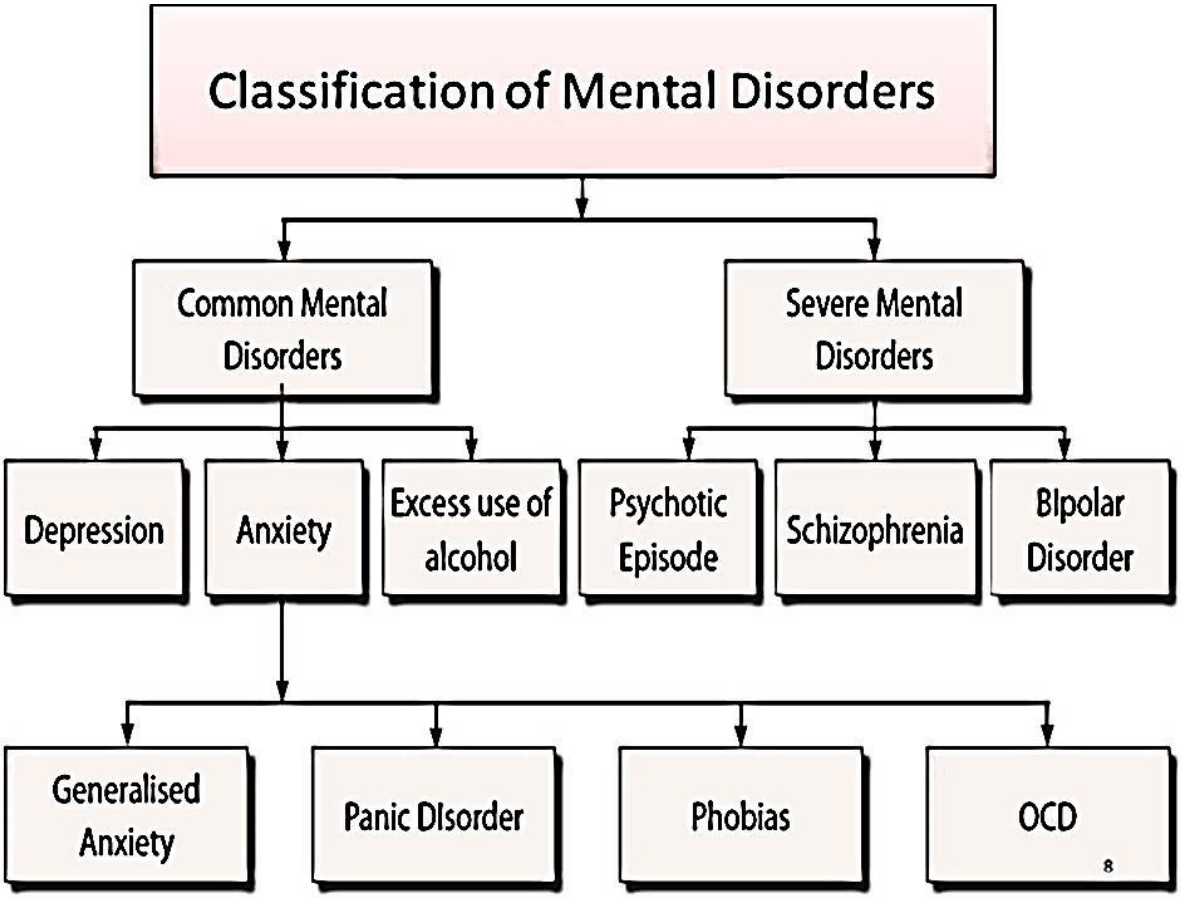
Close coordination between mental health and other services is essential for optimal practice.

Ask the participants what are the common psychiatric problem (mental health issues) among H/TGs.

Use the flipchart to write down the issues that participants come up with:

Explain the following:

According to WHO, Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse. Most of these disorders can be successfully treated.



Common psychiatric diagnosis / problem among H/TGs

1. Depression
2. Deliberate self-harm and suicidal tendency
3. Alcohol and substance abuse
4. Anxiety disorders
5. Adjustment disorders
6. Severe mental illness

Go one by one. Start with Depression in H/TG

Depression in H/TGs

There are various substantial reasons that cause depression among H/TG population. Let us discuss it. (These are some of the factual issues faced by the H/TGs. It is discussed to mainly to discuss to understand the issues of H/TGs in a scientific way)

- Most H/TG people experience depression. The depression may vary from mild to severe forms.
- H/TG people experience stigma and discrimination in the society. They lack family support.
- Most of them have experienced discrimination.

- H/TGs have been harassed by the power structure. This causes lot of shame to them and dents their self-esteem.
- H/TGs find it highly difficult to find employment in mainstream sectors.
- Begging is common among H/TG population. This also adds to their poor self-image and self esteem
- Most of them indulge in sex work to earn money. This again results in poor self-image and self-esteem. They also feel ostracized. Sometimes H/TGs face violence and physical / sexual abuse.

Due to these various issues, hijra and transgender population experience some form of depression.

Explain the following and discuss with the participants about the symptoms of depression occur to the depressed individual.

Following symptoms of depression are usually prevalent:

1) Sleep disturbance
2) Low mood
3) Crying spells
4) Easy fatigability
5) Poor attention and concentration
6) Loss of appetite
7) Loss of sexual interest
8) Death wishes, suicidal ideas, impulses behavior
9) Low self esteem
10) Lack of interest

Explain the participants about the following two standard Rating Scales that measure depression.

Ratings scales:

1) Hamilton's depression rating scale
2) Becks depression inventory

These above scales can used to assess the severity of depression

Discuss with the participants about the management of depression. Present by using PowerPoint Presentation the following:

Management of depression:

- Management of depression includes counseling, cognitive therapy, and medications:
- Counseling is to be given by clinical psychologist or psychiatrist. It involves patient listening, an opportunity to ventilate, generating solutions, reassurance
- Cognitive therapy involves identifying cognitive distortions like black and white thinking, overgeneralization, maximization, selective abstraction etc. Then the individual is encouraged to look at the situation in realistic and positive way.

- Medications: Antidepressants, usually selective serotonin reuptake inhibitors (SSRIs) are prescribed by a general practitioner or psychiatrist
- Physical exercise, yoga and meditation can also help the individual to overcome .These would be add on strategies which would supplement the above mentioned core strategies to overcome depression
- Referral to a nearby Psychiatrist /clinical psychologist at a nearby government hospital is warranted. .Counselors is required to refer the potential and probable clients to a nearby Government hospital.
- H/TG people have their reservations in visiting government hospitals. They have expressed the need for exclusive mental health centers for H/TGs which could be independent or associated with a CBO working with H/TG population. Such suggestions can be made to the government.

Deliberate self-harm and suicidal tendency

Deliberate self-harm includes harming oneself by cutting a part of the body, usually forearms chest etc. This behaviour is common in borderline personality disorder. Many H/TGs have co morbid borderline personality disorder which is characterized by maladaptive behaviour. It includes:

1) Lack of self-identity,
2) Recurrent deliberate self-harm
3) Intense and unstable relationships
4) Anger outbursts,
5) Fear of abandonment,
6) Chronic sense of emptiness,
7) Micro psychotic episodes characterized by hallucinations and delusions

A Deliberate self-harm usually might require hospitalization. It might also be minor injuries requiring OP treatment. Once the injuries are treated and patient's medical condition stable, they need counseling. Counseling should allow H/TGs to ventilate their problems. The counselor suggestion various solutions in the form of options and the H/TGs helped to arrive at decisions.

Suicide attempts:

Suicide attempts by consuming poison or tablet overdose or pesticides are other methods. Jumping from buildings, self-immolation, etc., are other methods that H/TGs resort for attempting suicide. Hence, prevention can be done by sharing existing helpline numbers in H/TGs community. Also the NGOs working with suicide prevention also have to be sensitized and trained about H/TGs issues.

Similar orientation programs about H/TGs issues would be need to clinical psychologist and psychiatrist and psychiatric social workers.

NGO/CBOs working with H/TGs also have to be aware of the possibilities and suicide attempts and restrict availability of phenol, cleaning acid sharp weapons. They have to be in lock and key and released only when necessary.

Management of deliberate self-harms and suicidal attempters would involve counseling. Medications like SSRis and mood stabilizers, benzodiazepines; antipsychotics might be prescribed by psychiatrist. Using the prescribed medicine again to attempt suicide is a common problem. It can be avoided and minimized by supervising the medication intake. The role of NGO/CBO and the H/TGs community in large is necessary. They have to be sensitized about suicide prevention

Dialectical behavior therapy is a type of psychotherapy done by clinical psychologist and psychiatrist to reduce deliberate self-harms. It includes CBT, mindfulness techniques and behavioral approaches.

Referral to nearby Govt. hospitals and recruiting trained professionals by the NGO/CBOs are ways to access the mental services. Establishment of exclusive mental health centers for H/TGs has been already discussed which can address many of these issues.

Discuss about alcohol and substance abuse.

Alcohol and substance abuse

It learned that almost 90 % -100% of H/TGs drink alcohol. This is their only relaxation to the various stresses they undergo. They also say that they feel bold to face the unfriendly public. Even when beaten up by Police if they are under influence of alcohol they would not feel the pain. These are the various reasons cited by H/TGs to their indulgence in alcoholics. Many of them have crossed the stage of alcohol use and have reached the stage of alcohol abuse and alcohol dependence.

Alcohol dependence is a stage of drinking characterized by

1) Craving
2) Difficulty in controlling the onset duration and terminations of drinking,
3) Withdrawal
4) Tolerance
5) Drinking despite physical and psychological complications
6) Decrease in alternative pleasures

Alcohol abuse: This term is used for people who end up in social, family occupations problems due to drinking but don't full fill the criteria

Physical complications of alcohol:

Physical complications of alcoholism mainly include Liver cirrhosis, Jaundice, blood-vomiting hemestemsis, head injury due to recurrent falls. Psychological complications of alcohol include alcohol induced psychosis and depression. Financial bankruptcy is also a complication of alcoholism. H/TGs also may not adhere to proper safe sex methods.

Screening questionnaire for alcohol use disorders:

1. 1.CAGE
2. 2.AUDIT

Management of alcohol dependence:

- It involves ad mission in a general Hospital. A general physician treats the physical problems.
- Detoxification is done using benzodiazepines to tide over withdrawal phase
- Counseling and 12 step AA methods to overcome alcohol addiction

- Psycho education about biological disease model versus moral model.
- Motivation enhancement therapy
- Cognitive behavioral therapy

Further, discuss about the anxiety disorders:

Anxiety disorders:

It is learned that Anxiety disorders are also common among H/TGs. It includes:

1) **Generalized Anxiety disorder:** It's characterized by free floating anxiety which is present most of the day along with worries.
2) **Panic Disorder**: It is characterized by episodic anxiety episodes characterized by chest pain, breathing difficulty, palpitations, tremulousness, feeling of going crazy, feeling of impending doom
3) **Social phobia:** Anxiety especially in situations, where they are assessed or criticized or watched along with avoidance. Usually it includes being in exams, stage performances, being in buses and public toilets.

Many H/TGs suffer from the above disorders. They must be identified and encouraged to seek treatment. Treatment involves relaxation exercises, breathing exercises, and counseling, cognitive behavioral therapy. Medications used to treat by doctors and psychiatrists include benzodiazepines, beta blockers, SSRIs.

Severe Mental Illness:

Severe mental illness like Schizophrenia and Bipolar affective disorder with manic presentations are similar to prevalence in H/TGs as in general population.

- Schizophrenia is an illness characterized by perceptual disturbances in the form of hallucinations and thought disorder in the form of delusions, disorganized speech.
- A Hallucination is an abnormal perception in the absence of an external stimulus.
- A delusion is a false fixed belief held by the patient.

Bipolar disorder, Mania:

- In Bipolar disorder, manic episodes alternate with depressive episodes.
- During the manic episodes they have elated mood. High self-esteem, grandiosity, increases speech and motor activity. They might have hallucinations and delusions.
- These severe mental illnesses can arise in a tg and then appropriate referral to psychiatric services need to be made.

Questionnaires to be used:

1. Gender Identity Questionnaire Docter & Fleming, 2001
2. Transgender Identity Survey Bockting, Miner, Robinson, Rosser, & Coleman, 2005

Certification as Gender Dysphoria:

- Certification as Gender Dysphoria is done by a government psychiatrist. This is usually done for issue of identity card as H/TG.
- Certification is also needed before SRS and hormonal therapy.

- Many H/TGs approach psychiatrist for certificate. Hence awareness about H/TGs issues has to spread among mental health professionals and psychiatrists.
- A protocol and guidelines for proper assessment and certifications needs to be developed.

Access to Psychiatrist:
Usually H/TGs do not approach psychiatrist for official help. This is because they feel that the psychiatrists are unfriendly and unaware of the issues of H/TG. Educating and orienting psychiatrists to H/TG issues and inviting TG representatives to Psychiatry meetings and conferences would reduce the barriers between them.

Access to Endocrinologist:

Hormonal therapy:
- Hormonal therapy is obtained from over the counter medications without prescription or consultation.
- There is need to educate the H/TGs to consult an endocrinologist for hormonal therapy. If government hospitals can provide free hormonal therapy, the financial burden of Tgs in this regard would be minimized.

Access to Surgeries:
Common surgeries done by H/TGs include SRS (Sex Reassignment Surgery), Breast implant,(silicone),and emasculation. Mostly surgeries are done illegally by quacks. Now after steps taken government to legalize the surgeries, People approach the government hospitals for surgery. Many still find the government hospital environment and attitudes unfriendly or time consuming and approach private sector for surgeries. Surgeries are offered in many private hospitals which are expensive. The need for expensive surgeries again push the H/TGs to desperate beg, indulge in Sex work, or steal. Making government hospitals friendly and approachable and nondiscriminatory to H/TGs would go a long way in this aspect.

Enhancing the Self Esteem of the PEs (20 minutes): Discussion on the Self-Questionnaire

Present as a PowerPoint presentation and discuss with the participants.

Explain the following:

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

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

The staffs of NGO/CBO are required to administer the self-questionnaire to all the PEs.

Introduce the self-questionnaire for H/TGs to enhance their self-esteem. Present the key areas of the questionnaire as given below:

What the PEs think of themselves and what they must do to enhance their self-esteem under the following key areas:

- H/TG engaged in sex work
- As human beings
- Ability to make decisions about our mental and physical well-being
- Social identity beyond our occupation
- Our legal status
- Our political status
- Our civic amenities
- As peer educator

The questionnaire:

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

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

Summary of the session and transition (05 minutes)

Summarize the key points of this session.

Ask the participants if there are any doubts/questions or if there is anything that requires clarification.

As per the agenda, ____ topic (please mention the next topic) will be covered in the next session. It will be presented/facilitated by so and so (please, name/introduce the facilitator for the next session). The facilitator is an expert on the subject and has a lot of experience in the field.

Session 16: Programme Management

Learning objectives:

- By the end of the session, the participants will be able to understand the basics of programme management, monitoring, recording, & reporting.

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	Programme Management including Programme Monitoring	30 minutes
3.	Tools for Monitoring Project Outreach Planning	30 minutes
4.	Principles of SIMS for Tis	30 minutes
5.	Summary of the session and transition	05 minutes
	Total	**70 minutes**

Preparing for the session

Prepare a slide on the learning objectives of this session.

Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Programme Management including Programme Monitoring (30 minutes)

Present as a PowerPoint presentation and discuss with the participants.

Explain the following:

The key objectives of the Programme Management at the intervention level are 1) To improve quality and management of H/TG TI, 2) To effectively deliver project services to H/TG people, and 3) To increase the coverage of, and uptake of services by the H/TG populations.

Role of CBOs and Non-Governmental Organizations (NGOs)

CBOs and NGOs implement TIs in their respective project areas and achieve objectives laid out by the project plan. The implementation of TIs follows the guidelines of NACP-IV. All CBOs and NGOs report to SACS/TSU and can seek support wherever required. Each CBO

and NGO prepares a project implementation plan or proposal along with its respective SACS/TSU. CBOs and NGOs will liaise with DAPCU, local health authorities and other CBOs and NGOs while implementing TI. Additionally, NGOs selected for Transgender – Hijras TI will work towards forming a CBO of Transgender – Hijras people and strengthen it so as to transfer their project to the CBO within a stipulated timeline (at least within two years). A separate NGO-CBO Transgender – Hijras TI transition guideline document (similar to that in NACP-III) can be developed, if necessary.

Programme Monitoring

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

Scaling up coverage

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

Scaling up infrastructure (0 – 3 months)

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

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

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

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

Improving service delivery

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

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

- National level by NACO
- State level by SACS & TSU & STRC

- TI level by CBO implementing the project

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

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

Financial Management

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

Tools for Monitoring Project Outreach Planning (30 minutes)

Present as a PowerPoint presentation and discuss with the participants.

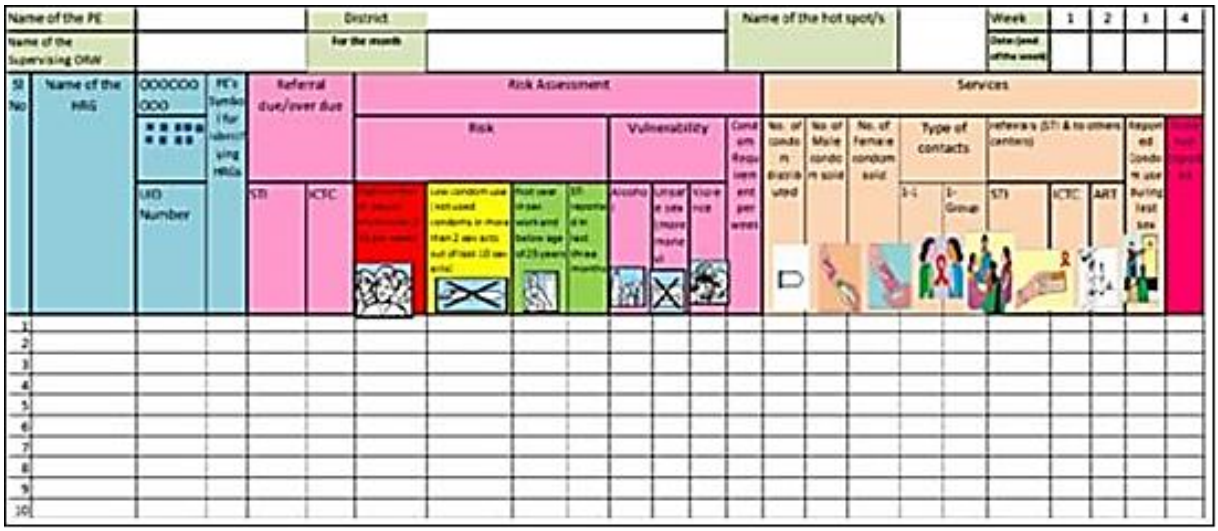
Introduce the following tools to the audience as excel sheets.

The following tools can be used by PEs and ORWs to evaluate progress in outreach and delivery of a minimum package of services to H/TG people in their area.

PE Daily Activity Report

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

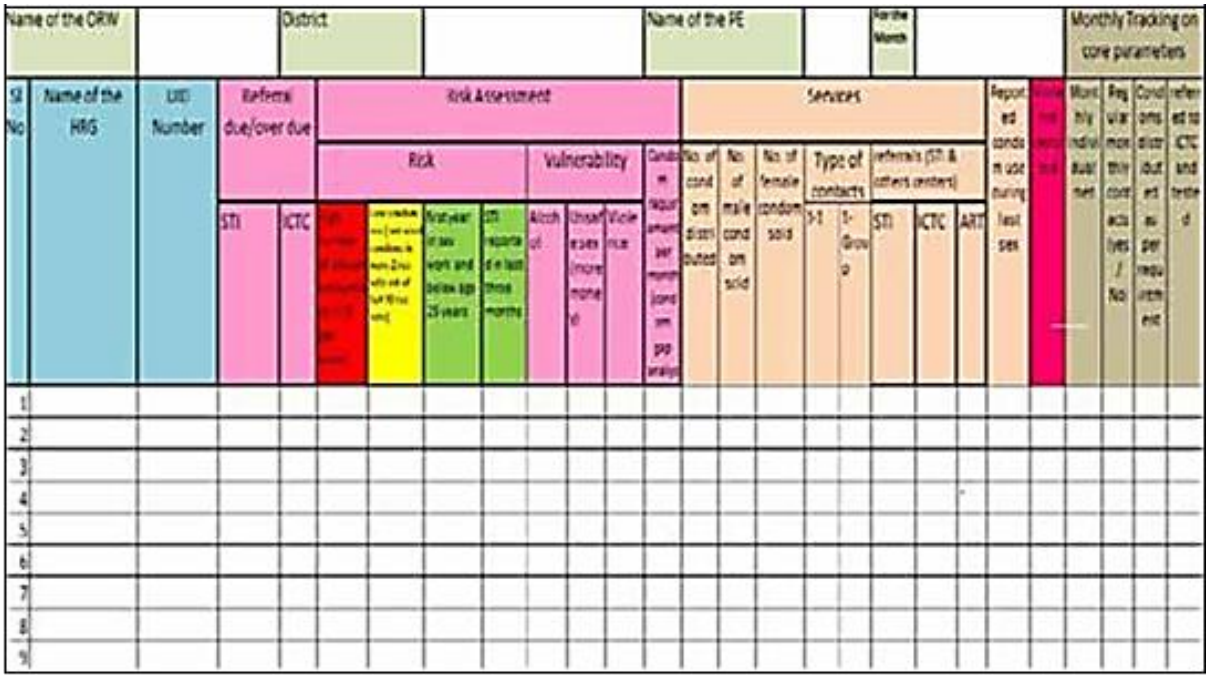
Sample PE Daily Activity Report



Individual Tracking Sheet

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

Sample Individual Tracking Sheet



Outcomes of Outreach: The "Minimum Package"

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

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

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

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

FORM C_1: Monthly summary sheet for FSW, MSM, TG and IDU (filled in by ORW)

Name of the ORW | For Month

Sl No	Name of the PE	Week	Services												Tracking on core parameters				
			Condom requirements per week (as per condom gap analysis)	No. of condom distributed	Type of contacts: 1-1	Type of contacts: 1-Group	Needles/Syringes requirement per week	No. of syringes distributed	No. of syringes returned	Referrals (STI & others centers): STI	Referrals (STI & others centers): Absc ess treat ment	Referrals (STI & others centers): ICTC	Referrals (STI & others centers): ART	No. of individuals reported not sharing needles/syringes during last injecting episode	No. of individuals reported condom use during last sex	No. of individual met each week	No. of regular contacts	No. of individuals provided needle/ Syringes as per requirement	No. of individuals distributed condoms as per demand	No. of individuals referred to ICTC and tested
1	PE 1	Week 1																		
		Week 2																		
		Week 3																		
		Week 4																		
		Total																		
2	PE 2	Week 1																		
		Week 2																		
		Week 3																		
		Week 4																		
		Total																		
3	PE 3	Week 1																		
		Week 2																		
		Week 3																		
		Week 4																		
		Total																		

Principles of SIMS for TIs (30 minutes)

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

Show a role play indicating how monitoring is very important. The role-play is required to emphasis the fact that how monitoring & evaluation plays a significant role in everyday life situation by presenting simple three incidences.

Role-play: Three different situations of everyday life:
First, an individual looking at a mirror:

1. **Scene 01:** The person by looking at the mirror by singing or whistling a song and does an action humorously correcting his/her hair with a comb that looks unkempt and also looking at his dress (turning humorously to see his/her front and back) and arranging the dress which looks little rumple. He/she takes time to correct him/herself. Finally, the person kisses the mirror as if thanking the mirror for confirming that he is satisfied with the final makeup and the dress style.

Immediately without any comments, the second one starts where two friends meeting at the road:

2. **Scene 02:** On the road, two persons casually meeting each other (with some humorous actions or greetings). There will be some conversations between each other. Suddenly one person will find some stain on the shirt at the back of the other person (expressing it that it looks very ugly and awkward). Finally, the person who found out that there is stain in the shirt, thanks the other person for informing him about it or otherwise people might be laughing at his back which he might have not aware about it.

Immediately without any comments, the third one starts where two judges reviewing a dance or singing competition:

3. **Scene 03:** A stage set up where one person is dancing with music or singing a song (dance or singing will be decided by the role-player performer as per the person's convenience). One or two minutes the dance or singing will go with little humorous moves or with comedy lyrics respectively. Once the performance is over, the judges will comment the performer with appreciation as well as the areas where the performer requires to improve upon. The judges will also suggest how the performer will have to work hard, learn and practice to bring in efficiency.

Thank the people who have performed the role play.

Ask the participants what they can understand from the role play. Explain the following:

- The first part of the scene indicates self-review. We always review ourselves everyday by using a tool called mirror. Without a mirror, it is difficult for us to review ourselves

about how we look, how our dressing looks like, whether it is appropriate, whether we look good, beautiful or handsome for the occasion.

- The second part of the scene indicates social mirror. Here the person helps his friend to know about the ugly stain on his shirt at the back so that the friend will correct himself to avoid embarrassment because people may laugh at him at the back.
- The third part of the scene reminds us about formal review or evaluation of a performance of an individual. Here the evaluation provides suggestions to improve upon.

These are common things happens in the society. We don't feel bad about it but instead we always like to practice it because these reviews and evaluations are very imperative for our growth every day and it helps us to enhance our performance efficiency and to bring in results.

Similarly, programme monitoring, periodical reviews and evaluations are very important for the programme to show results and bring in the desired outcome of the programme. I hereby want to emphasize each and every one of the participants not to be apprehensive about monitoring, reviews or evaluations in future. But instead we always choose to see it as an opportunity where we can show case our achievements and learn from the experiences.

Principles of SIMS for TIs

Present as a PowerPoint presentation and discuss with the participants.

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

SIMS:

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

Role of State AIDS Control Society (SACS)

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

Role of TSU & DAPCU

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

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

Being in the field

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

Community Involvement in Monitoring and Evaluation

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

Summary of the session and transition (05 minutes)

Summarize the key points of this session.

Ask the participants if there are any doubts/questions or if there is anything that requires clarification.

As per the agenda, ____ topic (please mention the next topic) will be covered in the next session. It will be presented/facilitated by so and so (please, name/introduce the facilitator for the next session). The facilitator is an expert on the subject and has a lot of experience in the field.

Closing Session

Learning objectives:

- By the end of the session, the participants will be able to:
- clarify on the various programme & technical terms & know-how
- complete the post-test
- complete overall feedback about the training programme

Session outline

SN	Content	Time
1.	Learning objectives and introduction to the session	05 minutes
2.	Gender transition-related health services for transgender people	30 minutes
3.	Summary of the session and transition	05 minutes
	Total	**40 minutes**

Preparing for the session

Prepare a slide on the learning objectives of this session.

Prepare a slide or write the key points on a sheet of flipchart paper and keep it aside until required.

Review the learning objectives of the session (5 minutes)

Show the slide or the flipchart and discuss the learning objectives.

Introduce the session:

The World Health Organisation (WHO) has defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Transgender people too, like any other people, have the right to enjoy physical and mental health and contribute to their families and the society.

The Intervention requires to attempt to assist the H/TG for improving access to and use of gender transition-related health services for transgender people. The TI needs to establish a network of referral and linkages with the health care providers who offer 'Gender-affirmative surgery' ('sex reassignment surgery' [SRS]).

Gender transition-related health services for transgender people (30 minutes)

Present as a PowerPoint presentation and discuss with the participants.

Explain the following:

Not all transgender people desire surgery or hormone therapy. Some proportion of transgender people would like to undergo surgery and/or hormonal therapy to align their bodies with their gender identity.

Except in a few government hospitals, gender affirmative surgery (sex reassignment surgery) and other gender transition-related services are not available for free in tertiary level government hospitals in different parts of India. A study conducted in 2013 to assess the situation of gender transition-related health services for MtF transgender people reported that:

- Lack of free sex reassignment surgery (SRS) in public hospitals and the prohibitive cost of SRS in private hospitals seem to be the key reasons behind why some hijras and other MtF trans people go to unqualified medical practitioners for surgery – resulting in post-operative complications that could have been avoided had the surgery been provided by qualified medical practitioners in public hospitals.
- Unwillingness among qualified medical practitioners to prescribe hormone therapy (for feminization), and self-administration of female hormonal tablets among hijras and other MtF transgender people.
- Lack of national guidelines on gender transition services and ambiguous legal status of SRS mean even qualified medical practitioners are hesitant to perform SRS.

The common gender transition-related service needs of transgender people are summarized in the Table below:

Challenges:

The services related to gender transition for FTM transgender population are ubiquitously not available in India. Even though many changes have happened particularly for H/TG population, yet there are many challenges regarding the provision of gender transition services for H/TG. These are the broad challenges that require multi-pronged approach at the policy level. Some of the general challenges are given below:

- Very little academic or grey literature is available on access to gender transition services for FTM transgender people in India.
  - Limited expertise in India on SRS (especially penile construction or metaidioplasty4) for FtM people: This means many FtM transgender persons wait for years before they undergo penile construction (phalloplasty). Note: Expertise for other surgical procedures such as hysterectomy, oophorectomy, and mastectomy already exist in India, as these surgeries are commonly performed among cis-women with certain medical/surgical conditions.
  - Limited knowledge among health care providers on the range of surgical and non-surgical options available for FtM transgender people. Examples:

- Lack of awareness about devices used by FtM transgender people such as binders, packers, urinating devices, and penile prosthesis (with air pumps to facilitate erection)
- Limited knowledge about male hormone therapy (for FtM transgender people) among HCPs. This means many FtM transgender people self-administer male hormones.

Summary of the session and transition (05 minutes)

Summarize the key points of this session.

Ask the participants if there are any doubts/questions or if there is anything that requires clarification.

As per the agenda, ____ topic (please mention the next topic) will be covered in the next session. It will be presented/facilitated by so and so (please, name/introduce the facilitator for the next session). The facilitator is an expert on the subject and has a lot of experience in the field.