Improving the Service Delivery Among Transgender/ Hijra People

BACKGROUND

Transgender/Hijra people are one of the most at risk, vulnerable and affected populations among marginalized groups practicing high risk behaviours. Given their tendency to engage in unprotected oral and anal sex with multiple sexual partners (regular, casual and paying), alcohol use before and during sex and poor health seeking behaviours, TG/Hijra persons are highly susceptible to STI HIV infections.

From a health systems perspective, TG/Hijra persons experience considerable social, cultural and structural barriers that prevent them from accessing HIV related services or availing social protection schemes. Barriers include social stigma, systemic discrimination, bad attitudes of health care providers and law enforcers, shortage of drugs, poor understanding about TG/Hijra persons, criminalizing legal provisions and absence of safe public spaces.

Staff and counsellors at Targeted Intervention (TI) projects and STI clinics may not have adequate knowledge and skills to address the unique life experiences and behaviours of TG/Hijra persons. Consequently, even those who come to TI Drop-In-Centres (DIC) or access health facilities for screening and regular medical check-ups view the visit as an imposition, inconvenience and burden rather than an opportunity to improve their quality of life.

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Being disowned by family, dispossessed of property rights, shunned by society and facing systemic barriers, TG/Hijra persons are drawn towards the Gharana/Jamath and owe primary allegiance to their Guru. During a time of intense distress and impoverishment, the Gharana/Jamath offers solace, protection and a sense of belongingness.

The Multi-Country South Asia (MSA) HIV Programme funded by the Global Fund has an overall goal to reduce the impact of, and vulnerability to, HIV among men who have sex with men (MSM) and transgender women by strengthening their community systems. Anecdotal evidence from the Multi-Country South Asia - Diversity In Action (MSA DIVA) program, being implemented by VHS with support from the GFATM Round 9 Programme through PR agency Save the Children, International, Nepal indicates that up to 70% of TG/Hijra persons belong to a Gharana/Jamath. Sex work is the primary occupation for two-thirds of all TG/Hijra persons and three-fourths of Gharana/Jamath based TG/Hijra persons.

This policy brief is to identify the current challenges faced in implementing the existing package of TI services amongst the beneficiaries of MSA DIVA interventions in selected states under NACP IV, with guidance from the National AIDS Control Organization (NACO) and in partnership with State AIDS Control Societies (SACS) for TG/Hijra people.

This policy brief summarizes the existing challenges in access to services such as: STI, HIV testing, condom, ART, HIV/TB; efforts needs to be undertaken to overcome the challenges at CBO, Community, SACS, TSU, & NACO level and innovations/pilot initiatives for improving the overall service delivery, consistent condom usage, application of information technology.

Research Method

Methodologies adopted for the qualitative study includes: Focus Group Discussions, In-Depth Interviews with community members, secondary review, etc. In-depth interview was conducted with TG/Hijra communities which includes Jamath based community member, Gharana based community member, Mobile base (moving to different location) Hijras/TGs, community member operating through social media (web), Peer educators and Community leaders. In-Depth interview was also conducted among stakeholders likes CBO's, technical experts and government officials.

Topline Findings – Focus Group Discussion

The salient findings from the study for each of the segments are presented below:

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

- The Intervention is able to reach the Hijras that stay as part of a congregation (with their Guru or with their chelas or with their guru-bhais) or in groups or at identified sex work sites (red light areas). The Kothi typologies that are mostly occasionally available are often catered by the MSM Interventions. The She-Males, Inter-sexed and Cross-dressers are mostly found online (via social media) and are not that easily accessible. There are some Hijras who stay independently (and not in their traditional congregation), who are sparsely accessible by the intervention. Most of them are accessible at the time of a major event or function within the community.
- The newer/younger generation of the community is Tech-savvy and is well connected through various WhatsApp Groups (Formal or Informal). Interpersonal Physical Communication and Collection at sites has gone down (though not

stopped completely). The communication channels have shifted to the Mobile Phone. Access to Internet is also reported by the participants.

F Social Media also is playing an important role as the networking platform for the community. Many of the groups are regular attendees of the party circles (both within the MSM and the TG Communities). Events like Birthday Parties and Social Get-togethers are also organized within the community these days. Some of the typologies (like the She-Male, CDs and Drag Queens) are accessible through Social Networking sites like Grinder and Planet Romeo (PR). Some Hijras who cannot write (type) messages in English use 'Hinglish' or regional language text or simply send a voice recording.

I Community members move from district to district within the state & move from state to state:

- The period varies from two months to six months during seasons (e.g.,) in north India, in the form of "Launda dancers" as a group of 20-25 members, moved to many states for performing dance programs. Similarly, in Kerala, January to June, TGs move to different districts for participating and performing in the Hindu religious festivals.
- For SRS, the community member may need to be away from the headquarters and stationed in other state / district for more than 45 days.
- Average cost for SRS will be between INR 30,000 to 1.5 lakhs.
- For GTRS (voice, breast, body hair, etc.), average cost will be 5-6 lakhs and they also need money for managing the consequences associated with that. Need for comprehensive communication kit for TGs in the form of resource kit including flip book, flash cards, condom demo kit, etc.
- This reason also shows as not reported or poor in seeking services. Hence, NGOs, SACS & NACO should identify these realistic gaps & develop systems for addressing the same.

2. Opinion on the existing package of service:

The existing service packages are more HIV/STI focused. There is a need to provide a more Community specific package of services along with the HIV/STI services. The approach should be holistic rather than stand alone or just health focused. Though health is an important determinant to be factored in tailor making the service delivery package, it should not be the ONLY focus.

2.1. Additional core package of services suggested:

The respondents felt that following services should be added with the HIV/STI services:

- Social Schemes such as access and linkage to Aadhar, PAN and Voter ID, Ration Card (PDS) etc.
- Trauma Center for crisis Management
- Income generation Avenues and Training.
- Sex Reassignment Surgery (SRS) Information Dissemination, Access to Safer and Cheaper avenues to avail such services. Either partial or complete SRS (including Laser Treatment for hair removal, breast implant surgeries, castration, emasculation and vagino-plasty, hormonal therapy, mental health).
- Formal or Informal Education for un-educate or illiterate members of the community.
- Better Housing and Living Conditions.
- Need to add specific Transgender Health related problems like Urinary Tract Infections and providing Mental Health Services from the TI.

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

- The peer led model of outreach is effective and is working for the community. There is a strong

networking within various groups through this sort of formal and informal peer based networks. The information about HIV, Condoms, STIs, etc., has percolated deep down within the community.

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

2.3. Opinion on the existing communication materials and IPC activities:

- The participants feel that the existing communication materials and IPC activities should be more specific to the needs of the community (and not generic). There is a sense that these materials and activities should be in local/regional languages, include words and lingo used by the community. Information regarding SRS, hormone therapy etc., should also be included.

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

- The existing interventions are unable to tap the new entrants, younger groups or hidden groups as effectively as the previous groups. There is a need to build capacity of the existing TIs and its staff to upgrade and reach out to such groups.

2.5. Helpfulness of existing mentoring support:

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

3. Existing challenges in access to services such as: STI, HIV testing, condom, ART, HIV/TB:

3.1. Condom usage:

- Majority of them avails condom from NGO office / ORWs.
- Few of them purchased condom from private shops – it is not being taken into account.
- Condom outlets are not available in the new areas (beyond hotspots) – considering the emerging non-hotspot based approaches.
- Transgender community involve in oral sex behavior so they demanding for flavored condom.

3.2. STI services:

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

- Non suitable timings
- Doctor's negative approach
- Frequent changes of doctors in the clinic and need to educate each time.
- Few are availing services with the preferred HCPs but not accounted by NGO.
- Registering as targets of all TGs, but not all TGs are involved in sex trade (some of them do blessings, begging, participating in ritual performances/dance performances, serving as Jamath and guide people, etc.)

3.3. HIV Testing:

- Community is well sensitized and willing, no-more a taboo or fears testing. Overall acceptance to testing and its results is prevailing in the community. Gurus are also promoting their chelas to get tested.
- There is Stigma and Discrimination faced by sections of the community. The Public Health Hospitals discriminates the community on basis of their HIV status and refuses to provide SRS or other treatments.

3.4. ART:

- There is a feeling that the medication can enhance life and quality of life. Community members are registered with ART center.

- However they felt that there is no systematic mechanism to motivate and follow-up on the adherence.
- Need intensive counseling to motivate on drug adherence (mobility pattern, non-hotspot operations, no residence, not taking food properly, etc.).

3.5. HIV/TB:

- The Community is petrified to access services at the DOTS/TB centers. There is greater awareness of the RNTCP program and there is normalcy around the disease.
- Difficult to administer the medicines at regular intervals because of mobility patterns.
- The intervention is not giving much focus on HIV/TB.
- The peer educators and outreach team not trained on HIV/TB.

4. Efforts need to be undertaken to overcome the challenges to access services:

- Use of mobile phones, technology devices, social media is the need of the hour for reaching, reinforcing and motivating to seek services – in line with this a road map for intervention among TG/Hijra people will be of more useful.
- Developing community friendly models such as: Satellite clinics, mobile STI clinics, collecting bloods from the field and testing at the labs, mobile ICTCs for promoting community testing, etc., will be of more useful to motivate community members to avail services without fail.
- Request SACS and TSUs to organize series of experience sharing meets, workshops for identifying field level issues and evolving suggestions, introduce provision for undertaking pilots / innovations for identifying new approaches, etc.

Topline Findings – In-depth Interview

In-depth interview was organised with Community members and Stakeholders including SACS, TSU, HCPs, CBOs etc.

1. **Existing challenges in the ongoing intervention and uptake of services:**
   Community members: Overall the community members are availing services like one to one, counseling, condom, motivation for testing and treatment, providing clarity, meeting regularly and promoting good habits. Condoms are not available regularly, at all times especially in hotspots, etc. Gharana based system requires permission from the head or group.

Hence, there is a need for advocacy with Gharana leaders, advocacy greater engagement and using them as peer educators. Introduce innovations and new approaches in promoting behavior change and health seeking behavior by using technology, innovative communication materials, game based materials, community prepared IEC materials, etc. This will help in strengthening the effective communication and motivating community to seek services.

Topline Findings – In-depth Interview continues..

Existing challenges continues..

Stakeholders: Peer led program needs motivation and systems for rotation of community members for ensuring interest and sustainability. The community members are not accessing STI services which may be due to inconvenient timing, tests and results requires two man-days, too crowd, stigma, untrained doctors, ineffective counseling due to overcrowd / unforeseen rush, need more coordination between NGO and service facilities. The NGOs should undertake continuous efforts to motivate the community members to seek services and undertake accompanied referrals. Computerized software may be developed to track the people those who have not undertaken services, generate pop-ups / preparation of reminder list and automatic sending reminders.

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

Community members : There are many new groups emerging among TG/Hijra people. This requires intensive study. However, the Jamath leaders will be able to share the details on the same. The intervention may need to more closely work with Jamath leaders to understand the emerging dynamics networks, sexual practices, etc.

Stakeholders : Community members expect tests and results on the same day. Frequently, the middle aged and the aged community members are visiting and undertaking services. The new entrance or young age members are not visiting the facilities to avail services. Since some of the community members are more knowledgeable, informative and aware, advanced level of communication is required.

3. **Effectiveness of current strategies:**

Community members : Overall efforts undertaken by NACO & SACS for TG/Hijra people were supportive. The package of services focusing on prevention to care continuum such as: behaviour change communication, condom promotion, treatment for STI, HIV testing, counseling, linkage with other services, positive prevention, etc.

Stakeholders : Operational guidelines for implementing TI, provides uniform guidelines for all the organizations working on prevention. NACO adopts prevention to care continuum by providing financial support, training, mentoring, needed operational guidelines, linkage with the services and support from different stakeholders. The branding of STI clinics, ART centre, ICTC is found to be more effective and non-stigmatized. Stakeholders felt that the system should continue.

4. **Suggestions to overcome challenges in accessing services:**

Community members : Expects recognition from the Govt., for the TG/Hijra people. This will help in getting more recognition, avoiding stigma & discrimination, improved self-respect, thereby adopt risk-reduction practices, etc. The intervention should provide more information on TG health issues at regular intervals both at intervention level and health facility level.

These services should be beyond HIV/AIDS. SACS and TSU may need to undertake holistic efforts to build the capacity of the outreach team in providing comprehensive counseling and services to the TG/Hijra people. However, the team can focus more on prevention. In addition, they should also provide other services as a part of their regular communication and counseling.

Suggestions to overcome challenges continues...

Counseling to TG/Hijra people need to be provided in HIV and beyond HIV including Psycho-Social, mental health, family counseling, partner counseling and other aspect to provide community friendly counseling. Efforts need to be undertaken to reach the dropouts and motivate them to re-enroll into the interventions and encourage for services. In case, if they are not found, delete them from the master list. This will help in arriving at correct beneficiaries and understand the linkage system for services.

Stakeholders : The Jamath and Gharana influence and encourage the community member to participate in the TI program and availing services are found at high level. This requires strong advocacy networking and greater engagement. The skills among the NGO team and outreach team need to be further enhanced through training for improving the documentation skills. Exploring on the possibilities to provide Psycho-Social support and effective counseling on risk reduction practices will be of more effective. The intervention should focus on creating the visibility for the key components like ICTC, STI clinic, ART center and other services.

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