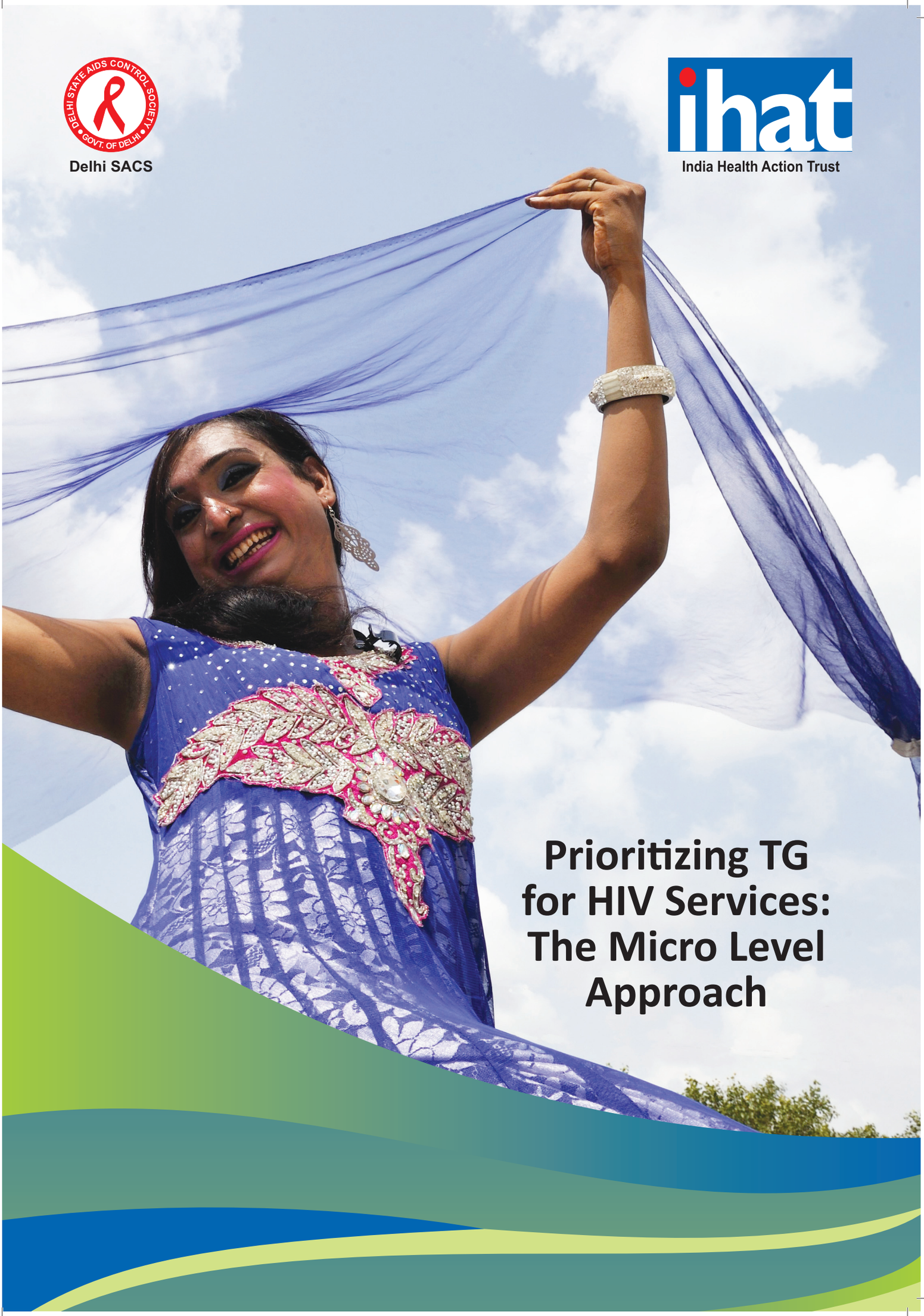
Delhi SACS

India Health Action Trust



Prioritizing TG for HIV Services: The Micro Level Approach

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'Prioritizing TG for HIV Services: the Micro Level Approach' is a guide to implement the NACO strategy of addressing HIV transmission among the TG/HIJRA. This document explains the micro level planning and prioritization for service delivery among the different categories of TGs and HIJRAs in Delhi.

Conceptualized and Edited	:	Dr. Joseph Francis Munjattu, Team Leader, IHAT TSU DSACS Dr. J.K. Mishra, Joint Director TI, DSACS
Compiled	:	Dr. Subash Ghosh
Acknowledgments	:	TG Community
	:	Staff of TG TIs
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सत्यमेव जयते

डॉ0 मृणालिनी दर्सवाल, भा.प्र.से.
परियोजना निदेशक
Dr. Mrinalini Darswal, IAS
Project Director

DELHI STATE AIDS CONTROL SOCIETY
(Govt. of Delhi)
Dharamshala Block,
Dr. Baba Saheb Ambedkar Hospital,
Sector-6, Rohini, Delhi-110085
Tel. : 27055717, Fax : 27055720
E-mail: delhisacs@gmail.com
pd.dsacs@gmail.com

दिल्ली स्टेट एड्स कन्ट्रोल सोसाइटी
(दिल्ली सरकार)
धर्मशाला ब्लॉक,
डॉ. बाबा साहेब अम्बेडकर अस्पताल,
सैक्टर-6, रोहिणी, दिल्ली-110085
फोन: 27055717, फैक्स : 27055720

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Preface

Historically, Delhi State has been the focus of many evidence informed decision in health sector programing especially for communicable diseases such as dengue, swine flu, HIV and AIDS. It is very important that program evidences should be used to made mid-course corrections to ensure that the end results are achieved with optimum resources and effectiveness and efficiency.

Delhi state shares border with several important States and Census 2011 recognizes that Delhi would be having highest flow of migrants. Keeping a tab on "Universal Health Coverage" it is important that Delhi State should have specific strategies for all its citizens. I have been informed by Delhi State AIDS Control Society that Delhi has been the forefront of many National Initiatives in HIV and AIDS program during last 30 years. Some of the notable examples, I would like to recall are initiation of treatment (first line and second line) for PLHIV/PLHA, Hospice based model of care for PLHIV/PLHA which was later taken up by NACO, Peer consultation meetings for key population, female condom programming, etc

I was also informed that the key population interventions in Delhi has brought significant impact among different sub-groups, yet many achievments are to be completed. I have been informed that the recent release of National Guidelines for interventions among Transgender by NACO has been implemented fully by Delhi SACS and TSU. Over the past one year, Delhi SACS and TSU has evaluated the implementation of the guidelines and they have found there is a need for elaboration of certain components.

I hope that the approach paper developed by Delhi SACS and TSU in consultation with community stakeholders, experts will provide guidance for better implementation of National Guidelines. I am sure that in future this approach paper would be implemented as per field requirements and the end result of keeping every one healthy would be achieved.

(Dr. Mrinalini Darswal, IAS)

Message from MT IHAT

HIV prevention program among the core groups is important to be sustained in the public health systems of India through community participation. Local level micro plans and grass-root level strategies will enable the sustainability of the changes made by the programs. India Health Action Trust (IHAT) is a pioneer civil society organization, which employ strategies developed through program science approach.

The Technical Support Unit of IHAT for Delhi SACS follows the same approach to address the HIV risk and vulnerabilities among the core and bridge groups in the state.

As per the mapping estimates of Delhi, there are about 7400 transgender populations who are at risk of HIV infection. A recent study and secondary data analysis by Delhi TSU highlight barriers to service access by transgender populations. Although the outreach coverage is about 70% but the service uptake and continuum has been impacted by both structural issues and community dynamics. Forty percentage of the TG population is DERA based and are influenced by the NAIKS/GURU (leaders) of the DERAs. This document is a guide for the Transgender (TG) Targeted Interventions (TI) programs in the state towards piloting a more effective micro level approach in line with the national guideline developed by NACO for TG intervention. Using the community structure for change is the core of the strategy proposed in the document. Prioritization of the population for services and choice of services are principles of approach.

This could be resulted as a practical model that focuses HIV community service responses on meeting the 90-90-90 targets outlined by UNAIDS to help end the AIDS epidemic by 2020.

I appreciate the TSU team and DSACS officials for their keenness in continuous interaction with community and proposing strategy shifts to improve the programs. Also I take this occasion to thank Project Director DSACS for the constant support to the TSU for achieving its goals.

Dr. Shajy K Isac
Managing Trustee, IHAT

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Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral therapy
DIC	Drop in centre
HIV	Human immunodeficiency virus
HRG	High Risk Group
ICTC	Integrated Counseling and Testing Centre
KP	Key Population
MSM	Men having sex with men
NACO	National AIDS Control Organisation
OI	Opportunistic Infections
ORW	Out Reach Worker
PT	Presumptive Treatment
PLHIV	People Living with HIV
RMC	Regular Medical Check up
STI	Sexually Transmitted Infections
SACS	State AIDS Control Society
SRS	Sex Reassignment Surgery
TG	Transgender
TSU	Technical Support Unit
TI	Targeted Intervention
UNAIDS	United Nations Programme on HIV and AIDS
VCT	Voluntary Counseling and Testing

Background

In line with National Strategy for reaching out key populations, targeted interventions are being implemented under Delhi SACS. As per the mapping estimates for Delhi, there are about 7400 transgender populations who are at risk of HIV infection. A recent study and secondary data analysis by Delhi TSU highlight barriers to service access by transgender population. Although the outreach coverage is about 70%, but the service uptake and continuum has been impacted by both structural issues and community dynamics.

Delhi SACS/TSU is planning to improve the service uptake by improving capacity of implementing partners especially the community structures; however, the approach has limited penetration to the community dynamics. Further the strength of these community structures has not been utilized to its fullest potential due to increasing importance on HIV related services in the outreach. Whereas the existing community structures has been the core strength for the transgender population to share their values and norms. Hence, Delhi SACS/TSU intends to strengthen approaches which can use these community structures in a participatory manner.

NACO's new Operational Guidelines for Transgenders is based on the need and understanding of the program requirements and increasing need for standardizing program management tools across all interventions. This guidelines provide an overview of the various components that needs to be addressed through targeted interventions as well as provides an overview of the role of various stakeholders. However, Delhi SACS/TSU is planning to elaborate the components of outreach, microplanning and prioritization of sub-populations within the TG community based on the broader understanding of the Guidelines.

The process of developing these approaches within broad framework of the Guidelines includes community consultation, review of existing TI data and field visits. SACS and TSU has taken steps to understand the specific service needs, current gaps in program and possible opportunities to implement National TG Guidelines in specific areas of prioritization of sub-populations, outreach and microplanning processes.

It may be noted that PEHCHAN Project during its implementation with TG Population in Delhi focused on strengthening capacity of the partners to improve delivery of counseling services, reaching out to the hidden population and networking with Gharanas. These learning and experiences need to be scaled up and modified as per the local requirements in line with National Guidelines.

A new approach to HIV outreach prevention and community based care and support for TG population has recently been developed based on the past experience of working with transgender communities and recent consultations with communities, gharanas. This new approach to HIV prevention need to be field tested successfully with transgender people in a small geography before being scaled up in Delhi or elsewhere. These innovations focus HIV prevention programming on decreasing undiagnosed HIV, promoting meaningful knowledge of HIV status through outreach for HIV testing that is linked to CTC and case management for newly HIV diagnosed people. A major aim of these innovations is to prevent loss to follow up of people from key population for HIV along the HIV Treatment Cascade. This result is a practical model that focuses HIV community service responses on meeting the 90-90-90 target outlines by UNAIDS to help end the AIDS epidemic by 2020.

This proposed approach of prioritization, outreach and microplan processes are based on the learning from implementation of National Guidelines for TG interventions in Delhi.

Current Challenges In Generating Demand For Services

The targeted intervention have several core approaches for reaching out transgender population with services. These are provision of clinical services for STI, condom provisioning through outreach and DICs, HIV testing and ART services through linking to the government facilities. However, due to lack of differential approaches in targeting specific needs of individuals or group of individuals the interventions have not been able to generate demand for services. The other key challenges for demand for services are:

- Availability and accessibility of services: Distance of the facilities and the limited knowledge, attitude of service providers towards the issues of transgender population.
- Limited access to transgender specific medical procedures such as information and services about SRS, hormone therapy.
- Lack of balance between biomedical and behavioural interventions. More focus on HIV related services.
- Limited services for young transgender population, who are in a transition phase – from their family to social networks, from their social networks to social normative networks etc.
- Services are often not available with one provider or one facility – there is a continuing self perceived stigma about how the different service providers would react to a transgender.
- Services are often offered inconsistently and do not consider quality from the perspective of the community members.

Current Challenges In Addressing Structural Barriers

Although the targeted interventions are now 20 years old in India, but the targeted interventions designed to address specific needs of transgender population are yet to be well thought of. Up till now they were considered to be sub set of the Men Who have Sex with Men (MSM) or their partners. Thus the interventions have not been actually considered the existing social milieu, social structures and more specifically the community specific vulnerabilities while implementing key HIV services for the transgender. The approaches for addressing structural barriers are yet to be well established and they are evolving in different settings.

Inherent to the community structures:

- The community structures in India are very closely knit and are governed by community norms to protect the community members from stigma and discrimination at different levels.
- The community structures have been away from the main stream societies because of lack of recognition under the law. However, with recognition of transgender as a third gender and growing activism is creating space for the community.
- The community structures are very hierarchical having limited space within the community members to participate in decisions made for the community or in relation to the outside structures. However, in India with growing examples of leading transgender lives in the mainstreamed society in various capacities have allowed its members to actively participate in decisions in a limited way.
- Community norms associated with the type of work the individuals are associated often makes individual's lifestyle more vulnerable. For example those who live upon begging are most vulnerable one because they are harassed by police, goons as well as fellow members in the community. Similarly those who are into rituals of blessing face the vulnerabilities of stigma and discrimination.

Areas related to reforms in law and creation of enabling environment:

- The various sections of transgender community have not been able to participate in the discourse around recent law reforms. There seems to be many myths and misconceptions associated with the law and possible consequences to individual life.
- The varying level of stigma continuing across various sections of society especially the trans phobia issue need to be addressed in a way that empowers everyone to participate in mainstreaming the transgender community.
- The study by Delhi TSU clearly highlights that there is a need for long term and sustained engagement with identified stakeholders to ensure that the transgender community are equally participating in the enabling environment process.
- The limited participation of transgender leaders or Gurus (as called in India) need to be channelized in order to address broader issues associated with the life and living of the community members. Their involvement should not only be limited to advocacy efforts or mere representation in committees.

Are there specific issues existing in the community of transgenders:

Like any other communities in Indian society, the transgender community members have specific issues associated with their age, sex, occupation or livelihood options they have, access to resources (financial, social, education and family). Unfortunately, their rights have been always negotiated in a way that they perceive stigma and discrimination in a social space. Thus there has been a marginalization among the transgender community especially those who are young. UNDP consultation on issues of transgender clearly highlights that although HIV programs have been able to bring focus on the specific issues that existing in the transgender community but the redressal has been very limited.

Experiences from HUMSAFAR Trust, Sahodaran Trust in India highlights that HIV related services were not enough to address various issues faced by the community. Recognition of small networks and empowering them to work for their own communities has not been tried in India. Various issues related to relationships among young transgender have not been addressed through counseling in the existing programs. Much focus on sexual risk has neglected the need for addressing vulnerabilities among various community groups.

Observations From Program Data

As per the requirement of NACO Guidelines, the interventions among TG report on 31 key indicators. An analysis of the information submitted by the interventions during April 2015 and January 2016 with 31 indicators reported following areas which are of importance.

While there is achievement of coverage (average of contacts during last 3 months), this does not translate into service uptake by TGs due to many operational and programmatic issues. The HIV testing against 2 times benchmark for each TG has achieved only 50.5% and similarly the condom distribution against the demand is only 42.5%. The following table summarises the performance.

Performance of TG TIs during April 2015 - Jan 2016						
No. of HRGs planned to be covered	No. of HRGs registed during April 2015 - Jan 2016	Total no. of clinic footfalls	Total no. of STI cases reported among the clinic footfalls	Total no. of RMC undertaken	Total no. of PT provided	Total no. of ICTC testing performed
5650	6060	16871	208	16341	330	6119
Total no. of HIV positive	No. of HIV +ve linked to ART	No. of new HIV infections	Syphilis screening done	Syphilis reactive among the tested	Condom Demand	Condom Distributed
36	29	31	5668	4	1813044	769808

The above table also suggests that the RMC undertaken against the clinic footfalls is better in terms of service uptake but the presumptive treatment provided and syphilis testing provided requires attention.

On analysis it is very clear that the TG interventions have great potential in improving service access but due to structural barriers and service delivery pattern not meeting the needs of the community – does not act as enabler for service uptake and continuum of services.

What has worked well with TG Targeted Interventions in Delhi:

- TG TIs have improved the outreach and registration of key population over the years. Individual level tracking of HRGs by their risk level could not be implemented due to lack of microplanning directly linked with specific vulnerabilities associated with sub-population i.e. gharana based, street based who are involved in begging and those who are into sex work.
- Total number of ICTC testing performed has also improved but classification of risk groups within the sub-population and improving service delivery requires further use of microplanning tools.

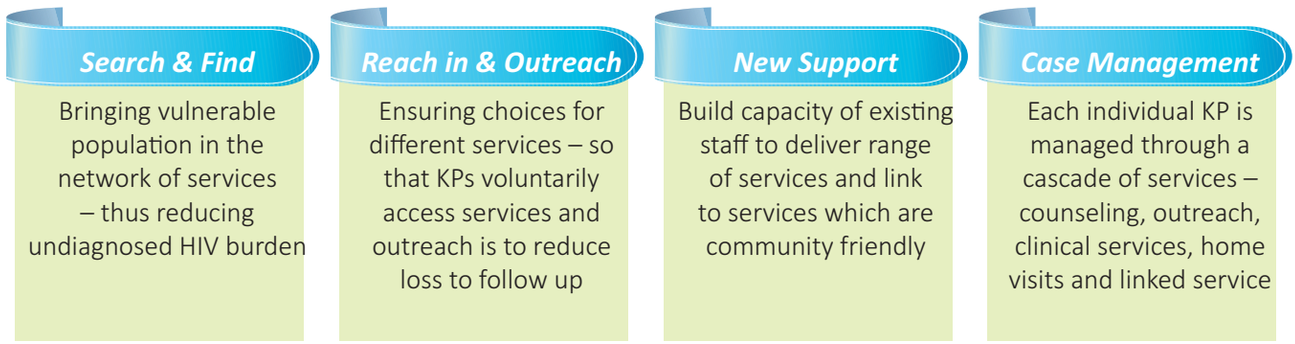
Potential areas with TG Targeted Interventions in Delhi:

- TG TIs have improved the outreach and registration of key population over the years. However, prioritization of sub-population based on risk and vulnerabilities has not been considered for planning, delivering services.
- The role of peer volunteers and Outreach workers for different settings should be clear to ensure that the services provided are complementing each other.
- The involvement of gurus and gharanas are critical especially creating demand for services, this can only be achieved, if there is clarity on their roles as well as respecting their societal roles and traditional norms.

Proposed Approaches

Existing targeted interventions need to consider review of existing approaches and add new cost effective yet community friendly approaches to move from a HIV risk perspective to vulnerability perspective. These changes require transformation in community organizational structures, cultures and in the management and supervision of HIV outreach prevention teams. They require transformation in the principles and practices of service delivery among outreach prevention staff. The development of professional social work skills within teams of community-based staff and volunteers is significant. This needs to be brought in to the program.

The following principle is being applied to improve reach and retention of key populations within a holistic health care delivery approach model:



The following are the objectives of the proposed approaches:

- To bring focus on individual and community vulnerabilities in order to design and strengthen interventions. (in TG context individual vulnerabilities is associated with their age, social milieu, the work they do and their social position within a gharana where as the community vulnerabilities are associated with the socio-cultural system they have, the position of TG community within broader social construct where they are excluded from the mainstream social activities – be it access to education, access to livelihood or access to the basic rights)
- To engage with community for leadership building and advocacy.
- To promote healthy transition of young transgender people. (when young transgender people are well informed and given choices – they would be able to make informed decisions instead of being carried out by the peer pressure)
- To address self stigma at all levels. (this is referred at the immediate community level where they live and spend their times, within the community levels)
- To build capacity and empower service providers, civil society for enabling environment
- To design, help access a multi-disciplinary services including HIV related services. HIV related services should be considered as an enabler not as a barrier itself.
- Build evidence as a base for advocacy especially in the areas of vulnerabilities to empower decisions among decision makers.

Review of existing practices:

It is very important that the community members, leaders among the communities, SACS and TSU need to review current practices in different settings. For example, during our recent field visits and meetings it was observed that community members and leaders wish they could access lot of information through mobile phones yet being anonymous. They feel that not only mobile phones can empower them about various issues and possible solutions but also the same can be used to ensure that they are updated with latest developments around various issues like recent verdicts.

The practices and changes associated with this new approach to HIV outreach prevention include:

- No longer working in the same places and always with the same networks, groups or communities. Instead, incorporating a 'Search and Find' approach to HIV outreach prevention that means outreach staff are regularly moving in and out of new places, networks and communities of key populations for different services.
- Mapping in local places on a continuous basis using a traffic light system to identify 'high', 'medium' and 'low' sites for undiagnosed HIV among the universe available in that area.
- Mapping using hard copy maps in weekly team meetings and discussing findings.
- Incorporating Maps in to the team's daily practice to understand the mobility pattern, availability and vulnerability pattern – this would ensure that the micro-plan is in line with actual on ground requirements.
- No longer only distributing condoms and information – accompanying clients to the nearest DIC, community friendly clinics and HIV counseling and testing is a core component of a new approach to HIV outreach prevention services. This not only brings confidence among the key population but also helps to improve access of services. The community members willingly participate in the program when they know they will not be abandoned and they would be supported irrespective of their HIV status (it was observed that the community as well as individuals are very stigmatized about opening up their HIV status). A new approach to HIV prevention delivers case management to seamlessly link to care for newly HIV diagnosed people. In this way, the model closes gaps across the HIV treatment cascade.
- Incentives may be thought of in-consultation with community members when the volunteers support a vulnerable community member to the nearest HIV testing center or nearest DIC for counseling. Moving from a peer based model to a peer support model with incentives linked with outcomes.
- Incorporating changes in to standard operating procedures for the management of outreach practice to transgender people.

Steps to consider for implementation of approaches in an existing targeted intervention settings:

These steps are to be implemented by the outreach team facilitated by the SACS and TSU team to ensure that this information are collected and used to design the outreach approach for specific areas.

Step 1: The existing targeted intervention should have enough information about the vulnerabilities of the community or individuals and these are:

- What is the social hierarchical structure of the community which is being served?
- Who are the decision makers in this community and how these decisions have impacted service access, service availability in the existing project?
- What are the vulnerability issues related to social, health aspect of the community?
- Are the community members and leaders aware of their rights and whether they are able to access these rights like any other citizens? If yes, how these processes have the community as a whole, if not, what are the barriers?
- What has been the most learning experience for the community and what has been the challenge(s) for the community to ensure that they are not marginalized?
- How the members of the community have been able to address the issues of stigma and discrimination on their own or with support of any of the stakeholders?
- According to the community, what are the leadership challenges and do they consider secondary leaders are important to improve and strengthen advocacy efforts?
- What are the issues and challenges they experienced regarding the transition of young transgender people – health, psychological, related to family, related to peer groups, related to their own community norms etc.
- What evidence community has been using to advocate their rights or access services? If no evidence is available, what are the structures and processes that can be established to capture new information?

Since most of these information requires series of discussion with the leaders (Gurus), various age groups and community structures through one to one and group meetings. Mostly these questions are to be put across in a way that the information collected through this process are more self reflections rather than problem finding.

Hence, as a first step of the process the targeted interventions team members should meet the Gurus and senior members and explain them the need of collecting this information and allow them to define the process, stages and intended respondents and team members for collecting information. The role of targeted interventions team should be facilitatory and through this process should empower the community. The information should be triangulated through a respondent driven sampling once the process is over for at least 10% of the respondents who have been part of the initial round of information collection.

- **Step 2: Review the information collected and allow the community to define the services that can be part of the targeted interventions including the frequency and nature of service delivery (facility based within the targeted interventions or linked with another facility).**
- **Step 3: Define the role of community leaders or Gurus in the process of defining, delivering and monitoring the services. This is to be done in consultation with Gurus, the SACS and TSU should have standardized questions on services and should allow the community leaders or Gurus to discuss on the questions related to defining, delivering and monitoring the services – they need to be consulted in a structured way.**
- **Step 4: Define the role of existing targeted interventions staffs and also identify the required skills or knowledge required to deliver the services identified.**
- **Step 5: Identify a timeline for delivering the services in a phased manner and ensure that the community feedback is used for improving services.**
- **Step 6: Use these evidences to mobilize resources and empower the community structures to access various services.**

Steps to consider for implementation of approaches in new targeted interventions settings:

- **Step 1: In new targeted interventions settings the implementation of these approaches should follow the model of exploratory study through a baseline and triangulation with community members through snow balling.**
- **Step 2: Allow community leaders or gurus to identify the entry points and there should be clarity of roles for both community structures and implementing agency through a structured and facilitative session.**
- **Step 3: Focus on building capacity, community to community interactions and talk by leaders from an existing intervention – this would help in building the vision of the community leaders and help them to identify their role better in their own settings.**
- **Step 4: Bring in specific skills among the staffs so that their focus should not be more on achieving targets by pushing target population rather than creating an environment for sustained demand over time.**
- **Step 5: Engage community leaders in frequent self reflection exercises, help them to recommend suggestions to improve and if required change in their roles to implement better.**
- **Step 6: Engage community members especially individuals in frequent community dialogues to reflect their experiences and inputs for improving the program outcomes.**

Approaches To Leverage Existing Services

Existing services	Add on services (if required)
Outreach services	• Information and enrolment for social entitlements • Collection of details of social entitlement forms • Group meetings to understand mobility and capture information for conducting cluster based camps for these services.
Preferred providers clinic or DIC based clinics	• Provide services for hormone (effects, ill effects) treatment • Provide services for general well being for both young and old transgender people
DIC services	• Expand to include services or information about vocational training or enrolment • DIC services to include services such as additional training or linkage to trainers on various interesting subjects including fashion designing, beauty parlor training etc.
Counseling services	• Counseling on transition phase for young transgenders • Provide counseling on family issues or peer group related issues, alcoholism or drug abuse related services. • Provide family visit and counseling of family members • Provide support to workplace sensitization programs
HIV related services	• Provide services beyond HIV for general well being especially related to ill effects of hormone therapy and ART interaction. • Provide services for OI management • Provide services for ART compliance especially in conditions of mobility – how those mobile TG people can access ART • Provide services for co-morbidities – such as HIV and Hepatitis C, HIV and any genital complications
Beyond HIV services	• The health facilities should provide services for sex reconstructive surgery – at least counseling and better linkage should be established • Hormonal therapy and its monitoring should be done to avoid abuse of hormonal therapy. • Drug abuse especially injecting practices or transition stages need to be addressed through proper counseling by Drug Deaddiction Centres
Family counseling services	• Ministry of Women and Child Development should provide services related to family counseling especially in case of stigma and discrimination.

What are the stages of introducing new package of services:

This will depend upon the existing demand of these services as well as availability of services. However, it has been found that in spite of availability of these services, the clients are not informed or they are not empowered to access these services.

Further, due to lack of sensitivity among health care providers these services are often denied or they are not made available in health facilities. Hence it is important that the range of services should be made available with adequate sensitization of providers and the information should be made available for the clients.

Approaches for service delivery:

The National Operational Guidelines for Transgenders clearly identify the core package of services, however to deliver these services the package and delivery mechanism need to be contextualized for optimum uptake of services. For example, during community consultation it was very clear that in Delhi, those transgenders who are at highest vulnerabilities are those who are into street begging/sex work – but due to time constraint they rarely access any HIV or health related services. Hence, based on these consultations and discussion with gharanas following service delivery approaches are suggested.

- **Outreach model –** several of the new services can start within existing outreach model and then when the clients are well aware of and the demand is generated, the outreach model can be shifted to facility based or DIC based model. For example, collection of information or enrolment of clients for social schemes, peer counseling on hormonal therapy or sex correction surgeries etc. Outreach services should be aligned to the timings of the key population availability, for example in case of sex work group among TG the outreach team should work in the evening and link up services with nearest preferred providers.
- **Peer support model –** this model is best suited for closely knit social networks. Peer group model is always a sustainable approach and can easily bring behaviour change. This can be facilitated by the leaders as well and hence peer support model should be encouraged. This can be used for family counseling, family support work, crisis response, supporting members for vocational training or jobs.
- **Network of Services model –** This works in a geographical area with better means of mobility, limited number of target population. In this existing preferred providers who are already sensitised and have been delivering services to the community can be further trained to provide counseling and treatment services for various range of services.
- **Universal health care approach model –** Existing public and private health facilities can be incentivized initially for providing a set of services and gradually withdrawing these incentives. Thus it brings an environment of incentivisation for providing range of services in addition the client can access other services which are also important for the client.

It is very important while deciding on these service delivery approaches, there is a need for prioritization of target population in different settings. Based on the risk and vulnerability matrix described above, the following prioritization may be followed:

Prioritization Levels	Target Population	Service Delivery Approaches
Medium	Adolescents	• Peer support model • Network of services model
Highest	Young those who are engaged in standing on streets and begging	• Outreach model • Peer support model
Highest	Young those who are engaged in sex work as individuals or groups	• Outreach model • Network of services model
Low	Young those who are engaged in rituals	• Universal health care approach model
High	Adult those who are engaged in standing on streets and begging	• Peer support model • Network of services model
High	Adult those who engaged in rituals	• Network of services model • Universal health care approach model

Criteria of risk categorization:

It is very important that outreach workers and program managers should be able to understand the rationale of risk categorization as well as able to use the same rationale for future risk categorization of target population.

Target population		Risk levels
Adolescents	• Lack of family or social support • High level of stigma, discrimination and violence faced • Lack of proper knowledge about lifestyles during transition phase • Non-access to information or mis-information about transgender life • High level of experiments based on facts available	Medium
Young those who are engaged in standing on streets and begging	• Highest levels of violence from police and goons • Long hours of work and stress leads to substance abuse • High levels of sexual violence • Lack of access to services – as they lack time or services are not available when they are free from work • Highly mobile and don't seemingly having a standard pattern of work	Highest
Young those who are engaged in sex work as individuals or groups	• Highest levels of violence from clients, police, goons. • Emotional insecurity and instability • Always in the borderline of commu nity norms and practices • Low self esteem and low on self motivation	Highest
Young those who are engaged in rituals	• Usually this group leads the community norms and practices • Low on emotional vulnerabilities • Low self esteem but high on self motivation • Varying degrees of social acceptance	Low
Adult those who are engaged in standing on streets and begging	• Highest levels of violence from police and goons • Long hours of work and stress leads to substance abuse • High levels of sexual violence • Lack of access to services – as they lack time or services are not available when they are free from work • Highly mobile and don't seemingly having a standard pattern of work	High
Adult those who engaged in rituals	• Usually this group leads the community norms and practices • Low on emotional vulnerabilities • Low self esteem but high on self motivation • Varying degrees of social acceptance	High and vulnerability level is high

Besides this there would be varying degree of vulnerabilities which would not fit into the above classification by age groups, however these vulnerabilities need to be considered on following areas:

- Whether the vulnerabilities are affecting individual's access to social, emotional and economic rights or opportunities.
- Whether the vulnerabilities increase individual's life style or day to day life.
- Whether the vulnerabilities modify individual's life style or day to day life and make their life more vulnerable from the present conditions.

Proposed micro-plan approaches:

First visit should focus on helping the individual + Second visit should focus on creating a support model + Third visit to access to health and HIV related services + HIV test result negative

- Applicable for those who are medium, high and highest level of vulnerabilities
- Plan for three to six monthly follow up plan with focused outcomes
- Provide education on prevention of STI and HIV infection through outreach or peer support model
- Contacts should be outcome focused especially on health rights, livelihood, substance abuse, life style

As described earlier, it is very important that the individual contacts made during outreach activities should be focused on outcomes. The outcomes should be linked with risk levels and vulnerabilities of individuals. Outreach should be designed and managed based on following priorities:

- Focus on outcomes – especially to address vulnerabilities – enabling individual requirements.
- Focus on reduction of vulnerabilities – identification of vulnerabilities – help and facilitate an individual to plan how they can participate in reducing vulnerabilities.
- Focus on creating a support model either through outreach team or peer group or service providers to attain the required goals of reducing vulnerabilities.

Following are proposed individual visit model based on the HIV status of target population:

Outreach workers should be supported by counselors and peer educators to achieve above objectives of each visit. These visits are not prescriptive but are important components of designing the microplan. All visits should not concentrate on providing information and condoms, rather the visits should be planned enough and should ensure discussion with the individual.

The information sharing and distribution of condoms should be restricted to contacts by peer educators but outreach visits should be well planned preferably over a phone call with the community member. So that the outreach worker visits are focused on outcome.

Use of micro plan for mapping of vulnerable networks in urban settings:

A unique community-based prevention-outreach system borrows from incidence and prevalence research techniques. It maps urban settings to identify networks with higher numbers of vulnerable population, undiagnosed PLHIV and with the potential for high levels of HIV transmission.

The model uses a traffic light system to categorize urban networks for HIV. The aim is to categorize places or networks as high, medium or low HIV and/or STI incidence/prevalence. First, identify a new network and test 10 people randomly in that network. Track what is learned on a map of the city and use that map to make service decisions based on the numbers of people who test HIV or STI positive who didn't previously know their HIV status.

High (Red or pink stickers on the map below): where 4-or-more out of 10 people tested in one network were positive for HIV. ***Conclusion:*** stay in this network and keep testing. Engage other key stakeholders such as community leaders, local health care providers at this site to provide the means to prevent HIV as well as HIV and STI health education.

Medium (Amber or orange stickers on the map below): where 2-to-3 out of 10 people tested in one network were positive for HIV. ***Conclusion:*** stay in this network and keep testing. Engage other key stakeholders such as community leaders, local health care providers at this site to provide the means to prevent HIV as well as HIV and STI health education.

Low (Green on the map below): where 0-to -1 out of 10 people tested in one network were positive for HIV. ***Conclusion:*** move on from this network and find a new site. Encourage other key stakeholders such as community leaders, local health care providers at this site. Encourage community members to participate in awareness and prevention education activities.

The image is a snapshot of an HIV prevalence-map of a city. Team meetings held at the end of each week, engage the team in categorizing the networks they are in. During these meetings, decisions are made about whether a network is high, medium or low prevalence for HIV and the team adds colored stickers to the urban map in order to identify them as such.

SACS and TSU team help the outreach team intensively to focus on places and networks where larger numbers are being diagnosed with HIV or STIs. This is an example of spatial map documented during mapping of sites.

This model of visual presentation of microplan with priority helps the outreach workers and peer educators to prioritize their work. It is an improved version of site load mapping and size assessment tools being used by National Program to cater to the mobility pattern of transgenders as well as to improve individual tracking information. The existing tools used under National Guidelines can also be used in addition to these tools. The peer educators need to be keep a tab on their target population and thus can plan BCC, condom and lube provisioning as well as linkage to care and treatment services by using this visual tool. The Program managers also can use the tool to improve availability of services through collaborating with community based HIV testing services.

Proposed Outreach Structure

Outreach and case management staff are put together in to teams that might be called outreach cells. Outreach cells are made up of seven full-time staff (1 Counselor, 4 outreach workers and 2 peer counselors) and community leaders who are volunteers. This team of outreach cell should provide services to at least 400-500 target population during a quarter.

There would be different composition of outreach cells for different settings. The following are suggested structure of the outreach cell in different settings:

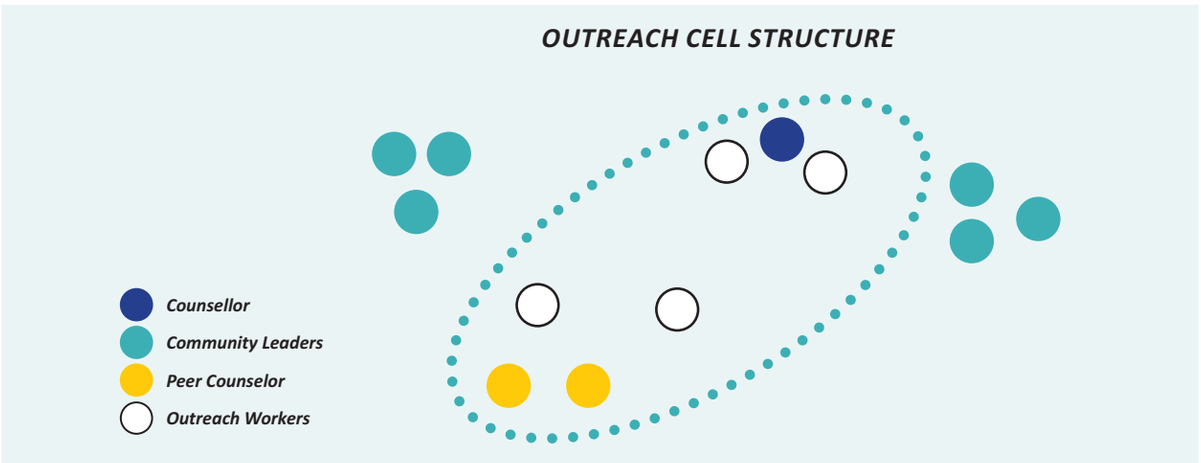
Type of settings	Outreach cell structure
Gharanas and adjoining other settings as mentioned below	1 ORW for 150 -200 population, 1 peer counselor for 100-120 population (these population is more stationary)
Street settings	1 ORW for 120-150 population, 1 peer volunteer for 80-100 population (these population is relatively stationary as well as mobile)
Purely sex work sites	ORW for 100-150 population, 1 peer volunteer for 50 population (these population are highly mobile)

A counselor manages one cell (see the blue circle in the diagram to the left).

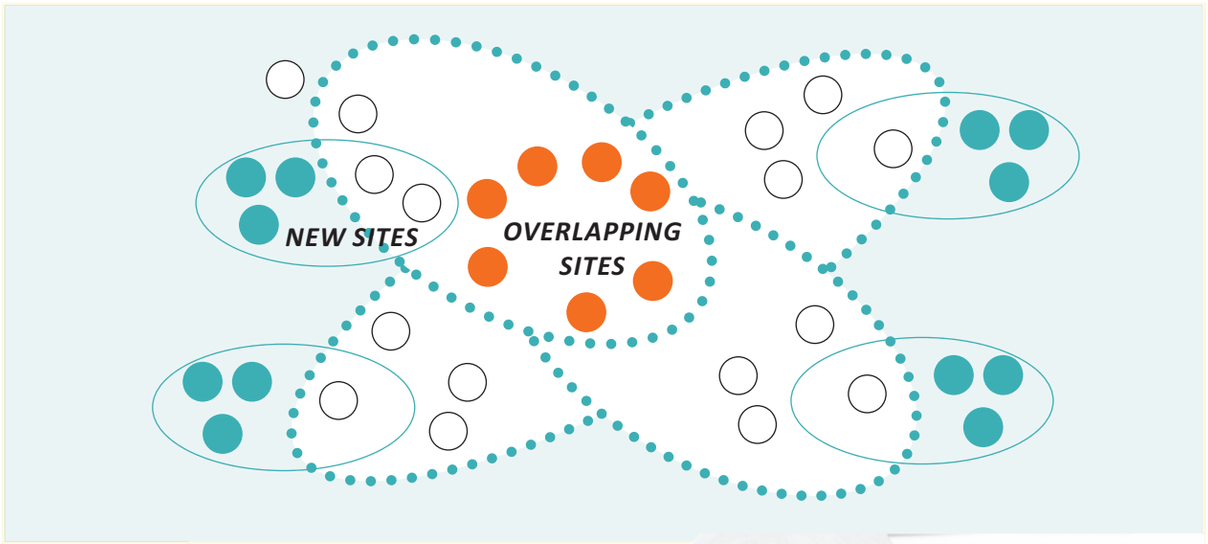
Outreach workers (see white circles in the diagram) spend their time 'in the field' managing relationships with external, local community leaders whose job is to stay in their local places, provide information to local people about HIV, recruit and liase with local community members to encourage support (see the green circles in the diagram).

While the Outreach workers help individual transgender to decide on how they can participate in the process of reaching the counseling services for their needs as well as work with community leaders for creating an enabling community norms and practices which sustains the motivation for seeking these counseling and clinical services. When operating at capacity, and depending upon the local constraints and context, each cell may be capable of testing between 100- 200 transgender people every six months. Each cell can provide casework support and case management to 150-300 newly met transgender people per year as they constantly look for new members and new sites to bring more people into the network of services.

The team provides holistic services that close gaps across the different needs not exclusively HIV related services. Outreach workers are trained in counseling and casework. This allows them to accompany individual transgender people for HIV testing and 'transform' in to caseworker for those who test HIV positive. In this system, PLHIV are put in face-to-face and education groups.



As described above the microplan should concentrate on outcomes and role of each member of the group. In this process, when overlapping of sites or new sites are identified it is important that peer counselors should play lead role in the centre of overlapping site. Whereas in new sites the outreach workers should continue to work with community leaders to ensure new members are gradually moved to be centre of the services by peer counselors.



Proposed Reach-In Structure

It is very important to ensure that the services which need specialized skills such as counseling and clinical services are adequately strengthened. For example, during community consultation and field visit it was observed that counseling services should include following areas to meet different needs:

- Gender and Sexuality – to help young and adolescent transgenders to cope with the transition
- Mental Health – to help all age groups to meet emotional challenges from various reasons
- Partners and relationship – to help all age groups to meet various situations arising from relationships especially to facilitate their decisions on these matters.
- Trauma and violence – to help all age groups to recover from the ill effects of trauma and violence from different conditions.
- Psycho-social, family counseling
- Counseling on social entitlements and link to social entitlements
- Counseling on vocational training and link to vocational training services
- Counseling on SRS services and prepare individuals, link them to qualified health care providers
- Counseling on general health for adults especially those who are old and need various emotional services within the counseling services.

Similarly the clinical services are to be provided by the trained clinicians or community preferred providers both in DIC or in community settings. The services should include counseling and treatment of STIs, counseling and treatment of asymptomatic STIs, counseling on hormonal therapy and SRS services.

When the relationship between outreach and casework team and clinical team is working well in the setting, counselors and doctors will refer clients that need follow up support to caseworkers. They may invite caseworkers into a consultation with a client who needs help beyond the capacity of the counselor or doctor.

The main objectives of in-reach include:

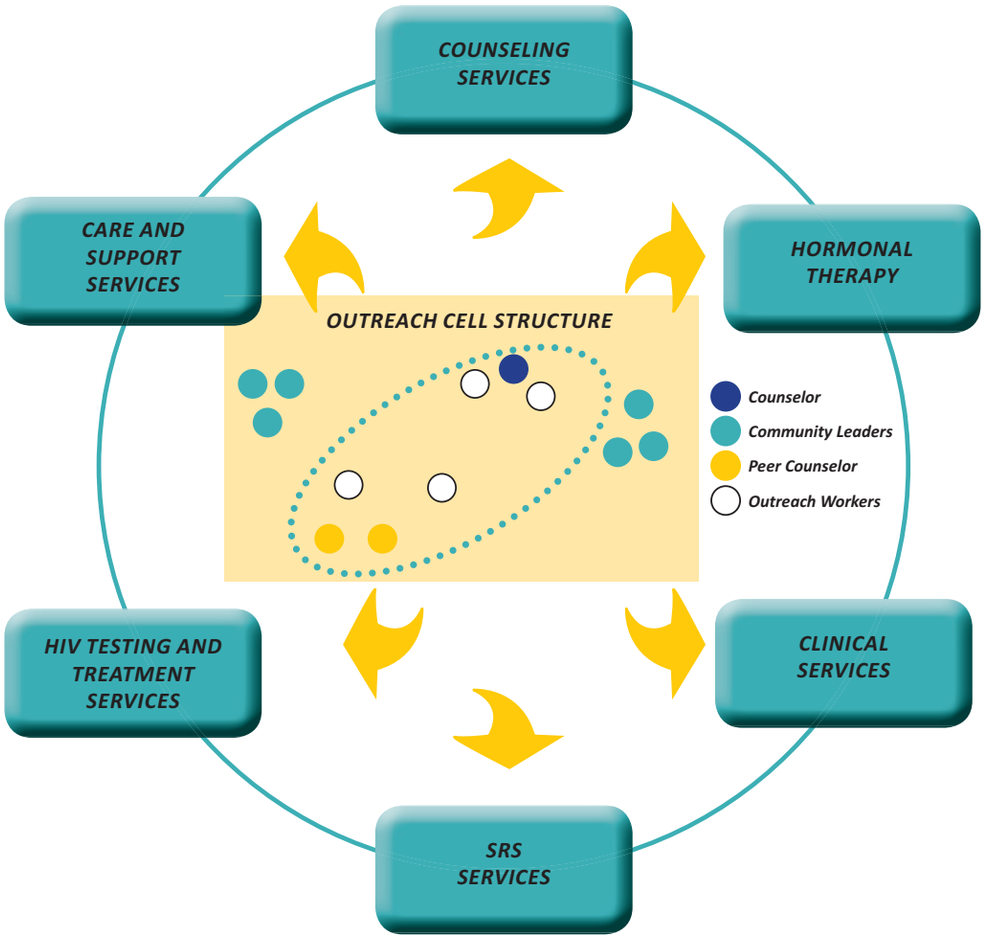
- Develop cooperative relationships with the staff of hospitals, clinics, drug de-addiction or harm reduction support services and other health and welfare services to facilitate shared service provision and referral of clients/patients.
- Develop supportive relationships with newly-diagnosed people with HIV so they are not lost to follow-up by the health system and are not isolated and alone. This means that hospitals providing HIV counseling and testing (ICTC) are a primary site for the service.
- Develop supportive relationships with patients who present with HIV-related symptoms at hospitals and clinics, and with people with HIV-related illness in their homes and in the community, so they can access the range of health and welfare services they need in a timely manner.
- Develop supportive relationships with patients being hospitalized with symptoms of HIV illness, so that support and assistance can be arranged for them while they are inpatient and so that the transition from hospital-to-home can be managed smoothly. This means that clinics and hospitals providing care to people living with HIV are a primary target of the work of HIV prevention casework services.

The model is a complex model of different services, but all these services can be accessed by the outreach cell members by referrals as well as each of these services can create referrals among themselves.

Hence it is very important that the providers in each service centres should be well appraised of services provided by other service providers.

It's a referral model from the outreach to different services as well different services can refer to each other for specific needs.

This model is very important to ensure continuum of services as well regular follow up and linkages.


COUNSELING SERVICES
HORMONAL THERAPY
CLINICAL SERVICES
SRS SERVICES
HIV TESTING AND TREATMENT SERVICES
CARE AND SUPPORT SERVICES
OUTREACH CELL STRUCTURE
Counselor
Community Leaders
Peer Counselor
Outreach Workers

New Knowledge and Skills

A closed and online support group may be used to support individuals to develop the skills, knowledge and social supports necessary to live successfully. These Online, closed and moderated support groups may be very successful, especially for those who lack time due to work commitments. Both of these face-to-face and online options help to impart emotional and social networking skills and opportunities for social support as well as health maintenance skills and guidance. The main areas of focus for these support process for people may include:

Emotional and social skills – peer-engagement that allow for the sharing of feelings and experiences about (a) being diagnosed with and living with HIV and (b) the encouragement of friendships and connections for social support between individuals.

Sexual and Social Skills – peer-led support and education group sessions linked with online support groups that allow for the provision of information on HIV positive prevention, HIV disclosure to partners, family and friends, legal protections for people with HIV and the help available to people living with HIV in Delhi.

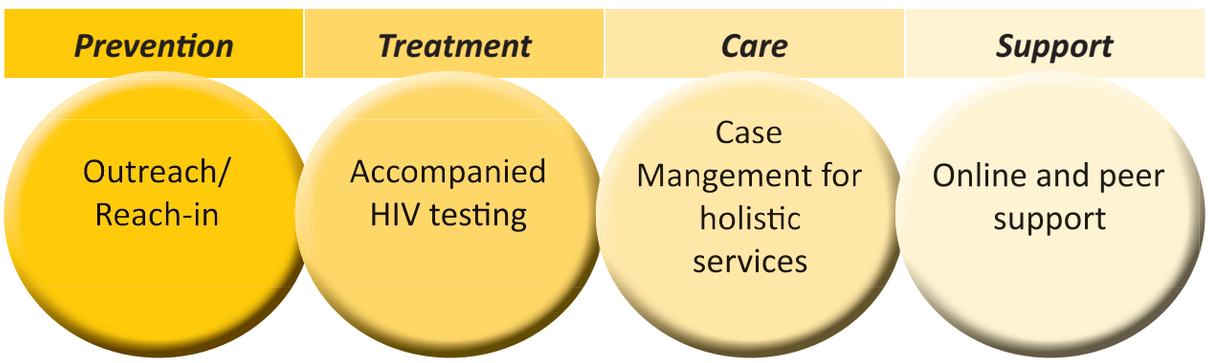
Clinical and Health Maintenance Skills – peer-led education on HIV basics, CD4 count, viral load testing, treatments for HIV, exercise, nutrition, emotional and spiritual Health. Exchange of experiences 'in real time' between people with HIV through online groups helps individuals to cope their emotional experiences better.

Take Home Message

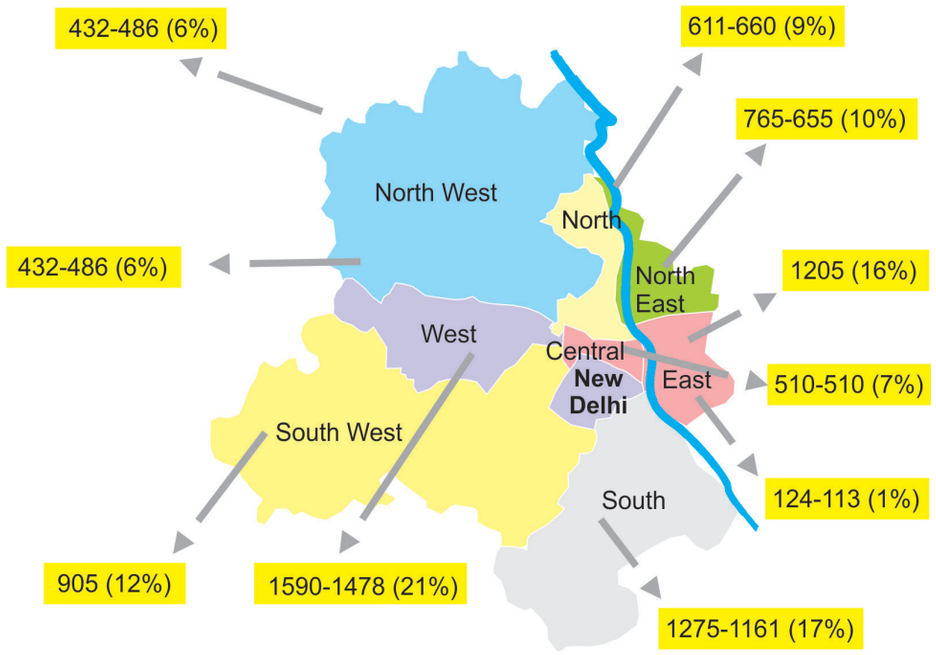
This proposed new approach to HIV prevention uses traditional prevention-outreach techniques that have previously been used in targeted interventions as well as brings new concepts of holistic approaches to enhance the capacity of outreach workers in locating undiagnosed people with HIV and retain them in care. This model incorporates the entire continuum of HIV prevention-to -care. It includes:

1. Outreach to the places key populations meet/ In-reach to HIV diagnosing clinics.
2. Accompanying to HIV testing facilities and being present after post-test counseling.
3. Case management for the newly HIV diagnosed to ensure baseline CD4 result received and HIV treatment initiation where appropriate.
4. Online and group interventions to build health literacy, provide adherence counseling, retain people with HIV in care.

In summary the proposed approaches is presented in the following diagram



District Wise Distribution of TG Population In Delhi



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OUR OFFICES

Registered Office
India Health Action Trust
#13, 1st Floor. 4th Cross
N S Iyengar Street, Sheshadripuram
Bengaluru – 560020, Karnataka
Phone: 080 4093 1045, Fax: 080 2346 9698
Email: ihat.bangalore@ihat.in
URL: www.ihat.in

Delhi
India Health Action Trust
11, 12. 1st Floor, Block-A3
Sector – 5, Rohini
New Delhi – 110085
Tele Fax: 011 4557 5683

Karnataka
India Health Action Trust
Technical Support Unit (TSU)- Karnataka
Karnataka State AIDS Prevention Society
2nd Floor, South Wing, C V Raman General Hospital
80 Feet Road, Indiranagar, Bengaluru- 560038
Phone: 080 25291237
Fax: 080 25291238

Rajasthan
India Health Action Trust
46, Jai Jawan Colony-II, Opp. Sanghi Motors
Tonk Road, Jaipur – 302018
Phone: 0141 2545 057 – 58
Fax: 0141 2545 059

Uttar Pradesh
India Health Action Trust
404, 4th Floor & 505, 5th Floor, Ratan Square
No. 20-A, Vidhan Sabha Marg
Lucknow – 226001
Phone: 0522 4931 777, 4922 350
Fax: 0522 4931 778

India Health Action Trust

India Health Action Trust
Technical Support Unit for DSACS
#11-12, 1st Floor, Block A-3, Sector-5
Rohini, New Delhi - 110085
TeleFax: +91 11 4557 5683
Email: ihat.delhi@ihat.in
URL: www.ihat.in