Best Practices in the Targeted Intervention Programme for HIV/AIDS in Delhi

Best Practices in the Targeted Intervention Programme for HIV/AIDS in Delhi

Publisher
Director, Communications
India Health Action Trust
#11-12, 1st Floor, Block A-3
Sector-5, Rohini, New Delhi 110085, India

Writing and compilation
Dr Parveen Kumar, APD, DSACS
Dr J K Mishra, Joint Director – DSACS
Samresh Kumar, Team Leader – TSU, IHAT
Dr Purnima Parmar, Programme Officer, ELM
Ritumoni Das, Consultant

Support
S N Misra, IAS, Project Director, DSACS
Dr Shajy Isac, Managing Trustee, IHAT

Editorial
Mallika Tharakan, Trustee, IHAT
Shaila M Faleiro, Consultant

Layout and design
129 Degrees Design Studio

Photography
Tom Pietrasik (cover image)
Nazish Mustafa
Shalini Chandra
Shailendra Gandharva
Dr Purnima Parmar
SPACE
Love, Faith & Action Trust (LFAT)

Acknowledgements

The authors wish to acknowledge the contribution of the TI teams at our NGO partners, SPACE, Society for Promotion of Youth and Masses (SPYM), Aarohan, Indian Medical Development Trust (IMDT), Shakti Vahini, Sharan, and Love, Faith & Action Trust (LFAT) implemented these best practices in their projects. Delhi Police lent assistance in setting up and implementing the OST centre at PS Chandni Chowk. Our thanks to the DCP, North District, for inaugurating the centre, and the SHO, Nodal Officer for the centre, for their continued support. Delhi Metro Rail Corporation pioneered the Employer-Led Model in collaboration with DSACS/TSU, coordinated between the DSACS/TSU and the contractors, and facilitated implementation and communication. DAPCU facilitated the initiatives. DSACS/TSU team provided handholding support to the initiatives. Ritumoni Das compiled the data and information. Shaila M Faleiro copyedited the document. The photographs in this document were taken by the DSACS/ TSU team.

Best Practices in the Targeted Intervention Programme for HIV/AIDS in Delhi

Contents

Boxes, tables and figure

Preface

S. N. MISRA, IAS
PROJECT DIRECTOR

एस० एन० मिश्रा, भा० प्र० से०
परियोजना निदेशक

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

दिल्ली स्टेट एड्स कंट्रोल सोसाइटी
राष्ट्रीय राजधानी क्षेत्र दिल्ली सरकार
डॉ० बाबा साहेब अंबेडकर अस्पताल, धर्मशाला खंड,
सैक्टर-6, रोहिणी, दिल्ली -110085
फोन 27055717, फैक्स 27055720

Preface

The National AIDS Control Programme (NACP) provides focused services to communities at high risk of acquiring HIV, such as Female Sex Workers, Men who have Sex with Men, Transgender individuals, Injecting Drug Users, migrant workers and truckers across India. In Delhi, the programme caters to these groups through Targeted Intervention programmes run by DSACS, with technical support from the IHAT Technical Support Unit (TSU). The innovations and best practices of targeted interventions, designed and executed by DSACS/TSU are evident in clubs and collectives, convergence and advocacy, and training programmes.

This document is a compilation of nine such practices initiated by DSACS/TSU and TIs across Delhi. I appreciate the insights they provide for further strategies, and that, they may act as a base for replicable models throughout India. It is definitely a step forward in our fight against HIV to achieve the goal of 90-90-90 by 2020.

(S. N. MISRA)

Message from the Managing Trustee

TSU was started in Delhi in 2014, with a mission to impact public health and development policies through evidence generation and knowledge sharing. Our technical team focuses on identifying and addressing gaps in the existing practices, and providing hands-on support to health facility staff, based on direct experience in the community and the field.

I appreciate the efforts of DSACS/TSU and our TI partners in devising these strategies to extend and improve coverage of highly mobile and vulnerable groups in Delhi. I hope they will enable other states to do the same for similar populations so that we meet the 90:90:90 target by 2020. I would also like to thank the Project Director and Additional Project Director, DSACS, for their continued support to the TSU.

Dr Shajy Isac
Managing Trustee, IHAT

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
CBNAAT	Cartridge-based Nucleic Acid Amplification Test
CSO	Civil Society Organisation
DAPCU	District AIDS Prevention and Control Unit
DIC	Drop-in Centre
DMRC	Delhi Metro Rail Corporation
DOTS	Directly Observed Treatment, Short Course
DSACS	Delhi State AIDS Control Society
ELM	Employer-led Model
EP	Extra-pulmonary
FSW	Female Sex Worker
GIPA	Greater Involvement of People Living with HIV/AIDS
HIV	Human Immunodeficiency Virus
HRG	High-risk Group
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User
IEC	Information, Education and Communication
MCD	Municipal Corporation Delhi
MSM	Men Who Have Sex with Men
NACP	National AIDS Control Organisation
NCPI	National Coalition of People Living with HIV in India
NDTB	New Delhi Tuberculosis Centre
NGO	Non-governmental Organisation
ORW	Outreach Worker
OST	Opioid Substitution Therapy
PE	Peer Educator
PLHIV	People Living With HIV
PPP	Preferred Private Provider
PS	Police Station
RNTCP	Revised National Tuberculosis Control Programme
SHO	Station House Officer
SPYM	Society for Promotion of Youth and Masses
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TG	Transgender
TI	Targeted Intervention
TSU	Technical Support Unit
UNAIDS	United Nations Programme on HIV and AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organization

Introduction

Background

HIV/ AIDS has been a major public health concern for both developed and developing nations since 1980. According to 'The Gap Report' by UNAIDS, India ranks third globally in the number of people living with HIV.[1] To address the problem, the National AIDS Control Organisation (NACO) drafted a national policy on HIV/AIDS prevention, a key strategy of which involves targeted interventions (TIs) for high-risk groups, i.e. female sex workers (FSWs), men who have sex with men (MSM), transgender people, injecting drug users (IDUs), migrant workers and truck drivers. As unsafe sex is a major cause of HIV transmission, the programme includes a massive effort to raise awareness about safer sexual practices, HIV testing, and treatment, and to create accessible and affordable public health services.[2]

This report details nine practices employed by DSACS and IHAT-TSU in cooperation with government departments and ministries, and through public-private partnerships and research, that exceptionally boosted service uptake and reduced stigma. The TI extends beyond clinical needs to encompass the social determinants of health (*Box 1: What is health?*). By reaching out to these high-risk groups (HRGs) and their partners, it maximises coverage through flexibility, collaboration, innovations, and public-private partnerships.

Box 1: What is health?

Health is "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity".
– WHO

Objectives

As accurate documentation, particularly of large-scale initiatives (*Box 2: Figures at a glance*) helps improve our understanding of risk reduction, the objectives of this document are to:

1. Document best practices for reaching HRGs.
2. Present models of functioning that can be replicated by other organisations.
3. Address the very important aspect of convergence of public departments within and across health sectors.
4. Help identify innovations and new areas for HIV intervention.
5. Help create and establish better community outreach programmes, and achieve high performance targets.
6. Set milestones to improve the quality of intervention services.
7. Assess and enhance programme monitoring indicators.
8. Increase the extent of collaboration between the private and public sectors.

Box 2: Figures at a glance

Number of TIs in Delhi: 79

Coverage

- **FSWs:** 40,665
- **MSMs:** 13,020
- **TGs people:** 5,647
- **IDUs:** 9,738
- **Truck drivers:** 50,000
- **High-risk migrants:** 1,95,000

Best practices of TIs for HRGs

The best practices included in this document have increased registrations at Directly Observed Treatment, Short Course (DOTS), extended community outreach through social security schemes and innovations, pushed employer-led models (ELMs) towards public-private partnerships, and helped identify new trends in sex work through research that will facilitate exploration into better intervention strategies. These best practices, based on TIs in Delhi, pertain to:

1. Strategies to cover virtual networks of FSWs.
2. Community mobilisation and engagement of transgender people.
3. Advocacy for social entitlements for the transgender community.
4. Scaling up enrolment of transgender people living with HIV in ART care.
5. HIV prevention intervention with the Delhi Metro Rail Corporation (DMRC).
6. Working with sex partners of IDUs.
7. Multi-stakeholder involvement in scaling and strengthening Opioid Substitution Therapy (OST) services in Chandni Chowk, Delhi.
8. HIV prevention interventions with the urban homeless.
9. Linkages with the Revised National Tuberculosis Control Programme (RNTCP).

[1] http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap report_en.pdf as accessed on 02/09/2017.
[2] HIV data available at: http://www.naco.gov.in/sites/default/files/HIV%20DATA.pdf as accessed on 02/09/2017.

01

Strategies to Cover Virtual Networks of Female Sex Workers

Context

The increased use of mobile phones, Internet and social media has led to a drastic change in the pattern of female sex work in Delhi, with traditional hotspot-based networks being replaced with virtual ones. The emergence of these new networks has increased the challenge of reaching out to individual FSWs. Consequently, a qualitative study was conducted to explore the trends and act as a foundation for further strategies.

Method

The study used participatory research methodology with TI programme staff, peer educators (PEs), pimps, FSWs, and secondary and tertiary stakeholders (*Box 3: Primary data sources*).

Box 3: Primary data sources

Focus Group Discussions

- **FSW TI staff** (118 individuals): 21
- **FSW community** (52 women): 6
- **Pimps** (108 individuals): 12
- **PEs** (144 individuals): 16
- **Clients** (15 individuals): 2

In-depth Interviews

- **TI project managers:** 11
- **TI ORWs** (57 individuals): 9

Sensitisation meetings with pimps: 8

Findings

An assessment of the shift of street- and home-based sex workers into virtual networks revealed critical information, particularly with regard to reaching young and vulnerable FSWs, as they are no longer available at the traditional hot spots. The findings and challenges are listed below.

1. There is a greater focus on business networking. Mobile usage has enabled people to share information immediately. Physical networking has decreased while secrecy and anonymity has increased. This has reduced the level of mutual support and collectivisation, and significantly increased vulnerability.
2. Improved transportation in Delhi as a metro city has increased mobility.
3. Pimps form the fulcrum of the changing pattern of sex work, acting as brokers between the sex workers and their clients. A large number of young, new sex workers were observed to be working with them.
4. The PE approach is no longer as effective as it was in the past.
5. The majority (83%) of pimps in contact with the TIs are female. Mobility is high among network-based FSWs, with 72% moving in and out of the state regularly. Seventy per cent of network-based FSWs are below the age of 22 years. Of these, 65% are unmarried, earning members of their family. Eighty per cent are literate and accustomed to the use of smart phones and apps.

Strategies

The following strategies have been adopted to identify and provide services to this population on the basis of the assessment:

1. Intra- and inter-pimp networks facilitate lucrative business dealings, such as providing or exchanging sex workers as the occasion arises. A record was made of the pimps in the area, the number of FSWs with each, and the monthly number of FSWs working with each pimp. It was found that there were 672 pimps and 10,710 FSWs working with them. About 1,742 (16%) of FSWs circulate every month. Sensitisation meetings about the HIV/AIDS programme are conducted regularly to establish better rapport and motivate the pimps, who control the FSWs, to encourage the women to seek services and use the condoms provided by the TIs.
2. As the PE approach is no longer very effective with this population, outreach workers (ORWs) approach the pimps directly to register the FSWs with them. This has increased registration of young and vulnerable FSWs.
3. The human resource allocation and outreach plan was modified on the basis of the risk and vulnerability assessment and exposure to the TI programme. ORWs reached out regularly to FSWs found to be at greater risk during the quarterly risk and vulnerability assessment. Those at lower risk or who had demonstrated behaviour change by availing services independently or after exposure to the programme were contacted once a month via mobile.

These new strategies have decreased the time the TI programme takes to reach women after their initiation into sex work (*Table 1: Changing patterns in average age and initiation into sex work among newly registered FSWs*).

Table 1: Changing patterns in average age and initiation into sex work among newly registered FSWs

	Indicator	Years
Average age at registration	FY 2015—16	26.1
	FY 2016—17	24.5
	Until September FY 2017—18	22.7
Average years in sex work at registration	FY 2015—16	2.6
	FY 2016—17	2.2
	Until September FY 2017—18	1.4

Recommendations

1. There is a need to identify and reach out to hidden networks of FSWs.
2. Capacities of pimps with regard to message delivery referrals and condom education must be built in order to reach out to FSWs effectively. Condom education and distribution must be linked to a pimp-centred strategy.
3. Digital media must be used for information, education and communication (IEC), behaviour change communication (BCC), programming, referrals, and social media to collectivise the community. Reporting must be simplified. Mobile apps may be devised for reporting, tracking and analysis.
4. Development and linkages with satellite preferred private provider (PPP) clinics must be revamped to address STI care for the community.
5. HIV screening may be decentralised through the use of whole blood test technique and capacity building of TI staff. A referral system may be used for HIV confirmatory tests.

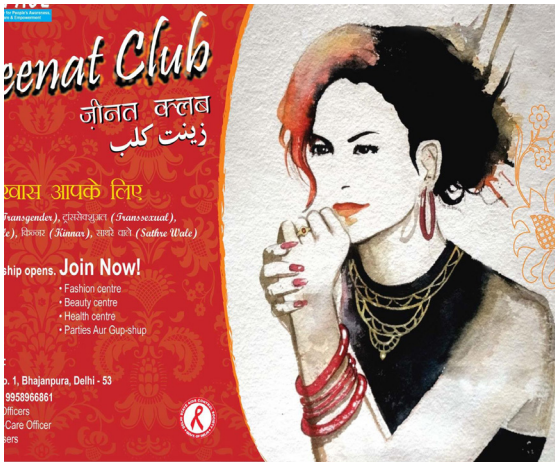
02

Community Mobilisation and Engagement of Transgender People

Context

Mobilising the transgender community has always been a challenge because of the community's lack of interest, their time constraints, the stigma of being associated with NGOs working on HIV/AIDS, and most importantly, their lack of engagement with the programme. In response to these challenges, DSACS initiated a TI project exclusively for transgender people at risk in North-East Delhi, in partnership with SPACE, a civil society organisation.

The Zeenat Club, Delhi's first TI programme for transgender people was launched to reduce the stigma and discrimination attached to HIV/AIDS and to associating with NGOs in that field. In addition to HIV/AIDS-related services, the Zeenat Club offers services in grooming, dress design, boutique and weight management. Registered members can avail these services free of charge. Events are periodically organised both to mobilise as well as keep the community engaged in the programme's conceptualisation, planning and execution. This participatory approach has proved very successful.



A branding poster for the Zeenat Club advertising the skills it provides to help reduce stigma and discrimination against transgender people

Response

1. Zeenat helpline: In the wake of the gang rape of a woman in a moving bus in Delhi in 2012, the members of the Zeenat Club set up a helpline for women and trans women in distress.
2. Advocacy: Advocacy forms a key part of the project, carried out every quarter with the community's senior leaders or gurus, and the police. Major events and activities are covered by the media to sensitise the public about the community's issues. On Raksha Bandhan, for example, a team from the club went to the office of the Union Minister for Social Justice and Empowerment and to police stations, to tie rakhis and build a rapport with these stakeholders.
3. IEC materials: Community members design posters for IEC and advocacy.
4. Skills building: Training in line with members' aspirations and interests, such as choreography, catwalk, communication, social interaction, and general grooming, is offered to boost their confidence.
5. Crisis Intervention Team: The very active Crisis Intervention Team has systems in place to deal effectively with medical crises, violence, death and cremation during the day as well as at night. Their commitment has been upheld as exemplary to other TIs.
6. Engaging external agencies: The support of agencies such as UNESCO, UNAIDS and the Netherlands Embassy was engaged to support soft skills development for Zeenat Club members, organise community events and facilitate regular service uptake.
7. School-based transgender sensitisation: SPACE began an initiative to reach out to school principals, teachers and students on transgender rights, and make schools inclusive and safe for transgender students. A booklet meant for teachers and students was also released.
8. Innovative community engagement and mobilisation: Several events have been organised to mobilise the community and increase membership of the Zeenat Club. These include:
    a. Super Queen beauty contest with transgender contestants: This first-ever event attracted over a thousand participants from Delhi, NCR, Jaipur, Meerut and Sonipat.
    b. Sitare Zameen Par: This event was hosted at a large club in Connaught Place, New Delhi, in honour of community workers who work in the field of HIV/AIDS despite the challenges. More than 1,200 community members participated.
    c. Sai Sufi Sandhya: This event was to inaugurate the new community centre allotted to the organisation by the Municipal Corporation of Delhi (MCD). The event was inaugurated by the then Law Minister, Kapil Sibal.
    d. Sapno ki Baraaat: A grand fashion show on the theme of 'I celebrate who I am' was organised to launch a skills development project for the community. Thousands of trans people participated, and the project, supported by the Netherlands Embassy, was widely covered by the media.
    e. Dil Dhadakne Do: A swayamvar is organised every Valentine's Day to celebrate the relationships of transgender members and their partners.[3]


Redefining
FREEDOM
Beyond Biases
ZEENAT CLUB

A local newspaper carries the story of Zeenat Club members

Outcomes

The Zeenat Club concept has had successful outcomes at multiple levels. These include:

1. Increased engagement: The club has 1,190 members who take pride in their membership, as it has lent dignity and recognition to the community.
2. Increased opportunities: Modelling agencies and the well-known fashion designer Anupama Dayal have approached participants of the fashion shows and beauty contests. Some of them are now models and others have received prominent media coverage in India and abroad.
3. Increased registrations: This strategy has been so successful that all the transgender members of SPACE have tested for HIV. All those who tested positive have registered with the ART centre because of the trust and rapport they have with the staff.
4. Increased sensitivity and mainstreaming: Successful advocacy has led to first-ever initiatives, such as skills development courses for mainstreaming, and sensitisation to make education accessible to the community and to reduce transphobia in schools.

Recommendation

It is crucial to engage with community leaders regularly, as they play a key role in encouraging service uptake and encouraging healthy outcomes for community members.

[3] In ancient India, a *swayamvar* was a practice in which a girl of marriageable age chose a life partner from among several potential suitors.

03

Advocacy for Social Entitlements for the Transgender Community

Context

The transgender community is marginalised by poverty, stigma, discrimination and the mainstream population's lack of awareness about them. Their access to healthcare is constrained by inadequate understanding of their health needs, and harassment and denial of care by healthcare providers. Aarohan, an NGO working in Delhi's Sultanpuri and Mangolpuri areas, has devised strategies to increase reach and mobilise transgender individuals to avail TI services. The TI programme currently has 766 registered members.

Response

When early efforts to mobilise the community by organising mega events proved unsuccessful, a survey was conducted with a sample size of 200 transgender individuals. Of these, 155 respondents said they had no official ID or access to ration cards or welfare schemes, such as the Pradhan Mantri Jan-Dhan Yojna. The TI team collaborates with the NGO CFAR to advocate for documentation and social entitlements for the community. The activities include:

1. Advocacy with key authorities for pension and ration card schemes.
2. Advocacy with the Department of Women and Child Development on sexual harassment.
3. Advocacy with magistrates to issue Aadhar cards, caste certificates, birth certificates and income certificates with easy or no documentation.
4. Imparting financial literacy to members of the community with regard to banks and schemes.

Outcomes

The outcomes of this initiative have been particularly significant as the transgender community is one of the most stigmatised and marginalised in India. By helping them procure official ID, the TI has enabled community members to access social entitlements thus far beyond their reach. This in turn has increased their involvement in the TI, and their willingness to avail its services.

1. The data suggests that reach and service uptake have increased after advocacy with the various departments (*Table 2: Increase in social entitlements*).
2. The initiative has improved rapport and acceptance by the community, thereby increasing the clinical footfall and number of attendees at the Drop-in Centre (DIC).
3. It has led to official recognition of the third gender, which in turn has increased self-confidence.

Table 2: Increase in social entitlements

Schemes	Number received
Aadhar card	252
Voter card	142
Ration card	40
Pradhan Mantri Jan Dhan Yojana	90
Birth/ death/ income/ caste certificates	32

Lessons Learnt

1. The primary lesson regards the importance of collaborating with other agencies and organisations.
2. It is essential to identify and understand the needs of the community to address the barriers to service uptake.
3. Action to meet the stated needs of the community helps build the TI's credibility and its acceptance by the community, thereby increasing uptake of check-ups and other services.

Recommendations

1. Rather than work in isolation, departments must collaborate with each other for outreach.
2. The community must be included in the process of intervention. In this case, the need for advocacy emerged from community members who were included in the evaluation process.
3. There must be a focus on needs beyond HIV to enable the community to protect themselves from other diseases as well.

A transgender community member at an Aadhar camp


Delhi's transgenders get to assert their identity—and their pride...

...And sex workers get entitlements they never knew they had

25-yr-old Deepika said the day she decided to assert her transgender identity, things started becoming difficult, leading up to her having to leave home. Now that she has a voter's card, Deepika hopes her transgender identity will reflect in her school certificates too

Print coverage of the social entitlements initiative

04

Scaling Up Enrolment of HIV+ Transgender Individuals into ART Care

Context

As mentioned earlier, the Zeenat Club has helped TI staff and community members establish a strong rapport that has increased community mobilisation and service uptake. In its first year of operation, about 25 of 236 transgender people who tested were found to be HIV positive. Their reluctance to register at the ART centre, either independently or via the TI, created gaps in the ART linkage. Currently, 124 of 800 transgender people who have tested positive are registered with the SPACE TI and linked with the ART centre. HIV positivity in this project stands at 15.5%.

Mobilising HIV positive individuals into ART care has proved a major challenge for the SPACE TI. The majority of those diagnosed were unwilling to accept their HIV status. While some were less perturbed, a large number became depressed, anxious and suicidal. They believed that treatment would be lifelong, and that it would affect their hormone therapy. They were also deterred by the prospect of their community leaders and partners learning of their illness, of taking four or five full days off to register into ART care, having to wait in long queues, the short hours for sample collection, the limited availability of the CD4 testing machine, the time it takes to receive reports, being harassed and delayed for work, and the impact on their relationships from repeated visits to the ART centre. Another crucial stumbling block was that most of them did not have any ID or address proof, which is mandatory for ART registration.

Response

The response was planned on the basis of inputs from community members themselves. These include:

1. Emphasis on confidentiality: As client confidentiality is the single most important factor in building trust, particularly in the transgender community, it is critical to emphasise it at every step of the process. Every member of the SPACE TI staff is required to sign an oath of confidentiality at the outset, and to understand that the organisation has zero tolerance for breaches in this regard.
2. Greater Involvement of People Living with HIV/AIDS (GIPA) sessions: SPACE organises monthly sessions with HIV positive speakers at the DIC to help community members living with HIV understand HIV- and ART-related issues, and the importance of ART linkages and adherence. Many members seek personal counselling after the sessions.
3. Home visits and personalised care: The SPACE TI team visits HIV positive members of the community at the latter's convenience, to discuss healthcare and regular medical check-ups on a one-to-one basis. These visits play a vital role in building rapport with community members and leaders, and in increasing service uptake.
4. Effective leadership: Strong leadership and regular guidance by the management has upheld staff morale in turbulent times. Specialised training for staff on confidentiality, and commitment to HIV prevention, care and follow up has resulted in 100% follow up with the clients.
5. Immediate follow up: The SPACE TI promptly addresses gaps between HIV detection and ART registration. HIV positive individuals are brought into the DIC as soon as they receive their test reports from the Integrated Counselling and Testing Centre (ICTC). They are accompanied to the centre by a staff member early the next day. The confidentiality measures, need for positive prevention and importance of linking with ART care was discussed in detail.
6. Counselling: Clients receive confidential, in-depth counselling about the benefits and side effects of ART and how they can avail free ART drugs that enhance positive living.
7. Conveyance support: The SPACE TI has mobilised the financial resources to cover the travel costs of HIV positive clients so that they can go regularly to the centres.
8. Aadhar card facilitation: The SPACE TI has facilitated the community's access to Aadhar cards, which are the Government of India's primary photo ID. This has been particularly useful to those who require ART.
9. Certification of address: A basic requirement for ART registration is proof of address. The SPACE TI certifies the address of HIV positive clients on its NGO letterhead.
10. Regular visits to the ART centre: SPACE TI staff regularly visit the ART centres to link and register transgender clients living with HIV. These visits maintain rapport with the ART staff, and enable the TI team to take note of clients' CD4 count and date of follow up.
11. Accompanied referrals: Accompanied referrals were initiated to reduce the delay in ART registration and support scaling up of the initiative.

Outcomes

1. Improved linkages with pre-ART care: Regular support and consistent follow up with HIV positive transgender individuals has resulted in all 124 people diagnosed HIV positive being linked with pre-ART care. Of these, 57 are on ART drugs. The 30—90 day gap between HIV diagnosis and ART registration has reduced to 7—11 days.
2. Stable CD4 counts: Accompanied referrals, regular visits to ART centres, home visits and certification of address have also helped clients with HIV to maintain stable CD4 counts.

Lessons Learnt

1. Confidentiality, counselling and confidence-building measures are invaluable to enabling HIV positive transgender people to cope with the depression, denial and trauma that commonly accompany a positive diagnosis. These measures help them realise that HIV is not a death sentence, and that ART care makes it possible to live well.
2. Prompt referrals are critical to ensuring ART linkage and reducing dropout.

Recommendations

1. Accompanied referrals to the ART centre should be carried out immediately after a positive diagnosis to minimise the chances of omitting clients. This has proved to be the most effective method of referral.
2. The commitment, dedication and attitude of the TI team and ART staff towards the community is crucial to achieving 100% linkage.
3. The concept of enlisting positive speakers to urge clients to link to ART care should be replicated across projects.

05

HIV Prevention Intervention with Migrant Workers of the Delhi Metro Rail Corporation

Context

Migration is a burning issue in the health sector, particularly with regard to HIV transmission in high-risk migrant communities. Regardless of whether a company or association operates in a low- or high-prevalence country, HIV/AIDS can strike if its workforce is at risk. Both the organised and the unorganised sectors are vulnerable to HIV/AIDS as the virus affects the most productive age group. This segment of the document deals with interventions adopted by IHAT-TSU for migrant communities in Delhi, a preferred destination for about 3,00,000 seasonal migrant labourers involved mainly in construction, casual labour and industries. Studies show that this population has a significantly higher risk of HIV infection (*Box 4: HIV/ STI risk among migrant workers, 2012—13*).[4]

The ELM described in this chapter was initiated in 2015, with the Delhi Metro Rail Corporation (DMRC), which has the equal equity participation of the Government of the National Capital Territory of Delhi (GNCTD) and the Central Government to construct and operate a Mass Rapid Transport System (MRTS). Construction is carried out by L&T, Pratibha, JVV, ITD, AFCONS and Hindustan Construction Ltd. Each of these contractors employs large numbers of migrant labourers from Bihar, Uttar Pradesh and Madhya Pradesh.

Box 4: HIV/STI risk among migrant workers, 2012—13

Temporary/ short-term migrants who visit commercial sex workers: 40%

Condom use among these: 25-29%

STI prevalence among male migrants: 5%

STI prevalence among female migrants: 13%

[4] Annual Action Plan, Delhi State AIDS Control Society, FY 2016-17.

Response

Phase three of DMRC construction employed 29,000 workers through its contractors. These workers change frequently, usually moving out of Delhi every quarter as new labourers join the contractors. The following activities were conducted as part of the TI for DMRC:

1. Phase 1: Sensitisation meetings across sites to enable senior managerial staff and partner companies of DMRC to implement the ELM smoothly.
2. Phase 2: Mass awareness programmes using videos, meetings and street plays at most DMRC sites.
3. Phase 3: Training of trainers to enable safety officers and paramedical staff to conduct HIV/AIDS awareness sessions for the workers during their safety/ toolkit sessions. Implementing the programme through trained trainers increases the referrals to the ICTC, and HIV testing through the mobile onsite testing facility, Mitwa.
4. The roles of the stakeholders were ascribed as follows:
    a. DSACS/TSU: Conducting training and awareness programmes, providing IEC materials, handholding to strengthen the programme.
    b. DMRC: Coordinating between DSACS/TSU staff and the contractors, facilitating implementation and communication.
    c. Contractors: Logistics, facilitating implementation of HIV/AIDS activities, conducting regular awareness sessions by trained trainers and peer leaders during safety sessions, sharing IEC materials and videos with the workers.

Outcomes

1. Equipped 96 senior officers and contractors to act as master trainers who can continually orient workers on HIV prevention.
2. Medical officers and paramedical staff were trained at 12 major DMRC sites.
3. A master trainer conducts weekly/monthly sessions on HIV prevention for workers at each site. About 1,39,250 workers have already been covered. The awareness activities are ongoing and continue into phase four of metro construction with more focus on testing and treatment.

Lessons Learnt

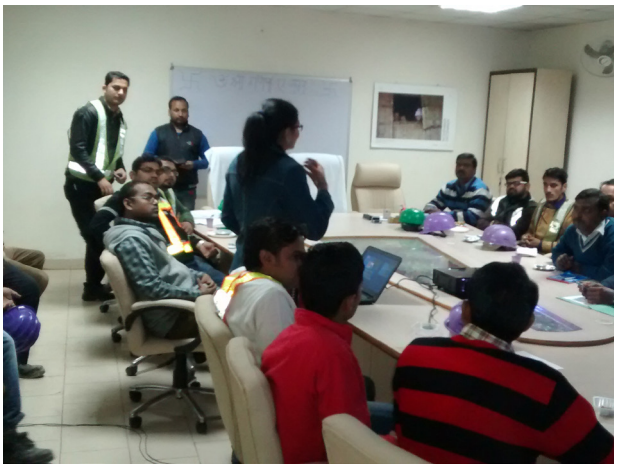
1. Sustained advocacy with the employer is necessary for programme success. DMRC's consistent commitment and support, born from continual advocacy, has been vital to the programme's success. The awareness programme currently covers about 1,20,000 construction workers annually. DMRC has elicited the support of its contractors for master training and sensitisation workshops for senior officials.
2. Regular follow up with contractors has helped integrate HIV prevention sessions into the weekly safety sessions.
3. Efforts were made to extend HIV testing services through mobile vans during awareness programmes at DMRC sites but it was found that the workers have no time to visit the ICTC nearby. The IEC material on HIV prevention was distributed during these awareness and training sessions.

Recommendations

1. Coverage of the HIV prevention programme in the NCR region must be increased.
2. Regular advocacy and follow up with DMRC and their contractors must be continued.
3. Sensitisation and training must be conducted every six months to maintain steady availability of master trainers.
4. There is an urgent need to improve HIV testing services and referral mechanisms at the sites.
5. Integration of IEC with DMRC must be prioritised.

Awareness programme at DMRC, Hauz Khas

Awareness programme at DMRC, Naraina Vihar



Training of trainers at DMRC

IEC materials at DMRC clinic

HIV testing camp

Taking the pledge on World AIDS Day

06

Multi-stakeholder Involvement in Scaling and Strengthening an OST Centre

Context

Chandni Chowk, one of Asia's largest commercial hubs, attracts thousands of daily wage labourers, rickshaw pullers, rag pickers and beggars, many of who are migrant workers. It is also a concentrated hotspot for IDUs, many of who are homeless and found begging for food, harassing shopkeepers or engaging in petty theft near the metro station, Shani Mandir, Gurudwara Sheeshganj and Old Delhi Railway Station. In 2014, shopkeepers and market associations in the area contacted the police and NGOs to control the crime rate associated with them. The Deputy Commissioner of Police (DCP), North Delhi, subsequently approached DSACS to initiate welfare services for the IDUs in the area.

DSACS began providing harm reduction services through a TI in partnership with the Society for Promotion of Youth and Masses (SPYM) and the Love, Faith & Action Trust (LFAT). As OST services and health facilities were unavailable in the area at the time, DSACS launched a pilot model project at Police Station (PS) Chandni Chowk in February 2015, in collaboration with Delhi Police and SPYM. Its purpose was to address the challenges that homeless IDUs face in accessing services, and engaging and retaining them in the OST programme, thereby helping lower the petty crime rate among them.

Response

1. Selecting a site: A detailed feasibility assessment was conducted in the Chandni Chowk area. As suitable facilities for an OST centre did not yet exist and the IDUs in the area were unwilling to go to OST centres in hospitals, the DCP agreed to provide space for one at PS Chandni Chowk.
2. MoU with partners: An MoU signed by DSACS, Delhi Police and SPYM stated the role of each stakeholder in the OST centre (*Figure 1: Stakeholder responsibilities at OST centre, Chandni Chowk*).

Figure 1: Stakeholder responsibilities at OST centre, Chandni Chowk

3. Sensitising police: Police personnel at PS Chandni Chowk were oriented to the programme, the status of IDUs in their area, and about how they can facilitate access to services at the centre.
4. Training OST staff: The National Drug Dependence Treatment Centre (NDDTC) managed by the All India Institute of Medical Sciences (AIIMS) conducted a five-day intensive training programme on OST service management for centre and TI staff.
5. Establishing a DIC-OST centre: The OST centre was set up in portable cabins at PS Chandni Chowk. A separate DIC was set up for recreation and rest, OST registration, counselling, medical consultation and dispensary. A doctor, auxiliary nurse midwife (ANM), counsellor and data manager were appointed to manage the centre's day-to-day functioning.

OST centre, Chandni Chowk

6. Community meetings: Clients are counselled, regularly sensitised about OST uptake and harm reduction services, and encouraged to link other IDUs to the DIC. Films on HIV prevention and harm reduction are screened and food provided by the gurudwara at the DIC.
7. Handholding support: A programme officer from TSU visits every month to support planning, implementation and reporting in line with the established protocol.
8. Stakeholders meetings: Regular consultations are conducted with the SHO at PS Chandni Chowk, TI staff, market associations and NGOs to discuss performance and resolve any issues.

Outcomes

1. The OST centre was set up in February 2015. In the first month there were 33 registered IDUs.
2. By March 2016, there were 126 registered IDUs.
3. By March 2107, there were 183 registered IDUs, i.e. almost all the IDUs in the Chandni Chowk area.
4. About 105 clients (57%) avail OST on a regular basis.
5. Petty theft complaints have decreased by about 20%.
6. Active clients are provided lunch at the DIC by the neighbourhood gurudwara.

Lessons Learnt

1. The participation of the police, market associations and TIs must be well coordinated for maximum coverage.
2. Efforts must be made to retain the IDUs in OST and engage them constructively.

Recommendations

1. Community meetings must be frequently organised to continually motivate people at risk to opt for OST.
2. Outreach services must be strengthened for follow up to ensure that clients continue availing the services.
3. Informal education and vocational training must be offered at the DIC so that people are constructively engaged and motivated to opt for OST.
4. Linkages with nearby hospitals should be strengthened to deal with emergencies.
5. The possibility of support from market associations should be explored both for health-related needs as well as other requirements, such as transportation to the ART centre and night shelters.

07

Working with Sex Partners of Injecting Drug Users

Context

In this context, sexual partners of IDUs include spouses living with them as well as others with whom they have regular sexual relations. It does not include non-regular or casual partners.

As a group, IDUs have among the highest HIV prevalence (21.8%) in Delhi. Although the probability that they will transmit HIV to their sexual partners is high, they often keep their partners in the dark about their usage. Furthermore, as they tend to be reluctant to talk about their sex partners, it is difficult for PEs and ORWs to identify and set targets for intervention with them. Another challenge to intervening with their partners is the difficulty of convincing them of the need for preventive or treatment services – many of them are in denial about their vulnerability and to the possibility that they may be infected.

Although data about their condom use, sex partner profile, marital status and children is limited, studies indicate that of 819 IDUs registered in the current TI, 341 have regular partners. Many married as well as unmarried IDUs reported having multiple sex partners. Some had their sexual debut before the age of 15 years.

Response

Reviewing the profile of IDUs in the context of their sexual partners is a key preparatory step to identifying and classifying them, preparing for potential challenges, and setting targets for the programme.

1. Discussions about HIV services for the sex partners of the users are always initiated with the users themselves as they may be unprepared for the consequences of revealing their drug use status to their partners.
2. The next step is to meet the user in an environment they consider safe, and discuss their drug use status, whether they have revealed or are ready to reveal it with their partners, their vulnerability to HIV/ STIs, and the services offered by SPYM.
3. After the user reveals their status to their partner, a meeting is arranged with the user, partner and ORW, PE or other staff. The concerned staff reviews the user's profile again, and carries their identity card, IEC material and other resources required for the discussion. It is advised that one male and one female member of staff be present at the meeting. A phone call confirming the meeting with the user, and the supervisor informed in advance about the visit.
4. Meetings with the partners begin on a general note. They then progress to information on the organisation's services, vulnerability of HIV/STIs, assessing one's own vulnerability, and discussions on who else in the family could be involved. Finally, the organisation's contact number and address is shared for follow up.
5. Follow up is carried out to discuss progress since the previous meeting, and to continually remind the user of the availability of services.
6. The partners are assisted with registration and uptake of services. Regular follow ups are conducted to ensure that services continue to be availed.

Outcomes

1. About 308 sex partners of IDUs are currently registered in the project.
2. Programme data from September 2017, indicates that last time condom use with regular sexual partners was 35%. Data on regular sex partners, number tested, number tested positive, and ART enrolment and referrals has not yet been gathered.

Lessons Learnt

1. Many sex partners of IDUs who have children voiced their concerns about their children.
2. Some sex partners are aware of their partners' drug use behavior but have no idea what to do about it.
3. Consistent condom use with sex partners is still quite low.
4. Identifying and profiling IDUs helps in planning, motivating and meeting their partners with a set plan.
5. It generally requires multiple visits to convince the sex partners that they require HIV preventive services.

Recommendations

1. IDU profiling should be done by updating their profiles after discussion with other staff rather than by simply referring to the master sheet.
2. Key family members who can support the user should be identified by the individual or the partner, rather than by the PE or ORW.
3. Venues for meetings with users and their partners must be proposed by the user or the partner rather than the PE, ORW or any other member of staff.
4. Home visits or meetings with the user are best conducted by a male and female PE or ORW, rather than a single person.

08

HIV Prevention Intervention with the Urban Homeless

Context

Homelessness is a major problem in Delhi. According to the *Hindustan Times*, three districts in the state — Central Delhi, New Delhi, and North Delhi— rank third, fifth, and sixth, respectively, in homelessness in the country.[5] A large number of the urban homeless are involved in unsafe sex work and drug use. While the TI in Delhi covers active IDUs and sex workers, this population, and the partners of people in this population, require immediate attention. However, their constant mobility and lack of official ID make it difficult to devise strategies for them. In response to this challenge, an innovative initiative to reach homeless people in night shelters was launched by DSACS and the Central Delhi district authorities.

Response

1. The district authorities provided information on the night shelters in Central Delhi. The people living there were identified, and an estimate of the number of people living in shelters across the state was derived.
2. Awareness sessions and counselling on HIV/AIDS was organised under the supervision and monitoring from DSACS.

[5] http://www.hindustantimes.com/delhi-news/homelessness-census-data-shows-three-of-india-s-worst-six-districts-in-delhi/story-xwTd5kl2R3eEFs4TJyLOoM.html as accessed on 09/09/2017.

Outcomes

1. Awareness and counselling sessions were held in 18 night shelters in Central Delhi in January and February 2017, under the direction of the Additional District Magistrate (ADM), Central Delhi. The awareness programme was one of a kind and has subsequently been extended to IDUs and other occupants of night shelters.
2. About 556 night shelter occupants have benefitted from the activity. Of these, 84 were already aware of their HIV status; another 86 were referred to testing.
3. The initiative's awareness sessions will link occupants of night shelters with health facilities.
4. The innovation drew attention to the intervention when it was covered by the print media.

PRESS MONITOR

Hindustan Times, Delhi
Tue, 31 Jan 2017, Page 4
Width: 13.34 cms, Height: 23.84 cms, a4, Ref: 20.2017-01-31.27

Awareness initiative at night shelters to help HIV+ occupants

Parvez Sultan
parvez.sultan@hindustantimes.com

NEW DELHI: To identify HIV positive occupants at the night shelters in central Delhi, the district administration has initiated an awareness drive in collaboration with the National Aids Control Organisation (NACO).

Counselling sessions are being organised at the shelters in which the occupants are convinced to undergo tests and if found positive, they will be taken for treatment.

This initiative is being coordinated by District Disaster Management Authority (DDMA).

Pravesh Ranjan Jha, additional district magistrate, Central District, said the exercise has started yielding results as 32 cases have been referred to Integrated Counselling and Testing Centre (ICTC) for HIV counselling and testing. At least 20 homeless have already undergone screening for HIV. The results are awaited.

"It will take time to ascertain how many of them have been found HIV infected," he said.

The drive was started two weeks ago and 12 sessions have been held so far in which over 400 homeless persons were counselled.

There are 58 night shelters in the district. The official added if one is found HIV infected, free medicines are made available to them.

The district covers ISBT Kashmere Gate, Daryaganj, old Delhi Railway Station, Sadar Bazaar, Karol Bagh, Rajinder Palace, Yamuna Pushta and Shastri Nagar area.

The homeless staying in the shelters are prone to having unsafe sex. The drug addicts often use infected syringes, which aids in spreading HIV.

"We are trying to create awareness through write-ups, graphics and picture, which are easy to understand as most of them are not educated," Jha said.

"Majority of them use the same syringe to inject drugs multiple times. We refer to Integrated Counselling and Testing Centre's located in the district without Out Patient Department slips. This is helpful because they don't have any identity proof. Apart from free medicines and treatment, they are given monthly financial grant of ₹1,000 as per the rule," he added.

Hindustan Times coverage, 31 January, 2017

Lessons Learnt

1. People who use night shelters are usually in extenuating circumstances that increase their vulnerability to HIV.
2. A programme for such a mobile and hard to reach population must be innovative.
3. Coverage must be through vigorous outreach and services, especially at night, when most of the population is available.
4. It is possible to provide multiple services such as awareness, testing, referrals, and possibly ART services in the future, as large numbers of people live in night shelters.

Recommendations

1. Sustained collaboration with other departments such as social welfare, police, slum improvement boards and organisations that run night shelters, will help improve the programme's effectiveness and efficiency.
2. This activity should be extended throughout the state.

Awareness sessions at a night shelter in Central District, New Delhi

09

Active Case Finding Campaign for Tuberculosis

Context

India has the world's second largest population of individuals estimated to have HIV-associated TB (*Box 6: HIV-associated TB occurrence in India*). FSWs, particularly those in brothels, and IDUs, generally live in conditions that increase vulnerability to tuberculosis (TB), such as poverty, unemployment, overcrowded or poorly ventilated housing, social deprivation, poor social capital, imprisonment, homelessness, malnutrition, smoking, stress, HIV infection and lack of access to healthcare.[6]

An important activity of a TI, therefore, is to refer members of high-risk groups to TB screening. As the percentage of referrals was almost nil, DSACS collaborated with the state TB Division to conduct a pilot among FSWs and IDUs in select areas. Its aim was to devise strategies to improve the quality of the programme.

Box 5: HIV-associated TB occurrence in India

Estimated HIV associated TB cases in 2015: 1.1 lakh

HIV-associated TB deaths in 2015: 37,000

Source: TB India 2017 RNTCP report

[6] http://www.who.int/bulletin/volumes/86/9/06-038737/en as accessed on 10/09/2017.

Response

1. **Coordination with the state TB Division**
   a. DSACS has collaborated with the state TB Division to screen TB cases in the selected areas.
   b. A series of meetings were conducted to understand the TB scenario in the selected group and consider the best way to reach vulnerable individuals.
   c. The TB Division has extended logistical and financial support, and recommended that the National Coalition of People Living with HIV in India (NCPI+) lend its expertise to the programme.
   d. Regular meetings are held to review progress.

2. **Site selection:** The areas selected on the basis of the vulnerability pattern were G.B. Road for FSWs, and Yamuna Bazaar, Chandni Chowk and Connaught Place for IDUs.
   a. G.B. Road: Garstin Bastion Road, better known as G.B. Road, spans about a kilometre from Ajmeri Gate to the Lahori Gate area in Central Delhi. Its brothel area, one of the oldest in Delhi, has 21 buildings housing about 3,000 FSWs in 95 crowded, unhygienic rooms.
   b. Yamuna Bazaar, Chandni Chowk and Connaught Place: Yamuna Bazar and Chandni Chowk in North Delhi and Connaught Place in Central Delhi have crowded markets with a high concentration of IDUs as they can find petty jobs here and food at the neighbourhood temples, gurudwaras and tombs.

3. **Team formation and staff training**
   a. Six teams comprising ORWs, NCPI+ members and a PE were formed.
   b. A workshop was organised at the New Delhi Tuberculosis Centre (NDTB) to sensitise TI staff, NCPI+, the area DOTS provider, medical officer, TB-HIV supervisor, DAPCU and DSACS officials.
   c. A questionnaire and a survey format for screening TB cases were discussed in detail.
   d. The supervisor of the Chest Clinic and the TB-HIV Coordinator of NCPI+ monitor the registration of presumptive TB cases at the NDTB Centre.
   e. Role of PE and ORW: The PE ensures that sputum samples are collected and handed over to an ORW or NCPI+ staff to take to the NDTB Centre. When sputum cannot be collected, a member of the team makes a home or hotspot visit to urge the person to provide a sample.
   f. DSACS/TSU coordinates activities at the TI sites, between projects, at the State TB Training and Demonstration Centre and at NCPI+. Its members also attended the programme meeting for effective active case finding (ACF) activities at STDC.
   g. NDTB supports the teams in diagnosing pulmonary cases.
   h. The Chest Clinic at Lok Nayak Hospital supports diagnosis of extra-pumonary (EP) cases, and Chest Clinic, SP Marg, treatment.

4. **TB screening**
   a. Community meetings were held to inform and sensitise high-risk individuals in the pilot activity area. Reports of community meetings and surveys are shared with the Chest Clinics.
   b. Pre-structured questionnaires are used to identify TB cases through door-to-door and hotspot surveys.
   c. Screening is conducted from 12—2 p.m. to reach as many FSWs as possible during hours that are convenient to them. IDUs are contacted in the morning.
   d. Presumptive TB patients are urged to accompany the ORW to NDTB for a chest x-ray and spot sputum sample. Presumptive EP cases and those presenting with parenchymal lesions are referred to the Chest Clinic, Lok Nayak Hospital. Symptomatic cases are provided a sputum container for a morning sample. The sample is collected by an ORW and deposited for direct smear examination at NDTB.
   e. Smear negative cases are referred for Cartridge-based Nucleic Acid Amplification Test (CBNAAT).

Outcomes

1. Six teams conducted TB screening to find symptomatic clients and refer them to the diagnostic and treatment centre (*Table 3: TB status assessment*).
2. A total of 1,875 FSWs and 328 IDUs were screened through the survey. Of these, 57 FSWs and 185 IDUs were referred to the Chest Clinic where 2 FSWs and 16 IDUs were diagnosed with TB and linked to the DOTS centre.

Table 3: TB status assessment

Particulars	Results	
	FSWs	IDUs
Screenings conducted	1,875	328
Clients referred	57	185
Clients found TB positive	2	16
Patients initiated on treatment	2	8

Lessons Learnt

1. It is crucial to address the needs of vulnerable communities such as IDUs and sex workers, both of which are sidelined in the current programmes because they are hard to reach -- brothel-based sex workers because their access to the public health system is restricted by their pimps, and IDUs because their health is a low priority while under the influence.
2. Collaborating with other departments fosters smooth implementation and increases reach.
3. The screening process is obstructed by the limited availability of members of HRGs.

Recommendations

1. Staff knowledge of TB symptoms and services must be improved to enable them to identify and refer TB cases to health facilities promptly.
2. Service quality can be enhanced through better coordination between departments, and by extending the intervention to other geographical areas. The former would facilitate timely referrals and prompt follow up. The latter requires screening high-risk individuals for TB and linking them to DOTS centres for treatment.

Press conference on reaching PLHIV and sex workers, organised by NCPI+ in collaboration with RNTCP and DSACS, 31 March 2017

10

Key Lessons

To ensure that TIs for HRGs are effective, these groups must be meaningfully involved at every stage of the programme, from design to evaluation. Activities must be scaled to all the TI areas to optimise coverage and reach the 90:90:90 target by 2020. Strategies to accomplish this must share the following features:

1. **Flexibility and Innovation**
   The best practices enshrined here demonstrate the internal flexibility to meet the community's stated needs, thereby motivating more people to avail the services. Initiatives such as the Zeenat Club and government advocacy by Aarohan exemplify innovation that must be encouraged.

2. **Sound Research**
   Research findings reveal that virtual networks are replacing physical networks in a key trend that calls for a new direction in HIV programming in India. Further research into areas of vulnerability in the new networks, changing sex work patterns, dera systems in the transgender community, and inter-sectoral collaboration is required.

3. **Supportive Supervision**
   DSACS/ TSU have played a vital role in providing supportive supervision of the NGOs involved and in designing harm reduction programmes with the police.

4. **Advocacy and Convergence**
   Advocacy (*Box 7: What is advocacy*) plays an essential role in a programme's success. Identified as a professional role as far back as 1887, it is considered by social workers to be an ethical responsibility. As client and societal needs evolve, universities must emphasise advocacy in their curricula, and the National Association of Social Workers should promote electoral and legislative initiatives that reflect an emphasis on social and economic injustices.[7] Similarly, convergence, which is crucial to delivering public services, must be an integral component of development programmes. By advocating for the rights of the transgender community in convergence with higher authorities such as the police and magistrates, this TI has created a holistic environment for development.

Box 6: What is advocacy
"… exclusive and mutual representation of a client(s) or a cause in a forum, attempting to systematically influence decision making in an unjust or unresponsive system(s)."

Source: Encyclopedia of Social Work

5. **Employer-led Models**
   ELMs in HIV programmes are partnership models with a multi-sectoral approach that helps integrate HIV counselling and testing into the infrastructure. The model has been used by the TSU to influence DMRC contractors to deliver health services to their migrant labourers. The model remains sustainable because continually trains the employers.

6. **Innovation and Inclusion**
   Innovation – through new technology, approaches and service delivery models – and inclusion of high-risk individuals extends the benefits of TIs to a larger population. In this case, the documentation of best practices is an innovative component that has helped extend community reach and service uptake. Incentives can be introduced to encourage this practice elsewhere.

Conclusion

Delivering HIV prevention services to members of HRGs is very challenging for multiple reasons. DSACS/ TSU incorporates field experience as well as an understanding of behavioural and other trends to formulate strategies for these groups as follows:

1. The intervention for the transgender community involves stigma reduction through social events and advocacy. It also facilitates access to social entitlements to encourage service uptake.
2. According to Integrated Biological and Behavioural Surveillance (IBBS) data, the prevalence of HIV among IDUs in Delhi was 21.8% in 2014—15. The challenges of reaching out to this population are compounded by the fact that a majority of them are homeless. To fill in the gaps, advocacy was conducted with different departments and stakeholders, and the night shelter approach adopted.
3. Delhi is a preferred destination for seasonal migrants involved primarily in construction and casual labour. The ELM with DMRC has facilitated access to healthcare for about 29,000 workers. The initiative remains sustainable as the workers are reached through trained employees of DMRC.
4. The approaches also looked into differentiated care, a client-centred approach that provides a framework for the re-examination of service delivery. This approach simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of people living with HIV (PLHIV) while reducing unnecessary burdens on the health system. This enables the health system to direct resources to those most in need.

[7] http://socialwork.oxfordre.com/view as accessed on 10/09/2017

Delhi TSU Office
India Health Action Trust
#11-12, 1st Floor, Block A-3
Sector-5, Rohini
New Delhi 110085, India

T +91 11 45575683 E ihat.delhi@ihat.in W www.ihat.in