Addressing the unmet sexual and reproductive health and rights of PLHIV

Results from a baseline study in four states in India

Authors

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Comprehensive interventions for PLHIV should include SRH programming along with positive prevention.

Background

With expanded access to antiretroviral treatment (ART) and subsequent increased longevity, people living with HIV (PLHIV) have an opportunity to live longer, lead fulfilling lives and plan their futures, including decisions about sex, sexuality and the possibility of starting or expanding families.

Evidence from India suggests that a comprehensive approach to sexual and reproductive health and rights (SRHR) for PLHIV has been lacking and that current responses have not sufficiently addressed vulnerability or improved sexual and reproductive health among PLHIV. Previous studies with PLHIV have shown high rates of unmet contraceptive needs, untreated STIs and lack of knowledge and skills on safer sex and positive prevention.

With support from the European Commission, India HIV/AIDS Alliance (Alliance India) is implementing the Koshish project that supports the development of advocacy skills in PLHIV networks in four states to promote better SRHR for vulnerable communities living with HIV. As part of this project, Alliance India carried out a study of PLHIV to understand issues related to their SRH and services available at the community level.

Methods

803 PLHIV aged 15-49 (352 men, 401 women, and 50 transgender or hijra individuals) were interviewed in five districts in four Indian states: Andhra Pradesh (AP); Gujarat; Maharashtra; and Tamil Nadu (TN). Lists of PLHIV supported by local CBOs were used as the sampling frame to select respondents. The required number of respondent households was arrived at using systematic random sampling.

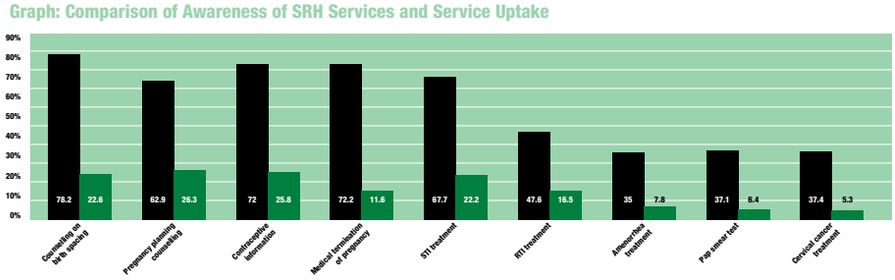
Results

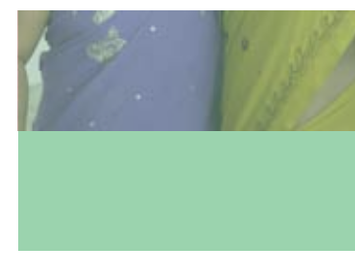
- The mean age of the respondents was 34 years.
- 57% were in a marital relationship, and 34% were either widow/widower, divorced or living separately.
- 78% of respondents were aware of at least one contraceptive method, although the level of awareness varied across states (55% to 98%).
- Awareness of SRH services was high for care on delivery (86.3%), antenatal (85.6%) and postnatal (85.8%), whereas it was relatively low for treatment of STIs (68%), RTIs (47.6%), and amenorrhea (35%). [See Graph.]
- Unmet contraceptive need varied from 3% to 8% across the four states.
- Comprehensive knowledge on HIV varied from 52% to 83% (low in Maharashtra & high in AP); misconceptions about how HIV spreads persist and ranged from 7.5% to 31.3% (low in Gujarat and high in Maharashtra).
- Nearly half of the respondents have regular sexual partners, and most of the widows/widowers have sex with either regular or non-regular partners.
- 91% respondents used condoms during their last sexual intercourse with regular partners. With non-regular partner, reported use was 81%.
- Approximately one quarter (21% to 30%) of all respondents reported STI-related symptoms in the previous three months.
- A minority of women in each state reported seeking maternal health advice during their last pregnancy: 12% in AP; 21% in Gujarat; 44% in Maharashtra; 27% in TN.

Conclusions

The study highlighted unmet SRHR needs of PLHIV in the four states. While most respondents reported frequent condom use, STI-related symptoms indicate unsafe sexual behavior. SRH and HIV-related knowledge levels are low, and respondents also reported SRH-related rights violations. This study confirms the need for interventions for positive prevention along with specific SRH programming for PLHIV as part of India's HIV response.

Graph: Comparison of Awareness of SRH Services and Service Uptake





Acknowledgements

India HIV/AIDS Alliance would like to thank the **European Commission** for its support for Koshish. Alliance India is grateful for the contributions to the programme by the state lead partners (CHETNA, MAMTA, PWDS and VMM), state and district-level PLHIV networks, and community-based organisations across the four implementation states.

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Addressing vulnerabilities of women who inject drugs

A community-based intervention model towards a holistic response to improve health and reduce HIV transmission among women who inject drugs in Manipur, India

Authors

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A package of services addressing vulnerability from drug use, unsafe sex and rights violations is required to meet the needs of women who inject drugs.

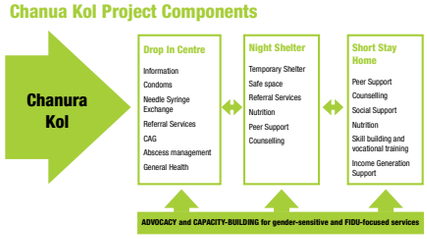
Background

Largely neglected in the current HIV strategy in India, women who inject drugs are highly marginalised and in need of a comprehensive response to meet their specific health and social needs and reduce their vulnerability to HIV. According to government estimates, women constitute approximately 7% of people who inject drugs in India. With support from the Elton John AIDS Foundation, the Social Awareness Social Organisation (SASO), in partnership with the India HIV/AIDS Alliance, initiated Chanura Kol, a project that designs and implements a holistic, community-based response to meet the needs of women who inject drugs. [See Diagram for project components.]

Methods

A quantitative knowledge-and-practices-oriented baseline study was conducted among women who inject drugs in Manipur. 100 women (18-45 years) who had injected drugs in the past three months were selected using proportionate sampling with 95% CI and 9% margin of error. Field work and data collection took place in September and October 2010. The study informed the design and implementation of the project model, which provides interventions to address women's vulnerability relating to injecting drug use, sex work and social exclusion.

Chanua Kol Project Components



Results

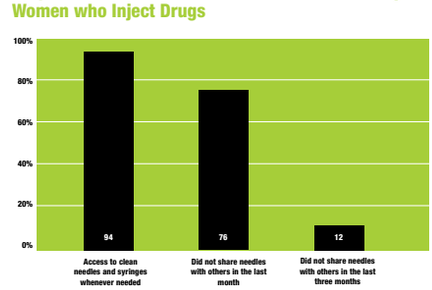
The baseline study showed that:

- Only 12% of respondents reported not sharing needles or syringes over the previous three months. [See Graph.]
- 42% reported consistent condom use over the previous month.
- More than half of the respondents reported STI-related symptoms ($p<0.05$).
- A high level of unmet contraceptive need (over 50% of respondents).
- 17% reported having experienced physical violence and 15% forced sex in the previous three months ($p<0.05$).
- 49% reported harassment, teasing and abuse by community members.

The baseline results confirm the need for interventions that address several sources of vulnerability to HIV, drug use and ill-health. Social exclusion, violence, human rights violations, inadequately targeted service delivery, injecting and sexual practices all contribute to the health conditions of women who inject drugs in Manipur. Chanura Kol endeavors to address these factors through a range of interventions:

- Outreach through peer educators mobilising women who inject drugs and providing outreach services and information
- Establishment of women-only drop-in centres in three sites across Manipur providing harm reduction, HIV and STI prevention information and counselling, STI treatment, support groups and referrals for Hep C testing and drug treatment
- A night-shelter for up to 15 women providing a safe space for women and their children to spend the night, access nutrition, emergency medical care and overdose management
- Referrals to a range of Government welfare schemes and entitlements
- Referrals to drug treatment options, either detoxification or oral substitution therapy (OST)
- Following detoxification or consistent OST use, six-month residence in a short-stay home that provides:
  - Health and drug use-related treatment and support services
  - Vocational and entrepreneurial training and financial and technical support for income generation activities
  - Support for reestablishment of family integration and community support systems
- Community Action Groups to immediately respond to cases of violence and harassment by providing emergency responses, referrals for support and legal services

Graph: Access to and Use of Clean Needles Among Women who Inject Drugs



Conclusions

A package of services addressing vulnerability from drug use, unsafe sex and rights violations is required to meet the needs of women who inject drugs. A gender-transformative approach will have more impact on addressing sources of vulnerability. A comprehensive approach to impact mitigation related to drug use, sex work and HIV is needed to address sources of vulnerability on an ongoing basis.

Addressing sexual and reproductive health and rights is required, including the direct involvement of men in addressing gender norms, negotiation skills for condom use, responding to gender-based violence and empowering women with information. Without addressing sexual health and rights-related factors, such as forced sex, limited knowledge about sex and sexuality, use of contraceptives and ongoing health issues related to menstruation, impact on HIV outcomes will be limited.

Acknowledgements

India HIV/AIDS Alliance would like to thank the **Elton John AIDS Foundation** for its support of Chanura Kol. Alliance India acknowledges the Chanura Kol team at SASO, and women who were interviewed for this study from the community.

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Are low levels of education among MSM, transgenders and hijras a barrier to building strong CBOs to serve as HIV prevention partners?

An analysis of data from the baseline survey of the Global Fund-supported Pehchān program in India

Authors

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Lack of education and work experience is a potential obstacle in efforts to empower MSM, transgender and hijra communities to address their needs and support successful HIV prevention interventions in India.

Background

HIV prevalence among MSM in India remains disproportionately high in India—most recently measured at 5.1% in provisional 2011 data from the National AIDS Control Organisation—as compared with overall national prevalence of 0.3%. Though currently under review by India's Supreme Court, the 2009 decision by the Delhi High Court to decriminalise homosexuality has improved the legal environment, even while stigma and discrimination continue to undermine the health and wellbeing of MSM, transgenders and hijras across the country.

India HIV/AIDS Alliance in consortium with four other organisations implements the five-year Global Fund-supported **Pehchān** program in 17 Indian states to build the capacity of 200 community-based organisations (CBOs) to serve as effective HIV prevention partners with the National AIDS Control Program and reach 453,750 MSM, transgenders and hijras using a community-driven and rights-based approach. Pehchān conducted a baseline study to understand demographics, behavior and needs of the target populations.

Methods

A cross-sectional baseline study sampled 2,762 MSM, transgenders and hijra in 55 districts across 10 states. Time and Location Cluster Sampling (TLCS) was used to identify these often hard-to-reach and relatively mobile populations. Data were analysed using SPSS. For the purpose of the baseline study, an umbrella term—"MSM spectrum"—was employed to capture collectively the range of identity sub-groups used by these populations in India to describe themselves: gay, kothi/B-MSM/mangalamukhi, panthi/A-MSM, double-decker/AB-MSM, bisexual, and those who self-identify as "MSM." In line with the program's model, 16.5% of respondents were transgender or *hijra*.

Results

- The median age of respondents was 27 years.
- 20% of transgender and hijra respondents were illiterate as compared to 11% of MSM.
- While primary education or above had been achieved by 88% of MSM respondents and 74% of transgenders and hijras, only 14% indicated that they were secondary graduates or above (MSM: 16%; TG/H: 9%).
- In the hijra sub-group, 27% reported being illiterate and just 3% reported as secondary graduates or above.
- Only 12% of respondents have undergone training on vocational skills. [See Table.]
- 36% were currently engaged in salaried employment, 13% with a family business, 8% as agricultural laborers, and 6% mentioned sex work as their primary occupation.
- An additional 23% reported sex work as a secondary occupation.

Table: Training on Vocational Skills

Vocational training	Gay	Kothi/ B-MSM/ M'mukhi	Panthi/ A-MSM	DD/ A-B MSM	Bisexual	MSM	Hijra	TG
Yes	37%	12%	12%	10%	12%	12%	6%	11%
No	63%	88%	88%	90%	88%	88%	94%	89%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
N (All)	*70*	*1,163*	*369*	*296*	*164*	*246*	*220*	*234*

Conclusions

Lack of education and work experience is a potential obstacle in efforts to empower MSM, transgender and hijra communities to address their needs and support successful HIV prevention interventions in India. Low education levels in these groups and inadequate or unsuitable work experience can undermine efforts to build effective CBOs.

Through a systematized training curriculum, Pehchān supports focused capacity building of CBO staff to address some of these gaps. Modules have been developed in a range of technical and organizational areas to build specific skill sets needed to manage effective and sustainable CBOs that can serve as partners in the Government of India's HIV prevention efforts. In the longer term, it will be necessary to address the societal and policy barriers that prevent MSM, transgender and hijras in India from completing their education beyond primary school, discourage them from pursuing higher education, and limit their employment opportunities.

Acknowledgements

India HIV/AIDS Alliance would like to thank the **Global Fund to Fight AIDS, Tuberculosis and Malaria** for its support of Pehchān. Alliance India is grateful for our collaboration with India's National AIDS Control Organisation and for their many contributions to the success of our efforts. Alliance India acknowledges the Pehchān teams at the Humsafar Trust, SAATHII, Sangama, and SIAAP, and the 2,762 members of the MSM, transgender and *hijra* communities in India interviewed for the baseline study.

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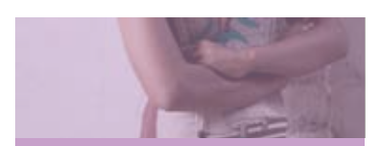

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Beyond Heroin

Patterns of drug choice diversity among People Who Inject Drugs in three Indian states: Findings from the Hridaya baseline study

Hridaya
Harm Reduction in India

Authors

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Region-specific interventions are needed to address variations in drug use patterns and diversification of drug choice among PWID in India.

Background

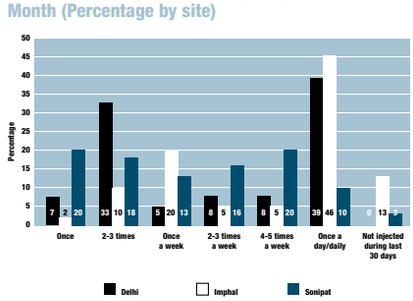
Injecting drug use has emerged as an important route for HIV transmission in India. The Government of India currently estimates that there are approximately 200,000 People Who Inject Drugs (PWID or IDUs) in India (NACO, 2010).Some studies indicate the numbers could be much higher. Surveillance shows HIV prevalence among PWID at 9.2% (NACO, 2010).

PWID inject a range of drugs based on preference and availability, which vary by region. Understanding the patterns of drug use by PWID is critical to successful intervention design. India HIV/AIDS Alliance conducted a baseline survey with PWID in selected sites in three states (Delhi, Manipur and Haryana) on drug use and behaviour patterns as part of the Hridaya project, the Indian component of the five-country, Dutch government-funded Community Action on Harm Reduction programme.

Methods

A quantitative cross-sectional baseline survey was conducted with PWID in one district/area selected from each of the three program states: Sonipat in Haryana, the north-eastern section of Delhi, and Imphal in Manipur. 183 PWID were selected through systematic random sampling using client information made available by partner NGOs at selected sites. Respondents included both men and women above 18 years of age who had injected drugs in the previous three months.

Graph 1: Frequency of Injecting Drugs in Last One Month (Percentage by site)



Results

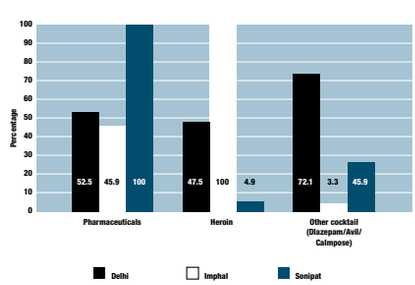
Covering a range of topics relevant to PWID in India, the Hridaya baseline survey asked specific questions about drug use patterns, including substance choice.

- The mean age of the respondents was 32 years.
- 59% of respondents in Delhi were uneducated, whereas a similar percentage in Imphal was educated up to high school or more.
- A majority of respondents lived on streets, special homes or railway platforms in Delhi (79%) and Imphal (53%), while in Sonipat more than 96% stayed in their own homes.
- A majority of PWID were economically dissatisfied. 56% in Delhi were rag pickers, day labourers & hawkers. In Imphal, more than one-fourth were unemployed.
- Family support is lacking. Overall, 43.7% felt only partial support from their families; 29% got no support; and 15.8% had been disowned by their families.
- Mean drug use duration varied from 10.9 years in Imphal to 7.8 years in Delhi and 6.3 years in Sonipat.
- In the previous 30 days, 32% of all respondents had injected daily, and 33% at least once a week. [See Graph 1 for data by site.]
- 99.5% of respondents inject opiates: 50.8% heroin; 2.7% liquid opium; 66.1% pharmaceuticals; and 18.6% buprenorphine.
- 35% inject more than one drug, and 19% inject a 'cocktail' of drugs. A few respondents (2.2%) reported the injection of sedatives.
- In Manipur, 100% of respondents use heroin predominantly due to its availability. In comparison, 100% of respondents from Haryana indicated predominant use of pharmaceuticals, while respondents from Delhi indicated use of both pharmaceuticals (52.5%) and buprenorphine (49.2%). [See Graph 2.]
- 72% of PWID in Delhi use a pharmaceutical cocktail (Diazepam/Avil/ Calmpose), while 18% inject Adnock.
- The highest levels of reported opiate overdoses in last 12 months were in Delhi (73.8%), followed by 42.6% in Sonipat and 23% in Imphal.

Conclusions

The type of drugs used by PWID varied beyond heroin, particularly outside Manipur. In addition to opiates, pharmaceutical drugs, often in cocktail, are popular. Region-specific interventions are needed to address variations in drug use patterns and diversification of drug choice among PWID in India. PWID and healthcare providers need new skills and training to respond to overdose and other health issues resulting from the injection of pharmaceuticals.

Graph 2: Type of Drug Use by Site



It was once easy and convenient to access my drug of choice and have a great time. My intake of drugs grew, but the quality of heroin went down. Constant police raids further worsened the situation. Then I was introduced to injectable pharmaceuticals, Now I'm on multiple drugs. The injecting habit has impacted me severely. I live by the needle.

28-year-old PWID, Imphal, Manipur.

Acknowledgements

India HIV/AIDS Alliance would like to thank the **Ministry of Foreign Affairs, Government of Netherlands** for funding Hridaya through the Community Action on Harm Reduction project. Alliance India acknowledges the contributions of the Hridaya teams at SASO, Sharan and Modern Education Society, as well as technical support from International HIV/AIDS Alliance and Alliance Ukraine. A special thanks to the PWID community members who were interviewed for the baseline study.

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Combination Collaboration

Leveraging government commitment, donor processes and community mobilization to develop a national program to build the capacity of MSM and transgender populations as HIV prevention partners: The making of the Global Fund-supported Pehchān program in India

Authors

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Pehchān remains the largest single-country grant focused on sexual minorities supported by the Global Fund.

Background

HIV prevalence among MSM in India remains disproportionately high—most recently measured at 4.43% in provisional 2010-11 data from the National AIDS Control Organisation (NACO)—as compared with overall national prevalence of 0.3%. India HIV/AIDS Alliance in consortium with four other organisations implements the five-year Global Fund-supported **Pehchān** program in 17 Indian states to build the capacity of 200 CBOs to serve as effective HIV prevention partners with the National AIDS Control Program and reach 453,750 MSM, transgenders and hijras using a community-driven and rights-based approach. The program represents an active collaboration of civil society, government and a donor committed to improving the HIV response for vulnerable sexual minorities.

Methods

Pehchān was initially included as part of the HIV component of a Round 8 proposal to the Global Fund in 2008. A group of civil society organisations working with MSM, transgender and hijra communities in India collaborated to develop a proposal that emphasized community systems strengthening as an essential and previously missing element in the government's efforts to control HIV in these populations. This initial proposal was not recommended for approval but was strongly encouraged for resubmission in Round 9 following revision.

Through a collaborative process, the civil society partners, NACO, UNAIDS and the India Country Coordinating Mechanism retooled the program strategy in response to the Global Fund Technical Review Panel's feedback. Additional evidence of the proposed implementation model's feasibility was requested, which led to the development of a pilot program called Sashakt funded by UNDP India from 2009-11.

Further negotiations with NACO led to the alignment of the proposal's implementation model to the national HIV prevention strategy. India's third National AIDS Control Program (NACP III: 2007-2012) had prominently included HIV prevention in high-risk groups through Targeted Interventions (TIs) for sex workers, MSM and injection drug users. Consequently, Pehchān was developed as a mechanism to strengthen CBOs to serve as government-funded implementing partners under the Targeted Intervention strategy for MSM and transgender populations.

Results

The revised proposal succeeded in Round 9, and after almost two years of implementation, Pehchān remains the largest single-country grant focused on sexual minorities supported by the Global Fund. In order to reach MSM, transgender and hijra communities with needed services, community systems strengthening and community mobilisation have emerged as priority interventions, though few programs or donors—in India or elsewhere—have attempted to engage these populations at the geographic scale of Pehchān.

At the end of the first eighteen months of implementation (1 October 2010-31 March 2012), Pehchān was on target, having achieved or overachieved the vast majority of its indicators and receiving an "A1" rating from the Global Fund. The collaboration that marked the development of the proposal has continued in the program's implementation. Government support has been essential to success, strengthening the program through engaged leadership and a commitment to community ownership of HIV prevention programming beyond the life of the program.

Combination Collaboration: Success factors to support action for HIV prevention in MSM, transgender and hijra communities in India

Conclusions

Even after more than three decades of sustained engagement with HIV, investments in programming targeting MSM and transgender populations remain vastly inadequate. A recent review of donor spending on MSM revealed that barely 2% of HIV prevention funding targets MSM in developing countries (MSMGF, 2011).

The Government of India's support for HIV prevention interventions for MSM and transgenders was established before the Delhi High Court's decriminalisation of homosexuality in 2009. India remains a remarkable exception; in far too many low and middle income countries, the criminalisation of homosexuality is used as a primary rationale for simply doing nothing.

Pehchān experience shows that collaboration—like interventions themselves—need to be tailored to local circumstances. The nature of the Global Fund as a multilateral financing mechanism with its commitment to national ownership enabled the development of a program for sexual minorities in India that might have been difficult to fund through other channels such as bilateral donors or government domestic spending, both of which are subject to more immediate political pressures. In countries without government support for such programming, the Global Fund model can fail sexual minority communities.

Nonetheless, in all epidemic contexts, civil society, government, and donors need to work together to develop and fund a wider range of intervention models—from large scale, national initiatives to smaller, less visible programs—that will address the prevention needs of MSM and transgender communities around the world.

Acknowledgements

India HIV/AIDS Alliance would like to thank the **Global Fund to Fight AIDS, Tuberculosis and Malaria** for its support of Pehchān and UNDP India for its support of Sashakt. Alliance India is grateful to NACO and State AIDS Control Societies for their many contributions to our efforts. At the heart of the program are the Pehchān teams at the Humsafar Trust, SAATHII, Sangama, SIAAP, Pehchān North Region Office and Alliance India Andhra Pradesh whose work supports strengthened MSM, transgender and hijra communities in India.

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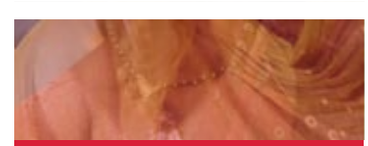

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Community engagement in the development and roll-out of a capacity building model to strengthen CBOs for MSM, transgenders and hijras

The Global Fund-supported Pehchān program in India

Authors

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Impactful HIV interventions for MSM, transgender and hijra populations require sustained and systematic investment in community systems.

Background

HIV prevalence among MSM in India remains disproportionately high in India—most recently measured at 5.1% in provisional 2011 data from the National AIDS Control Organisation—as compared with overall national prevalence of 0.3%. India HIV/AIDS Alliance in consortium with four other organizations implements the five-year Global Fund-supported **Pehchān** program in 17 Indian states to build the capacity of 200 community-based organisations (CBOs) to serve as effective partners in the government's HIV prevention strategy and reach 453,750 MSM, transgenders and hijras by 2015. The involvement of MSM, transgender and hijra (MTH) populations in the HIV response is essential, and CBOs are vital to accomplish improved HIV outcomes with these vulnerable and marginalized communities.

Methods

In order to stimulate the development of strong and effective CBOs for MSM, transgender and hijra communities and increase their impact in HIV prevention efforts, responsive and comprehensive capacity building is required. Pehchān developed a robust training program to build CBO capacity through a process of engagement with community leaders, trainers, technical experts, and academics in a series of consultations that identified training priorities. Based on these priorities, smaller subgroups then developed specific thematic components for each curricular module.

Results

Inputs from community consultations helped increase relevance and value of training modules. By engaging MTH communities in the development process, there has been greater ownership of training and of the program overall among supported CBOs. Technical experts worked on the development of thematic components for priority areas identified by community representatives. The process also helped fine-tune the overall training model and scale-up strategy.

Training Modules: Through a consultative, community-based process, Pehchān developed a training model responsive to the specific needs of the program and reflecting key priorities and capacity gaps of MSM, transgender and hijra CBOs. The training model comprises five modules and a total of 18 thematic components. [See Box.]

Pehchān Master Trainers: During two 'Training of Trainers' organised regionally, Pehchān developed 83 subject experts and community leaders as "master trainers." In this role, master trainers lead sessions as per the training modules to support capacity development primarily with staff of sub-sub-recipient (SSR) CBOs, but also with staff of Pehchān's sub-recipient (SR) partners.

National and Regional Training Centres: Considering the national scope of Pehchān, the program established four Regional Training Centres in the north, south, east and west to coordinate training activities. Working closely with the national training team at India HIV/AIDS Alliance, the four regional units are housed with the program's SR partners and are building additional capacity in these organisations to undertake large-scale, sustained training.

Current Progress: Through June 2012, Pehchan has trained 1,816 participants in 101 batches. While progress has been generally good, a number of challenges have been encountered during the roll-out of trainings across the four regions, including:

- Alignment of training timing to the program's "CBO Life Cycle"
- Identification of MTH community-friendly training venues
- Communication with SSR participants across multiple languages
- Management of demanding training program within a limited budget
- Attrition of trained staff at SSR CBO level

Within the constraints of the program, action has been taken at the national and regional level to address these issues and improve the overall effectiveness of Pehchāns training activities, including identifying more cost-effective and community-friendly training venues, increasing coordination of input timings to align with model, and translating materials into relevant languages. Quality checks have been also undertaken to strengthen trainings and increase impact.

Conclusions

Community-driven, need-based training model has served as a catalyst to increase community ownership and impact of capacity building and skill development efforts. Impactful HIV interventions for MSM, transgender and hijra populations require sustained and systematic investment in community systems. Training modules are part of Pehchān's objective to strengthen CBOs programmatically, organizationally and institutionally to improve the lives and health of MSM, transgender and hijra communities and reduce HIV vulnerability.

Acknowledgements

India HIV/AIDS Alliance would like to thank the **Global Fund to Fight AIDS, Tuberculosis and Malaria** for their support of Pehchān. Alliance India acknowledges the valuable collaboration with India's National AIDS Control Organisation for their many contributions to the success of these efforts. The Pehchān training model and modules are the product of an intensive and coordinated effort by the Pehchān partner organisations (Alliance India, Humsafar Trust, SAATHI, Sangama and SIAAP) and consultants from across India. We are deeply grateful for their commitment and inputs.

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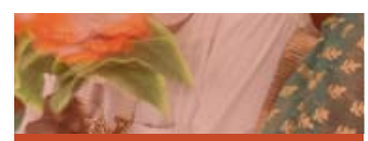
Box: Pehchān Training Modules

Module	Thematic Component	Description	Training Days
A	*Program Management*	Provides an overview of Pehchān and the role of implementing partners, the Global Fund, government actors and other key stakeholders in the program	1
	Financial Management	Establishes financial management and grant compliance processes of Pehchān	1
	Monitoring and Evaluation	Explains M&E basics and the structure and components of Pehchān's Performance Framework and its supporting M&E system	1
			Module A: 3 Days
B	*Leadership & Governance*	Strengthens CBO leadership and governance practices to achieve organisational goals including but not limited to Pehchān outputs	1
	Organisational Development	Supports systematic, planned and sustainable organisational growth for CBOs	1
	Resource Mobilization & Management	Identifies strategies for resource mobilization and new opportunity development for CBOs	1.5
			Module B: 3.5 Days
C	*Pre TI*	Explains the framework of the government's Targeted Intervention (TI) program for MSM and transgender populations	2
			Module C: 2 Days
D	*Identity, Gender & Sexuality*	Considers issues of sexuality and gender and the concept of identity within MTH communities and their impact on HIV prevention	1
	Family Support	Examines family issues from the MTH perspective and identifies support strategies	1
	Mental Health	Provides basic concepts on counselling and common MTH mental health concerns	1.5
	Addressing MTH with female partners	Discusses issues for MTH with female partners and programmatic strategies to reach out to them	1
	TG - Hijra Issues	Examines the experience and challenges of transgender and hijra communities in the Indian context	1
			Module D: 5.5 Days
E	*Life Skills Education*	Equips participants with life skills to successfully address common situations in an assertive manner	1
	Trauma & Violence	Establishes the connection between trauma and violence and strategies to address their consequences	1
	Human & Legal Rights	Explains basic human and legal rights and builds skills to recognize their violation and actions to respond	1
	Community Preparedness	Identifies strategies to empower MTH communities and encourage self-reliance	1.5
	Friendly Services	Presents concepts of MTH-friendly services and strategies to advocate for them	1
	Positive Living	Promotes positive living and provides basic information about ART and adherence.	1
			Module E: 6.5 Days
5 Modules	**18 Thematic Components**		**Total: 20.5 Days**



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Demographic and behavioural patterns that impact PWID injection practice

Findings from Hridaya Baseline Study in India

Hridaya
Harm Reduction in India

Authors

Visvanathan Arumugam[1], Kaushik Biswas[1], Shaleen Rakesh[1], Sonal Mehta[1], Charanjit Sharma[1], Francis Joseph[1], James Robertson[1]

[1] India HIV/AIDS Alliance, New Delhi

Socio-economic and demographic status of PWID influence injecting risk behaviour and should be considered while developing intervention strategies.

Graph: Regional differences among respondents in different risk activities

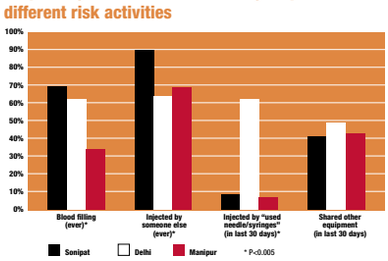

Table: Socio-demographic profile and risk activities

Characteristics	Used "Used Needle and Syringes" (in percent)	P value Asymp. Sig. (2-sided)
Education		
Basic incomplete and below	31.4	0.001
High school and above	8.7	
Marital Status		
Currently married	10	0.003
Widow/widower/divorced/separated	26.7	
Never married/unmarried	34	
Occupation		
Occasional earner	30	0.005
Unemployed	12.5	
Labour (Hawker, rickshaw puller, auto driver, etc)	40	
Permanently employed	0	
Self-employed	8	
Living status		
Home/special home	22.4	0.007
Street/ railway platform/ bus stand	37.5	

"My family deserted me; I am presently living on streets: AM I VULNERABLE?

People come and tell us to inject safely: AM I VULNERABLE?

I can barely afford drugs, hence sharing is common: AM I VULNERABLE?

I am a daily wage labourer: Does that make ME VULNERABLE?"

— 32-year-old PWID from Sonipat, Haryana

Background

Injecting drug use has emerged as an important route for HIV transmission in India. The Government of India currently estimates that there are approximately 200,000 People Who Inject Drugs (PWID or IDUs) in India (NACO, 2010). Some studies indicate the numbers could be much higher. HIV Sentinel Surveillance shows HIV prevalence among PWID at 7.14% (NACO, 2010-11). India HIV/AIDS Alliance conducted a baseline survey in 2012 with PWID in selected sites in three states (Delhi, Manipur and Haryana) on drug use and behaviour patterns as part of the Hridaya programme, the Indian component of the five-country, Dutch government-funded Community Action on Harm Reduction programme.

Methods

A quantitative cross-sectional baseline survey was conducted with PWID in one district/area selected from each of the three programme states: Sonipat in Haryana; the north-eastern part of Delhi; and Imphal in Manipur. 183 PWID were selected through systematic random sampling using client information made available by partner NGOs at selected sites. Respondents included both men and women above 18 years of age who had injected drugs in the last three months.

Results

- **Socio-demographic profile:** Seventy-five percent of respondents overall did not study beyond primary level; 59% were unmarried; a majority (68%) were either occasional earners or labourers; around 22% were living in street/railway platforms. Almost all respondents in Sonipat (97%) lived at home, while 48% of those in Imphal reported same. Thirty-eight percent of respondents in Delhi lived on the street or on railway platforms; in Imphal, 25% did.
- **Drug-use pattern:** Median duration of drug use was 6 years (mean: 8.4; sd: 6.2). 32% of respondents injected daily and 33% at least once a week. Forty percent of respondents injected 2-3 times a day during periods when they inject.
- **Injecting-related risk behaviour:** Overall, 46% of respondents have ever been involved in blood filling activity; 74% responded as ever having been injected by someone else in situations when the respondent was not in control over injection; 26% have injected with used needles/syringes in the last 30 days; and 44% indicated that they have shared other equipment in last 30 days. There are some important regional differences in these data, notably the high level of re-use of equipment reported in Delhi. (See Graph.)
- **Association of socio-demographic profile with risk activities:** Respondents who were unmarried, labourer/occasional earner, and those living on the street injected with used needles and syringes more often in comparison with other groups ($p<0.05$). (See Table for breakdown of socio-demographic profile and risk activities.) Respondents with lower education (up to primary level) were significantly more involved in all risk injecting behaviours such as blood filling (54%), injection by someone else (78%), injecting with used needles and syringes (31%), and sharing other equipment (50%) in comparison to those educated above primary level ($p<0.05$).

Conclusion

As the package of HIV prevention services under the national programme for PWID in India is standardized and not yet comprehensive, these data confirm that programmes like Hridaya need to focus on the unmet needs of PWID and expand toward a full range of harm reduction services.

The Hridaya baseline study suggests that lower educational levels and poor living conditions among PWID increase the risk of HIV infection. To help counter these factors, Hridaya has developed specific services, such as peer counselling that both addresses mental health issues and promotes safer injections and safer sex. The programme is reaching out to spouses and sexual partners of PWID and building their capacity to reduce vulnerability of their drug-using companions by encouraging harm reduction practices. Complementing referrals to health services, linkages have also been established with existing government welfare schemes to contribute to the economic and social wellbeing of PWID.

As some key risk behaviours differ across geographic locations, Hridaya is tailoring services to address particular local needs. In Delhi, activities include street-based counselling and enhanced efforts to motivate uptake of behaviour change interventions. In Sonipat, Haryana, efforts have been made to involve families of PWID to increase uptake of Opioid Substitution Therapy (OST). In Imphal, Manipur, promotion of sterilisation practices for all injecting equipment is included as an important element of community education because it has been observed that the sharing of other equipment such as mixing and heating containers is much higher in this area.

Acknowledgements

India HIV/AIDS Alliance would like to thank the **Ministry of Foreign Affairs, Government of Netherlands** for funding Hridaya through the Community Action on Harm Reduction project. Alliance India acknowledges the contributions of the Hridaya teams at SASO, Sharan and Modern Education Society, as well as technical support from International HIV/AIDS Alliance and Alliance Ukraine. A special thanks to the PWID community members who were interviewed for the baseline study.

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Getting High, Getting Laid

Injecting practices and sexual behaviour of People Who Inject Drugs in three Indian states: Findings from the Hridaya baseline study

Hridaya
Harm Reduction in India

Authors

Kaushik Biswas[1], Viswanathan A[1], Charanjit Sharma[1], Sonal Mehta[1], Shaleen Rakesh[1], James Robertson[1]

[1] India HIV/AIDS Alliance, New Delhi

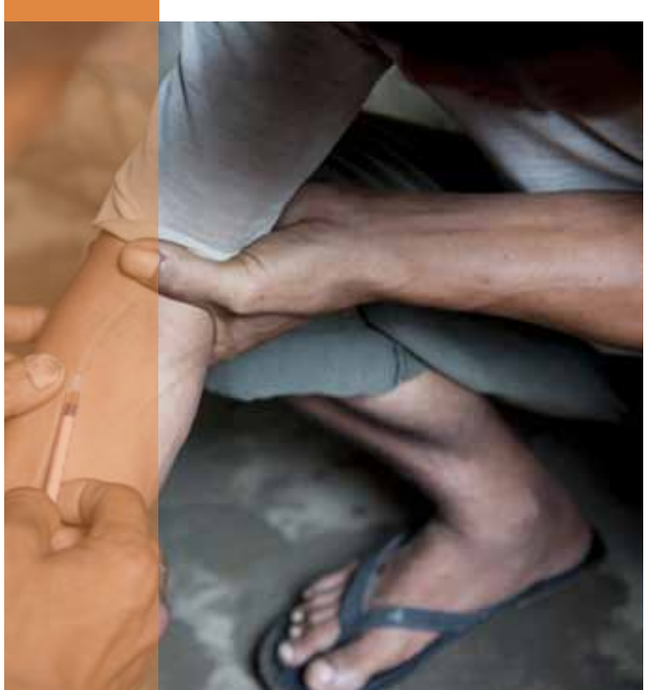
Unsafe injection practices along with low condom use are putting PWID at dual HIV risk.

Background

Injecting drug use has emerged as an important route for HIV transmission in India. The Government of India currently estimates that there are approximately 200,000 People Who Inject Drugs (PWID or IDUs) in India (NACO, 2010). Some studies indicate the numbers could be much higher. Surveillance shows HIV prevalence among PWID at 9.2% (NACO, 2010). Drug use often leads to poor health, social isolation, discrimination and poverty, factors that further compromise quality of life. India HIV/AIDS Alliance conducted a baseline survey with PWID in selected sites in three states (Delhi, Manipur and Haryana) on drug use and behaviour patterns as part of the Hridaya project, the Indian component of the five-country, Dutch government-funded Community Action on Harm Reduction programme.

Methods

A quantitative cross-sectional baseline survey was conducted with PWID in one district/area selected from each of the three program states: Sonipat in Haryana, the north-eastern section of Delhi, and Imphal in Manipur. 183 PWID were selected through systematic random sampling using client information made available by partner NGOs at selected sites. Respondents included both men and women above 18 years of age who had injected drugs in the previous three months.



Results

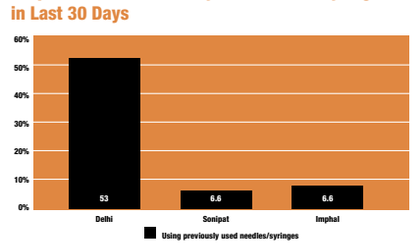
Covering a range of topics on drug use in India, the Hridaya baseline survey asked specific questions about PWID injecting practices and sexual behaviour:

- The mean age of respondents was 32 years.
- 59% of respondents in Delhi were uneducated, whereas a similar percentage in Imphal was educated up to high school or more.
- A majority of respondents lived on streets, special homes or railway platforms in Delhi (79%) and Imphal (53%), while in Sonipat more than 96% stayed in their own homes.
- 51% in Imphal, 34% in Sonipat and 13% in Delhi were currently in marital relationships.
- Mean drug use duration varied from 10.9 years in Imphal to 7.8 years in Delhi and 6.3 years in Sonipat.
- In the last 30 days, 32% injected daily and 33% at least once a week.
- Overall, 22% were using needles or syringes previously used by another person, with significantly higher reported reuse in Delhi. [See Graph 1.] Non-availability and access to clean needles or syringes were cited as reasons for using used equipment.
- In the last 12 months, 55% reported sexual intercourse with regular partners; 22.9% with casual partners; and 26.6% with commercial sex partners.
- Overall, condom use with casual partners was 64% and with commercial sex partners was 51.7%, again with notable geographic differences. Influence of drugs stated as a prominent reason for not using condoms. [See Graph 2.]
- 21% PWID reported being HIV positive.

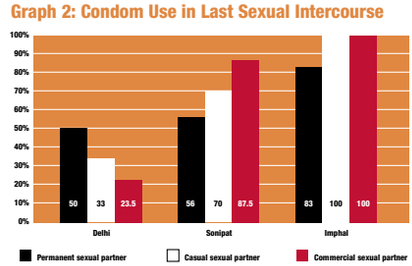
Conclusions

The Hridaya baseline confirms that unsafe injection practices along with low condom use are putting PWID at dual HIV risk. Focused advocacy is needed to strengthen interventions addressing safer sex and other issues of sexual health. Building on existing services for PWID supported by the Government of India, Hridaya aims to expand offerings for PWID towards a package of harm reduction services to improve wellbeing and reduce vulnerability to HIV and other factors through strategies that address both injection drug use and sexual behaviour.

Graph 1: Use of Previously Used Needle/Syringes in Last 30 Days



Graph 2: Condom Use in Last Sexual Intercourse



Acknowledgements

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Identifying quality-of-life priorities for People Who Inject Drugs

Findings from the Hridaya baseline study in three Indian states

Hridaya
Harm Reduction in India

Authors

Viswanathan Arumugam[1], Kaushik Biswas[1], Sonal Mehta[1], Shaleen Rakesh[1], James Robertson[1]

[1] India HIV/AIDS Alliance, New Delhi

India HIV/AIDS Alliance

Poor economic conditions and lack of social support compromise quality of life for PWID and contribute to their vulnerability.

Background

The Government of India currently estimates that there are 200,000 People Who Inject Drugs (PWID or IDUs) in India (NACO, 2010). Some studies indicate the numbers could be much higher. Surveillance shows HIV prevalence among PWID at 9.2% (NACO, 2010). Drug use often leads to poor health, social isolation, discrimination and poverty, factors that further compromise quality of life. India HIV/AIDS Alliance conducted a baseline with PWID in three states (Delhi, Manipur and Haryana) on drug use and behaviour patterns, as part of the Hridaya project, the India component of the five-country, Dutch government-funded Community Action on Harm Reduction program.

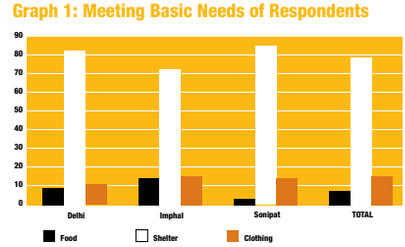
Methods

A cross sectional survey was conducted in three states. 183 PWID respondents were selected through systematic random sampling using client information made available by partner NGOs at selected sites. Data were analysed using SPSS software.

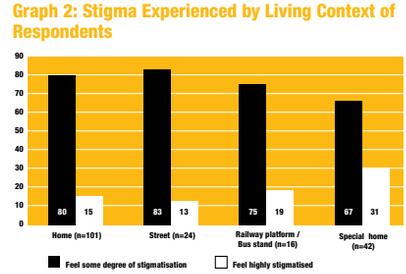
Results

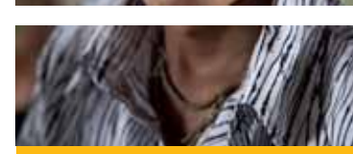
- The mean age of the respondent was 34 in Delhi and Sonipat (Haryana) and 28 in Imphal (Manipur).
- 59% of respondents in Delhi were uneducated, whereas a similar percentage in Imphal were educated up to high school or more.
- The majority of PWID were economically dissatisfied. For livelihood, a majority in Delhi (56%) were rag pickers, daily labourers or hawkers. In Imphal, more than one-fourth were unemployed.
- 92% of respondents said that their basic needs are not met, either partially or fully. [See Graph 1.]
- Anxiety and depression were acknowledged among PWID (77%) in all the three sites.
- More than 22% respondents lived on the street or on railway platforms.
- Family support is lacking: 43.7% received only partial support from their families; 29% got no support; and 15.8% had been disowned by their families.
- Respondents felt stigmatized (77% somewhat and 18.6% highly) in a range of contexts. [See Graph 2.]
- Many reported lack of support from their community. 44.8% did not get support from neighbours or other drug users.
- More than 65.5% of respondents reported negative attitudes by the police and law enforcement agencies.

Graph 1: Meeting Basic Needs of Respondents



Graph 2: Stigma Experienced by Living Context of Respondents





Conclusions

The Hridaya baseline confirms poor economic conditions and lack of social support for PWID at study sites, factors that compromise their quality of life and contribute to vulnerability. Focussed advocacy is needed with general community as well as with law enforcement authorities to create an enabling environment. There is a significant need for mental health services and psychosocial support interventions.

Building on existing services for PWID supported by the Government of India, Hridaya aims to expand offerings for PWID towards a package of harm reduction services to improve wellbeing and reduce vulnerability to HIV and other factors. Priority services include a peer and community support system to address stigma.

Acknowledgements

India HIV/AIDS Alliance would like to thank the **Ministry of Foreign Affairs, Government of Netherlands** for funding Hridaya. Alliance India acknowledges the contributions of the Hridaya teams at SASO, Sharan and Modern Education Society, as well as technical support from International HIV/AIDS Alliance and Alliance Ukraine. A special thanks to the community members who were interviewed for this study.

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Minimum Effort, Maximum Impact

Using Photos in Social Media to Share Messages on Sexual & Reproductive Health and Rights for Young People in India

Authors

Ankita Bhalla[1], Sophia Lonappan[1], Shaleen Rakesh[1], James Robertson[1]

[1] India HIV/AIDS Alliance

Photos and other visuals are proving to be invaluable tools in social media as it allows information to be shared more quickly and efficiently.

Introduction

With its growth in popularity, social media has become a tool for the nonprofit sector. What started out as a way to reconnect with friends and family has grown into a means for organizations to spread awareness about key issues, mobilize supporters, raise funds and foster online advocacy movements. Recognizing this opportunity India HIV/AIDS Alliance (Alliance India) under our Action Project launched an advocacy campaign over social media to create awareness around sexual and reproductive health and rights (SRHR) for young people.

Alliance India has a strong social media presence on Facebook and Twitter. As of January 2014, the organisation's page on Facebook has more than 81,000 likes, and 1,000 people follow us on Twitter. On average, our Facebook posts have more than 20,000 views.

With funding from the European Union, the Action Project (2010-13) strengthened and empowered civil society organisations and youth groups to advocate for more responsive policies addressing the SRHR of young people. The project focused on the most marginalised young people—men who have sex with men (MSM) and transgender people, drug users, sex workers and those living with HIV. The project was implemented in partnership with MAMTA and SASO in India and by HASAB in Bangladesh. Over its three-year duration, the Action Project contributed to shaping SRHR policies and their implementation in India and Bangladesh by supporting the meaningful participation of young people in relevant processes and programmes.

Methods

A two-pronged approach using photos and blogs was utilised. Relevant photos were selected, supplemented with text providing context and relevant data, and assembled as appropriate into online albums (collection of photos) and profiles (telling a story of an individual). Experience quickly showed that more than written words alone, the images get more attention in the social media world. A sample of five blogs and photos posted on Facebook over a period of six months (January-June 2013) were compared.

Results

Our review found that the photos had approximately 1.5 times higher number of views than blogs. The numbers of likes on photos were 2.5 times more than the blogs. Overall, the photos got 255,037 views, while the blogs had a total of 163,974 views. Similarly, the number of comments on photos was almost double of that of blogs. The photos got 58 comments, while blogs had only 31.

Conclusions

Images are one of the most popular forms of social media news content for a variety of reasons. This form of media is easily consumed, transfers information quickly, requires less time, and can share a great deal of information efficiently. More needs to be learned about how to maximize the impact of social media efforts to increase understanding of SRHR and other development priorities in the broader public, but photos and other visuals are proving to be invaluable tools in these efforts.

Acknowledgements

India HIV/AIDS Alliance would like to thank the **European Commission** for its support to the Action Project. Alliance India is grateful for the contributions to the project by the Action teams at MAMTA and SASO in India and HASAB in Bangladesh.

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This project is funded by the European Union.

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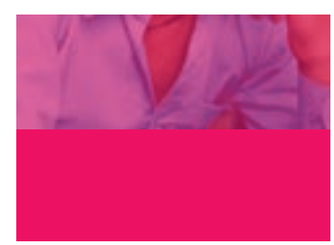

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Mixing Sex and Drugs

Socio-demographic Factors Associated with Sexual Risk Behaviour among PWID

Findings from the Hridaya Baseline Study in India

Hridaya
Harm Reduction in India

Authors

Visvanathan Arumugam[1], Kaushik Biswas[1], Shaleen Rakesh[1], Sonal Mehta[1], Charanjit Sharma[1], Francis Joseph[1], James Robertson[1]

[1] India HIV/AIDS Alliance, New Delhi

India HIV/AIDS Alliance

"I love to have sex when I am high on drugs. It doesn't matter whether I use condom or not—having sex after drug enhances my pleasure."

—PWID from Delhi

Background

Injecting drug use has emerged as an important route for HIV transmission in India. The Government currently estimates that there are approximately 200,000 People who inject drugs (PWID or IDUs) in India (NACO, 2010) although other studies indicate the numbers could be much higher. Surveillance shows HIV prevalence among PWID at 7.14% (NACO, 2010-11). Drug use often leads to other risk activities that further compromise quality of life. India HIV/AIDS Alliance conducted a baseline with PWID in three states (Delhi, Manipur and Haryana) on drug use and behavior patterns as part of the **Hridaya** programme, the Indian component of the five-country, Dutch government-funded Community Action on Harm Reduction programme (CAHR).

Methods

A quantitative cross-sectional baseline survey was conducted with PWID in one district/area selected from each of the three programme states: Sonipat in Haryana; the North-eastern part of Delhi; and Imphal in Manipur. 183 PWID were selected through systematic random sampling using client information made available by partner NGOs at selected sites. Respondents included both men and women above 18 years of age who had injected drugs in the last three months.

Results

Socio-demographic profile: Education levels were low as 75% had studied only up till primary school. Majority (68%) were either occasional earners or labourers. Most of the respondents (59%) were unmarried. Varying percentages reported living in their homes in Sonipat (97%) and Imphal (48%); whereas the numbers living on the streets or railway platforms were relatively higher in Delhi (38%).

Drug-use pattern: Median duration of drug use was six years. Thirty-two percent of PWID injected daily and 33% at least once a week. Forty percent injected 2-3 times a day during the periods when they inject.

Sexual Behaviour: Seventy-three percent of PWID had either permanent or occasional sexual partners; 36% had no permanent partner but had an occasional sexual partner or partners; and 9% were married and have other sexual partner or partners. In the last 12 months, 55% of respondents had sex with permanent partners, 22.9% had sex with casual partners, and 26.6% had sex with commercial sex workers. Condom usage was lower (52%) among those who had sex with commercial sex workers as compared to those with permanent and casual sex partners. There are some important regional differences in these data; lower levels of condom use, particularly with casual and paid sex partners, were reported in Delhi. (See Graph.)

Association of socio-demographic profile with sexual risk activities: A large percentage of PWID who are living on the street had sex with casual and commercial partners in the last 12 months when compared with those living at home ($p < 0.05$). Condom use was lower among those who had less than high school education ($p=0.006$). Consistent condom usage was lower in the 25-35 age group when compared with those <=25years and >35 years ($p=0.016$). Condom usage with any sex partner is notably lower among respondents from Delhi when compared with Sonipat and Imphal. (See Table).

Graph: Regional differences among respondents in different risk activities

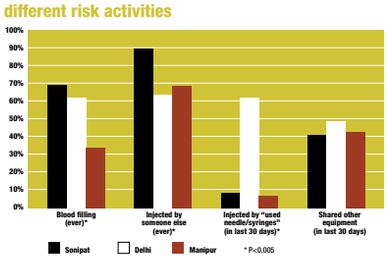

Table: Condom usage during last sex with any partner (permanent/casual/commercial)

Characteristics	Condom Usage (%)	P value Asymp. Sig. (2-sided)
Age		
<=25 years	61.1	0.016
25-35 years	32.3	
> 35 years	69.9	
Education		
Primary and lower	44	0.05
High School and above	68.2	
Location		
Delhi	28.6	0.000
Imphal	86.8	
Sonipat	65.1	

Conclusions

PWID between 25-35 years, undereducated, and living on the street are having unsafe sex more frequently as compared to PWID with other demographic characteristics. Condom use varies by location, indicating a need to encourage safer sex behaviours among PWID, particularly in metro areas. A qualitative study on the dual risks of injecting drug use and sexual behaviour would provide additional insights on the context and risk behaviours of PWID and would help contribute to the development of improved harm reduction intervention strategies to better address their needs.

Acknowledgements

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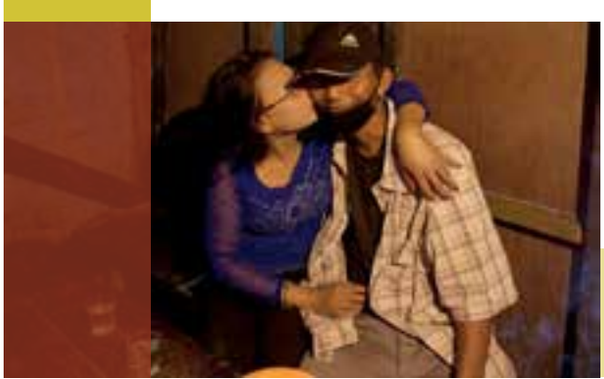

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Mobilising community collectivisation among female sex workers to promote STI service utilisation from the government health care system

Experience from Avahan: India AIDS Initiative

India HIV/AIDS Alliance

Authors

Parimi Prabhakar[1], Ram Manohar Mishra[2], Saroj Tucker[1], Niranjan Saggurti[2]

[1] India HIV/AIDS Alliance, Andhra Pradesh, India [2] Population Council, India

Community mobilisation is vital to encourage higher utilisation of HIV and STI services in government health facilities by geographically-dispersed rural female sex workers.

Background

A cost-effective approach to providing sustainable services for the management of Sexually Transmitted Infections (STIs) among female sex workers (FSWs) in rural areas is essential in India. With support from the Bill & Melinda Gates Foundation's Avahan India AIDS Initiative, India HIV/AIDS Alliance has implemented an HIV prevention program among FSWs and MSM in 14 districts of Andhra Pradesh since 2004. The program has worked with a total of 36,905 FSWs, of whom 14,180 were in rural areas and geographically dispersed.

In the program's community mobilisation efforts, rural FSWs are educated about the capacity of government health centers to meet their comprehensive health requirements, including sexual and reproductive health. Community mobilisation has increased demand for STI services in government health centers, and such initiatives have been shown to decrease vulnerability to HIV and STIs in this population.

Methods

This study examined the effect of community mobilisation on self-efficacy and utilisation of STI care services from government health centers among FSWs. Data were from a cross-sectional behavioural survey conducted among FSWs in Andhra Pradesh during 2010-11. FSWs were selected for the survey using time-location cluster sampling (for subjects based in public places) and conventional cluster sampling (for home/brothel/dhaba/lodge-based subjects). The total sample size achieved was 1,986.

Results

Data from this study showed the following:

Socio-Demographic Characteristics

Demographic characteristics	Values
Mean Age (SD)	29.2 (5.3)
Ability to read and write	46.2%
Currently married	57.1%
Typology of sex work	
Home-based	28.5%
Public place	63.8%
Brothel-based	7.7%
Mean duration of sex work in years (SD)	4.4 (2.4)

Key Independent and Outcome Variables

Indicators of Community Mobilisation & Service Delivery Model	%
Collective Efficacy: High	89.0%
Collective Agency: High	50.7%
Collective Action: High	12.7%
Summary Measure of Community Mobilisation: High	39.5%
Service Delivery Model: Partnership with government health centers	56.2%
Outcome Indicators	
Self-efficacy for service utilisation from government health centers	64.3%
STI treatment-seeking from government health centers*	69.8%

*Among FSWs who reported any STI in past one year (N= 1014; 51.1%)

*Overall Collectivisation** Project Partnership with Government Health Centers for STI Treatment

	Low*No	Low*Yes	High*No	High*Yes
Self-efficacy for service utilisation				
%	54.0%	59.9%	70.3%	78.2%
AOR (95% CI)	Referent	1.3 (1.0-1.6)	2.1 (1.6 – 2.9)	3.4 (2.6 – 4.6)
Treatment of STI from government health centers				
%	58.5%	67.4%	79.9%	76.6%
95% CI	Referent	1.5 (1.1 – 2.1)	2.9 (1.9 – 4.4)	(1.6-3.4)

The combination of dummy for STI service partnership with government health centers and levels of collectivisation represent FSWs with a low (or high) level of collectivisation from areas where intervention collaborated (or did not collaborate) with government health centers to deliver STI services. The proportion of FSW with high self-efficacy for service utilisation varied significantly across the combinations of levels of collectivisation and service delivery models.

Conclusions

The data show that the levels of community mobilisation are high among FSWs. There is a significant relationship between community mobilisation and accessing health facilities by FSWs. The degree of community collectivisation is predictive of self-efficacy and STI service utilisation at government health centers.

The results support growing evidence of the effect of community mobilisation on HIV/STI risk reduction and highlight the need for programs to provide ongoing support to vulnerable communities to sustain these efforts. The findings also suggest that targeted HIV interventions need to focus on geographical areas and sites where FSWs are less collectivised in order to motivate increased utilisation of government health centers.

Acknowledgements

India HIV/AIDS Alliance would like to thank the FSWs who took part in this study. This work was supported by the Population Council's Knowledge Network project, also funded by the **Bill & Melinda Gates Foundation** through Avahan. Both India HIV/AIDS Alliance and Population Council are grateful for the Foundation's support of our work. The views expressed here are those of the authors and do not necessarily reflect the official policy or position of the Bill & Melinda Gates Foundation.

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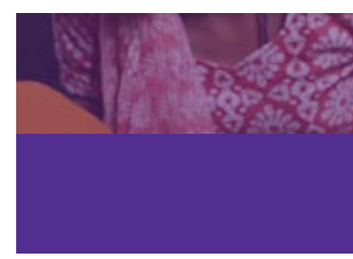

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Non-Commercial Partner Relationships and HIV Risk among Female Sex Workers in Andhra Pradesh, India

Experience from Avahan: India AIDS Initiative

Authors

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Increased attention is needed to address HIV risk and other vulnerabilities of FSWs that occur in non-commercial partner relationships.

Background

HIV prevention interventions in India have resulted in higher levels of consistent condom use among FSWs with commercial sex partners even while levels of consistent condom use with non-commercial sexual partners such as husbands, boyfriends, pimps, and police have remained lower. Non-commercial partners have been found to act both as protectors and as perpetrators of violence.

Although studies in other parts of the world have documented the role of non-commercial partnerships in increasing the vulnerability of FSWs to HIV due to low levels of condom use in these relationships, the impact of other effects of these relationships on HIV vulnerability of FSWs has not been studied and is less well understood. The present study examines the role of non-commercial partnerships—especially those with a husband—on HIV vulnerability among FSWs in Andhra Pradesh, a southern state with the highest HIV burden in India.

Methods

Data were drawn from a cross-sectional behavioural and biological survey conducted in 2009 among 3,225 FSWs in Andhra Pradesh, India. The study included the following:

- Independent measures:
  - Presence of any non-commercial sexual partner (no, yes)
  - Nature of such partnerships (steady, unsteady)
- Study outcomes:
  - Experiences of violence, practice of anal sex, inconsistent condom use with commercial partners
  - STI and HIV status
- Analysis:
  - Comparison of study outcomes by presence and nature of non-commercial partners
  - Use of multiple logistic regression models

Results

HIV prevalence was found to be higher among FSWs who did not have non-commercial partners compared to those who reported any non-commercial partner. FSWs who had non-commercial partners were more likely to have experienced: physical violence in the past six months; forced sex in the past 12 months; and practiced anal sex in the past week. [See Table 1.]

Table 1: Prevalence of HIV, STI and Associated HIV Risk Behaviors Stratified by Presence of Non-commercial Partners (N=3,225)

Outcome indicators	Presence of any non-commercial partner			
	No (N = 810)	Yes (N = 2,415)	Crude OR (95% CI)	Adjusted OR (95% CI)
HIV	18.3	11.5	0.6 (0.5 – 0.7)	0.5 (0.4 – 0.7)
Syphilis	7.2	5.8	0.8 (0.6 – 1.1)	1.0 (0.7 – 1.4)
Neisseria gonorrhoea	3.0	2.7	0.9 (0.5 – 1.4)	0.7 (0.5 - 1.2)
Chlamydia trachomatis	4.0	3.3	0.8 (0.6 – 1.3)	0.9 (0.6 – 1.7)
Inconsistent condom use with occasional clients	16.0	17.7	1.1 (0.9 – 1.4)	1.1 (0.9 – 1.5)
Inconsistent condom use with regular clients	16.9	17.8	1.1 (0.8 -1.4)	1.1 (0.8 – 1.3)
Experience of physical violence, past 6 months	18.9	25.9	1.5 (1.2 – 1.8)	1.7 (1.4 – 2.1)
Experience of forced sex, past 12 months	13.4	16.9	1.3 (1.1 – 1.7)	1.4 (1.1 – 1.7)
Ever had anal sex	18.5	26.1	1.6 (1.3 – 1.9)	1.5 (1.2 – 1.9)
Practice of anal sex, past one week	12.5	20.9	1.9 (1.5 – 2.3)	1.7 (1.4 – 2.1)
No condom use in last anal sex	7.8	8.2	1.0 (0.4- 2.1)	0.7 (0.4 – 1.5)

Note: FSWs who reported not having non-commercial partners were considered as the reference category for computing crude and adjusted odds ratios.

FSWs with non-commercial partners who had unsteady relationships were more likely to: be HIV-positive; have syphilis; practice inconsistent condom use with occasional clients; have experienced physical violence in the past six months; have experienced forced sex in past 12 months; and have practiced anal sex in the past week. [See Table 2.]

Table 2: Prevalence of HIV, Syphilis and Associated Risk Behavior by Presence of Husband/Spouse among those FSWs who have Non-commercial Partners (N =2,415)

Outcome indicators	Nature of non-commercial relationship			
	Steady (N=1,792)	Unsteady (N=623)	Crude OR (95% CI)	Adjusted OR (95% CI)
HIV	10.9	13.1	1.2 (0.9 – 1.6)	1.4 (1.1 – 1.8)
Syphilis	4.2	10.3	2.6 (1.9 – 3.7)	2.3 (1.6 – 3.3)
Neisseria gonorrhoea	2.3	2.8	0.8 (0.4 – 1.5)	0.9 (0.5 – 1.7)
Chlamydia trachomatis	4.3	3.0	1.5 (0.9 – 2.3)	1.3 (0.8 – 2.2)
Inconsistent condom use with occasional commercial partners	16.5	21.0	1.3 (1.1 – 1.8)	1.5 (1.2 – 1.9)
Inconsistent condom use with regular commercial partners	17.5	18.6	1.1 (0.8 – 1.4)	1.1 (0.9 – 1.5)
Experience of physical violence, past 6 months	21.9	37.4	2.1 (1.7 – 2.6)	1.9 (1.5 – 2.3)
Experience of forced sex, past 12 months	14.1	25.1	2.0 (1.6 – 2.6)	1.9 (1.5 - 2.4)
Ever had anal sex	22.2	35.2	1.9 (1.5 – 2.3)	1.9 (1.6 – 2.4)
Practice of anal sex, past one week	17.7	30.1	1.9 (1.6 – 2.5)	2.1 (1.7 – 2.6)
No condom use in last anal sex	8.4	8.0	0.9 (0.5 – 1.7)	1.1 (0.5 – 2.1)

Note: FSWs who reported living with husband were considered as the reference category for computing crude and adjusted odds ratios.

Conclusions

Study findings show that although FSWs who have only commercial sex partners have a higher burden of HIV, other vulnerabilities are higher among those who have non-commercial partner relationships as well. Among those FSWs with non-commercial partner relationships, vulnerabilities are significantly higher among those in unsteady relationships.

While HIV prevention efforts among FSWs should continue to focus on commercial sex, increased attention is needed to address HIV risk and other vulnerabilities of FSWs that occur in non-commercial partner relationships.

Acknowledgements

India HIV/AIDS Alliance would like to thank the FSWs who took part in this study. This work was supported by the Population Council's Knowledge Network project, also funded by the Bill & Melinda Gates Foundation through Avahan. Both India HIV/AIDS Alliance and Population Council are grateful for the Foundation's support of our work. The views expressed here are those of the authors and do not necessarily reflect the official policy or position of the Bill & Melinda Gates Foundation.

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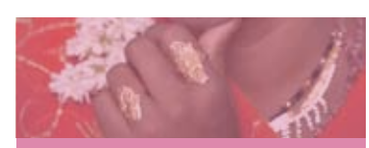

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Not a 'Minor' Issue

Does HIV Prevention Programming Address the Vulnerabilities of Adolescent MSM and Transgenders under 18 Years?

Findings from the Pehchan Midline Study in India

Authors

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Immediate and urgent action is needed to address HIV risk and other vulnerabilities of adolescent and younger MSM, transgender and hijra community members.

Background

HIV prevalence among men who have sex with men (MSM) in India remains disproportionately high at 4.43% as compared with overall national prevalence of 0.3% (National AIDS Control Organisation, 2012). India HIV/AIDS Alliance in consortium with five other organisations implements the five-year Global Fund-supported Pehchan programme in 17 Indian states to build the capacity of 200 community based organisations (CBOs) to serve as effective HIV prevention partners with the National AIDS Control Programme and reach 453,750 MSM, transgenders and hijras (MTH) using a community-driven and rights-based approach. Pehchan conducted a midline study to understand demographics, behavioural pattern and needs of the target populations.

Methods

A mixed method of evaluation was adopted using a cross-sectional study that sampled 601 MSM, transgender and hijra subjects (30% transgender/hijra) covering 23 districts across 6 states among CBOs that had provided services for at least six months under the Pehchan programme. Probability Proportion to Size (PPS) method and systematic random sampling were used. 72 focus group discussions (FGDs), 79 key informant interviews (KIIs), 24 in-depth interviews (IDIs) were conducted as part of midline's qualitative process. Active engagement of the MTH community was prioritised in all steps of the study from design to data collection and through to report finalisation.

Results

Demographic profile: Nine percent of respondents who were less than 24 years of age were illiterate. Eighteen percent in the 18-24 age group indicated sex work as their primary occupation, and 24% as their secondary occupation.

Sexual Behaviour: Two thirds of respondents reported first sex at less than 18 years of age, with median age at first sex of 15 years. For transgenders, it was lower at 14 years of age. Almost two-thirds of respondents (62%) had their first sexual encounter (peno-vaginal/oral/anal) with any female partner when they were in the age group of 18-24 years and 24% when they were below 18 years of age. Consistent condom usage in last one month was at 61% with regular partner and 73% with non-regular partner. This was lower when compared with the older age group (78.2%, $p<0.05$). (See Table.)

Increased vulnerabilities: A quarter of the 18-24 age group responded as having more than 10 sexual acts per month, higher compared to other age categories. Consistent condom use in anal sex in the last six months is lower ($p<0.001$) for this age group when compared to older age group. Though a lower proportion of younger respondents have undergone HIV testing ($p<0.05$), the reported sero-positivity in the age group 18-24 is 2.8%, and 4.3% among 18 and 19 year-old respondents. Qualitative study findings reveal MSM in the younger age group of 18-24 are sexually active and report exploring different types of sex with their partners. For this group, anal sex was reported as the most preferred sexual activity.

Table: Condom use among MSM, Transgender and Hijras

Type of Partner	Condom Use Percentage					
	Last Sexual Encounter		Consistent use in Last One Month		Consistent use in Last Six Month	
	18-24 Years	> 24 Years	18-24 Years	> 24 Years	18-24 Years	> 24 Years
Regular Partner	77	85	63	68	55	63
Non Regular Partner	86	90	70	82	59	77

Conclusions

While the mean age of sexual debut is lower than 18 years in both MSM and transgender/hijra subjects, HIV prevention interventions in India typically do not reach out to these populations until they reach the age of 18 due to concerns about working with legal minors. Without access to the information and resources like condoms and lubricant, these young people have sex often without understanding the risks to themselves and their partners. Young MSM reported low consistent condom use with regular and non-regular partners. Furthermore, risk perception is also low among young MTH. Considering the higher HIV prevalence among 18 and 19-year olds studied in comparison to the 18-24 age group overall, it can be inferred that some of them have acquired the infection before reaching 18 years of age. While more research is needed, these data indicate a gap in the HIV prevention response for adolescents in high-risk groups, requiring immediate and urgent action to address HIV risk and other vulnerabilities of adolescent and younger MSM, transgender and hijra community members.

Acknowledgements

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Public-private partnership as a sustainable model for STI service delivery

Evidence from Avahan-supported interventions in Andhra Pradesh, India

Authors

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Background

Providing quality STI services for sex workers without stigma or discrimination and providing the services at lower operating costs to make them sustainable are essential to HIV control efforts in resource-poor settings such as India. To identify the most effective healthcare model for STI service delivery, three models were introduced in 13 districts in Andhra Pradesh as part of a comprehensive HIV prevention intervention program funded by the Bill & Melinda Gates Foundation through its Avahan India AIDS Initiative. The three models were project-owned clinics, private clinics, and public-private partnership (PPP) clinics.

The PPP clinics were called Mythri Clinics. The model uses infrastructure and personnel of existing public healthcare facilities and provides an essential package of STI services; services are provided to clients from key population (KP) communities—female sex workers, men who have sex with men, and transgender individuals—after regular outpatient hours.

Methods

Analysis was performed on program data that showed 52,117 sex workers attended 127 clinics (49 project-owned clinics, 48 PPP clinics and 30 private clinics) between January and December 2010. Indicators used for analysis were: coverage of services, number of consultations, services availed, regular medical check-ups, STI rates, syphilis screening, and screening for HIV/STIs. For cost comparative analysis, the annual operational costs for each model were used to calculate unit costs, based on total clients who visited the site.

Results

The PPP model was cost-effective (INR 155 per patient per annum) in providing STI services when compared to project-owned model (INR 303 per patient per annum) and private models (INR 191 per patient per annum). [USD 1 = INR 50] Additionally, performance indicators of the PPP model were higher than those of the other models: higher percentage of KPs accessing clinical services (31% vs. 29%), availing STI consultations (72% vs. 70%), STI detection rate (6% vs. 3%), and higher percentage of screening for syphilis (86% vs. 81%) and for HIV (68% vs. 41%). [See Box.]

"Now I go to government hospitals like anyone else; thanks to Mythri Clinics, I am able to access STI services without any stigma. I'm healthier now."

32-year-old rural sex worker and Mythri Clinic client

Conclusions

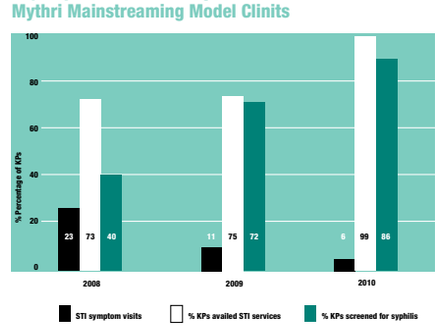
The PPP Mythri clinic model:

- Led to a more efficient use of infrastructure and personnel of the existing public healthcare facilities.
- Leveraged strengths of both the public and the private sector.
- Resulted in sustainable availability of STI services .
- Supported STI services that were more KP-friendly; KPs were less vulnerable to the stigma often found in STI clinics.
- Strengthened government facilities in terms of infrastructure and staff capacities.

Box: Outcome Indicators for Three Models of STI Service Delivery

Indicator	Mythri Clinics	Project-owned Clinics	Private Clinics
Number of total KPs covered	13,351	33,850	5,538
Percentage of KPs accessing clinic services every month	31%	29%	28%
Percentage of KPs availing STI consultations every quarter	72%	70%	70%
Percentage of KPs availing RMC every quarter	68%	68%	66%
STI rates	6%	3%	5%
Percentage of KPs screened for syphilis during the year	86%	81%	78%
Percentage of KPs screened for HIV during the year	68%	66%	62%

Key Population Accessing STI Services from Mythri Mainstreaming Model Clinits



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Reaching Key Populations in HIV/SRH Integration

Recommendations from a global intervention review to identify strategies to increase the responsiveness and relevance of integrated programming to the sexual and reproductive health and rights and needs of high-risk groups, including sex workers, MSM, transgenders, IDUs and PLHIV

India HIV/AIDS Alliance

Authors

Sunita Grote[1], Sarah Middleton-Lee[2], James Robertson[1], Sonal Mehta[1]

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Common challenges across integrated programmes for key populations highlight the need to follow good practice principles for programming for these communities.

Background

While policy and implementation support for HIV/SRHR integration is increasing, significant questions and uncertainties remain about what such programming means in practice. This is particularly the case in concentrated epidemics, where little is known about what integration should look like for key populations. While integration may be desirable in the long-run; concerns remain about how joining programmes and systems that are not ready could compromise quality of and access to services for these groups that already face difficulty in obtaining appropriate services for both HIV and SRH needs.

Methods

A global review of over 160 resources focusing on HIV/SRHR integration for key populations and available on websites of selected national and international organisations was undertaken. The objective of the review was to assess how HIV/SRHR integration can not only improve the efficiency of programmes but truly serve the needs of key populations. The review analysed successful approaches and lessons learned to inform future programme development, implementation and evaluation.

Results

- Common challenges across integrated programmes for key populations highlighted the need to follow good practice principles for programming for these communities (see Box.)

Box: 'Top 10' challenges in HIV/SRHR integration for key populations

1.	Stigma and discrimination related to HIV and key populations
2.	Low demand for HIV/SRHR integrated services by key populations
3.	Lack of rights-based approaches to HIV/SRHR
4.	Low attention to gender inequality in HIV/SRHR integration
5.	Missed obvious opportunities for HIV/SRHR integration
6.	Low understanding of key populations' specific and diverse HIV/SRH needs
7.	Presumptions or lack of expertise among service providers
8.	Lack of a strong referrals systems for HIV/SRHR integration
9.	Inappropriate design of HIV/SRHR integration
10.	Lack of political, technical and financial support to create an enabling environment for scale-up of integrated services

- Across documented programmes and guidance, the lessons learned of multiple organisations include key steps can be taken to put HIV/SRHR integration into action and maximise its effectiveness among key populations:

1. Promote good practice principles for key populations:
   - Recognise the centrality of community organisations and systems
   - Use a rights-based approach that recognises key populations' individual rights
   - Ensure the principle of the greater involvement of communities at all stages
   - Take a family-centred approach that supports not only the needs of key populations, but those around them
2. Plan and start HIV/SRHR integration by building on 'what's there', gathering evidence and identifying key entry points
   - Use a situational analysis to understand what type of HIV/SRHR integration is effective and/or possible
   - Identify, understand and respond to the diversity of HIV/SRHR needs within key populations
3. Ensure comprehensive HIV/SRHR integrated programming:
   - Use comprehensive definitions of HIV and SRHR that go beyond the 'usual suspects' for integration
   - Address how key populations' different types and levels of vulnerability inter-relate
   - Proactively address stigma and discrimination as a fundamental barrier
4. Ensure effective and creative service delivery:
   - Create demand as well as flexible delivery and supply for HIV/SRHR integrated services
   - Recognise peer education as a critical strategy in HIV/SRHR for key populations
5. Ensure a strong 'chain' of HIV/SRHR integrated services, including through high quality and systematic referrals:
   - If integration involves referrals, ensure the quality, confidentiality and 'key population-friendliness' of such services
6. Promote HIV/SRHR integration at all levels, including building an enabling internal and external environment:
   - Build a multi-level approach to HIV/SRHR integration for key populations that includes, but goes beyond, the provision of joint services
   - Ensure that training and spaces to support integrated programming for key populations are appropriately targeted, comprehensive and high quality
7. Address the political, legislative and funding context of HIV/SRHR integration for key populations:
   - Complement the provision of integrated services with local/national advocacy on legislative, structural and policy barriers to HIV/SRHR for key populations

Conclusions

Integration is a vital strategy to respond to the unmet HIV and SRHR needs of key populations. However, integration that is premature, overly rapid or too large-scale risks compromising rather than enhancing access to high quality HIV and SRH services. In the short-term, full HIV/SRHR integration is not required. Community systems and organisations (particularly those that are by and for key populations themselves) are critical to making integration happen.

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Reaching MSM and transgenders in HIV/SRHR integration

Recommendations from a global intervention review to identify strategies to increase the responsiveness and relevance of integrated programming to the sexual and reproductive health and rights of high-risk groups

India HIV/AIDS Alliance

Authors

Sunita Grote[1], Sarah Middleton-Lee[2], James Robertson[1], Sonal Mehta[1]

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Integration is a vital strategy to respond to the unmet HIV and SRHR needs of MSM and transgenders.

Background

Men who have sex with men (MSM) and transgender (TG) people often experience greater vulnerability to poor SRH, may have specific or more complex needs and experience additional barriers to accessing and demanding services. While policy support for HIV/SRHR integration is increasing, significant questions persist about what such programming means in practice for key populations. Integration may be desirable in the long-run; concerns remain about how joining programmes and systems that are not ready could compromise quality of and access to services.

Methods

A global review of over 160 resources focusing on HIV/SRHR integration for key populations and available on websites of selected national and international organisations was undertaken. The objective of the review was to assess how HIV/SRHR integration can not only improve the efficiency of programmes but truly serve the needs of MSM and TG people. The review analysed successful approaches and lessons learned to inform future programme development, implementation and evaluation.

Results

- There appears to be little clear consensus on the most effective HIV/SRHR integration strategies specifically for MSM and TG people.
- Common challenges across integrated programmes for key populations highlighted the need to follow good practice principles for programming for these communities. These include the need to address stigma and discrimination, demand generation, gender inequalities, service provider attitudes and capacity and to ensure rights based approaches, adequate and appropriate evidence and information to understand diverse needs, strong referral systems and adequate technical and financial support.
- What lessons have been learned about HIV/SRHR integration for MSM and TG people?
  - **Understand the different 'types' of MSM and TG people and, in turn, their different HIV/SRHR needs:** Experiences of social stigma and discrimination, and roles and relationships may differ between different men (including receptive vs. penetrative sex, male and/or female, multiple partners or paying clients)
  - **Recognise the specific vulnerability and needs of transgender people** – in many contexts, TG people are particularly marginalised from services, with their SRHR needs poorly understood or addressed
  - **Not make presumptions about the HIV/SRHR needs or desires of MSM and TG people**
  - **Emphasise the rights of sexual minorities and of MSM and TG people living with HIV**
  - **Provide specific support to female partners of MSM** – may require tailored referrals or direct service provision.
  - **Recognise and address the reality that most SRH services assume heterosexual clients** – especially married couples.

HIV/SRHR Service Package for MSM and Transgenders

The review indicated that, building on a generic essential package for HIV/SRHR, there are a number of components that may need specific attention in integrated programming for MSM and TG people. These include information, support and services related to:

- **'Tailor made' HIV prevention and behaviour change communication**
- **Sexuality and sexual health**
- **Support for TG people on gender reassignment and feminising procedures**
- **STIs**
- **Negotiation within sexual relationships**
- **Hepatitis information and vaccination**
- **Sexual violence, including PEP**
- **Screening, vaccination and support in relation to HPV and anal cancer**
- **Sexual dysfunction**
- **Condoms and lubricants**
- **Safer sex**
- **Legal support**
- **Support for sexual partners including FP, MNCH and other SRHR services for female partners**
- **Counselling and support for disclosure of sexuality and/or HIV status**

Conclusions

Integration is a vital strategy to respond to the unmet HIV and SRHR needs of MSM and transgenders. However, integration that is premature, overly rapid or too large-scale risks compromising rather than enhancing access to high quality HIV and SRH services for MSM and transgenders. Good practice principles are particularly critical in HIV/SRHR integration for these populations.

Acknowledgements

India HIV/AIDS Alliance would like to thank the **European Commission** for its support to Action Project. Alliance India acknowledges the Action teams at MAMTA and SASO in India and HASAB in Bangladesh.

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Reaching people who use drugs in HIV/SRH integration

Recommendations from a global intervention review to identify strategies to increase the responsiveness and relevance of integrated programming to the sexual and reproductive health and rights needs of high-risk groups

India HIV/AIDS Alliance

Authors

Sunita Grote[1], Sarah Middleton-Lee[2], James Robertson[1], Sonal Mehta[1]

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Integration efforts need to assess, recognise and address the complex interactions between drug use/harm reduction, HIV and SRHR.

Background

People who use drugs (PWUD) often experience greater vulnerability to poor SRH, may have specific or more complex needs and experience additional barriers to accessing and demanding services. While policy support for HIV/SRHR integration is increasing, significant questions persist about what such programming means in practice for key populations. Integration may be desirable in the long-run; concerns remain about how joining programmes and systems that are not ready could compromise quality of and access to services.

Methods

A global review of over 160 resources focusing on HIV/SRHR integration for key populations and available on websites of selected national and international organisations was undertaken. The objective of the review was to assess how HIV/SRHR integration can not only improve the efficiency of programmes but truly serve the needs of PWUD. The review analysed successful approaches and lessons learned to inform future programme development, implementation and evaluation.

Results

- There appears to be little clear consensus on the most effective HIV/SRHR integration strategies specifically for PWUD.
- Common challenges across integrated programmes for key populations highlighted the need to follow good practice principles for programming for these communities. These include the need to address stigma and discrimination, demand generation, service provider attitudes and capacity and to ensure rights-based approaches, appropriate evidence and information to understand diverse needs, strong referral systems and technical and financial support.
- What lessons have been learned about HIV/SRHR integration for PWUD?
  - Assess, recognise and address the complex interactions between drug use/harm reduction, HIV and SRHR – including how drug use can affect choices or decisions in relation to sexual pleasure and risk-taking and how different drugs and medicines interact.
  - Avoid presumptions about behaviours or the HIV/SRHR needs of PWUD.
  - Within integrated programming address the cross-cutting issue of gender dynamics –many programmes are male-oriented and focused on drug use and HIV. Acknowledge gender dynamics in sexual and injecting practices and adopt gender-transformative approaches.
  - Provide a comprehensive package of integrated SRHR/HIV support for people who use drugs. For example, a recommended package of service for drop-in centre level includes condoms and STI diagnosis and treatment, SRHR support for women who use drugs and the female partners of men who use drugs, BCC among sexual partners, and accompanied referrals to other SRHR services.

HIV/SRHR Service Package for PWUD

The review indicated that, building on a generic essential package for HIV/SRHR, there are components that need specific attention in integrated programming for PWUD. These include information, support and services related to:

- **Full range and 'drug use-friendly' options to prevent HIV, STIs and unwanted pregnancy**
- **Interactions between different types of drugs**
- **Safer sex practices while under the influence of different types of drugs**
- **Specific SRHR issues for people who use drugs (e.g. sexual dysfunction for men, impact on menstruation and fertility for women)**
- **Female drug users who are pregnant with access to a full range of supportive PMTCT and MNCH services**
- **Empowerment on sexual and health rights**
- **SRHR needs of female partners of men who use drugs**
- **Sexual violence, including PEP**
- **Sexual counselling (e.g. on the relationship between sexual drive, performance and drug use)**
- **Family welfare services**
- **(Where legal) access to safe and confidential abortion and (in all contexts) post-abortion care**
- **Diagnosis and treatment for TB and Hepatitis B and C**

Conclusions

Integration is a vital strategy to respond to the unmet HIV and SRHR needs of PWUD. However, integration that is premature, overly rapid or too large-scale, risks compromising rather than enhancing access to high quality HIV and SRH services for PWUD. Good practice principles are particularly critical in HIV/SRHR integration for these populations.

Acknowledgements

India HIV/AIDS Alliance would like to thank the **European Commission** for its support to Action Project. Alliance India acknowledges the Action teams at MAMTA and SASO in India and HASAB in Bangladesh.

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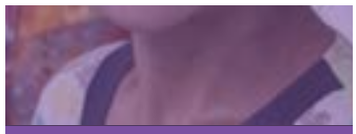

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MOPE403

Reaching the hard-to-reach

Community engagement and facilitation as a research strategy with MSM, transgender and hijra populations in the Global Fund-supported Pehchān program in India

Authors

Anindita Biswas[1], Kaushik Biswas[1], Goverdhan Kummarikunta[1], Abhina Aher[1], Simran Shiekh[1], Shaleen Rakesh[1], Sonal Mehta[1], James Robertson[1]

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Community engagement and facilitation is critical during both the design and implementation of studies with MSM, transgender and hijra populations.

Background

HIV prevalence among MSM in India remains disproportionately high in India—most recently measured at 5.1% in provisional 2011 data from the National AIDS Control Organisation—as compared with overall national prevalence of 0.3%. India HIV/AIDS Alliance in consortium with four other organizations implements the five-year Global Fund-supported **Pehchān** program in 17 Indian states to build the capacity of 200 CBOs to serve as effective HIV prevention partners with the National AIDS Control Programme and reach 453,750 MSM, transgenders and hijras using a community-driven and rights-based approach. Pehchān conducted a baseline study to understand demographics, behaviour and needs of the target populations.

Methods

A cross-sectional baseline study interviewed 2,762 MSM, transgenders and hijras (MTH) (TG/H: 16%) in 55 districts across 10 states. Active community engagement was prioritized in all steps of the study from design to report finalisation. This ensured that the research was done with appropriate sensitivity to community issues and needs.

The research instrument was developed using a community-led process, and respondents were interviewed by community members known as 'Community Facilitators' who facilitated access into cruising areas and other places where it might not be possible to enter without assistance or guidance. Time and Location Cluster Sampling (TLCS) was used to identify these often hard-to-reach and relatively mobile populations. Data were analysed using SPSS software.

Results

Community engagement helped break barriers to reaching MSM, transgender and hijra community members for the baseline study. This access permitted insights into the current behavioural patterns of the MTH individuals studied and facilitated exploration of topics considered sensitive or stigmatising.

Community facilitation offered a number of advantages, as it:

- Supported the development of a responsive research process and contributed to the subsequent analysis of data.
- Allowed a field investigation process with increased awareness of community concerns and perspectives.
- Enabled better access to respondents and improved the overall quality and accuracy of data collected.
- Helped interviewers ask sensitive questions on topics such as the experience of internalised stigma, marital status, disclosure of identity, usage of lubricants, sexual reassignment surgery (SRS), and violence.

Conclusions

The information gathered in the baseline provided direction for intervention planning and design strategies for Pehchan across India, particularly in states with few HIV prevention interventions for MTH communities and little data on their behavior and needs.

Community engagement and facilitation is critical during both the design and implementation of studies with MSM, transgender and hijra populations. The approach impacts the overall quality of research and permits more robust inferences to inform program strategy, implementation, and advocacy planning. Reaching out to MTH populations is a challenge due to social stigma and the hidden nature of their sexual lives. Building on the core values of Pehchān, such barriers were bridged with active community engagement and facilitation, an approach that has informed all aspects of the program.

Acknowledgements

India HIV/AIDS Alliance would like to thank the **Global Fund to Fight AIDS, Tuberculosis and Malaria** for its support of Pehchān. Alliance India is grateful for our collaboration with India's National AIDS Control Organisation and for their many contributions to the success of our efforts. Alliance India acknowledges the Pehchān teams at the Humsafar Trust, SAATHII, Sangama, and SIAAP, and the 2,762 members of the MSM, transgender and *hijra* communities in India interviewed for this study.

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Re-tooling Data Quality

Implementation of an automated validation tool to improve data quality in large-scale HIV interventions for female sex workers under Avahan programme in Andhra Pradesh, India

Authors

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The use of a simplified automated data validation tool for strengthening planning and focused capacity building of staff in all targeted intervention programs in India is recommended.

Screenshot of CMIS

Graph: Errors in outreach data

Background

India's HIV response has embraced UNAIDS "Three Ones" principles, which includes a unified national monitoring and evaluation system that ensures provision of high-quality data for analyzing the country's overall performance. Built-in quality assurance mechanisms such as data validation of indicators for error detection and correction are essential before submission of reports to the national monitoring system.

Currently, the data validation procedure is manually performed, labor-intensive, and time-consuming. Data are manually entered in an Excel file that captures six indicators: outreach, IEC; CBOs, linkages, commodity distribution; advocacy, TI – HR, trainings; STI services, diagnosis; syphilis, lab diagnosis, drugs; and STI – HR, trainings. There is high probability of errors in the report due to data compilation or calculation errors, typographical errors, errors due to misunderstanding of definitions, and data manipulation errors. On an average, it takes one to two hours to manually check each monthly report, and the state level validation process is also not thorough enough to detect all the errors.

The objective of this study was to compare error rate in indicator reports before and after the introduction of a data validation tool in Targeted Intervention (TI) HIV prevention programs for female sex workers (FSWs), supported by India HIV/AIDS Alliance in Andhra Pradesh with funding from the Bill & Melinda Gates Foundation's Avahan India AIDS Initiative since 2004. An automated validation tool was developed and launched in August 2012 to detect errors and to provide feedback to all NGOs.

Method

A simplified automated data validation and feedback tool was developed and piloted for validation of all indicators submitted by 36 sex worker HIV prevention interventions in the state. The validation tool was developed in VB ASP.NET framework and hosted on the Alliance India website. (See Screenshot.) The tool was available both online and offline. Monthly reports were classified as correct, incorrect and missing before and after utilization of the validation tool. Data values in 36 reports on 40,140 sex workers were compared monthly from September 2012 to December 2012. Proportions of total errors and missing values were compared using chi-square test.

Result

The total proportion of errors decreased from 540 (6.7%) in September to 72 (0.9%) in December for all reports ($P<0.001$). The proportion of errors decreased for outreach from 468 (11.8%) to 36 (0.9%); for HIV/STI from 72 (1.8%) to 36 (0.8%) (For all $P<0.0001$). (See Graph.)

The time for validation of and feedback on all monthly reports from Targeted Interventions decreased from four days to one hour, and timeliness of reporting improved in 35/36 interventions. Eighty percent of intervention-level staff appreciated the automation of validation and timely feedback for correction of reports.

Conclusions

The introduction of the data validation tool improved the quality of reporting with a significant reduction in missing and incorrect information and improvement in validation/feedback time. The validation tool has improved the planning of focused capacity building activities of NGO staff on documentation of outreach, condom distribution and tracking of high-risk key populations attending STI clinics. The use of a simplified automated data validation tool for strengthening planning and focused capacity building of staff in all targeted intervention programs in India is recommended.

Acknowledgements

India HIV/AIDS Alliance would like to thank the Bill & Melinda Gates Foundation for its support of Avahan in Andhra Pradesh. Alliance India acknowledges the valuable collaboration with the Andhra Pradesh State AIDS Control Society that has contributed to the success of these efforts.

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Sexual behaviour of MSM, transgenders and hijras with female partners

An analysis of data from the baseline survey of the Global Fund-supported Pehchān program in India

Authors

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Targeted behaviour change messages are needed to raise awareness of specific considerations for MSM practicing both vaginal and anal sex with female partners.

Background

HIV prevalence among MSM in India remains disproportionately high in India—most recently measured at 5.1% in provisional 2011 data from the National AIDS Control Organisation—as compared with overall national prevalence of 0.3%. Though currently under review by India's Supreme Court, the 2009 decision by the Delhi High Court to decriminalise homosexuality has improved the legal environment, even while stigma and discrimination continue to undermine the health and wellbeing of MSM, transgenders and hijras across the country.

India HIV/AIDS Alliance in consortium with four other organisations implements the five-year Global Fund-supported **Pehchān** program in 17 Indian states to build the capacity of 200 CBOs to serve as effective HIV prevention partners with the National AIDS Control Program and reach 453,750 MSM, transgenders and hijras using a community-driven and rights-based approach. Pehchān conducted a baseline study to understand demographics, behaviour and needs of the target populations.

Methods

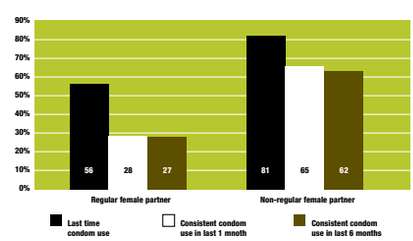
A cross-sectional baseline study sampled 2,762 MSM, transgenders and hijra in 55 districts across 10 states. Time and Location Cluster Sampling (TLCS) was used to identify these often hard-to-reach and relatively mobile populations. Data were analysed using SPSS. For the purpose of the baseline study, an umbrella term—"MSM spectrum"—was employed to capture collectively the range of identity sub-groups used by these populations in India to describe themselves: gay, kothi/B-MSM/mangalamukhi, panthi/A-MSM, double-decker/AB-MSM, bisexual, and those who self-identify as "MSM." In line with the program's model, 16.5% of respondents were transgender or hijra.

Results

Covering a range of topics relevant to MSM, transgender and hijra populations in India, the Pehchān baseline survey asked specific questions about sexual behaviour, including experience with male and female partners.

- The median age of all respondents was 27 years.
- 34%of MSM and 13% transgender and hijra respondents reported that they were married to a woman.
- Overall, 46% of respondents have had sex with a female partner at least once.
- Median age for first sexual encounter was 17 years with a male partner and 20 years with a female partner.
- 88% of those self-identified as "bisexual" have had sex with female partners, while this stood at 75% for double-deckers/AB-MSM and 71% for panthis/A-MSM. [See Table.]
- Of those reporting regular female partners, 80% have had vaginal sex, and 18% reported anal sex.
- Consistent condom use in the last six months was reported at only 27% with regular female partners while 62% with non-regular female partners. [See Graph.]
- 60% of respondents have a high level of knowledge about HIV prevention, and the vast majority (98%) has some knowledge.
- Only 5% reported that they have disclosed their sexual identity to their spouses.
- Fear of neglect and isolation (37%) and fear of rejection (24%) were cited as primary reasons for non-disclosure of identity.

Graph: Condom Use with Female Partners

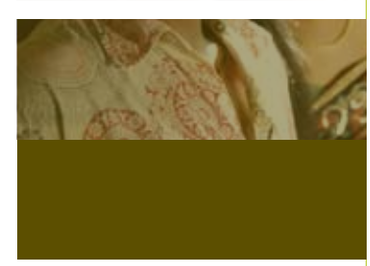


Conclusions

Female partners of MSM are often girlfriends and spouses, and the baseline data indicates that condom use with them is low. Anal sex with female partners is also not uncommon. The data also suggest that the dynamics of non-disclosure and inconsistent or incorrect condom use by MSM are placing their sexual partners at risk in spite of their own knowledge about HIV. Targeted behaviour change messages are needed to raise awareness of specific considerations for MSM practicing both vaginal and anal sex with female partners. Building on the baseline findings, Pehchān has developed a training and outreach strategy to engage with and respond to the specific needs of MSM with female partners.

Table: Ever had Sex with Any Female Partner (by self-identification)

Ever had sexual encounter	All	Gay	Kothi/B-MSM/ M'mukhi	Panthi/ A-MSM	DD/ AB-MSM	Bisexual	MSM	TG
Yes	46%	14%	35%	71%	75%	88%	45%	9%
No	48%	10%	61%	27%	22%	9%	53%	82%
No response	6%	76%	4%	2%	3%	3%	2%	9%
Total	100%	100%	100%	100%	100%	100%	100%	100%
N (All MSM & TG)	2,542	70	1163	369	296	164	246	234



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Understanding Barriers Faced by Transgender and Hijra Communities in India to Accessing Gender Reassignment Services

Research from the Global Fund-supported Pehchan Programme

Authors

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[2] Centre for Sexuality and Health Research and Policy (C-SHaRP)

"There is nothing in our medical curriculum that talks about gender reassignment surgery. We don't have any Indian SRS guideline or any regulatory body."

—A plastic surgeon in Delhi

Background

Feminization and gender reassignment services for transgenders and hijras (TGH) are not broadly available in India. India HIV/AIDS Alliance in consortium with five other organisations implements the five-year Global Fund-supported Pehchan programme in 17 Indian states to build the capacity of 200 community based organisations (CBOs) to serve as effective HIV prevention partners with the National AIDS Control Programme and reach 453,750 MSM, transgenders and hijras (MTH) using a community-driven and rights-based approach. Pehchan conducted an operational research study to identify barriers within the government health system and with private providers to offer feminization and gender reassignment services.

Methods

Maximum variation sampling was used to choose seven sites from different states where Pehchan works. Qualitative research methods were used to capture experiences and perspectives of TGH populations through focus group discussions (FGDs) and key informant interviews (KIIs) with stakeholders such as service providers and lawyers. Thirty in-depth interviews (IDIs) with TGH community members, 7 FGDs with a total of 42 TGH participants, 13 IDIs with health care providers, and 10 IDIs with other stakeholders were conducted. Data analysis involved first-level coding and inferences from the analysis of transcripts using the NVivo7 qualitative data analysis software.

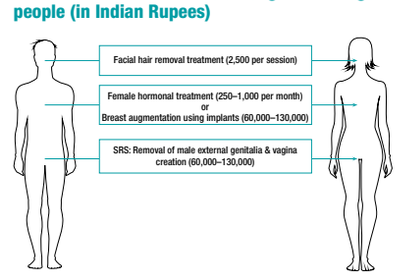
Results

IDIs focused on transgenders and hijras who have undergone or are currently using different gender transition services. Different MtF (male-to-female) transgender people have different needs related to gender transition. Not all require or want to undergo sexual reassignment surgery (SRS). These procedures are performed with varying degrees of expertise and success by qualified medical practitioners, quacks, or hijra community members (*Dai maas*) experienced in performing the process in a traditional manner (*Dai Nirvan*).

Often prior to SRS, many MtF transgender people undergo breast augmentation, using silicone or saline implants. Due to high costs attached to these services, some TGH people prefer to take hormonal tablets or injections to encourage breast augmentation and stimulate other feminizing characteristics. These drugs are often purchased from pharmacies without consulting qualified physicians. Incorrect dosages and self-prescribed drugs often lead to many side-effects. At present, hormonal therapy is offered only by a handful of qualified physicians in certain cities in India. Also due to the costs associated with engaging physicians for these services, many MtF transgender people opt for self-administered hormones. (See Diagram.)

At the structural level, TGH reported that due to the absence of a national comprehensive policy and guideline on gender reassignment, many health care providers refuse to offer services for fear of adverse legal consequences. Health care system barriers have interconnections with the legal and policy environment. Doctors are unclear about the legal implications of prescribing female hormones to self-declared TGH. Many hijras living with HIV do not report their positive status to doctors for fear of being refused services; this can have serious health consequences due to potential adverse interactions between ART and hormonal therapy.

Diagram: Costs associated with selected gender transition-related services among MtF transgender people (in Indian Rupees)



Conclusions

SRS and cross-sex hormonal therapy are two essential health services required for MtF transgender people to help them align their bodies in congruence with their gender identity. Available evidence indicates a near lack of gender identity-related services in even tertiary-level government hospitals and unaffordable SRS services in private hospitals. Lack of free or affordable services motivates many MtF transgender people to seek surgical services from unqualified medical practitioners and experience high risk of complications and inadequate counselling and care. To improve access to services, changes are required at several levels: structural & legal, healthcare system, community, and individual. Hence, there is an immediate need for:

- Formulation of a policy at national-level for sexual minorities that addresses gender transition-related health service needs
- Preparation of national clinical guidelines or standards of care for gender transition-related services for transgender people
- Provision of free gender transition-related services – especially SRS and hormonal therapy – at least in tertiary level government hospitals
- Provision of information and counselling on gender transition-related issues to the MtF transgender people reached through HIV prevention interventions.

Acknowledgements

India HIV/AIDS Alliance would like to thank the Global Fund to Fight AIDS, Tuberculosis and Malaria for their support of Pehchan and acknowledges our vital and valuable collaboration with India's National AIDS Control Organisation. Alliance India acknowledges the many contributions of the Pehchan teams at Alliance AP, the Humsafar Trust, PNRO, SAATHII, Sangama, and SIAAP to these efforts. This study was commissioned by Alliance India and implemented by Centre for Sexuality and Health Research and Policy (C-SHaRP). Special thanks to the members of India's transgender and hijra communities and other stakeholders interviewed for this study.

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Verbal TB screening among MARPs in concentrated epidemics

Experience from Avahan in Andhra Pradesh, India

Authors

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Verbal screening for TB is an effective tool for early detection of TB among most-at-risk populations.

Background

TB is the leading killer of people living with HIV globally. In 2010, there were 1.1 million people co-infected with HIV and TB and 380,000 TB-related deaths among PLHIV across the world. In India, 2 million new cases of TB occur every year of which an estimated 5 to 6.4 percent (41,500) are co-infected with HIV, the second-highest national caseload in the world after South Africa. In particular, Andhra Pradesh has the highest burden of HIV among all of India's states, with TB/HIV co-infection rates similar to those reported at the national level.

In 2010, more than 2.3 million people living with HIV were screened for TB, of whom 87% were in Africa. However, the effectiveness of verbal TB screening based on common TB symptoms towards case-finding among most-at-risk populations in concentrated epidemics is uncertain. India HIV/AIDS Alliance (Alliance India) undertook this operations research study to evaluate the utility of this approach.

Methods

Avahan India AIDS Initiative is an HIV and STI prevention program funded by the Bill & Melinda Gates Foundation in which Alliance India has been a lead partner in Rayalseema and Telengana regions of Andhra Pradesh since 2003. We evaluated the outcomes of verbal TB screening among key populations (sex workers, men who have sex with men, and transgender people) in Andhra Pradesh, India, through a retrospective review of Alliance India's Avahan programme records for the period 2008 to 2010. Cumulative and proportionate data on the population reached with verbal TB screening was calculated and reported.

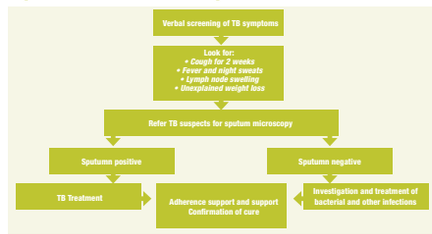
Symptom-based TB Screening Protocol

Do you have any of the following symptoms?

1. Cough for two weeks
2. Unexplained weight loss
3. Fever and night sweats
4. Lymph-node swelling
5. Headache, dizziness or neck rigidity
6. Fatigue or breathlessness

A referral protocol was developed in collaboration with the Government of India's Revised National TB Control Programme (RNTCP) and Avahan, which explained the process of active case finding, referral, diagnosis and treatment to outreach and clinic staff. (Figure.)

Figure: Verbal TB Screening Referral Protocol



Results

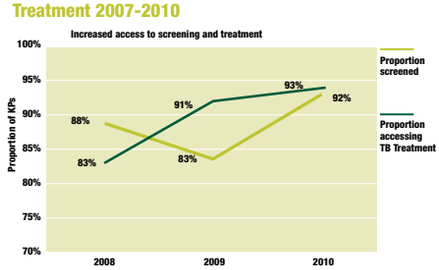
During the three-year period 2008 to 2010, the project provided:

- At least one service to an average of 53,745 female sex workers, men who have sex with men and transgender people annually of whom an average of 88% were screened verbally for TB .
- Between 5.1% and 7.2% of those identified as suspects on verbal screening were subsequently diagnosed with TB on sputum smear microscopy. [See Table.]
- The proportion of those diagnosed with TB and accessing TB treatment increased from 83% to 93.7%. [See Graph.]

Table: Use of Services by Members of Key Populations, Including Use of Verbal TB Screening

Indicator	2008	2009	2010
Number of KPs receiving at least one service per quarter	56,894	55,809	48,545
Number verbally screened for TB in the clinic	50,522	46,614	44,736
Number of TB suspects referred to RNTCP microscopy unit	1,471	2,003	1,098
Number of TB suspects diagnosed with TB on smear microscopy	106	103	64
Proportion	7.2%	5.1%	5.8%

Graph: Trends in Access to TB Screening and Treatment 2007-2010



Conclusions

Verbal screening for TB is an effective tool for early detection of TB among most-at-risk populations in concentrated epidemics, which should be scaled up within HIV prevention and care programmes in order to control TB/HIV co-infection.

Acknowledgements

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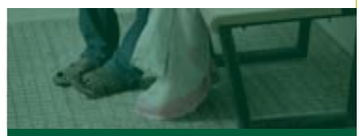

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What's harming harm reduction?

Reducing HIV vulnerability among women who inject drugs in South Asia

Authors

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The analysis of gender relations, roles, and identities is essential to the design of responsive programming for women who inject drugs.

Background

Globally, the number of women who inject drugs is increasing, along with HIV prevalence in this population. However, there are few services specific to the needs of these highly vulnerable women and inadequate access for them to harm reduction services, when available. Further research also suggests that there is dissatisfaction with existing services as providers can be unsupportive, and confidentiality at facilities is often not maintained. HIV vulnerabilities of women who inject drugs are further compounded as they are more likely to share injection equipment and engage in sex work; and they often experience related stigma and violence that undermine their self-esteem and capacity to demand appropriate services.

Methods

With the objective of strengthening capacity of organisations to support programmes for female injection drug users (FIDUs) and female partners of male IDUs across Asia, the Alliance Regional Technical Support Hub for South Asia developed a pool of 20 technical support providers (TSPs) from 10 Asian harm reduction organisations in Bangladesh, Cambodia, India and the Philippines as part of a UNDP-supported project. Through comprehensive trainings, the capacity of TSPs was built to address more effectively issues of gender and female IDUs. After the first training, TSPs were asked to pilot their learning in their work and organisations. After six months, refresher training was conducted for the same TSPs, enabling them to learn about each other's progress and challenges during the pilot period.

Results

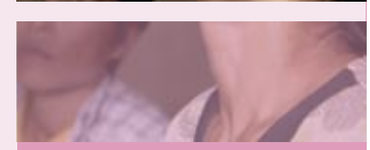
The project was developed to respond to the exclusion of FIDUs and the female partners of male IDUs in the global HIV response and more particularly in IDU programmes in the Asia region. The project also specifically aimed to fill gaps in technical capacity in the region to better address the gender dynamics that contribute to the HIV epidemic among IDUs and support the development of gender-inclusive and female-friendly IDU programmes.

By building the capacity of a cadre of TSPs in Asia and training them to identify and address the gender-based needs of FIDUs and female partners of male IDUs, the project was able to increase the availability of high quality and regionally appropriate technical support. The TSPs trained under this project are now available to provide technical support to IDU organisations, UN agencies, national AIDS commissions and healthcare providers in the region.

As part of the project, a Gender Guide on Programming for Women Who Inject Drugs was developed using community consultations and was subsequently field-tested. The gender guide and facilitators' manual are key resources for other capacity building efforts and have contributed to the Government of India's strategy for gender-sensitive harm reduction programming. Priority interventions for women who inject drugs are described below.

Priority Interventions for women who inject drugs

1. **Female-specific services such as sexual and reproductive health**
2. **Increased outreach to addressing self-stigma. women who inject drugs, in hotspots and places where they live**
3. **Expanded interventions to reduce stigma and increase support for women who inject drugs, including addressing self-stigma.**



Conclusions

Increased attention to the needs of women who inject drugs is resulting in new initiatives in Asia and other parts of the world to improve their quality of life and decrease their vulnerability to HIV. The analysis of gender relations, roles, and identities is essential to the design of responsive programming for women who inject drugs. Strengthened technical capacity is necessary to deliver improved and appropriate interventions for these women.

The project highlighted:

- The need to develop a gender framework that considers gender norms in the design, implementation, and evaluation of IDU programs to make them equitable, effective and sustainable.
- The importance of capacitating project implementers, technical support providers and government officials to increase the reach of services for women who inject drugs.

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