

Outcome Summary

PEHCHĀN
पहचान

Strengthened systems for MSM, hijra and transgender communities and increased reach and quality of HIV services and rights protections



India
HIV/AIDS
Alliance



About Pehchan

Named for the Hindi word meaning 'identity,' 'recognition' or 'acknowledgement,' the Pehchan programme strengthened and built the capacity of more than 200 community-based organisations to provide effective, inclusive and sustainable HIV prevention programming in 18 states in India for more than 435,000 men who have sex with men (MSM), transgenders and hijras. Pehchan was funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria and remains their largest single-country grant to date focused on the HIV response for vulnerable and underserved sexual minorities. Along with Alliance India, the Pehchan consortium includes the Humsafar Trust, Pehchan North Region Office, SAATHII, Sangama, Alliance India Andhra Pradesh, and SIAAP.

About India HIV/AIDS Alliance

Founded in 1999, India HIV/AIDS Alliance is a non-governmental organisation operating in partnership with civil society, government and communities to support sustained responses to HIV in India that protect rights and improve health. Complementing the Indian national programme, we build capacity, provide technical support and advocate to strengthen the delivery of effective, innovative, community-based HIV programmes to vulnerable populations affected by the epidemic.

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1 Executive summary

Over the last five years, the Pehchan programme has managed to scale up services for men who have sex with men (MSM), transgender (TG), and Hijra (collectively MTH) communities across India. It has contributed to the Government's AIDS response by building the capacity of MTH organisations; by increasing condom usage with MTH; and by providing a more enabling environment for MTH to access the services they need. However, MTH communities are still marginalised and face additional hardships in society. Discrimination and violence towards MTH, particularly when perpetrated by state actors such as police and public health care workers, deny MTH communities the protection and assistance that should be available to all citizens. Where community-based organisations (CBOs) currently provide only basic services to MTH, expansion of the services offered by these organisations need to be made as soon as the organisations' capacity is strong enough. Or where possible, stronger referral systems need to be established and MTH encouraged to access services outside of the organisation to which they are a beneficiary. However, government as well as society at large would choose to underestimate the number of people who need services and therefore there is extreme need of establishing organisations of and by MTH communities who can give services to them in friendly and stigma free environment, to control HIV and for longer term wellbeing. Attention must also be given to the differing needs and difficulties to be addressed for TG and Hijras separately from MSM.

2 Introduction

Pehchan means 'identity', 'recognition' or 'acknowledgement' in Hindi. The Pehchan programme began in 2010 and is being implemented in eighteen states. It is managed through Alliance India along with a consortium of six organisations, and is funded by the Global Fund to complement the government's AIDS response. The objectives of Pehchan include the scale up and expansion of HIV prevention services for MTH communities; building the capacity of over two hundred CBOs; and creating an enabling environment for MTH, encouraging healthy behaviours.

In 2011, a baseline study was undertaken to assess the situation of MTH in India. According to the baseline findings, there was a reluctance by MTH to disclose their sexual and gender identities with their families, at health facilities, and generally in society. The baseline also evidenced stigmatisation and included reported instances of discrimination and violence. In 2012, a midline study of the programme was conducted to track the changes in MTH behaviour and the context in which they live. Progress had been realised in condom usage, and in accessing health services by the MTH community.



This endline study comprised of desk-based research of secondary materials and primary research of quantitative data. The desk-based research focused on documentation review of baseline and midline study findings, while the primary research involved 1,682 face-to-face interviews with a sample of MTH Pehchan programme beneficiaries from 33 implementing partners, using a structured questionnaire. Information was collected on MTH demographics; sexual behaviour and history; condom usage; HIV/AIDS testing; services accessed; stigma, discrimination, and violence; and community mobilisation. The main limitation of this study was that participation was limited to MTH registered to the Pehchan programme.

To ascertain what progress the programme has made towards its outcomes after four and a half years of interventions, the primary research has been conducted in six states, namely Andhra Pradesh & Telangana¹; Karnataka; Maharashtra; Tamil Nadu; Uttar Pradesh; and West Bengal.

The aims of this study are to determine the programme's progress in key outcome areas; to help identify successes, challenges, and gaps within the programme; and to provide further recommendations for future MTH programming. The specific research objectives for endline study are:

1. To get an in-depth understanding on the different priority thematic areas such as condom usage and sexual behaviours; stigma, discrimination, and violence; and services accessed.

¹ Andhra Pradesh has been partitioned into Andhra Pradesh and Telangana on 2nd June 2014 <http://reorganisation.ap.gov.in/downloads/226-WCD&SC.pdf>

2. To track key outcome indicators in Pehchan:
 - a. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.
 - b. Percentage of TG and Hijra reporting the use of a condom the last time they had anal sex with a male partner.
 - c. Percentage of MSM reporting cases of violence by law enforcement authorities/police.
3. To assess the effectiveness of the delivery model of Pehchan programme in building an enabling environment that encourages healthy behaviour among the MTH community.

This report provides a summary of the study undertaken and interprets the results, leading to recommendations being outlined on what should be carried out next to improve the lives and sexual behaviours of MTH in India. **A full version of the endline survey of Pehchan is also available.**

3 Discussion of findings

3.1 Understanding MTH, the community, and their context

3.1.1 MTH profile

Kothi/B-MSM/Mangalmurti is the category most often self-identified by MSM. Of transgender and Hijra identities (collectively TGH), transgender is the category self-identified with the most. Despite the number of MTH with female partners, there is low self-identity as bisexual.



No major distinctions were found on the sexual behaviour and the services needed by older MTH, although very few respondents were over the age of forty-five. Given that older MTH respondents in Pehchan have accessed services more frequently over recent months, there are likely to be older MTH not receiving the services they need.

Compared to the general population in India², the MTH Pehchan respondents have a higher literacy rate, and the level of education completed has risen from the start of the programme. One in ten programme beneficiaries are current students. There is still a dissonance with TGH attending and completing higher levels of education which is mirrored by internalised stigma with more TGH than MSM avoiding or withdrawing from applying for college, higher education, or a job. The most popular vocational skills for MTH to learn are in computers, beauty, and fashion and MTH with vocational training has increased since the baseline.

The predominant occupations of MSM are in salaried employment or non-agricultural labour. More TGH earn income through begging, dancing, and badhai. One in three MTH undertake sex work as either a primary or secondary occupation, despite this decreasing significantly in four years. More MTH over the age of 25 undertake sex work than those under the age of 25. There is a very large divide between the states in which MTH participated in sex work. This finding mirrors that of female sex work in India which is more common in the southern states³. The states with highest MTH sex work are Andhra Pradesh/Telangana and Tamil Nadu. The lowest incomes are in Karnataka and West Bengal where over half MTH earn less than Rs.5,000 per month, equivalent to the minimum wage⁴. There has been an increase in MTH income since the start of the programme which follows rises in average income for the general population⁵, however one in three MTH are currently in debt.

MSM often live with their parents and more are doing so since the baseline study. While many TGH also still live with their parents, they are more likely to live alone or with the community than MSM. One in four MTH have married, the majority of who are still currently married and have children.

The majority of MTH remain in the town or village of their birth but TGH are more likely to move than MSM. Reasons for moving vary and can relate to stigma issues with being MTH such as wanting to be anonymous and moving away from family. Travel is more frequent for TGH than MSM and is predominantly driven by sex work. MSM are more likely to travel for their leisure or family.

² <http://www.census2011.co.in/literacy.php>

³ The World Bank, 2011. *The Global HIV Epidemics among Men Who Have Sex with Men. Directions in Development.* <http://siteresources.worldbank.org/INT/HIVAIDS/Resources/375798-1103037153392/MSMReport.pdf>

⁴ <http://indianexpress.com/article/business/business-others/minimum-wages-act-with-eye-on-basic-wage-rate-centre-plans-amendments/>

⁵ http://articles.economictimes.indiatimes.com/2015-02-09/news/58967932_1_capita-income-constant-prices-central-statistics-office



Alcohol is consumed by one in two MTH. Consumption patterns have changed over the years of the programme as with the general population⁶. At the time of the baseline if MTH drank alcohol, more number reported they would do so every day. Now this excessive drinking has decreased but the proportion of MTH consuming alcohol at a lower frequency as increased. Alcohol consumption should still remain a concern for the MTH population because when under the influence of alcohol, MTH have reported they are unsure whether condoms have been used during sex⁷.

3.1.2 Biological feminisation

The majority of TGH are aware of and undergo biological feminisation procedures. More than half the procedures are carried out by medical professionals and this has increased since the baseline. Yet one in three TGH experience complications especially with the removal of penises, testicles, and with hormone therapy.

3.1.3 Sexual history and behaviours

MTH are having their first sexual experiences at a younger age than before. This is especially true for TGH with their first sexual experience with a male partner. The first male partner for MTH are more often than not, older friends and act as the insertive role. TGH are also more likely to have a forced first sexual encounter as experienced by one in five and this continues with more TGH experiencing sexual violence in their life. However, there has been a decrease in forced first sexual encounters.

⁶ http://www.who.int/substance_abuse/publications/global_alcohol_report/profiles/ind.pdf

⁷ *Preventing HIV, protecting rights and ensuring health in MSM, Transgender and Hijra Communities in India. Midline Survey of Pehchan. September 2012*



More MTH have male partners that are non-regular than regular. Sexual acts are also more frequent with non-regular partners than regular ones, though there has been a decrease in the number of sexual acts since the baseline survey. One in three MTH have both regular and non-regular partners. Regardless of partner type, TGH act more as the receptive partner than as the insertive partner also. Almost half of the respondents have partners who pay in cash or kind. These transactional sexual experiences are even more frequent than that with non-regular partners. Contact with paying clients is mostly made through telephone or mobile communications or in public places.

One in two MSM have had a sexual experience with a female partner compared to less than one in ten TGH. The age at the first female sexual experience was older than that for male partners. One in four MTH currently have a regular female partner. All MTH with female partners have peno-vaginal sex. The frequency of peno-vaginal sex with regular female partners is comparable to the frequency of anal sex with regular male partners. However, the frequency is less for non-regular female partners. MTH are more likely to have anal and oral sex with non-regular female partners than regular ones but these are less common occurrences than peno-vaginal sex.

3.1.4 Condoms and lubricants

One in ten MTH had never used a male condom despite knowing where to obtain one from. Groups of MTH that are less likely to have ever used a condom include those over the age of 45 years, those that drink on six or seven days of the week, and those that beg or in badhai as occupations. More TGH have never used a condom than MSM and this corresponds to more TGH acting as the receptive partner, which could be the indication of their lack of negotiating power. TGH are also less likely to use condoms in

recent anal sex and are less consistent in their condom use over time as compared to MSM, again indicative of the common receptive role of TGH.

During the last anal sex with a male partner, almost nine out of ten MTH used a condom. Very few predictors of condom use were uncovered, and the strongest variable is the geographic location on a state level. Lowest use was in Tamil Nadu, with lower than average use in Uttar Pradesh and West Bengal as well. Those undertaking sex work are twice as likely to have used a condom as those MTH that do not. Also, those MTH with a regular male partner are less likely to have used a condom.

Condom use was highest with non-regular male partners, and then with transactional partners. Condom use was lowest with regular partners. Approximately one third of MTH do not use condoms because of dislike. Over one quarter of respondents still do not think condoms are necessary irrespective of the type of partner. One quarter of MTH also find that their regular and non-regular partners object to the use of condoms. However, during anal sex with non-regular partners the main reason for not using condoms is because they were not available.

Consistent use of condoms was reported by about three quarters of MTH over the past month and past six months but this varies between types of partner and across the states. Constant use of condoms is highest with transactional partners and lowest with regular partners. MTH in West Bengal and Uttar Pradesh are significantly lower with their frequency of condom use than the other states. Consistent condom use is also greater for receptive partners than for insertive partners. This indicates that respondents who act as receptive partners are able to negotiate for condom use with their male partner more often than not. However, opposing results show that insertive partners do not use condoms consistently enough.

The use of condoms by MTH with female sex partners is considerably different than that with male partners. One in two MTH use condoms during peno-vaginal sex with regular female partners. Condom use during peno-vaginal sex with non-regular partners is at a much higher rate. Condom use with non-regular female partners has increased overall. The frequency of condom use during peno-vaginal sex is increasing but remains low. Half MTH having peno-vaginal sex still think it is not necessary to use a condom with either regular or non-regular partners. Very few MTH have anal sex with a female partner, although condom use is at a higher rate than during peno-vaginal sex.

The use of lubricants is an increasingly common practice with MSM and even more so for TGH, although a minority of MTH do not use lubricants because they do not like them. Parallel with condom use, lubricants are underutilised in Uttar Pradesh and West Bengal. NGO/CBO was identified most frequently as the place to obtain lubricants. However, MTH still use condom-degrading lubricants such as oil and Vaseline®, especially in Tamil Nadu.

3.1.5 HIV/AIDS

There has been a significant increase in MTH HIV testing and now 95% of MTH within Pehchan have been tested at least once, and one in ten MTH have been tested more than once in the past two years. MTH which have been tested most frequently have also been in the programme for longer periods of time. However, those who self-identify as Panthi or A-MSM are the least likely to have been tested on more than one occasion. The majority undergo testing at government hospitals and clinics, or ICTCs. However in Maharashtra and Karnataka more MTH are tested at an NGO/CBO because they have less confidence in the government system. In general though, the reassurance of HIV test confidentiality has increased. NACO published data from the TI programme for 2014-2015 have a testing rate at ICTCs of 71% for MSM and 53% for TGH⁸. Therefore the Pehchan programme has a higher testing rate than the Government's intervention alone.

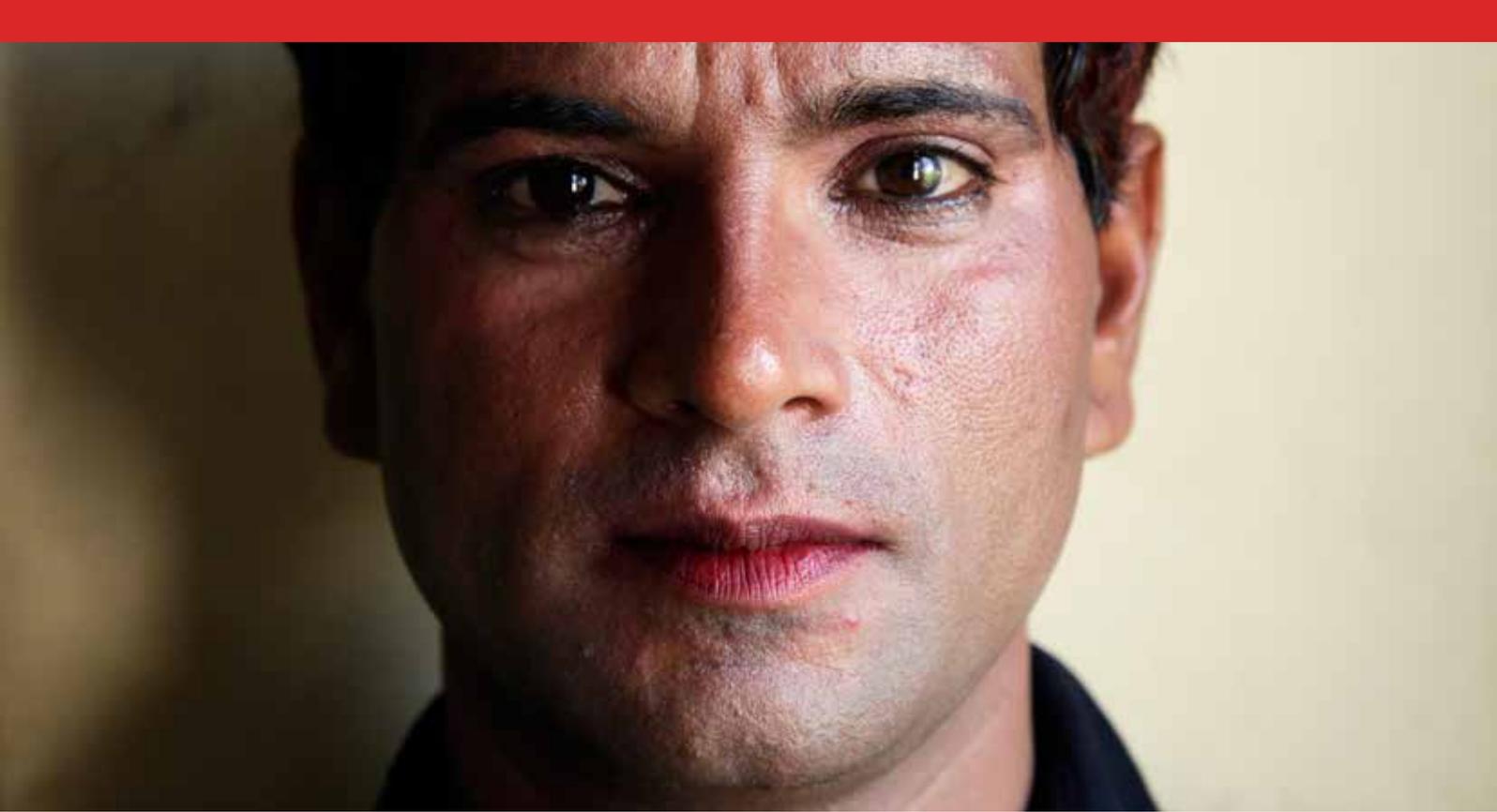
For the general population in India, HIV prevalence continues to decline below 1%⁹. The proportion of MTH reporting a positive HIV status has also decreased from the start of the programme, and in this study, a rate of 3.4% was found. More HIV positive MTH are reporting from Andhra Pradesh/Telangana and Karnataka which are two of the states which have relatively high HIV prevalence for the general population as well¹⁰. This geographical finding corresponds to the relatively higher proportions of MTH never using a condom in these two states. However, it does not match current and recent usage of condoms.

Positivity rates recently published by NACO from testing at ICTCs are lower than that found in this study¹¹, indicating that the Pehchan programme has encouraged the engagement of MTH living with HIV. However, given the small numbers involved with MTH living with HIV participating in this study, no further conclusions should be drawn from this regarding HIV prevalence or incidence for the MTH community overall in India. Those MTH living with HIV seem to have a good awareness of and access to relevant services such as CD4 counts, ART, and TB screening. There is also relatively low disclosure of status to others.

3.1.6 Stigma, discrimination, and violence

MTH are afraid of being neglected, isolated, and avoided although disclosure of their sexual or gender identity to friends, siblings, and parents has increased. Specific disclosure to spouses is high for TGH but low for MSM for fear of losing the family or being rejected, although an increase in disclosure by married MTH to their spouses has been seen since the baseline. Despite more disclosure by TGH and proud feelings associated with their identity, TGH are more likely to have depressive feelings than MSM, and more have changed their life goals. The mental health of MTH is of most concern in Tamil Nadu which could be in part associated with the relatively high levels of stigma and discrimination they face.

⁸⁻¹¹ Annual Report 2014-15, Department of AIDS Control, Ministry of Health & Family Welfare http://www.naco.gov.in/upload/2015%20MSLNS/Annual%20report%20_NACO_2014-15.pdf



All MTH have experienced at least one type of externalised stigma in the past year and this is suffered more by TGH than MSM, presumably because of the increased visibility of TGH. Issues such as being gossiped about, teased or insulted, and verbally abused by family or the public are faced by MTH particularly in Andhra Pradesh/Telangana and Tamil Nadu. Types of externalised stigma reported by MTH such as rejection from family and exclusion from social gatherings are realisations of the fears felt by MTH and the reasons for their non-disclosure.

One fifth of MTH have faced discrimination, again with higher rates in Andhra Pradesh/Telangana and Tamil Nadu. A predictor of discrimination is the primary identity with TGH being discriminated against twice as much as MSM. Again, this is likely due to increased visibility of TGH. Having a transactional MTH partner is also identified through modelling as a predictor of those discriminated against. This is supported by the finding that in these states, higher proportions of MTH undertake sex work.

MTH in Karnataka have the lowest perception of fair treatment in public spaces. Health settings in general were considered fairer than government offices, post offices, and banks. The issues faced by one quarter of MSM and an even higher proportion of TGH in health care often entail having to wait longer to be attended because a provider did not want to treat them, and receiving less care and attention than other patients. MTH, particularly in Andhra Pradesh/Telangana are still blamed and scolded because of their identity or sexuality by health care professionals, enforcing a barrier to not only for general health issues but also for HIV or STI prevention and education,¹².

¹² Patel, VV et al (2012). *Men who have sex with men in India: a diverse population in need of medical attention.* *Indian J Med Res* 136(4): 563-570

Similarly TGH are facing more discrimination from law enforcement authorities such as the police than MSM and discrimination is more frequent in Andhra Pradesh/Telangana and Tamil Nadu. Discrimination often takes the form of verbal and physical abuse, as well as blackmail and extortion. Predicting discrimination specifically by law enforcement has found that younger MTH are more likely to have problems than older MTH. Having a transactional MTH partner has arisen as a predictor again so analogously this is supported by more MTH undertaking sex work in the two states where discrimination and violence by police is more frequent. Only a small fraction of MTH had been arrested in the past year. Formal procedures during this time such as hiring a lawyer or obtaining free legal aid, or being allowed to make a phone call were not always respected. However the perception of police treatment to MTH compared with a year ago is considered fairer.

Awareness of the Indian Penal Code Section 377 has risen dramatically since the start of the Pehchan programme. This is due to the legal activity surrounding Section 377 in the programme timeframe. In 2009, the Delhi High Court lifted the ban on same-sex sexual activity among consenting adult men in private. However, in 2013, the Supreme Court of India upheld Section 377 as constitutional, making consensual sex between two men a crime in India again¹³. Over one hundred MTH surveyed had been discriminated on the grounds of Section 377 after the re-imposition in December 2013.

In the past year almost one third of TGH have been forced or coerced to have sexual relations against their will. This abuse is most likely from rowdy or goondas, male clients, and even the police. Less MSM have faced sexual abuse in the past year but when this did happen, the violations were often made by friends and neighbours. Intimate partners are also common perpetrators of sexual violence. For TGH the abusers are often male clients, and for MSM more regular partners force sexual relations. MTH that have been in the Pehchan programme for longer periods of time are less likely to have experienced sexual violence in the past year.

One quarter of TGH have experienced physical violence in the past year whereas one in ten MSM have. It would be interesting to find out whether perpetrators of physical violence are similar to those of sexual violence. Only half of the MTH experiencing violence sought support on this matter and did so from NGOs offering services for violence (Pehchan and non-Pehchan organisations) or from friends. Law enforcement authorities are the least approached for support. Panthi/A-MSM are the category of MTH who are least likely to seek support after experiencing violence, followed by MTH married and living with their female spouse.

¹³ ILGA 2014. *State-sponsored Homophobia. A world survey of laws: Criminalisation, protection and recognition of same-sex love* http://old.ilga.org/Statehomophobia/ILGA_SSHR_2014_Eng.pdf

3.2 Outcomes

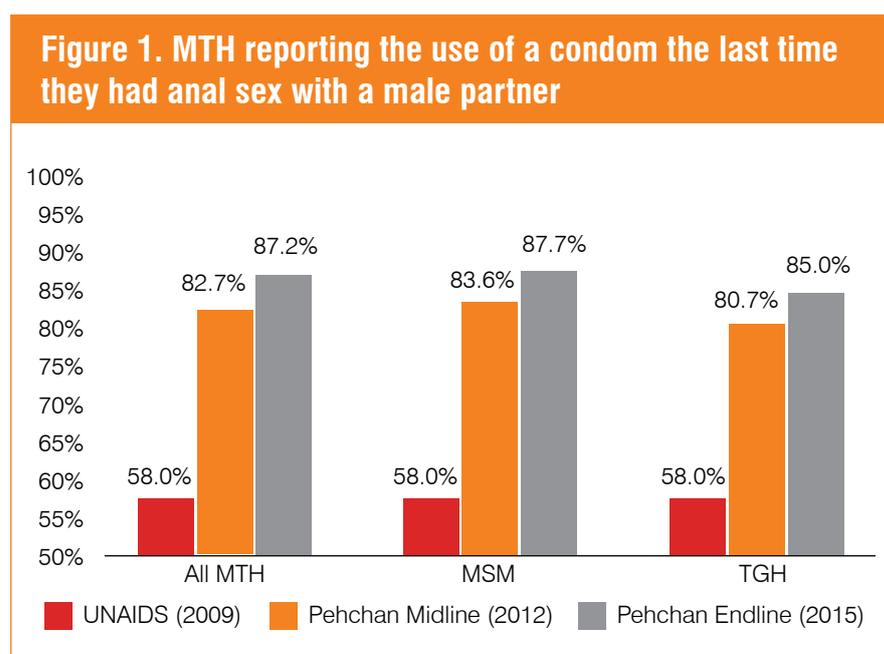
This section summarises the comparative analysis of the baseline, midline, and endline surveys to measure the progress that the Pehchan programme has made for MTH in India against the intended outcomes. Key outcome indicators have focused on condom use and the discrimination and violence towards MTH.

3.2.1 Condom use by MTH with male partners

One key outcome of the Pehchan programme is that a higher proportion of MTH are using condoms in their last anal sex with male partners. This outcome has been achieved.

Direct comparison for condom use during last anal sex with a male partner, irrespective of the type of partner, can be made to the midline due to the equivalent question omitted from the baseline study. This result is particularly pertinent given that one in three MTH have both regular and non-regular partners. Increased proportions of MTH have used a condom during the last anal sex and this has increased by 4% in three years. However, UNAIDS have data from before the Pehchan programme started and in 2009 for India and the percentage of men reporting the use of a condom the last time they had anal sex with a male partner was 58%¹⁴. Using this as a proxy for the baseline, an increase of 29% of MTH using a condom during the last anal sex with a male partner has been seen through the programme timeframe.

¹⁴ UNAIDS <http://www.aidsinfoonline.org/devinfo/libraries/asp/home.aspx> Accessed 30/12/2015



Comparisons of condom use during the last anal sex more specifically with regular and non-regular male partners can be made directly to the Pehchan baseline. For both regular and non-regular partners, condom use during last anal sex has increased from the baseline to the midline and increased further to the endline. The most progression has been made for anal sex with regular partners with an increase of 22% in four years. Condom use during last anal sex with non-regular partners has also increased in that time by 18%, similarly for both MSM and TGH. However, the largest increases across the states have been in West Bengal and Uttar Pradesh that had the lowest levels of usage at the baseline.

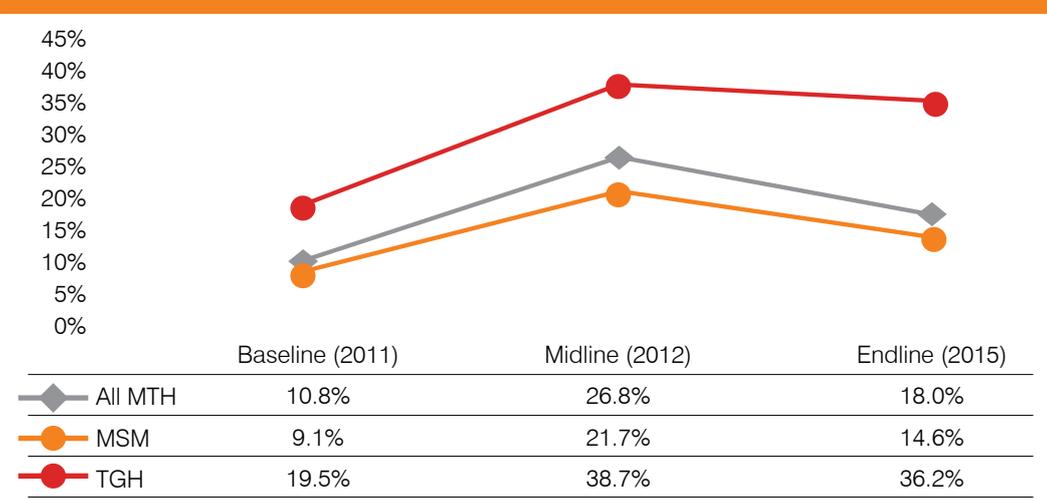
3.2.2 Discrimination and violence towards MTH

Outcomes for the Pehchan programme also involve reducing discrimination and violence towards MTH. Overall progression towards these outcomes are only now being realised with reductions seen from the midline. Discrimination of any kind to MTH has decreased slightly by 2%, and violence towards MTH by law enforcement authorities has decreased significantly by 9%. The proportion of respondents who reported experiencing any type of violence by the police/law enforcement agencies in last 6 months has also decreased significantly from midline (36%) to endline (22%). This observed decrease in MTH experiencing problems with law enforcement authorities is greater for MSM than for TGH.

Nevertheless for the programme in its entirety, there were significant increases in discrimination and violence towards MTH from the baseline to endline, primarily for TGH and in Andhra Pradesh/Telangana and Tamil Nadu. The only states which have achieved outcome progression throughout the programme from the baseline to the endline are West Bengal and Uttar Pradesh for general discrimination; and Maharashtra and West Bengal for discrimination perpetrated by law enforcement authorities.

There are however, further considerations that need to be made when assessing the change in discrimination and violence towards MTH. The alterations to IPC Section 377 throughout the programme timeframe would have increased debate and publicity surrounding the legalities of same-sex sexual practice and elevated visibility of the MTH community at these times, particularly in the period that the midline was undertaken.

Figure 2. MTH reporting cases of violence by law enforcement authorities/police



Other considerations are due to the rights-based interventions provided by Pehchan. MTH are now more aware of their rights and more likely to report incidences of discrimination and violence. Such human rights abuses may have previously been perceived by MTH as justified or the social norm. Increased reporting of incidents may also be due to more effective crisis management provided by CBOs¹⁵.

3.3 Programme effectiveness

This section reviews the services provided by the Pehchan programme and how the MTH community is supportive and empowered in India. Using the available data from the endline survey, this section assesses the effectiveness of the delivery model for building an enabling environment that encourages healthy behaviours amongst the MTH communities.

3.3.1 Programme exposure

The majority of MTH have been in the programme for as long as just a bit less than two years. Given this short timeframe, the advances that Pehchan has made for MTH and their communities are noteworthy. However, those in the programme for longer periods of time tend to access services more frequently which indicates the continual need for such MTH-centred programming.

3.3.2 Pehchan provided services

The comprehensive services provided by the programme include free condoms, lubricants, and medicines, counselling and support, as well as referrals to other services. Three quarters of the respondents are aware of the range of services available however this finding cannot be considered for the MTH population as a whole due to the survey being carried out at Pehchan CBOs with programme beneficiaries. The least well known services are those for limited subpopulations of MTH such as ART adherence support and sex reassignment surgery counselling. However, awareness of services has increased generally since the baseline. The notable exception being the provision of free lubricants which has decreased significantly even though reported lubricant usage in on the increase.

Access to services by both MSM and TGH are high and have increased since the baseline, particularly for free STI medicine; advocacy; referrals to ICTC; SRH services for female partners; legal support; and sex reassignment surgery counselling. Examining data for the last three months, older MTH tend to access a greater number of services, and TGH access more services than MSM. The main difference in general service provision is that MSM are provided with more free condoms than TGH which corresponds to condom use levels by these two groups.

Differences between the states for accessing services have been uncovered through the analysis. It is possible that these differences are due to the type of CBOs surveyed and the services that they offer in particular states, rather than an indication of the needs of the MTH communities in those states. Only one TI-Plus CBO was surveyed in

¹⁵ *Impact Assessment of Pehchan Programme: a qualitative study. October 2015. C-SHaRP*

both Uttar Pradesh and West Bengal. In these states, the respondents were less likely to have accessed psychosocial, mental health, and family support counselling which are provided predominantly by TI-Plus CBOs. However, access to these counselling services by respondents was highest in Andhra Pradesh/Telangana and Tamil Nadu where MTH are more likely to have negative feelings of desperation and depression. These two states are where MTH experience the most discrimination and violence and therefore could be an explanation of a greater need for counselling services.

Another advanced service with varying access across the states and between the two types of CBOs is sexual reproductive health services for female partners. Access was highest in Karnataka where there is the highest number of TI-Plus CBOs surveyed but lowest in Andhra Pradesh and Telangana where there are also relatively high numbers of TI-Plus CBOs. There is still ambiguity from the endline survey whether these services for female partners are not needed, not promoted, or not accessible enough in certain states to explain the lower access rate. However, analysing all the additional services provided by TI-Plus CBOs have found that respondents from these CBOs access the services more which is to be expected. Although it highlights that advanced services particularly mental health and psychosocial counselling are rarely accessed by respondents if not directly provided by the CBO they attend.

3.3.3 Community

The majority of MTH have at least one social entitlement, such as a ration card, Aadhar card, or voter ID. However, more MSM than TGH possess these and there are also differences in possession across the states. MTH have commented on having little information available to them on entitlements and the procedures required to obtain the entitlements. Family members often help MTH acquire the entitlements, although Pehchan staff from CBOs provide assistance as well.

Over half of the respondents belong to an MTH community collective, network, or organisation, and on average have been members for two years. However, collective membership is lower for younger MTH, those identifying as Panthi/A-MSM, and those from Pre-TI CBOs. The MTH surveyed do encourage others in their community to join collectives and access services. The positive value of collectivisation for encouraging healthy sexual behaviours, as well as addressing issues faced by marginalised MTH populations is well evidenced¹⁶ and can be seen in Pehchan as well.

MTH often turn to their community for support when they have worries and serious problems. The members of the community and CBOs directly assist MTH when they have been arrested, and also when they experience partner violence. Those helped by the community with partner violence are more likely to be connected to a TI-Plus CBO, and there is also strong support for those undertaking sex work. There are high

¹⁶ Saggurti, N et al (2013). *Community collectivization and its association with consistent condom use and STI treatment-seeking behaviours among female sex workers and high-risk men who have sex with men/transgenders in Andhra Pradesh, India. AIDS Care 25(supplement 1): S55-S66*

levels of confidence that the MTH community and CBOs can work together to increase condom use with clients and partners, improve the lives of MTH, speak up for the rights of MTH, and keep each other safe. This is important given the limited confidence in the government to provide quality, MTH-friendly services for the community. It is also of note that advocacy services have increased through the programme.

3.3.4 Added value of the Pehchan programme

Through the endline study, a few clear examples have been found which demonstrate the added value of Pehchan.

Relating to the key outcomes around condom use, CBOs are increasingly identified as the predominant place to obtain condoms. For the key outcomes regarding discrimination and violence, Pehchan CBOs help and support MTH who experience violence and also aid those who get arrested.

Three out of four MTH attend Pehchan group meetings at least once a month, giving attendees the opportunities to converse and learn more about MTH issues. The topics discussed recently have been dominated by HIV and STIs, gender and sexuality, services offered by drop-in-centres, and rights and entitlements.

Nine out of ten MTH have an exceptional level of satisfaction with the services provided by Pehchan, particularly with the quality of counselling services. These high opinions resonate through communities and encourage further uptake. Less MTH attending TI-Plus CBOs have negative feelings because of their identity or sexuality which is another indication of the effective counselling.

High awareness and access of other health care facilities have been exhibited by MTH. However, Pehchan readily provides referral services to HIV testing centres and for general health check-ups. Therefore Pehchan has contributed to higher access rates of MTH at ICTCs and government hospitals¹⁷. Specifically with HIV tests, the main reason for MTH to undergo testing is through advisement from a CBO and having pre-test education through the programme.

The community system strengthening approach has gone beyond traditional HIV programming and aided social cohesion and collective efficacy amongst MTH in India.

The final very important finding relates to the mode of Pehchan operations at CBOs. Members of the community are involved in making crucial decisions related to Pehchan CBOs that provide support, lending to the concept that this programme is 'for the community and by the community'.

¹⁷ *Impact Assessment of Pehchan Programme: a qualitative study. October 2015. C-SHaRP*



4 Recommendations

Capacity building of MTH CBOs and the services provided by these organisations have proved successful through the Pehchan programme in a relatively short period of time. Such community system strengthening has created an enabling environment and encouraged healthy sexual behaviours amongst MTH, but further progress can still be made with more time. Therefore it is important that these interventions continue to be provided by the MTH community, and that MTH continually access the services that the CBOs offer, as they directly address the needs of the communities.

The additional services currently provided by TI-Plus CBOs are accessed frequently by MSM and TGH alike when registered at these CBOs. However, the beneficiaries of Pre-TI CBOs rarely access these advanced services. Therefore they need to be made available to all MTH, either through robust referral systems if location-appropriate, or by expanding the service package offered by CBOs as soon as the capacity of the organisation is strong enough to provide a quality service.

To date, programmatic data collection on stigma and discrimination has focused on incidences as recounted by the MTH community and the support they required. Although sensitisation interventions underway have relieved some pressures, much more understanding around the circumstances of these issues is still needed. This information should be obtained from the perpetrators directly to give an indication of how best to sensitise them and to stop further abuse.

Other recommendations include the use of innovative methods to reach young MTH with prevention messages; ensuring continuous supply of free condoms, lubricants, and information; tracking regular HIV testing; providing advanced counselling and establishing specific support groups; encouraging disclosure; and assisting MTH in obtaining social entitlements and welfare. Increasing advocacy funding and efforts is also of great importance for achieving national HIV goals in India, given the punitive laws that sustain barriers for MTH to access the health services they need.

A major understanding taken from this study across all the thematic areas assessed, is that interventions need to be targeted on a state by state basis given that the lives of MTH and the contexts in which they live differ significantly by location. One universal package of services will generate impact but this would be facilitated further if directed services are planned from utilising strong state-specific evidence bases on and for MTH. The differences uncovered between MSM and TGH profiles, sexual behaviour, and discrimination faced, highlights the importance of separate HIV prevention strategies and TGH-targeted services as well.

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Unless otherwise stated, the appearance of individuals in this publication gives no indication of their HIV status.

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