

# WHAT **WORKS?**

SEXUAL AND REPRODUCTIVE  
HEALTH AND HIV LINKAGES FOR  
**MSM AND TRANSGENDER  
PEOPLE IN INDIA**

# INTRODUCTION TO SRH AND HIV LINKAGES

The evolution of the response to HIV and sexual and reproductive health (SRH) has revealed the importance of individuals as key catalysts in ensuring sustainability, continuity and ownership of comprehensive prevention, treatment, care and support initiatives. Sexual and reproductive ill-health and HIV share many of the same root causes, including economic inequality, limited access to appropriate information, gender inequality, harmful cultural norms and social marginalization of the most vulnerable populations. A linked sexual and reproductive health and HIV response has the ability to ensure that collectively many of these root causes are addressed in a more systematic and aligned manner.

The bi-directional linkages between SRH and HIV-related policies and programmes can lead to a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted action on the linkages agenda would yield many of the following mutually beneficial results:<sup>1</sup>

- Improved access to and uptake of key HIV and SRH services
- Better access of people living with HIV to SRH services tailored to their needs
- Reduction in HIV-related stigma and discrimination
- Improved coverage of underserved/vulnerable/key populations

- Greater support for dual protection
- Improved quality of care
- Decreased duplication of efforts and competition for scarce resources
- Better understanding and protection of individuals' rights
- Mutually reinforcing complementarities in legal and policy frameworks
- Enhanced programme effectiveness and efficiency
- Better utilization of scarce human resources for health.

It is generally accepted that HIV and sexual and reproductive ill-health tends to take the path of least resistance. Globally, that line runs through some of the world's least powerful communities: the poorest, most disadvantaged, stigmatized and underdeveloped groups. In many countries and regions of the world, the risk of and vulnerability to HIV infection is exacerbated by a mixture of behavioural, social, political and structural factors that disproportionately increase the risk of HIV acquisition by certain groups of people whose members constitute an increasingly disproportionate share of the world's HIV incidence. Key populations may vary in different places depending on the context and nature of the local epidemic, but in most places, they include men who have sex with men, sex workers, and people who use drugs (see box below).

In 2010, UNAIDS reported that:

- Asia's HIV epidemics remain largely concentrated among people who use drugs and men who have sex with men. About 16 per cent of people who inject drugs in Asia are living with HIV, and high HIV prevalence among men who have sex with men has been reported in several countries in the region, such as 29 per cent in Myanmar and up to 18 per cent in parts of southern India.
- In the Caribbean, high HIV infection levels have been found among female sex workers in the region, with 4 per cent in the Dominican Republic, 9 per cent in Jamaica and 27 per cent in Guyana.
- In Central and South America, most of the HIV epidemics are concentrated in and around men who have sex with men. Surveys among groups of men who have sex with men living in urban areas found an HIV prevalence of at least 10 per cent in 12 countries in the region.

Empowering and meeting the needs of people living with HIV and key populations is at the crux of the SRH and HIV linkages agenda and fundamental to the joint universal access goals of SRH and HIV.

The following seven principles represent consensus on the key philosophical foundations and commitments upon which linked SRH and HIV responses must be built:<sup>2</sup>

1. Address structural determinants.
2. Focus on human rights and gender.
3. Promote a coordinated and coherent response.
4. Meaningfully involve people living with HIV.
5. Foster community participation.
6. Reduce stigma and discrimination.
7. Recognize the centrality of sexuality.

A time-honoured concept espoused in the Declaration of Alma Ata on primary health care rests on “bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” and this ‘people sense’ argument is probably one of the most compelling as a cornerstone approach to HIV and SRH linkages.

Imperative actions for providing evidence-informed action to support both SRH and HIV outcomes for key populations lies in addressing some of the recognized bottlenecks which include:

### **1. Addressing stigma and discrimination through the capacity building of front line service providers:**

Reducing stigma and discrimination about HIV and SRH means facing and talking openly about issues that include sexuality, drug use, sex work, sexual violence, poverty and gender inequality. Health workers need resources, information, and skills and sensitivity training related to the specific needs of the diverse range of clients, including the importance of confidentiality.

### **2. Maximizing the understanding and promotion of SRH and HIV linkages in concentrated HIV epidemics:**

Addressing the SRH needs of key populations, people living with HIV, and other marginalized populations in countries and regions with concentrated epidemics is an area that requires increased focus. Increased operations research on issues such as the modalities of integration to better meet the additional needs of key populations will provide a strengthened evidence base for guidance on the relevance and effectiveness of SRH and HIV linkages in concentrated epidemics.

### **3. Creating an enabling policy environment to support rights:**

To enable outreach of sexual and reproductive health services to key populations as well as to people living with HIV, legal and social barriers need to be addressed through inclusion of the following programmatic elements: legal audit and law reform programmes, access to legal services, programmes to reduce stigma and discrimination, know your rights/law campaigns and training of key service providers – not only health care workers but also judiciary and police.

### **4. Recognizing the value and importance of community engagement:**

Enabling and fostering communities of the most vulnerable and marginalized people to play a leading role in the linkages agenda needs to be supported through adequate levels of resources and capacity development.

### **5. Providing improved access through bespoke service delivery:**

Meeting the SRH and HIV needs of key populations will have direct outcomes for both the SRH and HIV communities through the strengthening of current and expanding to additional essential services.

# THE CONTEXT

## OVERVIEW OF COUNTRY

### INDIA IN FACTS AND FIGURES<sup>3</sup>

#### General context:

- **Population (2011):** 1,210,193,422
- **Life expectancy (2008):** 63.7 years
- **Population living below poverty line (2007):** 25%
- **Population under 15 years (2011):** 29.7%

#### HIV context:

- **Adult HIV prevalence (2008):** 0.3%
- **Number of people living with HIV (2009):** 2,300,000
- **Number of people living with HIV receiving antiretroviral therapy (2010):** 322,561
- **Total funding for HIV (for NACP-III 2007–12):** 115,850 million rupees (US\$2.6bn)

#### HIV context for MSM and transgender people:

##### Men who have sex with men (MSM)

- **HIV prevalence (2008):** 7.3% (5.6–17.6%)
- **Could correctly identify ways to prevent sexual transmission of HIV and rejected major misconceptions about transmission (2009):** 17.4–56.7%
- **Used a condom the last time they had anal sex with male partner (2009):** 48.9–57.6%
- **Received an HIV test in the last 12 months and know their results (2009):** 17.0–46.3%

##### Transgender people

- **HIV prevalence (2008):** Unknown
- **Correctly identified ways to prevent sexual transmission of HIV and rejected major misconceptions about transmission (2009):** Unknown
- **Used a condom the last time they had anal sex with male partner (2009):** Unknown
- **Received an HIV test in the last 12 months and know their results (2009):** Unknown

## DEFINITIONS

### Men who have sex with men

**(MSM):** a term to describe all men who engage in consensual male-to-male sex, regardless of whether or not they have sex with women or self-identify with a specific sexual identity, and include men who are sex workers. MSM may self-identify as gay, bisexual, heterosexual or other culturally specific sexual identities.

**Transgender:** transgender is an umbrella term for individuals whose gender identity and expression does not conform to norms and expectations traditionally associated with their sex assigned at birth. Transgender people may self-identify as transgender, female, male, transwoman or transman, transsexual, hijra, kathoe, waria or one of many other transgender identities, and may express their genders in a variety of masculine, feminine and/or androgynous ways.

## SITUATION FOR MSM AND TRANSGENDER PEOPLE

There are an estimated 2.35 million MSM in India.<sup>4</sup> There is no reliable estimate for transgender people.

Within the country's concentrated epidemics, HIV prevalence among MSM averages 7.3% – over 20 times that of the general population.<sup>5</sup> In some cities, it is as high as 33%.<sup>6</sup> Recent studies indicate even higher HIV prevalence (17.5%<sup>7</sup> to 41%<sup>8</sup>) among transgender people. Meanwhile, prevalence of sexually transmitted infections (STIs) is also high among these communities, for example with syphilis at 5.8%<sup>9</sup> to 14%<sup>10</sup> among MSM, and 13.6%<sup>11</sup> to 57%<sup>12</sup> among transgender people.

There are several different groups of MSM and transgender people in India – depending on factors such as sexual orientation, gender expression and sexual roles. **Kothis** are the most visible sub-population of MSM. They generally have a feminine gender expression and play a receptive role in anal sex with **panthis** (their masculine sexual partners).<sup>13</sup> MSM who play both penetrative and receptive roles in sex are described as '**double-deckers**'. Broadly speaking, gay and bisexual-identified MSM tend to be from the middle and upper socio-economic classes, and are better educated than kothi-identified MSM (who tend to have lower socio-economic status).<sup>14</sup> A significant proportion of MSM (including panthis) may not self- and/or publicly identify as gay or homosexual – often due to social pressures and norms, and self-stigma.

In India, transgender people are often referred to as **hijras**. Sometimes described as 'third gender', hijras are people who were born physically male and generally identify with aspects of the female gender, including dressing as women.

All groups of MSM and transgender people share some degree of common needs in relation to HIV and SRH. However, sub-groups and individuals also often have *different* and/or *more* needs, for example depending on their level of risk in sexual relations, social marginalization (affecting access to services) and involvement in practices such as sex work and drug use.<sup>15</sup>

In 2009, the Delhi High Court overturned a law, enacted in 1861 and known as Section 377, which made "carnal intercourse against the order of nature with man, woman or animal" punishable by up to 10 years in prison. In its decision, the High Court declared that the law violated the Indian Constitution and exposed MSM and transgender people's communities to "harassment, exploitation, humiliation, cruel and degrading treatment" by law enforcement, and that fear of prosecution had prevented MSM from accessing HIV services.

## NATIONAL RESPONSE TO HIV, SRH AND SUPPORT TO MSM

In India, **the national response to HIV** – and primary responsibility for HIV-related services for people living with HIV (PLHIV) and key populations – is led by the National AIDS Control Organization (NACO). The National AIDS Control Programme III (NACP-III) for 2007–2012 includes targeted interventions among MSM.<sup>16</sup> These are based on five main components:

1. Outreach education on HIV and STIs.
2. Condom promotion and distribution.
3. STI screening and treatment (on-site or through referrals).
4. Enabling environment (advocacy with the police and health care providers).
5. Community mobilization (creating space for community events and the formation of community-based organizations (CBOs).

As of December 2009, under NACP-III, there were 131 targeted interventions exclusively for MSM, 29 of which were managed by CBOs,<sup>17</sup> with each reaching 400 to 1,500 MSM. Increasingly, interventions have also been introduced for transgender people. Furthermore, there are 200 broader interventions that provide HIV-related services to MSM and transgender people alongside other key populations, such as sex workers and people who use drugs.

The **national response to SRH** is led by the Reproductive and Child Health Programme II (RCHP-II), under the National Rural Health Mission (NRHM). However, neither the RCHP-II nor the NRHM plan mentions MSM



and transgender people, or provides for activities to promote their SRH. Furthermore, although a plan has been prepared to merge NACP and NRHM,<sup>18</sup> it does not articulate the specific SRH needs of MSM and transgender people.

Overall, HIV-related services for MSM are primarily available through targeted interventions – which are supported by government agencies (such as NACO and the State AIDS Control Societies, SACS) and donors. However, SRH services – such as STI screening and treatment – are often not available in the non-governmental organization (NGO) and CBO facilities that implement such interventions. Instead, such facilities often refer MSM and transgender people to government STI clinics.

## HIV AND SRH LINKAGES

In India, there is growing attention to the potential benefits of SRH and HIV **linkages and integrated programming** to meet the HIV, SRH and wider needs of MSM and transgender people. Beyond the general benefits of the approach (see **Introduction**), it ‘makes good sense’ for the community and in relation to the country’s context. Examples of key initiatives and trends include:

- **Expanding SRH services in HIV clinics:** The Humsafar Trust (see **Case Study 1**) is both an STI screening/treatment facility and a NACO-accredited voluntary counselling and testing (VCT) centre. This was possible as the Trust had adequate existing internal capacity and funding to integrate these services.
- **Increasing funding to HIV service providers:** With increased donor support, some agencies implementing HIV-related targeted interventions among MSM and transgender people have been able to integrate SRH-related components.<sup>19</sup> These include: prevention and care in relation to sexual violence; counselling MSM to disclose their STI/HIV status and take care of their female partners; counselling on sexuality; and counselling related to sex change and feminizing procedures for male-to-female transgender people.
- **Facilitating referrals to MSM-friendly SRH services:** Since 2009, some SACS have implemented a ‘Community-Preferred Private

Practitioner scheme’ – referring MSM and other key populations to local community-friendly private doctors and paying for consultations. This gives NGOs and CBOs that are implementing government-supported targeted interventions for MSM three options in relation to STI screening and treatment: referral to in-house clinic or doctor within the NGO/CBO premises (wherever possible); referral to a Community-Preferred Private Practitioner; or referral to a government STI clinic.

- **Sensitizing SRH health care staff to the needs of MSM:** FPA India (see **Case Study 2**) has integrated HIV-related services for key populations, including MSM and transgender people, in at least 4 of its 40 branches. These experiences have shown that it is possible to create a positive attitude among clinical and non-clinical staff of SRH organizations and build their capacity to provide competent and non-judgemental services.
- **Advocating for change on HIV and SRH:** In 2004, SAATHII initiated the HIV Support Centre Project<sup>20</sup> (see **Case Study 3**). The project focuses on increasing knowledge on gender, sexuality, human rights, sexual health and HIV, as well as providing technical support for, and capacity building on, responding to HIV. It has supported agencies that provide HIV information and services to MSM, transgender people and PLHIV to build their knowledge and experience on SRH and carry out related advocacy.

As described in the following case studies, and despite the progress outlined above, there remain significant challenges to providing integrated SRH and HIV services to MSM and transgender people. These include limited programmatic capacity and infrastructure; stigma in SRH services; and a lack of supportive policies (for example, hospitals lack policies to address discrimination on the grounds of sexual orientation, gender identity or HIV status). The challenges also include gaps in programming, for example, a lack of programmes to reach the female partners of MSM and transgender people, as well as specific sub-groups of MSM, for example, who are not reached through focused interventions on epidemic hotspots.

## CASE STUDY 1: THE HUMSAFAR TRUST

**An NGO for MSM and transgender people integrating HIV and SRH services.**

### ORGANIZATIONAL FOCUS

An NGO which has a holistic approach to the rights and health of sexual minorities and rational attitudes to sexuality, and advocates for the rights of sexual minorities.



### FOUNDED

1994

### LOCATION

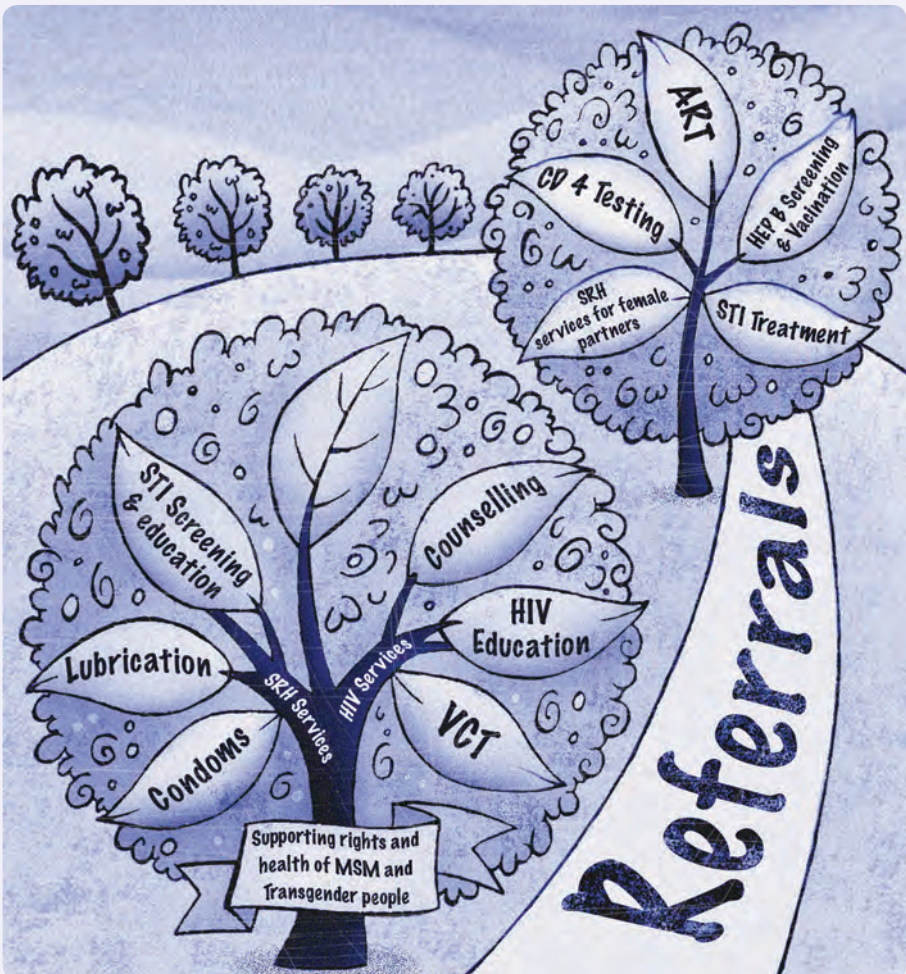
Mumbai

### CONTACT DETAILS

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[www.humsafartrust.org](http://www.humsafartrust.org)

### Steps towards SRH and HIV linkages

Humsafar's model involves integrating HIV and SRH into the organization's work with MSM and transgender people – through a combination of service provision and referrals – to provide a package of support:



### Humsafar's key steps towards SRH and HIV linkages

- In 1994, Humsafar started providing HIV- and SRH-related services almost simultaneously in response to the unmet needs of MSM and transgender people in Mumbai. The first step was offering workshops in its Drop-In Centre, focusing on issues faced by MSM such as coming to terms with sexuality, disclosure to families and friends, as well as providing for a range of SRH needs. HIV was a recurring theme for participants, who expressed concern about infection. In response, the Trust intensified its focus on HIV.
- In 1998, Humsafar completed a 'sex mapping' of cruising sites and meeting places, which estimated that 57,000 MSM accessed these places.
- In 1999, Humsafar with the support of the Mumbai District AIDS Control Society (MDACS) began to implement HIV prevention targeted interventions for 1,000 MSM – a project that was later scaled up. Furthermore, the Trust collaborated with the government's Lokmanya Tilak Municipal General Hospital and sensitized health care providers on health-related issues faced by MSM and transgender people. Also in 1999, NACO recognized Humsafar's Vakola Clinic, which began serosurveillance among MSM, as a VCT centre for MSM.
- From 2001, the increasing number of MSM testing HIV-positive led Humsafar to add care and support services, including mental health counselling and referrals for ART.
- In 2005, to reach a further sub-group of MSM involved in sex work, Humsafar established a STI clinic and HIV testing services at a separate site in Juhu, an area of Mumbai.
- Since 2008, the Vakola Clinic has provided a comprehensive package of services for clients living with HIV, including nutritional supplements, support group, mental health counselling, and home-based care and support provided by MSM community health workers.
- As of 2010, the Trust has provided outreach services to some 13,000 MSM and transgender people in Mumbai and Thane districts. Services include HIV and STI education and distribution of condoms and water-based lubricant, which are complemented by referrals to major government hospitals for STI screening and treatment, and HIV-related services such as CD4 testing and ART. Linkages have also been established with mainstream SRH organizations, including the Mumbai branch of FPA India – in order to provide referrals to the female partners of MSM, as well as hepatitis B screening and free hepatitis B vaccination.
- Humsafar has consistently provided support to MSM and transgender people for physical and sexual violence, and has established a crisis intervention unit to provide rapid responses to incidents.

### Successes in SRH and HIV linkages

The SRH and HIV linkages-related results and successes of Humsafar include:

- **Providing HIV and SRH services in a single facility:** Humsafar's integrated programme is designed so that MSM and transgender people are able to spend adequate, quality time with doctors and counsellors, and to save time and money by avoiding unnecessary travel.
- **Adding additional HIV and SRH services over time:** Humsafar has built the range and increased the scale of its integrated programmes over time in response to community needs, and in line with the Trust's capacities and resources.
- **Supporting the needs of female partners of MSM:** Humsafar's collaboration with FPA India, combined with sensitization of health care workers, has led to referral of married MSM and their female partners to clinics where both are offered SRH and HIV services, and supported in a confidential environment. The husband's sexuality is not revealed to the wife without his explicit consent.



## Issues and challenges with SRH and HIV linkages

The SRH and HIV linkages-related issues and challenges faced by Humsafar have included:

- **Differences within the sexual minority community:** Differences among sub-groups of MSM and transgender people have deterred some people from accessing Humsafar's services. The Trust has faced challenges in engaging different groups, especially as it was initially seen as an organization primarily for kothis and hijras – with masculine MSM (panthis and 'double-deckers') being uncomfortable using the same services. Among some long-term clients, this has been overcome by sensitizing masculine MSM about the issues faced by kothis.
- **HIV-related stigma and discrimination:** Some MSM are concerned about using a VCT/HIV centre in case they are seen attending the service. This fear has decreased over time, but still affects some new clients.
- **Disclosure of HIV status:** While many of Humsafar's services are located on

the same floor, those for MSM living with HIV are in a separate room and provided by a specific staff member. Some clients (especially recently diagnosed people) are reluctant to access these services for fear of revealing their HIV status. Humsafar tried opening a separate centre in a different location for MSM living with HIV, but found that men wanted to mingle with other clients and/or access wider services. Now, the Trust plans to relocate its room for MSM living with HIV and share responsibilities among a number of staff.

- **Reaching female partners of MSM:** Some MSM who have female partners do not reveal their marital status to services providers or other MSM, making it challenging to both address the full range of SRH and HIV needs of these men as well as to reach their female partners.
- **Maximizing the range of available services:** Not all clients are aware of, and access, the full range of services available, indicating a need to strengthen internal referral systems.

## CASE STUDY 2: FPA INDIA – TILAK NAGAR CLINIC

**An SRH NGO integrating HIV services and support for MSM and transgender people.**

### ORGANIZATIONAL FOCUS

An NGO which provides a comprehensive range of SRH services and supports the sexual and reproductive rights and choices of all.



### FOUNDED

1949

### LOCATION

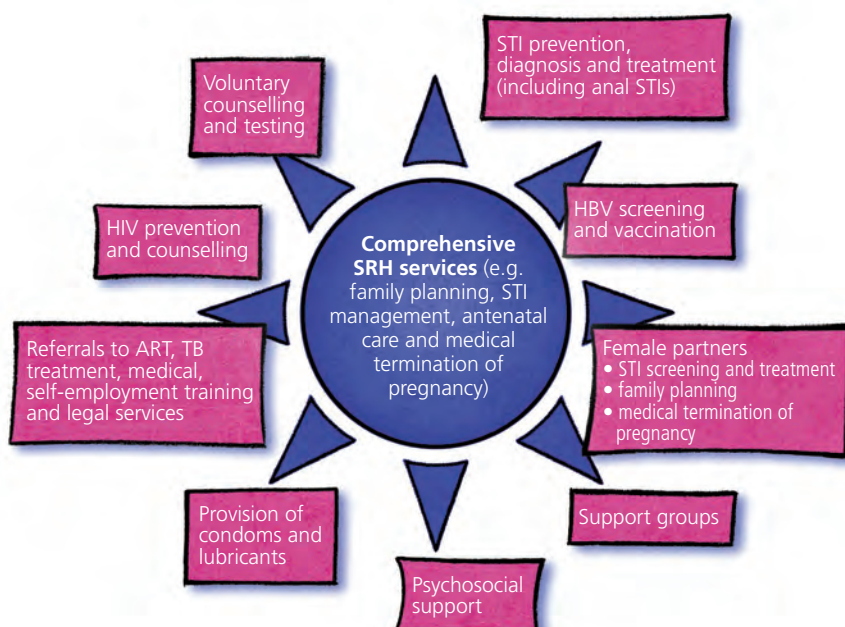
40 branches across India

### CONTACT DETAILS

FPA India  
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Mumbai – 400 021  
[www.fpaindia.org](http://www.fpaindia.org)

### Steps towards SRH and HIV linkages

The FPA India model integrates HIV into existing SRH services – through a combination of service provision and referrals – to provide a package of support for MSM and transgender people:



## FPA India's key steps towards SRH and HIV linkages:

- In 2006, while implementing HIV prevention interventions among people in underdeveloped areas, FPA India's Mumbai branch came across young people who were engaging in unprotected same-sex sexual behaviour and had limited access to information and prevention tools.
- As a result, the organization explored the sexual behaviours of young men through a situational assessment involving groups of MSM, to understand their unmet HIV and SRH needs.
- The resulting project began with a stakeholders' meeting, including NGOs and CBOs working with MSM and transgender people in Mumbai, which sought collaboration and support.
- Subsequently, the NGOs and CBOs were involved in the design and implementation of the project. This included helping to identify project staff, conducting training of FPA India staff, referring MSM clients to services, and providing ongoing feedback on the quality of services and any service gaps.
- Through this project, the FPA India Mumbai branch – particularly the Tilak Nagar clinic – now provides a package of support for MSM through a combination of service provision and referrals, including to the female partners of MSM.

## Successes in SRH and HIV linkages

FPA India's results and successes with SRH and HIV linkages include:

- **Integrated services in a single facility:** Clients report that having both HIV and SRH services has benefits, including receiving more comprehensive information and support, travel-related time and cost savings, and receiving non-discriminatory and good quality services in an understanding environment.
- **Flexible clinic hours:** Government hospital outpatient clinics close by 1 pm, making it hard for MSM involved in sex work to access services. The Tilak Nagar clinic opens until 5.30 pm, operating on a walk-in basis.
- **Client-friendly services:** Almost all MSM and transgender clients rate Tilak Nagar clinic's services as good or excellent, and are pleased with the welcoming environment and personalized attention, free from discrimination.
- **Popularizing the project:** Providing services valued by MSM and transgender people (such as free hepatitis B screening and vaccination) gained community support for the project and attracted an increased number of clients.
- **Entry point for other services:** Most MSM and transgender clients initially accessed the clinic for a particular need, for example, VCT or STI treatment. Through the integrated programme, they come to know about and access a range of support available to them, their partners and family members.
- **Supporting female partners:** Married MSM are comfortable bringing female partners to the Tilak Nagar clinic for services, as it is not viewed as 'MSM-specific' and their sexuality is kept confidential.

### Issues and challenges with SRH and HIV linkages

FPA India's issues and challenges with SRH and HIV linkages have included:

- **Competition among NGOs:** Initially, FPA India was seen as a 'competitor' entering the HIV field. Its outreach workers were not welcomed by other NGOs and CBOs working with MSM and transgender people, fearing a loss of clients. This was addressed by a stakeholders' meeting to explain the complementary role of FPA India's prevention and treatment services, and respective roles were agreed to prevent duplication.
- **Staff discomfort with change in clientele:** Traditionally FPA India focused on female clients, and some staff were initially discomforted by the change to include MSM and transgender people in their service provision. This was addressed over time by staff building their confidence through interactions with MSM and transgender people and training by CBOs working with the community.
- **Training and sensitization of staff:** FPA India found that to provide good quality facility-based and outreach services, both clinical and non-clinical staff required extensive technical training on the HIV and SRH-related issues of MSM and transgender people, not merely sensitization about the community.
- **Discomfort among existing clients:** Initially, some clients were concerned about sitting alongside feminine MSM and hijras in the waiting area, and some were reportedly offended by behaviours and language. The organization's management discussed this with local leaders from the MSM and transgender communities and explained that in the clinic they needed to be sensitive to others. As a result, hijras stopped engaging in behaviours that offended the general clients and reportedly developed a good rapport.
- **Supporting married MSM and their partners:** With the Drop-In Centre and clinical services located in the same facility, some MSM were reluctant to access the clinic with their female partners for fear of being seen by other MSM. In response, FPA India provides these clients with three options:
  - Referring the couple to any of the three other FPA India clinics in Mumbai and Thane districts.
  - Asking the couple to come to the Tilak Nagar clinic on days when the Drop-In Centre is closed.
  - Asking the husband and wife to come separately.
- **Client expectations:** Some MSM and transgender people had some expectations of integrated programmes that were outside the mandate or capacity of FPA India. For example, free CD4 testing and some prevention of mother-to-child transmission (PMTCT) services.
- **Diversity of community and needs:** There is significant diversity within the MSM and transgender community in terms of gender identities and sexual roles, requiring different strategies for outreach work and service provision, some of which may be outside the capacity of FPA India, for example, hijras requesting hormonal therapy for breast development and feminization of the body.



## CASE STUDY 3: SAATHI

An NGO for marginalized groups coordinating advocacy coalitions on SRH and HIV, involving MSM and transgender organizations and PLHIV networks.

### ORGANIZATIONAL FOCUS

An advocacy coalition which strengthens the capacity of organizations working with marginalized groups who are most vulnerable to HIV infection.



### FOUNDED

2000

### LOCATION

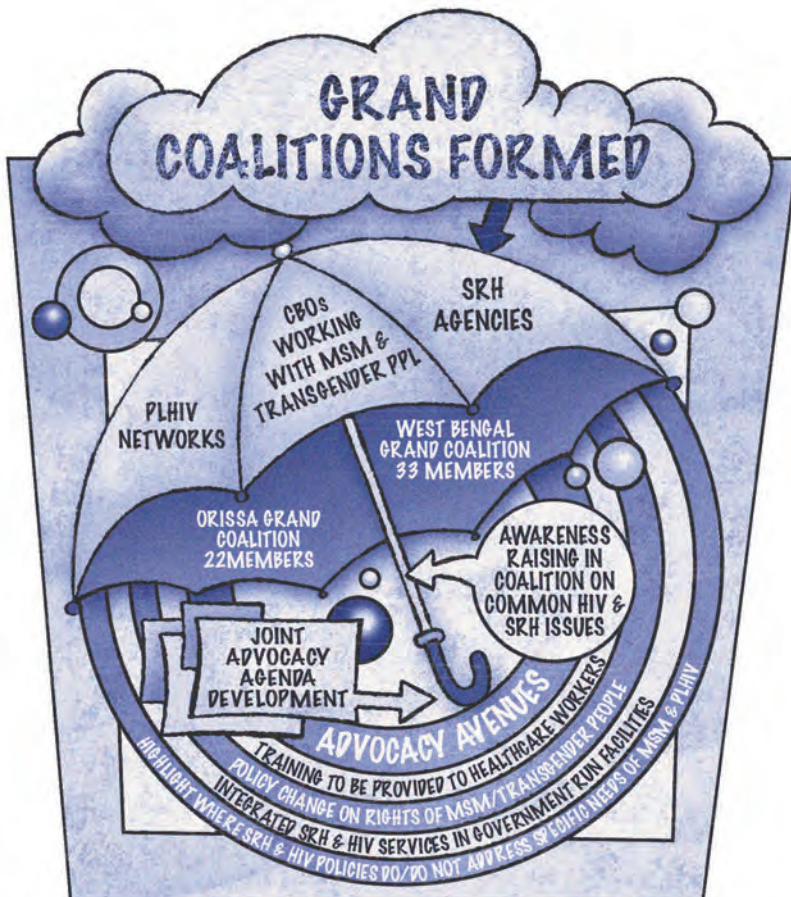
Eight branches across India

### CONTACT DETAILS

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Purbachal (North)  
Kolkata – 700 078  
[www.saathii.org](http://www.saathii.org)

### Steps towards SRH and HIV linkages

SAATHII leads a coalition-based advocacy project in both West Bengal and Orissa bringing together CBOs supporting MSM and transgender people and networks of people living with HIV.



### SAATHI's key steps towards SRH and HIV linkages

- In 2004, SAATHI started an HIV Support Centre Project that focused on providing knowledge; building on gender, sexuality, human rights, sexual health and HIV; and providing technical support and other capacity-building services for a variety of skills related to the HIV response. Of the nine main partner agencies – some of which were CBOs working with MSM and transgender people, and networks of PLHIV – most had experience in providing services or HIV sensitization, but limited SRH experience.
- In 2008, based on identified needs, SAATHI began a 5-year follow-up initiative (the Coalition-Based Advocacy Project), which aims to strengthen the advocacy capacity of partner agencies by assisting them to understand the SRH specific needs of sexual minorities and PLHIV.
- There are 33 (West Bengal) and 22 (Orissa) members of two state-level coalitions. Most of the members are CBOs working with MSM and transgender people and state-/district-level networks of PLHIV – the first time that a coalition in either state has contained both groups. The work has been strengthened through training each agency and a workshop to develop and agree on a common advocacy agenda.
- Alongside the coalitions, SAATHI is supporting over 40 agencies to integrate SRH components into HIV-targeted interventions for MSM and transgender people. Examples of SRH components include prevention and care for survivors of sexual violence, health promotion for the female partners of MSM, and gender transition counselling for transgender people.

### Successes in SRH and HIV linkages

SAATHI's results and successes in SRH and HIV linkages include:

- **Developing a common advocacy agenda:** This agenda is based on many common and overlapping issues for sexual minorities and PLHIV, such as access to services, stigma and discrimination, psychosocial support and livelihood options. It provides strong foundations for the work of the coalitions.
- **Advocacy at the policy level:** A policy review paper has been prepared on how current HIV and SRH policies (including the NACP/NRHM convergence plan) do or do not address the specific needs of sexual minorities and PLHIV. An advocacy action plan is being developed to address identified policy and programme gaps. A forthcoming activity is to advocate for the articulation of the specific SRH-related issues of sexual minorities and PLHIV in the next phases of the NACP and RCHP.
- **Advocacy at health care systems level:** The coalitions' activities include sensitizing health care providers on issues for sexual minorities and PLHIV; and advocating for technical training of providers on the specific HIV and SRH-related needs of these communities.
- **Complementing advocacy with service provision:** SAATHI and coalition members are increasingly 'putting advocacy into action' by integrating SRH into their provision of HIV services for MSM and transgender people.

## Issues and challenges with SRH and HIV linkages

SAATHII's issues and challenges for SRH and HIV linkages have included:

- **Initial tensions between coalition members:** Initially, there were tensions within the coalition due to allegations of discrimination against MSM and transgender people in PLHIV networks. This was gradually addressed by building a shared understanding of the overlapping HIV and SRH issues of the member constituencies.
- **Lack of funding opportunities:** The coalitions were challenged by the lack of a specific funding mechanism to advance the SRH of sexual minorities and PLHIV. While HIV-related activities are funded by NACO through NACP-III, SRH activities for the general population (especially women) are funded by RCHP-II/NRHM. The NRHM's plan does not mention the SRH of sexual minorities and PLHIV. As such, SAATHII was unsure whether funding would have been secured for the work, without external donor support.
- **Multi-pronged capacity building:** SAATHII's approach was needed to combine the building of understanding and capacity on:
  - SRH among agencies providing HIV services for MSM and transgender people;
  - issues affecting MSM and transgender people among mainstream PLHIV networks; and
  - the specific needs of MSM and transgender people among general SRH services.

This has created cross-linkages among the agencies in both their service provision and advocacy for improved policies and programmes, including SRH and HIV linkages.

- **Training for health care providers:** At the level of the health system, SAATHII and the coalition partners are advocating for sensitive and non-judgemental care for sexual minorities and PLHIV. This includes the need for technical training of health care providers on the specific HIV and SRH-related issues of the communities. The coalition is calling on the government to incorporate relevant issues into the formal training curriculum for providers in government hospitals.
- **Involvement of mainstream SRH agencies:** Only a limited number of agencies that work on mainstream SRH issues have registered as members of the two coalitions. However, many other SRH agencies have clarified that even though they are not formal members, they will support advocacy actions in relation to SRH and HIV linkages for sexual minorities and PLHIV. This will require further work in the coming years with SAATHII and the coalitions further strengthening their formal and informal links with other mainstream SRH and human rights agencies.
- **Fear of backlash against coalition members:** Some agencies expressed concern about potential negative consequences, such as losing funding due to criticizing the government or providing support to sexual minorities and PLHIV. In response, the coalition emphasized that while it is important to collaborate with the government, it is also important to highlight gaps in its services and policies to help the government to do its job better.

# TAKING LESSONS TO SCALE

The experiences of the Humsafar Trust, FPA India and SAATHII provide important lessons about ‘*What works?*’ in relation to developing, implementing and strengthening SRH and HIV linkages for MSM and transgender people at the policy, systems, and service delivery levels.

## POLICY LEVEL:

**1. Have a strong national policy on SRH and HIV linkages that articulates and commits to the specific needs of key populations.**

For example, in India – despite evidence of increasing government commitment to SRH and HIV linkages – relevant documents do not specifically address the needs of MSM and transgender people.

**2. Build a strong, collective movement to advocate on SRH and HIV linkages for MSM and transgender people.** For example, SAATHII found that bringing together organizations focused on MSM/transgender people and PLHIV which had previously worked in isolation provided ‘strength in numbers’ and a more powerful voice to address decision-makers. This required capacity building for *all* coalition members – for example, MSM/transgender groups learning more about SRH issues and PLHIV networks learning more about MSM/transgender issues.

**3. Maximize existing external funds for SRH and HIV linkages for key populations, while advocating for greater domestic investment.**

For example, Global Fund resources

have been critical to piloting and developing integrated programmes for key populations, including MSM and transgender people. However, resources provided by the government for SRH and HIV linkages – which currently funds HIV and SRH programmes separately – will be critical for scale-up and sustainability.

**4. Build an enabling legal and social environment for SRH and HIV linkages for MSM and transgender people.** In India, this includes addressing issues – such as anti-discrimination legislation, social stigma and discrimination within health systems – that present barriers to accessing services for key populations.

**5. Develop national understanding and buy-in for a comprehensive package of integrated SRH and HIV services for MSM and transgender people.** Alongside obvious components (such as condom distribution and STI screening and treatment), this should include specific issues related to the MSM and transgender community, for examples anal STIs, sexual reassignment surgery, and support for victims of sexual violence.

## SYSTEMS LEVEL:

**1. Ensure effective joint national planning, budgeting and monitoring on SRH and HIV.** For example, the government’s broad commitment to SRH and HIV linkages needs to be rolled-out through systematic and collaborative planning and programme management.

**2. Coordinate and identify specific, complementary roles and responsibilities for all stakeholders involved in SRH and HIV linkages for MSM and transgender people.** For example, FPA India found that collaboration with government health services and local NGOs/CBOs was critical to reaching more clients, to avoiding being viewed as a competitor, and to ensuring a complementary role.



**3. Develop effective referral systems to provide both comprehensive and high quality SRH and HIV integrated services.**

Such systems should maximize existing facilities, services and resources. They should facilitate the smooth flow of clients between facilities, while ensuring that quality services – for example, ones that are confidential and non-judgemental – are consistently offered by the range of service providers.

**4. Address SRH and HIV linkages in training curriculum and provide opportunities for health workers to implement good practice services for MSM and transgender people.**

For example, FPA India found that as well as general sensitization, it was vital to provide *all* SRH staff (clinical/non-clinical, clinic-based/outreach, etc.) with extensive technical training on HIV and issues affecting MSM and transgender people.

**5. Ensure that all agencies and facilities in the chain of SRH and HIV linkages have policies and commitment to the provision of non-judgemental services.** For example, in India, referral hospitals need to develop and implement policies that prohibit discrimination against people on the basis of sexual orientation, gender identity and HIV status.

## SERVICE DELIVERY LEVEL:

**1. Integrate new HIV or SRH services gradually, considering both needs and available resources.** For example, Humsafar considered factors including HIV prevalence among MSM and transgender people; demand from community members; input from community leaders; capacity of the organization; and availability of funding.

**2. Acknowledge and respond to the diverse identities, situations and needs of MSM and transgender people.** For example, Humsafar found that, far from being a homogenous group, a range of differences – from social class to sexual roles – affected community dynamics, as well as individuals' access to services, and needed to be recognized and incorporated within the design of integrated services. Similarly, FPA India found that the needs of MSM and transgender people varied enormously among married MSM, MSM in sex work, hijras and MSM living with HIV – and, in turn, it was vital to clarify exactly what needs its facilities could and could not address.

**3. Address the specific SRH and HIV needs of married MSM – supporting him and his female partner.** For example, Humsafar and FPA India found that, in addition to supporting MSM, it was also vital to support their female partners. This required careful planning, for example, to maintain confidentiality and ensure the availability of female-friendly SRH services.

**4. Ensure confidentiality in the provision of SRH and HIV integrated programmes for MSM and transgender people.** For example, both Humsafar and FPA India found that it was critical to address issues of privacy for MSM living with HIV and MSM who were married. This involved, for example, offering these men options to access services at different times to other clients or to be referred to other organizations for services.

**5. Involve MSM and transgender people in all stages of work on SRH and HIV linkages.** For example, Humsafar's programme was shaped by a mapping exercise involving community members, while FPA India found that frequent interactions with the community were critical to changing negative preconceptions among staff.

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## ABBREVIATIONS

<b>ART</b>	antiretroviral therapy
<b>CBO</b>	community-based organization
<b>CD4</b>	T-cells or T-helper cells in the immune system
<b>FPA India</b>	Family Planning Association of India
<b>Global Fund</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>GNP+</b>	Global Network of People Living with HIV
<b>HBV/HEP B</b>	hepatitis B virus
<b>HIV</b>	human immunodeficiency virus
<b>ICW</b>	International Community of Women Living with HIV
<b>IPPF</b>	International Planned Parenthood Federation
<b>MDACS</b>	Mumbai District AIDS Control Society
<b>MSM</b>	men who have sex with men
<b>MSMGF</b>	Global Forum on MSM and HIV
<b>NACO</b>	National AIDS Control Organization
<b>NACP</b>	National AIDS Control Programme
<b>NGO</b>	non-governmental organization
<b>NRHM</b>	National Rural Health Mission
<b>PLHIV</b>	people living with HIV
<b>PMTCT</b>	prevention of mother-to-child transmission
<b>RCHP</b>	Reproductive and Child Health Programme
<b>SAATHII</b>	Solidarity and Action Against The HIV Infection in India
<b>SACS</b>	State AIDS Control Society
<b>SRH</b>	sexual and reproductive health
<b>STI</b>	sexually transmitted infection
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>UNGASS</b>	United Nations General Assembly Special Session
<b>VCT</b>	voluntary counselling and testing
<b>WHO</b>	World Health Organization

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**CHECKLIST**



# Checklist for action

**The checklist summarizes 15 key steps towards sexual and reproductive health (SRH) and HIV linkages for MSM and transgender people. This can be used as a tool by organizations that are either 'getting started' on linking HIV and SRH or wish to strengthen their existing work with key populations.**

## Completing the checklist for action

To obtain the opinions and perceptions of a range of stakeholders associated with the organization, it is recommended that this checklist be completed in a collective manner. Following discussion and debate on the questions, staff and other stakeholders can assess the organization's performance by marking the appropriate box: *Yes, No, In progress, or Not relevant*.

## Developing a plan for action

After completing the checklist, a good starting point towards developing a plan for action is to review the questions that were answered '*in progress*' and '*no*' – these identify key areas in need of attention. Consider each question individually and reflect on ways that these areas could be strengthened and/or improved. Select the most relevant areas for the organization to improve upon in the short term. Based on this information, develop a plan for how these areas requiring more attention will be improved.

**For more information on SRH and HIV linkages, a collection of current resources compiled by experts from the Interagency Working Group on SRH and HIV Linkages is available from [www.srhivlinkages.org](http://www.srhivlinkages.org)**



ORGANIZATIONS LINKING HIV AND SRH FOR MSM AND TRANSGENDER PEOPLE			ISSUES TO THINK ABOUT	YES	NO	IP	NR
1	Does linking SRH provide a <b>good ‘fit’</b> to your organizational mission and objectives?		For example: <ul style="list-style-type: none"><li>• it matches skills set of existing staff;</li><li>• it is covered by the organization’s vision and values; and</li><li>• it fits within existing organizational policies.</li></ul>				
2	Has understanding and commitment to HIV and SRH-related issues for MSM and transgender people and SRH and HIV linkages been built among <b>senior level management</b> of your organization, including the Director and Board?						
3	Has a rapid <b>community assessment</b> been undertaken to: <ul style="list-style-type: none"><li>• identify the different groups of MSM and transgender people;</li><li>• identify the needs of MSM and transgender people in relation to HIV and SRH; and</li><li>• <b>map existing services</b> in your own and other organizations?</li></ul>						
4	Based on your research, and in collaboration with community members, has a <b>package* of essential information, services and commodities</b> for HIV and SRH for MSM and transgender people been identified?						
5	In order to implement the package, have the SRH and HIV services been identified that <b>your organization</b> will provide? Will they be provided through <b>referral</b> ?		For example, referrals to SRH clinics, VCT centres or ART clinics.				
6	Have <i>all</i> relevant staff and volunteers received <b>capacity building</b> on attitudes and technical areas?		For example: <ul style="list-style-type: none"><li>• on attitudes such as stigma against MSM and transgender people, or people living with HIV;</li><li>• on technical areas such as anal STIs, sexual reassignment; and contraception for the female partners of MSM and transgender people.</li></ul>				
7	Has a <b>strong and effective referral system</b> been developed?		For example: <ul style="list-style-type: none"><li>• monitoring client flow such as checking the uptake of appointments;</li><li>• ensuring quality services for MSM and transgender people such as prevention and treatment of anal STIs.</li></ul>				
8	Have <b>protocols for integrated services</b> been developed that specify which components of SRH should be linked with which components of HIV for MSM and transgender people?						
9	Within services, has particular attention been paid to the <b>‘hidden’ SRH needs</b> of MSM and transgender people?		For example, contraception for the female partners of MSM, and management of anal STIs.				
10	Has the <b>environment and physical infrastructure</b> been adapted?		For example, to ensure that it provides a safe and confidential space for MSM and transgender people – whether married or not, or living with HIV or not – to discuss their sexual practices and SRH needs.				
11	Have creative and innovative <b>service delivery methods</b> been used to provide integrated services?		For example, complementing clinic-based services with community outreach to places where MSM and transgender people socialize, meet for sex or sell sex.				
12	Have <b>logistics and management systems</b> been adapted?		For example, by learning about supply chains for commodities, and by developing monitoring indicators to assess the efficacy of integration.				
13	Have <b>MSM and transgender people</b> been involved in designing, implementing and monitoring your work on an ongoing basis?						
14	Has <b>advocacy</b> been undertaken with MSM and transgender people?		For example, to explain why SRH matters and why the integration of services is effective.				
15	Has <b>advocacy</b> been undertaken with local and national stakeholders to address the legal and structural barriers faced by MSM and transgender people in accessing HIV and SRH services?						

**‘What works?’** is a series of Advocacy Briefs on experiences, lessons and good practice in linkages between sexual and reproductive health (SRH) and HIV for key populations.

This Advocacy Brief focuses on SRH and HIV linkages for **men who have sex with men (MSM) and transgender people.**

**Audience and purpose:** This “What works?” brief is designed to help programme managers, advocates and policy makers from governmental and non-governmental organizations to more effectively link SRH and HIV services for MSM and transgender people at the policy, systems, and service delivery levels.

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