FROM THE FRONTLINE OF COMMUNITY ACTION

A compendium of six successful community based HIV interventions that have worked for MSM – TG - Hijras in India

'Research and Report :
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From The Frontline of Community Action

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The National AIDS Control Program (NACP) II and III interventions have brought to the fore that if 'core groups' have to be reached and saturated, then the best implementers of the programs are communities themselves. During the implementation phase of NACP II, successful models in various high prevalent states demonstrated that interventions for prevention efforts were made more sustainable by the process of CBO formations. This report documents six successful interventions with men who have sex with men (MSM) and male-to-female transgenders (TGs) in the country. Furthermore, we have also highlighted the lessons learnt from past experiences, the results (whether positive or negative), the feedback, and analysis of the outcomes, which could be used to draw conclusions and give recommendations for future actions with regards to MSM and TG programming. This work was made possible through support from the United Nations Development Program, India.

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The report is based on the literature reviewed and on the field work and assessment conducted by Shobhna S. Kumar and Pallav Patankar. Dr. Maninder Singh Setia has also contributed to the writing and finalisation of this report.

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LIST OF ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
APAC	AIDS Prevention and Control Project
CBO	Community Based Organization
CCHW	Committed Community Health Worker
CLSI	Community Led Structural Interventions
DACS	District AIDS Prevention and Control Society
DFID	Department for International Development
DiC	Drop in Centre
HIV	Human Immunodeficiency Virus
HST	The Humsafar Trust
IDU	Intravenous Drug User
IEC	Information Education-Communication
INGOs	International Non Government Organisation
KHPT	Karnataka Health Promotion Trust
KP	Key Populations
KSAPS	Karnataka State AIDS Prevention Society
LGBT	Lesbian, Gay, Bisexual, Transgender
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
NACP III	National AIDS Control Program III
NFI	Naz Foundation International
NGO	Non-Government Organization
ORW	Outreach Worker
PE	Peer Educator
PLHA	People Living with HIV/AIDS
SACS	State AIDS Prevention and Control Society
STI	Sexually Transmitted Infections
SWAM	Social Welfare Association for Men

TG	Transgender (male-to-female transgenders)
TI	Targeted Intervention
TNSACS	Tamil Nadu State AIDS Control Society
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
USAID	United States Agency for International Development
WHO	World Health Organisation

EXECUTIVE SUMMARY

Men who have sex with men (MSM) and male-to-female transgenders (TGs) form an important 'high risk group' for HIV prevention efforts in India. The HIV prevalence in these groups has been relatively high (≥5%) in many of the surveillance reports. Thus, interventions in these groups have been an important thrust area for the National AIDS Control Organization (NACO), India. Unlike, some other high risk groups (such as patients attending sexually transmitted infections [STI] clinics) these groups usually have strong community ties; thus, many interventions in these groups are community driven and often through community based organisations (CBOs). Indeed, successful interventions in these 'core groups' in some of the high prevalence states are because of active community participation though CBOs.

A total of six CBOs working with MSM and TGs (from different regions of the country) who had previously scored highly on intervention implementation were critically assessed. Relevant literature and annual reports of these organisations were scanned. This was followed by site visits to each of these organisations. During these visits, in-depth interviews were conducted with a range of individuals, starting from grass-root level workers of these organisations such peers, outreach workers (ORWs), community mobilisers to more senior level members including managers and board members. Furthermore, discussions were also conducted with their collaborators, partners, and State AIDS Control Societies.

This report presents the details of this assessment. For each of the six organisations, the discussion starts with a profile. The discussion later proceeds to the key interventions implemented by them, their partnerships with other members of the society (such as health, law enforcement agencies, funders etc.) if any, and some of the key outcomes of these interventions. Furthermore, some of the lessons learnt and replicable models that can be used for further interventions have been highlighted.

It was found that that some of these organisations based their community work on different aspects of community needs, for example health was an important focus and basis of

community interventions at the Humsafar Trust from Mumbai, whereas Sangma - Samara from Bengaluru had a more human rights and legal approach towards dealing with the community. Nonetheless, despite these different approaches the overall aim of these various organisations was community driven sustainable interventions for HIV prevention and care, and general health and well being of MSM and TGs.

Given the geographic and cultural differences in different parts of the country, it was but natural that there would be variations in approach to community issues in these regions. However, these differences also provide an opportunity to understand the successful models in various regions, and their replicability (even though not in their entirety) to communities and CBOs situated in other parts of the country. Some of the interventions/programmes by these organisations are beyond the mandate required by the national programme; thus these key interventions are important to be highlighted and understood by others working in the field. In addition, lessons learnt from this exercise are potentially useful in the creation of new organisations under an enhanced HIV Prevention Program.

Finally, the role of India Network for Sexual Minorities (INFOSEM) as an umbrella organisation for developing and streamlining community related activities in the country has been highlighted. All these six organisations are a part of INFOSEM; thus, their experiences can be shared on a common platform. This platform, in turn, provides inputs on needs and strategies for community led interventions in the country, thus making the relationship between the CBOs and INFOSEM a multidirectional association.

BACKGROUND

I. Men who have sex with men and male-to-female transgenders in India

MSM and TGs are among the highest priority subpopulations for HIV prevention as identified by the National AIDS Control Organization (NACO) in India. Though, this was one of the last 'high risk groups' to be recognised within the National Program, ever since the initial surveillance in 2000 in a couple of MSM sites, aggressive efforts have been undertaken to initiate HIV Prevention In 2006, national HIV sentinel that HIV prevalence was > 5% in MSM in 11 of 28 sentinel sites analyses by NACO. Furthermore, the surveillance reported that the prevalence had increased in many of these sites.

Even though the epidemiological term 'MSM' is used often in HIV prevention efforts, this umbrella term includes various typologies and sub-groups have been well documented in the literature[1] and recognised by NACO. For instance, some of these groups are: *kothis* (effeminate same-sex attracted males who are predominantly receptive); *panthis* (Masculine partners of *kothis* who are predominantly insertive); 'Doubles' or 'double-deckers' (who insert/receive in sexual encounters with males); and gay-/bisexual-identified MSM. Another important group which often gets incorporated in this umbrella term is that of male-to-female transgenders also referred to as TGs. Among these, the visible group includes *hijras*, who are biological males who reject their 'masculine' identity in due course of time to identify either as women, or "in-between man and woman" ('third gender'). They are a separate group socially, culturally, economically, and even from a public health perspective. Indeed, studies have documented that TGs have a higher HIV prevalence compared with MSM. Thus, the intervention needs of this group are separate from other MSM. Most of the current TIs mainly reach out to *kothis* and/or *hijras*, and often reaching out to other subgroups of MSM remains a challenge.

The epidemic is these sub-groups is complex. Not only do they have high a HIV prevalence but also may face other issues such as stigma (due to their sexuality/gender), poor health care access, violence, and in some instances even violation of their human rights.

Furthermore, some of these MSM may be married and may continue risky sexual behaviours with men as well as women (their wives); thus, making them an important bridge population. Even though some of these issues are relatively well documented addressing these in intervention programs requires necessary skills and sensitivity. Thus, the success or failure of an intervention program will not only depend on the quality of outreach, transmission of information, but also how sensitively the information is being discussed with the communities most at need. Thus, community led interventions are a useful tool in the HIV programs in MSM and TGs. The population size of MSM who engage in high risk behaviours and who access public cruising sites is estimated to be 23,52,133 and male sex workers are estimated to be 235213. During the NACP-III phase (2007-2012), NACO plans to 'cover' 1.15 million MSM. NACO estimates that 207 exclusive TIs (1 TI=600 MSM) and 767 composite TIs (each covering 200 MSM) might be needed. Since NACO's target is to have at least 50% of the exclusive MSM TIs to be CBO-led by 2012, it means 100 CBOs with necessary capacity to implement TIs among MSM are required.

II. National AIDS Control Program

A. Overview of the National AIDS Control Program

National AIDS Control Organisation manages its national mandate for effective prevention, care and support services for HIV/AIDS through the co-ordinated framework of the National AIDS Control Program.

The National AIDS Control Program has been in operation since 1992. The framework for project management, monitoring and evaluation for the Targeted Interventions has been shaped by the achievements of the organizations it funded. This is extensively documented in their statistical reports. The national body with its State and District AIDS Control Societies has also undertaken periodic site visits and consultations with the funded organizations, other stakeholders and policy makers to build upon its implementation objectives over the years.

B. National AIDS Control Program III

The National AIDS Control Program (NACP) is in the midst of its third phase (NACP III) of co-ordinating a national response of HIV and AIDS prevention, care and support. The current phase for NACP III is for the period of 2007 till 2012. Supported by National AIDS Control Organisation (NACO), the NACP III has partnered with over 1000 organizations through funding and technical support to fund Targeted Interventions (TIs.)

NACP III Operational Guidelines (Volume 1 for Core High Risk Groups and Volume 2 for Bridge Populations) provide a comprehensive set of standardised procedures to ensure delivery of quality HIV prevention interventions through target interventions (TIs) throughout India. They detail areas of program management, human resource requirements, service delivery, and linkages. They also ensure proper monitoring and evaluation procedures.

The Operational Guidelines Volume 1, 2007 (p7) states "it is estimated that more than 90% of HIV transmission in India is related to unprotected sexual intercourse or sharing of injecting equipment between an infected and an uninfected individual." One of the core high risk groups (HRGs) of individuals who are most at risk are men who have sex with men (MSM) and transgenders (TGs.)

The Guidelines present "Intervention Package for High Risk Groups under TIs" and the four components listed below are implemented in a range of styles, as per local environment. Though documentation of successful strategies is based on these components, it also looks beyond traditional accountability and reporting to record replicable aspects of each Intervention.

i. *Outreach and Communication*: Peer-lead, NGO supported outreach and behaviour change communication;
ii. *Services*: Promotion of condoms, linkages to STI services and health services with a strong referral and follow-up system;
iii. *Creating an Enabling Environment*; and
iv. *Community Mobilisation*: Building MSM/TG ownership of the TI's objectives.

III. Successful targeted interventions

Despite various hardships, there have been examples of community based efforts in which the MSM and TG communities have risen above all obstacles and delivered successful interventions on ground level. These interventions have made an effort to reduce the incidence of HIV and STIs among this highly vulnerable population.

The success of these interventions is defined through aspects which them different and special in their efforts. Furthermore, it is also based on the extent to which a specific intervention or service produces a beneficial result under ideal conditions.

The assumptions the authors have worked on are as follows:

i. The *mobilisation processes* were effective in catalysing genuine "ownership"— the sense among those involved that the problems identified are theirs and that they hold the primary responsibility for addressing them. Ownership in turn generated high levels of participation within the wider community;

ii. *Community-led action* occurred because of genuine ownership; and

iii. *CBOs are principal actors* in community-based health responses to the HIV epidemic. Even the health-focused CBOs tend to arise out of social and political movements, such as LGBT rights movement, and are typically staffed by individuals who represent the communities at risk.

IV. Conclusions

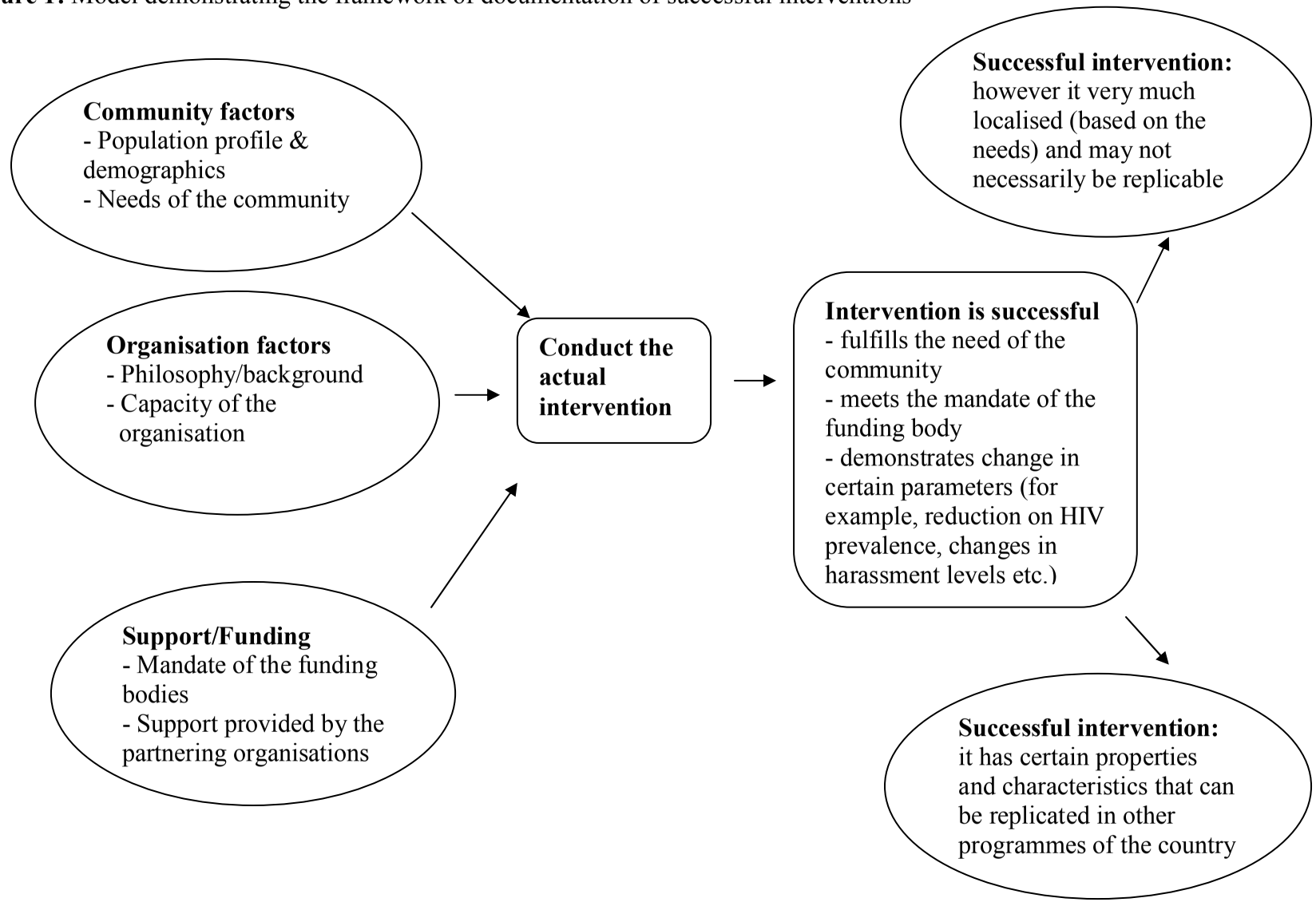
Though some of the existing interventions have been categorised as successful interventions, details of the nuances of these projects have yet to be documented in a substantive and qualitative manner. All targeted interventions follow NACP III Guidelines for Operations; yet each project and organization has to integrate local environments of culture, societal norms & prejudices, religious sentiments, political networks, geographical terrains, and economics of the day to implement the TIs. These factors take priority over the social and sexual networks, and linkages that the TIs are built upon. Understanding and knowledge of local sensibilities help

fine-tune the strategies that each TI team uses to connect with the key population and develop linkages and supportive networks.

This document is an attempt to grasp these aspects indigenous to these six CBOs. It is an attempt to begin to understand the experiences of CBOs who implement projects in a milieu of stigma and discrimination, with communities whose lives are cloaked in silence and until July 2, 2009 were criminalised for their sexual behaviours. In the backdrop of these assumptions, this is a unique document in that it describes and validates against specific criteria, social & political landscape and prevailing conditions, elements of a program, project, or specific activity which have contributed towards successful interventions.

Furthermore, this project is also an effort to showcase six projects in India that have relentlessly worked for over a decade with the community and have made a difference. The purpose of this documentation project is to capture the replicable aspects of these projects and present a framework that would serve as a reference point to various emerging community based voices in the country and agencies that are willing to support these voices.

Figure 1: Model demonstrating the framework of documentation of successful interventions



METHODS

This study is a documentation project of six CBOs - purposively sampled - working with MSM and/or TGs.

I. Data sources

This project used two sources of data. The first source was a literature review of existing documents. The second source was 'information' gathered during site visits of these organisations.

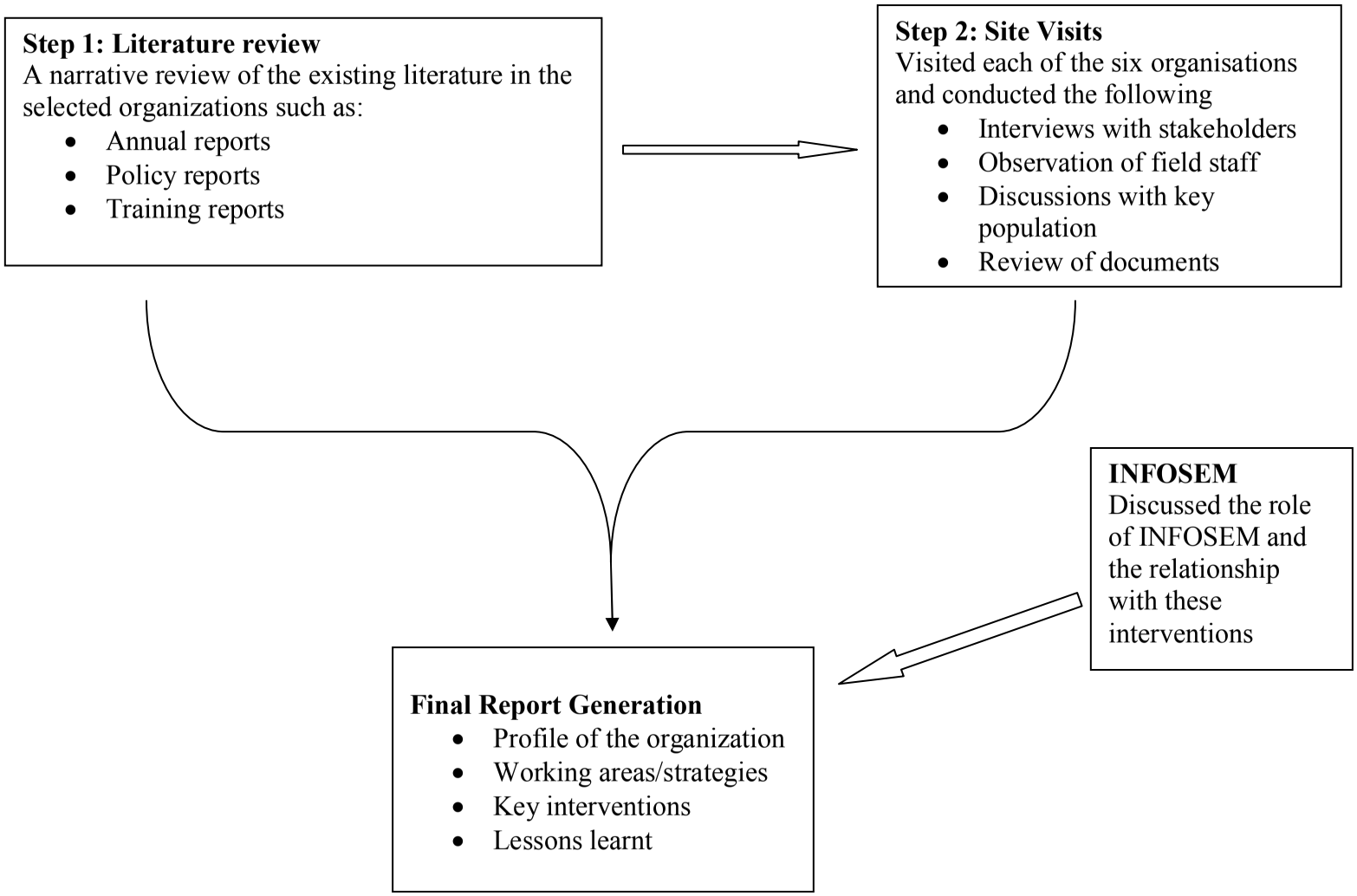
II. Literature review

The material for this narrative review included Organisation reports (annual and monthly reports submitted to funding agencies), training reports, needs assessment reports, evaluation reports, organization policies, research papers and other organizations documentation relating to TI components of advocacy, collectivisation, community mobilisation and events.

The documentation in all these organisations was not similar. However, information on the following from these documents was collected: philosophy/vision of the organisation, the structure and the work area, interventions (some key interventions, any particular intervention that makes the organisation different from others), partners and funders, and other issues such as advocacy, community outreach, and enabling and limiting factors.

As such, a part of the methodology for this project is based on the assessment of the available, or lack thereof, of coherent and systematic records and documentation of individual experiences of each organization in context of their environments.

Figure 2: Figure showing the overview of methods used in the report generation



III. Site visits

The following processes were employed on site visits:

- Interviews recorded with stakeholders
- Observation of field staff interacting with key population on site
- Discussions with key population during DiC sessions
- Perusal of organisation documents.

Each CBO was given a brief for site visits to be conducted with at least two Targeted Interventions (TIs) that:

- Were funded for interventions with MSM and TG communities during the initial set up phase of the CBO,
- Field staff who were employed during needs assessment and/or set up phase (who may have also been transferred to newly funded TIs),
- Different geographical locations of TIs to distinguish dynamics of different TIs within an area, urban (large and small cities) and rural and tribal TIs.

Interviews were conducted with:

- MSM and TG Targeted Intervention staff of Peer Educators, Out Reach Workers, Community Mobilisers and Advocates, Project Officers, Co-ordinators and where available ICTC staff
- Organization Managers and Board members
- Referral and Linkages – medical doctors, public hospital counsellors, PLHA Support Group Members
- States AIDS Control Society project/NGO liaison and/or Technical team member

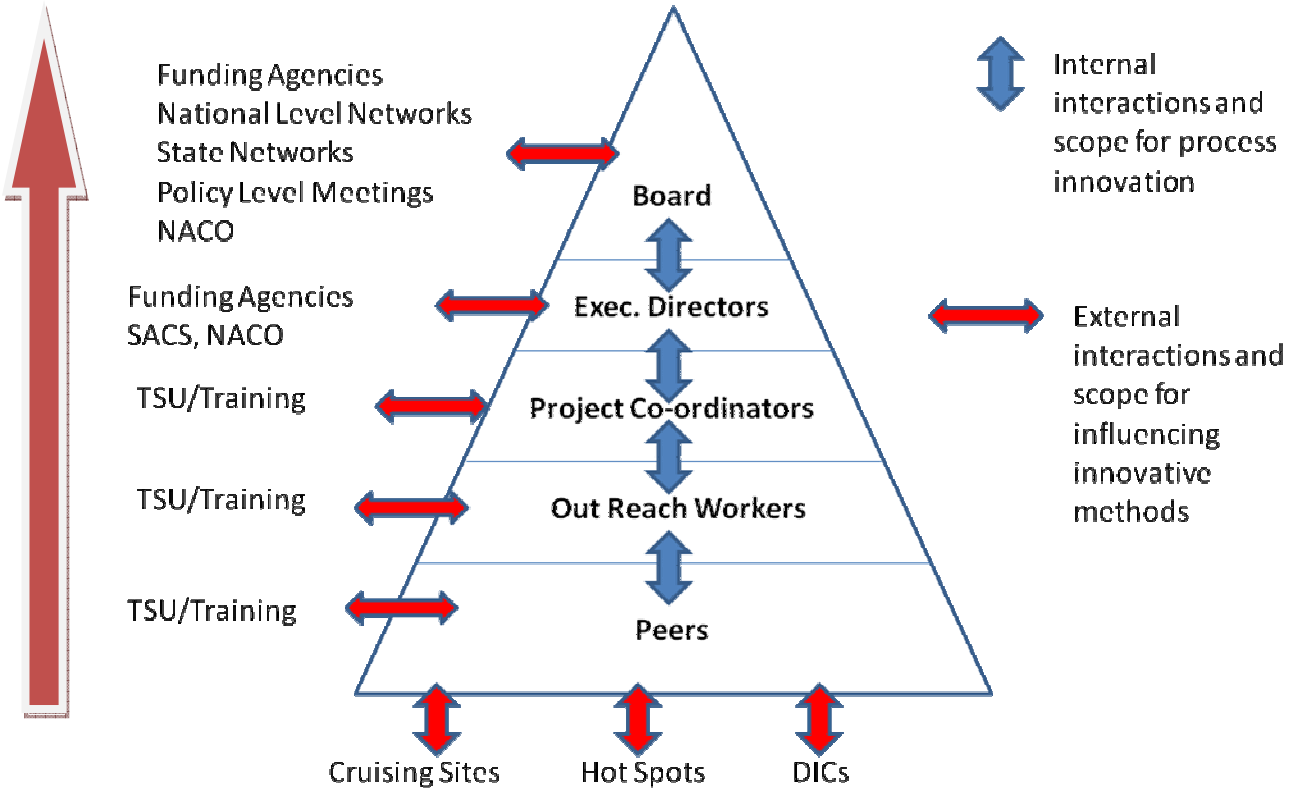
Consent was obtained to record the interviews. Interviews were prefaced by explaining the purpose of this project and emphasising the point that this was not a TI and CBO review or evaluation. This was important to set the tone of the interviews and develop rapport with, especially, the TI staff so they were able to talk freely.

IV. Methodology for Data collection

As discussed earlier, the initial aspect of data collection focused on gathering information from organisations by way of literature review of all materials available with the organisation - namely their annual reports, guidelines, policy documents, and the IEC material. This allowed for developing a sense of the organisation's work, and the values and principles that the organisation stood by through the vision and mission statements defined in their literature.

Furthermore, the second aspect of data collection was one-on-one interviews within the organisation. The approach taken for one on one interviews was a "bottom up" approach as illustrated in the figure (Figure 2). Discussions started with group interviews with Peers and then following the group interview process to the next level of seniority and reporting. The group interview process was used from 'Peers' upto the 'Project Co-ordinator' levels. In case of organisations wherein Multiple TIs were being run a group interview was conducted, however in case of single TIs only concerned Project Co-ordinators were interviewed.

Figure 2: Figure demonstrating the "bottom up" approach of interviews with the organisations



The group interview process helped in greater discussion, corroboration of instances and examples, and preventing staff from using the forum to discuss personal grievances. Group interviews also helped in people to seek ideas from what was discussed and add on to the TI experience making the discussion richer and a group view rather than a personalised individualistic view points.

The Group interviews focussed on these main points:

a. *Introduction*: Name, position, years of association (In some cases identity was disclosed out of volition with the expectation that the interviewer also disclosed his/her identity)
b. *Motivational factors for working in the TIs:* To understand if organisation, goals , missions, values, policies have had any effect on individuals
c. *Challenges faced at work:* This is within TIs, both internally in the organisation as well as on the field
d. *Methods adopted to overcome challenges*: Internal methods and external methods
e. *Future aspiration in the coming five and ten years*: Capacity building needs and methods taken by the organisation

The above method allows to understand the interactions at each level within a TI structure in terms of their internal dynamics (blue arrows in Figure 2) and their dynamics with their environment (red arrows in Figure 2). Each arrow indicates a process/policy opportunity for a potential innovation. As we went up the pyramid (arrow indicates the "bottom up" process of interviewing) interviews became more one-on-one such as those with Executive Directors. Interviews with Board members varied from one-on-one interviews to group interviews with the board. Adequate precautions were taken in selecting these individuals; the person being interviewed at the executive director or board level was directly involved in the decision making of the TIs and hence had a sense of the TI projects.

At every stage, issues were flagged and raised at the appropriate level above, thus getting a sense of real issues of the TIs on the ground, and how these ground level issues were addressed through policies and strategies at higher levels. Each level thus provided an opportunity for gauging the possibilities of innovative approaches that may have been adopted in the context of a particular environment.

V. Report generation

Information from the review and site visits was combined to generate the profile of each organisation, discuss the key interventions and outcomes, lessons learnt, and replicable aspects of these interventions.

The report also includes information (philosophy, structure, and growth) on INFOSEM a national network of Organisations working with sexual minorities including the MSM and TG population in India. We have tried to create a '***web-of-connection***' between the existing Organisations, the lessons learnt, and the common platform – INFOSEM.

In essence, this document is a record of innovative strategies trailed and implemented by CBOs and their field staff, sensitive to local culture and environment in accordance with the Guidelines for Targeted Interventions for Core High Risk Groups Volume 1, 2007.

VI. Assumptions and limitations

Several assumptions and limitations pertain to documenting successful strategies of Targeted Interventions. First, the site visits with each organisation took place at one point in time – it is a snapshot of an intervention. Time spent with each CBO was limited to three to five days only.

Second, data collection is based on anecdotal evidence only. Thus, documenting successful strategies of HIV interventions is based on the experiences of the organisations. As such, the success of each strategy was defined by the organisations themselves.

The third assumption, following from the above, is that each CBO developed and refined their successful strategies over a period of time, in context of local environments.

Fourth, the study has been limited to a selection of and site visits with at least three Targeted Interventions per CBO within a pool of over a thousand NACO funded projects.

PROFILE OF THE ORGANISATIONS

In the following section the profile of each of the six organisations has been discussed. The following aspects in each of these organisations have been highlighted:

- **Background/Profile:** The discussion starts with the description about these aspects of each organisation: structure of the organisation, organisational philosophy and growth, and working strategies to name some of the issues
- **Working areas:** This section discusses some of the key working areas and highlights some of the successes of the organisation
- **Key interventions/successful outcomes:** Though, some of the interventions have been discussed in the previous component, in this section we have highlighted some key successful interventions (upto two); some of these may have been beyond that required by mandate of the national programme.
- **Lessons learnt:** Finally, lessons learnt and some of the replicable aspects of the programmes which can be used by other organisations have been discussed.

I. THE HUMSAFAR TRUST (Mumbai/Thane - Maharashtra)

A. Background/Profile

The Humsafar Trust is a multi-faceted organisation serving various needs of the MSM and TG community with several activities to help the community in battling the HIV epidemic. In Hindi, the word *humsafar* means a companion on a journey. The Humsafar Trust is a male sexual health agency with the mission "to strive for the human rights of sexual minorities and for the provision of quality health services to MSM and tritiya panthi (*hijras*)". The Humsafar theory of change said that if they work towards the human rights of sexual minorities and the health of MSM and *tritiya* panthi (*hijras*), then this work will lead to acceptance and equality of sexual minorities and a healthier community. The Trust promotes the rights and health of sexual minorities in Mumbai and the peripheral metros in state of Maharashtra, specifically self-identified gay men and other MSM.

The Trust started as a support system for MSM in the city as the HIV/AIDS crisis started gathering momentum in the early 90's. The idea of a formal organisation was then mooted in 1994, thus it was formally registered as an NGO in 1994. Since then, the Trust has worked with various government bodies, public health authorities, medical establishment, and various social groups involved in sexual health and social empowerment. The Trust organised one of the first gay men's conference in the sub-continent in 1994; this was after consulting with other gay organisations. The objectives were to network with leaders of emerging gay groups of South Asia and to develop an effective strategy to fight the HIV epidemic. Over 70 men from India, Sri Lanka, New Zealand, the UK and the US attended this conference.

HST's community work started in 1994 with the free distribution of condoms at two MSM sex sites in Mumbai. In 1998 its first grant came from the Directorate of Health Services in Mumbai to conduct a sex mapping study that identified 77 sites where MSM meet regularly, either to seek partners or to socialize and exchange information. HST was awarded the first pilot project to 'Motivate Safer Sex among MSM at Selected Sites in Mumbai Metro' by MDACS in April 1999; this project was later up scaled by USAID/ FHI under its IMPACT project. Currently HST is a big family with 225 full time and part time staff consisting of community and non-community members and a brigade of community volunteers in support.

Photograph 1: Members of the Humsafar Trust at the World AIDS Day Rally

B. Working areas and strategies

- HST presents a model of an advanced MSM and TG NGO in development cycle terms. The Trust employs more than 220 people – mostly gay men and TG - in a range of tailored programs. It runs its own clinical services integrated into other health and wellbeing services. It provides some services to the broad MSM community and some services tailored to subpopulations like male sex workers. Its program is driven by an independent research unit that examines effectiveness and tracks changes in community demand and need.

- HST has pioneered a holistic and comprehensive approach to care, support, information, and advocacy for MSM. Through the Trust and in collaboration with public and private health institutions, about 8,500 men, mostly in their twenties, have been able to access vital health information care and support, especially with regard to HIV/AIDS and other STIs.

- As briefly stated earlier, in 1998, the Director of Health Services of Maharashtra state provided funds to the trust to conduct a sex map of MSM sites in Mumbai. The Trust identified 76 places where men meet either to seek sexual liaisons or simply to exchange information and socialise. Most of these sites were either train stations or bus terminals. Based on the study the Mumbai Districts AIDS Control Society funded an outreach program for a target population of 1,000 MSM. Using these survey findings, Humsafar programmers drew up plans for a much larger comprehensive, holistic, and support project in the sector, aimed at stabilising STIs and HIV in Mumbai. Furthermore, in due course of time, a support group for MSM living with HIV/AIDS was also formed to cater to the needs of the community.

- Other working areas include providing counselling services (including telephone counselling), mental health counselling, psychiatric help, legal services, and crises management, advocacy about the community rights. In addition, the trust also conducts multiple research projects (behavioural, social, clinical, and epidemiological) in collaboration with various national and international Universities and research organisations.

- The Trust also focuses extensively on interventions that alter sexual behaviours. The prevalence of HIV among MSM at baseline in 1999 – 2000 was 13.5% and as per the NACO national surveillance data 2009 it stood at 7.2%. HST is a sentinel surveillance site for NACO. The Government policy makers until a few years ago were unaware of the large number of MSM and *hijras*, and the extent to which they are at risk of both contracting and transmitting HIV and other STIs. NACP – III recognizes MSM, MSWs, and Transgenders as a core group. HST collaborates with public health care systems for ART. HST has created a model of intervention, care and support and treatment that can be easily replicated. HST HR Policy of the organization provides a minimum of 20% job opportunities or HIV positive MSM and *hijras*.

- HST has good working relations with the state and municipal AIDS societies; both of these have provided financial support to its activities. A sensitisation program was started

with doctors, nurses, counsellors, and other health professionals especially at Sion Hospital and Cooper Hospital, and they in turn did advocacy for HST with their colleagues. Rapport was established with the local police, *pan-wallahs*, the newspaper vendors, the tea sellers and other small traders in the neighbourhood. Advocacy involved giving condoms or referring them for STI/HIV counselling and testing. HST also conducted workshops for college and university students, industrial workers, the police, lawyers and journalists. In October 2002, the all women's SNDT University in Mumbai hosted an international gay and lesbian conference organised by HST.

- More than half of the people who work for the HST in Mumbai and Thane districts are engaged in outreach activities. Based on the Trust's reach, the outreach workers are assigned specific beats which they visit six nights of the week from approximately 7 pm until 11 pm. Most beats are located in or near railway stations and bus terminals. Before setting out on their beat, the outreach workers come to the Trust's office to write a report on the previous evening's work, and to replenish their supplies of condoms and informational material. While on their beats the outreach workers chat informally with individuals and groups about their problems, STI, HIV/ AIDS, and safer sex. They carry out demonstrations of how to put on a condom with each outreach worker distributing 70-80 free condoms per evening. They also distribute information material, invite people to visit the HST drop-in centre, and encourage people to be counselled and tested for STIs and HIV.

- Humsafar Trust has developed informal networks to sort out issues. The experience in Mumbai has shown that there are very few instances of state violence and harassment. The crisis usually occurs when fraudsters intentionally solicit sex with MSM and use that knowledge to blackmail them. Over the years the Crisis Cell has compiled a profile of people who are known to blackmail members of the community. Once a call for such crisis is taken, the person is urged not to give in to blackmail and to hand over details of mobile numbers and bank account numbers. If any of these numbers are traced to the potential blackmailer, the Crisis Cell in-charge calls the person to 'counsel' him. Note:

Perpetrators of violence and harassment can be family, police, local thug, workplace or the public.

Photograph 2: Clinical facilities at the Humsafar Trust

C. Key interventions/Successful outcomes

Though the Trust has multiple focus areas, the following key interventions as successful areas have been identified:

- **Public Health - NGO Partnership:** One of the key philosophies of the Humsafar Trust is that it does not want to replicate the services that are available in the public health care setting. This approach led to a break-though Public health-NGO partnership in Mumbai,

probably the first of its kind within the framework of MSM/TG programmes. This partnership was greatly beneficial to the community.

- In this partnership clinicians from a tertiary care centre and a teaching hospital, Lokmanya Tilak Municipal Medical College and General Hospital (Sion Hospital), provided services to the community. Though the clinic was based in the premises of the Trust, the community also had the option of accessing care in the hospital. Thus, the health care infrastructure (clinicians, administrators, ward boys, nurses) were sensitised to MSM and TG issues. This **'contact'** was in itself a useful intervention for the community as well as health care personnel. The HST – Sion Hospital public health-NGO partnership started right from sensitization of doctors at the Sion Hospital in 1999. Sensitization on sexuality and gender issues is most important for doctors in the public sector, especially regarding sexual minorities and communities most at risk like IV drug users and sex workers. What started off as a model public health-NGO partnership with the LTMG (Sion – one of the largest tertiary) Hospital has now over a period of time resulted in numerous such partnerships such as those with KEM Hospital, Jaslok Hospital, Bellasis Rd STI Clinic, Bhagavati Hospital and Rajawadi Hospitals.
- Another aspect of this partnership was creation of "Committed Community Workers"(CCWs). They sat in the Skin and VD OPD at Sion Hospital and directed marginalized group-members to fill case-papers, took them to counsellors and doctors who evaluated the clients with special care. All Humsafar clients are given cards at street level outreach which are recognized by nearly all the public hospitals in Mumbai. The CCW was a pioneering course which was initiated in coordination with the Sion hospital under the auspice of the Skin department and under the leadership of Dr. H R Jerajani. The Humsafar Trust's CCWs are also trained for care and support; the three month course includes first aid, care for fever, control of dehydration and vomiting, knowledge about cheap forms of protein intakes , when to call a doctor, and importantly they are instructed never to give medicine on their own. Additionally CCWs know how to take body temperature and also know what "high fever" is. Furthermore, they are also provided information about care of patients at home and feeding sick

patients. The HST places a counsellor and a health facilitator at each of these hospitals to increase access and easy passage to MSM and TG visiting these hospitals for ICTC – STI and allied services. The ownership and the dedication of the Sion Hospital to this partnership is noteworthy and the biggest possible share of this achievement goes to Dr. H R Jerajani, Head, Skin Department who not only ensured the initiation of this partnership but also saw that it survived the test of time.

- **Centre for Excellence (CeFE):** Building upon HST's vast years of experience in the area of implementation of HIV intervention projects for MSM, the Centre for Excellence (CeFE) was set-up in the year 2006. The aim of CeFE is to replicate best practices and learning's from all over the country to enhance the national response towards the HIV epidemic leading to policy implications. The core activities of CeFE are research, capacity building of other sexual minority CBOs, and advocacy; most of these initiatives are supported through various bilateral agencies and NGOs. Development of an independent full-fledged research unit is a key success in an NGO setting. The research unit is a direct interface between the academia and the community. Thus, the community provides feedback on the content and outcome of research. The Trust also has become the first community based organization to set up its own Institutional Review Board (IRB), an ethics review committee that has been registered with NIH and awarded the Federal Wide Acceptance (FWA) certificate.

HST does not seek to duplicate anything that is, or should, be offered through mainstream services. Rather than provide HIV treatment, it makes sure that MSM and TGs can access treatment in a supportive environment through public clinics. It has developed a set of enduring relationships with the agencies and service providers that its population most needs – hospital, clinics, local government structures, and so on. It has recently teamed up with women's health services to ensure that the wives and other female partners of MSM can access HIV testing, treatment, care and support. Having reached a level of organizational maturity and stability itself, HST is now able to mentor smaller emerging MSM and TG NGOs and CBOs throughout India and help them contribute to the comprehensive package of programs and services.

Photograph 3: Annual day celebrations at the Humsafar Trust

D. Lessons learnt

Some of the important lessons from the project have been discussed below:

- **Integration of programmes in the existing systems**: The programmes should be designed such that they are integrated into the existing infrastructure. This is particularly useful in the health care. Usually most of the funded interventions have a limited time mandate. Thus, integrating them in to the existing infrastructures will make at least some aspects of these interventions sustainable. This will also help build partnerships with various organisations in the geographic vicinity.

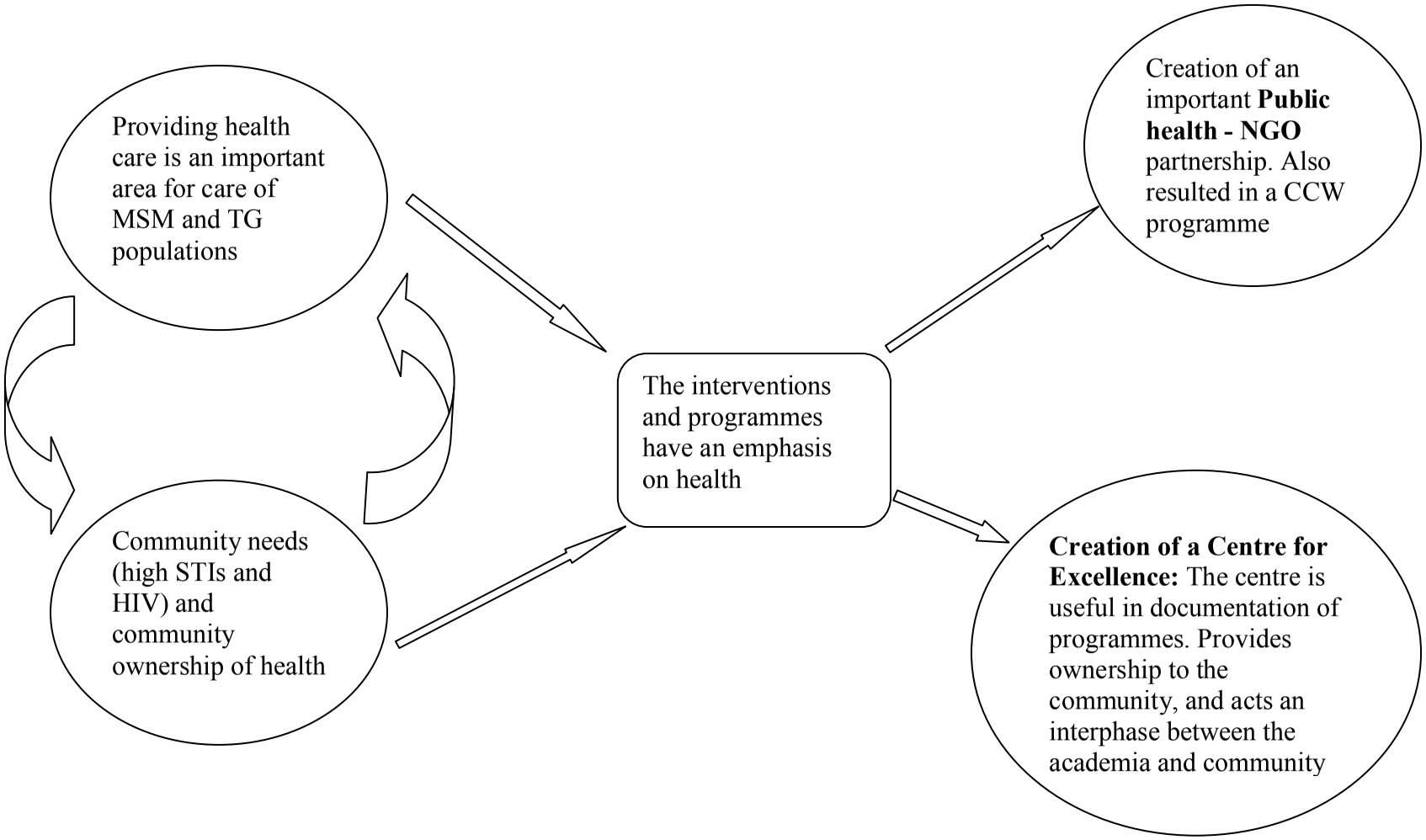
- Another important outcome of integrating the interventions is that there is a **regular interface between the community and the health structure** at large - **'contact'**. This can help reduce the prejudices and phobia against the MSM and TG community.

- **Facilitation and not replication of services**: The CCW programme highlighted the importance of empowering the community to facilitate the access to health care in times of need. Though, the CCWs were trained in basic health care, they were essentially empowered to cut through the structural and often personal barriers in health care access. This model can be replicated to other areas as well - for example, it may be worthwhile to provide basic training in legal aspect. Such facilitation will go a long way in empowering the community and making them visible in the various service sectors.

- **Creation of Centres of Excellence**: One of the important outcomes of such a Centre is community empowerment and ownership. Through such centres, the community taps into the potential both within and outside, and provides a uniform platform for discussion of important MSM and TG issues. Such centres may not be restricted to health or research but may extend to other areas depending on the local needs. For example, if there is need for legal help, then the organisation can develop a 'Legal Centre for Excellence'. This can then document all the procedures and outcomes which will be useful for other organisations as well.

Photograph 4: Offsite training of the Humsafar Trust

Figure 4: Figure demonstrating the working strategy and important outcomes at The Humsafar Trust, Mumbai



2) SAHODHARAN(Chennai/Pondicherry - Tamil Nadu)

A. Background/Profile

Sahodaran in Chennai is one of the oldest community-based organizations for men who have sex with men (MSM) in India. It_is involved in HIV/AIDS Prevention/Control activities within the MSM since October of 1998. It partners with the Tamil Nadu state government AIDS program to implement HIV prevention and community health promotion activities in Chennai, and has also spawned similar organizations in Cuddalore and Pondicherry. It is well known for media and cultural programming through events that employ arts, music, and dance to raise awareness of the public on issues of sexuality and sexual health. It is a non-profit, voluntary community-based organisation registered under the Societies Registration Act of Tamil Nadu in the year 2002. It was formed by a group of dynamic and professionally qualified, eminent personalities with a personal motivation to work with marginalized communities.

Sahodaran aims "*to improve sexual health and reduce the risk of HIV/AIDS andSTI among MSM in Chennai city through behaviour change communication to increase safer sex knowledge and promote safer sex practices among MSM, provide safe space and community support for MSM sub-groups, provision of MSM-friendly STI diagnosis and treatment, counselling services and referrals for VCT services, advocacy, and networking to build an enabling environment to reduce stigma and discrimination against MSM.*"

Currently, Sahodaran is staffed by competent and dedicated team of community members that manage TIs with minimal supervision from the Board of Trustees. It is also the recipient of UNAIDS - RED RIBBON AWARD 2006 for outstanding Community work at the grass root level.

Photograph 5: Media Advocacy by Sahodaran

B. Working areas and strategies

- Sahodaran has been conducting outreach in Chennai city on 30 sites that include certain allocated areas of the beach, parks, and train routes that traverse the city connecting to the suburbs. From 1998 to September 2003, Sahodaran implemented a male sexual health program with technical support from Naz Foundation International (NFI) and financial support from Department For International Development (DFID). Sahodaran was one of the implementing partners of the USAID/FHI IMPACT project to work with MSM in Chennai, from 2003 to 2006. From 2006 to 2008 SAHODARAN was supported by USAID/APAC.

- Sahodaran has had a long history of successful advocacy and sensitization to reduce homophobia, transphobia, and violence from the general population and specific groups.

In 2009, it conducted sensitization meetings with 36 autodrivers in the cruising sites. A Sahodaran team of five staff was also involved in conducting 54 sensitization events with police officers, sub-inspectors, and constables. During these events, the Sahodaran team provided an overview of issues of stigma and violence faced by MSM communities and appealed to the police force to avoid harassment of MSM and TG individuals in public spaces. Sahodaran, as a member of the Chennai Rainbow Coalition, participated in the Chennai Pride rally, and in a panel discussion and cultural performance evening held in June.

- Sahodaran also sensitizes physicians from the private sector on issues of MSM and TG in partnership with SAATHII. This is part of a USAID/APAC supported initiative to engage private sector doctors in providing stigma-free HIV and STI services for MSM, TG and other marginalized groups.

- As a part of research, it conducted focus group discussions in Chennai and Karur with members of MSM and TG communities. These were in connection with a study led by SAATHII to develop treatment literacy materials on HIV/STI and anti-retroviral treatment for MSM and TG.

- Key staff also underwent training on the MSM-TG treatment literacy module developed by the WHO along with SAATHII, and are now equipped with knowledge and skills to increase health-related treatment literacy for HIV-positive MSM and TG.
- Sahodaran also partnered with the Tuberculosis Research Center (TRC, a government research institution), Brown University, USA and the Fenway Center, USA, on an ongoing behavioural research and intervention study aimed at understanding and improving psychosocial health of MSM individuals.

- Sahodaran has also found innovative means of fostering staff motivation and building their knowledge and capacity to be a better worker. The Project Co-ordinator developed various tests and case studies to build technical knowledge. Time is set aside at team

meetings to build capacities and discuss skills and knowledge that needs to be built upon. Sahodaran also organizes resource people who come in and workshop with their staff.

Photograph 6: Members of Sahodaran at the Pride Rally

C. Key successful interventions/outcomes

- **Sensitisation of the Police force:** Sahodaran has worked on police sensitisation and training program in collaboration with Tamil Nadu State AIDS Control Society (TNSACS). Tamil Nadu is one of the pioneering states that has sensitised the police at every level. TANSACS had initiated a 'Police Advocacy' Program in February 2008 to create better understanding among police personnel about issues of HIV/AIDS and high risk groups such as female sex workers, injecting drug users, MSM, Transgenders and people living with HIV/AIDS. It has produced a module of training sessions. These sessions include: introduction of HIV/AIDS, MSM and Aravani communities; awareness of issues of drug users and the female sex worker community; and a final session on positive living. TNSACS also trained TI staff to conduct these training sessions. The police initially would create obstruction in the process of HIV intervention; however after these sessions they were made aware of HIV interventions. The training program used master trainers from community groups to train the police; this ensured that there was no ambiguity in the messages going out to the police. As a measure of success in one of the public rallies, the police escorted the rally and ensured that nothing untoward happened to the MSM and TG community during the procession.

- **Creation of a dance group:** Through a small grant from Royal Dutch Embassy, Sahodaran formed a small cultural troupe with the community members. The troupe members were trained to sing and dance, and know the finer nuances of performing street theatre. Following this, the team performed in slums and the group also performed few dances from films. In these sessions, the MCs then talked about HIV positive issues and a HIV positive person came and discussed issues on the stage. The program used cultural performance to change stigmatising and discriminatory attitudes towards MSM and transgender persons. This program has successfully sensitized local areas on the issues of alternate gender and sexuality. In 2006 Sahodaran was honoured with the UNAIDS red ribbon award for innovative ideas. They are now called for providing entertainment for TANSACS functions.

Photograph 7: Police sensitisation workshop organised by Sahodaran

D. Lessons learnt

Some important lessons learnt from this organisation have been highlighted below:

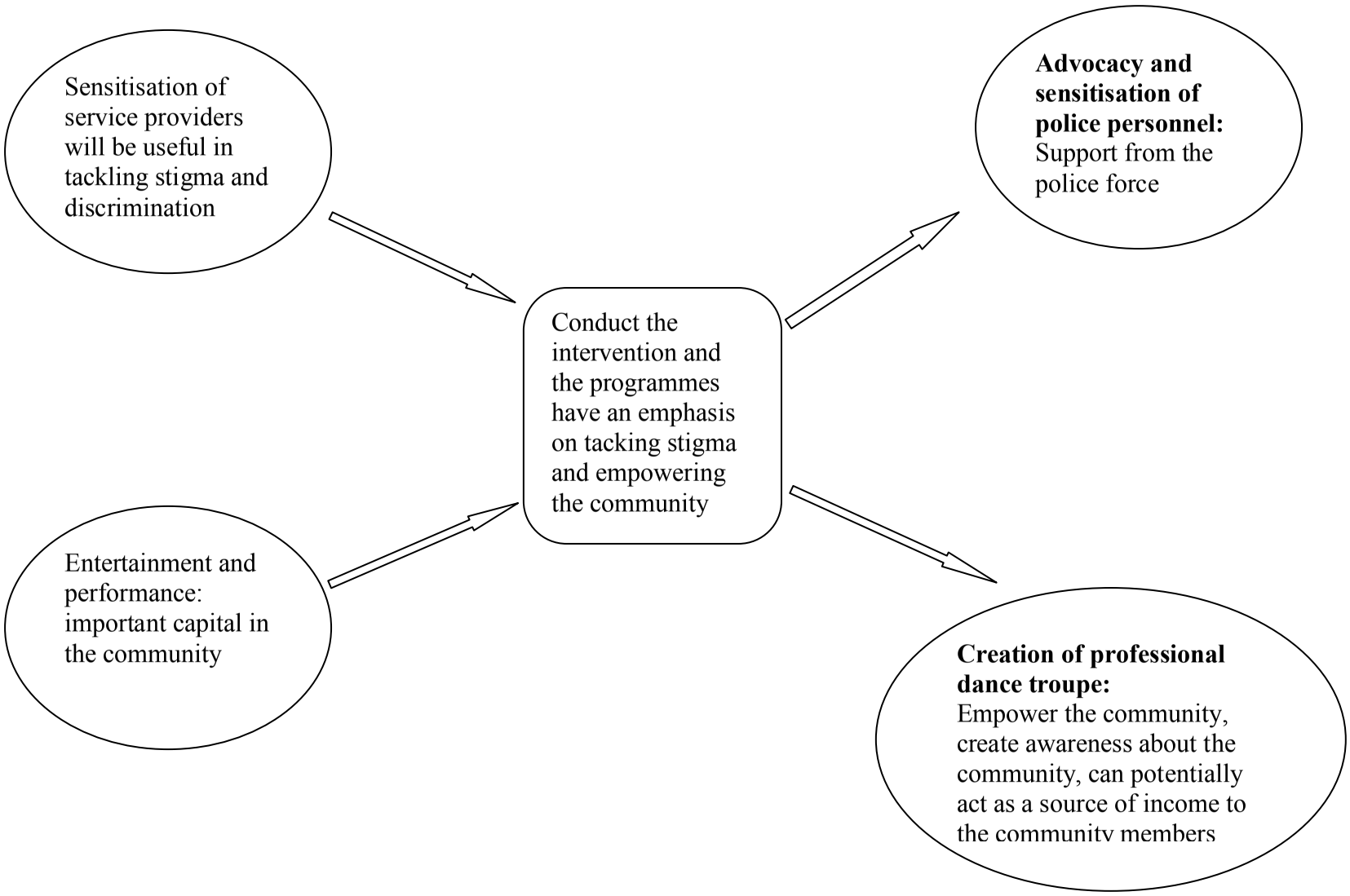
- **Create of Sensitisation programmes for service providers:** It is very essential for each organisation to create sensitisation programmes for service providers in the society (such as health care professional, legal personnel, and police). This is one of the first steps in tackling societal stigma and discrimination. In many instances, it is ignorance which often leads to fear; this may perpetuate stigma and discrimination. Organisations have to address this issue head-on by creating programmes, piloting them, and eventually work with State AIDS Societies to implement these on a structural level.

- **Use entertainment to empower the community:** Some of the community members are very talented and are often trained musicians, singers, and dancers. Rather than waste this talent as being *'naachne-gaane waale'*, this talent should be used to create awareness

about the community. They should be encouraged to perform in social spaces and the time should also be used to create awareness about the community and other HIV/AIDS related issues. There will be an entertainment factor in this, will empower the community, and may eventually act as source of income for the community members and organisations.

Photograph 8: Visit by the NACO officials

Figure 5: Figure demonstrating the working strategies and outcomes of Sahodaran, Chennai



3. SANGMA - SAMARA (Bengaluru - Karnataka)

A. Background/Profile

Sangma is a sexuality minorities' human rights organisation for individuals oppressed due to their sexual preference. Sangma helps to live their lives with self acceptance, self respect and dignity. They emphasise on the concerns of sexuality minorities from poor and/or non-English speaking backgrounds and sexuality minority sex workers, who otherwise have little to no access to information and resources. Founded in 1999, Sangma operates in Bengaluru and Chennai. Their aim is *"to bring sexuality, sexual preference, and gender identity into the realm of public discourse and influence class, caste, gender, and other human rights and social movements in India."* Sangma caters to a broad group of individuals such as: hijras, kothis, doubledeckers, jogappas, lesbians, bisexuals, homosexuals, gays, female-to-male/male-to-female transsexuals, and other transgenders. They campaign for the changes in the existing laws, which discriminate against sexuality minorities, including sex workers and People Living with HIV/AIDS (PLHA).

Sangma modelled the Targeted Interventions through human rights perspective as health being an essential right for all individuals. The TIs were nurtured up to a point where it could be handed off to Samara, another organisation mentored by Sangma. Sangma, as an organization, realised that providing health services was impinging on their core work on human rights issues. The community members also expressed a need for a CBO to take care of their health interests. Hence, plans were put in place to prepare the community through its 'Community Development Training' module to built capacity within the sexual minorities' communities to take ownership of TIs, with a separate identity. Samara, a separate CBO was thus registered in 2005 and has now taken independent charge of all TIs that were housed within Sangma with funding from Karnataka Health Promotion Trust (KHPT) and direct funding from Karnataka State AIDS Prevention Society (KSAPS).

Samara supports sexual minorities and actively employs them in TI projects. With KHPT, Sangma helped Samara get four out of the six zonal distribution of Karnataka for TIs with MSM – TG. Currently around 120 community members are working in different capacities on this

project; lesbian women are also part of the human resources working on this project thus making this intervention truly inclusive. Sangma provided oversight to management of Samara from 2005-2008. However, currently Samara manages its own organisational structures. It managed to reach about 6000 KP in 2009. Samara plans to be totally self reliant with minimal or no handholding support from Sangma. The board of Samara has 15 board members, who hail from different districts of Karnataka and come from various LGBT identities, such as Hijra (F2M) , Kothi, Bisexual, lesbian (LesBiT(M2F)LBWT), and FSWs. Samara provides support in 10 districts: Bangalore Urban, Ramnagar, Udipi, Badhapur, Thumkur, Kolar, Chiklpaur, Mangalore, and Mysore. About 1200 members form a part of the Samara society.

Photograph 9: Seminar on Transgenders and Law organised in Karnataka

B. Working strategies/areas

- Sangma started with Crisis Intervention, i.e. providing twenty four-hour support to a specific target community by active intervention in any crises that the community members may face. Currently they have six dedicated telephone lines to attend to these crisis calls. They also have in place a crisis intervention team that attends to and manages any situations that community members report. They provide full-time legal support. One of Sangma's most significant achievements has been the ability to bring about a reduction in the number of crisis situations faced by community members. NACO has also recognized this in the NACP III document. It has recognized that crisis intervention is an effective strategy which can be employed to bring down the prevalence of HIV infection.

- Sangma campaigns against unjust laws that criminalise/discriminate against sexual minorities and also work towards changing public opinion regarding these communities. They work directly in South India and also network with other organisations across India. However, their focused interventions are centered around Bengaluru city. Sangma actively advocates for the rights of the PLHIV, sex workers, and sexual minorities. Some of the campaigns undertaken by them include: repeal of IPC 377; the right of community members to health and health care; and access to medicines particularly for people living with HIV. They believe that all oppressions are interlinked, and therefore, there is a need to build greater alliance with social movements, human rights organisation and democratic people's organization for social change.

- Currently, Sangma implements a focused HIV intervention program that is specifically aimed at HIV incidence reduction among HKD (Hijras, Kothis and Double-deckers) and their partners in Bangalore. Through this program, they offer services such as the Drop-in-Centre facility as well as psychosocial and project-linked clinical support. They adopt peer-centred strategies, which utilise "Community Mobilisers" from the community to reinforce knowledge of HIV/AIDS and promote condom usage through community outreach activities. They also provide facilities for Community Voluntary Counselling Testing Plus (CVCTC+) extended care and support for persons living with HIV.

- Sangma is also actively involved in nurturing the sexual minority community democratically so that they understand their entitlements and are empowered to defend their rights. In this context, they have initiated Samara, a membership-based community organization of sexual minorities and another organization Suraksha, for sex workers. These organisations are groomed to take over the service provision work for the community.

- Over the years, Sangma has come in contact with a number of lesbian/bisexual/transgender women in situations of crisis, and several of them have expressed the need for a support system. In response to this, they have started Lesbit, a support group that provides safe space to discuss, engage and collaborate with the community. They also launched a Lesbit helpline to further their reach of the community.

- In response to the discrimination faced by HIV infected individuals from the sexual minority community, Sangma started Sadhane. It is a forum for sex workers and members of the sexual minority community living with HIV. They have also helped sex workers in Karnataka to unionise and form the Karnataka Sex Workers Union so that they can demand the rights of all sex workers.

- Sangma started a documentation unit and since last eight years they have been documenting issues about sexual minorities and their rights in print in Kannada, English, and Tamil. The documentation centre and library has books, news clippings, reports, newsletters, and articles from various journals and newspapers, video, research papers, and information from the internet. They organise workshops, public lectures, film screenings, meetings, and symposiums to sensitise social activists and the general public on issues of sexuality minorities and to strengthen the sexuality minorities' movement.

- Sangma has also produced two films - *Many People Many Desires* in 2004 and *A Human Question* in 2005. Many People Many Desires explores in depth the place of a person

from the sexual minority in Indian civil society through personal narratives. Cutting across class, gender, language, and caste, the film tells the stories of gay/bisexual/lesbian people living in Bangalore. Tracing the story of the global struggle to make HIV/AIDS drugs more affordable, A Human Question raises key questions of whether private ownership of knowledge can be at the cost of human life. The film explores the complex world of patents and HIV/AIDS medicines by connecting and contrasting personal narratives with those of international lobbyists and activists.

- Recently, Sangma has also implemented the learning site project. There have been many visitors/learners and others who come to study and understand the work of Sangma – its approach, paradigm, and achievements. These individuals are from different backgrounds – from community members to academicians and intellectuals. This learning system is being implemented by Sangma and supported by KHPT (Karnataka Health Promotion Trust). It is a bid to formalise the learning process at Sangma. The learning site located at Sangma is envisaged as a space to convey learning and experience sharing among community and the learners. The learning is facilitated through a core team and by modularisation of learning through various tools. Some of the tools like handouts, videos, multimedia presentations etc. are currently being developed. There is a coordinator and set of staff who manage the learning site project along with technical support from the core team of Sangma.

Photograph 10: Health facilities for the community members

C. Key successful interventions/outcomes

Though Sangma has broad range of interventions, these have been highlighted as the key successful outcomes

- **Crisis Intervention Team and Support:** Bengaluru like many other cities in India has very limited spaces where sexual minorities can meet/help/work with each other and acquire information about sexual orientation/gender identity. Sangma's work started in this backdrop with an aim for sexuality minorities' rights with information and education. It wants to not only work with sexual minorities but also their family members/friends/co-workers and the society at large. Sangma has a 24*7 crisis intervention cell which offers support to the LGBT community at the time of crisis. Most of the crises reported are due to confrontations with the police, rouges, or family members. There are currently six telephone lines in Sangma. The crisis team is made up largely of community members; however, they also have Sangma staff dedicated for this work. The crisis team responds instantaneously and if needed Sangma lawyers intervene.

In 2009, Sangma handled 20 such crisis incidents. Most of these were cases of police harassment. Other cases involved family members; these included estranged kothis' (MSM) reconciliation with their families and parental coercion for shock treatment (aimed to alter their kid's sexual orientation). Sangma also offers support and refers members of the community to appropriate counselling services.

The Crisis Cell works in collaboration with other issue-based organizations and groups, and is always prepared to lend support as and when needed. The process is that when a call for crisis intervention comes on the phone, the person responsible at that point in time takes details of the incident and reassures the person that it will be followed upon. Calls are placed with contacts in the geographical area of incident to reach person experiencing crisis within half an hour. If the person is within the vicinity of the incident, they are also expected to go to the site. Here, the situation is assessed in terms of status of person or people in crisis and an interim decision made for medical aid, legal assistance and/or community support. Once the immediacy of the situation is taken care of, long term solution is discussed with appropriate stakeholders and resolution facilitated. At times issues can be resolved at the local level but can lead to larger rallies protesting harassment or media campaign or petitioning for legal resolution.

- **Inclusive programmes:** Though Sangma started as an organisation to deal with legal issues and human rights of sexual minorities particularly MSM and TGs, it has been inclusive in its approach to the problem. It has catered to individuals with different sexual and gender identities (as discussed earlier) and has been able to link its work with other marginalised groups and populations. Furthermore, as required it has started groups to deal with problems of HIV infected sexual minorities and lesbian groups. It has also helped sex workers to form a union; thus, the work was not restricted to only sexual minorities. This approach fits well within the philosophy of the organisation - stigma and discrimination faced by all minorities needs to be addressed together.

Photograph 11: Members at a Community Event

D. Lessons learnt

The following lessons learnt from this organisation have been highlighted below:

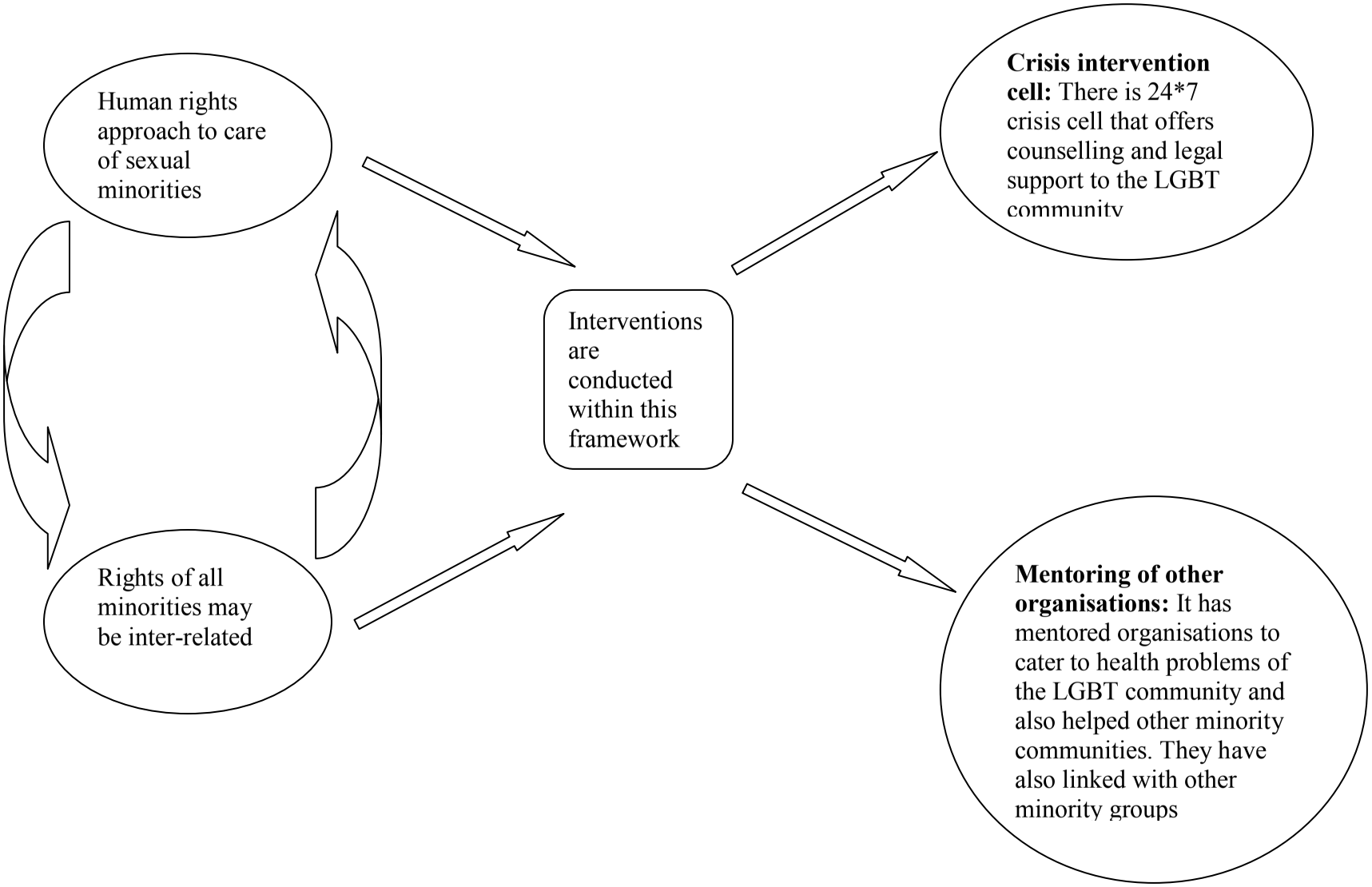
- **Human rights' approach is a useful strategy for minority issues:** Approaching the problems of sexual minorities within a human rights' framework is useful to address the stigma and discrimination faced by the community members in various sections of the society. Through its strategic interventions at multiple levels, the organisation was able to mobilise support for those affected and at the same time, hold the perpetrators to account. In addition, cross movement alliances have came in good use. The issue was brought to the attention of not only the LGBT groups but also non-LGBT and human rights groups across the country: dalit groups, Garment and Textile Workers Union, Suraksha, Alternative Law Forum, Samara, Sadhane, Lawyers Collective, and other organisations and individuals joined protest. Sangma's rights work has been recognised as one of the most effective models of responding to human rights violations against sexuality minorities. Many small sexuality minority community groups, particularly from Tamil

Nadu, have sought assistance in setting up their own rights-based intervention programs. This is a new and welcome development.

- **Mentor other organisations and have a flexible approach to care while maintaining the core principles of the organisation:** As indicated earlier, Sangma has mentored additional CBOs to handle health related work - Samara. This was due to the fact that some of the health related activities in the TIs often deviated Sangma's focus the key work area - crisis intervention and legal aid. Thus, Sangma's decision to create a new organisation indicates it flexibility to let go off some projects to its subsidiary organisation, while at the same time maintain its core competency of legal aid. This is a useful learning lesson for organisations that are often overwhelmed by additional responsibilities (health care projects etc.). They should be encouraged to mentor other organisations, and help them to acquire new projects from funding bodies and execute these projects.

Photograph 12: Members participating in a rally

Figure 6: Figure showing the working strategies and outcomes of Sangma, Bengaluru



4. MANAS BANGLA (MSM network in Bengal)

A. Background/Profile

MANAS Bangla (MB) is a state wide network of seven grass root level CBOs with the common agenda of social advocacy around issues related to males marginalised for their non-conventional sexualities and/or gender non-conformity and promotion of their sexual health and rights in the state of West Bengal. It is supported by the West Bengal State AIDS Prevention and Control Society (WBSAP&CS) – the Indian Government's pivotal State AIDS control body. The goal of the project is "*to improve the sexual health of men who have sex with men in West Bengal and to reduce spread of HIV infection among them."*

After two members of one such CBO were brutally harassed in a public park of Kolkata, the necessity to join hands and fight such incidents in the future was realized. In 2003, a group of like minded people started taking the initiative of forming MSM support groups to network in different parts of West Bengal. The goal was to advocate for the basic human rights of MSM, to promote stigma/discrimination free social environment, to empower them to take the ownership, and to reduce high risk sexual behavior. Seven such networks from the state held an informal meeting with NAZ foundation International in New Delhi. The Chandannagar branch hosted the first formal meeting in May 03 and the network with a rights based vision to address MSM issues in West Bengal, Manas Bangla, was formed.

Today, Manas Bangla is spread over eight districts in West Bengal and is the pioneering organization with a vision to provide services to MSM groups through a drop-in-centre and outreach among MSM in West Bengal. Apart from the seven founder members, the network presently has six more member agencies from across the state of West Bengal. The following are the partner agencies and their original fields of activities:

- Founder constituent members: Amitie' (Howrah & Hooghly), Astitwa Dakshin (24 Pgs – S), Dumdum Swikriti Society (Kolkata n-e, 24 Pgs – N), Miitjyu (Darjeeling hills), Prantik (24 Pgs – N), Pratyaya Gender Trust (Kolkata), Swapnil (Bardhaman)

- New tentative partners – Jalpaiguri Uttarapan (Jalpaiguri), Kolkata Rista (Kolkata), Koshish (Kolkata), Northern Black Rose (Jalpaiguri, Darjeeling plains), PLUS – Kolkata (Kolkata), Sangram (Murshidabad)

Photograph 13: Few teammates of Manas Bangla

B. Working areas/strategies

- One of the key working areas of MB is to provide a '**networking**' platform. They have done this by fostering a collective structure and creating a board to address the concerns and provide support to each of the constituent members. Each of the seven organisations that are part of the network has elected one person to the MB Board. This board has no say as to who will come from these autonomous organisations. These representatives then go on to become the managing committee; thus representing a totally non partisan and democratic process of self governance. MB has a common minimum program to work with the health issues of the MSM; this is incorporated in the implementation of the TI projects executed by them and their partner agencies.

- After getting registered in February 2004, MB started implementing West Bengal Male to Male Sexual Health Promotion and HIV Control Programme with funding support from West Bengal State AIDS Prevention & Control Society under the aegis of NACO. Later, one more intervention for the three hill subdivisions of Darjeeling district under Darjeeling AIDS Control Committee was started separately in 2006. Today under these two interventions, through 10 DiCs MB caters to a target population of 6500. Details of the DiCs with districts covered by them and categories of those districts are given below:

    - Bardhaman DiC – Bardhaman District – (A)
    - Baruipur DiC – South 24 Pgs (C) & Medinipur (B)
    - Bongaon DiC – North 24 Pgs (C)
    - Darjeeling DiC – Darjeeling (A)
    - Dumdum DiC – North 24 Pgs (C), Kolkata (A) & Murshidabad (B)
    - Kadapara DiC – Kolkata (A)
    - Kasba DiC – Kolkata (A)
    - Kurseong DiC – Darjeeling (A)
    - Siliguri DiC – Darjeeling (A), Jalpaiguri (B)
    - Srirampur DiC – Howrah & Hooghly (C)

    All the DiCs were placed in these areas keeping in mind two important factors:
    i) some of the ground work had already been done by the partner agencies of the network; and
    ii) based on the findings of the needs assessment done by MB in 2003 with technical assistance from 2 friendly NGOs.

- MB caters to the following groups of people: Kothis, Panthis, Duplis, Hijras, Gays, Bi-sexual men, MSM without any specific identities, male commercial sex workers, *laundas* & other male entertainment workers – all with very high risk behaviour. They have outlined specific measures to run the intervention programmes in different groups. For instance, they intend to have separate interventions for male sex workers. In addition,

they also necessarily want that interventions in various groups should be managed by those specific groups. Thus, the TG and hijra interventions should be run by TG and hijra CBOs.

- Currently through their constituent NGOs, they provide a range of services to the community. They have programmes in place wherein they provide safe drop-in-space, either directly or through extended DiCs. Some of the services provided at these centres are: psycho-social support to the community and staff members, community events, awareness programmes, skill building and confidence building training, condom & lubricant distribution and social marketing, and referral services for other needs.

- Besides these services they also have clinical facilities and field programmes. In the clinics, they have services for STI evaluation and treatment, testing for specific STIs such as syphilis (VDRL testing), condom distribution, and risk reduction counselling facilities. The field programmes include awareness programmes, advocacy and sensitisation programmes, crisis management, condom distribution, and referrals to name some.

- In addition, the constituent NGOs also provide community based ICTC services, wherein facilities for pre and post test HIV counselling, syphilis (VDRL) and HIV testing, distribution and social marketing of condoms and lubricants.

- The working areas of MB can be categorised in the following eight groups:

	Governance and leadership	Promote leadership at levels on issues related to MSM and TGs
	Decentralization	Autonomy at DIC level and CBO formation
	Coordinated response for HIV	Bridge gaps between Governing Body-Technical Team-Programme staffs, and to prepare and work on a joint coordinated response against HIV
	Role shift of Manas Bangla	MB ensures to strike a balance between reproductive rights versus HIV prevention

Organisation	*Visibility*	Promote MSM rights as an agenda of the organization and make Manas Bangla visible at various levels
	Role of the Technical Team	MB believes that Target outputs and implementation tools are useful for leadership
	Human Resource Preparedness	Another important working strategy of MB is that motivation alone does not make difference. One needs to transform the human group into a motivated and efficient agency. Furthermore, one needs to identify grievances anonymously and address grievances Worksite conflict management
	Sustainability	Alternative fund sources, reducing unit cost, cost recovery, IGP, SHG formation, promoting DIC level autonomy, smaller CBOs at zones

- Each of the CBOs under MB has different work agendas. They have their own separate office spaces and some of them may even be non-funded. However, if someone has problems accessing space, they can use the MB space. Handling conflicting demands at MB is a balancing act; the uniqueness of the approach is that that it is not viewed or perceived as conflict. The managing committee of MB is a conglomerate of individuals coming from different backgrounds and ideologies. Thus, there may be differences in opinions and working strategies but often these are not irreconcilable. MB provides a platform to talk about conflicting approaches and discuss them.

Photograph 14: Manas Bangla Consultation in progress

C. Key successful interventions/outcomes

- **Creation of a network of organisations:**
    - Though MB is a network of organisations, it may also be considered as a key intervention. Such a platform ensures that there is a co-ordinated response to the needs of the community. In general, many of the organisations on West Bengal had differing working ideologies. Such a structure often resulted in programmes being unnecessary replicated or 're-invented', and potentially also caused some conflicts with each other. Furthermore, presence of multiple organisations working in the same area can often be detrimental to the community due to conflicts between different organisations as all of them are "eating into the same portion of the pie". Thus, one of the main strategies of WBSCAS was to foster a collective organisation which will be able to provide a solid platform for each of the constituent organisations. That MB was eventually created and received

funding by the WBSACS is an *important success story* in the HIV intervention programmes in West Bengal.

- The constituent partners are the main source of strength of the network. By providing social, emotional, and other forms of support these CBOs have mobilised the fields and populations where MB runs its intervention. Though MB is the sole recipient of the fund and is the single implementing agency, it works in collaboration with its constituent partners. Apart from mobilizing the fields and populations, the partner agencies support the intervention by providing skilled and dedicated community members as staff and volunteers. They also send representatives to the Managing Committee of MB for a *true* participatory governance. But they don't hinder the programme by any undesirable interference. All conflicts are resolved through discussion on the basis of the policy documents and the terms and conditions of the MoU signed between the network and its partner agencies.

- **Communication strategies based on local culture and talent:** As a communication strategy, street theatre is very effective. It is deeply rooted in Indian tradition, is informal and draws a larger number of people. TI field staff report that because street theatre is seen as unexpected, free entertainment, people actually stop to see the performance. In an effort to contact individually with these people, the field staff are ready to be 'approached' by people and have IEC material and contact details ready to hand out. Here again, it is important for the field staff to make quick decisions as to how to react to the people who approach them or the many people who seem interested but are reluctant to make the initial contact. An example of a successful street theatre performance is the MB character, Bula *di*, as your friendly, homely, blue-sari clad character who invites people to speak with her with regards to their issues. These 'issues' are then discussed in a song and dance routine. West Bengal SACS has introduced Bula *di* as a character that features in an advertising campaigns and invites response from the public via telephone.

Photograph 15: Manas Bangla Stall – condom distribution

D. Lessons learnt

The following lessons learnt from this organisation have been discussed below:

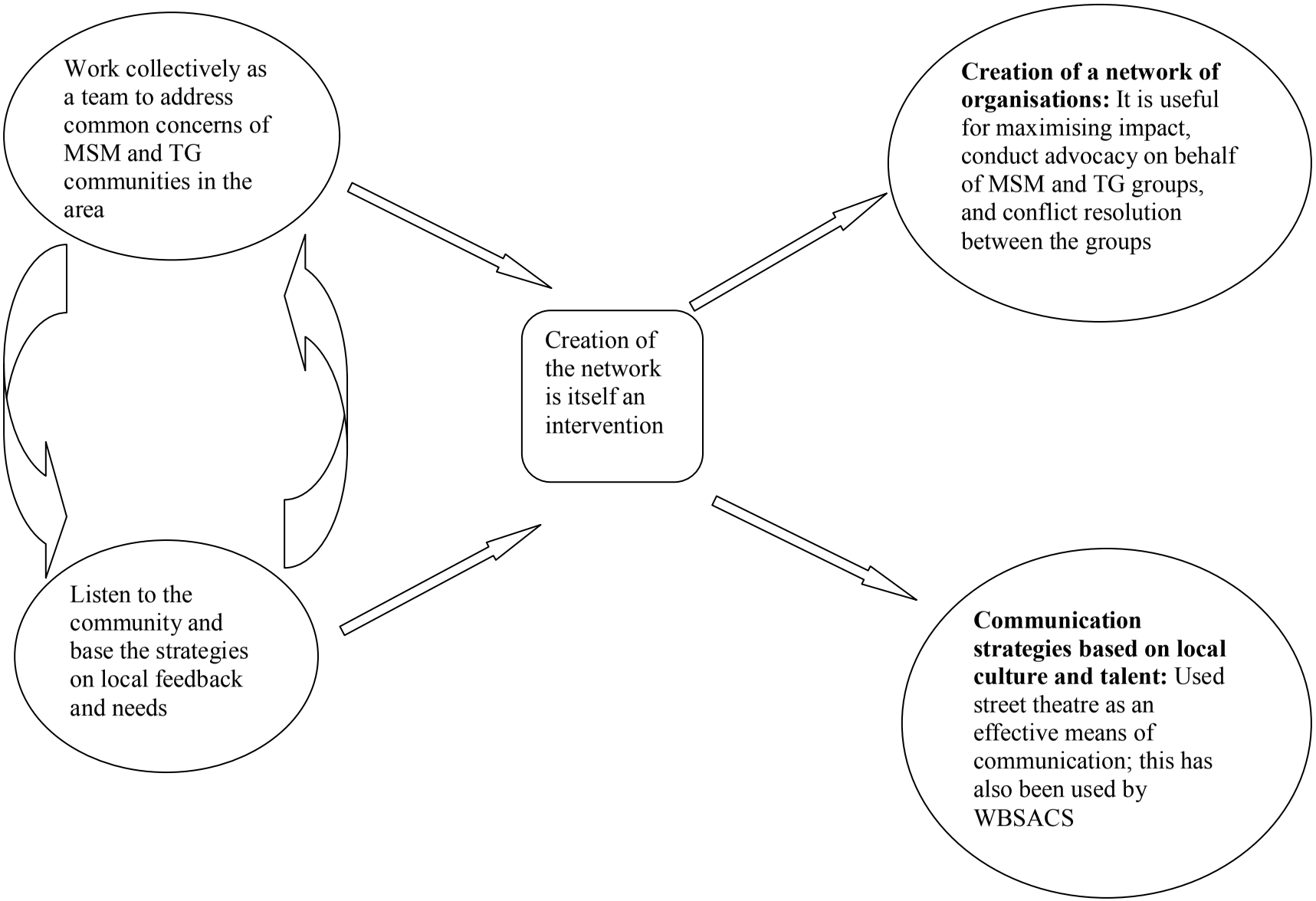
- **Collectivise the community and foster relationships between various organisations for impact and community ownership:** Community ownership is a crucial element to ensure that the network remains driven by the community and not get drowned by louder voices. The ownership of MB is with the communities thus bearing the testimony of the effectiveness of this network approach. Before the network was established, most member organisations functioned in semi-isolation and only those with common origins had some level of collaboration. Thus, fostering this relationship and collectivising the community became an important and useful strategy to deal with multiple partners in the body. However, now, though all member agencies continue to have their own goals,

activities and strategies, there is general agreement on the need for a greater level of commonality in policy and action. Joint advocacy increases the bargaining power of individual agencies and helps them in better sensitising individuals, organisations, institutions and systems that influence the lives of MSM and TG individuals.

- **Provide a platform for knowledge sharing and conflict resolution:** Not only did some of these organizations worked in semi-isolation there were also some ideological conflicts and working strategy differences. MB has emphasized the importance of listening to small community groups and balancing their competing priorities with the overall capacity-building goals of the project. The network was formed with the aim of sharing information, problems, needs, ideas and experience, and by this process work out common policies and action plans in a number of areas, build each other's capacities, resolve conflicts and avoid duplication of work. Past activities have focused on harmonising efforts of member organisations including advocacy. Such ideological conflicts may also be experienced in other parts of the country. Thus, a structure like MB provides a useful framework to be replicated in other parts, particularly if we are thinking of enhancing services and creating new organizations for MSM and TG interventions. In sum, this collective community network is a useful model for creation of a network at the National level.

Photograph 16: Workshop conducted by Manas Bangla

Figure 7: Figure demonstrating the working strategies and outcomes of MANAS Bangla, Bengal



5. LAKSHYA TRUST (Baroda, Surat, and Rajkot - Gujarat)

A. Background/Profile

Lakshya Trust, a community based organisation, is registered as a public charitable trust in the year of 2000. The organisation primarily works on issues related to social, economical, legal, psychological, and physical health of sexual minorities. The organisation primarily works on the sexual health issues of MSM population in three major cities of Gujarat state i.e., Baroda, Surat, and Rajkot on HIV/AIDS awareness and prevention. Lakshya Trust aims "*to work for the overall betterment of GBT (Gay Bisexual Transgender) populations with respects to their issues of sexuality, sexual health, mental health, social security, and social and emotional well being of these communities*."

Lakshya was informally started in early 1998 to bring together the MSM community of Gujarat on one common platform. The intention was to discuss common problems and find solutions to issues faced by the community. The main thrust was to get in touch with MSM who are not economically well off, especially from the remote interiors of Gujarat State, which have been neglected due to poor accessibility. This task of networking was started by collection addresses of MSM through internet, magazines, gay contacts etc. and corresponding with them. In this manner MSM were identified from almost all districts / important towns of Gujarat.

Through this networking with small and informal groups of MSM, various activities were carried out in Gujarat. These included informal meets at Rajpipla, Nadiyad, Anand and Daman, create awareness about HIV/AIDS, condom distribution programs at almost all important towns of Gujarat, distribution of literature on AIDS and STIs, counselling for marriage pressures, social problems, identity problems, education on gay rights, prevention of police harassment, provide employment opportunities and make the community self-reliant, and help HIV positive cases to get medical advice and treatment. Based on the highly effective work this organisation has done in the past few years among the high risk behaviour group of MSM men, Gujarat State AIDS Control Society had recently offered them to extend their branches in Jamnagar, Porbandar, and Vapi.

Photograph 17: Lakshya Trust Welcomes You – A nice reception

B. Working strategies/areas

- Lakshya Trust mainly works on HIV/AIDS awareness and prevention among MSM population in three major cities (Vadodara, Surat, and Rajkot) of Gujarat. It carries out various activities such as outreach and awareness programmes, condom promotion, STI treatment, free health camps, distribution of IEC materials for awareness, needs assessment of health services, and counselling on STIs. The organisation, through its HIV related outreach services, reaches out to more than 18,000 MSM. The project is totally managed by all gay staff. Their HIV related work is supported by the local government. The Targeted Intervention projects for HIV/AIDS have been awarded by Gujarat State AIDS Control Society.

  Apart from HIV/AIDS awareness projects, the organisation also has two Enabling Environment projects which primarily focus on education, employment and empowerment, sensitization of stake holders, and capacity building initiatives of MSM. The organisation also has undertaken a study project implemented by the Gujarat State AIDS Control Society, Ahmedabad with technical assistance of Sexual Health Resource

Centre, New Delhi. This study was funded by Department for International Development. This project primarily focused on prevalence of sexually transmitted infections among the MSM of Baroda city during the year of 2004. This surveillance is one of its kinds to be undertaken in the country.

- Lakshya Trust in Surat works with migrant MSM population from Orissa. The TI staff had to learn the language of the migrant population as there was no appropriately qualified people to work within this group. This becomes an important communication strategy - provide information and communicate in the language of the key populations. Another important communication strategy used by them is to incorporate the local cultural icons or characters from folk lore into IEC material. This has helped them engage with the key population. For example, they have incorporated Bahucharji Mata in their IEC materials.

- Lakshya Trust had demarcated its office spaces in all cities as per geographical areas of TIs. Each zone has an allocated office space and the wall space is used to display a large map of area and the matrix to capture data of targets and actual numbers achieved per month for the year. This creates systematic and structured approach to TI implementation and reporting. This technique is highly beneficial for continuous and concurrent analysis of status of TI implementation, also making sure that all reports are up to date.

- When Lakshya Trust started functioning, their main focus was to fight against Section 377 i.e., it was a rights-based approach. Later it shifted its focus to a more health-based approach. Since the last few years, Lakshya is also working on HIV/AIDS awareness and prevention programmes. Lakshya believes that both approaches - awareness and prevention, and a rights based approach must be merged. Beginning with a rights approach may not work, but when sufficient people have been mobilized for the common interest of preventing the spread of the pandemic, the rights based approach can be adopted.

- The major achievement of Lakshya was to organise Gujarat State's MSM conference at Rajpipla, which was attended by about 50 MSM from almost all districts of Gujarat andrepresentatives of GSACS, PSU, and Humsafar Trust. The inspiration of holding such a conference was derived by the Trustees of Lakshya who attended a Conference organised by Humsafar Trust at Mumbai where they saw NGOs from different states in India doing good work in the MSM sector. This conference received a very good feedback as MSM felt united to fight the common problems faced by them and thus develop a support system.
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- Lakshya Trust started with GSACS since April 2001; it was the first CBO to work for MSM in Gujarat. Lakshya has assisted GIDR in sex mapping process at Baroda & Surat. It has coordinated with other NGO Partners of GSACS for identifying and building rapport with MSMs in their respective target groups.

Photograph 18: Inauguration of an event by the Lakshya Trust

C. Key interventions/outcomes

- **Creation of a new organisation:** One major achievement was to create a community based organisation in a relatively virgin territory. This organisation executes all the interventions as mandated by the funding bodies or according to the needs of the community (such as STI care. HIV testing and counselling, condom distribution, IEC material distribution etc.). However, the creation of this organisation is in itself an important intervention. The presence of such an organisation empowers the community, provides space to the community to discuss issues, address the problems faced by the community, and generate localised responses to these problems. Such an organisation also helps in advocacy with various service providers such as health care providers and the police. Furthermore, they are also able to work with various stakeholders such as AIDS Control Societies and other funding bodies for writing projects and other research activities. Fortunately, for them there was an existing model - The Humsafar Trust for a community based organisation. Thus, new organisations base their working strategies on various existing models; however, the local realities need to be taken into account while working with the community. In addition to the existing model, the Trust also received massive support from the Gujarat AIDS Control Society; this was very important for effective

- **Programmes for wives of MSM:** Lakshya Trust has female partner referral notification systems in place that can be used by the client without fear of disclosure of sexual behaviour to family. The linkage is with the Reproductive and Child Health Programme (RCH) which was launched in October 1997 and is an initiative of the Ministry of Health and Family Welfare. It aims to provide need based, client-focussed, high quality services to beneficiaries with a view to enhance the quality of reproductive lives of the population and enabling the country to achieve population stabilisation. This referral is important because many MSM are married and/or do have casual relationships with other female partners. Many MSM also have children. It is important to introduce the topic of partner notification when client has been diagnosed with STI or has tested positive or in counselling, presents high risk sexual behaviours and admits to multiple partners. It is

also important to note that the counsellor must explain that admitting to sexually transmitted diseases may mean disclosure of sexual encounters outside of relationship. It may not necessarily lead to disclosure of sexual orientation or behaviours if client does not choose this path. It is imperative that the client is counselled on impact of their health on family members. Following on from the human rights perspective that NACP III is based on, it is also important to impress upon the rights of health of sexual partners, which may mean disclosure of sexual orientation and/or behaviour.

Photograph 19: Peer meeting at the Lakshya Trust

D. Lessons learnt

The following lessons learnt from the organisation have been highlighted:

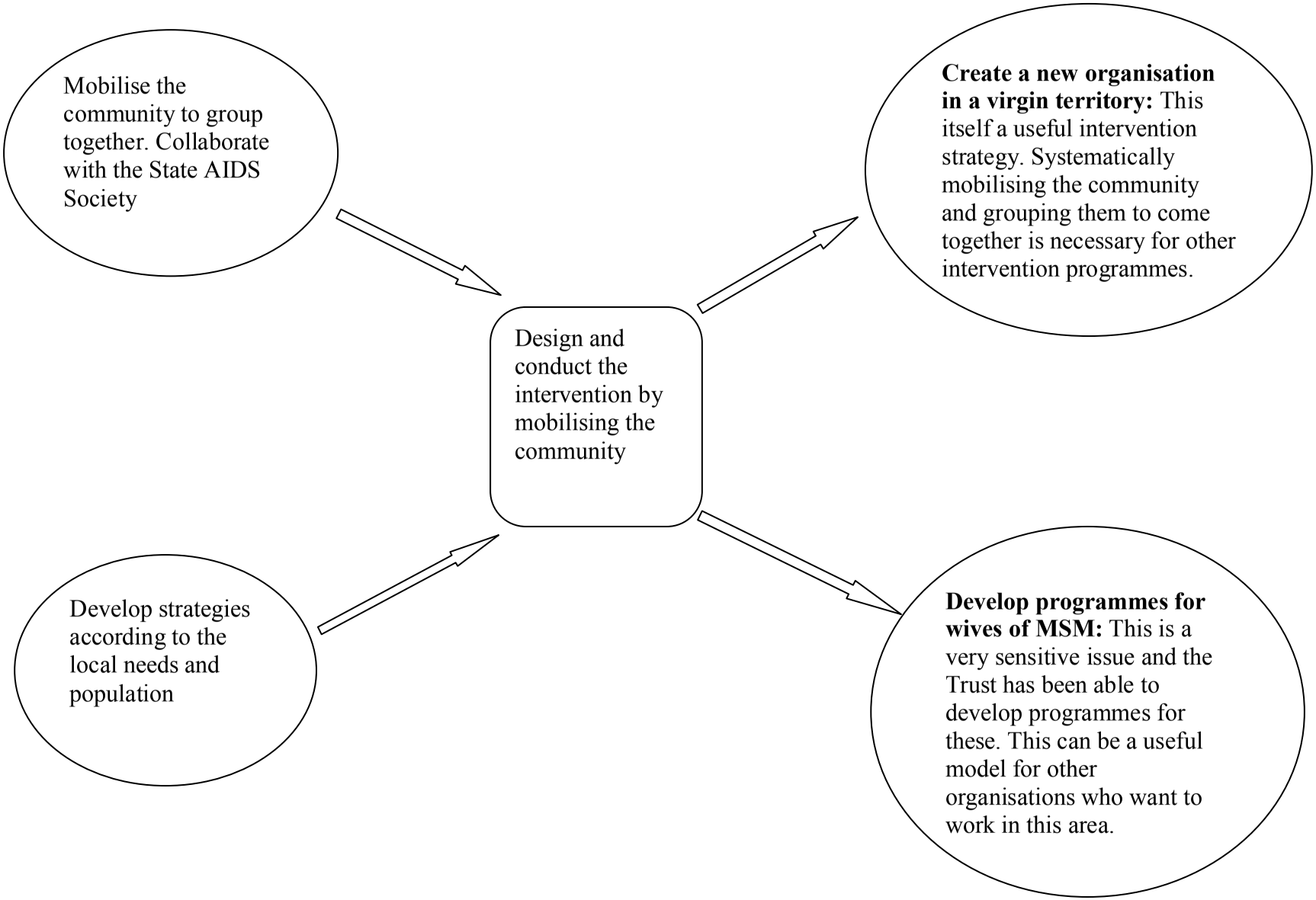
- **Community mobilisation requires a systematic approach:** Mobilising the community to create a new organisation should be done very systematically. For example, before Lakshya Trust was officially created, they contacted the community members through

their existing network. They then organised a meet of all these community members. This provided a platform to discuss common problems faced by them, and ways and methods to address them. They should also team up with some existing organisation to understand the working strategies in the community. Furthermore, they should also collaborate with the State AIDS bodies and work with them to devise strategies and funding priorities. Such an approach results in effective community participation in programmatic decisions.

- **Interventions should be tailor-made to local needs:** As discussed in the working areas and key interventions, Lakshya Trust changed their strategies according to the needs of the community. Thus, even though they started off with a focus on legal issues, they changed their strategy mid-way to a more health perspective. Later, they incorporated both the approaches. They also learnt the language of the TI; this is particularly useful in areas that have a higher proportion of migrant population. Though they incorporated the local icons in the IEC materials, a further useful strategy would have been to understand the local icons of the migrant population.

Photograph 20: Health centre at the Lakshya Trust

Figure 8: Figure demonstrating the working strategies and key outcomes of Lakshya Trust, Gujarat



6. SOCIAL WELFARE ASSOCIATION FOR MEN (SWAM - Chennai, Tamil Nadu)

A. Background/Profile

Social welfare Association for Men (SWAM) is a community based organisation and focuses on promoting the sexual health of those who self identify as kothi or gay. It also works towards tackling stigma/discrimination faced by them and protecting their human rights. The organisation was formally registered on 3rd April 1997, under the Tamil Nadu State Societies Registration Act, 1975. SWAM was founded in response to an urgent need to create awareness about HIV/AIDS among the homosexual community and to provide safer sex education to them. It is one of the first CBOs of MSM and TG people in Tamil Nadu and India.

SWAM was started in Chennai to provide a supportive environment for gay men, kothis and bisexual men, who faced stigma and ostracisation in the society. Its establishment coincided with the emergence of HIV/AIDS and its founder trustee was India's first out positive gay man. The organisation provided support to the likes of him at a time when there were little facilities in the society for HIV infected MSM. Over a period of time SWAM has developed a range of HIV/AIDS community activities supported by international donors. SWAM works with multiple objectives; they are "*to create awareness and increase the knowledge of HIV/AIDS and STIs among kothis and gay men, promote safer sex behaviour and enable them to protect themselves and their male and female partners, increase access to and use of condoms, increase access to community friendly sexual health services, promote and protect the rights of kothis and gay men who are marginalised because of their sexual orientation/behaviour or gender identity/expression.*"

SWAM is openly known as a gay/kothi organisation in Chennai and much of the publicity is through sexual networks in Chennai. Encouraged by the Tamil Nadu State AIDS Control Societies (SACS) and international donors funders such as USAID/FHI, SWAM has focused attention on HIV prevention and established its credibility with the public.

Photograph 21: The team at SWAM

B. Working strategies/areas

- SWAM's initiatives include a drop-in centre and MSM outreach by peer educators at cruising sites such as beaches and parks where men go to meet other men for sex. There are nearly 50 cruising areas in Chennai. SWAM's outreach workers meet kothis and gay men in various cruising areas of the city and educate them about STIs and HIV/AIDS with the help of an educational kit. This kit includes leaflets, a compact picture atlas of various STIs, and condoms and a penis model for condom demonstration. Outreach workers promote SWAM's services by handing out cards with its address and health services on offer, such as free medical examinations and treatment for STIs. Volunteers receive training from other health workers and staff the counselling service. Outreach workers provide face to face counselling to the kothis and gay men coming to the cruising areas.

SWAM's drop-in centre provides safe and supportive environment for kothis and gay men to meet and socialize with one another. Information on HIV/AIDS and STIs, safer sex education, and counselling services are also provided at this centre. Free condoms are available for the drop-ins to pick up. Trained counsellors provide counselling to the kothis and gay men attending the drop-in centre, In addition, they also provide telephonic counselling to anonymous callers. Kothis and gay men who have symptoms suggestive of STIs or who want to be screened for STIs and HIV are provided information on various modalities of care and treatment**.**

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- They also have a clinic; it provides sensitive and non-judgemental care to kothis and gay men with genitourinary or general complaints.

- SWAM provides education on sexuality and HIV/AIDS to school and college youth in collaboration with local service groups.

Photograph 22: Condom distribution by the SWAM team

C. Key interventions/outcomes

- **Care-cum-Shelter home for the PLWHA:** SWAM runs a temporary care cum shelter home for MSM- TG and PLWHA. The objective was to serve the most marginalised and at time destitute (MSM-TG) who have often run away from homes and have no place to go and stay. It provides an environment which cares, protects, restores self-worth and **e**mpowers them; all of this is provided in a safe community environment. What started off as service centre for vulnerable MSM – TG has now also extended its hospitality and services to PLWHAs as well. A trained counsellor & an HIV-positive gay man (peer counsellor) provide counselling on sexuality related concerns and issues. A physician provides STI treatment & risk-reduction counselling. The clients come with different problems like: non-acceptance of their own sexuality, coping with family pressure to get married, worry about sexually satisfying wife, the need to act as a straight person, suicidal ideation, etc. Some gay men also want to change their sexual orientation. The care home provides for food, shelter, medical needs, counselling, and job referrals needs of the people who come there in need of support.

- **Savings and micro-credit system:** SWAM has introduced a small savings and micro-credit scheme for the community members. This helps them save money for the future. It is particularly useful for individuals who do not have family support or those who have arrived in the city from outside. Furthermore, this saving scheme also helps them become self-reliant. This is an important method to empower the community. Initially, most of the interventions, including the space for shelter home was funded by personal funds of the founder, This helped the community at large, Thus, the philosophy of having funds at hand is a useful strategy for care of the community in future.

Photograph 23: SWAM – One of the many programmes

D. Lessons learnt

The following lessons learnt from this organisation have been highlighted:

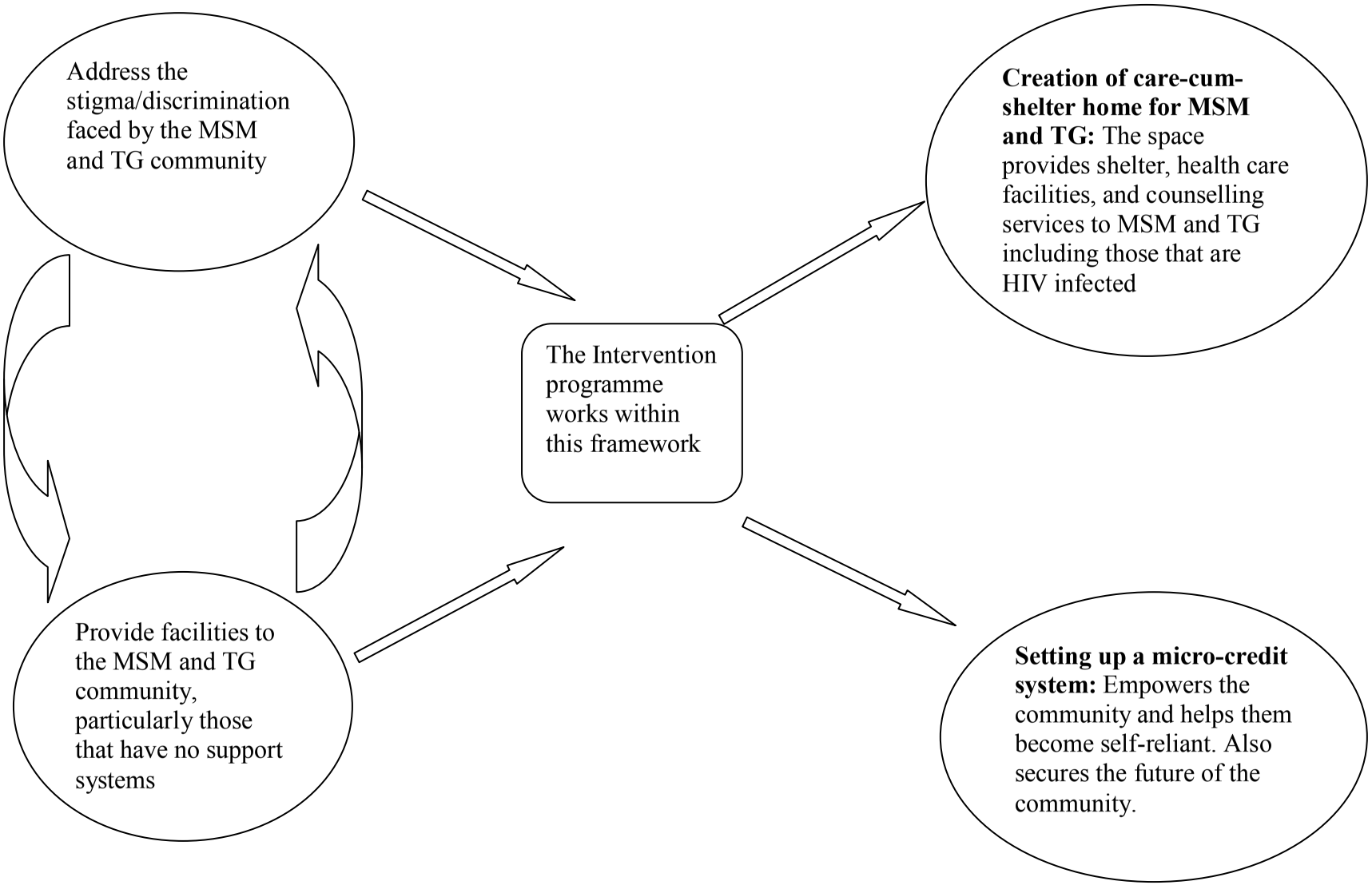
- **Tackling stigma/discrimination is a useful strategy for developing interventions:** One of the important reasons to start this organisation was to tackle the stigma/discrimination faced by the founder and other individuals. Tackling stigma head-on can provide an effective support system to the community. This sort of support system may then empower the community. Following this empowerment, the community is able to effectively address other issues, such as HIV/AIDS and STI care, as was observed in the case of SWAM.

- **Physical space for MSM and TGs living with HIV/AIDS is potentially useful for their care:** SWAM was able to create a physical space for MSM and TGs who were abandoned or left their homes to avoid harassment. This space was then useful a care home for those living with HIV/AIDS. This gives a sense of community to these

individuals. This space also provides opportunities for other interventions such as STI care, condom distribution, and counselling.

Photograph 24: SWAM welcomes everyone

Figure 9: Figure demonstrating the working strategies and key outcomes of SWAM, Chennai



GENERAL OBSERVATIONS AND INTERVENTION STRATEGIES OF ALL THE SIX ORGANISATIONS

Though we have highlighted significant aspects of each of the organisations, there are certain characteristics that are pertinent to all these organisations.

A. NACP III Framework: The Targeted Interventions under NACP III provides an excellent tool through its Operational Guidelines to project manage a program for communities of people who live under intense hardship of stigma, discrimination, and the resulting disempowerment in their everyday lives. This program allows a space to be created so the marginalized communities discover themselves and be amongst people who accept them. It demands MSM and TG individuals realize their basic human rights as citizens of India and empower them to take responsibility for their and their family's health. Each CBO has entrenched this philosophy while implementing the interventions. One common factor amongst the six CBOs visited, was that each intervention had the flavour of the local environment, culture, and experiences of its peoples woven around the NACP III framework. On the whole the TI relies heavily on the knowledge of the local area, people, networks and resources available. During implementation stage it is the field staff knowledge of local social and sexual networks that is important. It is their knowledge of the complex, informal systems that pave the way for easier contact and building of trust with key population. These contacts are nurtured over a period of time to become part of community that develop health seeking behaviours to make a successful TI.

B. Rapport building: The key factor to initiate contact and build rapport with MSM and TG is that the contact person from the agency should be from within the community. This is especially true for MSM and TG who may have never had contact with any health agency. This was evident in all the six organisations interviews; the stakeholders are wary of contact by strangers and even more so by people who talk about sexual matters in a judgemental manner. The ability to make a successful connection with the key population is in that first gesture; be it the lift of an eye brow, the words of familiarity with a stranger, or the way one stands. It is almost a clandestine meeting, with the field staff improvising their approach with a quick reading of the local situation and person. To build rapport, the field staff find it important to talk about 'other' issues and to get

know the person (and vice versa); talk about each other's work before broaching the topic of HIV/AIDS.

C. Outreach and communication: Peer-lead, NGO supported outreach and behaviour change communication is important in these interventions. Using popular communication strategies (such as street theatre in certain areas) and learning the language of communication of the TIs (while dealing with migrant populations) are effective communication strategies developed by some of these organisations. Furthermore, some of them also added a local flavour to communication strategies by creating or incorporating local icons. In addition, these organisations have also developed strategies to maintain continued and consistent connections with the key populations. Through individual histories, the field staff is able to connect with the key population in a timely manner and follow-up when clients do not attend DiCs or make medical appointments.

D. Providing Services: These include services such as promotion of condoms, linkages to STI services and health services with a strong referral and follow-up system. It is important to find condom vending spots that will not be vandalised; this is a constant challenge for TI staff. The range of innovative ideas depended on the location of the 'sexual activity' space, whether it be the urban or rural locale. In urban areas one can negotiate and impress upon the local pan or cigarette shop vendor. Many times it was a matter of negotiating with the gate-keepers to public toilets or other spaces where men are likely to pick up partners. The field staff develops friendly relations with the vendors and educate them about HIV/AIDS, and devise feedback strategies for replenishing supplies. The MSM and TG communities are then told about these spots by the field staff. People from within the communities pick up condoms as and when they need it. These contacts are reviewed periodically in case vendor changes. In other situations, the strategy is to find a hidden spot in a public space that is known only to the community, through word of mouth. For example, in rural areas, a spot would be found where the sexual activity is known to take place (e.g. in the bushes near the local lake or on branches of a tree) rather than where they pick up partners (e.g. the market place).

Linkages to STI services and health services are also strong component in all TI sites visited. Each program realises the importance of the availability of continued and consistent care of specialised health services and sensitised health care workers. An important initial step is to map out the public health services available within the area of intervention and specialised linkages in other locations. At this time, names and designations of medical staff and hospital administrators or heads of departments must be collated. With this information, permission must be sought (preferably in writing) to work with health care workers. It is crucial to note that sensitisation of health care workers takes time, with many disappointing moments faced in the initial phase. Thus, one needs to factor in time and repeated visits and explanations of the goals of the visit, reason for linkages, the local environment, and approximate numbers of clients expected while sensitising the health care workers. Furthermore, the TI staff must be make themselves available at the public facilitates so they become known to health care workers. The build up of such rapport allows for smooth progress of key population through the system. The experience must empower the key population, to increase their confidence in practising their health seeking behaviours.

E. Creation of an Enabling Environment: Some of the strategies by the organisations include sensitising and working with various service providers (such as legal personnel, health care providers, police etc.) to create a favourable and secure working environment. In addition, many of these organisations have systems in place to deal with crises on the field and in the community. Organisations also have formal or informal arrangements with lawyers to provide other legal services. The requests range from assistance with legal documents, drawing up lease agreements, advice on marital issues, etc. Furthermore, the CBO staff usually helps the community with PAN and ration card applications, opening bank accounts, etc and refer for legal help as and when necessary.

Finding and retaining trained staff is always a challenge for all these organisations. The field staff was from the community. As observed during the site visits, staff's natural passion and commitment to the cause are very high. For many a position in the organisation is the first time they have held a job that allows them to be who they are. It is about a sense of wonderment that '*I have gained tremendously from this CBO and must give back to the community*.' Many of

those interviewed had studied up to the tenth standard and saw this as a chance to learn more. They were motivated to acquire more skills, build their own capacity and develop as a person. Various means have been developed to foster staff motivation and developing their capacity. These include case studies to build technical knowledge, and regular meetings and workshops to build capacities,

F. Community Mobilisation: Building MSM and TG ownership of the TI's objectives has seen an organic growth since the first groups of sexual minorities met. This stems from the fact that staff interviewed came from situations of vulnerability to high risk behaviour and/or situation beyond their control because of their sexual & gender preferences. Upon employment they have developed as a person, learnt about safe sex, human rights, health seeking behaviours and community. Each CBO started with a felt need from individual or a group of people. In the pre-HIV funding period they initiated services to work within the community and have created a safe space. These actions, in various parts of the country, gave the MSM and TG communities' courage to seek services and solidarity from like-minded people. Creating community of people and a sense of belonging empowered MSM and TG, and encouraged them to seek others to share this space. The safe spaces allowed people to celebrate their religious and traditions in a way that was not possible in society. It encouraged talent and show-cased natural leaders. It gave the space for the communities to dream of providing similar services and help to were yet to discover the joys of community and belonging. In the meantime, they learnt of HIV/AIDS and used their resources and networks in the society to provide intervention to many more. Furthermore, all the CBOs have supported groups of MSM or TG to register their own CBOs.

Thus, all these organisations have developed some common and some individual strategies to deal with the community issues and initiate interventions. There were some key lessons learnt from these six organisations. They have been highlighted in Box 1; these can be used as guiding principles for an ideal NGO/CBO currently working with the MSM and TG community or creation of new CBOs. Furthermore, the key interventions and outcomes from each of these organisations can be shared in a common space. This platform is provided by the network INFOSEM; some of the details of the network are discussed in the next section.

Box 1: KEY LESSONS LEARNT

- **Collectivise the community and foster relationships between various organisations for impact and community ownership**
- **Community mobilisation requires a systematic approach**
- **Interventions should be tailor-made to local needs**
- **Be a regular interface between the community and the health structure**
- **Integrate the programmes in the existing systems**
- **Facilitate and not replicate the services**
- **Tackling stigma/discrimination is a useful strategy for developing interventions**
- **Human rights' approach is a useful strategy for minority issues**
- **Use entertainment to empower the community**
- **Create Sensitisation programmes for service providers**
- **Providing physical space for MSM and TGs living with HIV/AIDS is potentially useful for their care**
- **Create Centres of Excellence**
- **Use a flexible approach to care while maintaining the core principles of the organisation**
- **Provide a platform for knowledge sharing and conflict resolution**

INDIA NETWORK FOR SEXUAL MINORITIES (INFOSEM)

INFOSEM is a collective national effort by sexual minorities to ensure equality for themselves in all spheres of life, free from discrimination. The vision of the this organisation is to provide "*a democratic platform of organizations for joint action in capacity building, advocacy, resource mobilization and research on issues of gender, sexuality, sexual and mental health, and human rights in order to create better understanding of LGBT issues".*

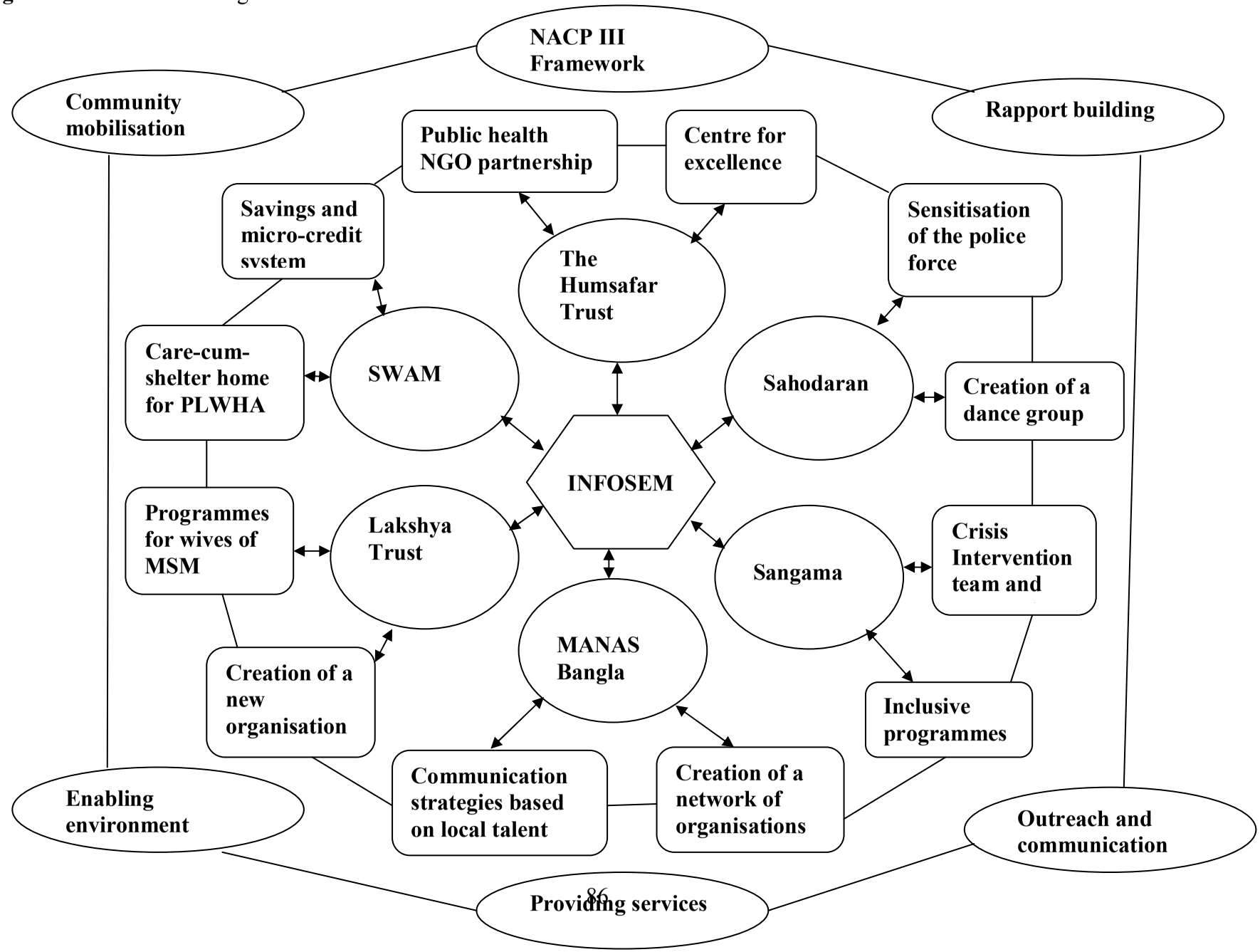
The objectives of this network are as follows: 1) clarify the legal status of transgender/ transsexual persons; 2) repel all discriminatory legislations that criminalises same sex sexual behaviours between consenting adults in privacy (such as Section 377); and 3) provide inputs and training to organisations in setting up and managing activities addressing health, social, and legal issues faced by persons belonging to sexual minorities.

Thus INFOSEM is involved in various activities such as advocacy, capacity building, information dissemination, research, networking, and resource mobilization and resource sharing.

It also provides a platform for knowledge sharing and conflict resolution. This is an important issue because some of the lessons learnt from each of the organizations can be used by others. Furthermore, some of the strategies used in successful interventions can be emulated by other organizations and in other locations. Thus, there is a multi-way relationship between INFOSEM and the member organizations. The collective approach further results in maximum advocacy and bargaining capacity on behalf of sexual minorities.

We have formulated a web-of-connection between INFOSEM, respective organizations, and some of the key interventions. It has been shown in Figure 9.

Figure 10: Model describing the Web-of-connection of INFOSEM



As seen in the above figure, we have discussed four levels of inter-connectibility of these organisations:

Level 1:

These are the common themes across all the organisations such as following the NACP III framework, rapport building, etc.

Level 2:

These highlight some of the key interventions from each of the organisations. Some of these may be present in other organisations as well. The models of some of these interventions may go beyond what is required by NACP III and potentially be replicable in other scenarios

Level 3:

These include the individual organisations. They work for the community within the framework of the earlier two levels of intervention.

Level 4:

The final level is INFOSEM. It provides a platform for all the organisations. This helps them share their experiences from community interventions and effectively address all the conflicts. Thus, it is a national network for:

1) exchange and documentation of TI and CBO experiences;
2) a coherent national advocacy;
3) community mobilization; and
4) information dissemination strategies for the MSM and TG communities

Thus, this framework will be useful in creation of new CBOs or change the interventions of existing organisations (if required).

Photograph 25: An INFOSEM meeting

IMPORTANT LESSONS AND CHALLENGES FOR THE CBOs

This section explores, in brief, lessons and challenges faced by CBOs whilst implementing Targeted Interventions from an overall perspective. This list was compiled after discussions with the six CBOs, upon realization that these issues are similar within all CBOs.

- **Each CBO was set up by an individual with a group of supporting people**. These individuals realised the need for awareness for HIV and AIDS through their own experiences and mobilised support from within the community to work on these issues. With the advent of funding for HIV and AIDS prevention, care and support they formalised their networks into Community Based Organizations, registered under Societies Act in respective states. Further, each CBO developed as an entity, in tune with the perspectives and philosophies of the Founder Trustee/s and strategies employed to deal with the local political and societal environments. For example, Humsafar Trust developed as an organization and its TIs actively working with the local authorities. In contrast, Sangma/Samara developed its strategies of confrontation and organizing protest rallies in response to the brutalities faced by the sexual minorities from the local authorities. This further influenced the philosophical perspective of implementing TIs. For example, the Sangma/Samara approach to TI implementation is based on Human Rights perspectives whereby staff and client see health and sexual identity as their basic human rights.

- **All TI staff displayed passion and spoke of loyalty** during the interviews. These emotions came from the belief that there were empowered by the TI and CBO, and were able to come to terms with their sexualities. The CBOs also provided them with a safe place to work – away from stigma and discrimination of everyday lives.

  It is imperative to note that even though the TIs and CBOs provide a safe space for the MSM and TG communities, it could become another closet to hide in. This would restrict empowerment to within 'safe' MSM and TG identified areas only, this unable or unwilling to step into mainstream spheres.

- **Information fatigue** – both the field staff and key population feel that there is information overload on issues of HIV/AIDS and communication during intervention and must include other aspects of MSM and TG lives. For example, field staff initiate interventions by seeking out information and discussing lives of the individual and the communities they live in. As a result, more time is spent during contact sessions and CBOs are now assisting key populations in other aspects like filing in application form for Ration Cards, Identity Cards, bank accounts, etc.

- **Behaviour change happens over a period of time** and only when the client realizes importance of their own health. As such, communication of health seeking behaviour and ensuring its adherence is a challenge for the TIs when trying to reconcile ground realities with achievements of NACP III through analysis of numbers.

- **Selection, training and motivating the right Peer Educators (PE) is the key to a successful interaction with the static key population**. This is because the PEs bring extensive knowledge of social, sexual, and other networks within a TI area. The PE is well versed in the complexities of local cultures and traditions, hierarchy of power, political dynamics, and, more importantly, they are able to negotiate these complexities to successful introduce TIs into the MSM and TG communities.

- The prevalent thought with regards to providing intervention to Kothis, Transgenders and effeminate men throughout the study is that this **practice does not work on behaviour change of penetrative partners.** The assumption is that the receptive partners will be empowered enough to insist on safe sex practices. In many instances, this does not occur as issues of loyalty and trust with the penetrative partner is questioned.

- Confidentiality can be compromised when a newly positive diagnosed person is referred to Care and Support Services from services that are based in-house. This is further exacerbated if the positive person holds the field staff responsible for the knowledge he or she has of their health, since knowledge of HIV status is now a burden. Their rationale is

that **it is better to go on living in ignorance and continue life as before, rather than inviting further stigma in their lives**.

- **The issue of female-partner notification is a controversial one** in many TIs as it is assumed that partner notification will lead to disclosure and therefore disturb family dynamics and status quo. Sangma/Samara, Humsafar Trust and Lakshya Trust have successfully deployed strategies for linkages with mainstream health facilities for female partner notification. Yet, the issue of disclosure and rights of the partner need to be discussed openly. This is especially so because NACO believes in implementing TIs with a rights-based perspective.

- A noticeable observation was that **the sensibilities of the key populations and therefore strategies of TI differed in localities differentiated by major cities, smaller cities, rural and tribal areas**. For example, rural areas had no regular hot spots or cruising areas, Project Co-ordinators were heterosexual and non-MSM and TG specific IEC material had to be used for interventions.

CONCLUDING REMARKS

As discussed earlier, we have presented details of six organisations that have been at the fore front of working with the MSM and TG community in India. Each organisation has developed programmes and interventions based on its philosophy, local requirements, and in some cases as mandated by the funding bodies. Though, some working areas are common to all these organisations, specific interventions have been developed in individual organisations. They can be a model for other organisations who intend to develop intervention programmes in those respective areas. Furthermore, the key lessons learnt from all these organisations (Box 1) are useful guidelines for new organisations.

Since this study was conducted with time limitations, and is based on experiences and observed behaviours, it is recommended that qualitative research be undertaken. This research will provide a blueprint for successful operations with a comprehensive understanding of the vast range of experiences, strategies and complexities of interventions within the MSM and TG communities. Another recommendation is that NACO and CBOs should increase range of soft-skills training for field staff and incorporate periodic narrative reports in current reporting requirements.

The year 2009 proved a significant year for MSM and TG communities in India; the Delhi High Court on July 2 read down section 377 of the Indian Penal Code to legalise consensual sex between same-sex adults. The National AIDS Control Organization (NACO) must be acknowledged for their support in this process and for submitting an affidavit to protect the right to health for these communities. This action seals the support of the national authorities to recognise lives of persons with alternative sexualities, the stigma and discrimination they face, and investment in infrastructures to reduce prevalence of HIV and AIDS in these communities.

An overwhelming, immeasurable factor to the success of the NACP III is the dedication and passion of the people who work to implement the TIs. This commitment to ‘help’ the people of the MSM and TG communities has been driven by the strength and sensibilities of the Founder Trustees of the CBOs. It forms an intrinsic part of every aspect of work with the key

population, within the structures of Targeted Interventions. It has evolved over time to incorporate other stakeholders and funds for the benefit of the communities. This dedication and passion is very much in evident in each project staff and needs to be nurtured to maintain the success of individualised and localised interventions that influence a national program to control the spread of HIV in India.

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