



Risks | **Responsibilities**
Male Sexual Health and HIV in Asia
and the Pacific-International Consultation
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COUNTRY : INDIA

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Annex : “National AIDS Control Programme in India: Scaling-up HIV-related interventions for men who have sex with men, transgendered people and *Hijras* – Inputs from regional and national consultations”

Men Who Have Sex With Men (MSM) and *Hijras* are formally organised

- Social groups : **Y** In metropolitan areas, smaller cities, towns, peri-urban areas
- Organizations : **Y** Same as NGOs and CBOs
- NGOs : **Y** Several NGOs work on mental health, human rights, STI/HIV programmes for MSM
- CBOs : **Y** MSM self-help initiatives date back to early 1990s, all-time CBO initiatives: 90-100, many registered
- Networks : **Y** National (NFI, INFOSEM), regional (Tamil Nadu, West Bengal), e-forums, population specific (MSM living with HIV, male / transgender sex workers)
- Other : **Y** *Hijra, Kothi* populations have a long history and culture of community formation that predates current forms of organised CBOs and NGOs

MSM specifically captured in the **National HIV Surveillance System** : **Y**

If “YES” : **National / Sub-national HIV prevalence** among MSM :

- Ranges from 0.54% to 15% in different states (2005)
- Only 15 surveillance sites for MSM out of 750 in 2005
- Only one site (in Mumbai) measured prevalence among *Hijras* – 44%

This includes **behaviour surveillance** : **N** (Behaviour surveillance is separate)

Last national BSS conducted by NACO in 2002 in 5 cities:

- Showed 69% of MSM respondents knew 2 correct ways of HIV prevention
- 83% aware about need for consistent condom use, but only 13% reported condom use with commercial sexual partner in month preceding the survey

HIV Surveillance **Report date** : November 2005

Covering [year] : **2005**

‘MSM and HIV’ - related research available, ongoing or planned : **Y**

If “YES”: Research published : **Y**

1. Sheena Asthana and Robert Oostvogels, “The Social Construction of Male ‘Homosexuality’ in India: Implications for HIV Transmission and Prevention”, *Social Science and Medicine*, No. 52: 707-721, 2001
2. The Humsafar Trust, “Knowledge, Attitude, Behavior and Practice Among Men Having Sex With Men in Mumbai and Thane”, The Humsafar Trust, Mumbai, 2002
3. Venkatesan Chakrapani and Others (SAATHII Working Group on HIV Prevention and Care among Indian GLBT / Sexuality Minority Communities), “Background Paper on HIV Prevention Among Men Who Have Sex With Men (MSM) In India: Review of Current Scenario and Recommendations”, Chennai, 2002

Continued

‘MSM and HIV’ - related research available, ongoing or planned : Y

If “YES”: Research published : **Y (Continued from previous slide)**

4. Ravi Kumar Verma and Martine Collumbien, “Homosexual Activity among Rural Indian Men: Implications for HIV Intervention”, *AIDS*, No. 18: 1845-1856, IAS, 2004
5. Shivananda Khan, “Masculinities, (Homo)sexualities and HIV Vulnerability Working with Males who have Sex with Males in India”, Naz Foundation International, Lucknow, 2005
6. Lalit Dandona and Others, “Sex Behaviour of Men who have Sex with Men and Risk of HIV in Andhra Pradesh, India”, *AIDS*, No. 19: 611-619, IAS, 2005

KEY INFORMATION GAPS that hinder establishing and/or scaling up ‘MSM and HIV’ - specific programmes and interventions :

1. **Lack of general knowledge and information** on gender, sexuality, sexual behaviour and sexual diversity → results in strong stigma against MSM and *Hijras* → which in turn leads to:
2. **Presumptions** about “**who** MSM are and **where** they are” → these inevitably lead to “identification” of only visible sub-sections of MSM (though even this is incomplete) → exact extent of male-to-male sex, including unprotected anal sex, does not get estimated accurately

This has generated a familiar vicious circle: no data equals no problem, no problem equals no intervention, and no intervention equals no need to collect data. This leads to insufficient financial and human resources allocation for ‘MSM and HIV’ specific programmes

Demographic data available : Y. Sub-national data on age (mean for rural MSM 28.6, *Verma & Collumbiene*), income, education, family size, marital status

MSM - specific budget [lines] in the National HIV Plan : Y (minimal)

- Under NACP-II, only 3% (30 out of 965) targeted interventions focussed exclusively on MSM or *Hijras*. A few composite interventions also addressed MSM / *Hijras*
- Under NACP-III, 235 targeted interventions (9% of the total 2,500) are planned exclusively for MSM / *Hijras* (up from 30 under NACP-II), and another 235 composite interventions will also address MSM / *Hijras*
- The National AIDS Control Organisation (NACO) will allocate Rs.12-18 lakh (equivalent of approx. US\$ 30,000) for each exclusive targeted intervention, annually
- NACP-III plan estimates a most at-risk MSM population of 2.35 million (including 0.24 million male / transgendered sex workers). Will NACP-III efforts be enough to achieve the target of 80% coverage (1.88 million)?

GFATM : Y Funds specifically earmarked for 'MSM and HIV' : **N**

Other international donor and/or multilateral institutions funds specifically earmarked for 'MSM and HIV' : **Y**. If "YES" List :

(1) DFID-India

(2) European Union-HIVOS

(3) B&MGF funds India HIV/AIDS Alliance in AP, 40% of Alliance India Andhra Pradesh's budget earmarked for MSM / *Hijra* targeted interventions

(4) USAID-Avert Society and USAID-APAC VHS

Donor coordination in supporting 'MSM and HIV' – specific programmes and interventions (donors themselves and donors with government).

(1) DFID-India supports some MSM / *Hijra* targeted interventions in tandem with NACO

(2) USAID supports interventions in Tamil Nadu and Maharashtra through APAC-VHS and Avert Society, respectively, in coordination with NACO

However, donor coordination on HIV in general needs to be improved. More importantly so on financing for MSM / *Hijra* interventions

There is an **operational National Strategic Plan on HIV** : Y. If “YES” :

There are ‘**MSM and HIV**’ - **specific interventions** in the National HIV Plan : Y

If “YES” : Coverage : 100%**X**.1% (indicate with “**x**” on scale)

MSM usage : 100%**X**.1% (indicate with “**x**” on scale)

NACP-III estimates a most at-risk MSM population of 2.35 million, but in nearly 70% of the states coverage is zero. In others it may be as high as 60%. These estimates are based on data that needs urgent re-examining

These programmes reach **sub-populations of MSM** (transgendered, etc) : Y

If “YES” : Coverage : 100%**X**.1% (indicate with “**x**” on scale)

MSM usage : 100%**X**.1% (indicate with “**x**” on scale)

- Sub-populations of *Kothis, Jogtas, Panthis*, gay men, and associated populations of *Aravanis / Hijras* are reached through some targeted interventions
- There is also some coverage of MSM with no specific gender / sexual identity. But no accurate scale of coverage available

Male-to-male sex is legal : N

MSM – specific HIV programmes face **problems with law enforcement** : **Y**

Obstacles [not related to information gaps] that hinder establishing and/or scaling up of ‘MSM and HIV’ – specific programmes and interventions : **Y**

1. “Moral guardian” stance of law enforcers makes CBOs / NGOs feel unsafe in providing sexual health information. **Solution:** Educate law enforcers about importance of sex, sexuality, sexual health, HIV, public health
2. Section 377, IPC criminalizes male-to-male sex: Places targeted intervention activities of CBOs / NGOs in “legal gray area” even if funded by government. Limits delivery of quality health services. **Solution:** Repeal or revise law, or provide “legal safe havens” for crucial life saving health work
3. Section 292, IPC criminalizes “obscenity”, which is defined in a vague manner: Limits frank communication on sexual health, which can easily be termed pornographic. **Solution:** Sexual health education for law enforcers, legal safe havens for CBOs / NGOs

‘MSM and HIV’ - specific interventions in the National HIV Plan : Y

If “YES” :

▪ **HIV transmission prevention : Y**

Plan includes STI/HIV awareness generation, field-based outreach services, drop-in centre services, condom and lubricants promotion, community-based VCT centres, STI treatment, vaccine trials and advocacy activities

▪ **Information & communication : Y**

Plan has provision for using inter-personal communication such as one-on-one discussions, group discussions and counselling and interactive exercises. More clarity is needed on how mass media will be used for MSM, *Hijras* and HIV issues.

‘MSM and HIV’ - specific interventions in the National HIV Plan : Y (Contd.)

If “YES” :

- **Peer outreach : Y**

Plan supports this approach as all targeted interventions for MSM and *Hijras* have adopted it with reasonable results. Besides delivery of targeted intervention services, it has also helped in community mobilization

- **Targeted condom distribution; including lubricants : Y**

Plan supports both free and priced (social marketing) of condoms and lubricants

But some targeted interventions have entered into deals with prophylactic makers for discounts and ensuring regular supplies as government supply, quality and budgets are not satisfactory

Some CBOs even make own lubricant sachets using glycerin solutions

‘MSM and HIV’ - specific interventions in the National HIV Plan : Y (Contd.)

If “YES” :

▪ **Access to treatment** : N

Plan lacks targets for care, support, treatment specifically for MSM / *Hijras* living with HIV

Social support measures needed to tackle double stigma MSM / *Hijras* face on account of their gender / sexuality *and* HIV status

For all M-to-F transgender people, attention needed on interplay between ART and hormone therapy

▪ **STI Services** : Y

Recognition of STI needs specific to MSM / *Hijras* growing, but queries on anal STI missing from government HIV sentinel surveillance survey protocols

Medical professionals and STI clinics need training to investigate and treat anal and oral STI in an unbiased and professional manner

‘MSM and HIV’ - specific interventions in the National HIV Plan : Y (Contd.)

If “YES” :

▪ **Enabling environment : N**

Plan does recognize impact of discriminatory social environment on MSM / *Hijra* targeted interventions. But lacks concrete measures to effectuate legal reforms as demanded by NGOs and CBOs.

Plan should also facilitate provisions related to general health, education and income generation for MSM and *Hijras*

▪ **Community engagement and empowerment : Y**

New Plan (NACP-III) envisages a central role for community mobilization and CBOs in a phased manner in tackling HIV epidemic among MSM and *Hijras*

‘MSM and HIV’ - specific interventions in the National HIV Plan : Y. If “YES” :

▪ **[MSM] NGO/CBO HIV competencies strengthening : Y**

STI/HIV education, counselling skills, testing and treatment information; home based care for PLHIV, developing referral systems, condom and lubricants promotion, developing BCC strategies and material, advocacy skills

▪ **[MSM] NGO/CBO other competencies strengthening : Y**

Gender and sexuality education, community mobilization, organizational and programme development, fund raising, monitoring and evaluation, needs assessments, process documentation, income generation programmes, administrative and physical infrastructure, networking, drop-in centres

Note: The Plan may not explicitly state strengthening of all these competencies, but a few SACS and their partner technical assistance agencies have undertaken training on these issues on their own initiative. In most other states such support is completely missing

'MSM and HIV' - specific interventions in the National HIV Plan : **Y**. If "YES" :

These interventions are run by :

- **CBO : Y** : Most successful, longest running targeted interventions run by CBOs – Humsafar Trust, Lakshya Trust, Sahodaran, SWAM. In West Bengal, MANAS Bangla network runs one of the largest interventions in the country

- **NGO : Y** : Naz Foundation (India) Trust, SASO run some of the successful targeted interventions. All key posts in these interventions have MSM

Several other NGOs run composite interventions covering MSM / *Hijras*. Example: Chuwal Gram Vikas Trust

- **INGO : Y** : Perform mainly a capacity building role. Example: NFI

- **Local government : Y** : SACS: Funding and technical assistance role

- **National government : Y** : NACO: Policy development and funding role

- **Other : Y** : Non-government donors; networks and NGOs such as INFOSEM and SAATHII (as capacity builders); other NGOs working on gender and sexuality

‘MSM and HIV’ are part of the country’s scaling up towards universal access to prevention, treatment, care and support initiative : Y

- NACP-III aims to achieve coverage of 80% of MSM and *Hijra* populations by 2011 – with respective communities taking centre stage in this endeavour
- At least 10% of target interventions will have exclusive community ownership by 2011
- But what constitutes “universal access,” specifically for MSM / *Hijras* needs to be articulated in the national target setting
- An exhaustive list of requisite “prevention, care, support and treatment services” relevant to MSM / *Hijras* needs to be prepared

Additional Information and / or Comments :

- There is a strong need to consider *Hijras* separately from MSM because of their unique social and cultural status
- Many other M-to-F transgender people may have overlapping needs with *Hijras*. Yet operationally, experience of separate targeted interventions has been more successful
- This however does not discount importance of joint political advocacy by all sexual minorities
- Neither can it be presumed that there is a homogenous category: 'MSM'
- The diversity inherent in 'MSM' vis-à-vis gender / sexual identities and sexual behaviours deserves respect
- Services must be customized to suit needs of various sub-sections of MSM even within a single targeted intervention