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[CDE0422] Challenges of scaling up community led structural interventions for reducing HIV risk in female sex workers (FSW), men who have sex with men (MSM) and injecting drug users (IDU) in India

[MOAD0303] Sexual risk behavior and HIV prevalence among male-to-female transgendered people seeking voluntary counseling and testing services in Mumbai, India

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Background: The transgendered community in Mumbai, India is marginalized, lacks knowledge about HIV, lives in poverty and has minimal access to health care services. This study describes sociodemographics, risk behavior, sexually transmitted disease and HIV prevalence among 205 transgendered people accessing Voluntary counseling and testing services (VCT) at the Humsafar Trust in Mumbai.

Methods: All consenting transgendered people accessing VCT services received pretest counseling, a behavioral questionnaire and blood draw for VDRL and rapid HIV tests. They received posttest counseling before collecting their reports. Data was entered using Epi Info and analyzed using STATA software version 9.1. Data output included basic frequencies and Pearson's chi square test or Fischer's exact test for dichotomous outcomes.

Results: Mean age of transgendered people was 24.5 years, 77% (157/205) were not castrated and 67% (137/205) were educated up to secondary school or higher. 96.1% (197/205) had their first sexual encounter with a male, 49% had greater than 10 partners in the past 1 month and 85% preferred practicing receptive anal sex yet only 14.2% (29/205) perceived risk from HIV. VDRL and HIV prevalence among transgendered people was 25% (27/108) and 40% (80/200) respectively. 64% of transgendered people reported sex work as occupation and did not differ significantly from other transgenders by sexually transmitted diseases, VDRL and HIV prevalence ($p>0.05$). Transgendered people differed from other MSM, as they had lesser education, reported sex work as an occupation, had higher number of sexual partners, preferred male partners and had high prevalence of STIs and HIV ($p<0.05$).

Conclusions: Transgendered people accessing VCT services in Mumbai, India have high rates of STIs and HIV. They are in urgent need of HIV education, risk reduction counseling and culturally sensitive behavioral interventions to prevent HIV acquisition.

[MOPE0482] Male and transgender sex workers in Tamil Nadu, India: multiple partners, multiple partner types and unintended beneficiaries of other HIV prevention programs in a modest way

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Issues: Male and transgender sex workers (MTSW) are a subset of men who have sex with men (MSM). MTSWs transact sex as anal-receptive partners for cash or kind working either part or full time. There have been few interventions with MTSWs/MSMs and data on them are limited. The Tamil Nadu AIDS Initiative initiated HIV intervention preventions with 8,500 MTSWs in 14 districts of the southern Indian state of Tamil Nadu in April 2004. A round one behavioural survey was conducted to determine risk behaviour for programming and monitoring impact.

Description: Eight districts were mapped to develop a sampling frame of MSW congregation points. Probability proportional sampling was used to select congregation points. 912 participants consisting of 410 kothis (self-identified receptive anal partner in all acts), 228 doubledeckers (self-identified anal-receptive partner in sex work, and anal-insertive otherwise) and 274 transgenders were recruited using snowballing technique. After consent, a structured questionnaire was administered.

Lessons learned: 57% of the sample had commenced sex work by the age of 20, with 81% having had their sexual debut by age 16. Paid sex was the sole source of income for 26%. About 5% reported short term migration for sex work in other states, mainly Mumbai. At the district level, 47-53% had a regular male partner, 27-53% had other non-paying male partners, 10-20% had regular female partners. The average number of occasional clients entertained in a week was 12 to 17. 60% of sexual acts with occasional clients were anal. Reported condom use during last anal sex act was 17-50% with regular male partner, 54-85% with other non-paying male partners, and 70-81% with occasional clients.

Recommendations: While there have been few interventions with MTSWs in Tamil Nadu, the protection offered by condoms seems to be known in some areas. However more needs to be understood about the sexual networks of MTSWs.

[MOPE0582] High risk behaviors among HIV positive and negative men having sex with men (MSM) attending Mythri clinics in Andhra Pradesh, India

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Background: The data on the prevalence HIV and risk behaviors in men having sex with men (MSM) are not readily available to develop HIV intervention programs in India.

Objectives: The objective of the study was to determine risk behaviors and sexually transmitted infections among MSM with known sero-status attending Mythri clinics in Andhra Pradesh, India

Methods: A cross sectional retrospective study of 539 MSM attending Mythri Centers between July to December, 2005 was conducted in 10 intervention sites in Andhra Pradesh, India. Demographic, sexual and clinical data from MSM were collected by using male clinic Attendance form. The data were entered and analyzed using EPI info version 3.2.2 (CDC, USA).

Results: The overall prevalence of HIV in MSM was 18.2%. The rate of HIV was higher in men reporting receptive anal intercourse (35.5%) compared to men reporting anal-insertive (15.3%) and men reporting both insertive and receptive behavior (12.5%) of MSM (P=.003) The average number of sex partners within the last one-month in HIV positive MSMs was 3.4 compared to 5.3 in HIV negative (P=NS). Twenty five percent (25%) of HIV positive MSM practicing bisexual behavior Sexually Transmitted infections rates: Urethral discharge 36.5 vs. 26.5 and Ano-rectal discharge RD 9.6 vs. 5.0, were higher in HIV negative MSMs compared to HIV positive MSMs.(P=0.01). Mean duration of symptoms was significantly longer (21 days) in HIV negative clinic attendees compared to HIV positive MSM. (8days) (P=0.004). Twenty nine percent of HIV positive MSM reported consistent condom use with male partners.

Conclusions: The rate of HIV in MSM in our study clearly indicates the need for implementation of positive prevention program. MSM interventions should also enhance efforts to target their partners including women to reduce the vulnerability to STIs and HIV.

[MOPE0788] Estimating numbers and researching practices of men who have sex with men: participatory mapping and site assessment as part of the Indian AIDS Initiative (Avahan)

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Background: Although men who have sex with men (MSM) are recognised as significant to HIV epidemic dynamics in India, there are few HIV prevention services designed to meet their needs. This is partly because the extent of male-to-male sexual practices in urban and rural areas is grossly underestimated.

Methods: Participatory site assessment was carried out in a rural district in Karnataka State in India. As part of the Bill and Melinda Gates Foundation supported Avahan Initiative, 28 local MSM and transgenders were recruited and trained to carry out the assessment by PATH, with support from local NGOs and MSM networks. The MSM assessment teams used participatory methods to estimate numbers of self-identified MSM, mapped hotspots, identified patterns of mobility and explored existing and potential HIV interventions. The methods used in the assessment also gave an opportunity for interpersonal communication with
participants about risk reduction. Information was analysed and fed back to the NGOs to inform the design of a new MSM HIV program in the district.

Results: Over 1000 MSM participated in the assessment overall. 146 hotspots were identified as being frequented by an estimated 7,000 self-identified MSM and transgenders. Profiles showed that non self-identified MSM came from all social and occupational backgrounds. The assessment also showed that specific sexual practices, stigma and police violence made MSM particularly vulnerable to HIV. Few HIV/AIDS interventions were found to exist for MSM in the District.

Conclusions: Peers can easily identify MSM and elicit their trust, generating in-depth information for site assessment. Participatory methods are effective in estimating numbers of self-identified MSM, but number estimation of non self-identified MSM is still problematic. Peer-led participatory interventions can successfully mobilise MSM, but they must be followed up without delay with other activities to avoid losing the momentum generated.

[WEPE0643] Globalisation, AIDS and the politics of sexual identity in India

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Issues: Homosexuality remains criminalised in India according to an anti-sodomy law instituted in 1860. Gays/lesbians and other sexually minority groups thus remain unreached by HIV prevention and care programmes. Sexually minority groups are now being mobilised and challenging constitutional validity of discriminatory laws before the Court. Sexual identity politics is an emerging grassroots politics that constitute an integral part of HIV prevention programmes.

Description: This research project is being carried out at the Department of Political Science, University of Hawaii at Manoa with funding support from the East-West Center Education Program. Broadly based on published literature and secondary data with some field investigation, this paper aims to capture multiple meanings, policy implications, cultural values and indigenous resistance associated with emerging politics of sexual identity in a sexually conservative society.

Lessons learned: Sexual identity politics still remain a class-based bourgeois obsession mostly confined in urban India. Those having homosexual behaviour in rural areas do not identify themselves as gay/lesbian. Globalisation, structural adjustment and transnational advocacy networks have important positive effects on horizontal mobilisation and identity politics of sexually minority groups. A totalising gay/lesbian identity can not be applied to those who do not identify themselves as gay/lesbian. Cultural resistance to accept sexual identity based categories is evident in the formulation of national laws and policies.

Recommendations: Homosexuality must be decriminalised and anti-sodomy laws criminalising such behaviour must be repealed. Efforts should be made to preserve indigenous sexual minority groups and cultures rather than mobilising them to evolve into a globalised gay/lesbian sexual identity category. Global networking and activism thus removes local differences and diversities and becomes self-defeating to the politics of identity. Though decriminalising homosexuality may help in HIV prevention, it may not help reduce stigma and discrimination against sexually minorities in India.

[WEPE0727] Spirituality, culture and sexuality: an ethnographic study of the use of mystico-erotic rituals as a means of expression of same sex relationship between men in Andhra Pradesh, India

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Issues: The expression of same sex relationship between men, within the sanction of spirituality and religious practices

Description: “Shiva Shakti” is a religious sect; majority of members being males, who believe that they are “wives” of the Hindu god - Shiva. Every year around 30,000 Shiv-Shakti followers gather in designated temples to get ritually married to lord Shiva. During the three-day nuptial festival, most Shiva-Shakti men dress up and conduct themselves as women (often with the support of their wives, since it is considered sacred). Also during these festivals, around 50,000 MSM and trans-gender persons descend to these temple towns and engage in sex. Many male Shiva-Shakti men, while engaging in rituals during the day, engage in sex with men at night. During these festivals, NGOs supported by the International HIV/AIDS Alliance organize AIDS awareness events, STI treatment camps, counselling sessions and distribute condoms and IEC materials.

Lessons learned:
1. Within a social environment of stigma and discrimination and a legal context that criminalizes homosexuality in India, the Shiva-Shakti sect and its annual mystico-erotic rituals provide a socially accepted space/outlet for the expression of homosexuality - including cross dressing.
2. Under these circumstances, sexual activity associated with alcohol consumption tends to be extremely indiscriminate, and given that many MSMs are also married, such circumstances act as major trigger points for the transmission of the epidemic,
3. Events of this nature present very good opportunity to organize effective HIV/AIDS prevention activities.

Recommendations:
1. Undertake mapping and risk profiling of such festivals
2. Partner with the temple authorities to organize health camps (including STI treatment), distribute condom and lube and generate awareness through the use of local popular media like street theatre and folk performances and
3. Undertake sensitive ethnographic documentation and dissemination of such religious practices, in order to reduce stigma around homosexuality in India.

[WEPE0736] Sociodemographics, sexual risk behavior and HIV among men who have sex with men attending voluntary counseling and testing services in Mumbai, India

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Background: The current study was designed to assess the HIV burden in Men who have sex with men (MSM) who sought voluntary counseling and testing (VCT) at the Humsafar Trust in Mumbai, India and to describe their sociodemographics, and sexual risk behavior patterns as well as presence of concomitant STI symptoms, all of which may become important in amplifying the growing Indian HIV epidemic.

Methods: 831 MSM attending VCT services answered a behavioral questionnaire and consented for VDRL and HIV testing from January 2003 through December 2004. Data was entered using Epi Info and analyzed using STATA 9.1 software. Bivariate analyses was performed for socio-demographics, sexual risk behavior and STIs with HIV result as an outcome. Multivariate logistic regression was performed using significant predictor variables from bivariate analysis.

Results: The mean age of MSM accessing VCT services was 24.8 years; 22.7% were married to a woman; 56.7% preferred male sexual partners and 23.9% preferred both males and females as partners. HIV prevalence among MSM was 12.5%. Multivariate analyses showed the following factors to be associated with HIV infection: being illiterate (AOR 2.28; 95% CI 1.08 - 4.84), married to woman (AOR 2.70; 95% CI 1.56 - 4.76) preferring only male partners (AOR 4.68; 95% CI 1.90 - 11.51) or being bisexual (AOR
2.73; 95% CI 1.03 - 7.23), presenting with an STI (AOR 3.31; 95% CI 1.96 - 5.61) or presenting with reactive VDRL test (AOR 4.92; 95% CI 2.55 - 9.53) on VCT visit.

Conclusions: MSM accessing VCT services in Mumbai have a high risk of being HIV-infected and bisexuality was common. Bisexual MSM may form a bridge population for HIV transmission from high-risk men to their wives or female partners. Interventions that target sexual risk behavior and STI prevention among MSM and bridge population of bisexual men are urgently needed.

[EPE0740] Disclosure of HIV status by HIV-positive men who have sex with men (MSM) to their sexual partners: implications for counseling practices and intervention design

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Background: Disclosure of HIV status may have important implications for HIV prevention. The purpose of this qualitative investigation was to explore secondary HIV prevention needs among HIV-positive men who have sex with men (MSM) in Chennai, India, with a focus on perspectives and contexts regarding disclosure of HIV status.

Methods: In-depth interviews were conducted with 10 HIV-positive Kothi-identified MSM (including married MSM) and three key informant community experts. Participants were recruited using respondent-driven/purposive sampling. All transcribed/translated interviews were subjected to narrative thematic analysis using a method of constant comparison.

Results: Findings emerged in four categories, illustrating the complex relationship between HIV status disclosure and safer sex: 1) Nondisclosure and unprotected sex: a married MSM couldn't rationalize condom use with his wife who had already undergone tubectomy as he feared revealing his HIV status; fear of physical violence prevented MSM from disclosing to policemen and ruffians who had forced sex with them;
2) Nondisclosure and protected sex: persuading casual/paying male partners to use condoms or avoid unprotected anal sex, without disclosure of serostatus; and "sex happens in night" and she "does not look down" enabled a married MSM to use condoms with his wife; 3) Disclosure and protected sex: steady partners of some participants used condoms after disclosure; and 4) Disclosure and unprotected sex: casual partners of some MSM disbelieved the disclosure and insisted on unprotected sex; continuing to have unprotected sex with a steady male partner since the partner may have already been infected with HIV.

Conclusions: Disclosure is not unilaterally associated with protected sex; and non-disclosure may lead to protected or unprotected sex in different contexts. Counsellors need to explore strategies to address various contextual factors that present obstacles to safer sex among HIV-positive MSM. Interventions must also address structural barriers to practising safer sex among HIV-positive MSM.

[WEPE0745] Strategies for reducing Hijra vulnerability to HIV/AIDS in West Bengal, India

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Issues: In West Bengal, India, general perception about *Hijras* is that they are sexually challenged and do not have any sexual life. Government bodies and NGOs are unaware that most *Hijras* are male-to-female transgenders who are sexually active and often participate in anal intercourse, mostly as receptive partners. Some *Hijras* depend on sex work for their livelihood. Stigma against *Hijras* and poor understanding about their sexual behaviours has led to *Hijras* being left out of HIV/AIDS programmes in West Bengal.

Description: MANAS Bangla, a network of seven CBOs of MSM and transgenders in West Bengal, has been working with *Hijra* communities since 2004. The *Hijras* have a sub-culture, hierarchy, language and music of their own, and are often skeptical of the outside world. They are reluctant to disclose their sexual lives in order to maintain a unique status, which makes it difficult to provide them with sexual health services. Regular visits by outreach staff to *Hijra khols* (residences) gradually broke the ice, and
seven *Hijra* peer educators were appointed in MANAS Bangla's STI/HIV/AIDS intervention programme. Today two drop-in-centres are running from *Hijra khols*, where FGDs are being conducted along with distribution of condoms, lubes and safer sex literature.

Lessons learned: *Hijra* involvement has enhanced the knowledge base and reach of MANAS Bangla's intervention. It has reduced distrust about MANAS Bangla's objectives among *Hijras*. There is immediate need for government bodies, donors and other NGOs to appreciate *Hijra* concerns by meaningfully involving them in HIV/AIDS and other development initiatives.

Recommendations: MANAS Bangla needs support to reach out to at least 100 *Hijra khols* all over West Bengal. There is strong need for development of BCC material specific to *Hijras*, and to train and employ more *Hijras* in HIV/AIDS initiatives as outreach workers and public speakers. Their potential as AIDS cultural activists also needs exploration.

[WEPE0766] Understanding socio cultural context of counseling MSM: addressing dual realities

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Issues: Counseling MSM (Men who have Sex with Men) is often seen as a specialized area in counseling.Counseling MSM in a heterosexist society puts demand on the counselors to understand the dual lives MSM lead. The duality of a heterosexual façade coupled with an inner world of same sex attractions often predispose MSM to risky behaviour and psychosocial trauma.

Description: Analysing data from 50 documented cases an ice berg model of the MSM dual life is proposed. This model attempts to explain the stains and stress faced by MSM. The ice berg model highlights pressures faced by MSM to confirm to heterosexist norms and also the often secretive life of MSM and the interface of these two worlds. Issues regarding cultual sensitive intervention are discussed.

Lessons learned: It is important for practitioners to realise that HIV interventions with MSM population have to acknowledge the pressures of heterocentric compulsions on MSM as well as a need for MSM to accept their identity and their effect on risk behavior.

Recommendations: Health care providers have to acknowledge the dual realities of MSM and incorporate them in all MSM intervention.

[WEPE0848] Risk awareness and condom use for HIV prevention among Hijras in Pune and Mumbai, India

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Background: Hijra is an umbrella term for individuals with a wide range of cross-gender characteristics associated with transgender features, typically biological males with a female gender lifestyle. Hijras cross-dress and some have a history of ritualistic castration, though not all hijras are castrated, and very few are hermaphrodites. Many hijras earn their livelihood from sex work, imposing risk of contracting HIV infection and AIDS. Our study examined awareness of risk and risk-related behaviour for HIV/AIDS.

Methods: In-depth interviews of 40 hijras were conducted (Pune-17, Mumbai-23), identified through snowball sampling to identify respondents willing to participate.

Results: Most respondents were castrated 22 (55%); about half (52.5%) reported facing violence and 24 (60%) were engaged in sex work for their livelihood. Most were aware of the sexual mode of HIV transmission (33, 83%), and 28 (70%) indicated particular concerns about HIV/AIDS. Of the 22 (55%) respondents under 31(mean age) years-of-age, 86% and of the 25 (63%) who used condoms, 88% indicated their concern about HIV/AIDS. Respondent engaged in sex work reported the use of condoms
(21, 88%), however 17 (71%) sex workers, and 18 (72%) condom users also reported that they were victims of violence. Most sex workers (16, 67%) were also under 31 years-of-age. Of the 16 hijras, not engaged in sex work, 12 (75%) reported no use of condom.

Conclusions: Members of the hijra community recognise the risk of HIV transmission through sexual contact and condom use as a preventive method. Yet, the amount of violence they face limits their power to decide on using condoms which in turn interferes with implementing recommended practices of public health prevention campaigns. Education and communication require attention to the context in which recommended behaviours are to be implemented if they are to be effective for vulnerable populations. Without that, recommending condom use is an inadequate intervention.

[WEPE0849] Male sex workers in Mumbai, India: an un-acknowledged bridge population?

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Issues: In India, numerous prevention programs have targeted female sex workers, but little effort has been directed toward male sex workers (MSW) whose existence is not widely acknowledged.

Description: To better understand this population prior to a larger survey, we performed a qualitative evaluation of MSWs using focus group discussions (FGD). Groups were comprised of 6-10 MSWs recruited through peer outreach. Participants were grouped according to how much they charged clients (high end: > Rs/2500 (55 USD); mid: Rs/250-2500; low end: Rs/20-250). Reasons for sex work, solicitation of clients, sexual behavior, condom use, perceived HIV risk, and service needs were addressed.
FGD were recorded, transcribed, and translated.

Lessons learned: Age range was 18 - 35 yrs; about half lived with their families. Most high-end MSWs also held steady jobs at call centers, as gym assistants, film extras or were students. Reasons for high-end sex work included having a “flashier” lifestyle, companionship, and moving-up professionally. Low income MSWs had irregular employment and used sex work to meet basic needs. Although virtually all their clients were male, most MSWs did not identify as “gay”, and some were married or had girlfriends. Client access was often obtained through agents or pimps. Other MSWs used the internet, friends, or cruised five-star hotels, night clubs or public places such as toilets. Overall, MSWs had reasonable knowledge of safe sex; many reported insisting on condoms with paying clients, but not with nonpaying or steady partners. Primary concerns were less about health and HIV than safety, police harassment, and failure to be paid.

Recommendations: MSW from many strata of society can easily be recruited in Mumbai and evaluation of a larger representative sample is needed. These men may act as a “bridge” between behaviorally heterosexual and homosexual populations. Prevention, VCT, and STI services need to be more easily accessible.

[THKC103] Development of an ethical committee for a community based organization in Mumbai, India

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Issues: Community based NGOs are positioned to collect in-depth and important public health information, particularly on vulnerable, invisible and difficult to reach populations. Gay, lesbian and transgender people are profoundly stigmatized in many parts of the developing world and they remain at high risk for HIV acquisition and transmission. In Mumbai, India a community based organization was unable to engage in data collection or participator research because it had no Institutional Review Board and no academic or medical institution that would collaborate with them.

Description: Collaborative exploration of barriers to research development, community based training, information sharing with sympathetic and concerned local scientists, researchers and community members.

Lessons learned: Ethical considerations vary from country to country and have various cultural implications. Developing an ethical committee was identified as being a remedy for addressing research development needs in this highly impacted community. Community members with appropriate skill sets were identified and trained in a participatory process and have created a functioning ethical committee.

Recommendations: Development of independent non-academic ethical committees should be considered on an individual situation bases. For successful capacity building there must be a focus on training participants of ethical committees in developing country to incorporate both multiple international ethical doctrine as well as local ethical guidelines. Additionally, it is necessary to create a framework that includes local interpretation of basic elements of western ethical guidelines like autonomy of individuals versus autonomy of communities in developing countries. Establishing ethical committees can be a tool used for building capacity that could evolve into sustainable international collaborations while simultaneously facilitating in-country accountability. With international development aiming for community responsibility and cross collaboration and train, ethical committee development is a useful tool for long term sustainability.

[THPE0272] Evidence based rapid scaling up of interventions with men who have ex with men (MSM) and trans-gender (TG) persons in Andhra Pradesh: lessons learnt from the international HIV/AIDS alliance's program in Andhra Pradesh, India

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Issues: It is estimated that around 31% of the sexual encounters between MSM in Andhra Pradesh include anal sex, out of which only 44 % are protected We present a model for rapid scaling up of interventions among MSM and TG populations.

Description: Alliance's intervention among MSM and TG in Andhra Pradesh (supported by the Bill and Melinda Gates Foundation) focuses on provision of sexual health services that are designed and implemented through the leadership of MSM representatives. Since inception in mid 2004, the program has reached out to over 120,74 MSM who are accessing 55 clinics and drop-in centres in 13 districts. So far, 4,423 STIs syndromes have been treated, 1,709 HIV positive MSM provided with essential AIDS care and around 20,00,000 condoms distributed. 14 community based organizations (CBO) of MSMs/TGs have been formed. 114 MSM representatives have taken up program management positions.

Lessons learned: Despite high levels of stigma and discrimination around homosexuality (including its criminalization by law), the program has succeeded in mobilizing a large population of MSM and promoted health seeking behaviours. The reasons attributed to this success are that the program has used participatory approaches to first enable community representatives to map MSM networks, analyse their needs and subsequently design and lead in the implementation of the services

Recommendations: 1. Using participatory approaches to mapping the problem and then designing the program is extremely critical to ensure involvement of MSMs right from the beginning of the project planning cycle. 2. Facilitating and building capacities of CBOs is critical for community mobilization and social capital building and finally on promoting safer sex. 3. Programmatically, it is important to place MSM representatives in program management and decision making positions and 4. Finally program services (clinics / drop-in centres) need to be selected and managed by MSM representatives themselves.

[THPE0273] Double stigma: discrimination and violence amongst female sex workers and men-who-have-sex-with-men in Andhra Pradesh, India

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Background: In 2003 there were 5.1 million HIV-infected individuals in India. Female sex workers (FSWs) and men who have sex with men (MSM) are populations that India cannot ignore in preventing the spread of HIV. About 1.1% of adult women are engaged in sex work and estimates of homosexual behaviour in the population range between 4-11%. Whilst anecdotal evidence points to stigma as a barrier to mobilizing and empowering these populations to prevent the spread of HIV, little empirical evidence exists on the nature and extent of stigma. Most imperfectly understood is the programmatic response needed to reduce stigma.

Methods: 64 in-depth interviews and 32 focus group discussions were undertaken with FSWs and MSM in 8 sites in Andhra Pradesh. Respondents were randomly selected with assistance from NGOs and key population informants from sites. Strict ethical procedures were followed. Transcripts were translated, transcribed and entered into Atlasti.

Results: Perpetrators of stigma, discrimination and violence for both FSWs and MSM include family, peers, police, clients and health workers. They face double or even triple stigma because of their gendered status, identity or occupation and often low caste status. Whilst there are differences between FSWs and MSM in experiences and means of coping, there are also similarities: both are powerless, marginalized and hidden. Both deal with feelings of rejection, degradation, isolation, loss of self-esteem and fear. They are stigmatized because they are poor, low caste, are the locus for enacting gender and masculinity norms, engage in deviant sexual behaviour and are seen as transmitters of infections. Differences and jealousies also exist
amongst key populations which can hinder the effectiveness of peer support groups.

Conclusions: Empowerment processes are key in promoting self-confidence and self-esteem amongst FSWs and MSM. A supportive enabling environment is also central in assisting key populations cope with stigma, discrimination and violence.

[THPE0314] Clients and families of female sex workers and men-who-have-sex-with-men: their potential role in prevention efforts in India

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Background: Though still a relatively low prevalence country - 0.91% amongst the adult population - India is second only to South Africa in absolute numbers: in 2003, 5.1 million people were HIV-infected. There is growing recognition of the need to focus prevention efforts on populations that are key to the epidemic, i.e. those that are more vulnerable to infection and onward transmission. These include female sex workers (FSWs), men-who-have-sex-with-men (MSM) and clients of sex workers.

Methods: In-depth interviews (64) and focus group discussions (32) were undertaken with FSWs and MSM in 8 sites in Andhra Pradesh. Respondents were randomly selected with assistance from NGOs and key population informants from sites. Strict ethical procedures were followed. Transcripts were translated, transcribed and entered into Atlasti.

Results: Findings show that FSWs and MSM face high levels of stigma, discrimination and violence from clients. This leads, amongst other things, to the inability to negotiate safe sex. Peers and support groups work together to deal with violent clients but effects are limited; street based sex workers and MSM working alone report the worst experiences from clients. Families are also perpetrators of stigma, discrimination and violence but they can also be sources of support; evidence shows that when FSWs and MSM disclose their identify/occupation to their family, a supportive family leads to increased levels of confidence and self-esteem which can translate into improved ability to negotiate safe sex.

Conclusions: HIV prevention programs in India have focused on sex workers to the neglect of clients - they are perpetrators of violence, stigma and discrimination and are a bridge between sex workers and the general population. This hidden population of clients could make a significant difference to prevention and care programs in future. Family focused programs are also key, since a supportive family environment can act as a springboard into the community.

[THPE0450] Experiences from MANAS Bangladesh

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Issues: Gender Identities, Sexuality Identities, Sexual Behaviour, Vulnerabilities, De-Stigmatisation and Issues of Mainstreaming.

Description: MANAS Bangla, MSM Action Network for Advocacy at Social level in Bengal, is the first MSM Network Intervention Project in South Asia working on Marginalised Males due to Gender, Sexuality and Sexual Behaviour. MANAS is spread in the whole state of West Bengal in India. It cuts across the urban elite class of the metropolis to the grass root people in villages practicing male to male sexual behaviour. The population reach covers ´kotis´ (or ´effeminate´ males), the ´hijras´ (or eunuchs), the ´duplis´ (or gay versatile) and the Pariks (or the ´real men´). Professional Male Sex Workers are found in each of the subgroup.

Lessons learned: As the population is highly diverse and dispersed it is found that separate strategy should be worked for ´visible´ and ´invisible´ population. Network based outreach requires to be emphasised rather than only cruising site based. Within this Sexuality spectrum the Marginalised Gender requires to be seen in the light vulnerability and risk of infection. It has been generally found that :- Drop-In space is very significant to ´kotis´, ´hijras´ like coming in the Drop-In space but is very secretive of their sexual life in public, ´duplis´ take the clinical service with the strictest confidentiality, ´pariks´ take services but are not involved in
rights and harassment issues.

Recommendations: The ´gaps´ between the different subgroups and gender inequalities according to sexual roles played requires to be addressed through basic knowledge dissemination of Sex, Gender, Sexuality and Sexual Behaviour. Inter Personal Communication and Community made Open Plays are to be stressed as tool for working as a change agent in de-stigmatisation and mainstreaming. Creation of other ´spaces´ of life is required to empower and mainstream the marginalised males.

[THPE0469] Vulnerability of men who have sex with men to HIV and AIDS in Tamil Nadu, India

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Background: This study was conducted to determine the prevalence of risk behavior among men having sex with men (MSM).

Methods: Using a structured interview schedule, the data regarding the knowledge on HIV/AIDS, sexual behaviour, risk perception and health seeking behaviour of the MSM was collected from a clustered sample of 300 between the age of 18-50 in 2004.

Results: Knowledge on the prevention of HIV/AIDS is 98.7%. 21.3% report sexual intercourse with female non-regular partners and 9.4 % of them have used condoms in the last encounter. 74% reported having engaged in anal sex. Condom use with male non-commercial sex partners is 78.9% and 81.8% with paid partners. Reported prevalence of urethritis is 7.3% and 86.4% received treatment from qualified doctors. The perception of risk among the non-users of condoms is 33.3%.

Conclusions: While knowledge on prevention is high, condom use remains poor. This could be explained by poor perception of the risk of infection. Prevention programmes need to increase the reach and focus on increasing risk perception, changing attitudes toward condoms and reducing unprotected penetrative sex.

[THPE0478] Challenges in establishing clinical services for MSM in an urban setting in Bangalore, southern India

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Issues: Although MSM are vulnerable to STI/HIV infection, STI/HIV prevention and treatment services are often not perceived as a priority. Ensuring equitable distribution, access and uptake of such services in an urban setting in Bangalore, southern India is a challenge.

Description: Community consultations with MSM were conducted to discuss service issues such as location, periodicity, working hours, preferred gender of health care providers, and the range of service beneficiaries (MSM, their partners, family members,etc.) with funding from the Bill and Melinda Gates Foundation's India AIDS initiative (Avahan). A clinic monitoring committee was established to assess client satisfaction. The clinic services included: clinical consultations, counselling, treatment for STIs and other common illnesses, and prevention education. MSM working as peer educators and outreach workers received training on STI/HIV prevention and care. They in turn motivated other MSM to avail themselves of services. MSM were employed in certain clinic operations to enhance comfort levels for service users.

Lessons learned: 300 community members attended the clinic within the first four months. 32% of the kothis (effeminate men) and 17% of the hijras (male to female transgenders) were diagnosed with a STI, of which 56%, 34% and 4% were due to urethral discharge, anorectal discharge and genital ulcers respectively. The clinic located in the drop-in centre was perceived as a safe space to receive treatment, without fear of stigmatization. Provision of regular monthly check ups, even if clients were asymptomatic, further increased the user-friendliness of the clinic. Clients who utilized clinical services shared their experience with non-users, resulting in increased uptake of services.

Recommendations: Successful establishment of STI/HIV-related clinical services for this vulnerable and difficult to reach population must include community consultation from the outset. Building the capacity of community members to enable them to take lead roles in establishing and running services contributed to increased service utilization.

[THPE0566] Mapping of key population female sex workers (FSWs) and men having sex with men (MSM) in 8 districts of Andhra Pradesh – a quantitative and qualitative analysis

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Background: HIV prevalence has been showing a steady increase in the State of Andhra Pradesh, India and it is important to ensure saturation of coverage of vulnerable - Key Population (KP) groups with HIV/STI prevention and control services. This requires a comprehensive mapping of the distribution of KP groups such as sex workers - FSW, MSM and PLHA as well as the sexual networks associated with the KP groups.

Methods: The study used a snowball method, which included key informants interviews at District and the sub-district levels, detailed interviews with KP representatives, observation and triangulation, mapping of health care services, condom outlets and other service providers. The study covered 8 districts over a 6-month period. In all 11601 key informants were interviewed at the district level. Mandals have been grouped as high and medium risk, 507 key informants were contacted at the mandal level. In addition 69 Focus Group Discussions (FGDs) were conducted. In addition to the FGDs, 65 in depth interviews were conducted
which included all the key population.

Results: From a programming perspective, the study has identified 293 new hotspots and sites for intervention, 18 potential NGOs that can be involved in program implementation and around 54,000 sex workers, MSM and their sexual networks. These data was aimed at development of program aimed at achieving district-wide saturated coverage.

Conclusions:
1. Scaling up of HIV/AIDS programs require the basic evidence and a good understanding of the characteristics of the key
population groups such as sex workers and MSM.
2. Evidence based programming includes proper mapping of the distribution of Key Population group, as well as mapping of their sexual networks and mobility patterns.
3. In addition to mapping the KP groups, the study has also established a robust methodology of rapid mapping, that involves representatives of key population groups as researchers and resource persons.

[THPE0668] HIV and domestic violence in the MSM domain

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Issues: 'Koti', a self defined term, is a feminine construction of gender identity and the feminine identity of 'koti' is a reflection of both the effeminate demeanor of these men and the stereotypical feminine gender roles. 'Giriya' is a term given by 'kotis' to their partners and they are considered as masculine because they are non-feminine and macho in demeanor. In a 'koti-giriya' relationship, 'giriyas' are often guardians, breadwinners and hand over their salaries to their 'kotis' partners.

Description: Further exploring this relationship 'control and power' emerges as important characteristics. 'Giriyas' inflict violence on 'kotis' in the domestic setting of their relationship in various ways such as physical violence, control, emotional and sexual violence. The restrictions on partner by 'koti' can be well explained by understanding the prevalent fluid relationship among the 'kotis' and 'giriyas'. This fluid relationship creates anxieties in the relationship resulting in possessiveness, which manifests in the form of violence. 'Giriyas' have sex with 'kotis' when he is not willing, refuse to wear condoms despite request from 'kotis' and
even force 'kotis' to have sex with his friends and that too without condoms. These kinds of sexual violence perpetuate the spread of HIV among MSM and also possess risks for female partners of these MSMs.

Lessons learned: The 'koti' community needs to understand that violence in any form is not equivalent to masculinity but reinforces the regressive patriarchal values. The negotiation skills imparted to 'kotis' and also working closely with 'giriyas' has helped a lot in sensitizing them towards the issues and linkages of violence and HIV/AIDS.

Recommendations: In our intervention program, we have created a safe and separate space for both "koti" and "giriya" communities. There are open discussions on issues related to sexuality, violence and HIV/AIDS. The trainings on negotiation skills and condom usage are regularly imparted.

[CDC0323] The unknown factor in HIV prevention programming: clients of female sex worker (FSW), male and transgender sex workers (MTSW) and their risk behaviour, attitudes and influence over sex workers

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Issues: Clients of female SW (CFSW), and clients of male and transgender sex workers (CMTSW) are little understood. However they can act as an important barrier to safe sex adoption by FSWs/MTSWs. Tamil Nadu AIDS Initiative (TAI) under the India AIDS Initiative (Avahan) of the Bill and Melinda Gates Foundation initiated prevention programs in April 2004 with around 24,000 FSWs and 8500 MTSWs in the Indian state of Tamil Nadu. A Round 1 behavioral survey of CFSW and CMTSW was done to determine risk behaviour, attitudes and influence over SWs for programming and monitoring impact.

Description: Eight districts were mapped to develop a sampling frame of FSW and MTSW congregation points. Probability proportional sampling was used to select congregation points. Key informants identified clients in the congregation points, who were then requested to participate in the survey. Refusal rates were 5% for CFSW and 3% for CMTSW. 1500 CFSW and 567 CMTSW respectively were recruited. After consent, a structured questionnaire was administered.

Lessons learned: Average client ages were 29-32 (CFSW), and 25-30 (CMTSW) years. 43-57% (CFSW) and 22-44% (CMTSW) were living with a spouse or live in partner. By district / region, 90-99% (CMTSW, CFSW) were residents of the respective district / region; 1.6-49.4% (CFSW) and 26.8-48.4% (CMTSW) had non-paying, casual female partners; 0.8-22.1% (CFSW) had had paid sex with a MTSW; 49-73.9% (CMTSW) had had paid sex with a FSW; 16-87% (CFSW) and 53-77% (CMTSW) had had 1 to 3 penetrative paid sex encounters in the last one month; 78-97% (CFSW) and 79-81% (CMTSW) reported condom use during last penetrative paid encounter but this drops to 47% (CFSW, non-paying female partner) and 62% (CMTSW, non-paying male partner).

Recommendations: There is a high degree of variation in behaviour across CFSWs/CMTSWs across districts. There might be significant intersection between MTSW and FSWs networks via CMTSWs.

[CDC0621] Sexual behaviours and STIs among male sex workers in Mumbai, India

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Background: Male sex workers have recently been recognised as an important risk group for STIs and HIV. There are few such studies describe the behavioural patterns and STIs among this population in India.

Methods: The Dept of Dermatology, LTMM College, Mumbai, collaborates with the Humsafar Trust to provide STI services and HIV counselling and testing facilities to MSM and Transgenders. We present the sexual behaviours, STIs and HIV among those reporting sex work.

Results: A total of 75 individuals, 24 males and 51 transgenders reported sex work in our clinic. The overall HIV infection was 33% (14% among males vs. 41% among transgenders, p=0.04). The overall STI infection was 47% (42% among males vs. 49% among transgenders, p=0.5). All the individuals reported anal sex (87% anal receptive sex and 13% anal insertive sex). Oral sex was reported by 82% of them. About 39% of them reported always using a condom and 21% never using a condom during anal sex. Syphilis was the most common STI - 28%, followed by HSV - 27% and HbsAg - 9%. HIV infection was common in syphilis (48% Males vs. 28% TG) and HbsAg (43%Males vs. 32%TG). Although the association was not statistically significant, we adjusted for gender and found no interaction with it. The adjusted OR for STIs was 1.3 (0.5-3.5) and for syphilis was 2.2 (0.7-6.4).

Conclusions: The male sex workers have high-risk behaviours, low consistent condom use and high STI and HIV infections. Although males had relatively lower HIV infection compared with transgenders, they do have similar STI infection. Thus, these groups should be the focus of intensive behavioural intervention - safe sex & condom use, STI prevention and care programmes.

[CDC0830] Intervention with sex workers, street based sex workers and MSMS in Jagitial and Metpalli: a success story of the rights based approach under the frontiers prevention program (FPP) in Andhra Pradesh, India

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Issues: HIV/AIDS prevention among key populations (KP) such as sex workers, MSM and PLHAs through Community Led Structural Interventions:

Description: Since mid 2004 “REACH” – a local NGO has been implementing a HIV/AIDS intervention supported by the International HIV/AIDS Alliance in Jagatial and Metpalli blocks. The interventions started with social capital building followed by provision of clinical services. The local NGO has taken a proactive role in empowering the community and placing the community in positions of decision making. 714 sex workers, 503 MSM and 210 PLHAs have been covered; 1,208 STIs treated; 2,60,700 condoms distributed; and a network for the caste based sex workers’ set up and a CBO of MSM registered. The KPs are being empowered to negotiate with different bodies of control and spaces have been created within the NGO in order to bring community perspective into the policy and decision making levels.

Lessons learned: Reliance on and a genuine partnership with the KP groups has raised the confidence and self esteem of KP members. This has enhanced community ownership, translating into high levels of community outreach, condom distribution and STI treatment. Community mobilization, empowerment and the creation of enabling environments are therefore essential prerequisites for risk reduction.

Recommendations:
1. The first step in the project cycle needs to include a Participatory Site Assessment (PSA) process that will involve members of the KPs in collecting, analyzing and sharing information, thereby creating a basis for design and implementation.
2. Subsequently, it is important to create physical and social spaces for KPs to meet, bond, discuss their problems and possible
solutions and then and build capacities of KPs to influence the environment.
3. Finally it is important to facilitate the formation of collectives, built capacities on occupation skills and induct community representatives as staff members at supervisory and decision making levels.

[CDC0845] Intervention with sex workers and MSM in Khammam - Andhra Pradesh: a success story of the rights based approach

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Issues: Building social capital, transferring governance to the communities and engendering the rights-based approach to the AIDS response

Description: Since mid 2004 “Jagruthi” – a local NGO has been implementing a HIV/AIDS intervention supported by the International HIV/AIDS Alliance in Khammam district of Andhra Pradesh and funded by the Bill and Melinda Gates Foundation. Community mobilization and collectivization was initiated by a team of 9 sex workers and 3 MSM peer outreach staff with Jagruthi taking a proactive role in building capacities of KP representatives. 1564 sex workers and 644 MSM have been reached out with
services; 1298 STIs treated; 5,30,525 condoms distributed; and two CBOs of sex workers formed. Sexual networks of secret sex workers has been mapped.

Lessons learned: Reliance on and a genuine partnership with the community has raised the confidence and self esteem of many community members. The NGO leadership has consciously encouraged the community articulate its priorities, be assertive and lead in program management - embodying the rights based approach. This has enhanced community ownership, translating into high levels of community outreach, condom distribution and STI treatment. Further, the formation of CBOs have led to a very high level of use of project services and improved health seeking behaviours

Recommendations:
1. It is important to do a participatory mapping of the sex worker and MSM network through a process that allows the key population (KP) groups to map their distribution, analyse their problems and discuss possible solutions.
2. The roll out of services has to go in conjunction with a process of community mobilization and social capital building that is built on community led structural interventions (CLSI).
3. The package of CLSI needs to include placing KP representatives in positions of decision making (within the NGO) and building capacities of KP representatives.

[CDC0861] Socio-demographic characteristics of male sex workers (MSW) in Mumbai, India

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Background: Thre are many reports on female sex workers, but few studies on interventions for male sex workers. We report the socio-demographic characteristics of individuals who attended a clinic for MSM in Mumbai, India.

Methods: The Humsafar Trust provides clinical services and HIV counselling and testing services to MSM and transgenders in Mumbai. The Dept of Dermatology (LTMM College), one of the collaborating departments provides clinical services to these individuals. We analysed the socio-demographic characteristics of the clinic attendees who reported sex work.

Results: Of the 75 individuals, 24 were males and 51 transgenders. The mean age of the group was 23.3 (+ 4.9) yrs. About 15% were married or lived with a permanent partner. Of these individuals, 85% reported sex work as a main source of income and 15% as an additional source. The primary occupation was sex work in 70% and 30% had other primary occupation (e g masseurs, bar boys). The venue for sex work was private in 67% of the workers and public in the rest. About 84% of them were into sex work for more than a year. The clientele was unskilled labourers for 59% of the sex workers. The overall HIV infection was 33%. HIV was associated with being a transgender (41% vs. 17%, p=0.04), age > 26 yrs (57% vs. 28% p=0.04), > 1 year of sex work (38% vs. 8% p=0.05) and income < Rs.2000 pm (62% vs. 27%, p=0.02).

Conclusions: Male sex workers are an important risk group for HIV in Mumbai. There is an urgent need of targeted interventions for prevention of HIV in this population. Qualitative research would be an important tool to identify social aspects of sex work, negotiation skills and other relevant issues.

[CDC0894] Community led rapid HIV/AIDS response in Chittoor, Andhra Pradesh

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Issues: Community-centred programming and how this approach leads to rapid delivery of services, scale-up, community ownership and high quality of services.

Description: Since mid 2005, PASS - a local NGO has been implementing a focused prevention program in the Chittoor district of Andhra Pradesh, with technical assistance from the International HIV/AIDS Alliance and funding from the Bill and Melinda Gates Foundation. PASS, along with a few selected sex workers and MSM facilitated a participatory site assessment; mapped sexual networks; and supported community representatives design an intervention. The location of the project services (clinics and dropin centres) have all been selected in consultation with the representatives of sex workers and MSM. 1085 Sex workers, 358 MSM and 36 PLHA have been reached over a 9 month period, 2 clinics and 2 drop-in established; 425 STI cases treated; 54,768 condoms distributed; 9 colour-coded STI kits successfully introduced to treat STIs; two collectives of sex workers and MSM formed.

Lessons learned: Community led program planning and design have led to marginalized communities being treated with dignity and respect by “outsiders” - thereby increasing their self-esteem and motivating them for self assertion and action. Community led STI service appraisal and design have made services user friendly. The Drop-in-centres have emerged as nuclei for community mobilization and solidarity building. A combination of participatory and empowering approaches coupled with exceptional commitment by the local NGO has ensured rapid launch, scale up and high degree of community ownership of the project.

Recommendations: 1.Respect, Recognition and Reliance on the community and building on the strengths of the community is important to promote greater ownership of the program. 2. It is therefore important to involve community members in the project from the beginning - planning, implementation, monitoring, review and feedback.

[CDC0968] Behavioral research / interventions

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Issues: Transgenders, a totally discriminated community.No laws to protect,no rights to excersise and no recognition. Yet 1lakh transgendered live in Tamilnadu in a condition that is inhuman. Getting ALMS and commercial sex are their predominant activities to win their bread and basic needs. Nearly 90% of the community is in commercial sex. They lac access to facilities, low level literacy and discrimination thwat them from main stream of population.

Description: Project THAA, Chennai, India, the first CBO of transgender that came to bring out intervention to impact on transgender behavior. Intially THAA concentrated on addressing the chronically ill through short stay home and drop-in center supported by UNAIDS / NACO. The services led groups of transgenders to office and resulted in organizing intervention for prevention through CAPAC project.THAA programs are community driven.Interventions with usual components like condom promotion, practicing safe sex is not sufficed. Social stigma, discriminatio, non accepttence and insecurity in life turn them a hard nut to crack. Strategies planned for community development and to improve quality of life in the intervention Involving more community members through peer groups in the program alone can sustain any effort. THAA adopts group based approach to provide with knowledge on STI / HIV / AIDS and access to treatment and care. Peer capacity building concept adopted to identify and follow up of HIV-infected transgenders. Over 1200 transgendered reached, counselled and treated fr STI ´s in Chennai city. Over 540 HIV positives treated for OI´s and 163 reffered for ART.

Lessons learned: Transgenders are amenable to positive behavior change. to find alternative jobs or sources for self employment - a challange. This needs advocacy for and protection of their rights.

Recommendations: This community driven program need to extented to other areas in the State to address this marginalized community in India

[CDC1024] Prevalence of unprotected anal sex and use of condoms and lubricants among men who have sex with men (MSM) in Andhra Pradesh, India

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Background:
1. To analyse the frequency of anal sex between men and the use of condoms;
2. To assess lubricants use among MSMs ;
3. To assess their feelings and perception around lubricant use;
4. To assess readiness and ability to pay for lubricants for sexual encounters.

Methods: A total of 476 MSMs were covered under the study conducted over three months. A structured questionnaire was administered to all 476 respondents and the results analysed through a multiple logistic regression analysis. The findings from the questionnaire were then supplemented with 12 focussed group discussions of 10-15 MSMs each.

Results: The average number of different male sex partners among MSM in AP (in the past 4 weeks) is 6. Around 31% of the sexual encounters among MSM included anal sex, out of which only 44 % were protected. Of those who used condoms during anal sex, 62.4% did not use any lubricants, 25.3 % used saliva, 13% used oil based lubricants and 0.3 % used water based lubricants. Of those who had anal sex but did not use condoms, 52.5% did not use any lubricant, 36.5% used saliva, 12.6% used oil based lubricants and 0.1% used water based lubricants. 73% of the respondents indicated that their sexual pleasure increased with the use of lubricants. Of the 476 respondents, 81% said that they were willing to pay around Rs. 1 for extra lubricant.

Conclusions: The study indicates a very high rate of unprotected anal sex between MSMs and low use of condoms and lubricant. There is therefore a need to promote condoms and lubricants amongst MSMs and emphasize the pleasure factor associated with lubricant use. Messages for health education should discourage the use of oils, creams and Vaseline and encouraging the use of water based lubricants, especially when it is used in conjunction with condoms.

[CDC1079] HIV related risk behavior of men having sex with men in Mumbai and Thane

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Background: The Humsafar Trust, Mumbai working for MSM assesses HIV related risk behavior among MSM in eighteen monthly cycles. Third round of evaluation (for year 2002-2004) is presented.

Methods: 240 self identified homosexual men in the mapped sites; a two-stage cluster sampling. Indicators: no. partners in last one month, peno-oral sex, peno-anal sex and consistent condom usage in last one month, no. of female partners and penovaginal sex, consistent condom usage during vaginal sex.

Results: average no. of male partners was 4, 82% MSM reported sex with non-regular partner, 85% were engaged in peno-oral sex in last one month. Low consistent condom usage by partner (16%) and respondent (12%) during peno-oral sex. Insertive anal sex was reported by 60% of which 72% used condom when sex had last time; only 16% reported having used condoms consistently during Insertive anal sex in last one month. Receptive anal sex was reported by 53% of which 83% reported last time and 76% reported last month consistent condom usage by the partner. 47% had sex with female partner and average no. of female partner was 2. Peno vaginal sex was reported by 88% of which 65% reported last time condom usage. 34% consistent condom usage in last one month with a female partner.

Conclusions: Challenges to tailor the program towards 100% condom usage, further reduction of partners. Respondents were risk taking when they engaged in unprotected insertive anal sex on their partners. This reflected that safe sex messages were skewed. Motivation to reduce number of female partners, improve condom usage during peno-vaginal sex.

[CDC1665] Assessment of the sexual networks and modus operandi at selected mandals in Karimnagar district of Andhra Pradesh for HIV prevention programming

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Back ground: Andhra Pradesh state ranks second in HIV prevalence with 1.5% prevalence in India. SEWS, an NGO has been implementing focused prevention programme among female and male sex workers in the five highly vulnerable mandals of Karimnagar district. This project covers 1200 female sex workers, 1000 MSMs and 300 registered PLHAs. Methodology: An exploratory participatory assessment has undertaken among the female sex workers at the beginning of the project. 30 female sex workers had involved in this exercise. Used various mapping tools like service map, focus map and vision map for collecting data on the number, location, modus operandi, mobility of sex workers, services they are accessing and they are expecting.

Results: The analysis revealed a total of 1200 sex workers and the modus operandi is very different in different mandals. In 2 mandals the 300 street based sex workers come to a common place for work and if they don't get the daily labor they solicit for sex. In 2 other mandals 180 sex workers come to the public place only for soliciting sex. Among the brothel based sex workers 40 sex workers come for short term contract and 113 were less mobile. Three patterns emerged from the 450 secret bases sex workers of which 40% operate with an agent, 45% through contacts and 15% are very volatile and unpredictable. The place of sex varies depending upon the various socio - economic condition of that mandals. Later the project has been designed using the above information. 89% of them were reached and availing services of the project
and among them 65.47% were availing clinical services and among these 53% are treated for STIs.

Conclusions: For focused prevention programme of HIV/AIDS in high mobility areas it is very important to understand their patterns and modus operandi for effective designing and implementation of the project.

[CDC1702] Prevention of HIV/AIDS among men who have sex with men (MSM)

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Issues: For long, Governments and non-governmental organizations have focused on HIV prevention among Men who have sex with Men (MSM) only from the point of view of providing condoms as a method of preventing spread of HIV/AIDS among MSM.
What they have failed to recognize is that sexual relationship between MSM cannot be attributed as the sole factor responsible for the spread of HIV, though it cannot be ignored altogether. There are a number of other factors surrounding MSM community that lead to a complacent behaviour on their part that affect condom usage such as non-acceptance by the family and society, stigma and discrimination, violence inflicted on MSM, criminalization of sexuality etc which in turn leads to their increased vulnerability to HIV/AIDS.

Description: Lotus Integrated AIDS Awareness Sangam (Tamil Nadu, India) a community based organization, was formed to cater to the needs of the MSM community and focus on all aspects that contribute to spread of HIV/AIDS among MSM. For the
past 5 years, we have focused on all above-mentioned factors that make MSM population vulnerable and have conducted trainings, advocacy campaigns, counselling etc to make the intervention efforts effective.

Lessons learned: Society is not yet ready to accept same sex behaviour and thus it will take a long time to gain acceptance of family and society for MSM. As a result of training imparted to MSM and platform provided for open expression of their feelings, at
least 10% of the population has ´come out´ to discuss the issue with other members

Recommendations: More efforts planned to gain family acceptance by preparing the family members of MSM and also networking with other agencies to decriminalize homosexuality thus making HIV intervention efforts effective.

[CDC1714] TI project of MANAS Bangla

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Issues: Conducive Environmental factors for HIV Prevention in Male to Male Sexual Behaviour.

Description: MANAS Bangla is a Network of 7 CBOs in West Bengal,India, working for the Prevention of HIV/AIDS in Male to Male Sexual Behaviour from sofisticated urban population to grassroot population. MANAS Bangla, MSM Action Network for Advocacy at Social level in Bengal, is unique in many ways. It is the first Network MSM Project in India. It is the first MSM Project in South Asia where leaders with various ideologies and phylosophies have come together for a common cause. The Project is based on Peer Outreach, Inter Personal Communication, Drop-in, STI Clinic, VCCTC Referral, Counselling, Community Event and Vocational Training Programme (for Marginalised Males (due to gender, sexuality and sexual behaviour supported by HRD Ministry, goverment of India). The Counselling components is divided into Peer, STI and Psychosocial.

Lessons learned: As the population is dispersed Peer Educators require to be localised and also require to travel. Peer Counsellors require to focus on Community issues, while STI Counsellors require to focus on sexual health issues and Psychosocial Counsellors require to focus and address the technical barriers towards a healthy life. Creativity is very high in marginalised males where vocational training will add to empowerment. Sexual Health has to be addressed along with Mental Health and Self Introspection methods like meditation.

Recommendations: Peer Educators of MSM Projects require to be looked in a different perspective. Psychological issues to be taken seriously for community development. Peer Counsellors to be trained on basic Counselling skills. Thorough IGP to be formulated for marginlied males. Skilled Management Professionals and Decentralisation of state-wide MANAS Project are required to make the Intervention effective and efficient. Last but not the least The Project require to make itself visible to all. Meditation Centres .....

[CDC1719] High prevalence of STIs among MSM in India & Ecuador: implications for HIV prevention

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Background: STI facilitation of HIV transmission has been well documented, particularly for ulcerative STI, including HSV-2. In India, recent data suggest that men who have sex with men (MSM) are a key group for the epidemic. In Ecuador, the epidemic has been concentrated among MSM. Recent data from the evaluation of the Frontiers Prevention Project (FPP) suggest that a large proportion of Indian & Ecuadorian MSM have unprotected sex and that bisexual behavior is common. This study reports the prevalence of HSV-2 & syphilis among MSM in India & Ecuador.

Methods: As a part of the FPP baseline evaluation survey, blood samples and socio-demographic information was collected from 6,661 MSM in 40 sites in Andhra Pradesh (India) and 2,500 MSM in 8 cities in Ecuador. Capillary blood was collected onto filter paper. Dried blood spot eluates were analyzed for HSV-2 and syphilis antibodies.

Results: HSV-2 prevalence varies across sites from 0% to 76% in India (mean 29%) and from 30% to 61% in Ecuador (mean 42%); syphilis ranged in India from 1% to 64% (mean 24%) and in Ecuador from 11% to 27% (mean 16%). Overall, 49% of MSM in Ecuador & 41% in India had at least one STI at the time of the survey.

Conclusions: Previous data from this population reported a very low proportion of protected sexual intercourse; the data presented here shows a very high prevalence of viral STI, in particular of HSV-2, a virus that has been associated with a higher HIV transmission probability. The extreme heterogeneity in prevalence across sites in India suggests very different levels of HIV risk in different subpopulations. The effect may be masked in Ecuador by the larger sample sizes per site. This evidence highlights the need to improve prevention interventions focused on MSM, in both India & Ecuador.

[CDC2034] Community mobilization – a core strategy in HIV prevention – experience of combined efforts of 3 NGOs in promoting community based organization in Karimnagar district

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Issue: Andhra Pradesh is one of the HIV high prevalent states in India. Many NGOs implement focused prevention among female and male sex workers. REACH, GNNS and SEWS are NGOs which are implementing focused prevention programs among FSW, MSM and PLHAs in 10 mandals of Karimnagar district with community mobilization as one of the core strategies.

Description: Involvement of community has been a central to this project. In the year two, for improving the solidarity among KPs and addressing marginalization, all the 3 NGOs have promoted CBOs separately in their operational area with all the three groups. There are 9 separate CBOs, work closely with each NGO. They have an average of 200 members in each group. These CBOs have a district level committee for coordination representing the 3 groups and 3 CBOs. These CBOs are taking a key role in K.P mobilization and NGOs complement with service delivery.

Lessons learned: Under these CBOs they started forming thrift groups for developing the fiscal discipline among the community members and also for helping them financially by coordinating with line departments for income generating activities for those who are aged and out of sex work. These CBOs are coordinating with community for services not provided by NGO like Care & Support. This also improves ownership of the programme by the communities. This model also helped in effectively combining prevention activities with care and support.

Recommendations: Involvement of the communities from the beginning of the project has improved their capacity and ownership of the project. These NGOs plan to strengthen the CBOs further both in organizational development and programme implementation. It is recommended to replicate similar model in order to improve the programme efficiency, effectiveness and ownership.

[CDD0078] Vulnerability to HIV/AIDS among massage parlor boys in Delhi

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Issues: The male sex work has assumed a new dimension as massage and it is getting extremely popular. The advertisements related to massage parlors appear in all major national dailies and very specifically state “male to male” and “satisfaction guaranteed.” Also these advertisements offer ‘home-hotel’ and ‘round the clock’ services at a premium price.

Description: The reason for growth of these parlors is the opportunity for male-to-male sex in safe and anonymous settings, economic opportunity for the workers and easy money. Also the increase in the sex tourism has fuelled the growth of such parlors.
The boys at these parlors are youngsters who are college dropouts. Diminishing sources of livelihood and lack of vocational trainings also play a major role in boosting this service. The owners of these parlors act as pimp. The main factors that increase the vulnerability of these male sex workers working as massage boys stigmatized and discriminated male-to-male sex, lack of protective legislation and policies and the working conditions, constraints of time and space. Also these boys have low self-esteem and the “need” to please the clients makes them agree to enter in unsafe sexual behavior.

Lessons learned: In our intervention with the massage parlor boys we constantly give them inputs on negotiation skills, sexual violence and substance use and also do the sensitization workshops with the owners of the parlors. The programmatic indicators of our interventions show increased treatment through STI clinic, decrease in STI symptoms and increased condom usage and lubricants

Recommendations: As the challenge in this area is mainly the lack of epidemiological data and inadequate and inappropriate health facilities we have set up clinic and counselling services. Also ongoing trainings with these boys and parlor owners have helped a lot in understanding the importance of safer sex practices and condom usage.

[CDD0195] Transgender; HIV/AIDS and law in India

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Issues: Legal vulnerability or lack of legal recognition heightens invisibility and marginalization and makes Transgender community vulnerable to HIV/AIDS. This also acts as a barrier in accessing healthcare and implementing interventions.

Description: Most transgendered persons in India are invisible and marginalized in society, as it does not allow them to live in their preferred gender compelling them to live double lives. Some of them live on the fringes of multiple identities as exotic dancers, female impersonators, sex workers, etc. All these factors heighten their vulnerability, as there is no legal recognition of change in gender, which can undermine their decision-making and make them susceptible to transmission of HIV virus. There are
many issues that arise in areas such as change of past documents after sex reassignment (birth certificates, etc), right to marry, inheritance rights, where the benefits available depend on one's sex. Though the Indian government has made some headway by inserting a provision in the passport for name and sex change, but procedural and documentary hurdles still come in the way of their getting their basic rights. Legal enforceability is still to be tested in the courts due to absence of case-law. Also, in the absence of any anti-discrimination laws, issues of discrimination are widespread. As a result the community becomes increasingly invisible and vulnerable.

Lessons learned: The transgendered community has seen some formation of support groups and, people have come forward for legal aid and advice to demand the rights denied to them due to absence of law.

Recommendations: There is a need to recognize transgendered persons through law reforms and amendments in various legislations that can give them their basic rights. This would help in empowering the community and creating an environment that
reduces marginalization and increases visibility.

[CDD0228] Self Image and HIV risk: a study of men having sex with men in India

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Background: Sexuality is an integral part of self and identity. Moreover, human behavior is a product of what people perceive about themselves. People behave according to social roles, statuses, place, situations and ordinances. This paper shows an interrelationship between self image and HIV among MSMs of Mumbai city in India.

Methods: study was carried out among 160 scientifically selected samples from 10 different cruising points of Mumbai by using quota sampling procedure. Both the quantitative and the qualitative techniques were used.

Results: almost every second MSM had experienced first sex with male during formative stage of their life (15-19 yrs.). Proximities were found to be responsible for shaping sexual orientation of MSM. Moreover, varied risk patterns were observed irrespective of their body images. Study reveals the existence of multiple partner sex, bisexual relationships, sex with casual partner, low condom use with wife and regular partners, and higher substance abuse among MSMs. Most of the MSMs have not revealed their actual sexual identity to family members and society. Fear of negative reaction and fear of loss of status in society also bar them to avail necessary health facilities. Due to stigma and fear of disclosure of their sexual identity they don't report their anal symptoms while seeking treatment. Moreover, those who have revealed their actual sexual identity, face strong reactions from society and family. The kind of uncouth places used by lower classes of MSM are quite hazardous for their sexual health.
Women in monogamous marriages are at a greater risk due to their partner's unknown sexual status.

Conclusions: Social stigma still prevents MSMs from disclosing their MSM identity and hence many MSMs prefer to have sex with strangers where scope for safe sex is limited and this provides an opportunity for HIV infection to percolate from MSM to MSM, and also from MSM to family.

[CDD0231] MSM-self identity in rural area, Tamil Nadu, India

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Issues: MSM behaviour needs acceptance. In a culturally diverse and a socially democratic nation like India, this takes time. Culturally, India has identified and recognized all sexual behaviours as natural. However, her economic disadvantages and social stigmatizations cause perverted views on sex and sexuality. Even voicing opinions cause concerns for one´s life safety. Given this background, MSM behaviour and identifying a person as MSM can cause severe damage. Besides, MSM are huge. This enormity coupled with inaccessibility to information result in increased high risk behaviour. In MSM, the risk is aggravated because, most of MSM here are also bisexuals. Barring in major urban centers, interventions among MSM are seldom made in rural India.

Description: Snegyitham, a CBO in Tiruchirapalli, through its Male Sexual Health Project has made intrusion into rural settings by contacting schools, NYK & youth associations, with the technical support from NFI. Snegyitham has organized 26 camps in rural areas presenting different sexual issues arising out of MSM behaviour. It has taken the support of physical masters in schools to get groups. Rural men are invited to Snegyitham Drop-In-Centers to avail education on sexuality. With the support
From Government Field Pulicity Office, we have organized health and education progammes to make youths, adults and married men to understand their sexual behaviour. Attendence at our Drop-In-Centers swelled; referring of family problems in self identity have gone up; over 1000 men from rural in just 18 months have identified themselves as MSM. Later, they are organized through our peers to form support groups in their respective villages.

Lessons learned: MSM population in rural areas are immediate in responding to any enabling environment. Rural MSM can be brought into a regular follow-up groups through peer development. The members are adept to information.

Recommendations: Counselling and referral services are planned to sustain their initiation.

[CDD0331] Men who have sex with men in southern India: typologies, behaviour, and implications for preventive interventions

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Background: Data on sexual risk behavior among men who have sex with men in India are limited. We examined knowledge about HIV/AIDS and sexual behaviour among MSMs in Bangalore.

Methods: We conducted in-depth confidential interviews among a stratified sample of MSM. MSM typologies included kothis (effeminate homosexual/bisexual men), hijras (transgendered men), panthis (generally dominant male partners of kothis, doubledeckers and hijras) and double-deckers (homosexual/bisexual man without rigid masculine or feminine roles). Sample sizes were: kothis 49, double-deckers 23, panthis 19 and hijras 9.

Results: 75% of respondents were not aware of any modes of HIV transmission. 89% of respondents reported having male partners during the past week, with a mean of six; hijras reported 14 male partners per week. 94% of kothis and all hijras had at least one male sex partner in the past week. 32% of respondents reported also having female sex partners in the past week, with a mean of two. This was mostly seen among double-deckers and panthis. 41% of all respondents reported insertive anal sex in the past week, with a mean of three episodes, and 61% reported receptive anal sex in the past week, with a mean of four episodes. 73% of kothis reported receptive anal sex. 27% of respondents reported both insertive and receptive anal sex. 44% respondents reported no condom use during last anal sex, and 70% of anal sex was without use of lubricants. 71% of respondents reported practicing oral sex as well, the majority without condoms.

Conclusions: A high proportion of MSM in Bangalore engage in unprotected anal sex, particularly kothis and hijras. Risk behaviours differ among different MSM typologies. Focused HIV prevention programs are required to increase knowledge, and promote condom use and lubricants. Prevention services and communications should also cover female partners of the MSM community.

[CDD0332] Sexual vulnerability and risk of men who have sex with men in India

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Background: This paper aims at assessing the sexual vulnerability and HIV risk sexual behaviour of MSM in Indian cities. India is home to large number of HIV+ve people and sexiual route is the major transmission. MSM is one of the high risk groups identified by the National AIDS Control Programme.

Methods: The paper is based on the analayis of the data from National BSS which covered 1387 MSM across 5 Indian cities. The BSS provides data on prevalence of STIs, treatment seeking behaviour, sexual behaviour and condom use. Statistical analysis is carried out to identify the risk factors.

Results: The MSM respondents were young (mean :28yrs), had low levels of education (9% illiterate), unmarried (66%) and with diversified occupation distribution. Though awareness of STIs and HIV is almost universal, awareness of HIV transmission modes and prevention ways is moderate indicating gaps in the knowledge. STI prevalence is moderately high among the MSM(41%) but one fifth of thes did not seek treatment or received home treatment. The MSM had early sexual debut (mean age: 19yrs with females and 16 yrs with males). The MSM had higher number of commercial male partners than non commercial partners (9.1Vs4.0). Use of condom with non commercial partners is more than that with commercial partners, though the maximum figure recorded was 53%.

Conclusions: The MSMs hav high risk behaviour and are vulnerable due to low socioeconomic status. There is a need to improve the awareness levels and imprat knowledge through effective BCC startegies. The BCC should also aim at behaviour change. Scaling up of the interventions is the need of the hour to control the STI sand HIV among the MSM across India. Research studies need to be carried out in non metro cities and semi urban areas as the mapping data indicates large concentration of the MSM in these areas also.

[CDD0333] MSM populations in low and middle-income countries: assessing magnitude, sexual behaviour and HIV prevalence

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Background: While men who have sex with men (MSM) still play a central role in most concentrated HIV epidemics, better evidence of this role is missing. We sought to bring together surveillance and research data on the prevalence of male-male sex among adults, and on the prevalence of HIV, consistent condom use, and lifetime heterosexual sex, among MSM in lower/middle income countries.

Methods: Literature searches were conducted and regional informants provided unpublished information. Quality of information was assessed. The best data available per region were identified and confidence intervals for indicator estimates were used to propose regional estimate ranges.

Results: 561 studies were identified, with significantly different numbers per region and virtually no information for all of Africa, the Middle-East, and the English-speaking Caribbean. Lifetime prevalence of sex with men (among males) was 3-5% for East Asia, 6-12% for South/South East Asia, 6-15% for Eastern Europe and 6-20% for Latin America. Prevalence of high-risk sex among MSM last year was 20-30% of the previous figures. Among MSM, HIV prevalence was 2% or less (MENA region), 10-20% (Latin America), 1-4% (China), and variable in South Asia (highest in India, 5-15%), South East Asia (highest in Cambodia, Thailand and Myanmar, 10-15%), and Eastern Europe (highest in Poland/Czech Republic, 6-10%). 33%-50% of MSM reported consistent condom use, and 30-50% of these men had sex with women at least once in all regions except East Asia where this rose to 60-70%.

Conclusions: Lifetime prevalence of sex with men among males was found to be 6-20%. HIV prevalence was 5-15% in parts of Latin America, South/South East Asia and Eastern Europe, with consistent condom use below 50%. Sex with women was frequent in MSM, particularly in East Asia. More valid data on MSM and HIV across regions is needed, which ensures comparability, allows for projections and supports programmatic action.

[CDD0360] First sex episode with a man and sexual identity in a population-based sample of MSM in India

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Background: With high vulnerability of men having sex with men (MSM) to HIV infection, better understanding of sex between men is needed for effective HIV prevention in India.

Methods: 6400 men (93.4% participation) aged 16-49 years representative of the population of Guntur district in Andhra Pradesh, India provided data on sexual behaviour through confidential interviews as part of a population-based assessment of sexual behaviour and HIV.

Results: 133 (2.1% crude, 1.9% adjusted) participants reported having ever had sex with a man. 109 (82%) provided data on male-male sex of whom 48 (44.4%) reported that their first ever sexual experience was with a man. Mean age at first sex with a man was 18 and 22.8 years for participants and their partners, respectively. The first partner was very well known man to 66 (60.6%), and first sex was forced for 17 (15.6%) participants. Penetrative sex (63% oral, 37% anal) was performed on 54 (49.5%) participants whereas 64 (58.7%) performed penetrative sex on their partners (85.9% anal, 14.1% oral) in the first episode. 65 (59.6%) reported having male-male sex on more than one occasion of whom 38 (58.5%) preferred having sex with a woman and 24 (36.9%) reported being naturally attracted to a man. These 24 men were more likely to report being different from the other men and consider themselves homosexual as compared with those who were not naturally attracted towards a man ($p<0.0001$). No participant knew about the law against sodomy in India.

Conclusions: 4 of 5 first male-male sex episodes involved penetrative sex, 2 in 5 MSM reported only one sex episode, and 3 in 5 MSM with more than one episode did not identify themselves as homosexual. HIV prevention programs in India should be aimed at the broader MSM community to ensure access also for MSM who do not identify themselves as homosexuals.

[CDD0364] Addressing felt needs of MSM through tele-counselling and e-counselling: preparing ground for AIDS awareness generation

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Issues: A key issue in AIDS prevention in MSM populations is addressing psychosocial needs around sexuality. It is crucial to help MSM overcome stigma and raise their self-esteem because emotionally healthy individuals better absorb AIDS related behaviour change messages. Tele-counselling and e-counselling services allow MSM to express their needs freely in anonymity.

Description: SAATHII operates a tele-counselling service for MSM in eastern India that answers queries on sexuality, human rights, sexual health and HIV/AIDS. The service is publicized through various media. Trained counsellors operate it in Bengali, Hindi and English. In 2004-05 the service received 470 phone calls from 445 clients. An associated e-counselling service received 53 e-mails from 40 clients from April 2004 to January 2006. All calls and e-mails were logged, documented and analyzed for client profile, nature of queries and referrals made.

Lessons learned: All phone queries (n = 720, many clients asked multiple queries) were classified under “information” (36% of the queries), “counselling” (5%), “seeking friends / partners” (22%), “referrals” (34%) and “others” (3%). Issues around sexuality and sexual acts dominated information queries (34%). Only 17% of the queries concerned STI/HIV/AIDS and sexual health. In the referrals category, 86% of the queries related to support group referrals, only 2% to HIV testing. The e-mail queries also centred largely on sexuality (58%) – compared to AIDS issues (28%). Most clients were males, 18-25 years, located in Calcutta. Sexuality was clearly the immediate concern for most clients.

Recommendations: Funding bodies need to prioritize sexuality education for MSM and their influencers as integral to AIDS programmes. Sexuality can serve as an important entry point for educating MSM about HIV/AIDS issues. Tele-counselling and ecounselling services for such education are needed beyond Calcutta, across eastern India and in local languages. These should be linked to local support groups catering to various socio-economic sections of MSM.

[CDD0379] Social and individual constraints underlying the emergence of “Gay” identity nd “Gay” support groups in India

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Issues: In India, most Males who have Sex With Males (MSM) do not consider their sexual identity as a political or social issue because of the given climate of denial and homophobia. Invisibility of sex between males hampers the development of social identity and organised community amongst MSMs.

Description: Extensive review of MSM literature and focused group discussions and interviews with 140 MSMs over a two year period have given insights into the problems associated with social identity and formation of support groups amongst MSMs

Lessons learned: Overt homosexual expression is absent because majority of MSMs either get married or remain single without cohabiting with a male partner. Sex between males being illegal, MSMs are targeted for persecution. Same sex relationships are considered as "unnatural", "perverted", "dirty", "immoral" etc. Penalties for being exposed as a “homosexual” are severe, which may include stigma, ridicule, isolation and even domestic and social violence. This results in guilt, low self esteem. Sex between MSMs occurs secretly, mainly in public parks, public toilets etc. where there is a constant threat of exposure and harassment. These factors do not provide social opportunities for bonding and forming social networks. Lack of space for socialisation leads to multiple partners and high partner turnover. Group bonding if present, is extremely weak. Anonymous sex between male strangers is purely a physical act and not an issue of affiliation, association or solidarity.

Recommendations: The approach for support group formation may include: 1. behavioural change - promoting self esteem and 2. community mobilisation and social negotiations, addressing MSM groups and broader social contexts. The aim would be to create a supportive social environment focusing on individual identity, group identity and collective response to HIV through awareness, advocacy and activism, coterminous with a safer sex culture amongst MSMs.

[CDD0524] Laundas - undercover male sexwork

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Issues: Trafficking of transgender males into sexwork and forced unsafe sex.

Description: Laundas are transgender males trafficked into the state of Bihar from neighbouring places ostensibly for dancing in marriage ceremonies and are forced into sexwork often at gun-point, Lack of awareness on HIV, non-availability of condoms and ignorance regarding its use, feudalistic system, gender inequity, myths around same sex behaviour, colonial anti-sodomy law, poverty and traditions worsen the situation. Gross violation of human rights and ignorance make the virus travel faster.

Lessons learned:
1. Transgender males are no less vulnerable than female sex workers,
2. Maintenance of human rights are essential for fighting HIV,
3. Male trafficking has very close connection with HIV.

Recommendations:
1. HIV awareness need be spread among Laundas and their client,
2. Condoms and their usage need be promoted,
3. Sodomy law should be changed,
4. Stringent anti-trafficking law and inclusion of males under its perview.

[CDD0535] Community de-stigmatization process, a key to AIDS prevention among transgender community member

A. Alphonse

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Issues: In India transgender-community is stigmatized as commercial sex-workers, it is only partially true. They do-not have alternatives, exploited and poverty drives them to sex-trade. Within them many want to come-out from sex-trade and live a dignified life thus form the mainstream.

Description: Past two-years CCOORR works with 500 transgender-members. Regular interactions and recognizing them as women are essential to build rapport; periodical cultural-events, social-gathering towards ventilation are essentially performed, looking after them holistically including health programs are performed. Annual convention for transgender held at two intervention sites of Tamil-nadu. 215 participants attended. This convention acted as outlet-forum and needs-assessment exercises in participatory way with guided exercises. One major process was to find-out whether they could give-up their sex-trade, if so how.
Full exercise done in small-groups; 65% members were optimistic about their coming-out of commercial-sex-trade even-though it is paying; as exit-strategy first they want to get organized in groups of 20, then get the full-support of local/district level political systems with strong advocacy, recognition from the police-force as changed people, and employed in small-scale industries/visibly self-employed ; this sort of visibility will go long way in their de-stigmatization process; they realize the danger of some of their members after rehabilitation slipping into again commercial-sex, to monitor this they wanted self-regulatory mechanism workedout.

Lessons learned: Transgender-community as single person could not give-up sex trade but possible in groups. Strong political will and police-support for the process is must; they need visible employment/self-employment for steady earning, towards community de-stigmatization. Economic-empowerment for this group is first-priority, and then HIV prevention-strategies could be easily implemented

Recommendations: Small groups' formation at local/district-levels towards unionization, strong advocacy with political-system and police-force, visibly economically empowered lead to community de-stigmatization; once achieved. HIV prevention is no challenge in transgender-community and becomes people-movement.

[CDD1442] Committed community health workers: paving roads for public private partnerships in public health system

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Issues: PLWHA have a wide range of needs for treatment and care. These include treatment for opportunistic infections as well as psychosocial support. However the vast majority of people yet do not have access to services. Reaching out to them is a priority in all care and prevention interventions.

Description: AIDS related care is a key element in the response to the epidemic. It not only does benefit PLWHA, but also helps to reduce the social and economic impactof the disease. In developing countries like India vast majority of people rely on the public health care.In Mumbai, the LTMG hospital is a tertiary care centre. The CCHW program developed by the Humsafar Trust is designed to make in roads into such public health care facilities. It places health workers in public health care systems to increase the access and reach of community. These health workers are recruited from the MSM community so as to increase the comfort levels of vulnerable groups like MSM and transgendered individuals accessing health care services.

Lessons learned: The health workers act as an interface between the community and the health machinery by short circuiting red tape and making services readily available to MSM and transgender population. This unique model has also lead to the initiation of public-private partnerships, as the hospital machinery too makes use of CCHWs in providing services to general population.

Recommendations: Adaptation and inclusion of similar models in care settings. Promotion of public - private partnerships to ensure sustainability of access to care. Increased access to public health care will in the long run reduce dependence on NGOs/ CBOs

[CDE0260] Can you hear me? Voices from the fringes

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Lakshya Trust, HIV/AIDS Unit, Vadodara, India

Issues: Hinderence caused due to police harressment in the HIV/AIDS awarness programmes for MSM population in Vadodara city.

Description: Lakshya Trust is a community based organization working on the issues of HIV/AIDS awarness and prevention with the MSM population in the city of Vadodara. Due to various sociocultural factors homosexuality is still a taboo. Illegal status of Homosexuality has hindered the prevention work done by the organization. Various sensitazion meetings involving top police officers, middle and lower level police personnel has been constantly done by the workers of the organization, more than 25 sensitazion meetings involving condom demonstrations, IEC material distribution have been done on an expermental basis. This process has yeld fruitful results as more than 700 police personnel are aware and sensitized about the activities of the organization which inturn has resulted in a positive conducive environment to such an extent that the organization houses more than five condom depots in the police stations. Police personnel has played a very positive role in the promotion of the activities of the organization,despite the illegal status of homosexuality.

Lessons learned: Advocacy,sensitazation and awarness programmes on HIV goes hand in hand especially for the fringe populations. More effective advocacy possibilities has yet to be explored to bring policy level changes. Small but effective changes can be made on a grassroot level by proactive involvement from those in power.

Recommendations: Similar culturally sensetive micro level strategies can be replicated in various programs globlally where policies marginalizes people.

[CDE0383] The vulnerability of bar dancers

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Issues: Whether the banning of bar dancing would lead bar dancers in to sex work and increase their vulnerability to HIV.

Description: In 2005, the Maharashtra legislature passed a law banning bar dancing without understanding the implication for the spread of HIV. There were 30,000 bar dancers dancing in bars in Bombay and about 15000 outside Bombay in state of Maharashtra, India. Most of the bar dancers were women; a few of them occasionally engaged in commercial sex work. The vast majority of the bar dancers earned their livelihood by dancing in bars. The banning of dancing in the bars by law passed in the Maharashtra legislature, in Bombay, leads to the absolute deprivation of source of livelihood of bar dancers. There were anecdotal reports about larger number of bar dancers engaging in commercial sex to eke out a living. Petition was filed in Bombay High Court challenging the law banning bar dancing, amongst others by women groups, HIV and health groups.

Lessons learned: HIV groups need to uphold the rights of livelihood of all sections of society, particularly those who can slip into activities which lead to vulnerability to HIV.

Recommendations: The members of the legislature must be informed and sensitized about passing legislation which adversely affect the spread of HIV. The civil society groups must mobilize public opinion to understand the impact of bad law.

[CDE0422] Challenges of scaling up community led structural interventions for reducing HIV risk in female sex workers (FSW), men who have sex with men (MSM) and injecting drug users (IDU) in India

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Care India, SAKSHAM, New Delhi, India

Issues: The lives of FSW, MSM and IDUs are frequently fraught with social, cultural and economic inequities that impoverish, stigmatize and reinforce social injustice, which, in turn, creates social risks and increased vulnerability to HIV. Interventions designed to reduce this vulnerability must move beyond traditional public health and behavioral issues and address the structures within which these behavioral issues function.

Description: Care/Saksham as part of the India AIDS Initiative funded by the Bill and Melinda Gates Foundation is working to build capacity of 151 NGOs working directly with vulnerable communities and the community members themselves to transfer ownership of the HIV prevention program. The capacity building includes handling NGOs in empowering communities through structured training, demonstrating CLSI processes through learning sites and creating cadre of community members as trainers.

Lessons learned: The challenges to building community ownership of the program are several. First, many NGOs are resistant to permit power to be shifted to the community and do not feel that the community can decide for themselves. Given the diverse settings of sex work across the sites, building a sense of community is not formulaic. The NGOs all have prior experience with communities and institutional frameworks that must also be modified. Communities need significant capacity development to take ownership. Finally there are repercussions by legal and social frameworks when sex workers step outside their “bounds”.

Recommendations: Building community capacity for ownership requires addressing resistance of implementing NGOs as well as being prepared for wider community backlash as FSW claim their rights and social space.