HPTN
HIV Prevention
Trials Network

Recruiting MSM, Transgender & minority populations for HIV research

HPTN083

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Establishment of YRGCARE

Vision

To prevent new HIV infections and to assist those living with the infection, live with dignity

Mission

To respond to the HIV prevention, care and research needs of the country

HIV in India

- ~2.3 million living with HIV infection
- ~85% of infections attributable to heterosexual transmission
- Prevalence has declined over time
  - Disparities across risk groups

MSM in India- Historical perspective

- MSM and transgender have existed in India for thousands of years- documented history exists
- Homophobia was documented under section 377 by British which continues today.
- MSM in India hence face multiple challenges- legal and social.
- Social intolerance and cultural pressures demand MSM engage in heterosexual linkages.
- MSM play a "bridging" role in HIV transmission

Engagement with Hidden population

- YRGCARE is currently implementing two cluster randomized trials- among MSM & PWID.
- Both studies together are implemented across 22 sites in India.
- Substantial community linkages with TG, MSM and PWID population.
- Studies are implemented in collaboration with Government of India (NACO) and State AIDS Control Societies.

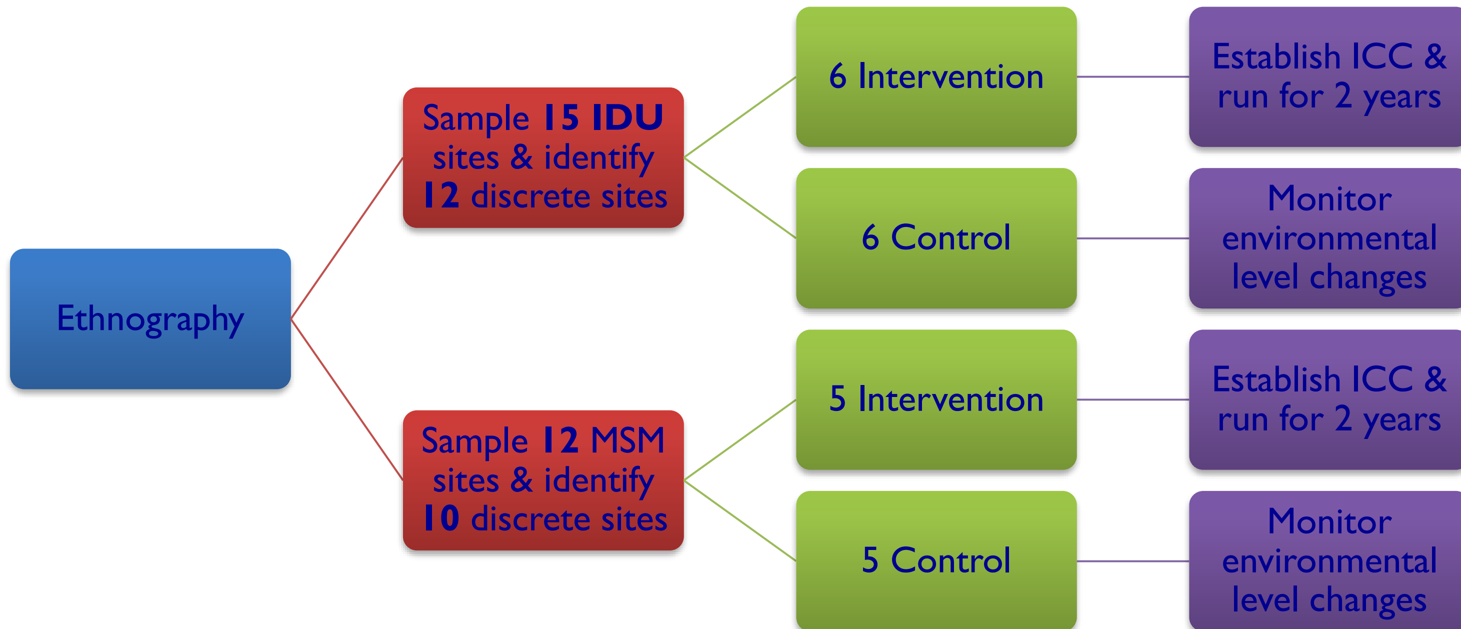
MSM in India

- ~2.3 million high risk MSM in India
- Estimates of same-sex behavior prevalence as high as 10%
- Historically, MSM have had poor access to services
  - Among 4597 MSM from AP, MH, TN and KN
    - 13-50% had ever had an HIV test
    - 6-18% had ever heard of ART
- Stigma, discrimination and harassment common
- Fragmented service delivery

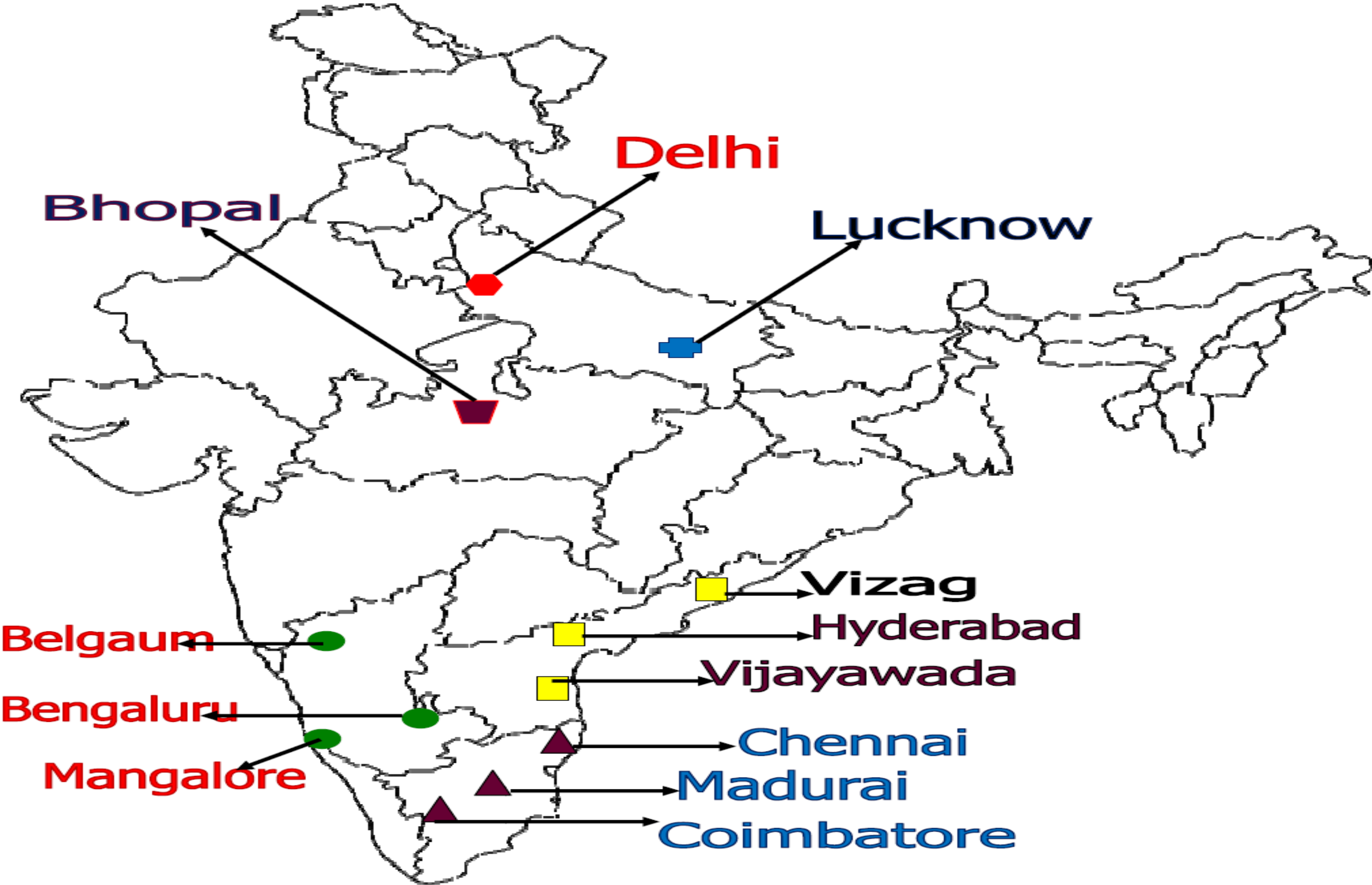
Research Question

"Can the provision of essential services for HIV prevention/treatment under a single roof in a stigma-free environment improve service utilization (and consequently impact HIV incidence) among disenfranchised populations (MSM/IDUs) in the Indian setting?"

Study Design: Cluster randomized trial with serial cross-sectional samples (respondent-driven sampling [RDS]) prior to and after the implementation of the intervention



Baseline Sites- MSM Study



Ethnography

- Focus group discussion
- In-depth interviews
- Objectives:
  - Identify "seeds"
  - Identify challenges to recruitment
  - Mapping MSM communities
  - Community preparedness

MSM – Baseline characteristics

	Andhra Pradesh			North and Central India		
	HY	VJ	VZ	BP	DL	LK
Number recruited	998	1000	1000	998	997	1000
Median age	26	28	25	21	22	24
Sexual Identity						
- Panthi (insertive)	40.4	52.1	42.6	42.0	69.3	44.3
- Kothi (receptive)	17.7	15.8	19.6	6.5	12.5	4.8
- DD (insertive and receptive)	23.0	20.7	26.5	32.9	7.9	5.8
- Bisexual	16.6	11.4	11.0	14.1	9.2	26.8
% Married	28.2	40.4	24.2	15.1	23.9	25.1
Median lifetime partners	20	40	190	7	12	5
HSV-2 prevalence	30.6	27.5	20.4	7.0	16.6	13.0

HY=Hyderabad; VJ= Vijaywada;VZ=Vishakapatnam; BP=Bhopal; DL=Delhi; LK=Lucknow

MSM – Baseline characteristics

	Tamil Nadu			Karnataka		
	CH	CO	MD	BG	BL	ML
Number recruited	1000	1000	1001	1003	1000	1000
Median age	25	32	26	30	29	32
Sexual Identity						
- Panthi (insertive)	22.8	42.4	38.8	51.0	16.6	23.2
- Kothi (receptive)	13.8	29.7	13.6	8.3	12.3	9.7
- DD (insertive and receptive)	15.8	20.2	44.9	16.3	23.4	20.7
- Bisexual	3.3	4.0	.6	9.4	43.5	33.7
% Married	22.4	42.9	32.1	57.8	31.7	45.3
Median lifetime partners	25	50	10	4	15	15
HSV-2 prevalence	15.4	22.5	16.9	16.5	23.4	16.8

CH=Chennai; CO=Coimbatore; MD=Madurai; BG=Belgaum; BL=Bengaluru; ML=Mangalore

Summary of baseline RDS

- Baseline assessment complete (Sep 2012 to July 2013)
- 12,022 recruited across 12 sites in 6 states
- 2 seeds per site (except Delhi – 3 seeds)
- Baseline characteristics:
  - Median age: 26 years (range: 18 – 75)
  - Sexual identity (40% insertive; 15% receptive; 42% both)
  - 34% currently married
  - 72% ever sex with a woman
  - 9% HIV prevalence
  - 22% HSV-2 prevalence
  - 70% reported UAI in the prior 6 months

Intervention process & way forward

- 15 integrated care centers across India currently case manage over 15000 individuals
- Of these 07 are MSM centers and the rest are offering services to PWID.
- An impact evaluation RDS is planned for end of 2016 to compare intervention outcomes.
- Future projects include offering incentives for ART adherence, comparing different RDS methods to assess most ideal tool to reach hard to reach population that could be linked to HIV care, studying spatial and network characteristics of hidden population to assess best methods to engage hidden communities in research and HIV Care.

Key issues around engaging MSM/ TG in research

- Perceived and perpetrated stigma prohibits uptake of services.
- Insufficient diffusion of information among this hidden group prevents active participation.
- Only visible population among this group are reachable- those selling sex, males identifying themselves as women- “kothis”

Issues around engaging hidden population in research

- Due to social issues hidden population do not adhere to visit schedules.
- Immense peer pressure and “herd” thinking impacts their decision making.
- Most MSM are married and there is very less or no conjugal communication about sexual preferences. This affects communication about participating in research.

Issues around engaging hidden population in research

- PWID are hard to reach as they have no family support or social acceptance.
- Their understanding of research is negligible as there is no structured diffusion of information to them.
- HIV and HCV are both issues that require consistent and high quality health care access. This is unfortunately not accessible to them.

How to effectively engage hidden population in research?

- CAB plays a critical role in designing, developing and overseeing community engagement process. They serve as a bridge between research team and communities.
- Developing a core group of opinion leaders, training them and ensuring delivery of consistent information amongst their social networks assures acceptance.

How to effectively engage hidden population in research?

- Providers, NGO partners, law enforcement agencies' sensitization is a critical next step in ensuring main streaming hidden population issues.
- Developing a priority list of service providers, engaging them in collaborative processes such as offering care to hidden population helps in better uptake of services and building confidence in hidden population.

How to effectively engage hidden population in research?

- Group meetings with hidden population on basics of research, understanding research priorities and mutual benefits help enhancing acceptance.
- Training research team on specific needs and expectations of hidden population assure better outputs.
- Partnering with at least one or two civil society organizations assure a sense of community ownership and support.
- If feasible, media support to mainstream issues of hidden population help mitigate stigma and thus better chances of participation in research.

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