Ministry of Health and Family Welfare
Government of India

National Stakeholder Consultation on Community System Strengthening (CSS)

(Defining course of action for CSS in NACP-V to strengthen community engagement for improvement of HIV comprehensive service delivery)

18 February, 2021

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Credits:

This document has been made possible by the active participation and contribution of community representatives, civil society organisations and bilateral partners (list attached in annexure) who joined the National Stakeholder Consultation.

Special thanks to the organising partners who supported the consultation - NACO, UNAIDS, USAID, CDC, FHI 360, and Swasti, The Health Catalyst.

Contents

List of Acronyms

CAB	Community Advisory Board
CBO	Community Based Organization
CLM	Community Led Monitoring
HRG	High Risk Group
CSS	Community System Strengthening
KP	Key Populations
NACP	National AIDS Control Programme
NACO	National AIDS Control Organization
PLHIV	People Living with HIV
TI	Targeted Intervention
TRG	Technical Resource Group
TWG	Technical Working Group

Executive Summary

India is one of the countries in the Asia Pacific region that have recorded significant decreases in new infections among Key Populations (KP) and significant increase in providing access to treatment among people living with HIV infection. The HIV Sentinel Surveillance Report of 2017 however, shows that the HIV epidemic continues to be concentrated with relatively higher prevalence among high risk groups comprising Female Sex Workers, Men who have sex with men, Hijra/Transgender, Injecting drug users, and bridge population groups. The highest prevalence recorded in the 2017 rounds of HSS was among injecting drug users at 6.26%, Hijra/Transgender at 3.14%, Men who have sex with men at 2.69% and Female Sex Worker at 1.56%, while the observed HIV prevalence among ANC clinic attendees, considered a proxy for general population, was 0.22% as per the *India HIV Estimates 2019 report.**

Since the inception of National AIDS Control Programme (NACP) under the National AIDS Control Organisation (NACO), community [1] has been at the centre of the HIV/AIDS response in India. The strategies adopted by NACO for prevention, treatment and care have predominantly worked because the National Program has kept the centrality of its response with key populations as well as PLHIV, such that the program is in constant consultation and conversation with them in advancing the response. Community Systems Strengthening (CSS) has been in consideration over the last few years and with commitments to ending AIDS by 2030, a much more considered and stronger attention to community engagement, involvement and ownership at all levels of the program has been envisioned. The primary consideration has been towards achieving outcomes in both the domains of prevention and treatment, with an emphasis on KP and prevention response; as well as people living with HIV and retention on treatment programs. The GFATM grant provides an opportunity to systematically approach CSS and Community Led Monitoring (CLM) that can improve impact, efficiency, effectiveness and accountability and thereby lead our country towards the 2030 goal to end AIDS.

NACO, in collaboration with UNAIDS, organised a National Stakeholder Consultation on 18th February, 2021 to facilitate community discussion and deliberation on CSS that can provide inputs into the development of a National CSS framework as well as processes and tools critical to undertake a CLM pilot. NACO had invited key stakeholders including development partners and community representatives to the consultation to ensure that CSS implementation and CLM roll out has the community at the centre with a strong partnership between the community (KPs and PLHIV) with District, State and National actors. Senior officials from NACO, UNAIDS, USAID and (President;'s Emergency Plan for AIDS Relief or PEPFAR), Swasti, and community experts and members from all KP participated in this one-day consultation.

A global overview of the CSS was provided , highlighting the objective to achieve improved health outcomes by developing a role for key affected communities in design, delivery, monitoring and evaluation of services related to prevention, treatment, care and support of people affected by HIV.

It was recognized that the CSS framework was key to ensure development of a community resource pool, strengthening CBOs that in turn provide closer engagement with governments, strengthening CLM and strengthening stakeholder linkages, while also ensuring the establishment of Central Community Steering Committee to oversee implementation.

The approach being developed by NACO is a bottom-to-top approach ensuring that the community is involved at every step. The importance of allocation of domestic funding for community systems strengthening towards institutionalization of the process over time, was emphasised along with the need for creating an enabling environment and evolving mechanisms of monitoring to develop a shared understanding of enablers and barriers to services.

It was reiterated that the leadership of NACO wants to ensure that community system strengthening and community led monitoring leads to the achievement of the overall 95:95:95 goals of the SDG by 2024 by India.

The participatory sessions (facilitated break-out sessions) provided inputs on four important areas of CSS which included: Steering mechanism and Community Advisory Board (CAB) in district level; Capacity building and CBO engagement; Selection and engagement of community champions; and CLM tools, process and timelines.

It was summarized that the Steering Mechanism and CAB at district level needs to include 80% community members and 20% non-community members. Mechanisms to maintain confidentiality with well-defined roles and responsibility need to be in place. It was observed that representation has to be ensured from new emerging sub-groups like youth and hard-to-reach populations based on geographies.

Emphasis was laid on empowerment and capacity building plans for system strengthening that ensure updated knowledge, community sustainability and resource mobilization for the long term. It was also articulated that an enabling environment needs to be created, by tackling barriers like stigma and discrimination, legal and structural barriers.

Lastly, for CLM to be a sustained approach, it was recommended that it is owned by the community and the government jointly, with access and escalation mechanisms down to the district level. Emphasis was placed on transparent and clear communication between stakeholders to ensure service quality and acceptability. (Detailed group discussion points are elaborated in the body of the report)

Shri Alok Saxena, Joint Secretary, NACO concluded the national stakeholder consultation by recommending the way forward based on the inputs delivered from the group sessions. He outlined the importance of engagement and involvement of the community at all levels of program implementation through CSS that includes regular and institutionalized monitoring. The operations framework, he mentioned, will be on the basis of our response in the context of both CSS and the planned pilot for CLM. The community working group, he said, was to consist of members of the community that would oversee, provide input as well as build broader consensus on further detailing the CSS framework and the pilot CLM roll out. He felt that the suggested 80% community participation at the Steering Committee was the way to go and this should resonate at the level of the Community Advisory Board at the district level. While the importance of capacity building initiatives should focus on empowering and inclusion of new youth leadership, he outlined the criticality of partnership, ownership and joint responsibility in making CSS work for the overall benefit of the people that NACO strives to serve. The following chapters capture the discussions during the day as well as recommendations and way forward.

**As per the India HIV Estimates 2019, NATIONAL AIDS CONTROL ORGANIZATION & NATIONAL INSTITUTE OF MEDICAL STATISTICS*

[1] Under NACP, Community is referred to as Female Sex Worker, Men who have Sex with Men, Transgender/hijra, Injecting Drug Users

Background

CSS aims to achieve improved outcomes of targeted intervention (TI) programmes in India which is one of the main prevention strategies under the NACP. Evidence and experiences suggest that the health outcomes can be enhanced by strengthening community based and community led systems for prevention, treatment, care and support. Under the Global fund grant, a systematic approach has been envisaged to strengthen the community systems in India. The main objective of this systematic approach is to supplement the ongoing TI programme by building capacity of the communities and strengthening systems which will lead to increase their participation in the national response.

An important aspect of CSS is CLM. The objective of institutionalising CLM within the National AIDS programmes is important as it will ensure that the programmes meet the needs of the communities at all levels. CLM is an important strategy to strengthen the programme's impact, efficiency, effectiveness, and accountability through a better collaboration between civil society, KP, PLHIV and national state and district level decision makers. Overall, CLM will contribute to the assessment of performance and service quality, the identification and addressing identified barriers such as access, stock outs, and stigma and discrimination.

For an effective CLM a strong participatory partnership between the community, KP, PLHIV and the district, state and national actors is critical, to ensure that the data is integrated in the monitoring systems and response time is minimal, through real time access to data collated and analysed to support decision making by the national authorities based on insights.

The objectives of the stakeholder consultation* are:

- To share the concept of CSS in global perspective with key stakeholders including development partners and community representatives
- To discuss and seek inputs on the CSS framework in respect with upcoming NACP-V
- To seek inputs on the process of CLM pilot

**The national consultation was organised virtually due to the restriction of the global COVID-19 pandemic*

Proceedings of the National Consultation

The consultation started with ***Ms. Ranjana Rawat, UNAIDS*** welcoming officials from NACO and representatives from development partners from UNAIDS, PEPFAR, USAID, CDC, Swasti, Civil Society Organisation and the community. She proceeded to introduce the main purpose of the National stakeholder consultation i.e. to define the course of action on Community System Strengthening (CSS) in NACP-V with the objective to strengthen community engagement for improvement of HIV comprehensive service delivery. She further broke down the objectives by reiterating the importance of sharing the concept of CSS from a global perspective with key stakeholders including development partners and community representatives, and to discuss and seek inputs on the CSS framework with respect to the upcoming NACP phase V and on the process of piloting Community Led Monitoring (CLM).

Ms. Rhea, Swasti shared housekeeping instructions for the meeting to the participants along with a brief on the overall structure of the meeting, including information on the break-out sessions as detailed in the agenda.

Ms. Nandini Kapoor, Senior Technical Officers, UNAIDS was invited to set the context on CSS and CLM in the global setting. She elaborated on the work that has been done in the last year on the CSS and CLM including consultations and discussion with Global Fund, NACO, development partners as well as the community. She started her presentation with defining CSS as interventions that support the development and reinforcement of informed, capable, coordinated and sustainable structures, the development of mechanisms and processes, creation of actors through which community members, organisations and groups that interact, coordinate and deliver their responses to the challenges and needs affecting their communities. She elaborated on the key principles and core components of CSS and CLM while emphasising the importance of community engagement. Community engagement, in the process of implementation CSS, will ensure that community members and CSOs have shared responsibility to strengthen services available and raise issues or challenges faced, by strengthening partnerships and collaboration, with an emphasis on empowerment of priority population groups, and towards sustainability of civil society in reduction of stigma and discrimination, removal of structural barriers, ensuring quality services, as well as continued functioning beyond government or private funding sources.

Dr. Shobini Rajan, Chief Medical Officer, NACO started her presentation on CSS & CLM in India, by welcoming everyone to the national consultation, praising the strength of the meeting. She elaborated on CSS in the Indian setting by citing examples of mechanisms like Technical Working Groups, Technical Resource Groups of NACO, Feedback dropbox by VHS, third party evaluation by YRG, etc. She reiterated the objectives for CSS as development of community resource pool, strengthening CBO & Government, strengthening CLM and strengthening stakeholder linkages, while also ensuring the establishment of a Central Community Steering Committee to oversee the implementation. Another main focus area would be on capacity building and leadership development under CSS including a training needs assessment, module development as well as training of trainers (ToTs) for community engagement to ensure that capacities are continually strengthen and updated, despite attrition or turnover. On community-led monitoring, she reiterated its core components as a system for collection, compilation and redressal of feedback of the community on services provided and accessed. Other core components of CSS would be focused on community mobilization on health and social issues, development of linkages of community with service providers and collaboration with all services under NACP as well as ensuring smooth coordination amongst all stakeholders from different vertical ministries relevant to HRGs.

On the community perspective on CSS & CLM, ***Ms. Mona Balani, NCPI*** brought forward the point that CSS is a principle that is applicable to all interventions in response to HIV, with the community comprising all vulnerable populations. The approach being developed by NACO is bottom-to-top, ensuring that the community is involved at

every step. As a person living with HIV, she has seen the initiation of system strengthening by NACO for the past 15 years starting from NACP III. We need to ensure strengthening of involvement of communities by providing technical support through TIs, ensuring inclusion of all KP groups in programs for the community and by the community; and the development of community advisory or monitoring boards as community feedback mechanisms at the district as well as the national level. She also emphasised that CSS is not only to ensure filling the gaps identified but also to ensure accessibility of programs at the grass-root level with equal ownership from the services providers and the beneficiaries. ***Ms Reshma, Dostana Safar*** continued by stating that it is heartening to see NACO take the initiative of community involvement beyond the Care and Support Centers (CSC) level. She emphasized that there is an urgent need to focus on strengthening organisational systems of CBOs and there need to be concrete plans for their capacity building to ensure sustainability of the organisations and service provision. There is a need to also ensure that the communities are involved at all levels of CLM when rolled out including groups like TGs and MSMs who are usually more invisible.

Dr. Sundaraman, from the Civil Society Perspective on CSS & CLM stated that since this initiative is about community systems and the strengthening of those systems, we have to ensure engagement of the community in a way that brings out the current and relevant needs towards achieving the HIV goals for India. He briefly spoke on the history of the HIV movement, when HIV was considered as a killer disease, and how civil society played a pivotal role, in bringing civil action which proved catalytic in mobilising community, moving community and making community take the lead in the response to HIV. This was further proved and endorsed when under NACP-III, it was decided that 50% of interventions were to be implemented by community-based-organisations. This initiative by NACO and the only government agency funded by Global fund on CSS, is taking responsibility to ensure that the community is in the middle of the response, are forerunners of community mobilization, and provide and promote strengthened community systems. He applauded the multilateral partners like UNAIDS, PEPFAR, CDC on their involvement in taking forward the agenda of CSS in India. Lastly, he emphasised the importance of allocation of domestic funding for community systems strengthening towards institutionalization of the process over time. He concluded with the hope that the consultation is a step towards realising a realistic plan and development of the national framework for implementation of CSS and CLM.

Dr. Sangeeta Kaul, PEPFAR in her session on PEPFAR priorities and experiences for CSS & CLM reiterated that PEPFAR believes full participation of community stakeholders and civil society organisations at every stage of programming and planning; from advocacy to service delivery is critical to the success and sustainability of the global efforts to combat HIV and AIDS. She highlighted the importance of creating an enabling environment by strengthening communities to actively and continuously monitor service access, , as it develops a shared understanding of the enablers on barriers to services for beneficiaries. She emphasised the essential role of peers and civil society organisations in providing insights about services using routine and systematic data collection processes leading to action and adaptation of programs to address the current and changing needs of the communities. Recognising that civil society has been a leading force in the response to HIV, by providing expertise, building relationships with communities and, by providing understanding of the current environment, they should be involved in informing the development of service delivery models. It is also essential to ensure that CLM activities should be community driven and implemented independently from Government and service providers.

Dr Melissa Nyendak, CDC started her presentation by stating that India remains unique in its implementation by ensuring the community is at the centre of its HIV response. Community wisdom, involvement and collaboration have value added to the expertise of the technical staff and service providers in public health. She cited the example of community scorecards- a two-way participatory tool used routinely for assessment, planning and monitoring and evaluation of health and HIV services, facilitating continuous and enhanced dialogue between beneficiaries, healthcare providers, while providing a detailed snapshot on issues of unmet needs, demand for quality of care or

supplies, infrastructure, and issues of stigma and discrimination. She expanded on the community scorecard; as a four phase process focused on continuous improvement, with scoring of all the indicators, development an action plan based on the results, dissemination of data to relevant stakeholders with advocacy focused on resolving issues highlighted, thereby directly enhancing community engagement and system strengthening. Citing lessons from India and Vietnam, the scorecard has seen increased ownership by the community, as a platform for wider understanding of barriers to services and ways to generate a dialogue towards advocacy to address those barriers. She reiterated that community system strengthening, and community-led monitoring efforts under NACO are an essential element of the partnerships to improve HIV comprehensive service delivery.

In his remarks, ***Dr. Bilali Camara, Country Director, UNAIDS,*** reflected on the importance of communities leading to get the community engaged and mobilised, with the communities defining the work of UNAIDS as well as NACO in the response to HIV. It is important to do more in terms of community strengthening and monitoring since the program response cannot be effective without the community as partners and collaborators. The voice of the community is essential to ensure success. He applauded NACO's leadership on working together with implementing partners to make a difference for the community and with the community. UNAIDS was grateful to be part of the process in taking CSS and CLM forward to make the goal of 95-95-95 as reality in India.

Dr. AK Puri, DDG, BSD, NACO, believes that CLM is a process based on the basic principle of *"nothing for the community without involvement of the community"* with the reach to the grass-root level in a public health response. He stated that the bottom-up approach will be most effective and impactful to ensure that the issues of communities are identified and addressed, ensuring benefit to all. There is also a need to include new members and develop new leadership, identify common agendas towards the national response and goals set by India.

Dr. N Goel, DDG, CST, NACO, reflected on NACO's history on working formally and informally on community system strengthening and the reason that India has better averages, in terms of parameters for new infections, AIDS related deaths, and prevalence; due to this history of engagement and strengthen communities. In this new phase, NACO is very serious on taking community system strengthening and community led monitoring to the next level and focusing on how the 95s will be achieved. He reiterated the focus being firstly on empowerment and leadership development, secondly on participatory learning at the field towards greater impact and ownership in the program, wherein community-led monitoring goes beyond routine monitoring and reaches the ones who can't be reached by the government systems; and lastly, to ensure a system of quick redressal of issues identified through data gathered via use of technology.

Ms. Shama Karkal, CEO, Swasti, presented the plan for the CLM Pilot implementation in 7 districts of Telangana and Maharashtra, with the key focus to generate inputs from recipients of HIV services in a routine and systematic manner that will translate into action and change in HIV services implementation. The key principles of the pilot are based on collaborative work with communities and service providers, respecting the community, solution orientation to improve outcomes while reducing human rights barriers to accessing HIV services. She also explained the steps for CLM pilot testing, with the first step being engagement with the community in the process, generating and gathering evidence for gap analysis, provision of solutions, engagement at the district and state level on the process of CLM, usage of scorecards and support from established CABs. The CLM process will use community scorecards which are a performance improvement tool, to ensure community engagement and to generate inputs on the quality and accessibility of HIV prevention and treatment services. The scorecard will assess all services providedon HIV testing, STI treatment as well as linkages to other health services, wherein the method for scoring, weightage and analysis is being drafted. The results from CLM will be then discussed to develop actions at the district and state level, in consultation with all stakeholders, to develop specific action plans. These action plans will then be monitored and reported on transparently.

Points of discussion from the participants:

» Under NACO, there is a strong component of CSS in the past year, which we are grateful for, but there is a need to ensure that there is strengthening of the systems and not only the community towards representation of voices from the ground. Secondly, there is no need to focus on increasing the capacity of CSOs and communities beyond funders and funding. And lastly, capacity strengthening is needed for CBOs and communities, to provide the space and increase advocacy for demand generation independent from involvement in the implementation of the programs.

- Suggestion to create a community expert group to make sure that the gains from rolling out CSS are strengthened and sustained beyond the period of the program and creation of advocates to influence decision and policy makers for the betterment of the overall communities.

Breakout session

The opening plenary was followed by the breakout session in which the participants were divided into four groups for discussion on the following:

Group – 1: Steering mechanism and CAB in district level

Group – 2: Capacity building and CBO engagement

Group – 3: Selection and engagement of community champions

Group – 4: CLM tools, process and timelines

The groups were divided keeping in mind the diverse representation from all KP, PLHIV as well as development partners invested in India. The design of the groups provided the opportunity for the group members to keep forward their agenda points ensuring adequate prioritization of all KP, related issues and build consensus on the details of CSS and CLM framework. At the end of the break out session, each group summarized and presented their discussions.

Summary of break out session discussions

Group 1: Steering mechanism and CAB in district level

Presenter: Yashwant, APD, Andhra Pradesh

List of Participants:

Shobini Rajan, Chinmoyee Das, Bilali Camara, Sangita Pandey, Yashwinder Singh, Sushena Reza-Paul, Mona Balani, Deepak Rana, Jamshir Bagwadia, Manjula R, Deshopriya Mahapatro, Raiguru, Shivlal Gautam, Anurag Saikia, T. Geetha Prasadini, SK Harikumar, Pankaj Kumar (IAS), Lakshmi Ramakrishnan, Rachana Mudraboyina, Shantanu Purohit, Deepika Joshi

Summary points of group 1

» Inclusion of 80% community as members with representatives from service providers (SACS, NGOs, other government departments, DALSA, SALSA, etc,.) with mechanisms to maintain confidentiality with well-defined roles and responsibility

» It should be seen that with majority community representation, it becomes a safe space for people to voice their concerns

» There should be access to and inclusion of all communities towards creating an enabling partnership. Support from legal advisors to be provided as needed

» There should be **community representation** including new emerging sub groups like youth the **hard-to-reach and actual community at the ground level** who are not connected to service provision

» Mechanisms should allow communities **access to CAB** at the grass-root level

» There should be **clear mechanism on the flow of information from district to state** and then to national level as well as on the redressal action, with CAB meeting at the district level on a monthly basis. Rotational participation with regular attendance of 12-15 members, quorum 2/3

» The stakeholders in the **CAB should have sufficient authority to take action**, and not just in a representative role (government)

» Direct influence of the steering committee to decision makers to resolve issues raised.

» The social line departments need to play a role too and to cover larger issues like advocacy, S&D, violence, human rights, social inclusion and benefits, wherein various departments' help can be sought and facilitated.

» There should be **creation of enabling environment** by tacking barriers like stigma and legal barriers

Group work presentation

The key steering mechanisms that should be initiated at the national, state and district levels.

» There is a need to form a steering committee with representation of 80% of the community and 20% from non-

community stakeholders, service providers, other departments of the government like WCD, SWD etc.

» Selection for the steering members for CAB should be done by communities themselves

» There is a need to understand mechanism and distribution of roles and responsibilities for steering committee

The key activities that will need to be undertaken towards the establishment of these mechanisms

» Could consider adoption of an existing mechanism for establishment of the steering committee or have an innovative system that ensures active representation from district /state level board of community

» Size of steering committee or quorum of the committee to be decided

» Composition of the steering committee to include with community groups of community and human right law network, DALSA, SALSA

The scope/roles and responsibilities of the members of these national and sub-national bodies, and the frequency of their meetings

» Steps of the grievance redressal to facilitate issues through the steering committee

» Frequency of the meetings at national, state district level

» Constitution of the committee with representation from CBO, CSO and other non community stakeholders with their specific role in the SC

» Place of meetings: need to decide venue of meetings. SACS, DAPCU not preferred, since the narrative should be controlled by communities. SACS DACS to participate

» There should be anonymous participation in the steering committee

» It was recommended by some members that the Steering Committee should be led by PLHIV community

» The Steering committee should have the level to influence decision makers on issues highlighted by the Committee

Group 2: Capacity building and CBO engagement

Presenter: Seema Sayed, AASTHA

List of Participants:

Seema Sayed, Shrirupa Sengupta, Jalpa Thakker, Anthony Reddy Yeruva, Murugesh, Richard Francis, Rita Prasad, Sagar Karmakar, Alok, Kusum Nagar, Chahat, Nandini Kapoor, Md. Saddam, Hauzel Manngaih Kim, Moses Pachuau, Suman Sehrawat, Kavitha Potturi

Summary points of group 2

» Development of **organizational development plan of CBOs** with emphasis on flexibility and adaptive capacity to emerging trends from the community in a sustained manner with the support from the government at state level.

» **Manuals and training to be developed based** on evidence and current knowledge gained from the community an unrestricted accessibility plan for the community members.

» **Emphasise on building second line leadership within CBOs** with shift from beneficiaries to stakeholder.

» Emphasise on system strengthening to ensure sustainability and resource mobilization for the long term and moving away from project or funder driven community work.

» Empowerment and capacity building to create an **enabling environment and reduction in stigma and discrimination**

Group work presentation

The barriers that currently exist towards optimal CBO engagement - Part A

Community Empowerment:

» There should be a shift from being seen as a beneficiary to being seen as an active stakeholder - both for the community and for the institutions

» Community members live in several "unknown fears" - for drug users, it is often to do with legalities; for women in sex work, it is also in terms of stigma and legal issues

» Building agency is important at communities, there are several power dynamics at the service provider level which need to be addressed.

» How do we partner with communities to ensure that communities are aware of their rights and are able to demand that their rights are respected by service providers?

» Community confidence to close the service gaps

» Loss of institutional learnings in CBOs as new leaders come in with little or no documentation trail

Platforms:

» Communities need to have a platform at regional, state, district and facilities levels where people are truly heard – moving beyond tokenism

» Geography is important to keep in mind. For example, North India has several regional variations - so many of the drug users live on the street and have their own individual struggles.

» Although TIs are an important and integral part of the community, their representation is not enough. We need participation from community members who may or may not be a part of TIs, participating in capacity building trainings

» Involvement of young people is important

» SACS, TSU, DAPCU, TI - must have community representation and participation

Inclusion & Enabling Environment:

» For community to be staff in programmes, the eligibility criteria will need to take in account their lived realities

» Feedback mechanisms need to strengthened

» The focus should also be communities not being reached by TI (non-TI groups) need to be a part of this effort

» Intersectionality needs to be factored in during program design

» The newer leaders, community organizations are often left out of different trainings. They must be included

» It is critical to operationalize the different actions taken before - such as different charters and agreements

The key areas of need for capacity building for communities:

» Leadership building – move from victimhood to becoming change agents, CBO institutional memory building

» Institutional building - governance systems and financial management, HR management, programme planning and management, proposal writing etc.

» Resource mobilization for sustainability- such as social enterprise and innovative finance, approaching CSR representatives and other funders

» Sustainable financing as a goal instead of limiting to project funding

» Building capacity of CBOs to apply for TIs and access more funding; ensure no one is left behind

The channels, mechanisms, modality and frequency for community capacity building:

» Establishing a cadre of community master trainers through ToTs so that there is continuous handholding and support at district, location level - trainers must have regional / cultural context and familiarity

» Leveraging the state institutions to maintain and access training resources

» Feedback from trainers (from the community) to continuously improve tools for trainings

» Guidance manual to help the CBOs strengthen their institutional capacity

» Networks need to be involved to mobilize community members for crucial trainings and meetings

» State level training institutions can have a segment for community members and trainers

» The trainers should have a feedback mechanism

» Community strengthening body should be autonomous from the state AIDS body so that it can reach the community where it matters

» The youth among the community must be prioritized for capacity building

» Reaching the last mile with onsite mentoring and handholding support with regular training.

» Using multiple channels based on content to reach the appropriate audience - mixed methods - A/V, WhatsApp, Audio etc

» Funding mechanisms such as Global Fund and PEPFAR can be explored

Group 3: Selection and engagement of community champions

Presenter: Raghav Singh, DUN

List of Participants:

Sumita Taneja, Sangeetha Kaul, Lalthlengliani, Kiran Misra, Raghav Singh, A. Vijayaraman, Snehal Shah, Abhina Aher, Prakash, Aparna Banerjee, T. Avinash Kumar

Summary points of group 3

» Some of the barriers that champions can face are the lack of financial support, lack of experience in advocacy and stakeholder engagement, and as an advocate might not be recognized as champion by both the community and the government at the same time

» **Champions should be nominated by the community themselves** based on their skills on advocacy and stakeholder engagement, knowledge on the issues of KP, and with a solution oriented mind-set

» To **adopt several approaches for identification of champions** ranging from selection from all HRGs, from the grass-root level service providers with their ear to the ground on issues of the KP, recommendations from SACS, CBOs, etc as well as focus on the approach of especially involving young people

» To **ensure inclusion and prioritization of all communities including sub groups** due to the trend of intersectionality and self-identification

» **Development of toolkits for community champions** on defining their roles and responsibilities

» To ensure **training of community champions on advocacy skills**

Group work presentation

Diverse communities which need to be represented within the CSS umbrella

Should have a pool of champions in each district (can go up to 20 persons)

» All typologies should be included (should consider sub-groups e.g KP member and PLHIV)

» They should be identified by the community themselves

» They should be self-driven and should be looked up to as an influencer by their peers

» They should have experience of TIs and should have been an active beneficiary of TI / HIV services

» It should be seen that person is non-political/credible

» Basic literacy skills (should be able to read/write)

» Will be good if the person is involved with a CBO (to have a CBO backing)

» It should be seen that champion is willing to give time

» They should be remunerated for their contribution. NACO/SACS to factor the cost of their travel and a reasonable honorarium

Should have a good rapport with the community and be a voice of the community

» They should be able to collect and pool the issues from the community

» They should be able to articulate their issues, and not just put-up the problems, but also propose solutions

» They should be able to have good rapport and negotiation skills with government facilities and departments

» They should have positive advocacy approach

» They must have good negotiation skills

» They should be articulate with good communication skills (should be able to make their point succinctly)

» Once champions are selected, they will need to be capacitated

» The rotation of champions should be considered

The key mechanisms through which community champions can be identified

Approach 1: Recommendations from CBOs/PLHIV networks

» Champions to be identified from among the TIs / peer educators (2-3 champions from each HRG)

Approach 2: Open call

» Post in TIs and other platforms; invite applications, conduct interviews to assess their self-motivation

Approach 3: Consultative selection involving SACS and CBOs

» Seek SACS and CBO recommendations and whoever are the common names could be considered

Approach 4: Identify young community champions to ensure that issues of young adolescents / youth who are most vulnerable are not missed

» Link with NHM adolescent health clinics, ARSH / RKSK, SRH programs, PLHIV networks where young PLHIV are registered

» Sensitize staff of the non-HIV clinics to ensure that they are sensitive to young / vulnerable populations (particularly MSM/TG/Drug users)

The barriers, facilitators and conditions for greater involvement of individuals who can be representative and effective voices of the community

Facilitators

» There should be a focal point at SACS/DAPCU for the champions to be in regular touch (regular/monthly meetings with champions)

» Orientation of the SACS/DAPCU on the role of community champions and their engagement

» Backing of a strong CBO for the champion

» Honesty and credibility of the champions will go a long way in ensuring good acceptance by SACS/DAPCU and line departments

Identify the larger ecosystem which surrounds the community to facilitate a conducive environment for community strengthening

» Will require support from NACO, SACS and DAPCU

» Having a focal point at NACO, SACS and DAPCU

» There needs to be enough resource allocation

» Should have the support of CBOs/local level PLHIV networks - should be a coordinated mechanism

» Should have district, state and national level champions

» Need to develop a toolkit for the champions – defining the role, engagement

Group 4: CLM tools, process and timelines

Presenter: Firoz Khan, Alliance India

List of Participants:

Abou Mere, Anupam Hazra, Ayeesha, Devi, Bhawani Singh, Firoz Khan, Ira Madan, Manish, Melissa Nyendak, Pushpalatha, Reshma Prasad, Rohit Sarkar, Sundar Sundararaman, Vandana Stapleton, Bhawana Rao, Malavika Nambiar

Summary points of group 4

» **CLM mechanism needs to be a sustained approach** owned by the community and the government with access down to the district level, and emphasis on transparent and clear communication between stakeholders

» The modalities of community monitoring must **focus on information collection at the grass-root, using IT technologies** to gather information in real time, accessible to all, with a smooth redressal mechanism to address specific needs and issues

» The mechanism should focus on **key indicators including service accessibility, availability, and treatment literacy, including removal of barriers** especially in the rural and remote areas

» The **mechanism should ensure anonymity** when it is about immediate grievances and feedback and also support the increase in awareness and treatment literacy along with system of quick redressal

Group work presentation

The Key Considerations for Rolling out of CLM across States

» Cannot be about "project"; needs to be sustained and hence requires buy-in and ownership at all levels especially at district

» District and State level focus is important

» How can anonymity be maintained throughout?

» Recognition needs to be given to the chosen community members

» How to structure a smooth channel of communication between the community and the state, where issues can be solved without involving national representatives

» CLM process itself would enable community to learn about their rights and services - important capacity building

» The implementing agency cannot be directly involved in service delivery

» Necessary to determine how CLM can address varying needs

» Attention to immediate issues which cannot wait for one month, quarter etc

» Ongoing, qualitative inputs on programme improvement

» CLM tools to be created along with the community

The Key Proposed Modalities

» Community Report Card instead of "Score Card"

» Create a transparent method

» This can be used as a tool to collect first-hand information from ground level

» This can be used as a tool to raise red flags during audits

» The system will incorporate the findings and feedback back into the system

» This can be both an online and an offline system

» The tool needs a short circuit method for real time feedback

» The community monitoring will be a continuous process and data collection will be conducted over time

» Grievance redressal system

» Create a mechanism of addressing challenges at both the district and state level. (Existing national programmes have a 'One size fits all' approach)

Key performance measures or indicators that must be monitored (in relation to the experience of recipients of services, barriers and enablers)

» Availability/accessibility products and services. Include stock-outs

» For ART centres, the diagnostic possibility of finding out:
  - Retention
  - Abbreviation of service
  - What do they actually think are going to be the areas of improvement

» Are the community aware about the range of services available?

» Has awareness been generated on the rights to services?

» Can the chosen modality be used as a reference point?

» Has the monitoring been conducted in rural and remote areas?

» Creation of a system to capture unconventional qualitative data, from smaller focus groups

Remarks on the group presentation

Dr A Vijayaraman, VHS remarked on the good insights from all the groups, and laid emphasis on the levels (CBO, district, state and national) that need to be reached when rolling out CSS and CLM with customised approaches. Secondly, it is important to identify communities at the district level and invest in capacity building along with a system of continuous mentoring of the community. It is essential to invest on capacity building as well as social capital for the CBOs in terms of their governance, resource mobilization and programme management or network communications particularly capacity for advocacy to ensure long term sustainability.

Mr. Murgesh, The Humsafar Trust highlighted the opportunity provided by NACO through this consultation to see and understand the roadmap for the implementation of CSS and CLM, with emphasis on community networks development and meaningful engagement.

Dr. Rita Prasad, India HIV/AIDS Alliance thanked NACO, UNAIDS and PEPFAR on the consultation and highlighted that Alliance India as an organization has been working on CSS and CLM (under Nirantar) with the community. Alliance India is looking forward to utilising the learnings and tools to collaborate with NACO and supporting their agenda of CSS along with other communities and relevant stakeholders.

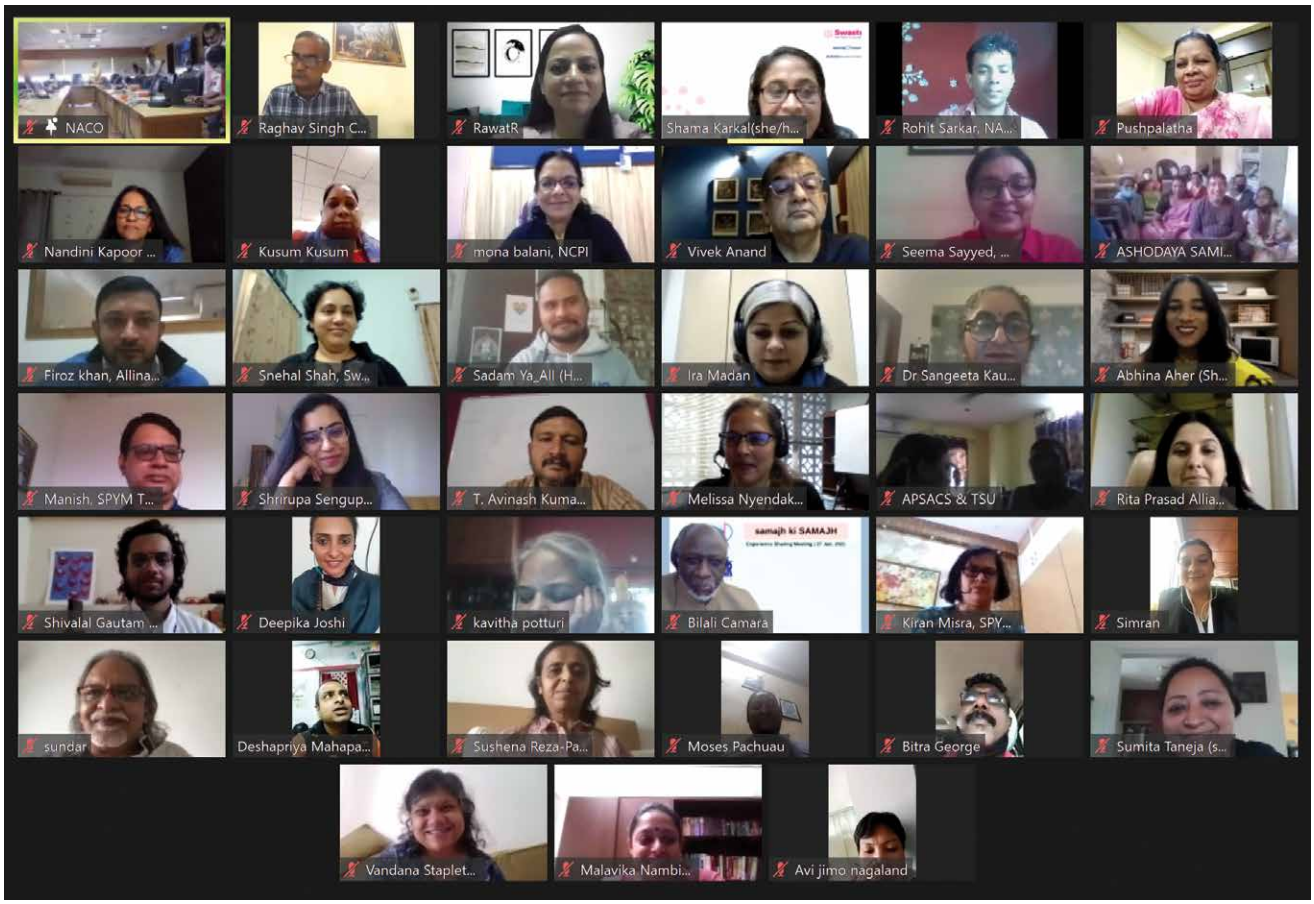
Mr. Anupam Hajra, SAATHII, thanked the leadership on organising the consultation with all the stakeholders involved as they would be working with VHS on rolling out the CSS component, from piloting the tools to being implementation ready when the Global Fund grant starts. He stated that they are looking forward to the opportunities to create synergies with Humsafar trust using everyone's strength for smooth roll out and implementation.

Dr Lalthlengliani, PD Mizoram SACS reiterated that community participation is essential for successful implementation of HIV response and the consultation helped in highlighting many important points. And she hoped that communities remain involved in a meaningful manner.

Dr. Bilali Camara, Country Director, UNAIDS, as co-chairperson for the breakout session addressed the participants by thanking everyone for the valuable inputs and making the consultation productive. He emphasised the importance of CAB and clearly defined ToRs for each district. He also emphasised that leadership of PLHIV and inclusion of youth is very critical for the successful implementation of CSS and CLM, with 80% participation of community and 20% of service providers to focus on identification of issues and solutions to address the same. He reiterated the need for development of skilled new leadership, young people to take forward the agenda of HIV/AIDS, human rights issues, and access to legal services. Thirdly, on the creation of champions at the district level, he reiterated that it is essential to understand issues at the grass-root level for reaching the unreached and capacity building of the community. In terms of CLM, it is essential to take the community along at every step, with constructive feedback and ensuring anonymity, while ensuring regular monitoring of services so that redressal steps can be taken quickly. Collaboration between SACS, DAPCUs and the community is critical to achieve strong CLM along with the three dimensional system to alert for immediate actions by decision makers, routine assessment and reporting, and periodic assessment as well as reporting on quality of HIV services by the community. He also highlighted the need to reach the community where they are at, especially looking at the situation that had arisen due to COVID related lockdowns, to ensure availability and non-disruptions of essential life-saving services to the community. Community based services have to be promoted to ensure quality health service provision, follow-up with lost to follow-ups, and with special focus on reduction in stigma and discrimination. He reiterated that the focus of the consultation is for everyone to work together to serve the people of India.

Shri Alok Saxena, Joint Secretary, NACO in his final remarks, reinforced that the communities need to inform on and monitor the implementation of the HIV program as the main objective of the consultation. He emphasised that NACO will not be monitoring the communities, but the program will be monitored by the community and the stakeholders. He said that we all need to work together and learn from each other through community and stakeholder engagement to ensure that with minimum resources we achieve the maximum impact. At this juncture, he said that we require the community to provide inputs on the roll-out and implementation of CSS and CLM; how we engage the communities, the terms of references, how to avoid conflict of interest and ensuring the optimization of resources. He said that we need to ensure that leadership is capacitated and second line leadership is created from the youth groups from within the communities. On conflict of interest, he said though the TI staff are not SACS/NACO employees, we will still need to be mindful of who all can be in the monitoring and supervision role. He reminded the group that for the past 28 years NACO has utilized staff to implement programs at grassroots levels and despite limited resources and skills available, they have been able to ensure that were no conflicts of interest. Lastly, he reiterated the importance of the reports that have come in from the group work of the consultation as these will be used for developing the action plan as well as the work plan, assuring that once shared with DG and himself in a compiled format, will be taken forward in a concrete manner.

Ms. Shama Karkal, **ended the consultation with a vote of thanks!**



Conclusion and Way Forward

Considering the addresses from the senior officials of NACO, panel members, development partners and representatives of community groups, one common message which clearly came out during this consultation was that the **CSS intervention can only be successful with the involvement and engagement of the community.** The national stakeholder consultation was successful in bringing out issues, defining the "asks" and expected outcomes from this one day consultation as it saw consistent participation from all the participants for the duration of the consultation. Some of the key messages that came out clearly and with consensus, are summarised as below:

- CSS intervention's success is dependent on the meaningful involvement and engagement of the community wherein they represent the gaps in the National response
- There is a need to empower new leaders from the youth group and other emerging subgroups and concentrated capacity building efforts are required wherein the training is beyond the SACS's scope of work
- Mechanisms like steering committees and working groups need to be established to ensure monitoring and inputting in the implementation processes of CSS and CLM pilots
- It is essential to reach the community where they are at, to ensure availability and non-disruptions of essential life-saving services, with quality monitoring by collaboration between SACS, DAPCUs and the Community
- Resources and platforms are needed for advocacy by the community to ensure no conflict of interest, optimization of resources, and building sustainable partnerships towards institutionalization of CSS models in the national HIV response including at NACO
- Main areas of work under CSS are to ensure the reduction of stigma and discrimination, by removing barriers to creating an enabling environment for access to HIV prevention, treatment and care services

Proposed timelines:

S. No.	**Activity**	**Timeline**
1.	Virtual stakeholder consultation at National level to finalize field testing modality, SOP and concept note of Community systems strengthening	31 January, 2021
2.	Presentation to NACO leadership and approvals	End March, 2021
3.	Field validation of CLM tool and compilation of end line findings through PEPFAR partners	Three months
4.	Engagement of National CSS team through SR under GFATM	By 31 May, 2021
5.	Finalization and dissemination of CSS Operational Framework	By 31 May, 2021
6.	Creation and notification of a National coordination mechanism for CSS	By 30 June, 2021
7.	Module development for various Community Health Workers and CBOs	Over three months
8.	Roll-out of field level activities through the PEPFAR partners and NG PRs under GFATM	From 1 October, 2021
9.	Quarterly and National monitoring through the National CSS team	Every quarter
10.	Integration of CMS tools into NACO's SOCH system	By 31 March, 2022

Annexures

National Stakeholder Consultation on Community System Strengthening (CSS)

(Defining Course of Action for CSS in NACP-V to strengthen community engagement for improvement of HIV comprehensive service delivery)

Date: 18 February 2021
Time: 10.30 am to 04.30 pm
Place: Virtual
Chair: Ms. Arti Ahuja, IAS, Additional Secretary & Director General, MoHFW

Objectives of the meeting:

» To share the concept of 'Community System Strengthening' (CSS) in global perspective with key stakeholders including development partners and community representatives

» To discuss and seek inputs on the CSS framework in respect with upcoming NACP Phase V

» To seek inputs on the process of Community Led Monitoring (CLM) pilot

Agenda:

Time	Agenda Item	Facilitator/Presenter
10:30 am	Welcome	Ranjana Rawat, UNAIDS
10:40 am	CSS/CLM context setting	Ms. Nandini Kapoor Dhingra, Senior Technical Advisor, UNAIDS, India
10:50 am	CSS& CLM in India	Dr. Shobini Rajan, Chief Medical Officer (SAG), NACO
11:00 am	Community perspective on CSS & CLM	Ms. Reshma Prasad and Ms. Mona Balani
11:10 am	Civil Society perspective on CSS & CLM	Dr. Sundaraman
11:15 am	PEPFAR/CDC priorities and experience for CSS & CLM	Dr. Sangeeta Kaul, PEPFAR/Dr. Melissa Nyendak, CDC
11:20 am	Remarks	Dr. Bilali Camara, Country Director, UNAIDS
11:25 am	Remarks	Shri Alok Saxena, JS NACO

Time	Agenda Item	Facilitator/Presenter
11: 30 am	Inaugural Address by Additional Secretary & Director General, MoHFW	Ms. Arti Ahuja, AS & DG, MoHFW
11:40 am	CLM pilot in India	Ms. Shama Karkal, CEO, Swasti
11:50 am	Introduction to the Breakout session	Ms. Shama Karkal, CEO, Swasti
	Breakout session	
11:55 am (75 min)	Grp – 1: Steering mechanism and CAB in district level Grp – 2: Capacity building and CBO engagement Grp – 3: Selection and engagement of community champions Grp – 4: CLM tools, process and timelines	Moderator and Rapporteur to be selected for each group; Specific questions for discussion will be provided
01:15 pm	Lunch Break	
2:00 pm (75 min)	Group presentations and discussions Chairperson: Shri Alok Saxena, Joint Secretary, NACO Co-chairperson: Dr. Bilali Camara, Country Director, UNAIDS	
03:15 pm	Summary of inputs received	Ms. Nandini Kapoor Dhingra, Senior Technical Advisor, UNAIDS, India
03.30 pm	Next course of action	Dr. Shobini Rajan, Chief Medical Officer (SAG), NACO
03.45 pm	Final remark from Joint Secretary	Shri Alok Saxena, Joint Secretary, NACO
03.55 pm	Vote of Thanks	Ms. Shama Karkal, CEO, Swasti

CSS Invitation Letter

Dated: 15th February 2021

Dear Sir/Ma'am,

Subject: Invitation for National Stakeholder Consultation on "Community System Strengthening" (CSS) on virtual platform on 18th February 2021– reg.

A **National Stakeholder Virtual Consultation** on Community Systems Strengthening and Community Led Monitoring is being planned by National AIDS Control Organisation in collaboration with UNAIDS on **18th February 2021 from 10.30 to 4.30 pm.** Community members, civil society representatives, programme experts, Global fund and other development partners, Bilateral agencies officials of SACS, NACO & TSU will attend the Consultation.

As you are aware that National AIDS Control Organisation (NACO), Ministry of Health and Family Welfare , Government of India ensures engagement of communities at every stage of programme implementation and focuses on strengthening community systems in India. The Community Systems Strengthening (CSS) aims to achieve improved outcomes of National AIDS Control Programme specifically strengthening Targeted Interventions programme, reducing stigma and discrimination, enhancing treatment literacy, Greater Involvement of communities in decision making, and developing structured systems of community monitoring.

An important aspect of Community System Strengthening is the Community Led Monitoring (CLM). The Community Led Monitoring ensure that the programmes meet the needs of the communities at all levels and envisaged as an important strategy to strengthen the programme's impact, efficiency, effectiveness, and accountability through a better collaboration between civil society, key populations, PLHIV and national state and district level decision makers.

The objective of this National Stakeholder Consultation is to share the concept of Community System Strengthening (CSS) in global perspective with key stakeholders, discuss and seek inputs on the CSS framework, and on the process of Community Led Monitoring (CLM) pilot. The expected outcome is to bring greater clarity on CSS among stakeholders and prepare the roadmap for effective implementation of initiative in the coming times.

It is our pleasure to invite you to the National Consultation 18th February 2021 (Thursday). The agenda and programme detailed is enclosed.

You are requested to kindly confirm your participation to Ms Shama Karkal at malavika@catalysts.org and Mr Rohit Sarkar at rohit21official@gmail.com.

Look forward to your gracious presence.

Warm Regards,

(Dr. Shobini Rajan)
Chief Medical Officer (SAG), NACO

Ms Nandini Kapoor-Dhingra
Senior Adviser, UNAIDS India

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CSS Consultation Background

National Stakeholder Consultation on Community System Strengthening (CSS)

(Defining Course of Action for CSS in NACP – V to strengthen community engagement for improvement of HIV comprehensive service delivery)

Community Systems Strengthening (CSS) aims to achieve improved outcomes of targeted interventions programme in India which is one of the main strategy prevention strategies under the National AIDS Control Programme. Evidence and experiences suggest that the health outcomes can be enhanced by strengthening community based and community led systems for prevention, treatment, care and support.

Under the Global fund grant, a systematic approach has been envisaged to strengthen the community systems in India. The main objective of this systematic approach is to supplement the ongoing targeted intervention programme by building capacity of the communities and strengthening systems which will lead to increase their participation in the national response.

An important aspect of community system strengthening is community led monitoring. The objective of institutionalising Community Led Monitoring (CLM) within the National AIDS programmes is important as they will ensure that the programmes meet the needs of the communities at all levels.

CLM is an important strategy to strengthen the programme's impact, efficiency, effectiveness, and accountability through a better collaboration between civil society, Key Populations, PLHIV and national state and district level decision makers.

Overall, CLM will contribute to the assessment of performance and service quality, the identification and addressing identified barriers such as access, stock outs, and stigma and discrimination.

For an effective CLM a strong participatory partnership between the community, KPs, PLHIV and the district, state and national actors is critical, to ensure that the data is integrated in the monitoring systems and response time is minimal, through real time access to data collated and analysed to support decision making by the national authorities based on insights.

The objectives of the stakeholder consultation are:

» To share the concept of 'Community System Strengthening' (CSS) in global perspective with key stakeholders including development partners and community representatives

» To discuss and seek inputs on the CSS framework in respect with upcoming NACP-V

» To seek inputs on the process of Community Led Monitoring (CLM) pilot

NACO Community Systems Strengthening (CSS) in India

Concept Note

Content List

National AIDS Control Organisation
India's Voice against AIDS
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in

1. Background:

Community[1] is at the centre of HIV/AIDS response in India since the inception of National AIDS Control Programme (NACP) under National AIDS Control Organisation (NACO). As a key strategy under NACP, communities are involved at all levels of programme planning and implementation the ongoing prevention programme. The Targeted Interventions programme has evolved over the years as more robust and effective model with greater involvement of communities who works at the grass root level, mobilise the communities and create an enabling environment to increase access to services and reduce stigma and discrimination. Community Mobilization goes one step further in mobilising the community to organize in a gradual process and take the lead through community ownership, formation of Community Based Orgnisations (CBOs) where the community runs and executes the targeted programme through a democratic process. It is also recognized that communities have been instrumental in the areas of advocacy, campaigning and participation in accountability; service delivery, including mobilizing demand; participatory, community based research etc.

1.a. Historical perspectives of Community engagement in NACP with a focus on community systems strengthening: One of the first intervention under NACP – I, was initiated in Sonagachi, Kolkata as form of STD and HIV prevention programme for Female Sex Workers (FSW) in 1992. This programme was pivotal in establishing strategic engagement of community as 'peer based approach', which ensure involvement of selective representatives of this High Risk Group (HRG) as front line service providers for the larger community through a systematic recruitment and capacity building process. This intervention also bring forth evidence of higher acceptability of community implemented programme and supported in defining of community based outreach for "Targeted Intervention" (TI) that is the backbone of community mobilisation and service provision.

In NACP – II, the TI programme was established with introduction of enabling environment as a distinct component. It is essential to note that these HRGs are considered marginalized section of the society super imposed with stigma and discrimination. Also it is desirable that an effective enabling environment creates a reinforcing atmosphere for sustenance of safe practices and

[1] Under NACP, Community referred to as Female Sex Worker, Men who have Sex with Men, Transgender/hijra, Injecting Drug Users

behavior reducing their vulnerability. At the same time, first ever TI on Men who have Sex with Men (MSM) was initiated in Mumbai, along with introduction of as "Knowledge Attitude Behavior and Practice" (KABP) at community level to understand efficacy of the programme to increase HIV related knowledge and safer practices by HRGs in periodic interval. Higher efficiency of this system in scientifically documentation of progress further led it to scale up across TI programme in NACP – III.

Following the course of NACP – III, community engagement is further enhanced through creation of dedicated platforms like Technical Resource Groups (TRG) / Programme Review Board. These systems ensure involvement of community for discussion related strategy development and policy modification, which in-turn contributed introduction of the distinctive component of "Community System Strengthening" (CSS).

1.b. Why community systems strengthening is required in the context of HIV/AIDS response in India and in reaching the goal for complete elimination of HIV/AIDS by 2030

The fast track targets and India's commitment to end AIDS by 2030, warrant focused and stronger attention of community involvement in the prevention response in India. The National Strategic Plan (NSP) focus on community system strengthening (CSS) and empowerment and even calls for community engagement at different level including cadre of health delivery system, placed at both NACO and SACS level.

Community Systems Strengthening aims to achieve improved outcomes of National AIDS Control Programme specifically strengthening Targeted Interventions programme, reducing stigma and discrimination, enhancing treatment literacy, Greater Involvement of communities in decision making, and developing structured systems of community monitoring. Evidences and experiences suggests that the health outcomes can be enhanced by way of strengthening community based and community led systems for prevention , treatment , care and support.

2. Introduction

2.a. Vision:

NACO's vision for CSS is to strengthen community systems to achieve strategic outcomes that together improve HIV/AIDS prevention response and access to high quality services to key population, hard to reach and vulnerable population, reduce stigma and ensure dignity.

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This vision contribute to India's commitment for ending HIV/AIDS epidemic as public health threat by 2030, and complements to the commitment given in the National Strategic Plan 2017-2024. This also complement s NACO's overall vision where every person who is highly vulnerable to HIV is heard and reached out to and every person living with HIV is treated with dignity and has access to quality care.

2.b Objectives:

The broader objectives of CSS is to identify and build up capacity of the communities , community organizations, and networks, overcome stigma and barriers for their effective and meaningful involvement all levels of planning and implementation at national and sub national level to ensure proper implementation of HIV /AIDS response in India.

The specific objectives of CSS are to;

a) Create a community resource pool at national and sub national level for all typologies of and build their capacity
b) Strengthen leadership and governance/ organizational capacity of Community Based Organizations (CBOs)
c) Strengthen community led monitoring and advocacy
d) Build networks, linkages, partnerships and coordination among different stakeholders including Government Ministries, Departments, Faith based organization, Civil society organizations etc.

2.c. Stakeholder type and involvement:

NACO: NACO will form a National Advisory Group or Caucus for Community System Strengthening, comprising Experts from UNAIDS, Community Representatives, Development Partners and Program Experts.

This caucus suggest and reviews the capacity building needs, suggest approach to monitor the capacity building efforts, help in identifying gaps and indicators for review on the progress of different activities. The expected roles and NAG is mentioned in Annexure-I.

The roles and responsibilities envisaged for Principal Recipient and the Sub Recipient of the grant are placed in the table below;

Roles and responsibilities of PR	Roles and responsibilities of SR
• Conduct Need Assessment at State, District , Sub district, municipal area level • Mapping and identification of individual and CBOs • Identification of National Resource pool for Capacity Building • Conduct Capacity Building (State/Regional Level) of at least two community member from each typology and PLHIV in all districts in India (Cascade Trainings) • Implementation OF Community Monitoring System through Cadre selected in all district through CAB or other modalities • Coordination of CAB activities at State and District Level • Conduct Advocacy meetings at State, district, Sub District and Municipal Corporation level and orient different stakeholders including Ministries/ Departments, Organizations etc. • Formation of Community Advisory Board and ensure meeting at State, district and local level • Implementation of community monitoring tools and systems • Organize National level Review of the programme • Develop communication tools/resources • Hand Holding of CBOs in each Major Geographies 2	• Develop Capacity building modules (a) CBO Development and (b) Community Leaders/ Champions / Representatives • Ensure training of National Resource Pool • Develop Community Monitoring System (SOP), implementation through IT platform • Ensure coordination at all levels for cascade training • Coordination with National Advisory Group • Formation of a Project Monitoring Hub at NACO • CBO development module will include gradation of CBOs, HR management, Seed funding etc. • Prepare transitioning and sustainability plan • Ensure coordination with PR and other health systems

The flow chart of the indicative activities of PR and SR for CSS is placed in the annexure-II & III

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3. Key components of CSS Intervention

The Community System Strengthening (CSS) has three major component that are as follows

3.a. Capacity building and leadership development:

Capacity building and leadership development is one of the integral component of CSS. This component is divided into specific inputs / activities to initiate CSS process

3.a.i Needs assessment: As the initial activity under CSS, a needs assessment to be carried out to understand existence of different community level systems across 600 high priority districts along with their current knowledge and capacity to provide HIV services. This exercise to be carried out with incorporation of different data collection methods, including desk review of available documents, discussion (both GD and FGD) with community networks, leaders etc.

3.a.ii Resource pool development: Along with needs assessment, identification of community advocates will be simultaneously carried out at the same 600 priority districts in consultation with SACS, TSU and DAPCU. Initially a review will be conducted to understand status of existing community resource pools / master trainers at each state level. It will be followed by a strategic review process to select experts with relevant experience to form state level resource and to understand skill level of each individuals.

3.a.iii. Module development: Aligning the needs assessment a set of module will be created to enhance skills on theme relevant to CSS. Some of the themes will be on leadership building, organizational governance and financial management, HIV / STI / TB / Harm Reduction / Gender and Sexuality, advocacy. This modules will be developed in collaboration with PRs and SRs of Global Fund programme. While, the national CSS caucus will be involved in reviewing the module

3.a.iv. Training of Trainers: Post module development robust plan of capacity building will be developed starting with training of trainers through a cascade training process at national – state – district level for effective translation of the knowledge till field implementation level.

After 18th months of programme initiation, periodic refresher on thematic issues will be conducted as per requirement of each of the district.

3.a.v. Creation of detail engagement plan for community champions at district and state level: Parallel with national ToT, a plan for community champion engagement will be drafted in support with national CSS coccus and trainees. This primary plan will be develop in alignment with CSS national level work plan focusing macro indicator. This primary engagement plan will be defined further through integration of specific activities at state and district level in respective trainings.

3.b. Community led monitoring and advocacy: Strengthening the existing community engagement systems under NACP, a strategic community led monitoring mechanism will be established to received feedback for improvement of service deliveries at Targeted Intervention (TI), Integrated Counseling and Testing Centers (ICTC), Designated STI / RTI Clinic (DSRC), Opioid Substitute Therapy (OST) centers and Anti-retro viral (ART) clinics. This mechanism will aim to increase community feedback on a set of issues related to services - including accessibility, availability, quality and stigma, so desire improvements can be assured for service uptake towards HIV control.

Currently, NACO is under process to trial this mechanism in selective sites to fine tune the implementation part.

3.c. Social Mobilization, Building Community Linkages and Collaboration and coordination: This includes activities to mobilize communities on health and related social issues and build community linkages. Communities will play a key role in building linkages among various service delivery facilities under NACP and beyond that includes One Stops Centre, Sampoorna Surakhsha Centre, TI, LWS, ICTC, DSCR, ART centre, OST, and other facilities and programmes such as adolescent health clinic, programme under social welfare, mental health etc.

4. Expected output:

The three major output expected from the CSS intervention are

- Increase capacity of community groups and individual
- Strengthening community monitoring system
- Improvement in HIV comprehensive service delivery

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5. Proposed Activities under CSS

In the light of the CSS components, the major activities envisaged are as follows;

- Needs assessment at national, State and district level to see the barriers and challenges relating to community participation,
- Identification of resource pool; individual and community based organizations(CBOs)
- Development of capacity building modules – Capacity building to be done in different areas but not limited to develop Communication skills, integrated services, Social security provisions, and networking, advocacy skills, self administer tool, conflict resolution etc.
- Formation of community Advisory Board
- Strengthening community monitoring systems
- Address adolescent related health services
- Address issues of communities relating to gender, human rights, legal and other socio economic.
- Integration of services
- Conduct advocacy meeting at National, State and Local level
- CBO/ Organization Development, registration of the organizations, grading and address issues relating to governance
- Development of tools for assessment of organizations
- Transitioning and Sustainability
- Strengthening community feedbacks mechanism including Community score card etc.
- Conduct review, experience sharing meeting at national ,state and sub national level

The above activities will be conducted under NACP by NACO and the global fund partners. In order to conduct the above activities smoothly and ensure seamless coordination between different stakeholders, the expected roles and responsibilities have been distributed among the Principal Recipient (PR) and Sub Recipient (SR) of Global fund Grant.

The Expected roles and responsibilities of NACO, PR and SR of Global fund grant are as follows;

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6. Expected Outcomes of CSS

CSS visions has three strategic outcomes as follows;

I. A pool of community resources created at national and subnational level
II. Capacity of community organizations and communities are build up and they take part in national HIV/AIDS response
III. Prevention, treatment and care are made available to all communities people (Increased coverage)

***

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Annexure - I

The role of National Caucus will suggest and reviews the capacity building needs, suggest approach to monitor the capacity building efforts, help in identifying gaps and indicators for review on the progress of different activities.

The expected roles NAG is as follows;

- Discuss methods, kinds, and levels of community involvement in community systems strengthening mechanisms to be conducted under NACO, PR and SR
- Suggest how communities will be involved in making strategic decisions on policy, priorities, and resource allocation
- Undertake review, consultation with strategic thinking on the gaps and level of community involvement in CSS activities, suggest road map for next course actions with timeline
- Suggest how to involve civil society for maximizing community involvement in HIV response in India
- Suggest the capacity building plan and content to be incorporated in the modules communities
- How to strengthen community led monitoring systems
- Develop set of new denominators and targets for assessing progress

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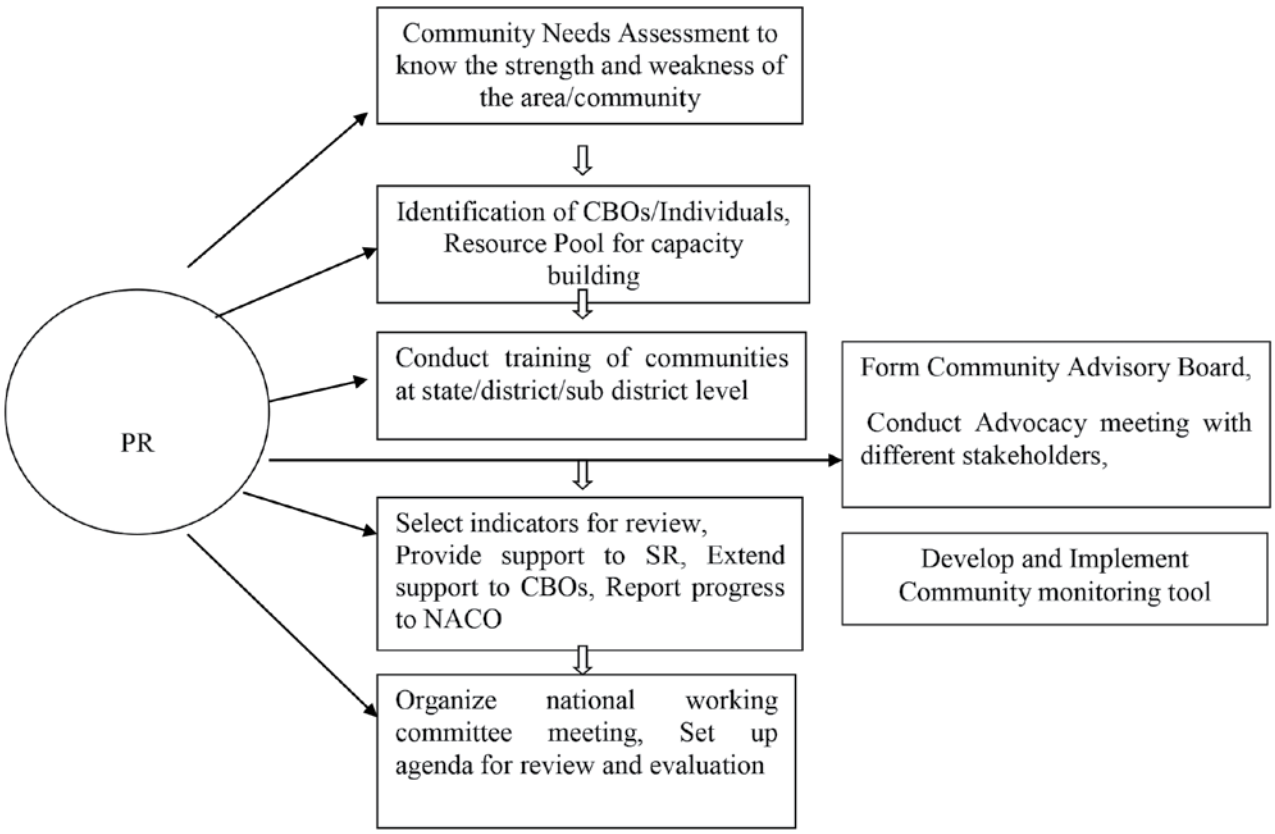
Annexure: II

Roles and Responsibilities of PR and SR under Global Fund

The flow chart of the proposed activities (indicative) of PR is as follows;



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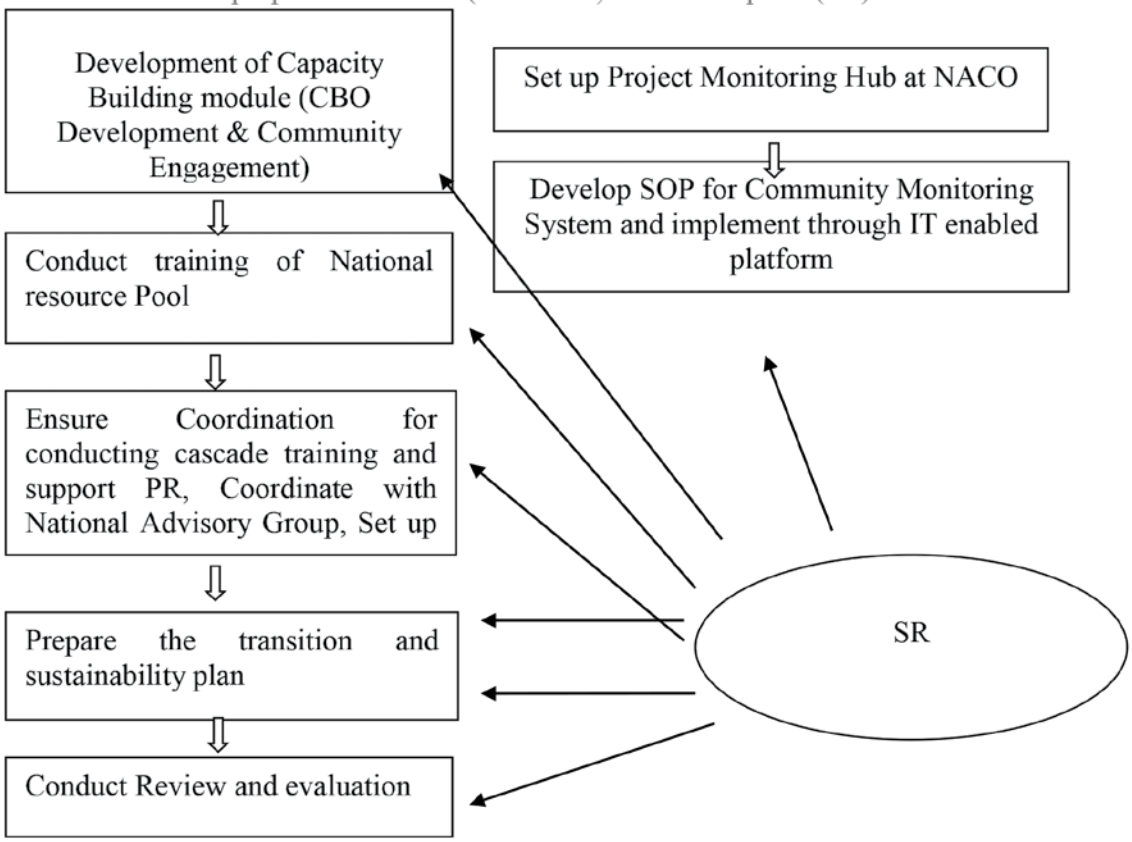
Annexure-II

Flow chart of the proposed activities (Indicative) of Sub recipient (SR)



UNAIDS PRESENTATION PPT

Community System Strengthening and Community Led Monitoring

Community System Strengthening

- **Community systems strengthening**' refers to interventions that support the development and reinforcement of informed, capable, coordinated and sustainable structures, mechanisms, processes and actors through which community members, organizations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities.
- The goal of CSS is to achieve **improved health outcomes** by developing a role for key affected communities in design, delivery, monitoring and evaluation of services related to prevention, treatment, care and support of people affected by HIV.
- Community systems are **structures** and **mechanisms**, **processes** and **actors** that are needed to support community responses
- **Key principles**
  - Significant role in planning, implementation, monitoring
  - Availability of resources for implementation of programmes and organisation capacity building
  - Networking amongst organisations and partnerships
  - Programming based on human rights including right to health and zero discrimination
  - Programming based on evidence and community experience and knowledge

Community Systems Strengthening Interventions

- Community-led monitoring
- Community-led advocacy and research
- Social mobilization, building community linkages and coordination
- Institutional capacity building, planning and leadership development

Core components and elements of CSS

- GFATM CSS framework identifies six core components-
  - Enabling environment and advocacy
  - Community networking, linkages and partnerships
  - Resources and capacity building
  - Community activities and service delivery
  - Organisational and leadership strengthening
  - Monitoring/evaluation and planning

Community Led Monitoring (CLM)

- A **mechanism** for national HIV responses, led and implemented by local community-led organizations of people living with HIV, networks of key populations, and/or other affected groups and entities.

- CLM uses a structured platform and trained peer monitors to:
  - **Systematically and routinely collect and analyze qualitative and quantitative data** on HIV service delivery, including data from people in community settings who might not be accessing health care, and
  - Establish **rapid feedback loops** with program managers and health decision-makers.

- CLM data **builds evidence** on what works well, what is not working, and what needs to be improved, with suggestions for targeted action to improve outcomes

CLM

- CLM can also be used to **monitor trends of service quality** for:
  - Other disease areas (TB, malaria, etc.),
  - Humanitarian situations,
  - Social and structural health interventions including combination prevention,
  - Human rights compliance, promotion and protection.

- Through the CLM process, **community-led organizations** and groups:
  - **Increase their capacity** to gather, analyse, use, and own data,
  - **Compliment the national health data system** and provide key information to fill critical gaps,
  - **Strengthen relationships** with other partners in the national AIDS response.

As the purpose of CLM is to serve as an **alert system for the national HIV response**, CLM is not community-based HIV service delivery or with the routine collection and reporting of by community-led organizations.

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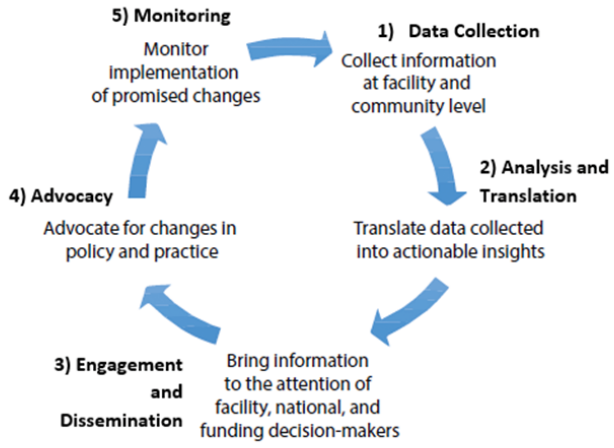
What does CLM process look like?



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Why Community Engagement?

- Inform - community members and CSOs have **shared responsibility** to strengthen services available and address issues or challenges
- Empower – emphasizes the **partnership and collaboration** of the community and facility (support the empowerment of priority populations.)
- Sustain – promote the **sustainability** of civil society to maintain the reduction of S&D, structural barriers, quality services, continued functioning beyond the funding source.

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CSS Consultation NACO PPT

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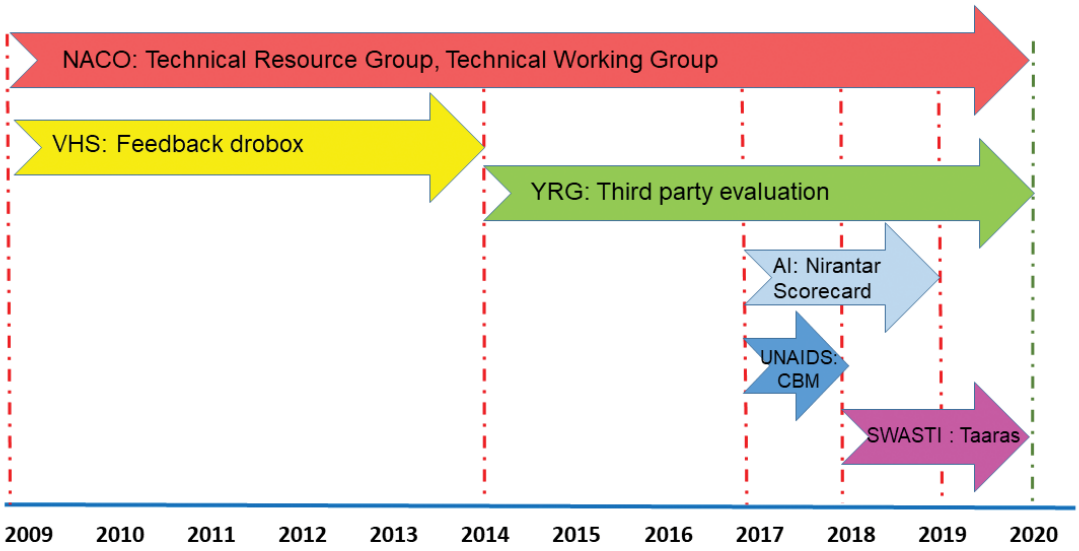
Community System Strengthening (CSS) in National AIDS Control Programme (NACP)

National AIDS Control Organisation (NACO)
Ministry of Health and Family Welfare
Government of India

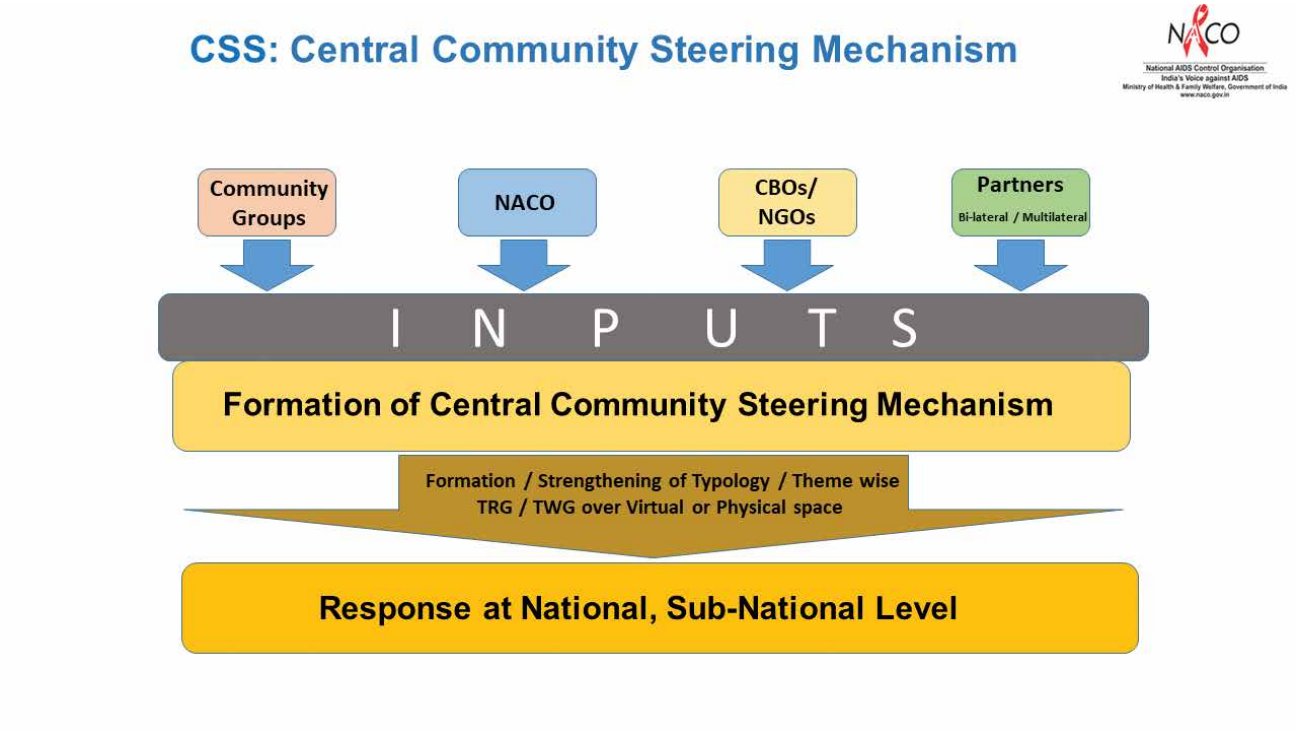
Community System Strengthening (CSS): The Concept

Definition - :
'Community systems strengthening' refers to interventions that support the development and reinforcement of informed, capable, coordinated and sustainable structures, mechanisms, processes and actors through which community members, organizations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities. – *CSS Technical Brief Global Fund*

CSS Examples in Indian Settings



Community System Strengthening (CSS): Main Objectives


CSS: Central Community Steering Mechanism
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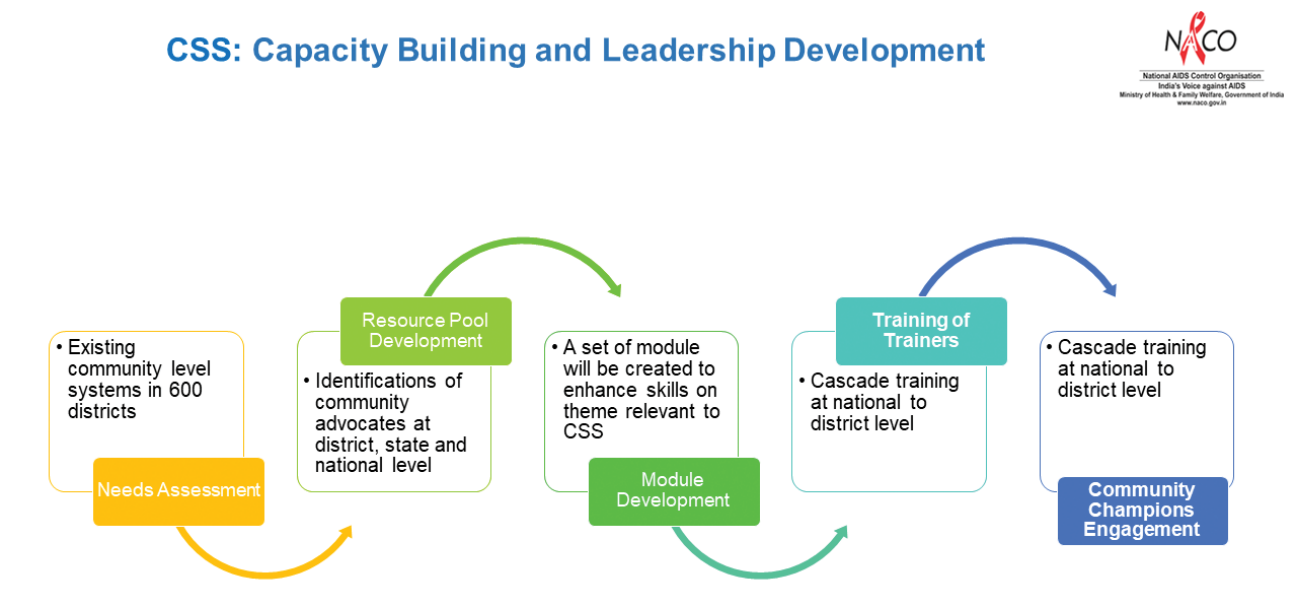
Community Groups
NACO
CBOs/ NGOs
Partners
Bi-lateral / Multilateral
I N P U T S
Formation of Central Community Steering Mechanism
Formation / Strengthening of Typology / Theme wise TRG / TWG over Virtual or Physical space
Response at National, Sub-National Level


CSS: Capacity Building and Leadership Development
NACO
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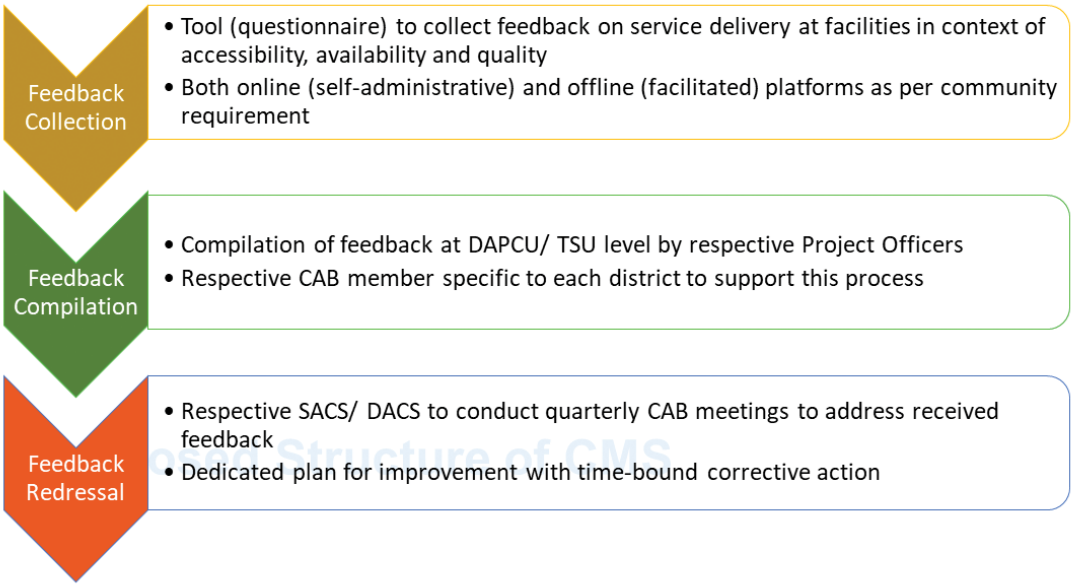
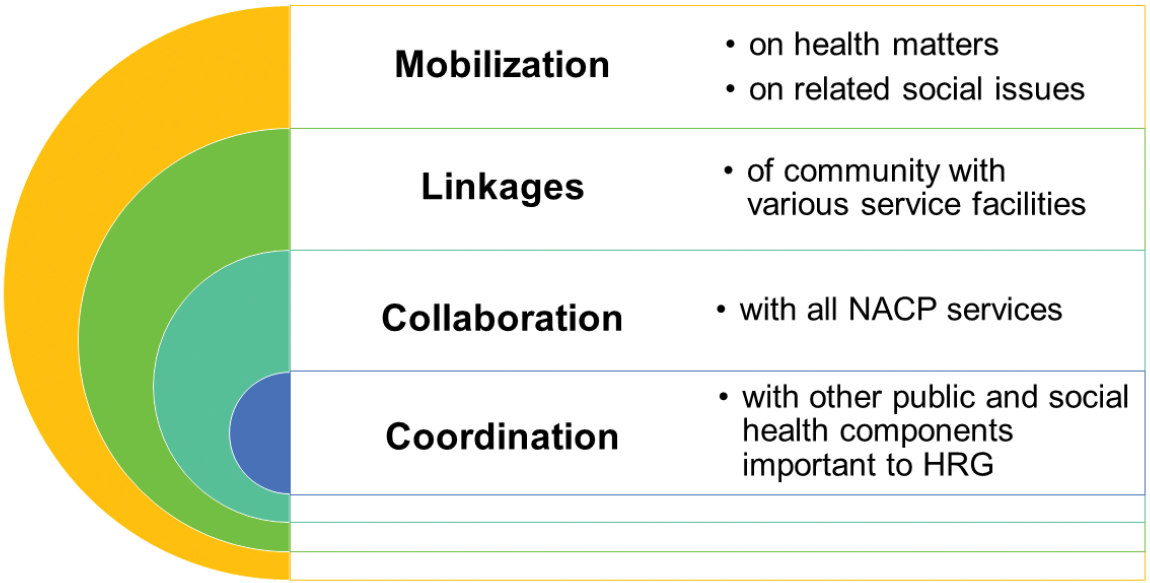
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in
• Existing community level systems in 600 districts
Needs Assessment
Resource Pool Development
• Identifications of community advocates at district, state and national level
• A set of module will be created to enhance skills on theme relevant to CSS
Module Development
Training of Trainers
• Cascade training at national to district level
• Cascade training at national to district level
Community Champions Engagement

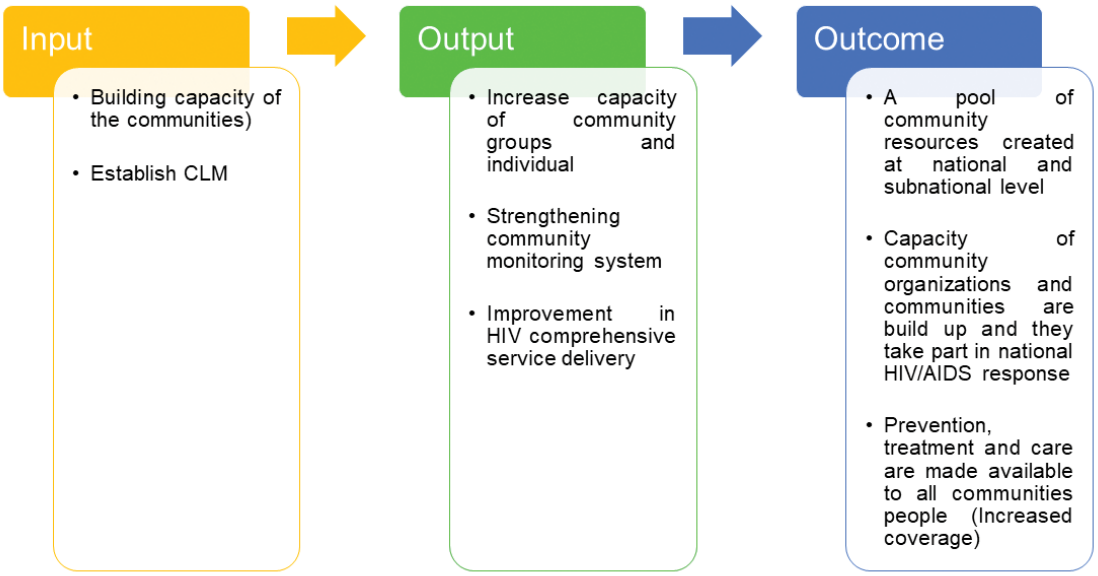
Core Component: Community Led Monitoring (CLM)



Core Component: Mobilization, Linkages, Collaboration and Coordination



Community System Strengthening Framework



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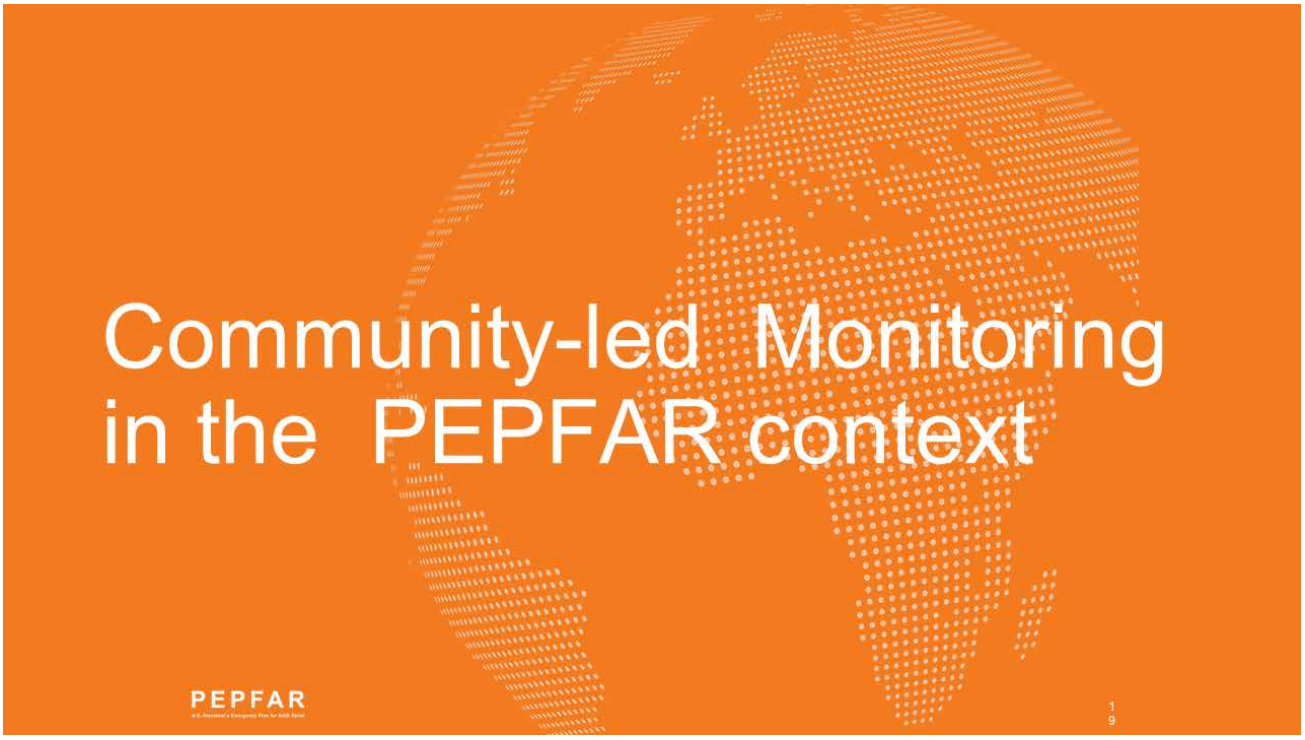
THANK YOU



Community System Strengthening, Community Engagement

- Full participation of community stakeholders and civil society in every stage of programming and planning, from advocacy to service delivery, is critical to the success and sustainability of programs and the global effort to combat HIV
- Engage with local community-based organizations and other civil society groups, networks of key populations (KP), people living with HIV (PLHIV), and other affected groups; other community entities that gather quantitative and qualitative data about HIV services.

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Principles of Community-led Monitoring

- Develop a **shared understanding of the enablers and barriers** to treatment retention in a manner that is productive, collaborative, respectful, and solutions-oriented
- The **scope and scale should be determined by community members** , but should be based on need
- CLM must be **routine**. One-off assessments are not sufficient but must be routinized to ensure follow up and continuous improvement.
- **Metrics or measures should be tailored** to a given context and address the needs and concerns of community members.
- Reflect an **'added value' and not duplicate collection of routine data already available**. E.g., information from beneficiaries about their experience with the health facility, information about barriers and enablers to access and retention in services etc.

PEPFAR COP Guidance, Section 3 Quality (pgs95-97)

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Essential role of peers and CSOs in providing insights about services using **routine and systematic data** that will lead to **action and change**

Community-led Monitoring will provide **first-hand perspective** on the implementation of quality services & minimum policies and standards

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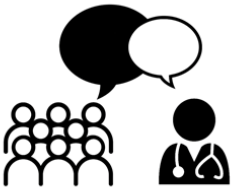
U.S. President's Emergency Plan for AIDS Relief

What CLM is NOT

PEPFAR International Treatment Preparedness Coalition(ITPC) 19

Community Score Cards (CSC) : A Strategy For CLM



What is a Community Scorecard?

A two-way, participatory, community-led QI tool routinely used for assessment, planning, monitoring and evaluation of health services.

How does a CSC improve services?

Communities can provide feedback directly to facilities.

Facilities get a direct link to communities.

Together they partner to identify and implement improvement actions.

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17 YEARS OF SAVING LIVES THROUGH AMERICAN GENEROSITY AND PARTNERSHIPS

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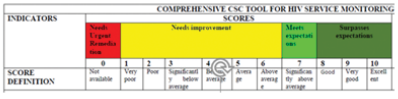
Community Score Card: Process, Indicators and Dashboard

- CSC is a four-phase process focused on continuous improvement.
- Facilitates continuous and enhanced dialogue between clients and health care providers
- Provides a detailed snapshot of multiple issues, such as HIV prevention services, treatment and care, and stigma and discrimination

SET 1.0: HIV PREVENTION SERVICES				
1.1	**Availability of condoms**			
	1.1.1 Availability of Female condoms			
	1.1.2 Availability of Male condoms			
1.2	**Accessibility of condoms**			
	1.2.1 Accessibility of Female condoms			
	1.2.2 Accessibility of Male condoms			



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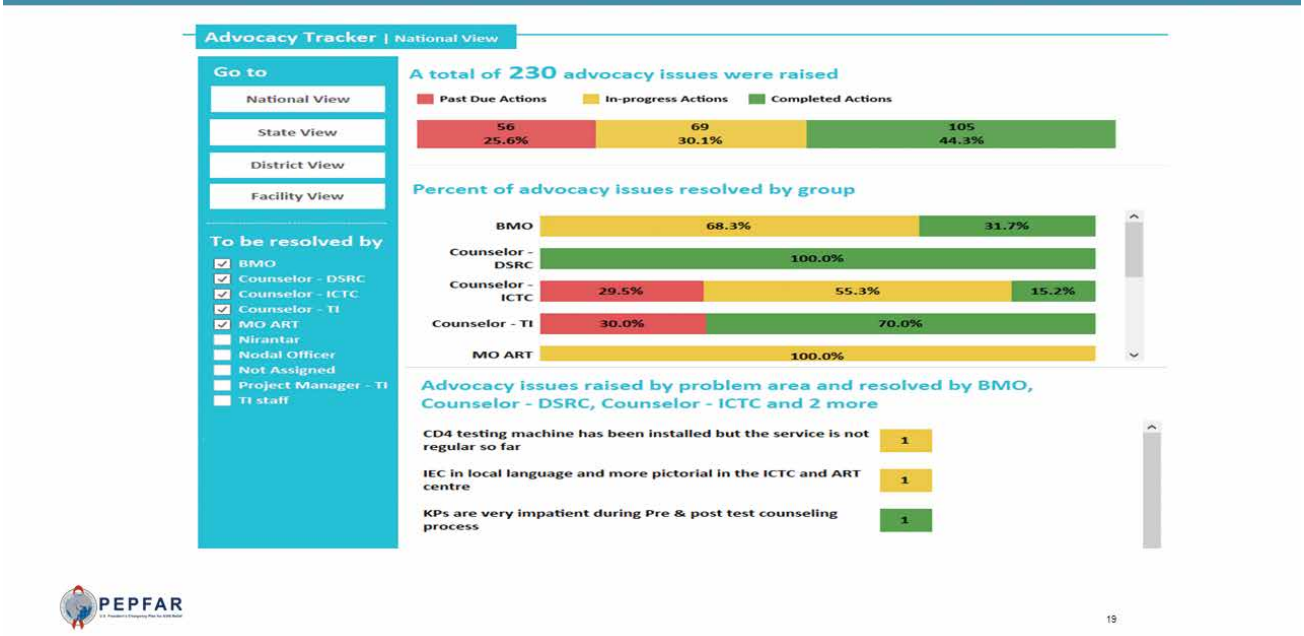
Community score card dashboard– Advocacy tracker



How does CSC affect Community Engagement?

- Vietnam CSC meetings provided KP and PLHIV representatives with transparent documentation on enablers and barriers to quality HIV service delivery and ownership over subsequent changes to issues found.
- India CSC meetings also provided a platform for KP representatives to engage health workers, to review the quality of services and understand the barriers to service provision and generate dialogue on ways they can improve services provision to KPs.

CSC Process Participant Feedback

The score card is a key innovation that allows for interactive evaluation of services and shared setting of quality improvement plans. KPs feel better involved, understood and have better access to quality services. Facility staff are also better equipped to meet the health concerns. – CSC participant

Life Centre (Vietnam)

C2P COMMUNITY PUBLIC PARTNERSHIP

Diversified Methods to Elicit Clients Feedback

- CBO has pro-active follow up with clients after appointments via phone/SMS
- Clients send instant messages, comments on CBO fan page
- Client satisfaction survey: Paper-based questionnaire and online survey
- Direct contact with clients during small group communication sessions

➢ Share compiled client feedback to C2P health facility on a monthly basis (one-on-one) and at quarterly meetings (with other facilities)

CBO Weekly Meetings to discuss:

- Programmatic data review
- Feedback from clients
- Sharing good practices on outreach/ communication methods

OUTCOME

- Clients received continuous care from reach to treatment
- Enhanced trust from clients
- More respect from health sector
- Community role and response recognized in provincial and national HIV/AIDS response

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Community-led monitoring efforts are essential partnerships in our shared success

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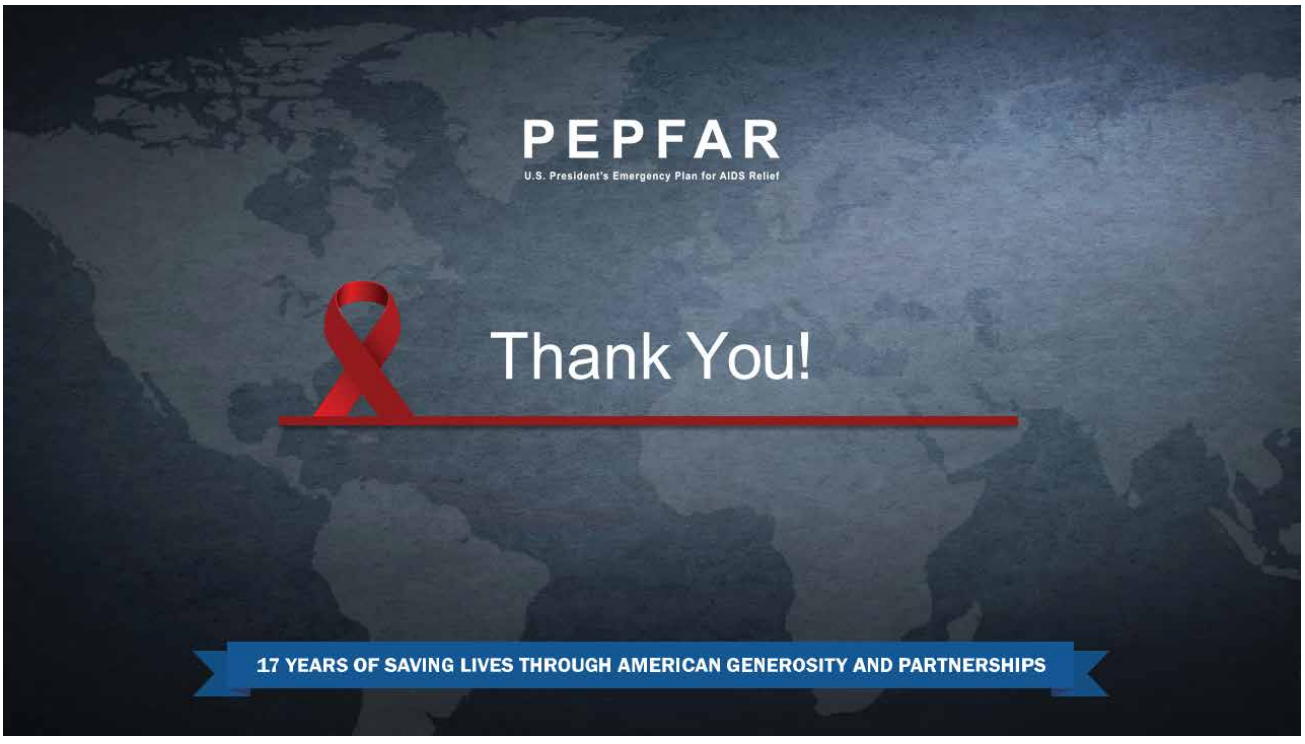
U.S. President's Emergency Plan for AIDS Relief

PEPFAR CLM Partners

1. USAID– SWASTI

2. CDC - UNAIDS



CLM Pilot Project

Rationale:

Currently there is a gap in understanding of barriers and enablers to accessing services at the client level and from the client perspective in facilities and communities.

Role of CLM:

Community-led Monitoring will provide first-hand perspective on the implementation of quality services & minimum policies and standards

Engagement of community s in providing insights about services using routine and systematic data that will lead to action and change.

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Key Features of the CLM Project

The Community-led monitoring (CLM) will be led by, and implemented by:

1) Local community-based organizations and other civil society groups,

2) Networks of key populations (KP), people living with HIV (PLHIV), and other affected groups,

3) Other community entities that gather quantitative and qualitative data about HIV services

Key focus : To **generate input** from recipients of HIV services in **a routine and systematic manner** that will translate into action and change in HIV services.

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CLM Pilot

Goal: Improve HIV service delivery and client outcomes

Key Principles:

- Being Collaborative: working with all partners and service providers
- Being Respectful: of community needs and requirements
- Solutions oriented: focused on improving outcomes
- Reducing Human Rights barriers

Currently planned pilot Districts

Telangana : Hyderabad, Rangareddy, Karim Nagar, Nalgonda, Mehbubnagar

Maharashtra: Pune, Thane

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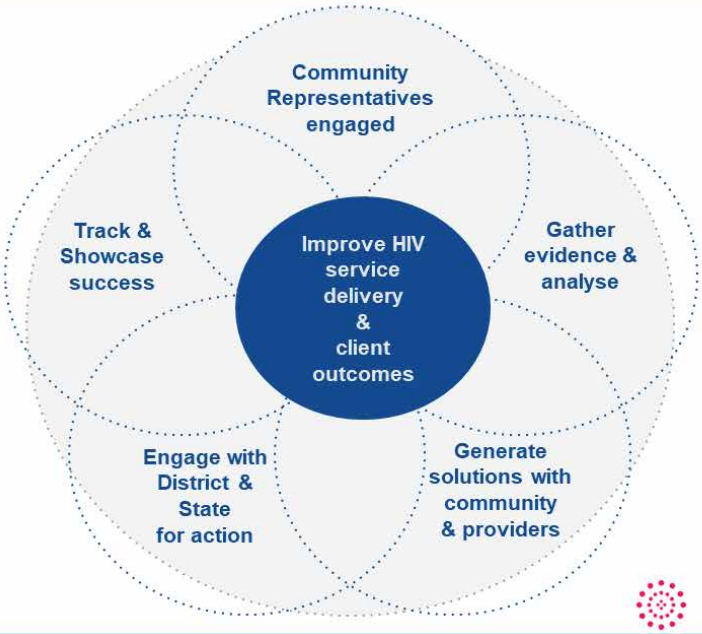
Pilot Process

The Community Led Monitoring process



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Community Representatives engaged

- In each district, community organisations of all KPs will be invited for discussions on CLM; all CSO partners will participate along with SACS, TSU, DAPCU
- The approach and process in local languages will be shared
- Feedback will be invited so that the whole process is co-created with the community.
- Community representatives will be invited to join the CLM team; this can be supported by CAB at district/State level
- The community representatives will undergo training on the tools as well as the facilitation skills, for CLM implementation

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Gathering Evidence and Analysis

- There currently exists various mechanisms for community-led monitoring such as:
  - Citizen Report Card (CRC),
  - Health Observatories/ Community Treatment Observatories,
  - Health Facility Committees
  - Community Score Card (CSC)
- The **community scorecard** (CSC) is a performance improvement tool which is now a widely used approach to generate community/citizen engagement and feedback on the quality and accessibility of health services.

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Gathering Evidence and Analysis

Scope of the ScoreCard

Prevention and Treatment services and products	Aspects monitored
Services: • TI services *(DIC and outreach)* • HIV testing *(at facility and community-based)* • STI treatment *(at PHC/DH as well as TI/referral STI care)* • Antiretroviral Treatment (ART) including CD4 - • Opportunistic Infections (OI) & Viral Load testing, PMTCT, Counselling • Link to other health services (Direct Oral Therapy (DOT) centres for TB)	1. Acceptability *(stigma, violence)* 2. Accessibility *(location, timing, client friendliness)*, 3. Affordability *(out of pocket expenses)*, 4. Appropriateness 5. Availability (*waiting time*) 6. Accountability 7. Responsiveness 8. Utilisation
Products: • Condoms, • Lubricants • Needles/syringes • OST • Drugs (STI, ART, OI)	

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Gathering Evidence and Analysis

- Questionnaire has been developed by NACO and UNAIDS
- These will be improved to include
  - Service Provider self-assessment (quantitative & qualitative)
  - Community Assessment (quantitative & qualitative)
- Each tool will have same questions
- Community facilitated group discussion with KPs & PLHIV groups for the Community
- Scoring, weightage and analysis methodology is drafted

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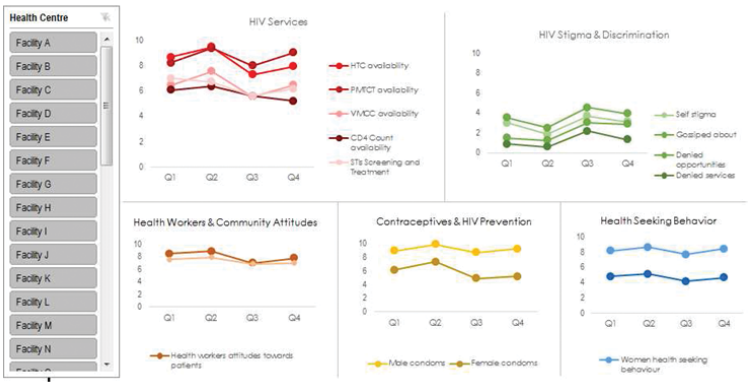
Gathering Evidence and Analysis

- Service -wise, facility -wise, district-wise results and trends
- *Sample image alongside from previous USAID project**



https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/tagged_apc_lci_community_scorecard_toolkit.pdf

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Engage with District & State for action

- Providers and Users meet to review results
- Identify key areas selected for improvement
- List activities/actions and responsibilities, timelines and resources
- These are documented and shared; made visible along with the ScoreCard Results on SACS website

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Track & Showcase success

- Service providers delivering quality services and going above and beyond, will be felicitated at district level events
- On a quarterly basis, convene with community, service providers, and district, State officials to review progress on action agreed
- Incorporate relevant aspects into the next round of CLM

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What next?

1. Inputs during Breakout sessions
2. A draft SOP on CLM to be shared with participants of this consultation for further inputs
3. Complete 1 round of CLM
4. Reconvene in 4 months to share findings and lessons

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Thank You

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Instructions for Breakout Sessions

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- 4 Groups - you will be moved to your respective group
    - Group 1: Steering mechanism and Community Advisory Board
    - Group – 2: Capacity building and CBO engagement
    - Group – 3: Selection and greater involvement of community champions
    - Group – 4: CLM pilot (tools, process, timelines)

- Facilitator assigned for each group who will brief and get discussions started
- Groups will select a rapporteur and presenter
- Presenter will share during the plenary session (post lunch)
- If you get dropped out for any reason, use the zoom link (on your email) and come into the main room; you will then be sent back to your respective group.

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CSS Consultation NACO PPT

Group 1

Steering mechanism and Community Advisory Board

The key steering mechanisms that should be instated at the national, state and district levels.

- Need to form the steering committee with the representation 80% of the community and 20% from non -community stake holders, service providers, other departments of the government like WCD, SWD etc.
- Selection for the steering members for CAB
- Need to understand mechanism of distribute the role and responsibility for steering committee

The key activities that will need to be undertaken towards the establishment of these mechanisms

- Adoption of the existing mechanism for establishment of the steering committee or need to have some more innovative system by ensuring the active representation from district /state level board of community
- Size of steering committee or quorum of the committee.
- Composition of the steering committee with the all group of community and human right law network, DALSA, SALSA.

The scope/roles and responsibilities of the members of these national and sub-national bodies, and the frequency of their meetings

1. Steps of the grievance redressal for facilitate the issues through steering committee.
2. *Frequency of the meetings* at national, state district level
3. Constitution of the committee with representation from CBO,CSO and other none community stake holders with their specific role SC.
4. Place of meetings need to decide where it will happen at SACS, DAPCU or another place
5. *Anonymous participation* in steering committee.
6. Committee needs to be led by PLHIV community
7. Influence to the decision maker for the highlighted issues from the Steering committee .

Group 2

Capacity building and CBO engagement

The barriers that currently exist towards optimal CBO engagement - Part A

1. **Community Empowerment:**
    a. Community members live in several "unknown fears" - for drug users, it is often to do with legalities; for women in sex work, it is also in terms of stigma and the unsurity
    b. Building agency is important at communities, there are several power dynamics at the service provider level which needs to be addressed.
    c. How do we partner communities to ensure that communities are aware of their rights and are able to demand that their rights are respected from service providers.
    d. Community Confidence to close the service gaps
    e. Loss of historical learnings in CBOs as new leaders come in with little or no documentation trail
    f. There has to be a shift from being seen as a beneficiary to being seen as an active stakeholder - both for the community and for the institutions

The barriers that currently exist towards optimal CBO engagement - Part B

1. **Platforms:**
   a. Regional, State, District and Facilities need to have a platform where people are truly heard - beyond tokenism
   b. Geography is important to keep in mind. For example, North India has several regional variations - so many of the drug users live on the street and have their own individual struggles.
   c. Actual community members participating in trainings become important instead of TI representation
   d. Involvement of young people is important.
   e. SACS, TSU, DSPCU, TI - must have community representation and participation
2. **Inclusion & Enabling Environment:**
   a. For community to be staff in programmes, the eligibility criteria will need to take in account their lived realities
   b. Feedback mechanisms need to strengthened
   c. Communities not being reached by TI (Non TI Groups)
   d. Intersectionality needs to be factored in during program design
   e. Newer leaders, community organizations are often left out of different trainings
   f. It is critical to operationalize the different actions taken before - such as different charters and agreements.

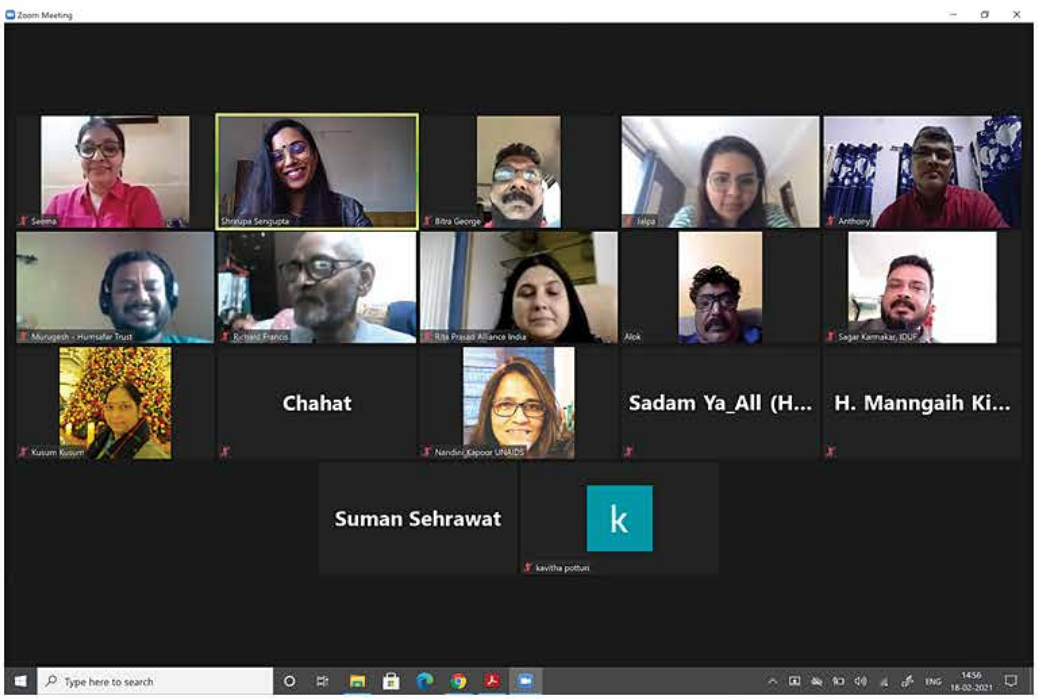
The key areas of need for capacity building for communities

1. Leadership building - move from victimhood to becoming change agents, CBO institutional memory building
2. Institutional building - governance systems and financial management, HR management, programme planning and management, proposal writing etc.
3. Resource mobilization for sustainability- such as social enterprise and innovative finance, approaching CSRs and other funders
4. Sustainable financing as a goal instead of limiting to project funding
5. Building capacity of CBOs to apply for TIs and access more funding; ensure no one is left behind

From an enabling environment point of view, it is important to simplify the process for CBO applications and revisiting criterias so that more CBOs stand a chance to become TIs

The channels, mechanisms, modality and frequency for community capacity building

1. Establishing a cadre of community master trainers through ToTs so that there is continuous handholding and support at district, location level - trainers much have regional / cultural context and familiarity
2. Leveraging the state institutions maintain the training resources
3. Feedback from trainers (from the community) to continuously improvise the tools of trainings
4. Guidance manual to help the CBOs strengthen their institutional capacity
5. Networks need to be involved to mobilize community members for crucial trainings and meetings
6. State Level Training Institutions can have a segment for community members and trainers
7. Trainers to have a feedback mechanism
8. Community Strengthening body should be autonomous from the state aids body so that it can reach the community where it matters
9. The youth among the community must be prioritized for capacity building
10. Reaching the last mile with on site mentoring and handholding support with regular trainings.
11. Using multiple channels based on content to reach the appropriate audience - mixed methods - A/V, WhatsApp, Audio etc
12. Funding mechanisms such as Global Fund and PEPFAR can be explored



Group 3

Selection and greater involvement of community champions

The diverse communities which need to be represented within the CSS umbrella

- Should have a pool of champions in each district (can go up to 20 persons)
  - All typologies should be included (should consider sub-groups e.g KP member + living with HIV)
  - Should be identified by the community themselves
  - Should be self-driven and should be looked up to as an influencer by their peers
  - Should have experience of TIs and has been an active beneficiary of TI / HIV services
  - Person should be non-political /credible (constructive criticism), should be young leadership
  - Basic literacy skills (should be able to read/write)
  - Will be good if the person is involved with a CBO (to have a CBO backing)
  - Someone who is willing and able to give time
  - Should be remunerated for their contribution – NACO/SACS will need to factor the cost of their travel and a small honoraria
- Should have a good rapport with the community and be a voice of the community
  - Should be able to collect and pool the issues from the community
  - Champions should be able to articulate their issues, and not just put-up the problems, but also propose solutions
- Good rapport and negotiation skills with government facilities and departments
  - Positive advocacy approach
  - Good have good negotiation skills
  - Should be articulate / good communication skills (should be able to make their point succinctly)
- Once champions are selected, they will need to be capacitated
- Consider rotation of champions

The key mechanisms through which community champions can be identified

Approach 1: Recommendations from CBOs/PLHIV networks

- Could identify champions from among the TIs / peer educators (2-3 champions from each HRG)

Approach 2: Open call

- Post in TIs and other platforms; invite applications, conduct interviews to assess their self motivation

Approach 3: Consultative selection between SACS and CBO

- Seek SACS and CBO recommendations and whoever are the common names could be considered

Approach 4: Identify young champions to ensure that issues of young adolescents / youth who are most vulnerable are not missed

•Link with NHM adolescent health clinics, ARSH / RKSK, SRH programs, PLHIV networks where young PLHIV are registered

Will need to sensitize staff of the non-HIV clinics to ensure that they are sensitive to young / vulnerable populations (particularly MSM/TG/Drug Users)

The barriers, facilitators and conditions for greater involvement of individuals who can be representative and effective voices of the community

Barriers

- Resources could be the biggest barrier to ensure commitment
- Ending up with champions without TI experience (conflict of interest if honorarium is being given as a champion)
- Identifying champions from most vulnerable communities – e.g. Hijras, or Drug users (most vulnerable, may relapse)
- Will need to submit written documents and reports (may not be able to do it themselves)
- Seeking appointments with government offices etc. (will need support for liaising)
- Risk of misuse – ethics; data confidentiality will need to be ensured
- How do we get someone who is preferred by both community and government

The barriers, facilitators and conditions for greater involvement of individuals who can be representative and effective voices of the community

Facilitators

- There should be a focal point at SACS/DAPCU for the Champions to be in regular touch (regular/monthly meetings with Champions)
- Orientation of the SACS/DAPCU on the role of Community Champions and their engagement
- Backing of a strong CBO for the Champion
- Honesty and credibility of the Champions will go a long way in ensuring good acceptance by SACS/DAPCU and line departments

Identify the larger ecosystem which surrounds the community to facilitate a conducive environment for community strengthening

- Will require support from NACO, SACS and DAPCU
  - Having a focal point at NACO, SACS and DAPCU
  - There needs to be enough resource allocation
- Should have the support of CBOs/local level PLHIV networks - should be a coordinated mechanism
- Should have district, state and national level champions
- Need to develop a toolkit for the Champions – defining the role, engagement


Breakout Room Participants (14)
Find a participant
SS Snehal Shah, Swasti (Me)
DL Dr Lalthlengliani, PD Mizoram SACS
DL Dr. Lokesh (JD- TI Maharashtra)
RS Raghav Singh Convener DUN
S skaul
KM Kiran Misra, SPYM-TSU West Bengal
P PRAKASH
AA Abhina Aher (She/her) - ITECH India (Tech Expert)
AB Aparna Banerjee, Amitie Trust
AJ Avi jimo nagaland
ST Sumita Taneja (she/her), FHI 360
TA T. Avinash Kumar, Swasti
V Vijayaraman,VHS
N NACO-RA


Group 4
CLM Pilot (Tools, Process and Timelines)
bhawna_rao_nac...
NACO Dr Bhawani

The Key Considerations for Rolling out of CLM across States

- Cannot be about "project"; needs to be sustained and hence requires buy-in and ownership at all levels especially at district
- **District** and State level focus is important
- How can **anonymity** be maintained throughout?
- **Recognition** needs to be given to the chosen community members.
- How to structure a smooth channel of **communication** between the community and the state, where issues can be solved without involving national representatives.
- CLM process itself would enable community to learn about their **rights** and services – important capacity building
- The implementing agency cannot be directly involved in service delivery.
- Necessary to determine how CLM can address varying needs:
    - Attention to immediate issues which cannot wait for 1 month, quarter etc
    - Ongoing, qualitative inputs on programme improvement
- CLM tools to be created along **WITH the community**

The Key Proposed Modalities

- **Community Report Card**
    - Create a transparent method
    - Can be used as a tool to collect first hand information from ground level
    - Can be used as a tool to raise red flags during audits.
- The system will incorporate the **findings and feedback** back into the system.
    - This can be both an online and an offline system
- The tools needs a **short circuit method** for real time feedback.
    - The community monitoring will be a continuous process and data collection will be conducted over time.
    - Grief redressal system
- Create a mechanism of **addressing challenges** at both the district and state level. (Existing national programmes have a 'One size fits all' approach)

Key performance measures or indicators that must be monitored

(in relation to the experience of recipients of services, barriers and enablers)

- **Availability/accessibility** products and services. Include stockouts.
- For ART centres, the diagnostic possibility of finding out:
  - Retention
  - Abbreviation of service
  - What do they actually think are going to be the areas of improvement
- Are the community **aware** about the range of services available?
- Has awareness been generated on the **rights to services**?
- Can the chosen modality be used as a reference point?
- Has the monitoring been conducted in **rural and remote areas**?
- Creation of a system to **capture unconventional qualitative data**, from smaller focus groups

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India's Voice against AIDS
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in

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