NACP IV: TI Working Group Meeting
MSM Sub-group Report: Version 2-5 May, 2011

"More and Better: There's No Looking Back"

1. Overview:

This document is designed to feed into the National AIDS Control Programme – Phase IV (NACP-IV) plan outlining the programme focus for MSM[1] interventions in continuum of prevention to care, primarily as part of targeted interventions (TIs), but also in areas of condom and lubricant promotion; STI management; HIV testing, care, support and treatment; and BCC / IEC development.

Keeping the guiding principles of universal access, human rights, stigma and multiple vulnerability reduction, and quality response in the center, the plan is designed to balance public health with the individual mental well-being in mind. The need to integrate selected services with other ministries and programmes at the national level with comprehensive and community friendly responses at all levels has determined the tone, scale and depth of the document.

It is important to acknowledge at the outset that NACO's HIV programme is the only programme in the country which has shown the courage to respond to the health and development needs of MSM and male-to-female transgender (TG) populations (the latter now separately from the MSM umbrella), besides other marginalized populations. It is therefore all the more imperative to keep the programme going for its sheer scope and effort in bringing such groups into the ambit of public health delivery systems.

Considering two decades of HIV interventions, determining the right size and designing strategies to serve hard-to-reach populations should be the major focus in this phase of NACP-IV.

It is a given that the center of the NACP-IV response will keep HIV prevention as a primary focus. But in order to reach the right populations, there is a need to invest in linking HIV services to wider health and development services for a change that is progressive and sustainable. Such linkages stand a better chance of ensuring vulnerability reduction. HIV prevention and protecting human rights together will lead to more efficient interventions through correct commodity supplies (lubricants, condoms and medicines), strengthened BCC components, stronger linkages between prevention, care, support and treatment, organized trauma-violence response and attempts to reach out to groups linked to MSM, like their female sexual partners.

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[1] In the initial stages of NACP, 'MSM' was a term inclusive of male-to-female transgender (TG) populations. Over time, however, the need to look at TG concerns separately from those of MSM has gained acceptance, and NACP-IV has underscored this factor by considering a separate TI design for TG populations. In this document, therefore, the use of the term MSM in general does not subsume TG.

Emphasis on collecting data and investing in use of data at local, state and national levels to feed into planning is encouraged. Stigma still remains the single largest barrier to access to HIV services, and for MSM populations, it is the stigma of HIV coupled with stigma of sexual orientation / behaviour. With the dynamics of the epidemic slowly tightening its grip on marginalized populations, stigma is becoming subtle and therefore much more difficult to tackle. Clear strategies defined to tackle external discrimination and internal stigma from within the community is crucial for future access to services in the HIV programme and in other arenas. Finally, collectivization and ownership of the community remain the corner stone of the proposed plan, with decentralization in spirit and action as main strategy which is possible only by supporting flexibility to design local specific interventions within a boarder framework rather than a standardized and deadening format across the country.

Key Recommendations

- **Maintaining prevention focus with increasing linkages to wider health and development services:**

  It is a given that the center of the NACP-IV response will keep HIV prevention as a primary focus. But in order to reach the right populations, there is a need to invest in linking HIV services to wider health and development services for a change that is progressive and sustainable. Such linkages stand a better chance of ensuring vulnerability reduction.

- **More efficient interventions through:**
  - § Correct supply of commodities (condom, lubes and commodities)
  - § Strong BCC component based on learning from NACP-III
  - § Strong linkages between HIV prevention and care, support and treatment
  - § Organised response to violence against the community
  - § Reaching out to groups linked to MSM (such as their female sexual partners)

- **Efficient collection and use of data for action:**

  Collection of data at local, state and national levels with immediate feedback into programme and future planning is needed.

- **Clear strategies to tackle stigma and discrimination:**

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- **Strengthening collectivization and community ownership:**

  Collectivization and ownership of the community remain the corner stone of the proposed plan, with decentralization in spirit and action as main strategy.

- **Flexibility to design local specific interventions**

2. Background:

NACP-I was essentially a public health initiative to explore the evidence of HIV vulnerability and chart out a course for NACO to set up a vertical health programme. It was only in NACP-II that NACO got seminal evidence that MSM (and TG) populations were a priority group and a major at-risk bridge population. By the time NACP-III came around, India was one of the few countries that had an agreed upon denominator for MSM (and TG) populations, as well as the most-at-risk among them at hot spots, that had a government buy-in. This accelerated efforts at facilitating access for MSM (and TG) in the HIV prevention programs.

An equally strong effort by the MSM and TG communities to organize began as these groups started collectivizing and making themselves visible to dock into NACO's programme. 'A People Stronger', a report commissioned by UNDP (in 2010) on 'the collectivization of MSM and TG groups in India' records the efforts by sexual minorities to finally emerge out of the darkness of invisibility onto the national stage. The report on Page 54 mentions:

"By 1986, HIV had 'officially' arrived in India. And by the mid-nineties, HIV had begun to make its presence felt within the homosexual population. The second phase of the NACP, which began in 1992, responded by identifying MSM as among the sub-populations most at risk. (This had already been done in the West). Substantial funds became available to implement the targeted interventions supported by NACO. But few knew, as yet, who was at greatest risk and how the spread could be limited. What was already clear though was that the population of MSM would have to be involved in finding the way. This led to a mushrooming of CBOs of sexual minorities. Identities within the community became more polarized and terms such as gay, kothi, hijra and MSM emerged into the common consciousness. In an interesting development, terms such as MSM, previously used to describe sexual behaviour, also began to be used to describe sexual identities".

On another level, the HIV epidemic made the various sub-groups at risk within the MSM and TG umbrella also acutely aware of their at-risk profile without really looking at the evidence coming from the sentinel surveillance sites which government slowly but surely built up to gather more evidence for constructing strategies around targeted interventions aimed at health delivery to these sub-groups. The report notes this also in plain terms:

"It was inevitable that HIV and AIDS would have far reaching implications for the collectivization of sexual minorities. At one level, much of the community organization in the post-HIV period had to do with the delivery of services related to the prevention of HIV and AIDS. Thus the HIV epidemic also brought with it an official acceptance of the existence of MSM in Indian society. Government programmes were designed for the prevention and care of HIV and AIDS among MSM. The HIV programme in India has been a categorical example of mobilization leading to collectivization".

In other words, the visibilizing factor cut both ways. It quickly allowed the emergence of MSM and TG as at-risk groups within the NACP and also led to acute identity issues around these risk profiles (identities being defined by risk profiles).

"NACP-II was thus the calalyst for this huge bloom of MSM / TG CBOs, whereas NACP-III led the way to dovetail these groups into the national programme and fit it into the care and support programs being built into the public health system. NACP-III in many ways "normalised" MSM and TG into India's public health system which decentralised their issues right down to state and district levels through DAPCUs. They were also sought to be unsuccessfully fitted into the migrant and link workers programmes, though there was a much more successful attempt by advocacies with the Planning

Commission and Election Commission, and getting into staff positions of development agencies which recruited them as a wilful effort to mainstream their issues".

3. NACP-III achievement highlights in relation to MSM (and TG) populations:

- Expanded coverage: 2,74,000 (out of estimated 4,12,000)

    – Seven-fold increase from NACP-II

- More TIs: 155 exclusive and 200 composite

    – 67% coverage of most-at-risk MSM and TG populations

- About 150 surveillance sites for MSM and TG populations

- Reporting of discrimination and violence initiated

- All states now have MSM (and TG) TIs

Note: All data effective as of the mid-term review of NACP-III in 2009

The major result of these efforts has been that MSM (and TG) TIs, which "cold started" from hardly 40 TIs in NACP-II, have been ramped up to 155 exclusive TIs under NACP-III to reach an expanded coverage of 2.74 lakh – a seven fold increase in service delivery to a hitherto invisible group. Besides, there are composite TIs, a relic of the past, where MSM (and TG) have been embedded into already existing HIV prevention efforts with programmes directed at other most-at-risk populations like female sex workers and IDUs. This has helped cover around 67% of the most at-risk MSM (and TG) in hotspots (cruising sites). Consistently collecting a flow of evidence on HIV prevalence among these populations, are more than 150 HIV sentinel surveillance sites.

4. Need for strengthening the response among MSM populations:

The national response to the HIV epidemic among MSM (and TG) populations has come a long way where many factors have contributed to the development of interventions, implementing them and reviewing them. There are areas nonetheless, which need some more investment at a strategic level. **Annexure 1** shows a detailed TI component wise analysis undertaken by the MSM TI Working Group participants. Based on this analysis, the following broad strategic recommendations are made:

- **Need for flexibility (no size fits all):** There is need for a flexible approach in terms of both budgeting and targeting the interventions. Not only do the peer-based approaches need to be built upon, but also cluster work needs to be taken up with MSM during important community events like Rainbow Pride marches, and major cultural and religious festivals. The aim being to reach out to dispersed populations in district rural settings with services. Each sub-group of MSM requires a different strategy based on the geographical locale and cultural context in which the sub-group flourishes and lives. This requires a dynamic with CBOs at every level with hand holding and building up reservoirs of resource persons with enough experience in already existing programmes.

This flexibility should also translate into budgeting for these activities within a broad framework.

- **Need for emphasis on diverse sub-groups of MSM:** Currently, there are no specific HIV and related services available for married MSM and their female sexual partners, non-self-identified sub-groups of MSM and minor MSM. Under NACP-III, there has been an emphasis only on Kothis (receptive partners) as they were considered most-at-risk among MSM. But evidence from programmatic data and studies conducted in Andhra Pradesh and Gujarat show that Panthis and other MSM are just as much at risk as Kothis.

- **Poor to zero access to lubricants:** NACP-III clearly acknowledges access to lubricants as part of the essential package of services for MSM (and FSW) interventions. Sadly, most of the SACS, barring one or two, have not yet ensured the same. The problems are multiple starting from availability of resources to lack of creativity and commitment. In Andhra Pradesh and Tamil Nadu, lubricants are available in interventions because of resources supplied by the Avahan Project, while in Gujarat lubricants are available because of the initiative taken by the SACS of pooling resources from each intervention, adding some more and going for collective bargaining. In other states, even these initiatives are missing, and supplies are contingent to the initiative of the MSM CBOs, who only manage ad hoc and limited supplies through donations.

  NACO has initiated a special research with HLFPPT to determine the cost of production of a single pack of one super lubricated condom with one pouch of lubricant. It is understood that initially NACO cannot provide a pouch of lubricant with every condom that is handed to MSM groups, but will try and cover every episode of anal sex based on evidence from sex sites. However, this is work in progress that NACP-IV can be readied to take up as NACP-III tries out pilot projects on the supply of lubricants and their social marketing.

- **STI management concerns:** NACP-IV must design a technically sound, community-friendly and systematic transition plan for STI management from TI-based STI clinics to government facilities over a period of five years with community participation. The transition should not be a hasty one.

- **Inadequate efforts to address the needs of MSM living with HIV, including positive prevention:** PLHIV networks at the state and national levels in India are some of the largest networks in the world, but access to these networks for MSM has been limited and ownership even poorer. A key factor has been stigma and lack of understanding within the networks around gender and sexuality diversity. While training and development of BCC / IEC material specifically suited to the needs of MSM (and TG people) living with HIV have been undertaken by NACO and WHO, the issue of MSM living with HIV finding an integrated, unbiased space for care and support within the larger PLHIV support system remains a concern.

- **Need to improve advocacy and enabling environment with respect to methodology and approach for ensuring reversal of the HIV epidemic:** Advocacy approaches have to be multi-dimensional, evidence-based, systematically planned. MSM TIs are yet to fully learn and appreciate relevant advocacy skills and deploy them to their advantage. There

is a need to be able to differentiate between sensitization, BCC / IEC development, awareness generation and advocacy skills, and their inter-linkages. Extensive training in this area is recommended.

A specific area of advocacy should be on establishing formal links between NACP and key ministries like Home and Panchayati Raj to address stigma and discrimination in police settings and rural areas. Advocacy is also needed with the Directorate of Medical Education on revising the medical curriculum to include gender and sexuality education in the MBBS courses.

- **Need for TI linkages with wider services:** As mentioned earlier, the cause of HIV vulnerability reduction will be better served if TIs were trained and supported in developing meaningful rather than token linkages with services around mental health, family support, livelihood, social security benefits, non-formal education and shelter. Greater mobility of Peer Educators and Outreach Workers needs to be facilitated in order to serve sections of the population that do not access TI run drop in centres.

- **Stronger BCC focus:** Issues of anal and oral STIs, oral hygiene, presumptive treatment, regular medical checks, Hepatitis B and C currently do not receive adequate attention through BCC and IEC components of TI projects. These need to be emphasized, as also the potential of mobile telephony and internet in health messaging and community mobilization. Example: FPAI's recent collaboration with Airtel to provide sexual health messaging through mobile phone services; the growth of internet-based sexual minority community mobilization for not just events and campaigns, but also CBO formation.

- **Limited inputs for Peer Educators for ongoing training and other capacity building:** There is a need for more resource persons providing support and mentoring in this regard on a regular basis.

- **Need for capacity building around monitoring and evaluation (M&E):** NACP-IV will need to nurture a culture of efficient data collection, analysis and dissemination that seems connected with programme design at the TI level, as well as at the state and national levels. Besides, an M&E approach that not just collects data from the TI beneficiaries but also shares the data collected with them towards the purpose of analysis, will be more successful and respectful of human rights. It will win the confidence of the beneficiaries, which will impact TI implementation beneficially. Additionally, the M&E systems at the TI level need to be rationalized. Repetitive elements need to be weeded out, and data recording simplified for Peer Educators and Outreach staff in TIs to ensure accuracy **(details in Annexure 2)**.

- **Need to increase investment in and support for MSM CBOs:** NACP-III ushered in a welcome change when it promised to emphasize on CBO-lead TIs. But the implementation of this promise has some way to go. Many SACS have not invested enough in CBO development, and then forwarded the lack of capacity among CBOs as the reason for not granting CBO-lead TIs. Where the MSM communities and SACS have been proactive in this regard, as in Maharashtra, Gujarat or West Bengal, CBO-lead TIs have become the norm. In contrast, in states like Orissa, there is not even a single CBO-lead TI for any marginalized population.

In this context, there is also urgent need to clarify the roles of NGOs (as facilitators / catalysts) and CBOs. NACP-IV needs to design a clear process of transition of ownership of TIs from NGOs to CBOs within specific timelines. While an organic growth of CBOs is always welcome, the NGOs must have it in their mandates to facilitate growth of CBOs in order to honour the principle of community capacity building, involvement and ownership of the national HIV response.

5. Revisiting MSM TI structure:

In keeping with the strategic recommendations, some changes are suggested in the TI staffing and activity structure (mainly re-aligning with only one addition):

1. The core emphasis of the MSM TI should be on behaviour change and not medical interventions (thus emphasis on STI, HIV and presumptive treatment related targets needs dilution)

2. Peer Educators need to be renamed as Community Mobilizers with a more rationalized task list. It should be recognized that Peer Educators as honorary workers (within the given activity and pay structure in TIs) are best placed for community identification, mobilization, rapport building and provision of only those services that require an element of trust (such as, awareness generation and condom / lubricant promotion). Hence the name change and reduction in MIS documentation responsibilities

3. Outreach Workers to have prime responsibility of MIS documentation, beginning with individual registration of MSM individuals with the TI project (line listing)

4. DIC attendant upgraded to Community Care Worker

5. It should be ensured that every MSM TI has a counsellor, not ANM

6. A position of Advocacy Officer to be added to institutionalize the emphasis on protection of human rights and advocacy into the TI structure. This officer will have the responsibility of developing an enabling environment and linkages

The following graphic illustrates the above points:
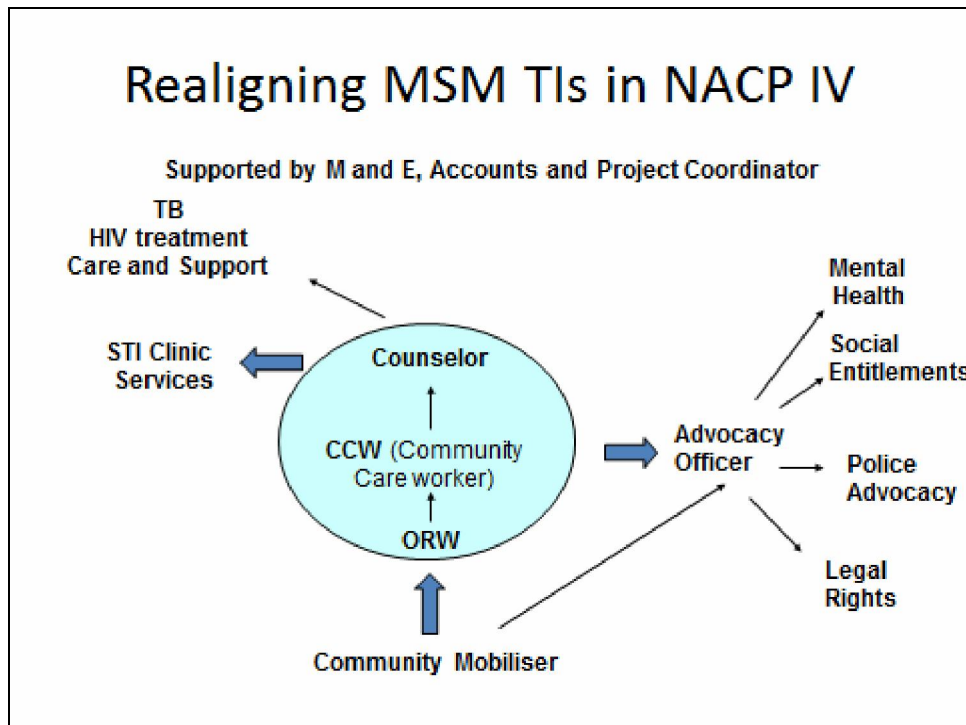
Key ToR points for TI personnel:

a) Community Mobilizer (former Peer Educator) – five per Outreach Worker

*   Each responsible for microplanning detailed linkages with only 30-50 individuals (as against 60 earlier) over a period of three years[2]; gaining an understanding of the outreach site (hotspot) dynamics; promotion of condoms and lubricants; identifying and undertaking preliminary crisis response; basic MIS documentation in relation to these activities

*   Directing flow of clients to Outreach Workers, and in case of crisis, also to Advocacy Officer

b) Outreach Worker (7 nos.)

*   Field visits, line listing, monitoring and supervision, facilitating MIS documentation, and sending data onwards for M&E

*   Directing flow of clients to Community Care Worker, Counsellor and Advocacy Officer

c) Community Care Worker (CCW):

*   Pivot for encouraging health seeking behavior (basic care) among DIC visitors and individuals forwarded by the Outreach Workers

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[2] 30 individuals in year 1, 40 in year 2 and 50 in year 3

- Initiator of HIV care, support and treatment services (including positive prevention) through referrals recommended by the Counsellor

- Also responsible along with Outreach Worker and Counsellor to refer individuals to the Advocacy Officer

It is recommended that all posts be full-time and no part-time or volunteer posts be included. All other posts currently granted varyingly by different SACS can be scrapped. All round higher pay structures are also recommended.

6. Guiding principles for MSM TIs in NACP-IV:

The strategic approaches listed in the previous section need to be backed by the following guiding principles:

- Rights-based approaches to ensure that NACP-IV provides or facilitates all HIV and related services that MSM populations are entitled to

- Universal access – inclusion of all MSM potentially at risk in the HIV TI programme – regardless of gender or sexual identity, marital status, age or sexual behaviours (receptive or penetrative). In this context, positive prevention also needs to be emphasized to ensure services for MSM living with HIV

- Elimination of stigma and discrimination

- Community systems strengthening

- Gender transformative approaches: Ensuring that MSM TIs not just look at MSM alone, but also their female sexual partners. Within MSM, emphasis needs to be on both feminized and non-feminized populations

- Addressing multiple vulnerabilities

- Emphasize quality of messaging and services

- Flexibility to design locally responsive interventions

- While NACP convergence with NRHM is welcome at certain levels (SRH and HIV services availability and referrals), NACP must continue to prioritize most at risk populations like MSM. Programmes like NRHM (and upcoming NUHM) were not designed with the specific HIV and associated needs of MSM in mind, and they first need to be prepared in this regard. Currently, only NACP-IV can address MSM needs, and the timeframe of NACP-IV can be utilized for preparing other national health programmes wherein MSM concerns can eventually be integrated.

7. Suggested targets:

With an overall goal of improving quality and coverage within interventions for MSM population, the targets for NACP-IV could include:

1. Universal access and saturation of all at-risk MSM accessible at outreach sites (latest estimate according to NACO being 4.12 lakh)[3]

2. Annual validation of MSM populations

3. All 'A' and 'B' category districts in terms of HIV prevalence covered with at least one MSM TI

4. All metro cities (national and state) must have at least one (or more) MSM TI

5. All current TIs upgraded with comprehensive package of services (include lubricants, vulnerability reduction interventions and linkages for social support)

6. 70% of MSM TIs to be transitioned to CBOs (higher from the NACP-III aim of 50%)

7. 100% of anal sex acts protected by condoms and lube

8. In the case of at least 30% of MSM with female sexual partners, the latter must receive relevant sexual and reproductive health services through appropriate linkages with the RCH / NRHM programmes

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[3] While this target may be relevant in the context of NACO's priority of looking at only anally receptive MSM with a specific number of sexual partners every month, it would be better if NACO could consider looking at all MSM irrespective of whether they are anally receptive or not. The emphasis on number of sexual partners also needs to shift to number of sexual encounters in a month. It can also be considered that while 50% of the emphasis can be on individuals with large number of encounters, some weight is also given in the programme to individuals with fewer encounters. This is to recognize that risk and vulnerability are not entirely eliminated by reduction in encounters (the nature of encounters also plays a role), as well as the possibility of an individual currently with few encounters increasing his encounters in future.

Annexure 1: Component Wise analysis of MSM (and TG) TIs under NACP-III

No.	NACP-III TI Component	Experience under NACP-III	Proposed for NACP-IV
1	Outreach and Peer Education, including site mapping, outreach planning and spot analysis	1) If the PE's job is full time, then the remuneration does not match amount of work pressure (field work targets, MIS documentation). Target of 60 clients to be reached per PE is unrealistic, as well as targets for health referrals 2) PE loyalty to the project compromised, only a few committed individuals, others look at this work as "easy money" 3) TI projects lack emphasis on human resources development and PEs do not get the attention they deserve as TI project workers	1) PEs to focus only on identifying individuals in an outreach site, and passing on the individuals to ORWs. This way PEs' workload comes down to only playing basic frontline role, more in line with their pay. Change designation of PE to Community Mobilizer. **Note:** PEs and ORWs must all be from MSM community 2) Reduce client targets per PE 3) Allocate small budget for training within TI budget for ongoing training of PEs
1b	Line listing of individuals	1) This target intensive process has increased inhibitions about TI projects among MSM, driving them away and becoming more difficult to access	1) Retain but make targets realistic (max 30 clients per PE in 1st year, rising to 50 by 3rd year). Increase number of ORWs (7) with 5 PEs per ORW. PEs to focus more on client identification and management, condoms and lube distribution and crisis reporting, thereby enhancing the quality of their client interaction
1c	DIC services	1) Many DICs not functioning optimally, not as much of a safe space as was expected, many not well located	1) Develop standard of services for DIC which can range from minimum package to ideal. Increase budget for DIC rental to match tier of cities / towns
2a	STI, HIV and other clinical services and referrals (including positive prevention)	1) Clinical targets have been unrealistic: 4 RMCs in a year (even though this is a good health seeking behaviour), ICTC visits and VDRL tests each twice a year, presumptive STI treatment by default for anyone who walks into a clinic. Instead of encouraging individuals to	1) Stop looking at these good practices as mandatory project performance indicators. Also make targets as "all services to be provided minimum twice a year", no more. Take away the "compulsory" nature of these practices 2) While earlier targets maybe ideal ones, let us examine what kind of IEC or BCC and research efforts have been put in so far to check resistance

		access health services, the emphasis has become on "forcing" them to undergo these tests, which has added unhealthy pressure on TI project staff, even encouraging them to fudge MIS data on clinical services, and alienated the target populations	among MSM to access these services. Basic IEC and BCC work has to be stepped up if the ideal targets have to be met. TI projects cannot move forward medically till basic communication efforts are in place. Bring back the focus on BCC and sustainable behaviour change. 3) Conduct laboratory-based operational research among some of the TIs in a year to see whether presumptive treatment is beneficial and needed compulsorily, between now and NACP IV roll out. 4) Linkages should be strengthened through a dedicated staff member for this purpose 5) Buddy system needed to support PLHIV (budgetary allocation)
2b	Regular medical check-ups (RMCs)	1) No clarity on what RMC consists of – not just at the TI project level, but also at the SACS / TSU levels 2) TI clinics often do not have relevant equipment	1) A rigid definition of what an RMC consists of needs to be re-looked. Compulsory physical examination (including proctoscopy) for every one without suiting their needs will be counter-productive, and even against basic human rights
3	Condoms and lubes distribution	1) Lube sachets availability has been a serious concern – both in terms of budgets provided in TI projects and actual cost-effective availability	1) Proportion of anal sex reported in most sexual health studies among MSM is at about 40% of all sexual acts. So let us consider budgeting for lube sachets to be accompanied with condoms. Social marketing of condoms and lube together should be piloted and included in NACP IV.
4	Community mobilization	1) Confined to CBO and SHG formation, but involvement of the community in mainstreaming efforts was almost zero	1) Flexibility is needed in scope of work under community mobilization 2) Providing training on life skills and a range of other SRH and HIV issues to be considered as part of community mobilization 3) Education, employment and social support to be included as part of community mobilization 4) Events like pride marches, fairs, film festivals to be included **Note:** Project Pehchan modules can be used beyond the CBOs covered with support from SACS budget

5	IEC / BCC development	1) SACS have retained entire budgets for IEC / BCC development (though TI operational guidelines do not say this can be done), and little material has been developed over time. Whatever has been developed, did not have community inputs or vetting	1) Even if SACS retains budgets, material development must take place with MSM community inputs, and final development must have community buy-in 2) Community panel to be set up to examine existing material and take up modifications / adaptations, possibly feed into MSM-specific IEC material development task taken up by DFID-TAST on behalf of NACO 3) TI projects must be given some part of the IEC / BCC budgets to develop locale specific material 4) Mobile gaming and internet technologies need to be explored towards BCC work 5) Consider options to one-on-one and one-to-many communication at the outreach sites
6	Enabling environment / advocacy	1) Change around Section 377 IPC has not impacted TI project functioning much as MSM continue to be harassed by the police in relation to other local public nuisance laws	1) Pool of community sensitive counsellors needed; trained MSM community members can be placed as counselors 2) Linkages with uniformed personnel through UNAIDS 3) Links with Nehru Yuva Kendras, NSS, other NGOs for addressing minor MSM issues 6) Police advocacy in every district with community involvement (replication of southern India model and Alliance India model) 7) Mental health, family counseling and livelihood linkages 8) Sensitization of the judiciary right down to the district level 9) Sensitization of PRI and other elected leaders, CMOH, Block Officers, District Collectors 10) Sensitization in educational institutions – basically the teachers/management/faculty need to be trained to prevent dropout of MSM and TG students 11) Linkages with migrant programme needed as many TG and MSM populations are migrant

			12) Provide appropriate budget and personnel to focus on and carry out this work
7	Project MIS and analysis of data generated by TI projects	1) Project Managers have not taken the lead in such data analysis, which could also feed into project monitoring 2) SACS, TSUs have not capacitated TI projects to undertake such analysis	1) MIS tool and formats need revisiting to determine appropriateness and method of data collection 2) Software should enable some analysis at site, state and national level to be fed back for programme planning 3) Information like gap analysis and site mapping should be fed by M&E Officer only
8	Organizational development for CBOs, including NGO to CBO transition of TIs		1) Avahan tools are available to study how a CBO evolves and there will be GFATM project Pehchan tools available on CBO development 2) Training on leadership building and governance in a structured way

Annexure 2: M&E and Documentation

It is widely acknowledged that an emphasis on M&E and documentation is not only necessary to keep track of work, but also for planning, monitoring and defending the HIV programme in India. While as a country we are proud of the data systems in the HIV programme, there is a growing discomfort on the load of data collection, over emphasis on M&E issues against programme implementation, and lack of feedback loop to the site level which enables effective micro-planning for TIs.

Suggestions for this area include:

- NACO needs to rationalize monitoring systems from national to state to district levels: Revisit cost benefit in multiple monitoring systems (National level – TOs and NTSU; State level – TSU, SACS PO, STRC; and District level – DAPCUs).

- Need to reduce redundant and repetitive documentation by Peer Educators, Outreach Workers, Counsellors and Project Coordinators.

- Simplify documentation so that it better reflects the work of Peer Educators:

  Maintain Peer Diary and simplify data collection tools and formats

  Map sites once a year

  Develop gap analysis based on M&E data analysis twice a year

- Provide specific data analysis software for TI, state and national levels, and ensure a feedback loop as well as build capacity to use the data.

- Review evaluation tool for TIs

  Drop mundane indicators which do not reflect quality of TI and are sometimes contradictory.

  Reduce emphasis on structure of governance in case of CBOs (disadvantage to CBO).

  Do away with unrealistic standardized targets that do not relate to geographical or community composition.

- Need for flexibility in the committees needed at the local level.

- Revisit system for target setting and performance indicators.

- Allocate separate training budget for Peer Educators within the TI on documentation issues