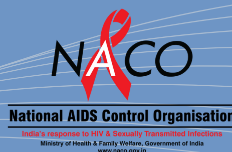
National AIDS Control Organisation

COMMUNITY SYSTEM STRENGTHENING RESPONSE IN INDIA

under the National AIDS and STD Control Programme, Phase-V

2024



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under the National AIDS and STD Control Programme, Phase-V

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आज़ादी का अमृत महोत्सव

AIDS Helpline 1097

जानें समझें, जुग-जुग जीयें।

राष्ट्रीय एड्स नियंत्रण संगठन
स्वास्थ्य और परिवार कल्याण मंत्रालय
भारत सरकार
National AIDS Control Organisation
Ministry of Health & Family Welfare
Government of India

Foreword

India has embarked on a Fast-Track strategy to end the AIDS epidemic as a public health threat by 2030. In order to reach this visionary goal, the National AIDS and STD Control Program (NACP) phase V is enhancing and harnessing partnership, creating accountability for results, and ensuring that no one is left behind. Further, NACP recognizes the need for community - engaged responses as key to elimination of HIV/AIDS related stigma and discrimination. NACP phase V institutionalizes community engagement and meaningful participation at the most granular level in the form of community system strengthening (CSS).

Through CSS, a bottom-up approach has been adopted from constituting Community Resource Groups representing all the typology of the Key Population and people living with HIV at the District and State levels to training of Community Champions and building the capacity of community-based organizations. The program ensures representation of all key population typologies including female sex workers, men who have sex with men, hijra/transgender individuals, people who inject drugs, and PLHIV including youth.

The CSS process document is developed to equip the community, networks, community-based organizations, implementing partners and bilateral partners on the process that is followed and adopted throughout the CSS implementation process. I believe that the document will play a critical role in augmenting the HIV response in India and beyond in terms of how one can undertake a bottom-up institutionalized community system strengthening towards achieving the goal of ending HIV as a public health threat by 2030.

(V. Hekali Zhimomi)

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Preface

India is committed to achieve the target of ending the epidemic of HIV/AIDS by 2030 and hence is focused on strengthening community system intervention to achieve strategic outcomes. One of the guiding principles of NACP Phase V has been to keep the beneficiary and community in the center while implementing programs. The Community System Strengthening (CSS) initiative under NACP Phase-V aims to strengthen community engagement by keeping the beneficiary and community at the center.

NACP phase V aims at maximizing the benefits to its diverse target population by offering a basket of tailored integrated services across prevention-detection-treatment and care spectrum. CSS catalyzes the improved health outcomes of NACP specifically through strengthening targeted interventions (TI) programs, advocacy and rapid response reducing stigma and discrimination, enhancing treatment literacy, greater involvement of communities in decision making and finally developing structured systems of community-led monitoring (CLM).

Aligned with the above, the CSS process document has been developed by ensuring community participation anchored by the National Program and has resulted in the active involvement of the community, shared responsibilities among the service beneficiaries and service providers including implementing partners, community networks, community-based organizations and bilateral partners.

(Nidhi Kesarwani)

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Message

Under the National AIDS and STD Control Programme - Phase V, the vision for Community System Strengthening (CSS) is to ensure meaningful involvement and active engagement of Key Populations (KP) and people living with HIV (PLHIV). The focus is on strengthening community system interventions to achieve strategic health outcomes. The core component of CSS is to mobilize, link, collaborate and coordinate with all KP, PLHIV including Youth and with the overall health systems.

Based on one of the NACP Phase V guiding principle, CSS has been implemented in India with a defined strategic modification involving concentrated focus on capacity building of community resource pool like Community Master Trainers and Community Champions resulting in strengthening leadership, institutionalization of Community-led-Monitoring and advocacy, aiming towards strengthened linkages and active stakeholder engagement leading to zero stigma and discrimination by 2030.

Under the CSS, a total of 100+Master Trainers who are from the Community have been trained in a span of one year across the 35 States, Community Resource Groups (CRG) as well as Districts CRG have been constituted in 600+ districts under the leadership of State AIDS Control Society. Further, to break the silos and build synergies, structured feedback process has been piloted wherein Community Champions collect information on issues faced by the community, which are then discussed and solutions for the same are co-created with all the key concerned stakeholders.

The CSS process document has been developed to outline the process involved, the roles and responsibilities of the people involved, the tools and resources that have been developed under CSS. I am sure this document can be a guidance document for any other public health program where all concerned stakeholders brainstorm and conduct mid-course correction towards achieving a common goal towards enhancing HIV and Health service outcomes.

(Dr. Shobini Rajan)

Message

Through the U.S. Government's President's Emergency Plan for AIDS Relief (PEPFAR), the United States Agency for International Development (USAID) is proud to partner with India's National AIDS Control Organization (NACO) in the fight against HIV and AIDS to address response gaps through a health equity lens, with an evidence-based, person–centered approach. India's HIV response is acclaimed as a global model, and NACO's work in Community System Strengthening will institutionalize community engagement as a key aspect of the HIV and AIDS response in India.

PEPFAR continues to inform and guide India's National Community System Strengthening framework and its implementation at national and state levels. This process documentation of community system strengthening is a key step in documenting the emerging knowledge, experiences and rich learnings of this critical pillar of a response grounded in health equity. We hope that other countries, programs and states will stand to benefit from India's leadership in developing robust mechanisms of community engagement and empowerment, such as formation of state and district community resource groups, training of community champions, and localization. We continue to support the sustainability of organizations led by key populations and people living with HIV, through demonstration pilots for institutional capacity building, social enterprise development, and innovative financing.

PEPFAR is proud to support India as it accelerates its progress to end HIV/AIDS. This documentation will provide a model for community engagement and empowerment for local and global stakeholders to follow, firmly rooted in the principles of health equity.

Michelle M. Lang-Alli, Health Office Director, USAID/India

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Acknowledgement

The Community System Strengthening has been implemented in India with larger objective of building the capacity of communities through community resource pool and aiming towards their active engagement and leading to zero stigma and discrimination by 2030. This process document was written with the active contribution of several stakeholders whose time and valuable inputs we want to acknowledge.

We are grateful to Ms. V. Hekali Zhimomi (IAS, Additional Secretary & Director General, NACO) for her dynamic leadership and unwavering guidance. We are also grateful to Ms. Nidhi Kesarwani (IAS, Director, NACO) for her valuable experience in defining the scope of the project. Dr. Anoop Kumar Puri, (DDG - NACO), Dr. U.B. Das, Sr. CMO (SAG) (DDG – NACO), Dr. Shobini Rajan, Sr. CMO (SAG), (DDG – NACO) and Dr. Chinmoyee Das (PHS Grade I – NACO), Dr Bhawani Singh (DD, NACO) and Dr. Bhawna Rao (DD, NACO) for their valuable technical input, guidance and timely directions.

The cooperation of various organizations like Global Fund CSS project implementing partners and CLM implementing partners that supported our work and contributed to the process is sincerely acknowledged. We also appreciate the contributions of all the State AIDS Control Society as well as the CSS-National Working Group that subsequently led to the completion of the CSS process document.

We extend our appreciation towards the Community Representatives, members and experts from the National Working Group. We would also like to acknowledge the role of our development partners under CSS-CLM from GFATM and PEPFAR, namely- India HIV/AIDS Alliance, The Humsafar Trust, Plan India, YRG Care, Swasti, Sattva, FHI360, Path, FH India, I-tech India, VHS, JHU and bilateral partners such as UNAIDS, USAID, CDC and WHO.

We take this opportunity to acknowledge the efforts of Dr. Shantanu Purohit, National Consultant, Ms. Ira Madan, Technical Expert and Dr. Narendra Jangid, Consultant. We extend our thanks the consultant Mr. Shankar Talwar for framing this document.

We thank Dr. Rita Prasad, Project Management Specialist (HIV), Health Office, USAID India, the team from USAID India — Ms. Deepika Srivastava Joshi, and Ms. Vandana Stapleton — for their support in successfully developing the CSS process document.

The hard wok put in for the process documentation of CSS have been immense and we sincerely acknowledge the valuable time, experience and expertise of all the contributors. The list of contributors towards the successful release of this document is enclosed.

(Dr. Saiprasad P. Bhavsar)

अपनी एचआईवी अवस्था जाने, निकटतम सरकारी अस्पताल में अपनी मुफ्त सलाह व जाँच पाएँ
Know your HIV status, go the nearest Goverment Hospital for free Voluntary Counselling and Testing

Table of Contents

Abbreviations 5

1. Background 9

2. Introduction 13

2.1 Vision of CSS in India 14

2.2 Objectives of Community System Strengthening 14

3. Framework of Community System Strengthening 15

3.1 Evolution of Community System Strengthening 16

3.2 Framework of Community System Strengthening 17

3.3 Implementation Structure of Community System Strengthening 18

3.4 Expected Outcomes of Community System Strengthening 21

4. Community System Strengthening Approaches 23

4.1 Developing Community Resource Groups (CRGs) 24

4.2 Community Championship Initiative (CCI) 24

4.3 Capacity Building for Communities, Community Networks and CSOs 24

4.4 Social Mobilization, Community Linkages, Collaboration & Coordination 24

4.5 Community Led Monitoring (CLM) 24

5. Developing Community Resource Groups (CRGs) 27

5.1 Objectives of constituting State and District level CRG 28

5.2 Structure and Functioning of CRG 29

5.2.2 Structure and Functioning of State CRG 30

5.2.3 Structure and Functioning of District CRG 31

5.3 Good practices, Challenges and Lessons learnt in developing CRGs 34

6. Community Championship Initiative 37

6.1 Selection of Community Champions 39

6.2 Engagement of Community Champions 40

6.3 Good Practices, Challenges & Lessons learnt in Community Championship 40

7. Capacity Building for Communities, Networks and CBOs 43

7.1 Capacity Building of Communities and Networks 44

7.1.1 Objectives of capacity building 44

7.1.2 Process of developing capacity building modules 45

7.1.3 Capacity building modules developed 46

7.1.4 Capacity building cascade 46

7.1.5 Good practices, Challenges and Lessons learnt in Capacity building 48

7.2 Capacity Building of Civil Society Organizations (CSOs) 49

7.2.1 Process of selecting CBOs for capacity building 50

7.2.2 Capacity needs assessment and prioritization 50

7.2.3 Approaches used in capacity building of CSOs 50

7.2.4 Challenges and Lessons learnt in capacity building of CSOs 51

8. Social Mobilization, Community Linkages, Collaboration & Coordination 53

9. Community Led Monitoring (CLM) Experience 55

9.1 Goal and Objectives of CLM 56

9.2 CLM Implementation Process 57

9.2.1 Stage-1: Engagement of community representatives 58

9.2.2 Stage-2: Collection of Information and Analysis 58

9.2.3 Stage-3: Co-creating solutions with community and service providers 59

9.2.4 Stage-4: Engaging district and state teams for action 59

9.2.5 Stage-5: Track and showcase the success 59

9.3 Role of State AIDS Control Societies in CLM 60

9.4 Good practices, Challenges and Lessons learnt in CLM 60

10. Conclusion 63

11. Annex 65

12. Credits 69

Abbreviations

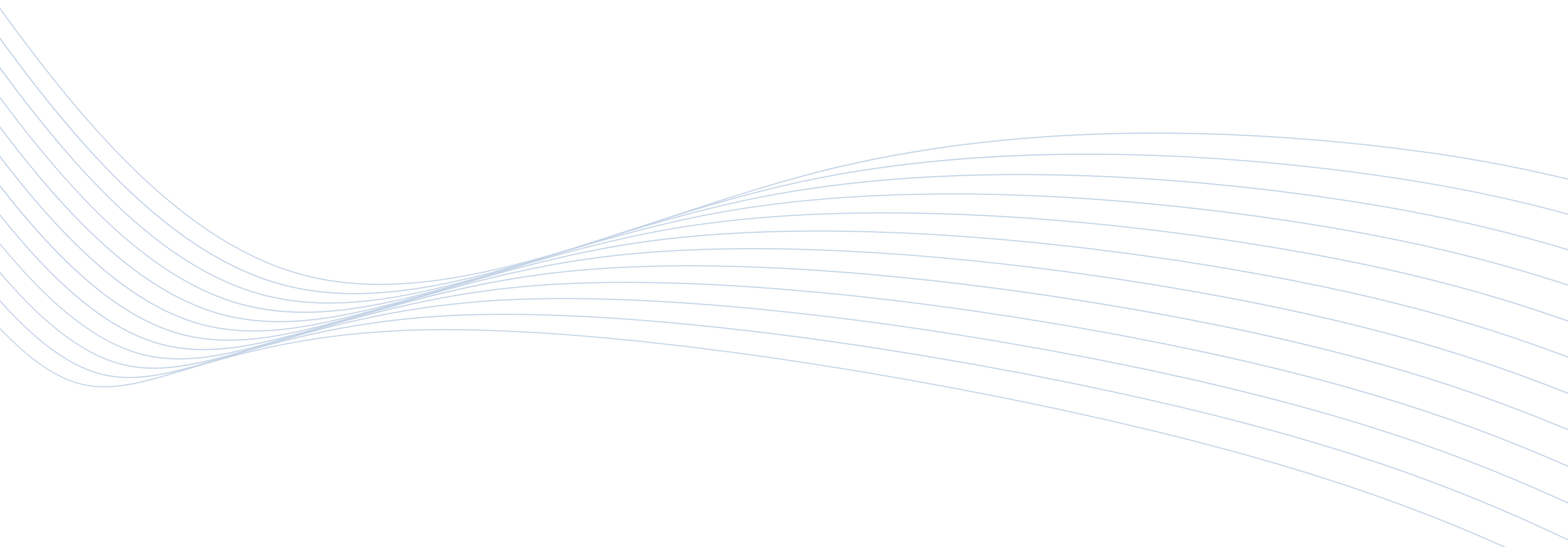
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BMGF	Bill and Melinda Gates Foundation
CBO	Community Based Organization
CC	Community Champion
CCC	Community Care Centre
CCI	Community Championship Initiative
CDC	Centre for Disease Control
CFT	Client Feedback Tool
CLM	Community Led Monitoring
CR	Community Representative
CRG	Community Resource Group
CSC	Care and Support Centre
CSO	Civil Society Organization
CSS	Community System Strengthening
CTO	Chief Technical Officer
DACO	District AIDS Control Officer
DACS	Districts AIDS Control Society
DISHA	District Integrated Strategy for HIV/ AIDS
DC	District Collector
D-CRG	District Community Resource Group
DFID	Department for International Development
DIC	Drop-In Centre

DM	District Magistrate
DMC	Diagnostic Medical Centre
DNH&DD	Dadra and Nagar Haveli and Daman and Diu
DOT	Directly Observed Therapy
DPM	District Program Manager
DSRC	Designated STI/RTI Clinic
DTO	District Tuberculosis Officer
ECAP	EpiC Capacity Assessment and Prioritization
EJAF	Elton John AIDS Foundation
EOI	Expression of Interest
EpiC	Meeting Targets and Maintaining Epidemic Control
FGD	Focus Group Discussion
FSW	Female Sex Worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
H/TG	Hijra/ Transgender
HIV	Human Immunodeficiency Virus
HLFPPT	Hindustan Latex Family Planning Promotion Trust
HRG	High Risk Group
ICTC	Integrated Counselling and Testing Centre
KP	Key Population
LWS	Link Worker Scheme
MDACS	Mumbai Districts AIDS Control Society
MO	Medical Officer
MSM	Men who have Sex with Men
MT	Master Trainer
NACO	National AIDS Control Organization
NACP	National AIDS and STD Control Programme

NGO	Non-Governmental Organization
NWG	National Working Group
OI	Opportunistic Infection
OSC	One Stop Centre
OST	Opioid Substitution Therapy
PD	Project Director
PEPFAR	US President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
EPTCT	Elimination of Parent to Child Transmission
PWID	Persons Who Inject Drugs
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
S CRG	State Community Resource Group
SMO	Senior Medical Officer
SOE	Statement of Excellence
SOP	Standard Operation Procedure
SSC	Sampoorna Surakhsha Centre
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
TG	Transgender
TI	Targeted Intervention
TOR	Terms of Reference
TRG	Technical Resource Group
TSU	Technical Support Unit
UNAIDS	United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
VHS	Voluntary Health Services

01

Background and Introduction of National AIDS and STD Control Programme



Background

National AIDS and STD Control Programmeme (NACP), implemented by the National AIDS Control Organization (NACO), is one of the most successful public health programs in India. The program would not have been successful without the greater involvement of the community of key population groups and people living with HIV. Community involvement in planning and implementation has been a key strategy of the National AIDS and STD Control Programmeme. The targeted interventions have evolved over the years as a robust model with the effective involvement of communities for increased access to services and reduction of stigma and discrimination. Communities were mobilized, through the formation of Community-based Organizations, to own the program and become active agents of advocacy, create demand for services, enhance service delivery, ensure accountability and conduct community-based research.

Community Engagement in National AIDS and STD Control Programme

It is important to look at how the communities were engaged during different phases of the National AIDS and STD Control Programmes for over three decades in India. During the first phase of the program (NACP-I), the representatives from the community were engaged as 'peer educators' to lead the program on STD and HIV prevention among Female Sex Workers in Sonagachi, Kolkata. The strategic approach to involving peers from communities of key populations as frontline service providers to engage with the larger KP community was a success. There was greater acceptability of community-based outreach for targeted intervention, which involved mobilizing communities to provide services.

The second phase of the Program (NACP-II) focused more on creating an enabling environment for adopting safe behavior among communities who suffer stigma, discrimination and marginalization. In addition, the first ever-targeted intervention among Men who have Sex with Men (MSM) was initiated in Mumbai with a focus on increasing HIV related knowledge and promoting safer practices. The results encouraged scaling up these initiatives in future programs.

In NACP-III, community engagement was further enhanced through the creation of dedicated platforms like Technical Resource Groups (TRG) and Program Review Board. These systems helped in the involvement of communities for discussion related to program strategy and policy modification, thereby contributing to the introduction of a distinctive component of "Community System Strengthening." NACP-IV had a strategic objective of community strengthening and community engagement for effective contribution to the national HIV/AIDS response. Community strengthening strategies included community mobilization, formation and strengthening community groups and networks, and linking them to government facilities for accessing services. For more than two decades, several NGOs and CBOs implementing targeted interventions have become effective partners in the country's response to HIV/AIDS. The capacities of these organizations was built as a part of the targeted intervention model for HIV/AIDS prevention and care. PLHIV networks, at the national and regional level, have become effective advocates for treatment and they also run Care and Support Centres (CSCs) across the country. Several programs supported by multilateral partners like DFID, BMGF, PEPFAR, Global Fund , UNAIDS have strengthened the communities and community-based organizations. Many new community-based organizations have come into existence in the past twenty years of HIV intervention in India. These organizations have been able to develop second and third generation leaders, who have become the voices of the communities.

One of the guiding principles of NACP Phase V has been to keep the beneficiary and community in the center while implementing programs. NACP-V is aimed at maximizing the benefits to its diverse target population in a friendly ecosystem offering a basket of tailored integrated services across prevention-detection-treatment spectrum. The service delivery is focused on protecting and securing the human rights of people infected and affected by HIV in line with the provisions of the HIV and AIDS (Prevention and Control) Act, 2017.

The National AIDS and STD Control Programmeme is committed to the principle of Greater Involvement of People Living with HIV/ AIDS (GIPA). The program made significant progress in this direction and involved PLHIV and their networks at various stages from program planning to implementation. The person responsible for GIPA (AD-GIPA) has been shouldering the responsibility of implementing community system strengthening. Under NACP V, the District Integrated Strategy for HIV/AIDS (DISHA) is also aimed towards augmenting the HIV response at the district level. DISHA as a strategy uses a cluster approach to monitoring the HIV epidemic in more than one district. District AIDS Control Officer (DACO) as a lead person of DISHA Unit/DISHA Cluster is designated as a Member Secretary of the district level Community Resource Group (CRG). The DACO is responsible for facilitating and monitoring the CRG at the district level. DISHA Unit/DISHA Cluster will provide the necessary support for community system strengthening in the district.

Over the years, the National AIDS and STD Control Programmeme has made a lot of investment in community system strengthening in India without actually naming it as "Community System Strengthening." Communities have been involved as not only implementing partners but also as technical resources.

Communities have become valued partners in the national program, and have a respectable space at the table in the government department of AIDS and STD. It was only a matter of time before a formal structure of Community System Strengthening was created, and it happened during the NACP Phase-V. The national program aims to make CSS a sustainable institutional mechanism in the country. The history of HIV/AIDS response in India, in some ways, reflects the history of how the communities were engaged and strengthened as effective partners in HIV/AIDS response.

Community System Strengthening for Eliminating HIV/AIDS by 2030

The national adult HIV prevalence in India was estimated to be 0.22%. Although this seems to be a small figure, compared to the prevalence in other middle-income countries, it translates into a number as high as 23.18 lakh (2.3 million) people living with HIV due to India's large population. India has embarked on a Fast-Track strategy to end the AIDS epidemic by 2030. In order to reach this visionary goal, the country will need to use all the tools available, hold one another accountable for results, and make sure that no one is left behind. India has embarked on a Fast-Track strategy to end the AIDS epidemic by 2030. Indian National Strategic Plan for HIV/AIDS and STI (2017-24) also focuses on CSS with definite roles for key affected populations and PLHIV communities, CBO's and networks in designing programs, delivery of services, monitoring and evaluation, and contributing to achieving the overall program results. Supplementing the NACP-V, calls for a consortium of partners such as as Global Fund CSS implementing partners, USAID, PEPFAR, UNAIDS, CDC has intensified the CSS effort in ensuring that the core objective of NACO on strengthening community is achieved. Considering the foundation of CSS is to mobilize, link, collaborate and coordinate with KP, PLHIV including Youth and the health systems with the objective to create resilient and sustainable health systems to achieve goals of NACP.

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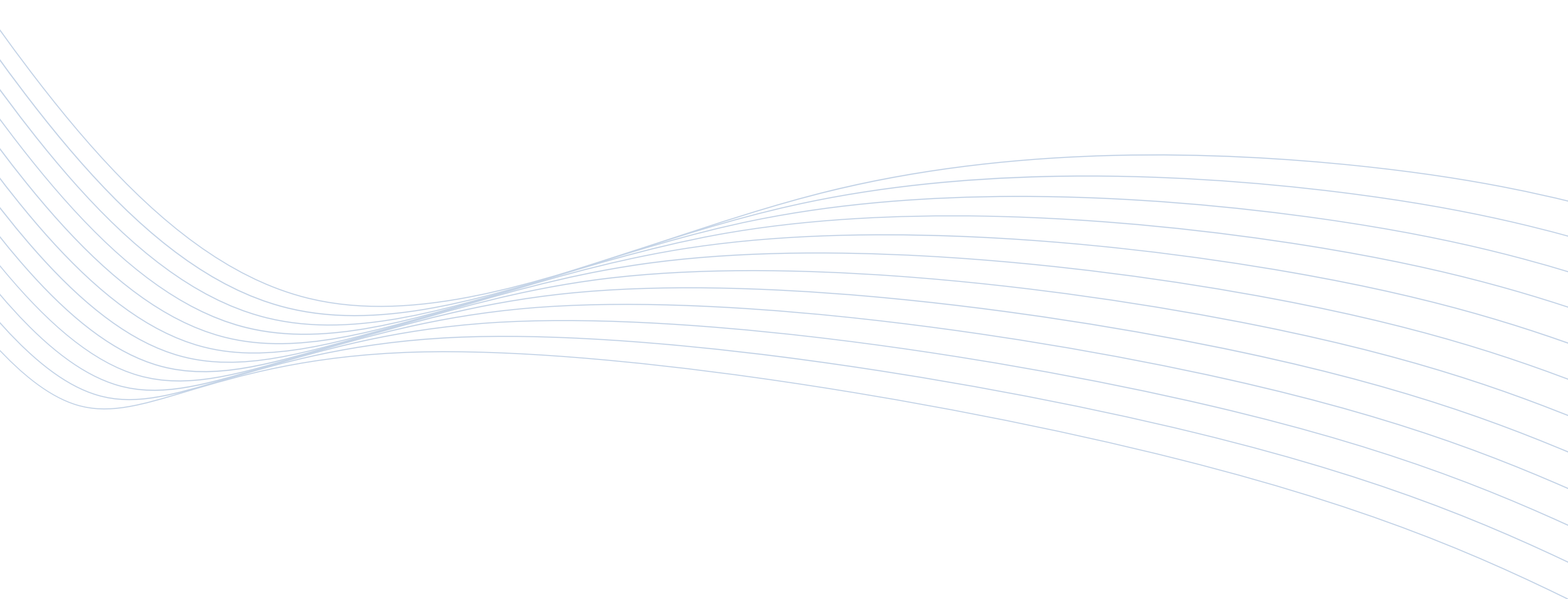
1 *National AIDS Control Organization (2022). Strategy Document: National AIDS and STD Control Programme Phase-V (2021-26). New Delhi: NACO, Ministry of Health and Family Welfare, Government of India.*

2 *National AIDS Control Organization. (2022). District Integrated Strategy for HIV/AIDS (DISHA) (Revamped DISHA) Operational Guidelines. National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India.*

3 *National AIDS Control Organization (2020), India HIV/AIDS estimates 2020. Technical Brief. NACO and ICMR-NIMS. Ministry of Health & Family Welfare. Government of India.*

02

Introduction of National AIDS and STD Control Programme



Introduction

2.1 Vision of CSS in India

NACO's vision for CSS is to strengthen community systems to achieve strategic outcomes that collectively improve HIV/AIDS prevention response and provide access to high quality services to key population , PLHIV, hard to reach and vulnerable population, reduce stigma and ensure dignity. This vision contributes to India's commitment for ending HIV/AIDS epidemic as a public health threat by 2030, and complements the commitment of India's National Strategic Plan for HIV/AIDS and STI, 2017- 2024. This also complements 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.

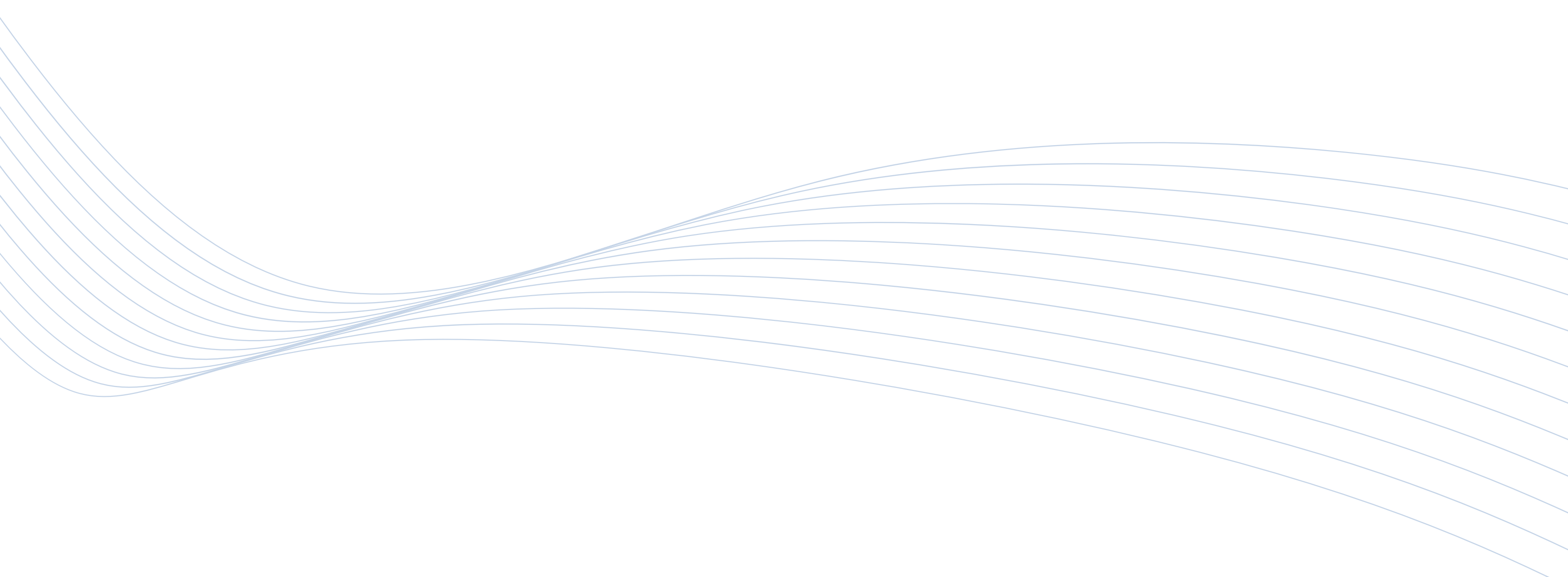
2.2 Objectives of Community System Strengthening

The broader objective of Community System Strengthening is to build the capacity of communities, community-based organizations and networks for effective involvement in planning and implementation of HIV/AIDS programs and reducing stigma and discrimination as a national HIV/AIDS response.

Fig 1. Objectives of Community System Strengthening

03

Framework of Community System Strengthening



Framework of Community System Strengthening

The evolution of Community System Strengthening in India, and the recent efforts made by NACO to provide a framework of implementation, its current structure within the National AIDS and STD Control Programmeme, and the expected outcomes of community system strengthening are discussed in the current section.

3.1 Evolution of Community System Strengthening

Based on the global discussion on Community Led Monitoring (CLM), UNAIDS India office initiated a dialogue on CLM by involving the development partners working on HIV/AIDS. The first meeting was supported by the USAID through their partner, Swasti CSO. The discussion was focused on the need for building a Community Led Monitoring system with a greater role for the communities in providing feedback on the quality of services and improving service delivery. The discussion was also extended to building Community System Strengthening as a part of the National AIDS and STD Control Programmeme.

These discussions on Community Led Monitoring in 2019 led to the discussion on Community System Strengthening and its inclusion in the GFATM grant. In 2021, a formal discussion on the framework of community system strengthening was held by NACO, and opened it to build consensus on the strategy when implemented under GFATM.

National Stakeholder Consultation on 18 Feb 2021: In collaboration with UNAIDS and USAID partner SWASTI NACO organized a National Stakeholder Consultation on 18 February 2021 to facilitate discussions on CSS which provided inputs for the development of a National CSS framework defining the activities to be undertaken under CSS including CLM. NACO had invited all the key stakeholders including development partners and community representatives to ensure that CSS implementation including CLM had a strong partnership among the community (KP typologies and PLHIV) and the HIV/AIDS programs implemented at the District, State and National levels. Senior officials from NACO, UNAIDS, USAID and PEPFAR, Partner organizations, and community experts and members from all the Key Populations and PLHIV participated in the one-day consultation.

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

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[5] *National AIDS Control Organization (2021). 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. Ministry of Health and Family Welfare, Government of India*

The consultation focused on different thematic areas including, steering mechanism of CSS, community resource group at the district level, capacity building and CBO engagement, selection and engagement of community champions, and tools and methods used in Community Led Monitoring.

Constitution of National Working Group - Based on the recommendations of consultation on 18 February 2021, NACO asked UNAIDS to facilitate the process for nominations from the community networks and community experts for the constitution of a National Working Group (NWG) to guide and oversee the Based on the recommendations of consultation on 18 February 2021, NACO asked UNAIDS to facilitate the process for nominations from the community networks and community experts for the constitution of a National Working Group (NWG) to guide and oversee the implementation of CSS in India. NWG was also asked to provide inputs and help in developing an Implementation Framework and Standard Operating Procedures (SOPs), or NACO to adopt as national guidelines, and monitor and provide inputs on the implementation of CSS and Community Led Monitoring (CLM).

The National Working Group of CSS consisted of key population members, PLHIV community representatives, youth representatives, and community experts. NWG also invited UNAIDS, USAID, CDC, FHI360, SWASTI, Humsafar Trust, Voluntary Health Services (VHS), Alliance India, and other implementing partners working on CSS/CLM as special invitees. More than 24 members served as members of the National Working Group. NWG had the liberty to identify its own Chairperson, and moderator on a rotational basis, and all the meetings of NWG were facilitated with the support from UNAIDS. NWG conducted the meetings at a frequency of once a month (Virtually/ partly physically) and as and when required in alignment with the roll out of CSS related activities.

National Working Group Meetings The National Working Group conducted monthly meetings and sub-group discussions where the guidelines on CSS and CLM were discussed. Draft SOP for identifying community champions were developed with inputs from NWG members and NACO The National Working Group started functioning on a routine basis. Based on the inputs from NWG, the Terms of reference (TOR) for forming State and District Community Resource Groups were developed and shared with State AIDS Control Societies. The National Working Group had a tenure of one-year. NACO worked with nine implementing partners to support the implementation of CSS related activities across the country. NWG and other partners gave inputs in developing modalities for "Community Championship Initiative."

3.2 Framework of Community System Strengthening

Community System Strengthening is implemented by NACO under NACP-V in partnership with communities and their networks, community-based organizations, District and State AIDS Control Societies, and several multilateral donor agencies in the country. NACO with the support of its CSS sub-recipient under Global Fund grant developed Capacity Building Modules for CSS. The partner also acted as a focal point for coordinating constantly with the partners implementing CSS related activities for training of Community Champions under the guidance of NACO and NWG. The National Working Group, with adequate representation from the communities, was a guiding force in strategizing the implementation of Community System Strengthening in the country.

As depicted in the diagram below, there are three main parts in the overall proposed framework of Community System Strengthening, including the formal hierarchical structure (national, state and district level implementation), components of CSS, and the key population typologies involved in CSS. The hierarchical structure consisted of National Community Resource Group (also known as NWG), State Community Resource Group (S-CRG), and District Community Resource Group (D-CRG). Such hierarchical structure is in harmony with the implementation hierarchy of the National AIDS and STD Control Programmeme at the national level (NACO), state level (State AIDS Control Societies) and district level (District Integrated Strategy for HIV/ AIDS). The hierarchical structure helped in embedding CSS in the formal structure of the National AIDS and STD Control Programmeme.

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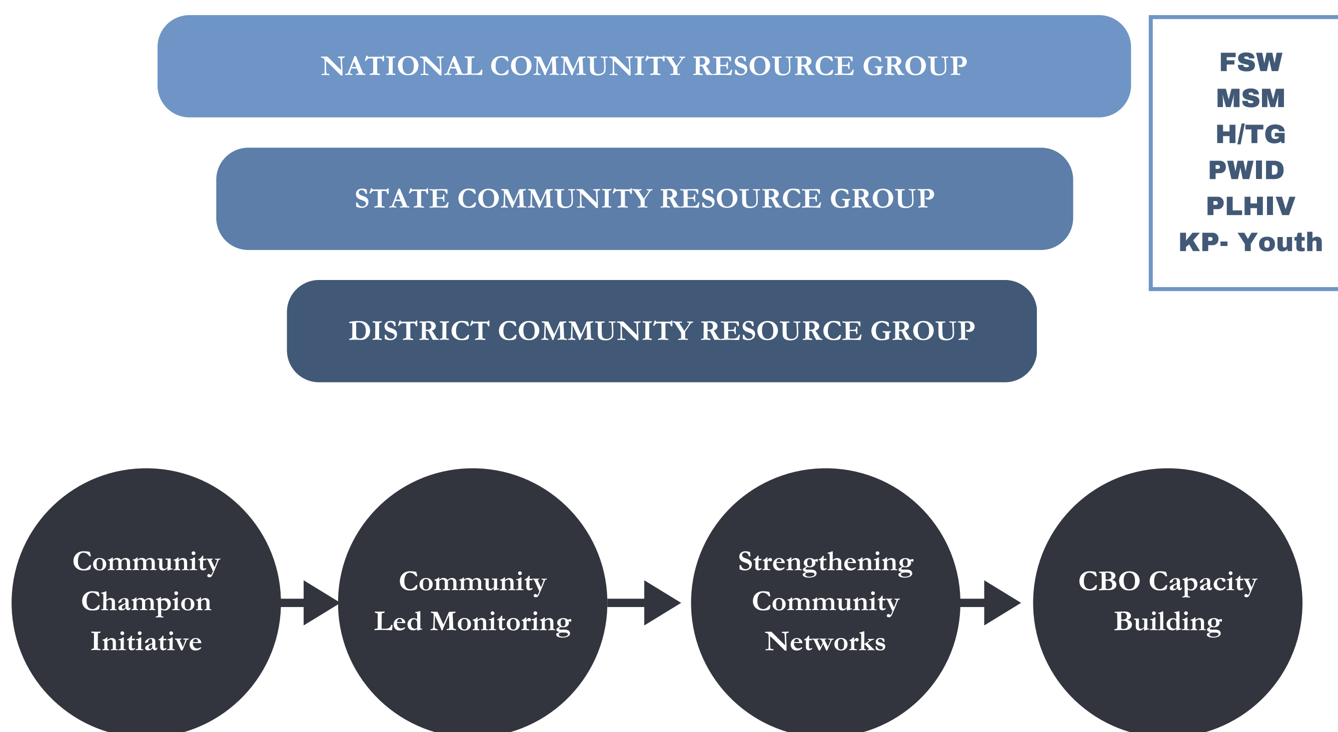

Fig 2. Formal Structure of CSS

The Community System Strengthening has four components or approaches, which included Community Championship Initiative, Community Led Monitoring, Strengthening Community Networks and Engagement, and Capacity Building of Community Based Organizations. Each of these components have been discussed in detail in the remaining part of the document. Different key population groups, including Female Sex Workers (FSW), Men who have Sex with Men (MSM), Hijra/Transgender (H/TG), Persons who Inject Drugs (PWID), People Living with HIV/AIDS (PLHIV) and Youth from the key population groups are at the centre of Community System Strengthening activities.

3.3 Implementation Structure of Community System Strengthening

National AIDS Control Organization has evolved a bottom-up approach to structuring the Community System Strengthening strategy. The inputs for strategizing Community System Strengthening come from the Central Community Steering Committee (also known as National Working Group) represented by the community representatives of key populations, community-based organizations and networks, and supported by partner organizations (bilateral and multi-lateral), and the program team of NACO.

The National Working Group conducted meetings to review and provide inputs towards strengthening the operational framework for implementing Community System Strengthening, and for developing Standard Operating Procedures for Identification of Community Champions. The National Working Group also gave inputs on different areas of capacity building and leadership development, especially in developing framework for capacity building modules for communities, community networks and CSOs. The National Working Group guided the process of forming State and District level Community Resource Groups. The National Working Group was not only a think tank for providing critical inputs, but also a balancing force to build consensus among all the stakeholders from the community involved in Community System Strengthening.

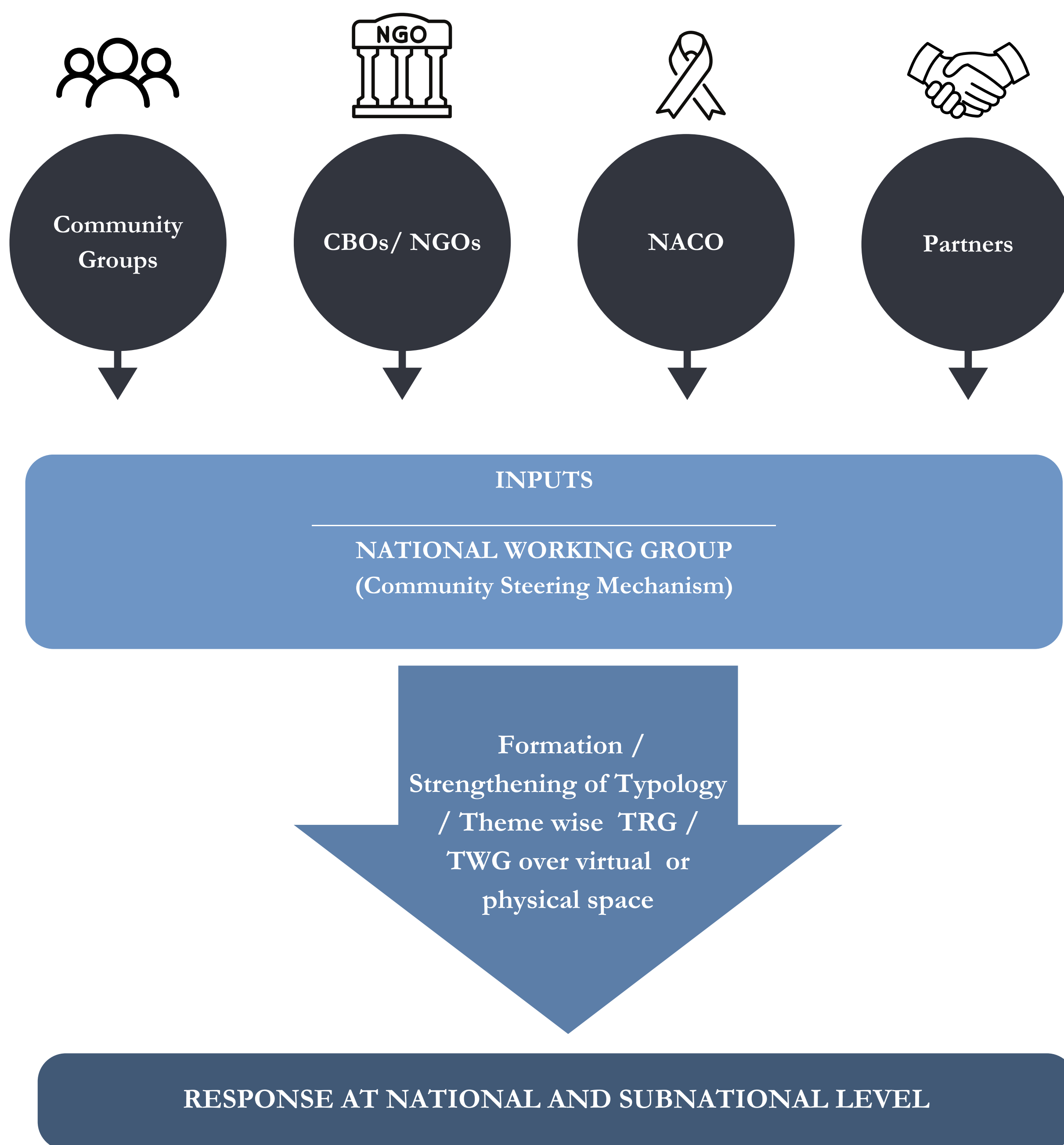

Fig 3. Implementation Structure of Community System Strengthening

Besides the think tank, the community members shared their perspective and acted as a source of community intelligence, which helped in building consensus as partners to the National Program. Other development partners, as special invitees, ensured that the process was run through the NWG, in terms of finalizing the documents and implementation as planned. The National Working Group monitored the progress of implementing CSS and CLM in the country.

CSS Implementation Partner Matrix

Community System Strengthening is implemented in partnership with multilateral and bilateral organizations who have been supporting HIV/AIDS programs in the country. Key funding organizations included GFATM (Global Fund to Fight AIDS, Tuberculosis and Malaria), PEPFAR (President's Emergency Plan for AIDS Relief). Community System Strengthening has four components including developing Community Resource Pool, Strengthening Leadership and CBOs, Community Led Monitoring and Advocacy, and Strengthening Stakeholder Linkages. The activities under these components are distributed among different implementing partners (principal and sub-recipients) for execution. These implementing partners included India HIV/AIDS Alliance, the Humsafar Trust, Plan India, YRG Care, PATH, Voluntary Health Services, and FH India, Swasti and Sattva Consulting. The implementation partner matrix is illustrated in the following diagram.

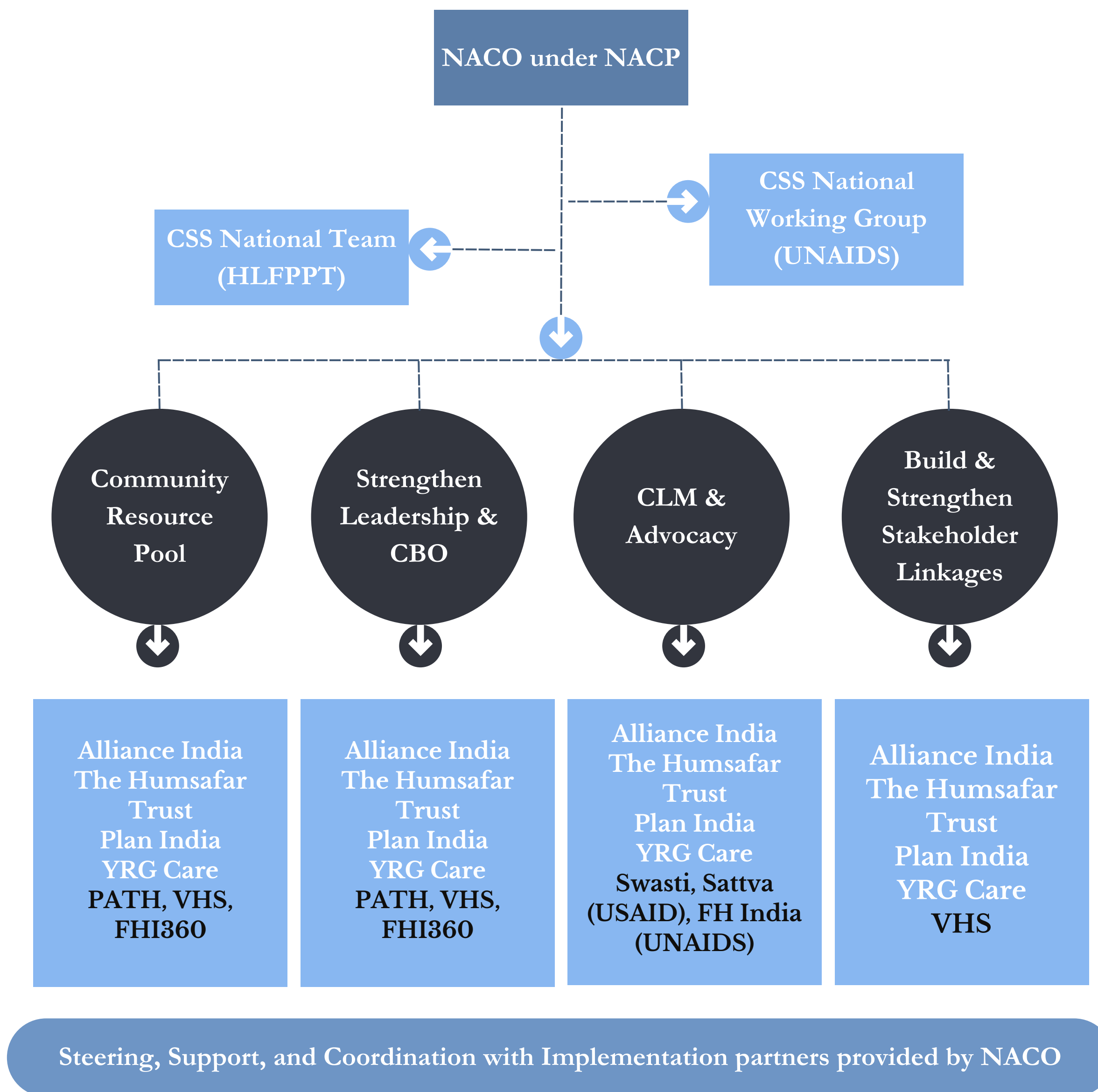

Fig 4.CSS Implementation Partner Matrix

Some implementing partners with historic experience of working with specific key population typologies were assigned with respective groups. While Alliance India catered to the PLHIV networks, the Humsafar Trust (HST) has been working with Men who have Sex with Men (MSM) and Female Sex Workers (FSWs). Both Plan India and YRG Care have been working with Transgender (TG) and People who Inject Drugs (PWID). Although partners covered multiple states, one Lead Partner has been assigned to work in one state in coordination with the State AIDS Control Society.

3.4 Expected Outcomes of Community System Strengthening

Strategic and long-term outcomes of community system strengthening are as follows:

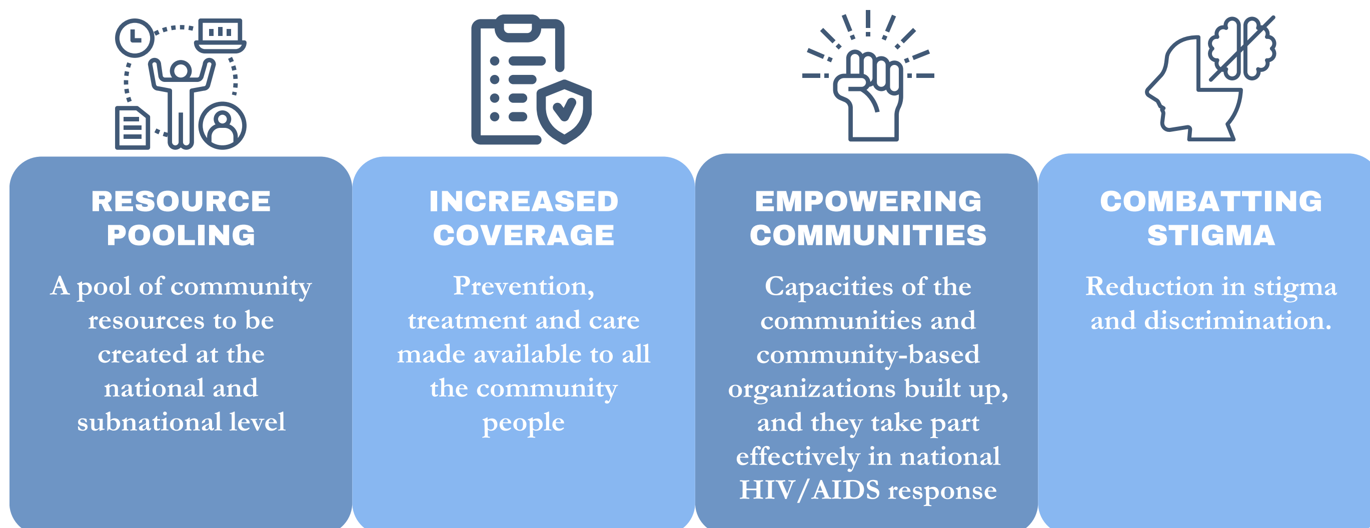

Fig 5. Expected Outcomes of Community System Strengthening

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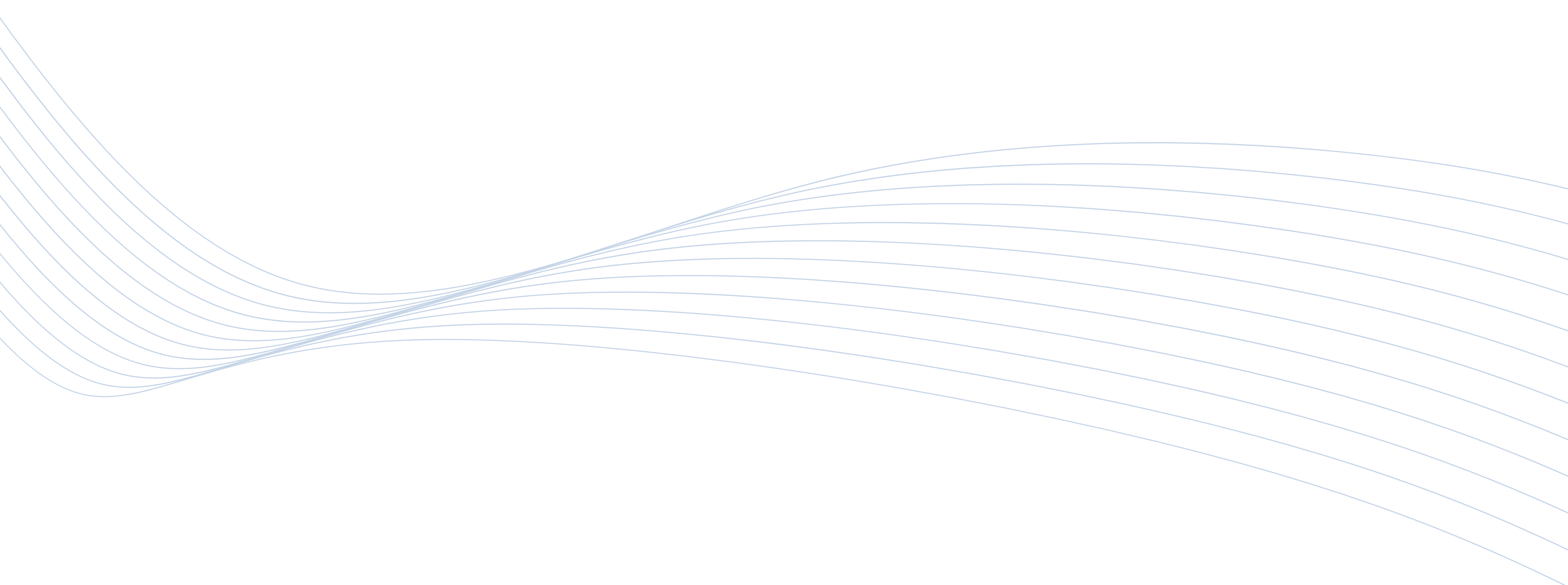
Community System Strengthening Approaches



Community System Strengthening Approaches

The purpose of this section has been to briefly introduce the key components or approaches adopted by the National AIDS Control Organization in implementing Community System Strengthening under NACP-V. All the components of community system strengthening have been discussed in detail in the remaining part of the document.

4.1 Developing Community Resource Groups (CRGs)

It was considered important to empower the key population communities and PLHIV to participate effectively in the national AIDS response to achieve the millennium goal of eliminating AIDS by the end of 2030. Apart from the National Working Group (represented by the key population communities, PLHIV, CBOs/CSOs), Community Resource Groups (CRGs) were created at the district and State levels to ensure that the key population communities and PLHIV and service providers work in tandem to ensure that the HIV/AIDS services are made available to all the people effectively.

4.2 Community Championship Initiative (CCI)

Based on the inputs from the implementing partners, community members, community networks, a plan for engaging community champions in CSS was drafted by the National CSS working team and trainers. The engagement plan was in alignment with the national level work plan of CSS focused on the macro indicators. The primary engagement plan of community champions was developed keeping in mind the specific activities planned at the state and district level in the respective trainings.

4.3 Capacity Building for Communities, Community Networks and CSOs

Building the capacity of key population and PLHIV community and community networks was aimed at developing a cadre of community champions (local resource pool) trained on various aspects of NACP and community system strengthening, and available in the community and to the national program as a resource. The capacity building of community-based organization was focused on organizational development.

4.4 Social Mobilization, Community Linkages, Collaboration & Coordination

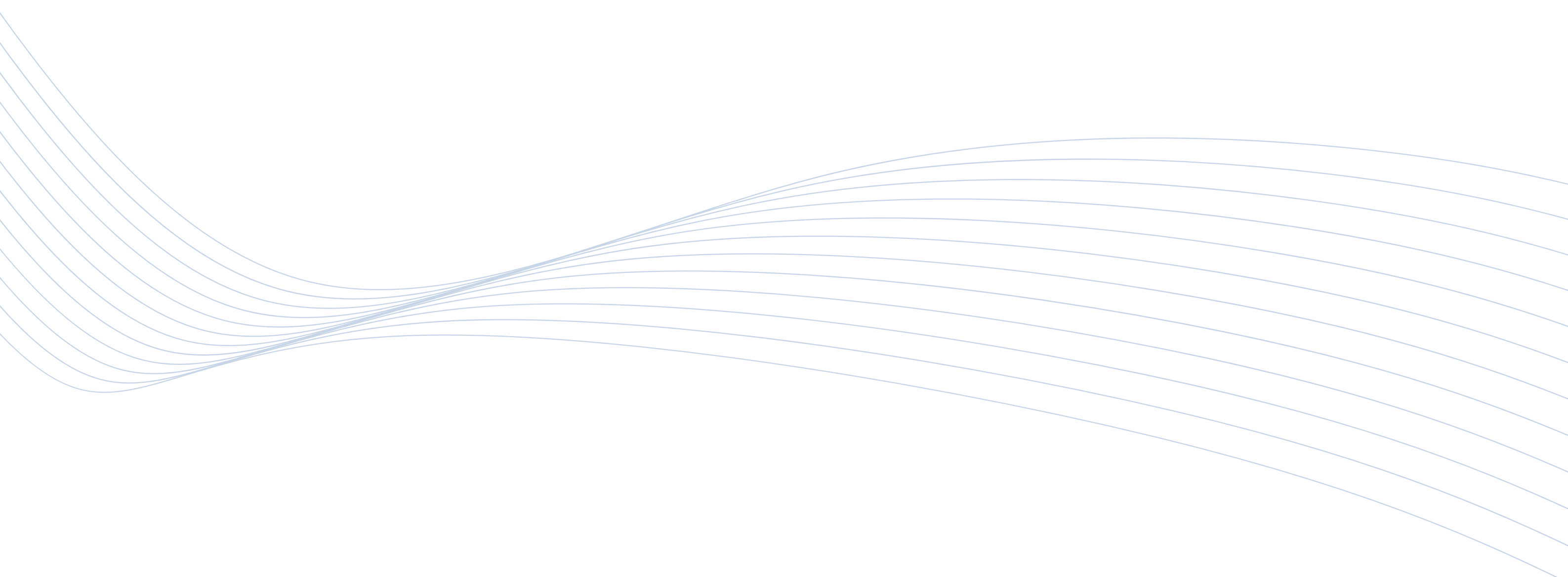
A key component of Community System Strengthening has been to mobilize communities on health and related social issues and build community linkages. Communities play a key role in building linkages among various service delivery facilities under the National AIDS and STD Control Programmeme and beyond. The services included One Stops Centre (OSC), Sampoorna Suraksha Centre (SSC), Targeted Interventions, Link Worker Scheme (LWS), Integrated Counseling and Testing Centre (ICTC), DSRC, ART Centre, OST Centre, and other facilities, and programs, such as, adolescent health clinic. Further linkages and coordination with other programs under social welfare, mental health etc. are important parts of Community System Strengthening.

4.5 Community Led Monitoring (CLM)

Community Led Monitoring is currently being implemented as pilot projects by the partners in different parts of the country. NACO is planning to come up with a national strategy and implementation guidelines on CLM, based on the experience of the pilot projects. In order to strengthen the existing community engagement under NACP, a strategic community led monitoring mechanism will be established to receive feedback for improving

service delivery in Targeted Intervention (TI), Integrated Counseling and Testing Centers (ICTC), Designated STI/RTI Clinic (DSRC), Opioid Substitute Therapy (OST) centers, Anti-retroviral Therapy (ART) Centres and Directly Observed Treatment for TB (DOTS) . Community Led Monitoring was aimed at increasing community feedback on services provided, including accessibility (location and time), availability (of services and supplies), quality and stigma, so that suitable improvements could be made for service uptake by the key population groups and PLHIV.

Developing Community Resource Groups (CRGs)



Developing Community Resource Groups (CRGs)

Community engagement has been fundamental to the program implementation under NACP, where NACO engaged key local stakeholders and community members to foster a sense of ownership among the community members, and create a conducive environment for smooth and successful implementation of program activities. As a part of the community preparation, a formal structure of Community Resource Group has been established in each state to identify, understand, resolve and address the concerns of the community. The formal structure of CRG has representation of all the key population groups and PLHIV. The objectives, structure, and functioning of community resource groups have been discussed in the following paragraphs.

5.1 Objectives of constituting State and District level CRG

Community Resource Group is a formal structure anchored in the National HIV/AIDS Response at the district, state, and national level to identify, understand, resolve and address the community's concerns with their meaningful representation. These communities included Female Sex Workers, Men who have Sex with Men, Hijra/Transgender, Persons who Inject Drugs, People Living with HIV and Youth from the key populations. The specific objectives of forming community resource groups at the state and district level were:

1. **Enhanced Community Engagement**
   Facilitate active community participation in planning, implementation, and supportive supervision of HIV/AIDS programs
2. **Structured Involvement**
   Establish formal structures at the state and district levels, to meaningfully engage key population groups, People Living with HIV/AIDS, and Youth community members.
3. **Optimizing Community Support**
   Facilitate maximum community support and cooperation during the implementation of HIV/AIDS programs
4. **Prompt Resolution of Stigma and Discrimination**
   Ensure timely identification and redressal of issues related to stigma and discrimination.

5.2 Structure and Functioning of CRG

Community Resource Groups at the State and District level are the key elements of the Community System Strengthening initiative under the National AIDS and STD Control Programmeme. NACO has made efforts to ensure that the structure and functioning of CRGs are in accord with the operational structure of the national program at the District, State and National level. The following paragraphs contain the description of structure and function of both State and District level CRGs.

5.2.2 Structure and Functioning of State CRG

The structure and functioning of State Community Resource Group (S-CRG) has been discussed in the following paragraphs.

Structure of State CRG (S-CRG) based on the recommendation of the National Working Group, all the State AIDS Control Societies were provided with guidelines (in the form of TOR) on the formation of the State Community Resource Group (SCRG). The first step towards forming SCRG was to conduct state level orientation for SACS involving TSU, Community members, Lead Partners and stakeholders of CSS. The team at NACO coordinated and facilitated the formation of CRGs in all the states. CRGs were formed in all the states with the representation of community members. One State CRG was formed in every state, irrespective of the size of the key population in the state. The CSS implementing partners in the state supported the CRG formation. he State CRG comprised persons from the Key Populations (one member from different typologies), PLHIV and youth from KP Communities under the chairpersonship of Project Director, SACS. SACS sent invitations for nomination of members from the community networks to be part of the CRG.

While the Project Director of SACS Chaired the S-CRG, a representative from the community was chosen as Co-chair by the nominated representatives. As a co-chair, community members had an opportunity to voice their concerns and seek remedial measures. In some states, CRG had two co-chairs for better representation of community members (in terms of region or KP typology). For example, in the State of Jammu and Kashmir and Ladakh, one co-chair each from Jammu and Kashmir were represented in the CRG. Community members participated in the CRG as co-chair on a rotational basis. State CRG also had special invitees, who represented NACP facilities, other government departments (like Health, Justice, Public Distribution), Research Institute or University. The structure of State CRG is represented in the following diagram.

Chair	Project Director, State AIDS Control Society
Co-Chair	Community representative (1 or 2)
Members	One each from the Population under NACP programs—PLHIV, FSW, MSM, H/TG, PWID and youth representatives (18 to 29 years). SACS/TSU (agency providing support to SACS)
Member Secretary	Nodal officer of National AIDS and STD Control Programmeme (Additional Project Director or Joint Director nominated by PD)

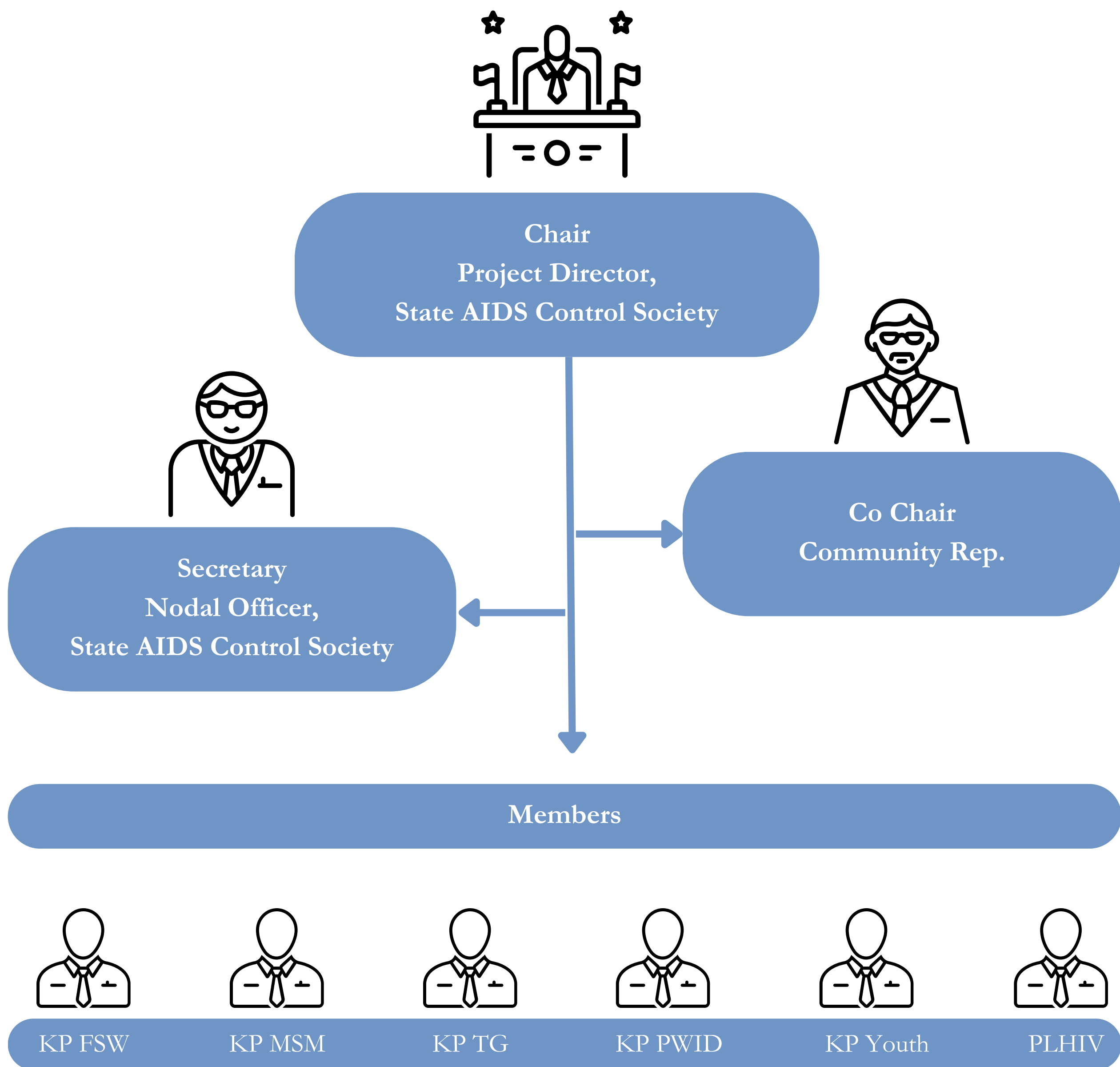


Fig 7. Structure of State CRG

The nodal officer of the National AIDS and STD Control Programmeme (usually the Additional Project Director or Joint Director nominated by PD) was responsible for facilitating and monitoring the CRG at the state level. With the intention of promoting ownership of the program, Project Directors were given the liberty to appoint the nodal officers from any division in the SACS. The member's tenure in the CRG was for a maximum period of two years, with the possibility of extending the duration based on consensus of the group. The formation of SCRG took more time than expected – acceptability was critical, as the approach demanded co-chairing of the committee by the members of the community. Although GIPA was there, representation of all the typologies was required. NACO's SR partner under GFATM 2021-24 , HLFPPT , coordinated with the nodal officers of SACS through six-monthly meetings, which involved sharing of experience. So far, two such coordination meetings have been conducted.

Functioning of State CRG The State CRG conducted meetings on a quarterly basis, or as and when required, on HIV service provision and other community led activities envisaged under the NACP. A quorum of two-third members of CRG was required for conducting a meeting – to ensure representation of each KP typology as applicable and of PLHIV and youth representation in the state. The expenses involved in conducting S-CRG meetings were borne by the concerned SACS.

State CRGs have been working as advisory bodies for appropriate redressal of identified/ escalated issues, including those of stigma and discrimination, of the District Community Resource Groups (D-CRGs), and provide solutions with timelines and engagement with the relevant stakeholders. S-CRG could escalate issues/ concerns to NACO directly in case of non-resolution of issues raised and highlighted.

State CRGs have also been involved in other activities like review of existing guidelines of HIV comprehensive services in the state and providing recommendations for better implementation of NACP. State CRGs supported SACS and DCRG with technical inputs and guidance on planning, monitoring and evaluation, and implementation of NACP and facilitated discussion for the redressal of issues concerned with various departments/ agencies involved in service provision in the state. State CRGs is expected to provide recommendations to SACS/NACO on community led initiatives like CSS, SSS, virtual intervention, One Stop Centers, etc. Some State CRGs had already begun reviewing the reports of "action taken" and CLM implementation at the state and district level on a quarterly basis.

As indicated in the following table, different Lead Partner Agencies were given the responsibility to coordinate and support in the formation of CRGs and conduct training of community champions.

State Lead Partner Agency	States
India HIV/AIDS Alliance	Bihar, Delhi, DNH & DD, Gujarat, Madhya Pradesh, Maharashtra, Meghalaya, Tripura, Uttar Pradesh
The Humsafar Trust	Andaman & Nicobar, Chandigarh, Haryana, Himachal Pradesh, Punjab, Rajasthan, Uttarakhand
Plan India- YRG Care	Assam, Chhattisgarh, Goa, J&K and Ladakh, Jharkhand, Karnataka, Kerala, Manipur, Odisha, Puducherry, Sikkim, Tamil Nadu, West Bengal
PATH	Arunachal Pradesh, Mizoram, Mumbai, Nagaland
USAID Partners - Sattva and FHI 360	Telangana , FHI coordinated with Alliance in Maharashtra
VHS	Andhra Pradesh

5.2.3 Structure and Functioning of District CRG

Based on the guidelines (in the form of Terms of Reference) provided by the NACO, some of the states had already formed District level Community Resource Groups (D-CRG). For example, Mumbai, being a large metropolitan district with strong community networks, had made substantial progress in forming a district level CRG and conducting meetings. Lead implementing partners supported the formation of district level CRGs in their respective states. Like in S-CRG, the district level CRGs comprised persons from the KPs, PLHIV, youth communities and special invitees (when required).

Structure of District CRG In terms of both structure and function, the district level CRGs were modeled on the State level Community Resource Groups. The district level CRGs were chaired by the administrative heads of the district, District Collector/ District Magistrate (or an official nominated by DC/DM), with a community representative as a co-chair. A greater role was envisioned for the DTO (District Tuberculosis Officer) of D-CRG (to review and brief the agenda for a meeting) in case the Chair was a deputed person. District level officers of the AIDS control program functioned as a nodal officer with the responsibility of facilitating, reviewing and reporting the activities conducted by the D-CRG. The district level CRG meetings are conducted every month with a required minimum quorum of two-third members of DCRG. Further, it was mandatory to display the names of members of the D-SCRG on the notice board of DACO/DISHA.

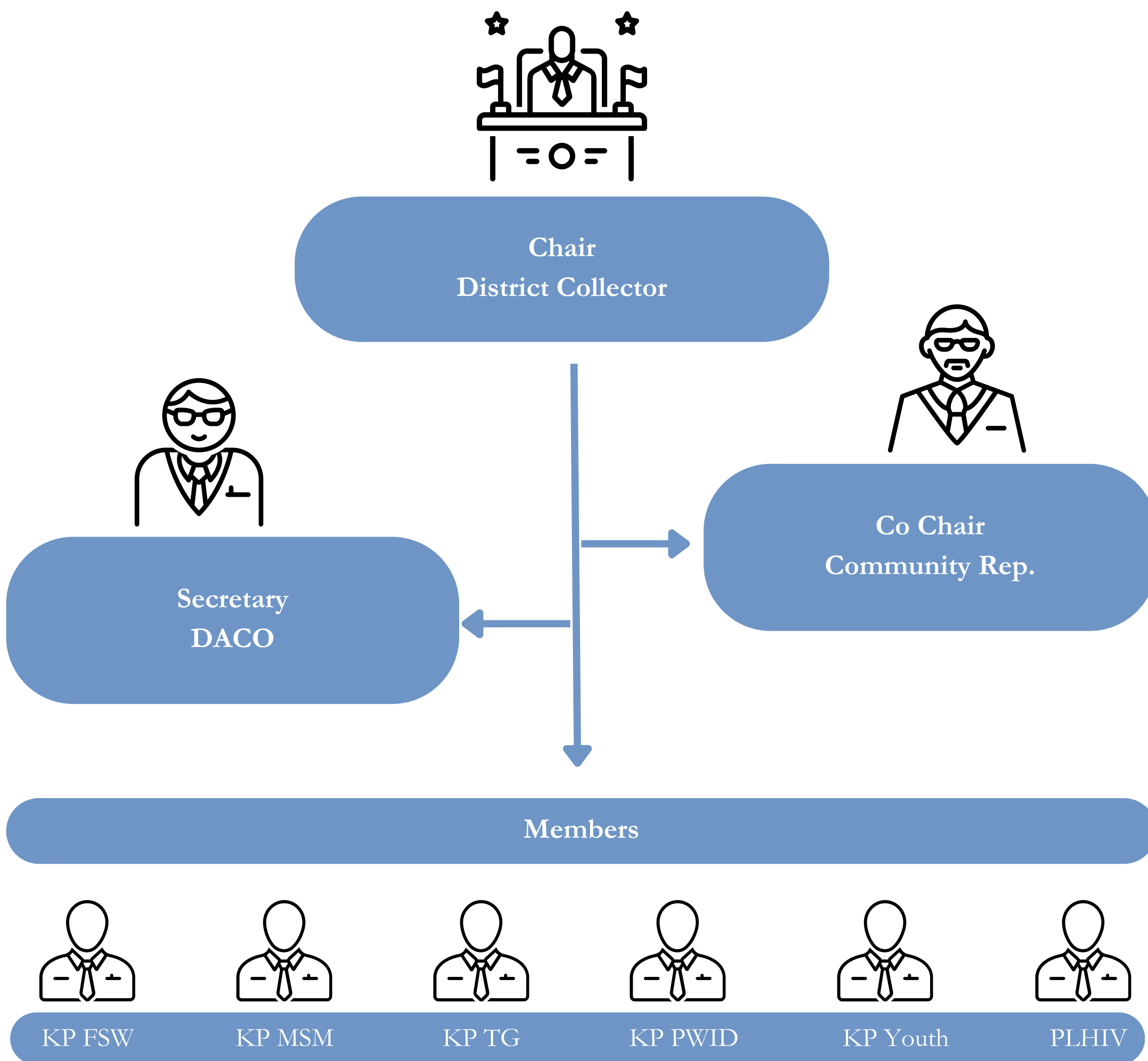


Fig 7. Structure of District CRG

District Collector (DC)/District Magistrate (DM) has been chosen to chair the D-CRG because of the highest power vested over different departments in the district. It was considered advantageous to have the position of the highest authority as a chair for DCRG for better coordination with other government departments in addressing the concerns of the communities. Since DC/DM are generally too busy with the district level administration with multiple responsibilities, the idea of having the DC/DM as a chair is yet to be tested for its feasibility in the end. The national program would review the strategy of involving DC/DM as a chair of D-CRG based on the field experience.

Chair	District Collector (or a person nominated by the DC)
Co-Chair	Community representative
Member	One each from Population under NACP programs—PLHIV, FSW, MSM, H/TG, PWID and youth representative. SACS/TSU
Member Secretary	DACO
Special Invitees(Based on the involvement or need concerned)	From all NACP facilities, District administrative authorities, District Medical and Health Officers (DMHOs), MSJE nodal officers, MSJE NGOs, appropriate NGO working on development sector in the non-covered locations as well as appropriate prison authority at the district level. Community gatekeepers

Based on the consultation with SACS, NACO has developed a detailed approach and strategy for constituting district level Community Resource Groups. Forming CRGs was rather quick and easy in states/districts with presence of strong community networks. For example, in the state of Manipur, with the presence of strong networks of PWID even at the district level, DCRGs were formed quickly and ensured PWID representation, which is not the case in majority of the other states in terms of PWID.

However, Manipur state had a different challenge of mobilizing other key population groups like FSWs, MSM and Transgender who were not that well organized as networks. All the states were hoping to have district level CRGs formed in the current year.

Functioning of District CRG District level CRGs have been formed to work as advisory bodies for the implementation of community led monitoring, for ensuring redressal of identified issues, including those of stigma and discrimination, and providing timely solutions by engaging with relevant stakeholders. D-CRGs also support SACS/DISHA/Clusters with inputs from the community in planning and implementation of programs under NACP. D-CRGs are involved in periodic monitoring and providing supportive supervision based on information from the grassroots community. DCRGs were also responsible for providing recommendations to SACS and NACO on different community led initiatives like CSS, SSS, virtual intervention, One Stop Centers, etc.

Mumbai District Community Resource Group is one of the active District level CRGs functioning as envisioned in the CSS initiative. After the formation of D-CRG in Mumbai on 21 Sep 2022, a meeting was conducted on 3 Nov 2022 for shortlisting the community champions for Mumbai district. Subsequently, the first Community Resource Group meeting was held on 6 March 2023, where several issues were discussed by the CRG members including, the need for Hepatitis screening and vaccination, setting up of a Community Care Centre, formation of Self-Help Groups among PLHIV and others, facilitating Transgender ID card and voter Identity Card. The second District CRG meeting of Mumbai was conducted on 19 June 2023.

5.3 Good practices, Challenges and Lessons learnt in developing CRGs

Based on the experience of forming Community Resource Groups at the state and district level by different State AIDS Control Societies, the following good practices, challenges and lessons learnt are indicated in the following paragraphs.

Good Practices

Coordination with SACS

NACO requested the SACS to nominate a nodal person for CSS .The provision of nominating a nodal officer for CSS was a good strategy and it proved critical in rolling out CSS in SACS . As per the NACO guidance SACS could decide and nominate a Nodal officer from any division ,this is in line with NACP V policy of breaking the silos .Having a point person in SACS for coordination was very crucial. In SACS where a full time point person was assigned had better results than States without one. A lead partner was selected for each state based on NWG discussion and consensus of all implementing partners .The lead partners at state supported SACS with all guidance regarding the implementation of activities at the level including CRG formation. With close collaboration of NACO, SACS and implementing partners , the first batch of training of community champions was piloted in Rajasthan with support of USAID /FHI 360 . All partners and NACO officials were involved in this pilot training, wherein the feedback from the 1st batch of training helped in further refining the agenda for cascade training in other districts and states.

Community consultation/Sensitization

In some states, community consultation was conducted using a hybrid model – physical and virtual meeting. There was a good response from the line department (Police, Legal, Municipal, rural development, Disability department (TG), Women and children Department, Skill development), JDs and DDs from the line department were asked to participate. All the community leaders of different typologies participated in the consultation. District level team connected virtually.

Leveraging Inter-Facility Collaboration and Innovative Outreach Strategies

Many of the SACS involved staff from TI, ICTC, ART and other HIV facilities towards nomination of community members in the State level community resource group formation. In the initial phase, where community networks did not exist, members were contacted through the reference using snowballing approach. The CSS implementing partners helped in spreading words among community networks for nominations for CRG , this was very crucial in many states where a particular typology of KP had lower prevalence.

Challenges

Formation of CRG

In States where there was no strong community network, the formation of CRG faced challenges. In some states, the PLHIV and TG leaders were very proactive and vocal, but the Youth and female sex workers were not actively involved. Therefore, in many states, TG leaders were selected as co-chair in CRG. In some states, whenever there was a competition between different typology groups to become a Co-chair, the SACS would give the complete ownership of the decision to the community groups and ask them to decide the co-chair. Not all the members participated actively despite logistics support provided to attend meeting or training. Some CRG members were unable to participate in CSS activities due to their other priorities. In the state like DNH&DD, where SACS did not have existing targeted interventions, it was difficult to mobilize the key population members to involve in CSS activities. Comparatively it was also difficult to get the youth key population to participate in many of the states.

Lessons Learnt

Community consultation/sensitization

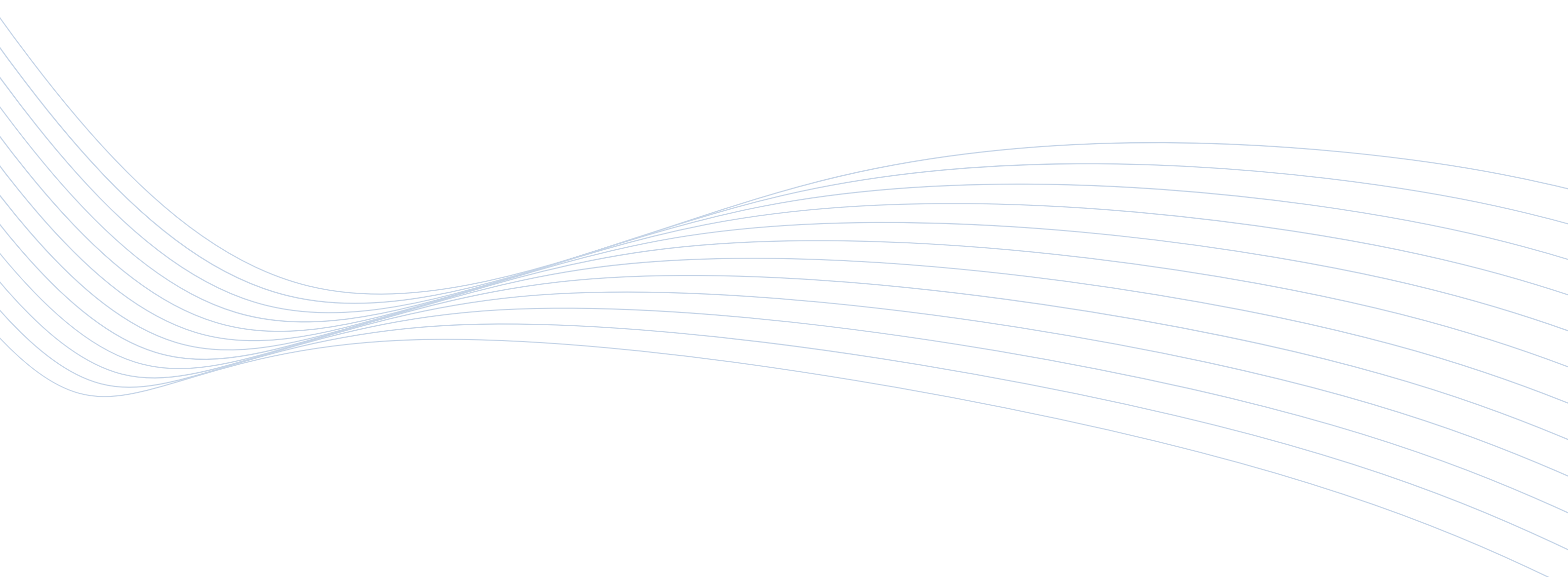
One of the key lessons learned was on the constant and continuous community engagement .The frequent consultation with the HRG communities was very much helpful, especially with with marginalized group of Sex workers and PWID communities and in some states with MSG and TG community based on the stigma and discrimination faced in different states and regions. Another key lesson learned was before starting the work of mobilizing the community, preparatory work should be done to know how many there are and who are the influential members of the community, etc. It was important to engage with the line department (other than health) on a continuous basis and immediately after the consultation meeting.

Formation of CRG

Forming CRG was considered a good opportunity to involve all the state leaders on a single platform during the meetings in the presence of Project Director of SACS. Regular meetings and talks increased the overall engagement and coordination of the CRG members and community champions. The involvement of key populations helped in finding new members of High-Risk Groups and engaging them in prevention services and addressing Stigma and Discrimination associated. SCRG should conduct regular meetings and plan on how to sustain the initiative immediately after the training of community champions. In Nagaland, PWID key populations were more socially accepted than FSW, MSM and TG. Nagaland being a Christian state was considered one of the reasons for increased stigma and discrimination towards FSW, MSM and TG. Possibly, because of that reason, they were not well organized as community networks. However, targeted intervention functioning on the ground were helpful in mobilizing all the community groups. Unlike in other parts of the country, northeastern states did not have problems with the participation of PWID.

06

Community Championship Initiative



Community Championship Initiative

While NACP remains the program with the most engagement of communities and community-based organizations, there is recognition that the goals of the program, especially the Fast Track targets, would be achieved only if we were to develop mechanisms and pathways that enable increased and meaningful community participation. The need for building the capacity of the communities and community-based organizations was considered critical to unleash the power of community for proactive participation. Community Championship is one mechanism that is being adopted as a part of the CSS strategy to bring forth Community voices, create opportunity across different typologies of key populations, vulnerable groups and PLHIV to engage as per their strengths and create structured engagement processes within the NACP

Community Champion is an individual from the Community (key population, PLHIV and vulnerable groups) with a strong motivation to play an active role in the National AIDS and STD Control Programmeme, and actively supports the cause of the Community.

The Role of Community Champions

The Community Champions were expected to understand various components of the National Programme and communicate the same to their peer networks. They were also required to provide inputs to the program through the different mechanisms available and encourage their peers to participate. In the long term, Community Champions were expected to emerge as a local resource pool, available to their own Community as well as to the National Programme. Community Champions, as volunteers, were expected to take up the following work in their districts, without expecting any additional remuneration:

1. **Holistic Inclusion**
   Strengthen the concept of 'Community Championship' to include Community representatives in all aspects of program planning, implementation, and monitoring.

2. **Needs Advocacy & Redressal**
   Identify the community needs and support CRG in advocating for their redressal with relevant stakeholders

3. **Mobilization Support**
   Support SACS/ TI in mobilizing KPs / PLHIVs for specific events (supported by SACS)

4. **Continuous Learning**
   Attend training programs as and when required under the Community Championship Program.

5. **CBO/DLN Engagement**
   Engage with CBO/DLN on CSS related Activity

6.1 Selection of Community Champions

Based on a series of discussions by the National Working Group, NACO had laid out a set of essential and desirable criteria for selecting the community champions. The essential and non-negotiable criteria were that the person should be above 18 years of age belonging to the key population community with fluency in the local language.

The desirable characteristics expected in the community champions were

- Have a large network of peers
- From the local district and state
- Able to understand and communicate the Community's needs.
- Is active within Community initiatives, is motivated to contribute to Community empowerment and ensure Community participation in enhancing the NACP program
- Are not employed full-time within the NACP program (within TI, ART centres, etc.) to prevent conflict of interest

Community champions were selected through the process of nominations and screening. Although it was a voluntary position, several nominations were received. Nominations were sought from the community networks, CBOs and HIV/AIDS programs (TI, LWS and ART centres). A format of Expression of Interest (EOI) was floated online through the SACS and in physical form for the community members to fill out and submit. All the nominations received were collated and screened by the selection committee formed under the State CRG at the SACS level. The selection committee involved members of different key populations, and representatives from the implementing partner of PEPFAR ,GFATM, SACS/DISHA, and civil society organizations. Community members were given 15 days to file their nominations. All the nominations received were collated and screened within five days for consideration by the SCRG. The nominations were segregated by KP typology and PLHIV in each district. The selection committee used different methods (Lottery, Voting and Rating based on interview) to shortlist the community champions. Some states took more days to complete the process of selecting community champions for various reasons mentioned in the following paragraphs. The progress of selection of the community Champions was monitored by the NACO using a weekly update. The process of selecting community champions is depicted in the following diagram.

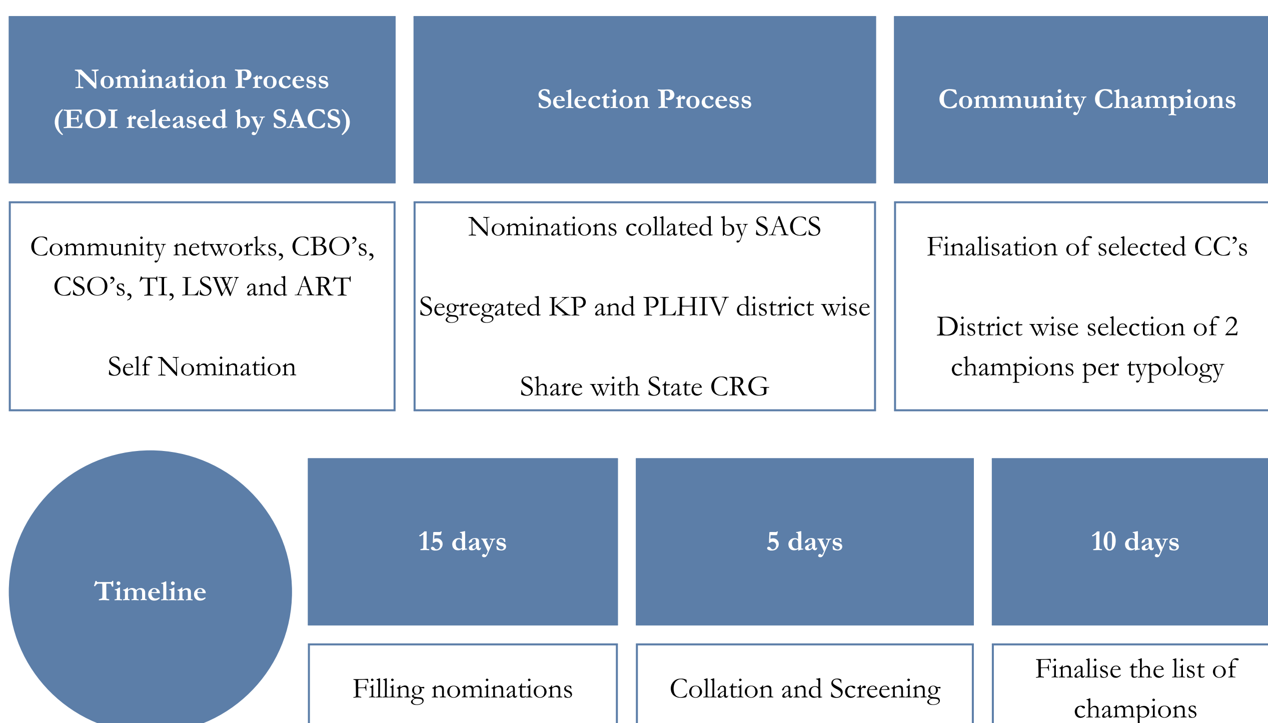


Fig 8. Selecting the Community Champions

The Selection Committee had ensured adequate representation of PLHIV & KPs (minimum two from each typology per district) and geographical areas (rural/urban; district headquarter/blocks). However, the committees faced challenges in ensuring adequate representation as planned initially. In some states, there were fewer nominations from the remote districts, while in other states, such as Jammu, Kashmir and Ladakh, the nominations from certain KP typology like PWID were fewer than expected. Interestingly, some states faced difficulty in getting adequate representation from the youth key population group. Therefore, SACS had to float the Expression of Interest more than once to get enough nominations.

In the State of Delhi, finalizing the list of community champions took more time than expected due to the unprecedented number of nominations from the community members who were enthusiastic to participate in the program. The selection committee had to negotiate with the members to ensure a fair representation in terms of KP typology, geography, etc. Northeastern states (such as Nagaland) had to make extra efforts to mobilize nominations from the less organized community networks among FSWs, MSM and Transgender.

6.2 Engagement of Community Champions

After selection of the community champions, the first ever formal engagement with champions was through a three-day training in different States. These trainings were meant to build the capacity of community champions to function effectively in community engagement and with NACP. In this initiative, community champions were expected to ensure good representation of different communities in program planning, implementation and monitoring. As a part of the community, community champions were supposed to identify the needs and problems faced by the community, and advocate for redressal. Community champions were also expected to mobilize the community members to participate in all the events and activities conducted by the State AIDS Control Societies, CBO and Civil Society Organizations. They were also required to engage with the community-based organizations and district level networks to support community system strengthening activities.

Having completed the initial training, the community champions have begun engaging with the NACP program. Community champions were engaged in Community Led Monitoring in all the districts where the CLM PILOT was implemented. Community champions were involved in collecting feedback, co-creation workshop for solution and monitoring the resolution of problems in a time bound manner. In States like Telangana, SACS and CSS implementing partners have started engaging with community champions by taking them to different HIV/AIDS service facilities at the district/state levels. In several states, community champions were connected with each other through a WhatsApp group to ensure greater connectivity among them and with the service providers.

Some of the states are exploring the possibility of engaging community champions in the Health System in the manner Anganwadi workers (Ministry of Women and Child) were engaged in the past. Community champions have started helping other community members to access the benefits of social protection programs. Community champions have become means to reach out to the unreached KP groups in areas where targeted interventions (TI) did not exist and the community networks were weak or non-existent. The role of a community champion goes beyond HIV/AIDS targeted intervention to address issues of general health, social protection, livelihood, education of children, etc.

6.3 Good Practices, Challenges & Lessons learnt in Community Championship

All the good practices followed, challenges faced, and lessons learnt in community championship initiative by different partners, networks and State AIDS Control Societies are indicated as follows:

Good Practices

Inviting EoI via WhatsApp garnered positive responses. Translating forms into local languages boosted nominations. CSO involvement increased Community Champion participation. Utilizing PWID networks facilitated easy mobilization, with TI NGOs aiding other key population groups.

Challenges

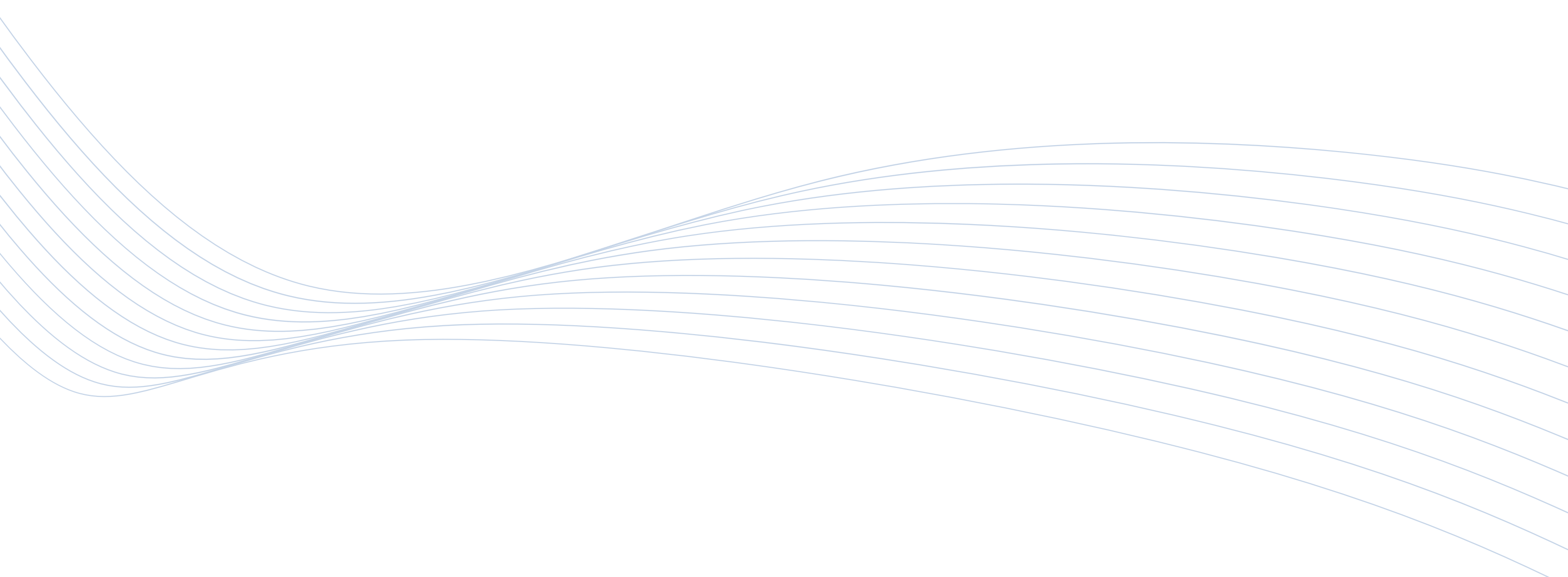
With respect to nominations for all the geographical areas, it was difficult to get nomination from every ward or block and for all the typologies. Although many community members applied for Community Championship, they refused to participate in the training at a later stage.In a State with low burden like Sikkim, there were challenges in getting good representation from the PLHIV network because some of the PLHIV of Sikkim were seeking services in other states in the northeast. Identifying Community Champions from other KP groups (other than PWID) was a challenge in Nagaland, while other KP groups are not well organized or active in the community.

Lesson Learnt

A sensitization meeting Physical /Virtual to discuss about the Concept of Community Champions with all the community members who had applied for CC were helpful in some states and this is can be adopted by all states in any future nominations .It was critical to engage Community Champions continuously through WhatsApp group and introduce them to different HIV facilities, engage in HIV programs, and continue to send messages on HIV on WhatsApp group.

07

Capacity Building for Communities, Networks and CBOs



Capacity Building for Communities, Networks and CBOs

Along with the needs assessment among the key population groups, a need assessment of PLHIV CBO and community members was also carried out before finalizing the content for the capacity building module.

National Stakeholder Consultation - 10-11 December 2021 A National stakeholder consultation was conducted in Bhopal, Madhya Pradesh on 10-11 December 2021 with the objectives of identifying and prioritizing the core areas for capacity building of the community members, community networks and CSOs. The consultation also included deliberations among the key experts to build consensus on the specific activities under CSS & CLM for the National AIDS and STD Control Programmeme as envisioned. The consultation provided clear recommendations for developing Standard Operating Procedures to identify community champions, and Terms of Reference for forming community resource groups at the state and district level. The meeting was attended by NACO, SACS, PEPFAR , Global Fund partners and community members. Thereafter, a set of training modules focused on different thematic areas for community engagement under NACP was developed. The modules were finalized by an extensive consultative process by members of the working group . partners and community members .All the identified resource pools were trained as Master Trainers in a five-day national level Training of Trainers. Thereafter, a cascade training at the regional level (state and district) were rolled out. The following flow diagram shows the process adopted in capacity building of community resource pool and community members.

7.1 Capacity Building of Communities and Networks

One of the approaches under Community System Strengthening is to develop the capacities of communities and community-based organizations. The purpose of capacity building of Community Champions and Community-based Organizations has been to develop a cadre of community champions (local resource pool) trained on various systems of community strengthening who are available to their own community as well as to the national HIV/AIDS program.

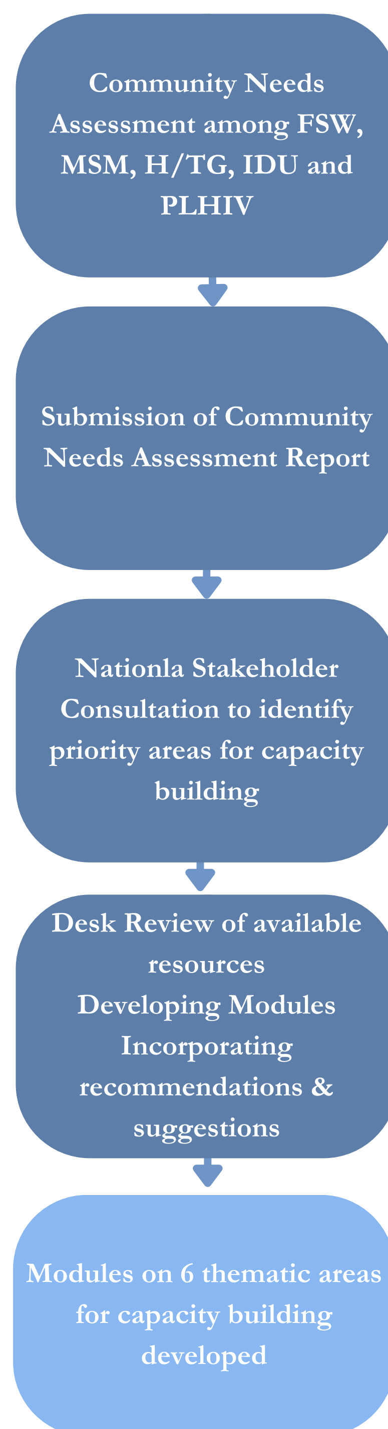
7.1.1 Objectives of capacity building

Objectives of Capacity Building of Community Champions and CBOs under CSS were -

- **To enable effective service delivery** and advocacy models, maximize resources, and coordinated, collaborative working relationships to maximize impact.
- **To improve the policy, legal and governance environments,** and to improve the social determinants of health
- **To improve organization capacity** towards sustainability
- **To ensure service accessibility** to all who need them, evidence-informed and based on improved knowledge
- **To Strengthen M&E systems,** evidence building, research, learning, planning and knowledge management.

7.1.2 Process of developing capacity building modules

A systematic process was adopted in developing modules for building the capacity of key population groups, youth and PLHIV communities. At the very beginning, the implementing partners carried out needs assessment among different key population groups. The reports of these assessments were shared with community networks and discussed in a national consultation meeting to identify the gaps and priority areas for capacity building. Based on recommendations by experts, NWG and implementing partners, six thematic areas were identified as priority areas for capacity building among the communities (champions) and community networks. The following diagram shows different steps involved in developing capacity-building modules.



As the initial activity under CSS, a needs assessment was carried out to understand the existence of different community level systems across 600 priority districts along with their current knowledge and capacity to participate actively in providing HIV/AIDS prevention and care services. This exercise was carried out by using different data collection methods, including desk research of available documents and Focus Group Discussions (FGDs) with community networks, leaders etc. Alliance India conducted community consultation for Need Assessment through a virtual platform where 35 participants from 17 states participated and gave their inputs. Another implementing partner, Humsafar Trust conducted needs assessment through eight regional community consultations (virtual) with the community leaders, and CBOs of MSM and FSW groups.

Other implementing partners also carried out a similar exercise of needs assessment among different key population groups. Based on the needs assessment, a framework for development of the capacity building modules was developed.

7.1.3 Capacity building modules developed

The following six capacity-building modules were developed to address the learning needs of the Community Champions, Community Networks and CSOs in the field of HIV/AIDS prevention program.

- **Module 1:** Advocacy
- **Module 2:** Community networks, linkages, partnerships, and coordination
- **Module 3:** Resources Mobilization
- **Module 4:** Demand Generation
- **Module 5:** Organizational and leadership strengthening
- **Module 6:** CLM & Knowledge Management

7.1.4 Capacity building cascade

The capacity building of community champions was conducted in two phases. In the first phase, a community resource pool of about 100 Master Trainers were identified and trained. In the second phase, a training cascade of about 7,000 community champions was rolled out in different parts of the country.

Training of Master Trainers The geographical distribution of key populations and their typology were taken into consideration in deciding on the distribution of Master Trainers in the country. Community Networks and CSS implementing partners were asked to nominate Master Trainers. The selection of master trainers was based on the criteria of – 1) experience in the HIV field specifically in training, 2) communication skills, 3) their availability for cascade down training for Community Champions, and 4) HIV burden in different regions. While training of the first batch of Master Trainers was conducted in May '22, training of the second and third batches were conducted in September and October 2022 respectively. A resource pool of 100 master trainers was created and trained in three different batches for a duration of five days each.

	Central	East	North	North-East	South	West	Total
MSM	4	2	1	2	5	4	19
FSW	3	4	3	1	4	3	23
H/TG	4	1	2	4	6	2	14
PWID	7	2	2	7	3	1	21
PLHIV	5	3	4	4	5	2	23
Total	**23**	**12**	**12**	**18**	**23**	**12**	**100**

Under the leadership of the SACS, the cascade training of around 7,000 community champions were facilitated by the designated lead partner in collaboration with the trained Master Trainers in different parts of the country. Preparatory meetings were conducted for each training to discuss the agenda and plan the sessions. SACS along with the implementing partners involved in CSS worked together to build synergies and optimize resources through deciding geographies by consensus. Further, This was a useful strategy as resources were pooled to cover districts and states within a stipulated time frame . In some states there were delays which led to some of the Master Trainers moving on with jobs and migrating to other locations.

Training Cascade of Community Champions

While HLFPPT coordinated the training, the SACS with the Implementing Partners developed the schedule for a 3-day cascade training of selected Community Champions in their respective geographical areas. Cascade training and formation of Community Resource Groups took a lot of time and efforts in general. The training calendar of Master Trainers and the Community Champions is indicated in the following table.

Sl. No.	Capacity Building Activities		Timeline
1	Develop Capacity building module and module for CBO development - NACO SR HLFPPT	NA	Sept 21 – May'22
2	Identification and Training of National Level Resource Pools (Potential Master Trainers) for further cascade Training of Community Champions . A pool of 100 master trainers was created. Supported partners in coordination for potential master trainers across regions.	Training of National Level Resource Pool (Induction)- NACO SR HLFPPT . The PEPFAR and Global Fund partners provided technical assistance based as per needs	May'22 – Oct'22
3	Identification and further Training of Community Champion at the district level. Rolled out training of 7000 community champions across the states with close coordination with PEPFAR and Global Fund partners. The training were lead by state AIDS Control Societies in partnership with Lead CSS partner	Identification based on SoP shared with SACS and Implementing Partners	Jul'22 onwards
		Training of Identified Community Champions by Implementing Partners . SACS and NACO ensured training were as per plan	Dec'22 onwards

Feedback on the training Pre and post training assessments were conducted among community champions in all the training to know the impact of the training on community system strengthening. Additionally, in some training, the implementing partners collected feedback from the community champions using oral deposition or video recording. Many community champions gave feedback on whether the training had helped them gain knowledge about HIV/AIDS (P&C) Act 2017, advocacy, the importance of community based organization, service facilities that are available to the community members, etc. Some of the anecdotal responses from the participants are presented below.

> *This is the first training I had ever attended in my life; these three days were highly valuable in my life and I understood about the HIV/AIDS prevention act and the schemes available to our community. Before that, I thought we were only eligible for PLHIV pension. Now, I learned there were more schemes available for us and we had the same rights as others.*

Noor Johan (Name changed), Goa, Age 28

> *Before attending the CSS training, I thought advocacy was for raising funds and publicizing about the organization. Now, I understand it helps us to solve our community issues/problems that were hindering in getting services or help.*

Vishnu (Name changed), Chhattisgarh, Age 26

7.1.5 Good practices, Challenges and Lessons learnt in Capacity building

All the good practices followed in capacity building, challenges faced and lessons learnt by the implementing partners and State AIDS Control Societies are discussed in the following paragraphs.

Good Practices

The feedback from communities was to have more practical discussions and less theory. Group work and role-playing were more effective in creating awareness, disseminating knowledge and involving community members during the training. Involvement of the State Community Resource Group in some states was commendable. Another good practice was close collaboration of states and partners for the training and resource persons for training Since Master Trainers were not available in each state, they had to be invited from other states for conducting the training.

The collaborative process involved in the development of capacity building modules was an important step in the entire process. The content of the capacity building module was prioritized based on the community consultations and needs assessment done by Global fund non-government principal recipients and content was finalized and vetted by working group members along with community members. Each chapter's training methodology was discussed in detail and reviewed extensively before finalization by members of the working group.

Challenges

Community mobilization for the residential training was challenging for the FSWs and TG as they were attending the training they were losing on earning money. It was considered challenging to retain the Community Champions following training due to their voluntary role.During the training, it was difficult to maintain the timings of sessions as some community members arrived at the venue late and wished to leave early.

Lessons Learnt

During the training, it was learnt that many key population groups did not know about the social protection schemes of the government and the availability of treatment at the district level including ART, TB, Hepatitis, STI, and Syphilis.The time gap between the selection of community champions and conducting the training should be minimal to keep the interest level high.Refresher training should be provided to those Community Champions who take up the role of Community Champions in community system strengthening.Involvement of the State CRG in the Community Champions training would help in CSS activities.

7.2 Capacity Building of Civil Society Organizations (CSOs)

Under the auspices of community system strengthening, three implementing partners, including Alliance India, FHI360 and the Humsafar Trust were involved in building the capacity of CBOs/CSOs. While Alliance India focused on forming PLHIV networks at the districts and state level, Humsafar Trust provided seed grants to the community-based organizations to work towards creating an enabling environment for HIV prevention, care and treatment. FHI360 had a deeper engagement with CBOs/CSOs to identify specific areas of capacity building requirements and provided handholding support.

Strengthening PLHIV networks Alliance India had a target of developing 30 PLHIV networks in the project cycle of three years and planned to provide training to 160 CBOs of PLHIV and KPs on governance, organizational development, financial management, compliance, and resource mobilization. As a part of capacity building of community-based organizations the State and District level networks of PLHIV were formed. By the end of December 2022, Alliance had formed nine community-based organizations, including four state level networks and five district level networks of PLHIV. State level PLHIV networks were formally registered with the relevant government authorities in Rajasthan, Madhya Pradesh, Himachal Pradesh and Punjab. In all, five district level networks were formed in three states – three in Haryana and one each in Gujarat and Punjab.

Seed grant to CBOs for enabling environment As a part of community system strengthening, the Humsafar Trust provided seed grants to community-led organizations for community-driven initiatives for innovative concepts that helped in creating an enabling environment at the local, state or national level. These initiatives included highlighting issues on violation of human rights, 6 innovative approaches to reach the unreached and other strategies that focused on the health and human rights of MSM and FSW communities. The themes of the innovative seed grants were identified in consultation with the network representatives, NACO and SACS before they were rolled out.

Institutional capacity building Under the PEPFAR-USAID supported EpiC grant, FHI360 supported CBOs in PEPFAR priority districts in Telangana and Maharashtra. The project goal was to improve the organizational capacity of local CBOs, PLHIV networks and NGOs for self-reliance and sustained engagement in HIV response of key populations. Technical assistance was provided in the area of organization development and systems strengthening, building sustainability through innovative financing and resource mobilization. The results have shown that CBOs, PLHIV networks and NGOs supported through EpiC had enhanced organizational capacity and readiness to raise and manage funding from diverse sources.

7.2.1 Process of selecting CBOs for capacity building

Mapping of PLHIV population and networks Before undertaking the capacity building of CBOs (PLHIV Networks at the state and district level), Alliance India had conducted mapping of PLHIV population (number of PLHIV in all the districts in the country) and the presence of networks in each district. In all, about 400 districts were identified to have People Living with HIV without any PLHIV networks formally registered as an institution with the government as either a Trust or Society. The mapping of PLHIV and networks helped in identifying the districts to form PLHIV networks and build their capacities. Alliance completed the formation of nine CBOs (networks) (4 state and 5 district level) by the end of December 2022.

Advocacy and reaching the unreached population The Humsafar Trust had identified 12 CBOs for providing seed grants (maximum of INR 250,000) to facilitate community-led intervention, particularly among MSM and FSW populations, to reduce harm and negative impact from the HIV epidemic. Smaller community-based organizations operating in semi-urban and rural areas were preferred for providing the seed grant. An external

selection committee was formed to seek grant applications and to review the application based on pre-decided criteria.

Graded approach to selection of CSOs **F**HI360 gave priority to CSOs that were focused on or led by key populations in the PEPFAR priority districts. All the shortlisted CSOs were contacted individually through virtual meetings or in-person for further interaction with the leadership to understand their current work and funding status. More CSOs that were implementing targeted interventions in Maharashtra were identified through snowballing approaches and in discussion with the Maharashtra State AIDS Control Society.

7.2.2 Capacity needs assessment and prioritization

In the group work during the national consultation on identifying the priority areas for capacity building of CBOs, it was suggested to divide the CBOs into three groups, including nascent, growing and mature based on the level of growth. Working groups had also recommended priority areas of capacity building of CBOs, including financial management, resource mobilization, and sustainability. It was suggested to make learning modules available on the Learning Management System (LMS) portal.

Focus on governance and compliance Alliance India focused on the core issues of CSO management including governance and compliance. Alliance India was a lead partner in nine states, including Bihar, DNH & DD, Delhi, Gujarat, Madhya Pradesh, Maharashtra, Meghalaya, Tripura and Uttar Pradesh. Alliance India is building the capacity of CBOs of Key Population groups and PLHIV in the areas of governance, organizational development, financial management and compliance, and resource mobilization.

Self-assessment and prioritization by CBOs FHI360 provided capacity-strengthening support to 32 local key population led civil society organizations (CSOs) and networks of people living with HIV (PLHIV) to enhance organizational systems and employ resource mobilization strategies to diversify their funding. Using a facilitated self-assessment – the EpiC Capacity Assessment and Prioritization (ECAP) tool – CSOs prioritized capacity development goals to develop a capacity development plan unique to their organization. The CSOs received capacity-strengthening support including mentorship, training, and access to relevant tools and resources. With EpiC's mentorship support, most CSOs were able to streamline and strengthen their governance systems.

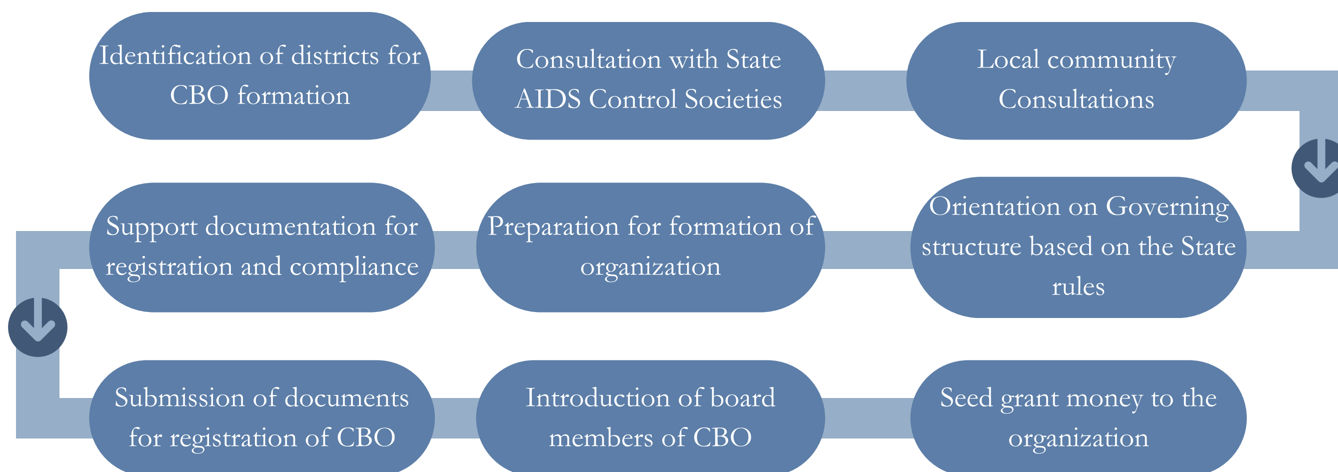
ECAP tool was used in a facilitated process of self-assessment of organizational capacity in ten capacity areas, categorized under functions of organizational management, program management and resource mobilization. For each of the ten capacity areas, there were activities to help develop a common understanding of the definition and performance ideals. Scoring was done by all the participants of CSO on a scale of 1 to 4 from low to high capacity. It included components of individual scoring which were averaged into group scores to give mean scores for each capacity area. Once the scoring was completed, participants reviewed how Statements of Excellence (SOE) were ranked in terms of both capacity and importance, to identify those SOE that were of low capacity but high importance for achieving the organizational goals. Participants then prepared a Capacity Development Plan focused on addressing the gaps in the identified SOE.

7.2.3 Approaches used in capacity building of CSOs

Different approaches and methods used in developing the capacity of community-based organizations/CSOs by Alliance India, the Humsafar Trust and FHI360 have been discussed in the following paragraphs.

Formation of PLHIV networks After identifying the Networks to be registered, Alliance India conducted local community consultation among the PLHIV population. They were briefed about the legal requirements of registering an organization. All the nine networks formed in 2022 were provided with a grant of five thousand Indian rupees to meet the expenses of registration. At the same time, they were asked to conduct group discussions and consultations to understand their needs and gaps in services. Further, these networks were

given a grant of INR 9,600 per month for a period of six months. Alliance had a MOU with all the nine networks before releasing the grant. These networks were supported for registration, opening a bank account, getting tax identification number (PAN) and registering with the planning commission (Darpan). Alliance used the following process in the formation of CBOs:



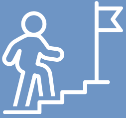
Virtual meetings were conducted to sensitize and build the capacity to manage the PLHIV networks. Finance officers from the Alliance traveled to the locations of CBOs to train them on regulatory compliance. Similarly, the Program Management team of Alliance visited the organizations to train the governing body of networks. Networks were also provided with capsule training on how to write proposals and present them to the funding bodies. Since there was no dedicated budget for training, the capacity building activities were carried out as a part of program management.

Workshops and supervisory visits The Humsafar Trust conducted workshops among the selected CBO members to build their capacity on varied topics, such as managing organizations, financial management and compliance. In addition, supervisory visits were conducted to provide handholding support on implementing the project funded under seed grant. All the supported CBOs were linked with the State AIDS Control Societies and DISHA in order to provide an opportunity to explore further partnerships.

Mentoring for capacity building One of the main approaches used for Capacity Development was regular communication and coordination by the District Mentors/Coordinators who conducted joint performance tracking and coordinated with other EpiC team and Technical Experts to offer support to the implementing partners to reach the desired Standards of Excellence (SoE). In addition to the on-site mentoring support by the District Mentors/Coordinators, other approaches such as: thematic workshops on key capacity areas; technical assistance by experts and agencies; immersion visits to other organizations that have demonstrated capacities; and exposure visits to organizations with specific strengths are also used.

7.2.4 Challenges and Lessons learnt in capacity building of CSOs

The challenges faced and lessons learnt by Alliance India and FHI360 in building the capacity of CSOs have been presented in the following paragraphs.



Challenges

Alliance felt that the idea of assigning lead partners to a particular state/ region to work with all the KP typologies was not very helpful since partners in general were more focused on a few and specific KP typology rather than region. Sustaining community champions as volunteers over a period was considered a challenge. Continuously engaging with the community champions and keeping their motivation levels high was considered a challenge. According to Alliance partners, PWID engagement in CSS was a challenge as they faced difficulties in sitting through the training. It was felt that only about 20% of the PWID champions were able to participate in the program effectively.

Lesson Learnt

Based on the experience of building the capacity of CSOs in Maharashtra and Telangana, it was felt that the technical assistance on institutional capacity strengthening must be aligned with the unique needs of each CSO to ensure ownership, accountability, and action. CSO board members, management, staff and community members must actively participate at all stages of the institutional capacity development process to help build consensus on the gaps in capacity, define a shared vision for the organization and ensure individual and collective action for positive change in systems and capacity. A multi-pronged approach to capacity building involving mentoring, coaching, training in thematic areas, twinning and immersion visits to other successful CSOs, can be an effective way to inspire CSOs to adopt a vision for growth and diversified funding. based on experience it was felt that for long-term sustainability, equal focus must be given to improving systems and capacity standards on governance, program management and resource mobilization. It was a strong realization for Alliance India that sensitizing and motivating the members of the network worked very well in building the capacity of PLHIV networks.While State AIDS Control Societies in Haryana and Punjab gave seed money to the networks, CBO members in other states managed on their own. Forming nine CBOs was a milestone for Alliance, but they all needed capacity building to ensure that the networks sustained on their own. Integrating with non-PLHIV community members would help in creating a bigger platform across different community members. It was felt that providing ID cards and regular engagement of community champions would make them more effective.

08

Social Mobilization, Community Linkages, Collaboration & Coordination

Social Mobilization, Community Linkages, Collaboration & Coordination

Social mobilization and linkages are an integral part of community system strengthening. Social mobilization by creating awareness about the problems faced by the communities and linking them to different services that are already available. Key population communities are mobilized by providing information and linking them to facilities to access services. KPs further collaborate with the service providers and work towards ensuring that services are available to all the people in need. Different approaches used in community system strengthening including CLM and Community Resource Groups help in linking, collaborating and coordinating with the service providers and facilities for access to improved services by the communities.

With the formation of State and District level Community Resource Groups, the grassroots activities of community mobilization and linkages under CSS have begun in different parts the country. Further, linkages with other programs under social welfare, mental health, social justice, etc. have become an important part of the Community System Strengthening in HIV/AIDS program.

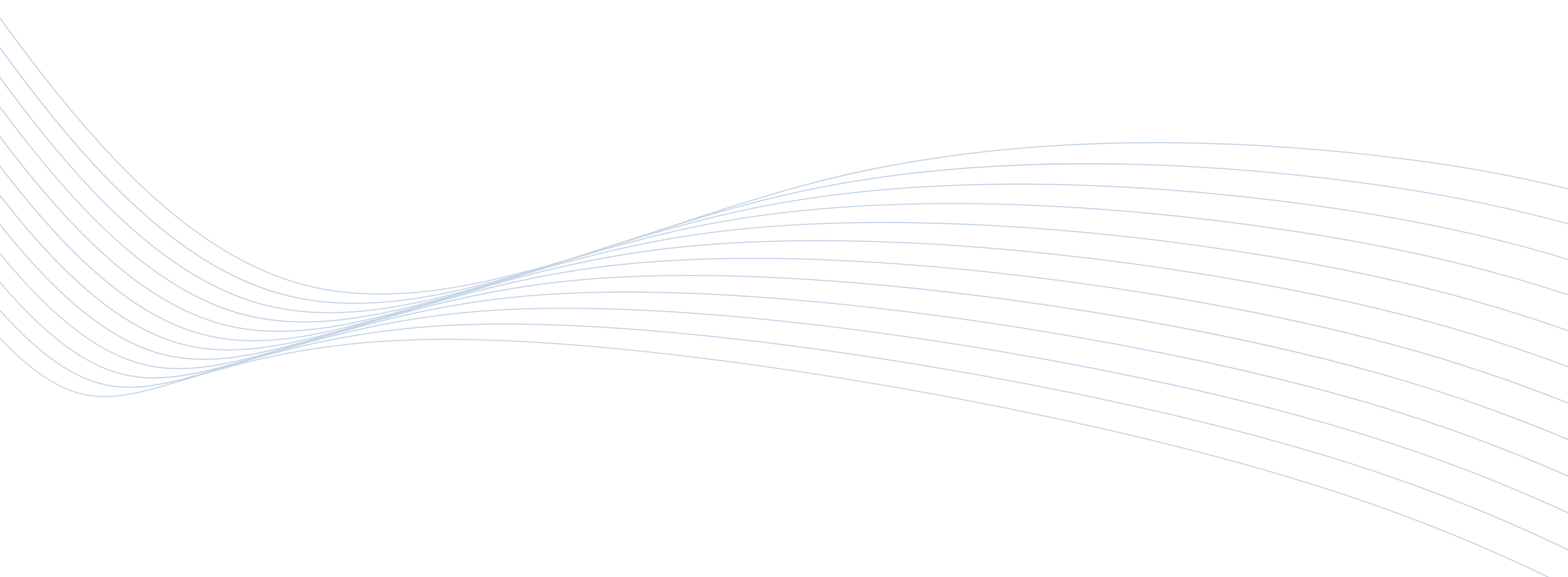
Developing networks In Dadra and Nagar Haveli and Daman and Diu (DNH&DD), the State AIDS Control Society of DNH&DD has started engaging the Community Champions identified under CSS in organizing networks and community-based organizations.

Hepatitis screening and vaccination After the formation of Community Resource Group, Mumbai Districts AIDS Control Society conducted two District level CRG meetings very successfully. Considering the lack of awareness about Hepatitis (HBV and HCV) among transgender, the Community Resource Group came forward to conduct Hepatitis screening and vaccination, in partnership with a local CSO, United Way. Other key population groups including FSWs, PWID, and MSM also participated in the awareness campaign.

Mumbai District CRG identified one of the Community Champions to conduct advocacy with the Social Justice department to ensure that all the transgender members are provided with TG Identity card. Further, MDACS took the responsibility of forming SHG and identifying centers providing free dialysis for the PLHIV community. MDACS also assured the members about conducting a workshop on the HIV/AIDS (Prevention and Control) Act, 2017. In addition, it was decided to provide a format to the community champions to report on any crisis, incidences of violence, stigma and discrimination in the community.

09

Community Led Monitoring (CLM) Pilot



09

Community Led Monitoring (CLM) Pilot Experience

In this section, we discuss the experience of implementing CLM pilots by four partners across the country. CLM is a crucial part of Community System Strengthening aimed at ensuring National AIDS Programs meet community needs. The objective of institutionalizing CLM within the National AIDS Programs was to ensure that programs met the needs of the communities at all levels. Overall, it assesses performance, addresses barriers like access, stock outs, and discrimination.

Building on this objective, NACO, in 2020, expanded the technical working group on KP interventions to designate it as Technical Working Group (TWG) on CSS. The group has been instrumental in providing technical guidance on CSS to NACP. Early in 2020, just before the COVID-19 pandemic set in, PEPFAR took the initiative to pilot a full-scale CLM project in Maharashtra and Telangana to support India's NACP in adopting CLM in the Indian context as well as providing a standard operating procedure (SOP) and Client Feedback Tool (CFT) to its stakeholders to implement CLM among KP groups with clearly defined steps.

Scorecards for improving service delivery are not new in India's HIV/AIDS programs. In the Nirantar program (2014-18), implemented in Chhattisgarh, Madhya Pradesh, and Odisha with CDC's PEPFAR support, a community scorecard approach ensured quality service delivery.

Under the CSS umbrella, NACO adopted a systematic approach for community feedback. With NACO's guidance, UNAIDS and USAID organized a fortnightly stakeholder meeting on CLM. The Client Feedback Tool and methodology were finalized by the CSS national working group based on feedback received during the fortnightly meetings conducted by the CSS-NWG with all the CSS and CLM implementing partners and the Community as well. The finalised CFT was then translated into local languages by the CLM implementing partners. In 2020, as part of its focus on CSS, NACO initiated a pilot on the CLM program through Swasti with the support of USAID in seven districts in two states. Prior to the intervention in Delhi, the CLM pilot had been initiated in five districts in Telangana, namely, Rangareddy, Mahbubnagar, Nalgonda, Karimnagar, and Hyderabad, as well as in two districts in Maharashtra,Thane and Pune.

In 2021, besides the above 3 states, CLM was piloted in Manipur,Mizoram and Nagaland by FH India with the support of CDC and UNAIDS and then in Uttar Pradesh by YRG Care.

9.1 Goal and Objectives of CLM

The goal of CLM is to establish and institutionalize a mechanism of community feedback for the overall improvement of all service delivery under the NACP. The specific objectives are:

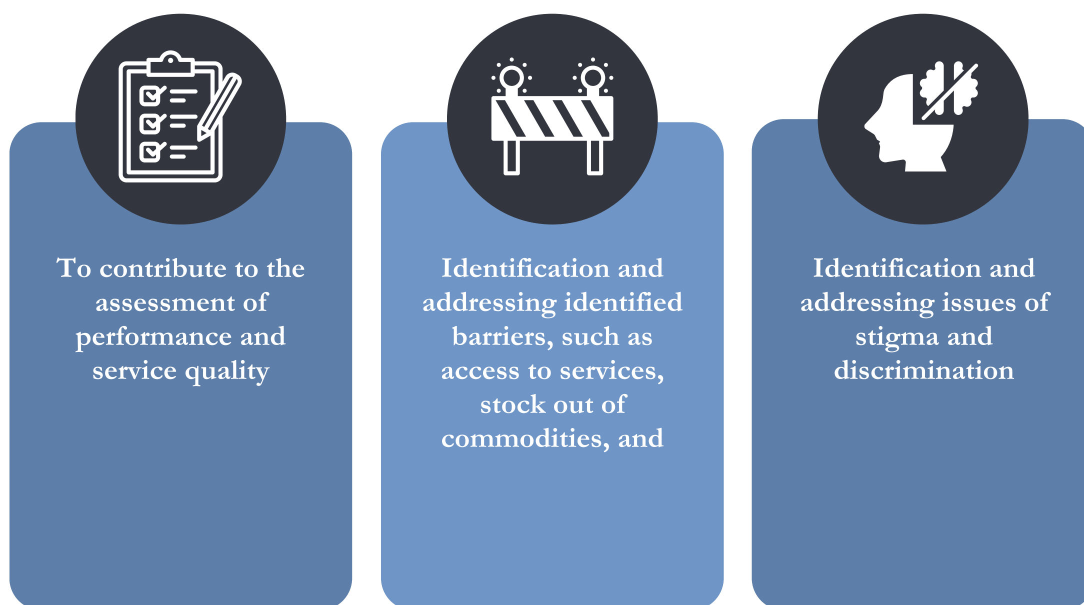


Fig 8. Goals of CLM

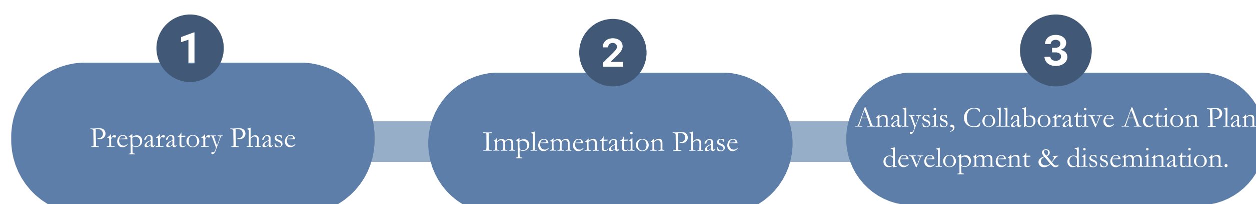
CLM can improve HIV outcomes and support the Sustainable Development Goal of eliminating HIV by 2030, through the involvement of service providers and key beneficiaries. It fosters collaboration, identifies treatment retention enablers and barriers, and diagnoses persistent challenges at the community and facility level. By offering data-driven solutions, it improves service delivery and accountability within the health system, establishing shorter feedback loops, advocacy and strengthening community structures.

CLM strengthens program impact, efficiency, and effectiveness by promoting collaboration among various stakeholders. It's essential to clarify what CLM is not: it's not about monitoring people, nor is it a government monitoring system with community-centered indicators. It goes beyond periodic check-ins by facilities and instead focuses on assessing performance, addressing barriers, and integrating data to support quick decision-making by authorities.

9.2 CLM Implementation Process

Four pilot projects have been implemented as follows: Swasti, supported by USAID, conducted its pilot in five districts of Telangana and two districts of Maharashtra from January 2021 to April 2022. In Delhi, Swasti implemented CLM between January and September 2022. Family Health India completed the CLM pilot in five districts each of Manipur, Mizoram, and Nagaland in Northeast India to showcase effective community-led data-driven decision-making at various levels. YRG Care concluded the CLM pilot in Uttar Pradesh in May 2022, while Sattva Consulting is currently implementing CLM in Delhi, Telangana, and Maharashtra.

CLM Implementation Stages Family Health India has grouped all the CLM activities under three phases:



The CLM process, adopted by Swasti and Sattva, comprises five stages, involving all relevant stakeholders from NACP and TB programs, including the community.

Stage 1: Engagement of Stakeholders and Training of Community Champions

Stage 2: Feedback Collection and Analysis

Stage 3: Co-creating solutions with all key stakeholders

Stage 4: Engaging district and state for action

Stage 5: Track and showcase the success

9.2.1 Stage-1: Engagement of community champions

In the first step of CLM, key stakeholders, including various service providers like ICTC, TI, ART, DIC, STI/RTI Clinics, OST etc., and community representatives working with key populations were identified. Community representatives, willing to volunteer, were briefed on their CLM roles and HIV service delivery under NACP. In Delhi, representatives were trained to use the CommCare app for data collection through the Client Feedback Tool (CFT). In Sattva Consulting's recent CLM initiative, community champions actively participated in the entire monitoring process, including data collection.

The preparatory phase of CLM in the Northeastern states by the Family Health India involved seven steps – 1) Setting up project implementation team, 2) Landscape analysis, 3) Preliminary meeting with stakeholders, 4) State and district level consultations, 5) development of operational plans, 6) Support for the formation of Community Resource Group at the SACS levels, and 7) Selection of Community Consultants for involving in CLM.

The landscape analysis identified service providers, community organizations, PLHIV networks, and networks in the 15 priority Northeastern districts for CLM. State-level consultations engaged key communities and stakeholders and involved representation from SACS, DISHAs, partner agencies, PLHIV networks, and key population groups. Operational plans and toolkits were shared with SACS in all three states, and Community Consultants were chosen from the resource pool of Community Champions for data collection.

9.2.2 Stage-2: Collection of Information and Analysis

Prior to CLM rollout, tools were field-tested with a sample of respondents by community volunteers, leading to questionnaire adjustments. Once the tools were finalized, Community Representatives/volunteers/consultants were introduced to their roles and the assigned facility staff.

Methods of data collection Swasti's pilot used assisted, non-assisted, and minimally assisted data collection methods. In assisted data collection, Community Representatives (CRs) used a CommCare app on their Android phones with the CFT. Non-assisted collection involved facility staff providing survey forms to

beneficiaries. In the minimally assisted approach, CRs informed their peers about a toll-free feedback number, encouraging Key Populations and PLHIV to use it for an IVRS-based survey (CFT).

In Uttar Pradesh, Google Forms were used for feedback, while in the Northwestern states, community consultants manually recorded responses on hard copies with unique codes. With the help of a technology partner, an open source digital tool (an integrated application with real-time digital response dashboard) was developed that supported the data entry through mobile phone, data collation, cleaning, analysis, and visualization.

Data analysis and scorecards In Delhi, Maharashtra, and Telangana, the data from client feedback forms was used to assign scores to each facility. These scores were then converted into grades, ranging from A+ to D, based on five key aspects: Accessibility, Availability, Acceptability, Affordability, and Awareness. The report cards were generated for each cluster and facility, combining quantitative scores with qualitative observations from the Community Representatives (CRs) to assess service quality.

In the Northeastern states, the reports comprising dashboard, facility summary, scorecards, key results, and qualitative observations were generated at the level of Facility, District, and State. The scoring was based on indicators that included availability, accessibility, appropriateness, responsiveness, and satisfaction. The facilities were rated on a 5-point scale indicating the scores - 'Red Alert' (0 20%), 'Work in progress' (21 40%), 'Getting there' (41 60%), 'Above average' (61 80%), and '5-star facility' (above 80%).

9.2.3 Stage-3: Co-creating solutions with community and service providers

In Delhi, Telangana, and Maharashtra, a co-creation workshop involved various stakeholders, including key population representatives, CSOs, NGOs, donor agencies, PLHIV networks, TI staff, and service providers. The SOLVE card approach was used, consisting of five steps: problem selection, root cause identification, solution location, volunteer involvement, setting a deadline, and execution/evaluation. This process aimed to strengthen service delivery at both facility and community levels through data-informed integrated responses.

Participants were divided into five groups for the co-writing session using the SOLVE approach. Each group focused on different types of facilities, such as ART, DMC, ICTC and PPTCT, DSRC, OST, and TI (DIC). They used a template to identify root causes of problems and develop detailed action plans with assigned responsibilities, monitoring, and timelines.

9.2.4 Stage-4: Engaging district and state teams for action

In Stage 4, district and state teams engaged in discussions regarding the implementation plan, with community representatives ensuring facility-wise follow-up. These discussions involved HRGs, CSOs, CRs, PLHIV networks, TI staff, and key service providers from different clusters.

Project Directors of State AIDS Control Societies played a key role in chairing these meetings to promote ownership. The objective was to review and accelerate the action plan developed during the Co-Writing Workshop and integrate SOLVE card and CLM concepts into the regular activities of State AIDS Control Societies.

9.2.5 Stage-5: Track and showcase the success

In the Delhi, Telangana, and Maharashtra CLM pilot by Swasti, a tracking sheet was used to update action point statuses for facilities and clusters. Monthly reviews by DISHA and SACS assessed problem resolution progress, and field-level coordination was improved through CRs who highlighted issues in real-time. Monthly review reports were forwarded to DISHA, SACS, and NACO for potential follow-up actions.

9.3 Role of State AIDS Control Societies in CLM

CLM involves key population communities and PLHIV in five stages, engaging various stakeholders like NACO, SACS, Key Service Providers, Community Resource Groups, and implementing partners. SACS is vital for regional CLM implementation. Key roles and stakeholders include:

Fig 9. Role of SACS in CLM

9.4. Good Practices, Challenges & Lessons learnt in CLM

Good practices, challenges, and lessons from the Family Health India, Swasti, and Sattva Consulting pilot interventions are detailed below.

Good Practices

Effective practices in CLM implementation involved the supportive role of state Nodal Officers from SACS, who provided guidance and assistance. Community capacity-building increased understanding and ownership of the CLM process, fostering better communication between communities and service providers. Early orientation of facility staff improved collaboration. CLM served as a valuable feedback mechanism, addressing improvements and acknowledging the contributions of service providers.

Challenges

The concept of community-led monitoring was relatively new, requiring time for assimilation into existing programmatic structures. Unanticipated delays impacted project execution, necessitating mid-course corrections to ensure timely completion despite constraints.

Lessons Learnt

Collecting feedback

Introducing data collectors to facility staff before data collection proved beneficial. The adapted CLM tools were well-received, user-friendly, and suitable for respondents' literacy levels. The mediated model of data collection was deemed appropriate in Northeastern India. While the Minimally Assisted model aimed for self-administration, it was mainly collected by data collectors

due to service providers' time constraints and beneficiaries' discomfort. Paper-based data collection led to additional time for data entry. In Delhi, the assisted model ensured a 100 percent response rate and facilitated issue escalation to higher authorities.

Co-creation workshops

Sharing findings promptly with service providers for co-created action plans is essential. Co-creation of solutions through methods like the SOLVE card process and workshops facilitated interaction and trust-building between communities and service providers. These workshops also enhanced coordination between HIV and TB programs, involving key officials at state and district levels. They provided valuable insights and strategies for effective program implementation, fostering collaboration and proactive issue resolution during service delivery.

CLM Process

Community Consultants in the northeast required compensation for their time and travel, a crucial factor for the viability of the CLM process. Periodic CLM cycles were vital to monitor changes in HIV service provision effectively. The active participation of key service providers in co-creation workshops was attributed to leadership and ownership demonstrated by state-level officials, particularly from SACS and DISHA.

10

Conclusion

NACP recognizes the need for community engaged responses as key to elimination of HIV/AIDS related stigma and discrimination. The Community System Strengthening (CSS) initiative under NACP Phase-V aims to strengthen community engagement and build the capacity of key population groups to participate effectively in India's national HIV/AIDS response. Through the CSS a bottom-up approach has been adopted from constituting Community Resource Groups representing all the typology of the Key Population at the District and State levels to training Community Champions and building the capacity of community-based organizations. The program ensures representation of all key population typologies including female sex workers, men who have sex with men, hijra/transgender individuals, people who inject drugs, and key populations living with HIV/AIDS.

CSS focuses on four key components - developing community resources, strengthening leadership and community organizations, promoting community-led monitoring, and building partnerships and coordination. Significant progress has been made in each of these areas over the past two years. Around 7,000 Community Champions have been trained across the country as local community resources. Capacity building of CBOs has focused on organizational development, financial management, and resource mobilization.

Community-led monitoring pilots have been implemented in multiple states to gather community feedback for improving HIV service delivery. CRGs are now established in all the States, starting the process of formal community participation in planning and monitoring NACP implementation. While challenges remain in mobilization and retaining engagement of some key population groups, CSS has laid the foundation for institutionalizing community voices within NACP. Continued mentoring of community champions, capacity building of emerging CBOs, and expanding CLM would help take forward this process of strengthening community systems and ownership in the national HIV response.

Annex

Link to all Community System Strengthening documents -

Standard Operating Procedure for Identification of Champions
https://naco.gov.in/sites/default/files/Revisied_Guidelines.pdf

Terms of Reference of State and District Community Resource Group
https://naco.gov.in/sites/default/files/Terms%20of%20Reference%20_State%20and%20District%20Community%20Resource%20Group%20under%20CSS.pdf

Terms of Reference of Community System Strengthening National Working Group
https://naco.gov.in/sites/default/files/National_Document.pdf

National Stakeholder Consultation on Community System Strengthening (18 Feb. 2021)
https://naco.gov.in/sites/default/files/National_Stakeholder_Consultation_on_CSS.pdf

National Stakeholder Consultation towards Identification of Priority Areas for Capacity Building of Communities & Community Groups under CSS (10-11 Dec. 2021)
https://naco.gov.in/sites/default/files/Final_Report_of_National_Stakeholder%20Consultation.pdf

Presentation Booklet on Capacity Building of Community, Community Network and Community Based Organisations
https://naco.gov.in/sites/default/files/Capacity%20Building%20of%20Communities%2C%20Community%20Networks%2C%20and%20CSOs_PRESENTATION%20BOOKLET.pdf

Module 1- Advocacy
https://naco.gov.in/sites/default/files/Capacity%20Building%20of%20Communities%2C%20Community%20Networks%2C%20and%20CSOs%20Module%201%20Advocacy.pdf

Module 2- Community Networks, Linkages, Partnerships and Coordination
https://naco.gov.in/sites/default/files/Capacity%20Building%20of%20Communities%2C%20Community%20Networks%2C%20and%20CSOs%20Module%202%20Community%20Networks%2C%20Linkages%2C%20Partnerships%20and%20Coordination.pdf

Module 3- Resource Mobilization
https://naco.gov.in/sites/default/files/Capacity%20Building%20of%20Communities%2C%20Community%20Networks%2C%20and%20CSOs%20Module%203%20Resource%20Mobilization.pdf

Module 4-Demand Generation
https://naco.gov.in/sites/default/files/Capacity%20Building%20of%20Communities%2C%20Community%20Networks%2C%20and%20CSOs%20Module%204%20Demand%20Generation.pdf

Module 5- Organisational and Leadership Strengthening
https://naco.gov.in/sites/default/files/Capacity%20Building%20of%20Communities%2C%20Community%20Networks%2C%20and%20CSOs%20Module%205%20Organizational%20and%20Leadership%20Strengthening.pdf

Module 6-Community Led Monitoring and Knowledge Management
https://naco.gov.in/sites/default/files/Capacity%20Building%20of%20Communities%2C%20Community%20Networks%2C%20and%20CSOs%20Module%206%20CLM%20and%20Knowledge%20Management.pdf

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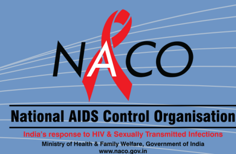

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