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National AIDS Control Organisation

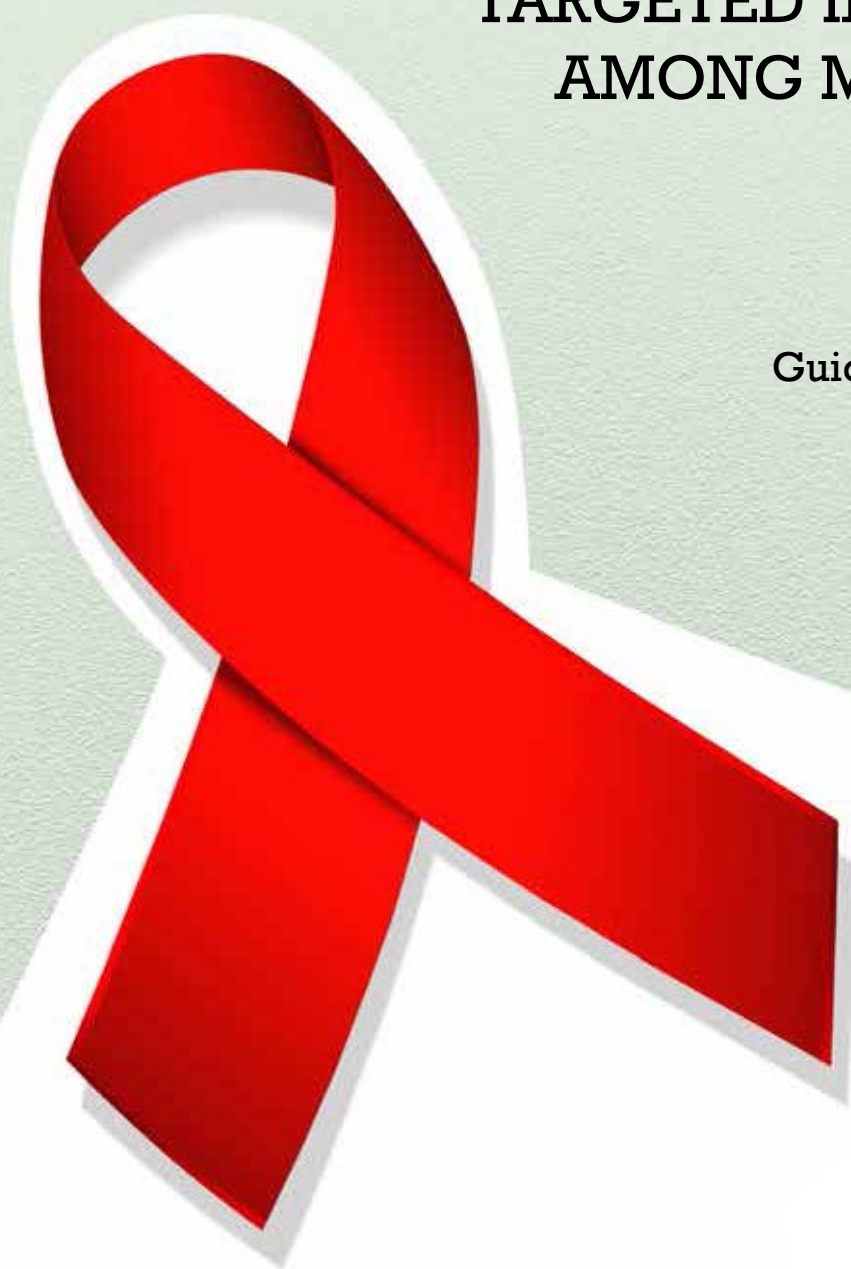
India's voice against AIDS

Department of AIDS Control

Ministry of Health & Family Welfare, Government of India
www.nacoonline.org

OPERATIONAL GUIDELINES FOR IMPLEMENTING HIV TARGETED INTERVENTIONS AMONG MEN WHO HAVE SEX WITH MEN IN INDIA

Guidelines for CBOs/NGOs,
SACS and TSUs





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Acknowledgment

The National AIDS Control Organisation, in partnership with UNDP, has prepared these Operational Guidelines after a series of consultations with technical and community resource persons, representatives of civil society, government, core groups, donors and other stakeholders.

The guidelines describe how model targeted interventions (TIs) for men who have sex with men (MSM) can be operationalised. They also provide detailed information on issues related to programme management, services required in terms of human resources, infrastructure, linkages and monitoring and evaluation indicators for each programme area.

This draft was written by UNDP and finalised by the TI division and Technical Support Unit (TSU) team at NACO.

I take this opportunity to acknowledge the contributions made by the resource persons, the TI and TSU teams at NACO, and the technical team at UNDP in preparing these guidelines. We hope that these will help State AIDS Control Societies, potential partners (non-governmental organisations, community-based organisations and networks), programme managers and other staff working in TI projects and TSUs implement and manage TI projects more effectively.

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भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
राष्ट्रीय एड्स नियंत्रण संगठन

Government of India
Ministry of Health & Family Welfare
National AIDS Control Organisation

FOREWORD

The National AIDS Control Organisation (NACO) has been implementing exclusive Targeted Interventions (TI) for the high-risk group of Men having Sex with Men (MSM). Currently, there are 149 exclusive MSM TIs and 385 Core Composite TIs covering 2.38 lakh MSMs. NACO has already come out with training modules for Doctors, Programme Managers, Counselors, Out Reach Workers (ORW) and Peer Educators (PEs), as well as modules on Advocacy and Induction for building the capacity of various functionaries of TIs. Keeping in view of the importance of highly vulnerable MSM population, NACO decided to bring out a specific Operational Guidelines (OG) to engage with the community and thereby improve service implementation in the MSM TIs and in all spheres of MSM intervention.

This Guideline for the TIs working with the MSM community has been prepared and developed after extensive consultation with technical/programme experts, and community members. This OG is aimed at enhancing the capacity of the CBOs/NGOs implementing MSM TIs so as to ensure sensitive and quality service delivery to the target group. This OG can also be used by national public health officials, managers, health workers and other stakeholders.

I would like to acknowledge the effort and the hard work put by technical/programme experts and the community members in developing the OG. The contributions made by the Targeted Intervention (TI) and National Technical Support Unit (NTSU) Divisions of NACO for developing and coordinating with the various stakeholders to bring these guidelines to fruition is appreciated. I am grateful to all the community leaders and members who have contributed to the development of the various chapters. I thank the State AIDS Control Societies (SACS), Technical Support Units (TSUs), State Resource and Training Centres (STRCs) for providing relevant inputs in developing this OG. I would also extend my sincere thanks to UNDP for the technical and financial support in developing and printing this OG.

It is hoped that this OG will be of help to the programme implementers and promote excellence in MSM TI programme interventions, by upgrading the skills of the frontline workers across the nation.


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अपनी एचआईवी अवस्था जानें, निकटतम सरकारी अस्पताल में मुफ्त सलाह व जाँच पाएँ

Abbreviations and Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CBO	Community-based Organisation
DAPCU	District AIDS Prevention and Control Unit
FSW	Female Sex Worker
GIPA	Greater Involvement of People Living with HIV/AIDS
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
ICTC	Integrated Counselling and Testing Centre
IEC	Information, Education and Communication
MHP	Mental Health Professional
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non-governmental Organisation
ORW	Outreach Worker
PE	Peer Educator
PLHIV	People Living with HIV
SACS	State AIDS Control Society
STI	Sexually Transmitted Infection
STRC	State Training and Resource Centre
TI	(STI/HIV) Targeted Intervention
TG	Transgender
TSU	Technical Support Unit

List of Annexures

- Annexure 1: Site and needs assessment
- Annexure 2: Terms of reference for TI staff
- Annexure 3: Peer-led outreach and planning
- Annexure 4: Peer progression
- Annexure 5: Dialogue-based interpersonal communication by and with MSM
- Annexure 6: Crisis response system
- Annexure 7: Indicators for assessing and evaluating community mobilisation
- Annexure 8: Broad mapping (overview)
- Annexure 9: Tools for virtual/internet mapping
- Annexure 10: Programme management
- Annexure 11: Mandatory community committees and its composition, roles, responsibilities
- Annexure 12: NACP-IV strategy paper on MSM



TABLE OF CONTENTS

Sr. No	Details	Page number
1	Chapter 1: Introduction and Background	1 – 3
2	Chapter 2: Operationalising Targeted HIV Interventions for MSM: Guidelines for CBOs/NGOs	4 – 46
3	Chapter 3: Operationalising Targeted HIV Interventions for MSM: Guidelines for SACS/TSU/DAPCU	47 – 59
4	Annexures	60 - 166



Chapter 1

Introduction and Background

1. PURPOSE AND TARGET AUDIENCE OF THE GUIDELINES

1.1 Purpose of the Operational Guidelines

For HIV interventions targeted at men who have sex with men (MSM) to be successful, there is a need for conceptual clarity, implementation ability and an enabling environment. In order to ensure the programme's performance and achieve the intended outcomes, it is essential that adequate quality control and improvement mechanisms are in place along with regular monitoring and evaluation systems, and lessons learnt from prior experience are used to improve the programme.

In India, the national HIV programme for MSM needs to be scaled up while maintaining quality to reduce the prevalence of HIV among the MSM population and to promote access to prevention, care, support and treatment services for these populations. These guidelines, prepared by the National AIDS Control Organisation (NACO), articulate the essential and comprehensive package of services along with procedures for implementation, monitoring and evaluation, in order to achieve this end.

1.2 Target Users of the Operational Guidelines

These guidelines are primarily intended for the use of community-based organisations (CBOs)/non-governmental organisations (NGOs) responsible for implementing the Targeted Intervention (TI) programme for MSM in India with support from NACO and States AIDS Control Societies (SACS). They provide adequate information to plan, implement and monitor the provision of high

quality HIV prevention services to MSM. These guidelines will be useful as a reference point and quality check for NGO/CBO project officers in charge of implementing TIs. Some of the guidelines are directly applicable to NACO and SACS regarding their role in creating an enabling environment and building the capacity of various stakeholders, in addition to supporting NGOs/CBOs in the implementation of TIs among MSM.

2. BACKGROUND

Under the National AIDS Control Programme Phase IV (NACP-IV), MSM continue to be featured as a high priority group. The prevalence of HIV among MSM in India is estimated at 4.43 per cent,¹ which is more than 10 times that among the general population (NACO, 2011). The prevalence of sexually transmitted infections (STIs) is also high among MSM (e.g., Syphilis: 5.8 per cent² to 14 per cent³).

The achievements of NACP-III in relation to MSM and transgender (TG) populations include:

- Expanded coverage: 2,74,000 (out of an estimated 4,12,000 population)—a seven-fold increase from NACP-II;
- More TIs: 180 exclusive and around 200 composite TIs, which achieved 67 per cent coverage of most-at-risk MSM and TG populations;

1 NACO, HSS 2011.

2 Gupta, A et al. 'Same-sex behavior and high rates of HIV among men attending sexually transmitted infection clinics in Pune, India (1993–2002)', *Journal of Acquired Immune Deficiency Syndromes*, 2006, 43: 483–490.

3 Newman, PA et al. 'Correlates of paid sex among men who have sex with men in Chennai, India', *Sexually Transmitted Infections*, 2008, 84: 434–438.

- About 99 HIV Sentinel Surveillance Sites for MSM/TG populations;
- Initiation of reporting on discrimination/ violence against MSM;
- Presence of MSM TIs in almost all states (based on the information from the mid-term review report of NACP-III).

NACP-IV intends to build on these achievements and intensify efforts to prevent HIV infection among MSM, while offering a range of necessary comprehensive services.

2.1 Goal and Guiding Principles for MSM TIs under NACP-IV

Goal

Zero new infections among MSM by the end of 2017; and universal access to HIV prevention, care, support and treatment services for all at-risk MSM.

Guiding Principles

- Universal access, inclusion of at-risk MSM;
- Ensuring that NACP-IV provides all comprehensive and necessary HIV-related services to MSM and continues with the national policy of voluntary HIV testing and clinical screening;
- Elimination of stigma and discrimination against sexual minorities in various settings (health care settings, workplace, family, and society);
- Investing in the strengthening of MSM community groups to promote community ownership of the HIV programme;
- Addressing multiple vulnerabilities related to sex work, marital status, multiple stigmas and low socio-economic status;

- Emphasis on both the scale of services as well as on the quality of messages and services to maximise effectiveness, and ensuring that interventions and services are to evidence-based to the maximum extent possible;
- Ensuring that MSM TIs not only provide services to MSM who already have access to TI services, but also focus on prevention of HIV/sexually transmitted infections (STIs) among their steady partners—both men and women—through linkage of services;
- Providing a comprehensive service package with a continuum of prevention, care, support and treatment services;
- Transition of certain services (such as STI clinical services) to the National Rural Health Mission (NRHM)/ National Urban Health Mission (NUHM), which becomes possible after ensuring proper sensitisation of government health care providers about the issues faced by sexual minorities and improving their competency to provide optimal clinical and counselling services.

A Rights-based Approach to HIV Programming for MSM in India

A comprehensive and effective response to HIV and AIDS requires addressing human rights. Since the early days of the epidemic, social, legal and economic marginalisation have been associated with vulnerability to HIV. A rights-based approach to HIV endeavours that address these disparities and improve the overall performance and impact of programming would be the best way to contain the HIV epidemic and move towards zero prevalence among MSM. MSM have always been heavily affected by HIV and AIDS. Evidence indicates that the vulnerability of MSM to HIV is contingent on the degree to which their rights are recognised and addressed. The 1948 Universal

Declaration on Human Rights codified this connection between health and rights in Article 25 of the document. India voted in favour of this declaration and has affirmed its strong support of human rights over the years, along with its support to several other international commitments and agreements. The interconnections between human rights and health became more obvious and urgent as the AIDS pandemic emerged. A human rights-based approach to health looks beyond a clinical services model of disease control and provides a framework to address the contextual and structural factors that contribute to health and well-being. India needs to adopt the human right to health as a guiding principle of NACP-IV and address critical barriers that increase the vulnerability of MSM and other most-at-risk populations. By protecting and affirming the right to health among these populations and by ensuring that they are able to access services without experiencing discrimination, legal sanctions, social stigma, or violence, India will be able to effectively build on the foundation of its earlier national AIDS strategies and help sustain the momentum of these efforts.

2.2. Strategic Objectives

The goal can be achieved through the following strategic objectives:

1. To reach diverse sub-groups of MSM through complementary outreach strategies, to contact all at-risk MSM and provide behaviour-change communication (to promote safer sex and access to services);
2. To offer a comprehensive package of prevention, care, support and treatment services to meet the specific needs of various subgroups of MSM (and to ensure a continuum of prevention, care and treatment);
3. To create and sustain an enabling environment to promote human rights to health and access to services for MSM;
4. To mobilise and strengthen MSM communities to effectively contribute to national responses to the HIV epidemic.



Chapter 2 – Operationalising Targeted HIV Interventions for MSM:

Table of Contents

1. INTRODUCTION: NEW INTERVENTIONS

2. PHASE 1 OF INTERVENTION: START-UP

2.1 Step 1: Recruitment and Training of Staff (Other than Peer Educators)

2.1.1 Hiring outreach workers and other TI staff

2.1.2 Capacity building of TI staff

2.2 Step 2: Site Assessment

2.3 Step 3: Establishment of Basic Services

2.3.1 Tips for planning services

2.3.2 Safe spaces: Drop-in centres (DICs)

3. PHASE 2 OF INTERVENTION: FROM PEER EDUCATOR RECRUITMENT TO SCALE-UP

3.1 Step 4: Peer Educator Selection and Training

3.1.1 What is a peer educator?

3.1.2 Why peer education?

3.1.3 Role of the PE

3.1.4 PE selection criteria

3.1.5 Process of PE selection recruitment

3.1.6 Capacity building plan for PEs

3.1.7 Review and Rotation of PEs

3.1.8 PE progression pathways

3.2 Step 5: Package of Services for MSM Populations

3.2.1 Essential package of services

3.2.1.1 Outreach Behaviour Change Communication and IEC

3.2.1.2 Drop-in Centres (DIC) Safe Spaces

3.2.1.3 Clinical Services

3.2.1.4 Positive living

3.2.1.5 Counselling

3.2.1.6 Condom and Lube Programming

3.2.1.7 Voluntary HIV Testing and Counselling

3.2.1.8 Crisis/Violence prevention and mitigation (Crisis Response Team)

3.2.2 Additional Package of Services

3.3 Step 6: Outreach Planning

3.4 Step 7: Community Mobilisation

- 3.4.1 Community mobilisation at the TI level
- 3.4.2 Support for formation, and strengthening of formal and informal community groups
- 3.4.3 Support for strengthening of existing national and state level networks
- 3.4.4 Proactive Linking and docking these networks with other government agencies
- 3.4.5 Extending community mobilisation to virtual networks

3.5 Step 8: Creating an Enabling Environment

3.6 Step 9: Role of DAPCUs in MSM TIs

1. INTRODUCTION: NEW INTERVENTIONS

These guidelines are designed for NGOs/CBOs initiating a new TI for MSM or scaling up an existing intervention. They assume that a desk review and/or broad mapping of existing TIs on the ground has been completed by an external agency in collaboration with MSM communities, and that the number and location of sites, and an estimate of MSM populations are available.

Steps in initiating and scaling up TIs

1. Recruitment and training of staff
2. Site assessment
3. Establishment of basic services
4. Peer Educator (PE) selection and training
5. Scaling up of services
6. Outreach planning
7. Community mobilisation
8. Creating an enabling environment
9. Linkages with other services

2. PHASE 1 OF INTERVENTION: START-UP

Phase 1 of the TI comprises three major steps: recruitment and training of staff (other than PEs); site assessment; and provision of basic services.

2.1 Step 1: Recruitment and Training of Staff (other than Peer Educators)

2.1.1 Hiring outreach workers and other TI staff

The NGO/CBO should carry out the selection of staff based on the organisation's own recruitment policy. NACO staffing guidelines for TIs stipulate that one outreach worker (ORW) should be hired per 250 MSM. During recruitment, MSM communities are to be provided equal opportunity and priority if they meet the requirements (e.g., educational and/or other qualifications, reporting skills) for the job. The geographical and social network also needs to be considered during the allocation of high risk groups (HRGs) to each ORW.

The ideal qualities in an ORW include:

- Being non-judgmental and willing to work with at-risk MSM;
- Good communication and interpersonal skills. Ideally, should have undergone some in-house counselling and sexual health training and be experienced in community mobilisation;
- Readiness to mingle with all individuals;
- Skills and experience in outreach;
- Strong communication skills;
- Capacity to monitor reports and guide a team;
- Proficiency in report writing and data analysis;
- Proficiency in local language(s).

Refer to Annexure 2: Terms of reference for TI staff

2.1.2. Capacity building of TI staff

On recruitment, all staff should receive orientation on basic facts about HIV and MSM, and attend induction training. The induction training should cover:

- Introduction to HIV/AIDS, including basics of transmission, prevention and treatment of HIV and other STIs;
- Orientation on TI operational guidelines for MSM;
- Orientation on sexuality and gender and the dynamics of sex work;
- Orientation on prevailing socio-cultural norms of MSM communities;
- Skills on active listening and building rapport with marginalised groups;
- Methodology of site validation;
- An orientation on the geography of the TI sites, e.g., which spots are frequented most and how;
- Orientation on microplan (outreach planning, condom and lubricant demand calculation);
- Information about the range of available referral services;
- Basics on how to ensure safety for self and clients when carrying out outreach operations;
- Orientation on job description of TI staff.

In addition to the induction training, TI staff should undergo job specific modular training i.e, Peer Education, Outreaching and Communication, Counselling and Project Management.

2.2 Step 2: Site Assessment

The needs, lifestyles, and concerns of MSM differ from those of hijras and TGs, and programmes need to consider their uniqueness. Many men who have sex with men may not identify as MSM,

live in secrecy, and/or may be afraid to tell people about their sexual history. Site assessments which involve trained members of the MSM community help to characterise the community, identify HIV-related needs and gaps, and facilitate implementation of the TI.

The methodology of site assessment is described in detail in **Annexure 1, Site and Needs Assessment**. The assessment is carried out by trained members of the MSM population under the leadership of SACS/Technical Support Units (TSUs), which conduct a series of interactive and participatory exercises with members of their communities, using visual tools (drawings and maps) to solicit information.

The objectives of the site assessment are to determine the site-specific design of TIs through:

- Validation of broad mapping size and location estimates;
- Contact with at least 50 per cent of the mapping denominator, at least once in three months (as a form of validating the presence of key population);
- Gaining details on risks/vulnerabilities by typology and location of MSM;
- Initiating intervention activities.

Apart from the quantitative information gained in the assessment, there are qualitative outcomes:

- Establishing contact with the community: site validation helps the project meet at least 50 per cent of the estimated population in a given location on a one-to-one or group basis;
- Generating interest and curiosity about the project;
- Dispelling myths about the intervention before it even begins, and communicating correctly the project's scope and plans, avoiding false promises;
- Identifying potential PEs for future hiring.

2.3 Step 3: Establishment of Basic Services

In order for the community to have faith in the project and see early signs of its benefits, the NGO/CBO should ensure that staff in the TI:

- Have comprehensive knowledge of the health and social needs of MSM;
- Have the ability to talk to clients about a range of health and social issues that impact HIV prevention and care and their overall well-being. This could also mean addressing issues of identity, mental health concerns, sexuality disclosure with partners or other individuals in social networks.

Knowledgeable members of MSM community recruited as staff are more likely to possess these competencies.

2.3.1 Initiating activities

The basic services that can be initiated from the outset are:

- Referral systems for treatment of STIs, other general health and social needs;
- Availability of free condoms and lubricants;
- A drop-in centre (DIC);
- It is important to get the community involved in the planning of these services. Use the following approach: talk to the community in a group setting and make a list of all required/requested services;
- Differentiate between services that can be offered on site and those for which linkages/referrals are needed;
- Explore with the community how project-driven services (condom promotion and STI services) can be maximised.

Box 1: Criteria for DICs to be safe spaces for HRGs

- Members should feel at ease, without the fear of being intimidated, hurt or penalised for their behaviour.
- Should serve as a place to meet, share hopes and ideas, and be heard.
- Should increase access to prevention services like counselling, condoms, treatment services, referrals and ancillary services.
- Should serve as a space to build group strength for taking ownership of the programme.

1.1.2 On-site safe spaces: Drop-in Centres

Public sites such as streets and communal parks do not allow much contact and quality time for ORWs or peers, so the provision of DICs as 'safe spaces' becomes important. Safe spaces are critical in the early phase of service delivery, especially for street-based populations.

- At DICs, community members can interact with each other, rest, discuss and seek advice on high risk behaviours, share information, approach someone in case of a crisis, or pick up condoms.
- Educational material on treatment adherence and mental health issues can be made available.
- Other popular DIC activities are teaching self-defence, literacy classes and rotational savings schemes trainings.
- Counselling and/or STI services can be provided at the DIC through counsellor and/or doctor visits on certain days/times.
- Referral to satellite services such as de-addiction, crisis response, and social welfare schemes and services can also be provided through the DIC.

The DIC should ideally be located close to the hotspots. The choice of the centre location will be dictated by availability and the preference of the community.

3. PHASE 2 OF INTERVENTION: FROM PEER EDUCATOR RECRUITMENT TO SCALE-UP

3.1 Step 4: Peer Educator Selection and Training

3.1.1. What is peer education?

Peer education involves peers communicating HIV prevention information and strategies in ways that can lead to behavioural change. Peers are people who are alike in several respects: age, gender, interests, language, use of time, aspirations and so on. Peer education respects the influence of peers in enhancing health seeking behaviour within the community.

Peer education honours informal education. It is based on the recognition that education about HIV, condom use, health issues, alcohol, and drug use has a better chance of leading to behavioural change when its source is a peer. Peer education that focuses on MSM is conscious of the factors that stand in the way of effective communication between different typology of MSM population, especially where personal and sensitive issues are concerned.

Many people wrongly believe that the job of educators is to put things into people's heads. Education really begins when we engage others in conversation, leading or pulling out what is in their heads and in their experiences, so that they can consciously examine the behaviour that puts them at risk. When people become concerned about the risk of unsafe sexual behaviour, they adopt safe sex practice. Therefore, the messenger is as important as the message. PEs are the key messengers in promoting behavioural change through interpersonal communication.

3.1.2. Why Peer Education?

Peer education enables members of a given group to effect change among other members of the same group. It is considered to be one of the most effective and sustainable tools for changing group behaviour. PEs play an important role in TI implementation as they can:

- Help to build trust and establish credibility with the vulnerable group;
- Provide a vital two-way link between the project staff and the community;
- Provide important information about the vulnerable group to other stakeholders and the wider community;
- Reach a large number of people effectively;
- Provide a link between the service and the community (for instance, by introducing people or accompanying them to the service facility).

3.1.3. Who is a Peer Educator?

A PE is a person from the MSM community who works with her/his colleagues to influence attitude and behaviour change. PEs are responsible for providing information on HIV/STIs and risk reduction among colleagues/peers, which ultimately results in peer pressure for behaviour change. They often distribute condoms and lubes. They also provide basic data for monitoring a TI project. PEs are paid an honorarium for their contribution to the project as per NGO/CBO costing guidelines.

The PE to MSM ratio is set at 1:60 (i.e., one PE per 60 MSM)

Without exceeding the budget allocated for peer education, the implementing NGO/CBO, with approval from the respective SACS, may decide on the number of PEs required based on need. (In case the population is very scattered and is beyond the reach of one PE, the TI may be

permitted to revise the PE ratio to better serve such a population.)

3.1.4. The Role of a Peer Educator

- Conducting outreach: This includes identifying new MSM, in addition to maintaining regular contact with one's network of 40–60 MSM;
- Meeting all contacts at least once in 15 days;
- Providing dialogue-based inter-personal communication (IPC) to MSM;
- Encouraging service and commodity uptake, motivating MSM to visit the DIC, distribute condoms, make referrals;
- Advocacy with known power structures;
- Training of new PEs from within the project and outside it;
- Maintaining the DIC;
- Generating demand for welfare programmes and facilitating the identification of beneficiaries;
- Regular visits to condom service centres to gather information and to improve service;
- Building skills of priority groups in understanding and assessing high risk behaviour, and in condom use, condom negotiation, identification of STIs, etc.;
- Attending review meetings;
- Preparing and daily reports and presenting them to ORWs;
- Attending all trainings, workshops and seminars.

Key programme focus areas

A good PE invests a great deal of effort in cultivating and maintaining a social network. This includes identifying new entrants through geographic/social networks of the community and introducing them to the services as soon as possible.

A PE should also be able to identify and segment his portfolio to identify and serve MSM with the highest risk profile (high volume, low condom use, new and young MSM, etc.).

3.1.5. Selection criteria for Peer Educators

- PEs must be from within the community;
- Availability for the programme in terms of time;
- Commitment to the goals and objectives of the programme;
- Being representative of, and accepted by, the MSM community
 - Representative of multiple 'social networks' from different locations/sites,
 - Representative in terms of age of their social network;
- Being knowledgeable about the local context and setting;
- Sensitivity to the values of the community, and ability to maintain confidentiality;
- Ability to value accountability to the MSM community and not just to the project;
- Tolerance and respect for others' ideas and behaviours;
- Good listening, communication, and inter-personal skills;
- Demonstrating self-confidence and potential for leadership;
- Potential to be a strong role model for the behaviour one seeks to promote among others;
- Willingness to learn and experiment in the field;
- Commitment to being accessible to one's peers in times of crisis.

3.1.6. Process of Selection/ Recruitment of Peer Educators

Informal approach

- a. Treat community guides as potential PEs during qualitative and quantitative surveys or while getting to know the community.
- b. Involve the community while selecting a PE from among them and recommend the preferred candidate to the TI for recruitment.

- c. The TI management can evolve a process for the recruitment of such PEs.
- d. PEs must also be representative of different sub-groups of MSM.
- e. Give priority to existing guides and key informants if they are suitable for peer education training. Ask them if they are willing to work as PEs.
- f. Explain why you want to work with them.
- g. Tell them how much time they will need to spend on peer education work.
- h. Explain the procedure of selecting PEs (i.e. training, assessment, etc.).
- i. Work out a possible strategy for a peer outreach cycle in collaboration with selected peers.

Formal selection process

The formal selection process should be clear and transparent to all MSM in the area. The peer selection process should be well publicised within MSM networks so that all those potentially interested in being peers can be considered for selection.

- a. Conduct basic interviews to rank the candidates based on the criteria listed in Section 3.1 .5 above.
- b. Conduct a Contact Mapping exercise, facilitated by ORWs, to determine the size of the potential candidate's social network and whether he is well networked within his community (*for details, see Annexure 3, Peer-Led Outreach and Planning*).
- c. Create a consolidated list from the contacts gathered from all candidates. Discuss the need and ways to avoid duplication of contacts. If there is duplication, determine who knows the duplicated MSM better.
- d. Ask each potential peer to bring his contacts to the project office. Organise a meeting with them to assess his contacts/rapport with the group.

- e. Conduct a discussion with the group to find out whether they will accept/nominate him as a PE.
- f. Create a system to enable monitoring of the PE's performance by the community as well. Community members should be able to contact the project if they have any issues related to their PE.
- g. PEs also need to be selected from various sub-groups of MSM (Kothi, Double Decker, etc.)

3.1.7. Capacity Building Plan for Peer Educators

As with other staff, PEs requires support and training from the programme/NGO in several key areas:

- Sex and sexuality;
 - Sexual and reproductive health;
 - STIs and peer role in STI management;
 - Basics of HIV/AIDS and tuberculosis (TB);
 - Condom promotion;
 - Negotiation skills;
 - Self-esteem;
 - Care for people living with HIV (PLHIV);
 - Peer-led monitoring;
 - Advocacy;
 - Community mobilisation;
 - Innovative approach towards outreach and communication through social networking sites.
- Capacity-building efforts must include hands-on exposure in the field and not be restricted to classroom sessions.
 - Further, training of PEs should be done in their respective TI locations so that technical support can be provided in the field should the need arise.
 - Training of PEs should be limited to a maximum of two days based on a training needs assessment.

- When PEs are called out of their locations for training, their time away from their work must be suitably compensated.
- Periodic training needs for PEs should be assessed by the project management and in-house capacity building exercises should be carried out.
- Need-based exposure visits to identified learning sites can be initiated for PEs.
- A PEs' convention of all TIs of the state could be organised once a year as a platform for sharing of experiences and enabling cross-learning across TIs.

3.1.8. Review and rotation of Peer Educators

The performance of PEs should be reviewed on a monthly basis against specific indicators reflecting service uptake. Since all key components of the TI are led by PEs, monthly review is critical to keep track of the quality of the intervention.

The peer selection process described above may be repeated after 12 to 24 months to ensure that the PEs in the network are 'active' peers, as opposed to PEs whose social networks have eroded/changed. This method also provides opportunities for more MSM to participate and thereby helps develop a second-line leadership.

3.1.9. Progression pathways for peer educators

Providing clear progression pathways for PEs is critical. The table below indicates the types of growth and positions PEs can attain. It should be noted that the progression pathways and positions shown are merely indicative; they are not watertight compartments and may vary according to realities on the ground.

Honorariums and travel expenditure of PEs should be based on the TI costing guidelines provided by NACO.

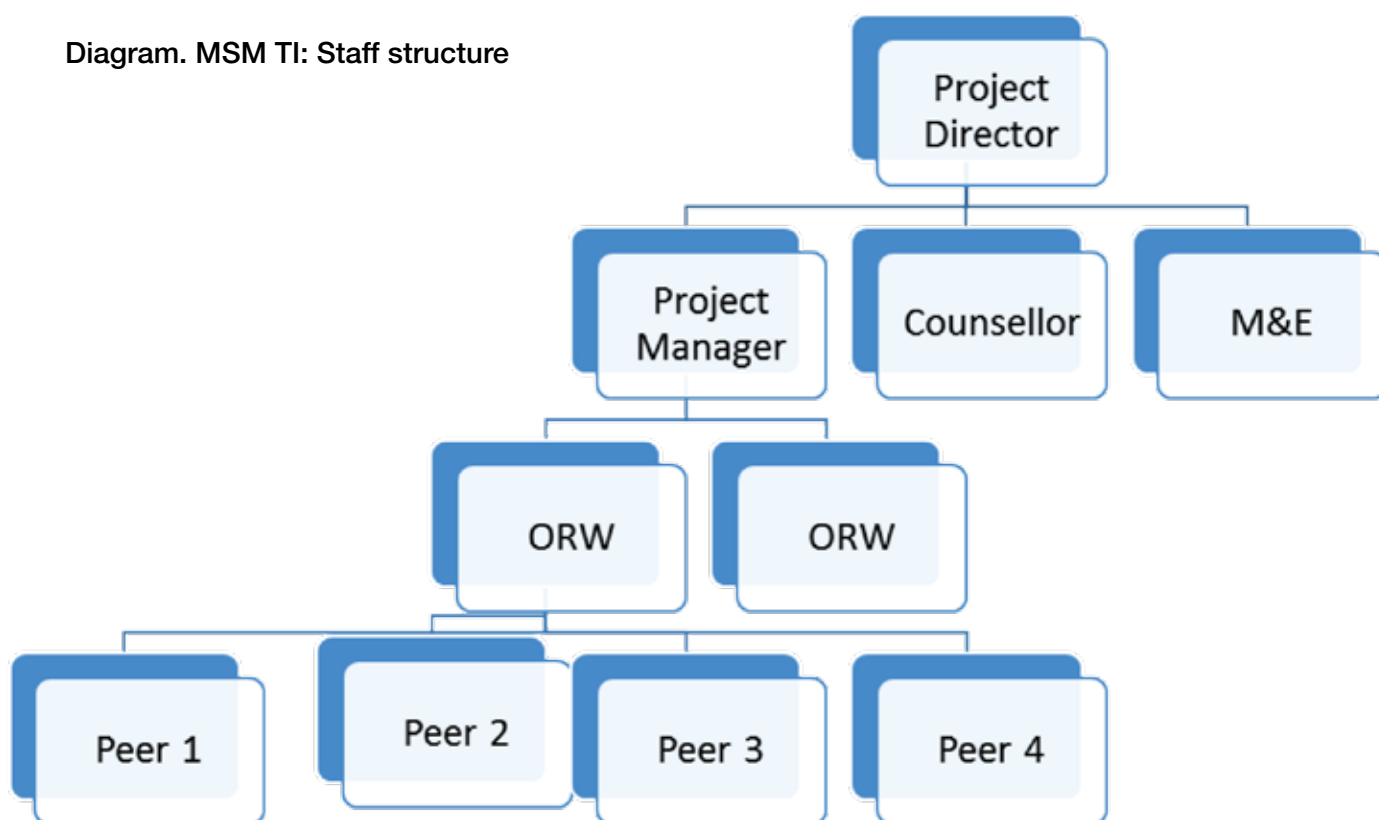
Growth Progression	1st Stage (Initial)	2nd Stage (Growth)	3rd Stage (Growth)	4th Stage (Mature)
Horizontal growth within project	<ul style="list-style-type: none"> ▪ Community member ▪ Peer volunteer 	<ul style="list-style-type: none"> ▪ Active member ▪ Community guide ▪ Peer Educator 	<ul style="list-style-type: none"> ▪ Peer Educator ▪ Core committee member ▪ Peer guide 	<ul style="list-style-type: none"> ▪ Coordinator of committees ▪ Advisory group member ▪ Peer mentor
Vertical growth within project	<ul style="list-style-type: none"> ▪ Community volunteer ▪ Peer volunteer 	<ul style="list-style-type: none"> ▪ Peer Educator ▪ Peer co-worker 	<ul style="list-style-type: none"> ▪ Sub-committee member ▪ Team member 	<ul style="list-style-type: none"> ▪ Coordinator of core committee ▪ Team member and leader
Growth across boundaries	<ul style="list-style-type: none"> ▪ At project/programme level ▪ Participant as community member 	<ul style="list-style-type: none"> ▪ Between projects ▪ Peer Educator ▪ Core committee member ▪ Community consultant 	<ul style="list-style-type: none"> ▪ At programme level ▪ Sub-Committee Member ▪ Advisor-community development 	<ul style="list-style-type: none"> ▪ At programme level ▪ Coordinator ▪ Programme Mentor ▪ Advisory group member

Tool: Annexure 3

Tool for Peer-led Outreach and Planning

3.2. Step 5: Package of Services for MSM Populations

Diagram. MSM TI: Staff structure



The strategic objective of NACP-IV is to offer a comprehensive package of prevention, care, support and treatment services to meet the specific needs of various subgroups of MSM and to ensure continuum of care.

The MSM population needs to be provided with a range of HIV-related services both

directly through TIs and by linking them with the government (and sometimes, with private/non-governmental) health facilities and others to address their vulnerabilities. These include the essential package of services (both on-site services and referrals, which need to be made available by TIs) and an additional package of services, as suggested below. Together, they form a comprehensive package of services.

Comprehensive Package of Services

Essential Package of Services <i>(Services provided by TIs and referral services)</i>	Additional package of services <i>(Referral services)</i>
<ol style="list-style-type: none"> 1. Outreach and Behaviour Change Communication 2. Drop-in Centre 3. STI screening (Syphilis/other STIs) and management of both asymptomatic and symptomatic STIs (including partner referrals) 4. Voluntary HIV testing and counselling, and risk reduction counselling 5. Condoms and lubricants 6. Positive living and positive prevention 7. Crisis/violence prevention and mitigation (Crisis Response Team) 8. TB Screening and referral for diagnosis and treatment 	<ol style="list-style-type: none"> 1. Counselling related to sexuality and mental health issues and/or marital issues 2. Anal cancer screening for HIV-positive MSM 3. Social protection/entitlements 4. Alcohol dependency treatment and drug-dependent treatment programmes 5. Treatment of Hepatitis-B 6. Screening for Hepatitis-C, in the case of a history of injecting drug use

Identification and Establishment of Infrastructure for Basic Services

Infrastructure establishment is highly essential for the visibility of the TI as well as the point of service delivery for the community. The following resources need to be in place within three months of contract signing.

- ☐ Setting up of a drop-in centre;
- ☐ Systems for treatment of STIs: Static clinic within the TI office/Referrals to government STI clinics/Referrals to preferred private practitioners;
- ☐ Availability of free condoms and lubricants through the project/staff/community;
- ☐ Referral systems for HIV testing, antiretroviral therapy (ART), and screening of syphilis and TB. Referral systems to be extended to regular partners, both male and female.

Community (MSM) involvement at this stage is imperative to understand their needs and preferences in order to establish accessible and community-friendly (non-discriminatory) services. Focus group discussions should be organised to identify all the required and requested needs of the community. As the needs of the MSM community are varied and many, it is important to clarify to the community and differentiate between services the project can offer and those for which linkages are to be established. Explore with the community as to how the project-driven services (STI, Condom, HIV Testing, Care, Support and Treatment) can be incorporated. Ensure that the DIC, static clinics, preferred private practitioner clinics, condom outlets and others are within the reach of the community (mid-point to all hotspots desirable). Carry out a resource mapping exercise along with the community and identify referral centres as per the needs within the project and outside.

3.2.1 Essential package of services

3.2.1.1 Outreach Behaviour Change Communication and IEC

The outreach and behaviour change communication (BCC) strategy for MSM groups was developed based on various studies and experiences of working with these communities over the last two phases of NACP. The strategy aims to achieve the desired behaviour change towards:

- Increased service uptake for HIV prevention, early diagnosis and treatment services;
- Normalisation of services.

The basic **design of the strategy** is driven by principles of **messaging re-enforcements** at various levels within and outside TIs to achieve the above.

Where, Who, How and Why?

BCC is to be executed through **direct and indirect messaging** in the following locations. Direct messaging is to be on a one-to-one or one-group basis.

- a) Hotspot level: PEs and ORWs
- b) DIC: ORW (CM-A)/Auxiliary Nurse Midwife (ANM)/Counsellor
- c) Clinic: ANM/Counsellor/Doctor
- d) Virtual Space (Internet—discussed elsewhere in the document, mobile phones and helpline⁴): Counsellor and ORW

Through the various outreach strategies, information and peer counselling on STIs/HIV and sexual health, services for STIs/HIV

screening and treatment, condom and lube use, and information about human and legal rights, are to be provided (mostly by PEs). Depending on the nature of information/counselling, ORWs or counsellors will be the key staff involved in providing the next/higher levels of information and BCC. Similarly, diagnosis and counselling by the doctor strengthens the messages provided by the outreach and clinical teams. Appropriate tools to assist in behaviour change will be developed in local languages. These tools will cater to the specific needs of diverse subgroups of MSM, taking into account **the diversity in sexual identities, socio-economic and educational status, marital status and HIV status**. The various geographical (physical) and virtual outreach strategies have been elaborated elsewhere.

Indirect messaging is done in large groups through Information, Education and Communication (IEC) materials and approaches:

- Mid-media: TI/external teams
- Mass media: NACO/SACS

Mid/Mass media can be used to reach out to men who do not consider themselves same-sex attracted (or 'homosexually oriented') even though they engage in same-sex sexual practices. This also helps in decreasing the vulnerability of their female partners. Messages about safe sex with partners of any gender (women, men and TG), safe practices in anal sex, and responsibility towards the health of the partner of any gender need to be integrated.

Mid/Mass media can also be used to provide information about STI and HIV resources/facilities as **normalisation tools** for vulnerable communities.

Mid-media (such as street theatre, role plays, message songs and dances) can be designed by TI/community or external teams and organised

4 Best Practices Document: APSACS, 2010 (detailed at the end of document)

Box 1: Criteria for DIC as a Safe space for HRGs

- Members should feel at ease, without the fear of being intimidated, hurt or penalised for their behaviour.
- DICs should serve as places to meet, share hopes and ideas, and be heard.
- DICs should increase access to prevention services like counselling, condoms, treatment services, referrals and ancillary services.
- DICs should serve as spaces to build group strength for taking ownership of the programme.

by SACS/NACO. In most cases the IEC material and messaging reinforces the messages provided at the TI level to the communities at a larger level, creating an enabling environment towards increased service uptake. These will be designed by the NACO/SACS (posters, films, short films, TV commercials, etc.).

1.2 Drop-in Centres: Safe Spaces

‘Safe spaces’ are critical in the early phase of service delivery, especially for street-based populations of MSM. Public sites such as streets and parks do not allow much contact time for ORWs or peers. Therefore, the creation of safe spaces in the form of DICs is important.

Why DICs?

At DICs, MSM community members can interact with each other, rest, seek advice, share information, approach someone in case of crisis or pick up condoms and lubes.

Box 2: Information to be displayed in a DIC

- Brief information about the organisation implementing the TI
- Organogram of the organisation
- Information regarding staff and contacts
- Service area and hot spots
- Timing/ hours
- Helpline numbers and Emergency helpline
- Rules of Conduct
- Details of grievance redressal mechanism and how to access it
- Do's and Don't's agreed by the community to be displayed at the DIC

Being a safe space, DICs can be utilised for a variety of socialising activities for MSM as well as activities to promote service uptake by MSM. Some of these activities include self-defense classes, literacy classes and trainings on rotational savings schemes. The DIC needs to be open to all sub-groups of MSM (kothis, double deckers, panthis, etc.) and the NGO/CBO may organise DIC activities for different sub-groups at different timings, and where relevant there can be activities open to all sub-groups.

DICs are also to be used as referral hubs to provide links to satellite services such as mental health (psychosocial support—dealing with sexuality/identity issues, disclosure and marriage and marital issues, etc.), de-addiction, crisis response, social entitlements, and social welfare schemes and services.

The DIC should ideally be located close to hotspots. The choice of the centre location will be dictated by availability and the preference of the community as to whether the centre should stand out or be relatively anonymous. Counselling and/or STI services can be provided at the DIC through clinic doctors and ANM or counsellors in consultation with a doctor.

The DIC is a service to focus and strengthen collectivisation that hastens community ownership of the TI and also ensures service uptake through TIs. The concepts of community ownership and collectivisation can be defined through tangible activities or modules that help in fostering community spirit (e.g., by offering training on self-development and leadership skills development). DICs focus on providing services to the community and should be oriented towards providing quality services and standards. A DIC can serve as the focal point that channelises community synergy towards the uptake of services both internal and external to the TI. DIC

protocols must be strengthened to make efficient use of the space. They should be of an adequate size to accommodate enough people to hold meetings and other related community activities. Hence, budgets for DICs must be commensurate with the city tier (category of the city/town) and the needs of the specific MSM community typology. Note: In case of a dispersed population (possibly with different 'clusters') within TI project area, more than one DIC can be planned in line with the approved costing guidelines.

3.2.1.3. Clinical Services

a) STI/RTI management among MSM populations and their partners

(Note: Refer to the STI treatment/operational guidelines of NACO)

I. Planning and Training

Planning for STI services should be done with the MSM community. It is important to gather the following information through focus group discussions and resource mapping exercises with the community:

- List of physicians preferred by the community (preferred private⁵ practitioners)
- List of current barriers to accessing STI services
- Ways in which STI services can be made accessible and acceptable to the MSM community in terms of location, operating hours, etc.
- Possible modes of delivering STI services, e.g.:
 - **Project-based clinic:** This ensures confidentiality, less marginalisation and better quality of care. Easy to follow up but difficult to sustain.

- **Referral to the public sector:** Referrals to government facilities for free STI services can also help MSM access general health services that the TIs presently do not provide. Also, their female partners can access those services. A preferred mode of service delivery for MSM populations and their partners.⁶
- **Referral to preferred private practitioners:** Members of the community may prefer to avail services from a private practitioner with whom they are comfortable. Preferred private practitioners should be trained on STI operational guidelines.
- **Mobile clinics:** These can be considered in geographic areas with a scattered population and lack of availability of health care facilities (e.g., parts of Nagaland and Manipur) in collaboration with the STI division (SACS) and/or NRHM.

Once this information has been gathered, health care services can be established through the preferred modes of service delivery. The STI management services should be designed based on the above information gathered from focus group discussions with MSM and other stakeholders to maximise their reach among the populations. Not all TIs need to have clinics located within their office premises. Some TIs may have their own clinics (static/project-based) while some others may have to establish linkages with local government hospitals or private practitioners (referral clinics) for STI screening and treatment. TIs could also have a combination of static and mobile clinics (hybrid STI service delivery model). **Training** for the medical and paramedical staff at the STI clinics must cover sex and sexuality, STI/RTI management, and clinical standards and

⁵ Some may be government physicians.

⁶ Chakrapani, Boyce, Dhanikachalam. 2011. 'Women partners of men who have sex with men in India', 'MSM Situation Paper' series, NACO.

operating guidelines. Capacities of STI, Integrated Counselling and Testing Centre (ICTC) and ART service providers need to be strengthened to ensure sensitivity while exploring same-sex sexual history among men and to provide quality clinical and counselling services. Wherever there are TIs for MSM, the local government health care providers also need to be sensitised and trained on the health service needs of MSM.

Special attention should be paid to ensuring **community-friendly STI service delivery** options, which include:

- Clinicians with the right attitude towards the community;
- Availability of services as per the needs of the community, e.g., evening/late-night access (especially for sex work sites);
- Accessibility of services at the optimal location (i.e. not too far from major sex work sites, close enough not to require an auto rickshaw ride);
- Basic infrastructure facilities (these should be maintained at the standards stipulated by the NACO STI Clinic Operation Guidelines);
- Maintenance of confidentiality among the clinic team and the community.

II. Treatment

The effective prevention and treatment of STIs among MSM requires attention to both **symptomatic and asymptomatic infections**. For this, NGO clinics should have the following two components:

- **Management of symptomatic infections:** NACO syndromic management flowcharts and laboratory diagnosis should be made available at clinics. STI management must include oral and anal STIs.

- **Screening and management of asymptomatic infections:** Keeping quarterly records of sexual history, physical examination and simple laboratory diagnostics (where available).

- Treatment for asymptomatic gonococci and chlamydial infections is to be provided at the first visit and repeated after six months, if MSM has not attended the clinic for regular medical check-ups for two consecutive quarters.
- Semi-annual serologic screening for syphilis through referral to a laboratory (public or private or ICTC) is to be ensured. Currently, all ICTCs provide rapid plasma reagin (RPR) testing facilities to detect syphilis, in addition to HIV testing, and are therefore preferable as both tests can be undertaken in one prick. In places where 'single prick-two tests' facilities are not available, point-of-care syphilis screening (e.g., immunochromatography strip test) can be adopted. This is a whole blood finger-prick test that can be done by ANM in the STI clinic when MSM come for regular medical check-ups. The test requires no elaborate laboratory setup, has high sensitivity and specificity, and is acceptable to the community.

The packages of STI services to be provided are (see *NACO STI Guidelines*):

- Anal and oral STI screening will continue to form a part of the current STI prevention strategies. Proctoscopy as a procedure for detecting symptomatic anal STIs requires the explicit consent of the patient and is deemed necessary depending on his sexual history. It is important to counsel MSM (especially those with a history of unprotected anal sex in the past or condom breakage/slippage) about

the importance of undergoing proctoscopy, but it should not be forced;⁷

- Health promotion and STI prevention activities, such as promoting the correct and consistent use of male condoms and water-based lubricants and other safe sexual practices;
- Provision of free male condoms and lubricants;
- Immediate diagnosis and clinical management of STIs;
- Provision of STI medicines and directly observed therapy for single dose regimes. STI drugs are available in colour-coded packs;
- Health education and counselling for treatment compliance, correct and consistent use of condoms and lubes, and regular partner treatment;
- Counselling for risk reduction;
- Periodic STI check-ups, syphilis screening and treatment of asymptomatic infections;
- Partner management programmes (i.e., contact/partner referrals).

- Strong linkages with outreach activities targeted at MSM and their regular partners;
- STI surveillance as requested by NACO/SACS/TSU.

As per the NACO STI procurement guidelines, all STI drugs are to be procured by SACS/NACO. Colour-coded drugs are to be given by NACO/SACS to TIs. No drugs for STIs are to be purchased by NGOs.

b) Referral and follow-up services for MSM and their regular partners

- Verbal screening for TB, and if MSM are suspected of having TB, referral to the designated microscopic centre (DMC). In case of a TB diagnosis, there should be regular follow-ups to ensure complete treatment;
- Counselling support for HIV-seropositive persons;
- Prophylaxis and treatment of simple Opportunistic Infections;
- Referral linkages to ICTC, HIV care and support and other relevant services to ensure continuum of care;

⁷ STI operational research (2009) by FHI and Avahan clearly indicates that asymptomatic anal (gonorrhoea/chlamydial) infections were high even among MSM who identified themselves as panthis or admitted only to being penetrative partners. Taking explicit consent is a crucial step to prevent charges of human rights violation by forcibly using invasive proctoscopic examination, which is considered to drive away other potential beneficiaries from seeking such services.

c) TI management strategy and implementation approaches for MSM

i) Management Strategy

Technical Strategy	Role of NACO	Role of SACS/TSU
<ul style="list-style-type: none"> ▪ Accessible and acceptable TI static/mobile, and referral clinics ▪ Adequate clinical services to provide effective STI services for MSM (syndromic management of symptomatic STIs, regular screening and treatment of asymptomatic STIs for MSM) ▪ Counselling on HIV risk reduction and informed choice on HIV testing ▪ Utilisation of strengthened strategic government facilities for STI services, HIV testing and treatment, TB treatment – upgrading of strategic government facilities 	<ul style="list-style-type: none"> ▪ Develop clinical operational guidelines and standards on: <ul style="list-style-type: none"> ○ STI management ○ STI and HIV counselling ○ Syphilis screening and laboratory quality assurance ○ Establishing referral network ▪ Capacity-building of SACS/TSU/SSC: <ul style="list-style-type: none"> ○ Training ○ Regular technical support ▪ Develop tools for clinic service monitoring (STI services, counselling including process, outcome and quality of services) ▪ Monitor process and outcomes – clinical services ▪ Evaluate effectiveness of STI services 	<ul style="list-style-type: none"> ▪ Facilitate implementation of clinical operational guidelines and standards ▪ Capacity building of NGOs <ul style="list-style-type: none"> ○ Training ○ Adequate technical staff to provide regular technical support (defined as quarterly field visits to each TI to assess quality of STI services – see below for details) ▪ Develop referral network for syphilis and HIV testing, STI/HIV treatment and care, and sexual and reproductive health services for MSM and regular partners ▪ Monitor STI referral services

ii) Implementation Approach

Technical Area	Implementation Details	Lead	Timeline and Frequency
STI TREATMENT SERVICES			
Effective and quality provision of STI services that are acceptable and accessible: Syndromic treatment of MSM, regular screening (proctoscopic exam for MSM who engage in anal sex) and treatment of asymptomatic STIs, including syphilis screening, STI services coordinated with outreach, ensuring condom and lube promotion and community involvement	<ul style="list-style-type: none"> ▪ TI-owned clinic established where cost-effective ($\geq 8,00$ /MSM/site or high risk) ▪ TI-owned outreach clinics (fixed day, fixed site) established to reach smaller number and most at risk MSM ▪ For smaller groups of MSM (≤ 200), establish linkages with strengthened STI government facilities or trained preferred private practitioners ▪ Adequate and quality STI services, STI and HIV counselling, adoption of the NACO operational guidelines for STI management ▪ Ensure involvement of community members in clinic operations, including hiring and training of MSM/in-clinic operations and management and quality monitoring ▪ Community members take ownership of the clinic – NGO supports community members to establish and design clinical services and to plan, manage and monitor them ▪ Qualified, trained and supervised staff, ANM and/or counsellors to provide quarterly STI screening and clinical services ▪ Ensure that client's consent is taken for undertaking any invasive procedure, e.g., proctoscopy and syphilis/HIV testing. Counselling support must be provided in the clinic to overcome barriers to internal examination ▪ Adequate resources and commodities to provide free STI drugs, condoms and lube, and to implement operational guidelines and establish referral network ▪ Regular coordination of clinic staff and outreach/peer education ▪ Community should be encouraged to bring regular male/female partners to government health care facilities 	TSU/SACS/NGO	<ul style="list-style-type: none"> ▪ Clinics (static/mobile and referral) established within 3 months of initiating the TI ▪ Linkages with government facilities established by 6 months ▪ Syndromic case management and asymptomatic treatment by 3 months ▪ Universal regular STI check-up by end of first year ▪ Community ownership of clinic: ongoing
Point-of-care (POC) tests or links to laboratories for syphilis screening	<ul style="list-style-type: none"> ▪ Train the clinic staff on point-of-care syphilis screening tests or establish linkages with a lab that has quality assurance systems for serologic testing of syphilis (as per NACO guidelines) ▪ Ensure quality assurance systems are in place for POC or referral laboratories 	NGO TSU/SACS/SSC	<ul style="list-style-type: none"> ▪ Universal serologic screening for syphilis every 6 months

Technical Area	Implementation Details	Lead	Timeline and Frequency
REFERRAL – HIV/ART/CARE & SUPPORT SERVICES			
Referral network for HIV prevention, treatment, care continuum and positive prevention	<ul style="list-style-type: none"> ▪ Identification of referral organisations with the community, documentation and follow-up of referrals, organising meetings on referral mechanisms ▪ Establishment of formal referral mechanisms for quality HIV testing and counselling. HIV testing and counselling referral facilities should be sensitive to MSM-specific issues and have a strong referral mechanism for HIV treatment, care and support and other related services ▪ Establishment of formal referral mechanisms for management of opportunistic infections, TB and ART, including follow-up management ▪ Establishment of linkages to community care and support and self-help groups ▪ Clinic to maintain a referral directory, document referrals and ensure follow-up. Referral directory should include details of the referral agency, timings and contact person, and should be displayed in the clinic and DIC. 	TSU/SACS NGO/CBO NGO/CBO	<ul style="list-style-type: none"> ▪ Clinic with established referral linkages by 6 months ▪ Full referral network functional by end of first year
REFERRAL – FOLLOW UP AND ADDITIONAL SERVICES			
Broader referral systems for additional services as necessary (TB management, STI complications, sexual and reproductive health needs, medical care, social support, legal support, injecting drug user (IDU) services and mental health)	<ul style="list-style-type: none"> ▪ Establishment of other referral linkages based on community-identified needs and services available in the community ▪ Referral linkages with rehabilitation centres for alcohol-dependency and drug dependency treatment ▪ For MSM having drug dependency – referral to IDU TI or detoxification programmes, as appropriate ▪ Referral for Hepatitis-C, for those with a history of injecting drug use ▪ Clinic to maintain a referral directory of other services, documents referrals and ensure follow-up of referral services 	NGO/CBO	<ul style="list-style-type: none"> ▪ Referral directory developed within 6 months of establishing clinic ▪ Referral mechanism established

Technical Area	Implementation Details	Lead	Timeline and Frequency
ESTABLISHMENT OF SYSTEMS – RECRUITEMENT, MONITORING AND DOCUMENTATION			
Systems and staff in place to implement STI services and quality monitoring based on STI technical guidelines and STI operational guidelines provided by NACO	<ul style="list-style-type: none"> TSU/SACS with adequate number of trained technical staff to provide capacity building support, conduct regular supportive supervision, and monitor the TI clinics. Monitoring key areas on clinic operations, staff clinical knowledge, skills and performance, coordination of outreach programme, community involvement, client satisfaction and response, clinical management of STIs, infection control and waste management, drug and supply management, education and counselling, ethical standards, confidentiality, referral systems, monitoring, evaluation and reporting 	TSUs/SACS	<ul style="list-style-type: none"> Staff in place by the time clinics are established Technical supervisors to conduct quarterly visits to all STI clinics
	<ul style="list-style-type: none"> Paper-based recording and reporting of clinic activity utilised to improve clinical services Regularly entering of paper-based clinic reports into the computerised management information systems (SIMS) to generate information on clinic activities and STI outcomes 	NGO and TSUs/SACS	<ul style="list-style-type: none"> Paper-based system developed when clinic established SIMS operational by 2nd year
	<ul style="list-style-type: none"> Systems in place to monitor and track overtime quality of clinical services in all clinics 	TSUs	<ul style="list-style-type: none"> Annual clinic audit to track level of quality service provision
	<ul style="list-style-type: none"> Random visits to STI clinics to monitor clinic functions/performance 	NACO/SACS	<ul style="list-style-type: none"> 5% of clinics half-yearly

3.2.1.4. Positive Living and Positive Prevention⁸

For MSM diagnosed with HIV, the following services are to be provided by the TI or through referral:

- i) The counselling and health education by the counsellor and doctor at the STI clinic should include treatment literacy

⁸ Several definitions of 'positive prevention' exist. In one way, it refers to protecting the health of people living with HIV by assisting them in adapting safer sex and safer injecting practices, and in protecting the health of their sexual or needle-sharing partners. However, the positive prevention framework also includes the concept of 'shared responsibility' (that both HIV-positive and HIV-negative/unknown HIV status partners are responsible for their decisions during safer sex or needle/syringe sharing).

and effective communication for better knowledge to access services. It should also encompass:

- a. Treatment for basic Opportunistic Infections (OIs);
- b. Assistance in disclosure to steady partners and providing information about where to refer their steady partners (men and women) for HIV screening and treatment;
- c. Counselling on safer sex with sexual partners and reducing the risk of sexual transmission (correct and consistent use of condom during any sexual encounter, condom negotiation and sexual communication skills);

- d. Prevention of transmission through non-sexual routes (injecting drug use);
 - e. Advice on how to prevent other infections, such as STIs and TB;
 - f. Support and monitoring of MSM on care, support and adherence to ART;
 - g. Advice on good nutrition and encouraging physical activity.
- ii) Referral to ART centres and TB Directly Observed Treatment Short course (DOTS) centres. The community members may require additional support for accessing services at ART centres. This can be achieved through the buddy system for MSM living with HIV, wherein one or more members of the staff—e.g., greater involvement of people living with HIV/AIDS (GIPA) at TI—is given the responsibility of providing necessary support for accessing referral services; Placing of or regular visits by PE or ORW at ART centre may also help facilitate service uptake by MSM living with HIV.
- iii) Support the formation of support groups of MSM living with HIV, provide referral to mainstream PLHIV networks and ensure proper sensitisation of network staff/members.
- iv) Referral to other government schemes for PLHIV (nutrition support, pension schemes, travel support).

3.2.1.5. Counselling

Counselling services at the TI level reinforce the outreach message and support MSM to adopt safer sex practices and improve health seeking behaviour. The counselling will include:

- a. Risk assessment and risk reduction

- counselling for prevention of STI/HIV, including condom promotion;
- b. Male Sexual and Reproductive Health (SRH) issues;
- c. Counselling related to sexuality and mental health and marital issues. Refer to higher centre, if needed;
- d. Correct and unbiased information on proctoscopic examination;
- e. STI counselling, including treatment compliance and partner referral;
- f. Counselling and motivation on voluntary HIV testing, and referral to ICTC for those who consent;
- g. Post-test counselling for HIV-positive MSM (even if it has already been provided at an ICTC) for reinforcement of certain messages;
- h. Support for disclosure and positive living;
- i. Quality counselling to be ensured for specific needs of MSM subgroups (with regard to issues of married MSM and of older MSM, etc.).

3.2.1.5 Condom and Lube Programming

1. Ensuring the availability, accessibility and correct and consistent usage of condoms by MSM has been a core imperative of NACP-III and this will continue in Phase-IV. Free condoms and lubricants for MSM will be sourced to meet their expressed needs and will continue to be provided free through TIs to cover all the estimated anal sex episodes of the beneficiaries they reach. Supply of free condoms and lubes will be timely and distribution will be made more efficient. Training will be provided to TI staff to calculate the condom and lube requirements. Methods of observing lube uptake and corresponding adjustments on lube indents will be fine-tuned to prevent wastage or stock-outs at TI levels in parallel to the stocking of condoms.

Strategy for Condom Promotion for MSM

Free supply of condoms and lubes to MSM through TIs by NGOs/CBOs

Condoms and lubes should always be available to MSM for free. If and when the demand for socially marketed condoms arises in these groups, appropriate mechanisms must be in place to ensure that the free and socially marketed supplies do not overlap.

2. The basics of free condom and lube programming for MSM

- Ensuring availability alone is not enough—distribution does not equal usage.
- Ensuring accessibility is not enough—access does not equal usage.
- **The goal is increased correct and consistent use of condoms and lubes by MSM.**

3. **Address barriers to condom and lube usage.** It is important to understand various aspects related to condom and lube usage among the MSM population at the site level before initiating condom programming. Considerations may include:

- The barriers to condom usage, e.g., alcohol intake, 'difficult clients', pleasure, good-looking clients;
- Misperceptions and myths regarding condom and lube usage, e.g., not required for anal sex;
- Condom and lube availability in the area;
- Condom and lube accessibility—are condoms and lubes available at the point of sex (or do MSM have to travel to

procure the condom) and at the time of sex (often in the evening/at night)?

- Creating demand for condoms and lubes (see guidelines for Condom Social Marketing).

4. **Assessing condom and lube requirement at any given site of intervention** is critical in order to ensure that these are not being 'dumped' and to avoid stock-out. Ultimately, condom availability depends on the risk profile of the individual site and cannot be averaged or aggregated at the state level.

The following formula can be used to calculate condom requirement for MSM at a given site:

$$D = (S \times I \times N) - C$$

Where

- **D** is the condom requirement
- **S** is the number of MSM visiting an area
- **I** is the number of total sex acts (anal/oral sex) per week
- **N** is the number of weeks MSM are 'sexually active' in a given month
- **C** is the number of condoms brought by male partners from other sources

S, I and N can be determined through the processes of site assessment and outreach planning. C can be determined by special surveys among MSM. If such surveys have not yet been carried out, NGOs/CBOs can estimate the proportion of condoms brought by male partners by polling a random sample of MSM.

Calculation of requirement of water-based lubricants per month

The following formula can be used to calculate the requirement of water-based lubricants for MSM at a given site for a month:

$$L = (S \times I \times N) - C \text{ where}$$

- **L** is the water-based lubricant requirement
- **S** is the number of MSM in the area

- **I** is the average number of anal sex acts per week
- **N** is the number of days MSM are sexually active in a week
- **C** is the number of water-based lubricants brought by partners of MSM from other sources (usually this proportion low enough to be negligible)

Thus, in effect, $L = (S \times I \times N)$

S, I and N can be determined through the processes of site assessment and outreach planning.

Note: An important assumption is that condoms are used in all these anal sex acts (i.e., 100 per cent condom use is assumed).

Establish distribution channels. Key channels for ensuring condom and lube distribution among MSM include:

- **Direct distribution:** Condoms and lubes given directly to MSM are more likely to be used and less likely to be wasted.
 - Distribution by PEs and ORWs in the field
 - At the DIC by and project staff
 - At the STI clinic
- **Indirect distribution:** Locations should be chosen carefully to minimise wastage or the chance of the condoms being sold. For example, condom outlets in public toilets, petty shops, tea shops, and railway stations. Ensure that condoms and lubes available during religious festivals and functions where MSM gather in large numbers (e.g., gay pride march, queer film festivals).

The monitoring of condoms and lubes occurs at three levels:

- **Monitoring of distribution/availability:** This can be done at the PE level to ensure that the all high-risk acts are being covered by distribution channels. Availability of condoms at hotspots, especially beyond 9:00 p.m.,

should be measured in each state by an independent research firm. The target is to ensure over 80 per cent availability.

- **Monitoring of accessibility:** This can be done in a variety of ways, including condom depot monitoring and individual tracking through PEs (**see Annexure 4, Tool for Outreach Planning and Management**).
- **Monitoring of usage:** This can be done through PEs, used condoms at depots (counting used condoms at hotspots and matching with estimated sex acts), and through peer counsellors at the clinic.

Condom stocking/reporting

- Each implementing NGO should make sure they have an adequate stock of condoms and lubes. Re-ordering is recommended when there is three months' stock in hand (**see Annexure 9 for tools on indenting**).
- NGOs/CBOs should have adequate storage space for condoms and lubes. Care should be taken that they do not get damaged in storage or during transit to outlets.
- Documentation of condom and lube supplies should be ensured. TI partners should be able to provide data on where, when and how many condoms/lubes are supplied.
- When assessing condom requirements, the number required for condom demonstrations and trainings should be factored in.

Special studies to assess condom use

- Special studies such as a 'polling booth study on condom usage' can be carried out regularly to assess the changes taking place among MSM in knowledge, attitude, and practice with focus on negotiation skills about condom use.
- Condom and lube programming should be assessed as part of the annual review/evaluation and redesigned accordingly.

Condom breakage during anal sex and the importance of lubricants/ lubrication

Breakage of condoms is a common complaint by MSM. There are several possible reasons for breakage, which include:

1. Poor quality of condoms,
2. Condoms used after the expiry date,
3. Incorrect use of condoms,
4. Poor lubrication and use of incorrect lubricants (other than water based lubricants, e.g., coconut oil, Vaseline, creams, grease, etc.)

It is important to communicate that reasons 3 and 4 can be avoided by emphasising condom demonstrations and education on the use of correct lubricants—water or silicone based.

- Evidence suggests that most MSM use saliva as lubricant. This is not optimal since saliva dries rapidly, becoming sticky, which can increase the level of friction and result in greater damage to the anus.
- Other forms of lubrication that are used include Vaseline, ghee, butter or some other oil-based product. These oil-based lubricants can damage the condom (by damaging the latex) and should not be used.

3.2.1.6 Voluntary HIV Testing and Counselling

Voluntary HIV screening for MSM at half-yearly intervals is recommended. MSM should be provided proper counselling on HIV testing to ensure early detection and treatment, and only those who consent for testing are to be sent for HIV testing and counselling.

3.2.1.7 Crisis/Violence Prevention and Mitigation (Crisis Response Team)

Crisis forms a part of any outreach work and rapid response to crisis builds the faith and confidence of a marginalised community that often finds itself on the receiving end of stigma and violence. Every TI needs to not only react to crisis but also look at preventive actions that can avert any unpleasant situations. Crisis response is part of creating an enabling environment and hence needs to be addressed by all TIs. A crisis response team usually includes a project manager, counsellor, ORWs and local (area) peers. Each TI should also take up proactive advocacy strategies to prevent future crises. The prevention of sexual and physical violence should be part of such proactive strategies. Crisis response teams also take care of the service needs of victims of sexual violence by connecting them with medical services, helping them in filing cases and linking them to free legal aid.

3.2.1. Additional package of services through linkages

- a) Counselling related to sexuality and mental health issues/marital issues, linkages with NGOs working on mental health issues, and local psychiatrists and psychotherapists or mental health counsellors.
- b) Anorectal cancer screening, especially for HIV-positive MSM. Anal cancer is commonly associated with the human papilloma virus (HPV). This virus causes warts in and around the anus and cervix, and affects both men and women. HIV-positive MSM with a history of anogenital warts need to be screened periodically for anorectal cancer and precancerous lesions.
- c) Treatment of Hepatitis-B infection.

- d) TIs need to build linkages with government hospitals to screen and treat Hepatitis-B infection.
- e) Alcohol dependency treatment and drug-dependent treatment programmes.
- f) Linkages with alcohol and drug de-addiction centres are to be established for MSM populations.
- g) Social protection/entitlements.
- h) Screening for Hepatitis-C, in case of history of injecting drug use.

TIs are to list government and NGO/ CBO-based service centres for the services that are not available through the project-based clinic and establish linkages with them for appropriate referral services.

Tools

NACO STI Guidelines

Annexure 3: Tool for Peer-led Outreach and Planning

Annexure 5: Tool for Dialogue Based Interpersonal Communication (IPC) by and with MSM

3.3 Step 6: Outreach Planning

The objective of outreach planning is to enable outreach to 85–100 per cent of the available MSM population on a regular basis in the form of physical and virtual outreach, in order to maximise the coverage and impact of HIV prevention efforts. PE-led outreach planning also empowers PEs, thereby increasing a sense of ownership of the project by the community and peers.

The elements of physical and virtual outreach planning serve the following purposes:

PHYSICAL OUTREACH TOOLS			
	OBJECTIVE	QUANTIFIER	TOOLS/STRATEGIES
1	Improve quality of outreach	Reach out to all contacts at least once a month	<input type="checkbox"/> Spot analysis <input type="checkbox"/> Contact mapping <input type="checkbox"/> Geographical and social networks <input type="checkbox"/> Individual tracking
		Reach out to all contacts regularly twice a month	<input type="checkbox"/> MSM typology-wise outreach planning for each hotspot <input type="checkbox"/> Site load mapping <input type="checkbox"/> Seasonal calendar <input type="checkbox"/> Force field analysis <input type="checkbox"/> Individual tracking
2	Improve service levels	STI clinic attendance, condom distribution	<input type="checkbox"/> Preference ranking <input type="checkbox"/> Peer map for condom distribution <input type="checkbox"/> Condom and lubricant availability and accessibility and mapping (including acceptability)

3	Build PE's capacity to monitor his own preference	Monitor own performance and fill gaps proactively	<input type="checkbox"/> Peer education card <input type="checkbox"/> Peer calendar/Peer diary
4	Continuously improve programming	Uptake of services	Opportunity gaps analysis
5	Eradicate violence against MSM	Build self-defence skills to tackle violence	Adapt existing training model in Tamil Nadu
7	Reach mobile MSM population	Network among TIs	Build network among MSM TIs through mutual sharing of migrant MSM
8	Reach rural MSM for uptake of TI services	Involve specific self-identified MSM (kothis, etc.) social groups	<input type="checkbox"/> Sensitise self-identified MSM groups <input type="checkbox"/> Network with LWS and Pehchan Project
9	Extend TI services to small remote MSM groups	Connect with Link Worker Scheme (LWS) wherever available, or with local Primary Health Centres	Develop linkage plan with SACS and TSU
10	Protect human rights of MSM	Educate core group of peer volunteers about human rights and what constitutes violations	Organise training on human rights
11	Sustain interest and provide updated information on HIV to MSM	Develop target-specific IEC for MSM	<input type="checkbox"/> Design, develop, print and distribute MSM-specific IEC material <input type="checkbox"/> Explore innovative material
12	Strengthen referral services	Address community needs	Provide referral for alcohol dependence anal cancer, social protection/entitlement, TB prevention, control and treatment for Hepatitis B, Hepatitis-C screening for injecting drug using MSM
13	BCC	Outreach during MSM social/festival gatherings	Create awareness, strengthen referrals, collectivisation
14	Reach hard-to-reach MSM	Adopt virtual outreach programme, pilot internet-based outreach	Develop and disseminate information through SMS; and social networking sites and apps (e.g., Facebook, MySpace, PlanetRomeo, Grindr, Whatsapp, etc.)

Table. Strategies to reach hard-to-reach MSM⁹

Subgroups of Hard-to-reach MSM	Barriers to reach	Potential strategies to reach (to provide information/counselling and link with services)
Gay or bi-sexual identified MSM	<ul style="list-style-type: none"> - Do not visit current hotspots of TIs - Socio-economic class differences between current TI ORWs - Do not want to be seen talking to kothi-identified/feminine persons in public places or even allow kothi ORWs from TIs in gay parties or other gay-specific venues - Do not want to visit DICs located within CBOs/NGOs which are seen as predominantly kothi-oriented 	<p>Sensitise the gay-specific local groups (e-groups) or other social groups on the importance of HIV interventions for gay-identified men and get their support. Gay peer ORWs can be identified with the help of these local gay groups.</p> <p>Employ gay-identified ORWs acceptable to the gay community—depending on the settings (e.g., urban areas)—who can then access gay-specific venues (parties, bars, etc.).</p>
Married MSM	<ul style="list-style-type: none"> - Community stigma (kothi/gay) related to married status - Fear of disclosure of sexuality to wives and its negative consequences 	<p>Create a conducive environment for married MSM in TIs by addressing community stigma around married status of self-identified MSM.</p> <p>Anonymous referral and Follow Up services (phone/internet) for married MSM who do not wish to come to TI sites/DICs.</p>
Self-identified MSM who do not visit DICs/TIs and cruising sites	Want to receive anonymous services	<ul style="list-style-type: none"> <input type="checkbox"/> Helpline-based service referrals/follow-up <input type="checkbox"/> Internet-based interventions
‘Older’ MSM (> 50 years of age)	Not prioritised by HIV agencies especially in HIV agencies where mostly young MSM ORWs are employed	Need to educate TI staff about the importance of reaching out to older MSM
Same-sex attracted legal minors (below 18 years of age)	Legal barrier to provide services in the current TIs	Sensitise the existing youth/adolescent-friendly clinics on the issues of same-sex attracted legal minors and establish linkages with such government or non-governmental agencies. Guidelines need to be developed to address this issue (i.e., being a legal minor as an access barrier).
Non-self-identified MSM (See Diagram below)	Not coming to cruising sites and TI projects; and not even using MSM-specific internet sites	<ul style="list-style-type: none"> <input type="checkbox"/> Integrate messages/counselling in existing HIV interventions for men (migrants, college youth, drug users, prisoners, truck drivers, etc.). <input type="checkbox"/> Mainstream mass media campaigns on HIV: Generic messages on safer sex with partners of any gender. <input type="checkbox"/> Strengthen the capacity of health care providers to sensitively find out about same-sex sexual histories of men who visit government health care settings (STI clinics, ICTCs, ART centre, etc.).

⁹ For a definition and explanation of ‘hard-to-reach MSM’ please refer to the glossary.

Diagram. Reaching non-self-identified MSM

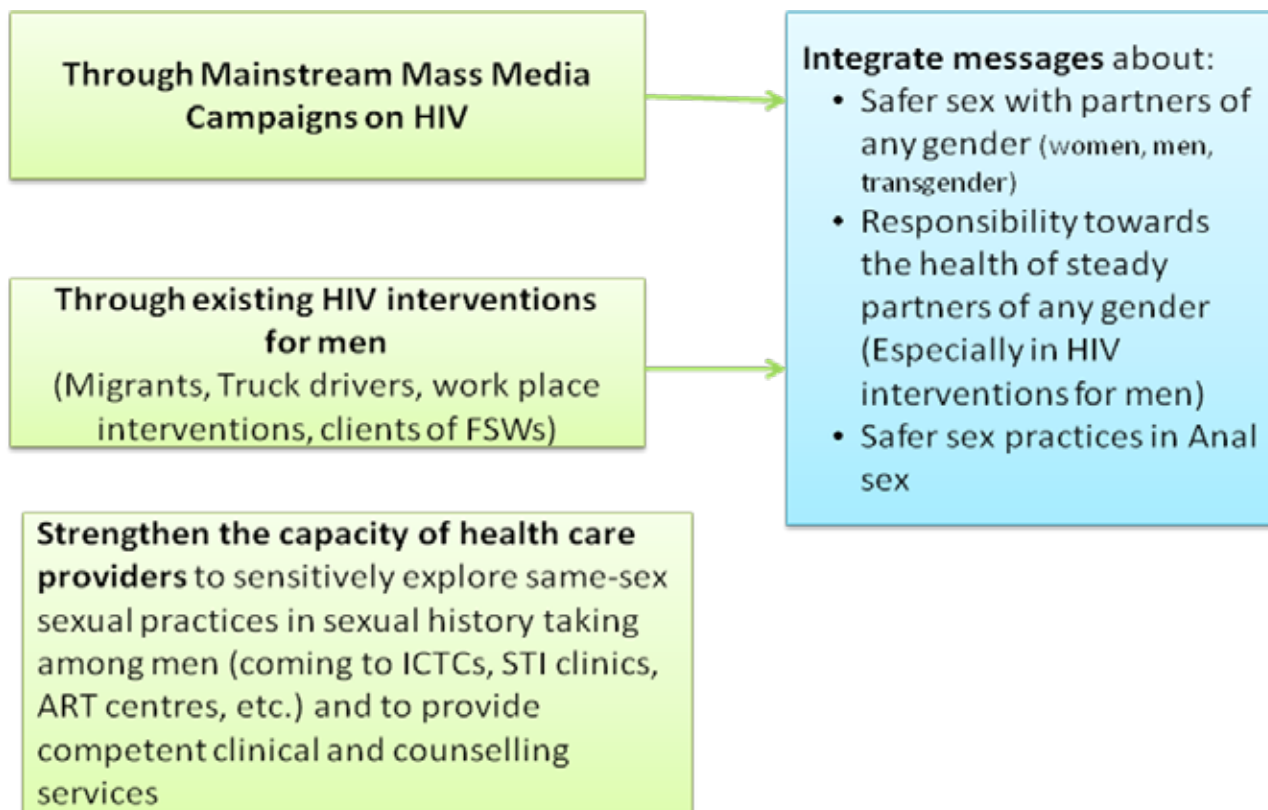


Diagram: Physical Outreach

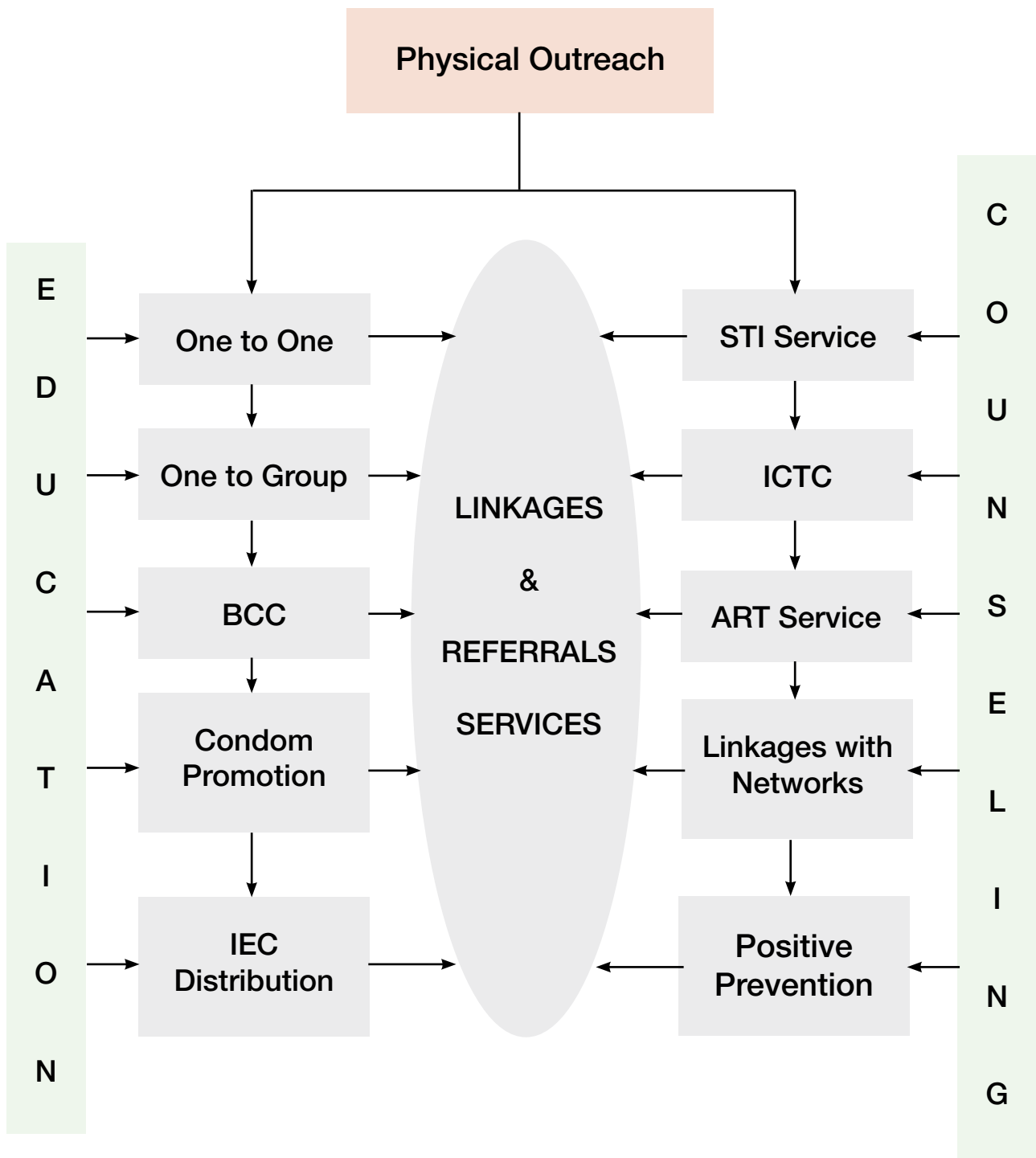
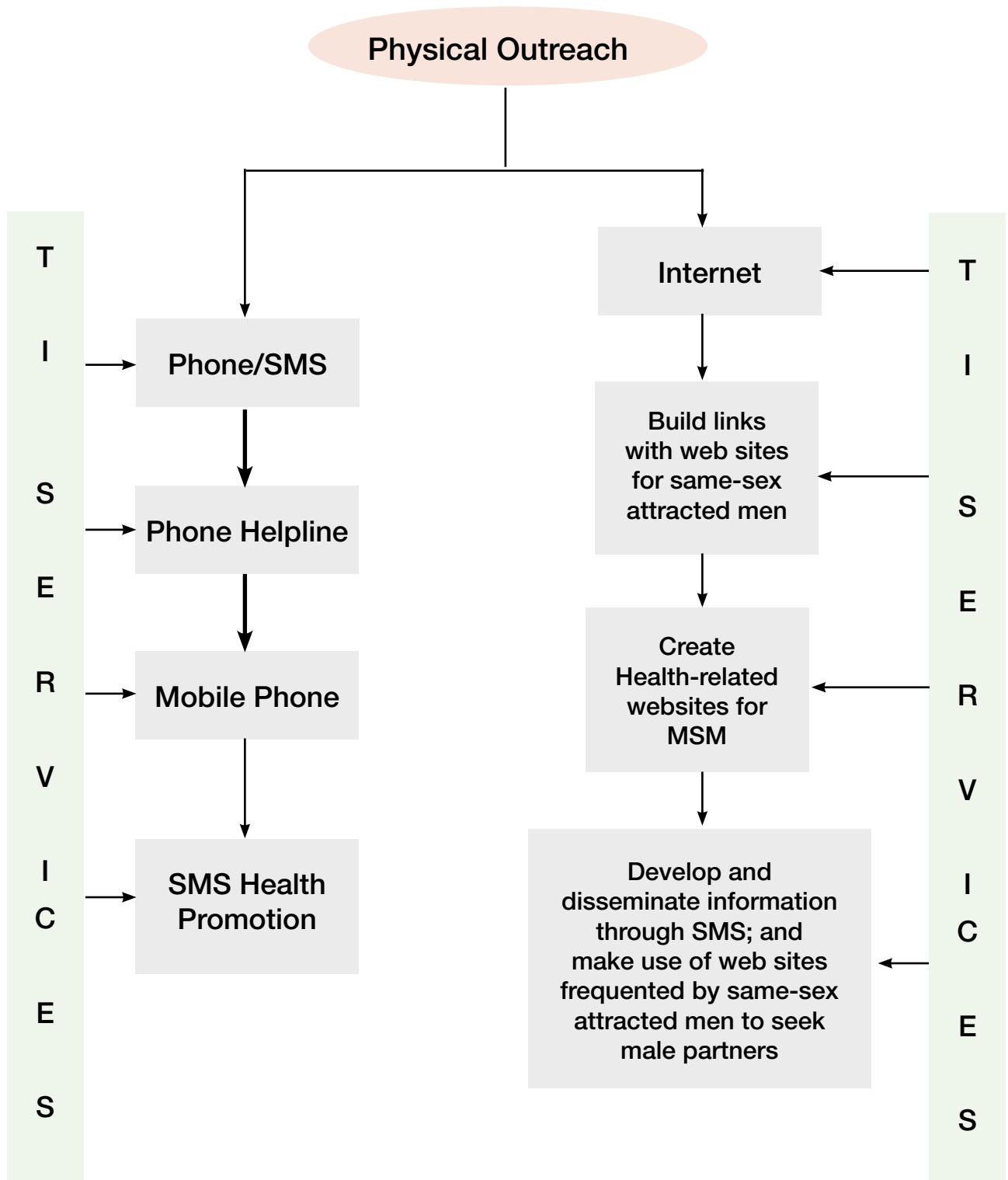


Diagram: Virtual Outreach



3.4. Step 7: Community Mobilisation and Community Strengthening

Community mobilisation and HIV prevention is an attempt to bring human resources and other resources together to undertake developmental activities with the goal of HIV prevention in order to achieve Zero new HIV infections by 2017', along with the sustainable development of communities that are most at risk. Community mobilisation and HIV prevention is also a process through which action is stimulated by the community itself, or by others, that is planned, carried out, and evaluated by a community's individuals, groups and organisations on a participatory and sustained basis to improve sexual and overall health in the community. It involves a group of people who have transcended their differences to meet on equal terms in order to facilitate a participatory decision-making process and prevent HIV infection. In other words, it can be viewed as a process which begins a dialogue among members of the community to determine who, what, and how issues are decided, and also to provide an avenue for everyone to participate in decisions that affect their lives in HIV infection. While **Community Involvement** implies the involvement of the community in activities and programmes, **Community Engagement** is the process of building relationships with community members who will work side-by-side with organisations as ongoing partners, in any and every way imaginable, building an army of support for the mission, with the end goal of making the community a better place to live. **Community Mobilisation** goes one step further in mobilising the community to organise in a gradual process and take the lead through **Community Ownership**, where the community runs and executes the programme through a democratic process.

For brevity, the term 'MSM communities' has been used in this document. It does not, however, mean that all MSM consider themselves as part of any 'MSM community'. Communities (geographical or virtual) are usually formed by MSM who have particular identities related to their sexuality—it can be, for example, 'gay' or 'kothi'.

Community mobilisation includes building active participation within the community, **community involvement**, community decisions, **community ownership** and long-term sustainability through community-led service delivery of community initiatives and community-based organisations (CBOs). Creating community norms is important to sustain behaviour change among individuals in any community. Community mobilisation in an HIV/AIDS programme context mainly aims at collective action and influencing norms within the community for safe sexual behaviour, and hence, also to address other structural barriers and improve access to and use of HIV prevention and treatment services. A community mobilisation process should provide opportunities to each and every community member in the project area to participate in collective decision-making on various issues that affect the community, by establishing successful democratic processes. Any member should be able to become a selected or elected leader or representative in one of the various organisational/social forums.

The design of the TI also needs to be approached from the community perspective to meet the goals of the National HIV Programme. Under NACP-IV, community mobilisation in the context of TI is seen in a particular aspect—mobilising the community for the uptake of services pertaining to HIV prevention. Community mobilisation and BCC run parallel or consecutive to each other but the approach to community Mobilisation will be bottom-to-top (designed according to community needs to reach national HIV goals

as well as address other non-HIV needs) and top-to-bottom for BCC (designed according to national HIV goals to fulfill HIV needs of the community). Hence, all the TI components, including community mobilisation, need to be addressed at different levels viz. local, district, state and national.

MSM communities are quite diverse. Not all MSM want to be part of informal or formal groups of MSM. The reasons behind the formation of MSM community agencies may be different. Some of these are formed to address the health needs and advocacy issues of same-sex attracted men. Some other community groups are informal (non-registered), and possibly even primarily e-group-based, and they may focus on issues of importance to same-sex attracted communities and/or to socialise and meet with potential sexual or life partners. They, however, constitute a sexual network that follows specific practices, behaviours and language which, for the purpose of a TI, may lead them to being identified and addressed as a community. Communities are stronger when identities are clear and associations and bonding happen on the basis of multiples factors such as sexual behaviour, gender identity, political identity, geography, socio-economic background. In the MSM context, these parameters would play an important role to understand the environment in which the TI operates. There may be huge differences between the dynamics in rural and urban settings.

Some of the MSM community agencies have formed national and state level networks. There are experienced national and state level networks of sexual minorities. Recent years have seen the beginning of community mobilisation and strengthening around human rights issues, which are reflected in pride marches and queer events that have a large part of the MSM community participating along with other sexual

minorities such as lesbian/bisexual women and TG men and women. Although such forums are limited in HIV prevention dialogues, they present an opportunity for community mobilisation and TI outreach to access unreached population that does not come into the TI fold. Presence and involvement in these activities help in highlighting the TI's efforts and attract new members from within the community for volunteer work in TIs.

Thus, **community mobilisation and strengthening processes need to take into account all these existing and emerging community structures.** Community mobilisation and strengthening, in general, will thus not only be focused on building the capacities of the communities to address HIV-related issues, but also **to address the broader health-related issues and rights issues.** The goal of community mobilisation and strengthening from the national government's perspective is to strengthen the communities so that they can eventually take ownership in addressing HIV/health-related issues and rights issues.

Community strengthening strategies include:

1. **Community ownership building at the TI level** (established CBO/NGO);
2. Support for formation, and **strengthening of formal and informal community groups within the TI;**
3. **Proactive linking and docking of these networks with other government agencies** to facilitate broader mobilisation of the community by addressing MSM issues linked with national goals for progressive, rational and scientific thinking;
4. **Extending community mobilisation to virtual networks and including these populations in TI services.**

1.1.1 Community mobilisation at the targeted intervention level (established CBO/NGO)

At the TI level, community mobilisation may refer to mobilising community members at the grass-root level to understand their health-related issues and rights, improve their access to services and to help them collectivise and enjoy/realise their rights. This, in turn, will greatly assist in moving towards the national goal of zero new infections by 2017 through developing and strengthening community ownership of the programme.

TI-based community ownership building activities include (but are not limited to):

- Conducting events of importance and attraction to the communities with larger representation from the grass-root level community members (not just PEs or CBO/NGO staff). For example, community events like ‘Melukolupu’ in Andhra Pradesh, and Ghutiari Sharif Mela in West Bengal.
- Mixing information with entertainment (‘Infotainment’) during DIC activities and in the field.
- Encouraging community members to **actively provide periodic feedback** to check and ascertain whether the services meet the needs of the beneficiaries and are of acceptable quality.
- Community **participation in planning of outreach** at hotspot and cluster levels, and crisis management groups at intervention sites.
- **Participation of community members in planning, implementing and monitoring** activities at TI level.
- **Community involvement in the designing of various capacity building modules and communication materials**
- **Community committees**

Community participation cuts across all the parameters of community mobilisation. It takes place at different levels through a variety of mechanisms, one of the most important of which are community committees. These ensure community participation in planning, implementing

and monitoring activities at the TI level.

The following are mandatory community committees which need to be functional in a TI:

1. Outreach and communication committee;
2. Clinic/Health committee;
3. Crisis and advocacy committee;
4. DIC committee;
5. Condom committee;
6. Project advisory committee.

The common minimum key roles to be performed by community committees are:

- Generating demand for service delivery in the TIs from the community;
- Collecting feedback on service delivery, utilisation and needs from respective hotspots;
- Communicating this feedback to executive body members through committee meetings;
- Conducting community committee meetings on a regular basis.

Community committee meetings:

- All the committees except the project advisory committee should meet on a monthly basis;
- The project advisory committee should meet on a quarterly basis (where quarters should be based on the financial year, i.e. April to March).

1.1.2 Community involvement in decision-making processes

The commitment of the government through the national principle of greater involvement of people infected and affected by HIV/AIDS (GIPA) will facilitate the mobilisation of marginalised communities, including MSM. Accordingly, MSM communities need to be involved in programme/

policy designing, implementation and evaluation during GIPA policy planning. The recently approved national GIPA policy is also applicable in the case of affected communities such as MSM (whether HIV-positive or not), and procedures set in the national policy will be adapted to involve the MSM communities in the design, implementation and evaluation of HIV programmes.

The formation of NACP-IV strategies for MSM involved the active participation of community representatives from various parts of India, which reflects the commitment of the government to involve affected communities in programme/policy designing. Similarly, the support for the formation and strengthening of CBOs (and networks) to implement TIs shows the active involvement of the communities in the implementation of the programme by taking ownership. Community representatives, on the other hand, will also be

involved in the review and evaluation of national and state HIV programmes.

1.1.3 Extending community mobilisation to virtual networks and including these populations in TI services

1.1.4

- Where necessary, use TI resources (computer and Internet) to include a virtual network outreach component to the TI.
- Send regular communication messages to MSM to get them involved in community events and thereby seek services from the TI.
- Understand the community needs of this population and customise services as per feasibility and requirement.
- Encourage this population to bring their peers to the DIC.

	Level of Community Mobilisation	Processes for Community Mobilisation	Major Activities	Rationale and Outcome
I	I-TI LEVEL			
	I-1a-	Providing a safe physical space for self-identified MSM and providing a convenient virtual space for non-identified MSM	DIC (or virtual space) with adequate infrastructure and support mechanisms at convenient location (physical or virtual)	
	I-1b-	Community involvement through community events and information with entertainment ('Infotainment') in physical space	Regular activities according to the local demand of the community <ul style="list-style-type: none"> □ Conducting events (at least twice a year) of importance and attraction to the communities (through a 'cycle of celebration' throughout the year) with larger representation from the grass-root and other level community members. It may be noted that 	High community turnover in community activities from different sub-groups with reflection in service delivery through motivation and peer influence to take services linked through community events

			<ul style="list-style-type: none">□ separate or joint events organised for all sub-groups have to go beyond kothis and bring together other sub-groups like male sex workers, gays, double-deckers, panthis, etc., through fashion shows, parties, etc., catering to different sub-groups due to the different characteristics of these sub-groups, depending on feasibility and local conditions. Here, separate events may be required to address the different needs of the sub-groups within the community as well as to meet the overarching need to bring all the sub-groups together through joint events—again depending on feasibility and local conditions. For rural and semi-urban areas the events have to be suitably modified to provide a platform for service uptake. Ideally, this would also be the platform to link them to services with facilities through community events.□ Mixing information with entertainment¹⁰ ('Infotainment') (at least once a month) during DIC activities and field activities catering to different sub-groups in different venues, according to the needs of the various sub-groups besides the Kothis	
I-1c-	Draw the attention and interest of community members in the virtual space about different activities taking place in physical spaces in their respective geographical area	Virtual space activities include: <ul style="list-style-type: none">□ Information about events at the DIC/ TI level□ Infotainment at the DIC/TI level□ Information about all community activities	Extend participation from the virtual to physical spaces like DIC/TI level community events, infotainment/ edutainment and information sharing, peer influence and motivation towards uptake of services	

10 Community events and 'Infotainment' activities may also be combined with service delivery activities by balancing the immediate goals of service delivery and the long term goal of community mobilisation.

I-2a-	<p>Networki ng within the community: moving beyond peers and staff members of NGOs/CBOs by building ‘community affinity’ among different sub-groups at hotspot/hot-zone level (micro level)</p>	<p>Conducting community meetings; specific activities can be developed to bring MSM together in small groups initially, e.g., meetings (at least monthly) held by each PE with his/her contacts (30–60 as per guidelines)</p> <p>One-day community event (at least half yearly) by all PEs to bring all their contacts together (30–60 as per guidelines)</p> <p>Involvement of MSM in crisis prevention and response and management through pro-active networking and advocacy (see also Annexure, Crisis Response System)</p>	Community involvement and participation at hotspot/hot-zone level (micro level)
I-2b-	<p>Increasing peer engagement and MSM involvement in service delivery</p>	<p>Both sharing and displaying of programme budget by NGO with peers and community members to initiate the process of transparency and accountability, and to provide an impetus for community involvement and development.</p> <p>Ensuring peer-led outreach with the support of community mobilisation activities.</p> <p>Ensuring community-friendly services through community committees (see Annexure on Community committees) for ensuring community-friendly services and enhancing community involvement and engagement</p> <p>NB-The number of such committees may be decided according to the need for HIV and non-HIV services in the community, viz. service delivery like counselling and clinical services, advocacy and crisis prevention and management, networking and social entitlements, etc., where the number of committees will depend on practical needs and feasibility</p>	Greater representation and active participation of the community at need-based committees
I-2c-	<p>Increasing peer engagement and MSM involvement during the design, planning, implementation, monitoring, review and evaluation of project components</p>	<p>□ Encouraging community members to actively provide periodic feedback (at least quarterly) to check and ascertain whether the services meet their needs and are available, accessible, acceptable, and affordable to the beneficiaries, and also encouraging active participation (at least quarterly) of community members in monitoring, reviewing and evaluating activities at the TI level</p>	Community involvement in the design, planning, implementation, monitoring, review and evaluation of the project components through needs-based committees (Refer to Annexure on Project Advisory Committee Roles)

			<input type="checkbox"/> Active participation (at least monthly) of community members in the design, planning and implementation of the project, including in-house capacity building and key message and materials development exercises, at DIC, hotspot and cluster levels, and crisis prevention and management of groups at intervention sites	
	I-2d-	Increasing community ownership of the project at the beneficiaries, staff and management levels	Ensuring peer progression activities	Incidence of community progression from peer to ORW and other staff and to PM
II	II- NGO-CBO Level (Local level)	<p>Mobilising and strengthening MSM initiatives at the local level</p> <ul style="list-style-type: none"> <input type="checkbox"/> Initiating CBOs from NGOs, and strengthening systems of CBOs <input type="checkbox"/> Capacity building to strengthen community initiatives from NGO to CBO <p><i>[Note: Refer to NGO-CBO transition section]</i></p>	<p>Increase membership and enhance capacity-building of community groups through the following activities:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Increasing the membership of community groups or collectives through democratic processes <input type="checkbox"/> Capacity building of community leaders through SACS/TSU/ State <input type="checkbox"/> Training and Resource Centre (STRC) beyond classroom training, e.g., hand-holding for administrative, human resource and financial systems and welfare initiatives, social protection schemes and legal awareness related to individuals and organisations 	Presence of community initiatives with basic systems and procedures in place for community mobilisation

III	NACO			
IV	IV-SACS/TSU/ STRC Level (State level)	Strengthening of MSM CBO TIs at the state level	<ul style="list-style-type: none"> □ Facilitating the formation of CBOs in NGO-led TIs; addressing HIV and non-HIV needs by providing links between projects for social welfare and social protection □ Yearly peer conventions may be held at the state level to recognise community initiatives held in the previous year and to develop a focused plan for the next year that addresses HIV as well as non-HIV needs □ Facilitate state level community events through CBOs to mobilise the community, viz. 'Melukolupu' in Andhra Pradesh, Ghutari Sharif Mela in West Bengal, etc. 	<ul style="list-style-type: none"> □ The formation of CBOs leading to community ownership and sustainability in the long run □ More community members taking lead roles at state level to address key issues of the community □ Community mobilisation through community events for better response of the community to key issues
			Linking and docking (tying up) of these CBOs at the state level with other state government agencies to facilitate broader mobilisation by addressing MSM issues linked to national goals of progressive, rational and scientific thinking	More policy level programmes of state level networks linked and docked for broader mobilisation by addressing issues of MSM
V	V- NACO Level (National level)	Strengthening of MSM community ownership with SACS	Linking with other government agencies to address MSM issues linked to national goals of progressive, rational and scientific thinking	More policy level programmes of national level network linked and docked for broader mobilisation by addressing issues of MSM

Note: Community members here go beyond PEs and CBO/NGO community staff members who are actually termed as beneficiaries, clients and end-users.

Steps towards building Community Ownership at TI level: For service uptake and CBO formation

Formation of groups at PE level and strengthening of activities under the guidance of SAC/TSU

- A. Each registered MSM must be aware about the DIC space; the DIC venue and timings will be decided in consultation with at least 50 per cent of the registered and active population.
- B. All community events and programme budget expenditure will be planned in consultation with MSM and the ORW will hold consultation meetings at the peer site level. Over a period of time these decisions will be made by site groups.
- C. The TSU and STRC will prepare the ORW, interested community leaders at the TI level for the new roles of leadership, facilitator and advocacy.
- D. As per instructions of the SACS and contract each TI will display its budget in the office in the local language and will educate and update the staff and peers on the approved budget and expenditure during monthly meetings. PO TSUs will document the process and will ensure the same during every visit.
- E. Each TI will promote the selection of ORWs from the community based on the minimum requirements laid down in the TI guidelines.
- F. NACO will include a monitoring indicator on the number of groups formed and number of MSM involved in groups from each TI.
- G. Respective SACS have to issue instructions that each ORW will assist the PE, and
 - a. each peer will be from the community only
 - b. will form groups of MSM under her/ his coverage

- c. will conduct regular meetings
- d. will facilitate the selection of a President, Secretary and Treasurer.

No additional costs of community events are to be incorporated in the existing budgets of TIs. The SACS training budgets for TI staff will include the costs involved in the refresher trainings of all level of TI staff and peers. Bringing them together will also give them a group identity, leading to increased self-esteem and therefore improved negotiation skills, health seeking behaviour and safer sex practices. Transformation towards care for each other's health, economic and emotional needs will be cultivated and issues of violence by regular partners, harassment by police, local leaders, goons, etc., can be addressed.

3.5 Step 8: Creating an Enabling Environment

A supportive or enabling environment, which includes policies and legislations that address stigma, discrimination and violence, and psychosocial vulnerabilities, is critical to achieving universal access to HIV prevention, treatment, care and support. Activities to promote such an enabling environment, thus, will not be limited to advocacy with the immediate stakeholders around the TI implementing sites but include changing the negative attitude of the general public and health care providers towards same-sex attracted people. Both proactive and reactive advocacy strategies will be used by key stakeholders towards this end. Depending on the nature of the issue, the activities could involve training and sensitisation, legal reform, and partnerships with agencies working on human rights issues. Also, some of these advocacy activities will take place at the national level, some at the state level, district level or TI site level.

Table A. Key advocacy activities to create an enabling environment

No.	Advocacy Issues	Activities	Agencies to be involved			
			NACO	SACS	TIs	Other agencies
1	Mental health concerns of MSM	a) Training TI staff (especially the outreach team) on mental health concerns of MSM	Developing training module on 'Mental health concerns of MSM' for TI staff	Taking lead in these trainings at the state level	Outreach team (including additional in-depth training to counsellors) to use this knowledge to provide mental health counselling	
		b) Training of Health Care Providers (HCPs), including Mental Health Professionals (MHPs)	Advocating with Ministry of Health to include health concerns of sexual minorities (including mental health concerns) in the medical and nursing curriculum	--	--	Ministry of Health; Indian Psychiatric Society (IPS), Indian Association of Clinical Psychologists
			Developing a module for orientating/ sensitising existing HCPs and MHPs on these issues	To forge collaborations with state level medical and psychiatrist associations in conducting these orientation sessions	To assist STRC in selecting participants for such orientation sessions	Training agency to use supportive mental health experts as resource persons for these trainings

2	<p>Enabling MSM (especially MSM involved in sex work) to access social entitlements (identity documents, economic schemes)</p>	<p>Training TI staff (especially the outreach team) on these issues so that they can enable (through information dissemination, and guidance) their project beneficiaries to access such social entitlements. Although these issues are not specific to MSM, this approach could be used to attract the population (especially unreached MSM from economically/socially disadvantaged backgrounds) to TI services</p>	<p>Developing a module / information pack on the following :</p> <ul style="list-style-type: none"> □ Where and how to get these social identity documents □ What kind of social protection schemes are available and how to access them 	<p>SACS to conduct these trainings</p>	<p>Outreach team to use this knowledge to enable project beneficiaries to access social entitlements</p>	<p>In some cases referrals could be made to the National Legal Services Authority (NALSA), State Legal Services Authority (SALSA), District Legal Services Authority (DALSA), and SACS legal aid cells, where those exist</p>
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3	Advocacy with Police	<p>Training police personnel at all levels (using the Tamil Nadu model/UNAIDS nodal points)</p> <p>Note: Each training to have personnel from the same level to ensure a more open discussion and better interaction among the trainees</p>	Developing an appropriate training module (the Tamil Nadu model to be adapted/further developed)	<p>SACS to train a group of Master Trainers (selected from TI staff/community members)</p> <p>SACS to collaborate with state police authorities to conduct these trainings</p>	Master Trainers to be selected from the communities among other experts	DIG Police, Police Academies and other relevant government departments
		Orientation/sensitisation of police personnel at the local Police Station level	<p>Developing a training module for TI staff on legal rights, various laws that can/are being used against MSM and how to deal with police harassment/rights violations faced MSM</p> <p>Motivating SACS to initiate/scale up/strengthen their legal aid cells</p>	<p>SACS to train TI staff on these issues</p> <p>SACS to initiate/scale up/strengthen their legal aid cells and pro-actively take up cases of rights violations/police harassment</p>	To build rapport with the police stations within their project area	Human Rights Commissions, various organisations and agencies working on human rights issues, local lawyers (who have been sensitised regarding these issues)

4	Advocacy with Judiciary	<p>Sensitising judges (at the national, state and district levels) and lawyers</p> <p>Using Alternate Dispute Resolution (ADR), Lok Adalat for resolving conflicts/rights violations at the local level/rural settings</p>	To collaborate with relevant government ministries and departments, and other development partners to facilitate such sensitisation sessions	<p>Facilitating sensitisation sessions at</p> <p>the state and district levels</p>	Sensitising local lawyers/referring them to such sensitisation sessions carried out by SACS	<p>Judicial Academies, Ministry of Social Justice and Empowerment and Ministry of Law, HR Commission</p> <p>Development partners (such as UNDP), Human Rights Commission</p> <p>NALSA, SALSA and DALSA</p>
5	Advocacy with people representatives	<p>Advocating with MPs and MLAs, towards getting support from relevant ministries</p> <p>Ensuring community representation at the National AIDS Committee</p>	<p>Advocating with MPs regarding the need for NACO to work with MSM populations</p> <p>Advocating with the Parliamentary Forum on HIV/AIDS</p>	<p>Advocating with MLAs and with the State Level Legislative Forum</p> <p>Training TI staff/CBO board members to advocate with MLAs</p>	TIs to support SACS in advocating with MLAs	National AIDS Committee, Parliamentary Forum on HIV/AIDS, state level legislative forums
6	Crisis management at the TI level	Strengthening Crisis Management Cells (CMCs) with the TI to deal with crisis	Developing a training module for TI staff for the efficient management of CMCs	SACS to carry out these trainings	To involve CBO board members/community members to strengthen their CMCs	

3.3.6 Step 9: Role of District AIDS Prevention and Control Units in MSM TIs

The effectiveness of TIs can be enhanced to a great extent through coordination with other structures present in the district. One such structure is the District AIDS Prevention and Control Unit (DAPCU). During NACP-III, DAPCUs were established in high prevalence districts as part of a decentralised mechanism to facilitate, coordinate and monitor HIV activities at the district level. A DAPCU supplements the function of programme officers of TSU while extending support to TIs in the district.

The objective of a DAPCU is to enhance the quality of all HIV-related activities in the district and facilitate delivery of services to the vulnerable population including female sex workers (FSWs)/MSM/TGs. SACS may involve DAPCU as a part of a Joint Assessment Team during the assessment of NGOs for the selection of TIs in the district.

- Based on the monthly reports shared by TIs, DAPCU will facilitate coordination between different service facilities in the district like ICTC, DMC, DSRC, ART centre, etc.
- DAPCU will provide district-level insights on SACS on a regular basis and help SACS in formulating strategies for the district.
- Based on relevance, SACS will consider the feedback given by DAPCU while implementing programme related activities in the district.

In addition to the above, DAPCU will also help the TI programme in the following ways:

- Obtaining necessary support and commitment from the district

administration to help implement the Employer Led Model (ELM) for migrant interventions in industries in the districts.

- Finalising the route map for mobile ICTC and Mobile Medical Units under NHM in consultation with TI NGOs to cover vulnerable populations in hard-to-reach areas.
- Replenishment of stocks of commodities in TIs such as condoms, STI drug kits, etc., by leveraging support from NHM.
- Facilitating linkages of HRGs with ICTCs, DSRCs and PLHIV with the ART centre; flagging issues or raising concerns related to the timing of ICTCs, availability of counsellors and provision of quality services at the centres.
- Following up with key persons in various industries under ELM on migrant strategy.
- Coordinating with the ART centre, CSC, Help-Desk and line departments for facilitating extension of benefits of entitlements and social protection schemes to HRGs and PLHIV.

Chapter 3 – Operationalising Targeted Interventions for MSM Guidelines For SACS, TSU, and DAPCU

Steps in Mapping and NGO/CBO Selection

Step 1: Estimating the extent and nature of HIV risks and vulnerabilities among MSM through mapping

- Objectives of mapping/assessment
- Guiding principles and ethics
- Methodologies
- Organisations involved
-

Step 2: Analysing the coverage and quality of current TIs among MSM

- Analysing existing TIs
- Criteria for TI allocation
- TI unit size
- Geographic distribution of TIs: spread / density/rural/urban

Step 3: Recruitment and capacity building

- Recruiting NGOs/CBOs/networks
- Capacity building for NGOs/CBOs
- Underlining community role in outreach and peer-led interventions
- Gender and sexuality training

Step 4: Programme management

- Organisational roles
- Principles of SIMS
- Financial management

NACP has already conducted mapping exercises in all the major sites and robust data is available for the scaling up of coverage. NACO manages quarterly site validation in all TIs to ensure effective coverage of HRG populations. New hotspots are identified through the site validation process and HRGs are also estimated in each hotspot. The tools for site assessment are listed in Annexure 1.

VIRTUAL SITE MAPPING

Each SACS is responsible for initiating the process of mapping virtual sites for the state. Until now NACP has maintained a larger focus on physical sites and site-based outreach. Current TIs are geared to the idea of physical outreach and providing services to these sites. While even today this may be the most relevant in most of the TIs, it is being increasingly observed that there is a trend among MSM resorting to the use of communication technology to access other MSM and thereby sexual encounters. These sexual encounters do not necessarily take place in hotspots and recognised sites and therefore cannot be addressed using the current outreach strategy alone. Communication technology used by MSM mainly involves the internet as well as mobile phone networks. While mobile phone networks may still have connections with hotspots and physical sites, internet-based encounters do not have any rigid geographical basis. Interactions and meetings can happen amongst MSM irrespective of the city, state

2.1 Size Estimation and Site Assessment (Virtual)

or even country they are located in. Hence, within a TI paradigm, we may need to redefine 'site' as being physical or virtual.

It is necessary to mention that similar to the physical mapping of sites, it is important to map the number of internet users who 'cruise' on the internet and visit particular sites to assess the need for mapping and subsequent detailing of an internet-based outreach programme for a particular location. E.g., Mumbai may be more suited for an internet-based outreach programme compared to Nanded (a semi-urban site) in Maharashtra, based on primary and secondary data analysis of MSM populations and internet users.

Total number of active virtual sites

In addition to the process of listing down physical sites and the distribution of MSM across these sites, a similar exercise can be conducted for the internet. Although the MSM community may give feedback on the most used internet sites for a specific location it would be important to have an evidence-based decision making process. Most MSM/gay internet sites give location-wise data of individual profiles. Thus, the number of files for a specific location can be aggregated. Websites have different formats of sharing data; therefore, it is important to have a data gathering tool ready to standardise data details from different sites. This will make it easier to compare MSM data within and across states. **Refer to Annexure on virtual mapping** for suggested data gathering mechanism across sites.

Ethical concerns: Many MSM share their personal data and information on internet sites. Such data should be strictly used for academic purposes of mapping and determining efficacy of an internet based outreach programme. Consultants, policy makers and SACS should in no way interfere in community dynamics by creating profiles on

these sites to engage the community. Community engagement should be strictly restricted to CBOs and community-appointed staff after conducting thorough research on effective BCC and messaging through the internet.

Steps for virtual mapping:

Determine the number of MSM/gay internet sites in use in a state/city by conducting focus group discussions

- Use an existing community profile to log on to various internet sites.
- Go to the 'Users' section (remember that website layouts differ and hence it may be advisable to take the services of an individual from the community who can navigate them easily) and note the aggregate data of profiles registered under various locations. (Note: Details will be aggregated on the basis of state, city or even district. Note the number of profiles on a district-wise basis, or to the extent of smallest geographical unit available.) It is also important to look at travelling advertisements of profiles into a particular location (e.g., some locations may not have any local MSM, but have a huge population travelling from outside).
- Another aspect of mapping is tracking the online profiles of MSM/gay men on internet sites in a 24-hour cycle. (E.g., most people are active online from early evening till late night.) This exercise will be key to understanding internet outreach times for effective message delivery for BCC and outreach.
- A similar exercise for travelling profiles can be tracked for a year to understand the annual cycle of individuals travelling to particular locations. E.g., Darjeeling and Goa may have local MSM populations but may show a spiked increase during their respective tourist seasons.
- Mapping for a particular location can be

done purely on the basis of primary data from these internet sites. This can be further corroborated by secondary indicators such as internet coverage, and the number of internet subscribers on city/district basis. A high concentration of cyber cafes could also be considered an indicator as some towns/districts may have fewer personal internet connections but a strong cyber cafe subscriber base.

Determine the size of population that is accessing the sites in a certain state

It is important to note that the actual number of profiles need not necessarily translate into the actual number of MSM/gay individuals in a particular location. Many men have more than one profile on these sites and the result may be an inflated account of the actual numbers. Since there is no evidence based data on the number of profiles maintained by MSM/gay men on an average, it would be safe to discount the number of profiles by 20–30 per cent after a small dipstick survey of 100 individuals in a location. Moreover, very often people in smaller towns and districts park their profiles under the heads of larger towns and cities for anonymity, but continue to access and message individuals connected to their locations.

Prioritise the cities with 250 profiles and more

After discounting, any town/district/city that has more than 250 profiles should be considered for an internet-based outreach programme. At this stage it would always be wise to understand the composition of the profiles in terms of local/travelling profiles to give further inputs for outreach and BCC strategy.

Select the most appropriate TI and allocate the virtual TI to them

Ideally, it would be necessary to pilot the project in a particular location and further strengthen outreach and BCC strategy. Any internet-based intervention would require the following:

- Staff that is trained to use computers and has knowledge of internet and basic navigation on internet sites;
- All internet-based ORWs need to go through basic counselling modules to effectively handle internet communication;
- A dedicated computer for internet-based outreach at each TI;
- Good understanding of services within the TI, a strong physical site-based TI, and strong linkages and referrals to direct internet populations towards health seeking behaviour;
- A preferred private practitioner at each TI to refer internet walk-ins to paid services, decide indicators, targets, etc.

Plan a single-point intervention for the rest of the members of the state to be linked to one-point service with links to the local TI

Each SACS needs to take a decision on whether the internet outreach programme needs to be operated through a single-point contact put in place by the state or as an additional service provided by a TI. Initially, during the pilot it will be necessary to implement the programme rigorously. In areas where CBOs have adequate capacity, internet based outreach can be implemented through the CBO TI itself. At locations where such capacities are missing the SACS can take the onus of initially running the programme with recruitment from within the community and then transferring skills to the CBO TI.

Negotiating with websites to not be considered as spam

The site administration can be requested to give specific messaging rights to outreach profile

IDs. This will allow these IDs to send out BCC messages about HIV and access services without being labelled as spam. NACO needs to negotiate with the website owners at the national level.

Need assessment

Determine time and traffic (24-hour participant observation)

Determine peak time, counsellor access—if required, deciding shifts, number of staff for the intervention

Decide the quality of computer and broad band connection

Design the plan for linkages to services

Linkages to DAPCUs

Tools

Annexure 1 Site and needs assessment

Annexure 8 Broad mapping

Annexure 9 Mapping of virtual sites

2.2 Analysing the Coverage and Quality of Current TIs among MSM

2.2.1 Analysing existing TIs

In the state the first priority should be to complete size estimation of MSM by category.

Based on mapping and size estimation data, a set of analyses can help define the scope and scale of required TI coverage in the state:

- There should be a physical map of the state describing mapping data for each location and site.
- The data should include all the detailed information collected during mapping and site validation (e.g., locations of sex workers, typology, number/concentration by region).

- The map should also include information about existing TIs and their coverage.
- This geographic picture of the state will highlight the gaps in TI coverage. Based on these gaps, TIs can be configured or supplemented as per the criteria below.

2.2.2 Criteria for TI allocation

TIs should be allocated or, where they already exist, an analysis of whether they are able to saturate coverage of the existing MSM should be conducted, based on the following criteria:

- Locations where sizeable number of MSM exist with some TIs but not enough to cover 100 per cent of the MSM;
- Locations where TIs exist but coverage (outreach to MSM on a monthly basis of >80 per cent) is low to ensure economic efficiency—maximum coverage within existing TI (maximum may go up to 1,500);
- To achieve 90 per cent coverage of MSM.

2.2.3 TI unit size

Evidence shows that for interventions among MSM to be cost-effective and impact efficient, each TI unit should aim to provide services to 300–1500 MSM members.

If a particular NGO or CBO is already working with a larger population of MSM, and has the necessary capacity to provide a comprehensive package of services to them, it can be assigned more than one TI unit, depending on the actual size of the population it works with.

Similarly, even in areas where new TIs are to be started, an NGO/CBO can be assigned more than one TI unit, each covering 300–1,500 MSM, provided there are such numbers in a particular geography and the NGO/CBO has the appropriate capacity.

In some areas, the size of the MSM population may well be less than 300. In such instances the TI can address a composite group, that is, a combination of FSWs, MSM and TGs, and/or IDUs so that the total population size addressed by the TI unit is 300–1,500.

Thus, there are only two possible types of MSM TIs under NACP-IV:

1. TIs for a single core group, e.g., MSM-only or Hijra/TG-only TIs; and
2. Core composite TIs for multiple core groups, e.g., TIs for MSM and FSWs in a given geographical area.

2.3 Recruitment, Capacity Building and Programme Management

2.3.1 Recruiting NGOs/CBOs to implement TIs

Under NACP-I and II, the focus has been on implementing TIs through NGOs. NACP-IV (like NACP-III) aims to implement these through both CBOs and NGOs.

To bring about a systematic and transparent process for identification, field appraisal, selection, funding and monitoring of suitable NGOs, CBOs and networks, NACO has developed ‘NGO/CBO Guidelines’ and ‘Guidelines on Financial and Procurement Systems for NGOs/CBOs’, which serve the following functions:

- Delineate the process involved in calling for applications, partner identification, appraisal and contracting, capacity building of partners, monitoring and evaluation;
- Explain the steps in each stage and outline the process;
- Enable SACS/TSUs to establish procedures for the various stages by adapting them to specific contexts.

Each SACS is to recruit suitable NGOs and CBOs following the processes laid out in the guidelines to implement the number of TI units required to saturate coverage of the MSM mapped and estimated in the state. Interventions implemented and led by MSM themselves lead to faster and more effective and extensive coverage than NGOled interventions. In order to achieve this comparative advantage, CBOs and MSM require highquality capacity building. There are three possible types of interventions under NACP-III:

1. Funding of existing or new NGOs;
2. Funding of existing CBOs; and
3. Funding of NGOs along with capacity-building to help them transition to a CBOled model of intervention, with NGOs continuing to play a role in support and technical assistance.

Note on CBO selection and transition guidelines:

The CBO guidelines outline the process of CBO formation and development, either as offshoots of NGOs, or de novo (from scratch). It is critical to note that CBO formation takes time, and the percentage of funding expected to go to CBOs may vary based on the stage of existing interventions in states. For example, states with longstanding interventions and existing CBOs may be able to develop more CBOs which could be funded before States without longstanding intervention. To implement and operationalise the TIs and ensure quality services, the capacities of SACS/TSU and DAPCU, as well as the NGOs, CBOs or networks that will run the TIs, must be strengthened.

2.3.2 Capacity-building Plan for NGOs and CBOs Implementing TIs

Note: The budget for capacity-building will be earmarked under the SACS budget. If there is an STRC in the state, SACS will release TI training budget to the STRC.

Please refer to the training modules developed by NACO.

Table. Recommendations for capacity-building plan for MSM TI staff (position-wise) under NACP-IV¹¹

MSM TI project staff	Components									
	Outreach & BCC	STI/RTI Management	Referrals: ICTC, ART, etc.	Enabling Environment	Community Mobilisation	Financial Management	MIS and Documentation (M&E: Data analysis and use)	Project Management	Organisation Management	Commodities: Supply Chain Management
PD (Director)	Needs and sites assessment Outreach planning Sex, gender, and sexuality	Establishment and management of STI clinic Standards of care for STI	NACP-IV guidelines relating to referrals	Forming and managing community committees Advocacy skills and strategies Addressing structural barriers Knowledge about structural interventions	Community mobilisation and collectivisation for service uptake Meaningful involvement of MSM and TG communities	Fund flow Financial management in NGOs/CBOs Financial systems of NACO and SACS	Basics of MIS (importance & use) MIS for strategic decisions	Strategic planning and participatory approaches Project monitoring and evaluation skills Effective utilisation of funds in line with project	Developing HR policies Staff recruitment process Constant capacity building of staff: ways and means TI staffing policies	Supply chain management systems
PM (manager)	Need and site assessment Outreach planning (participatory approaches) BCC strategies Microplanning MSM and TG outreach strategies Mapping and line-listing of MSM, male-to-female transgender and hijra (MTH) populations	Establishment and management of STI clinic Clinical stock maintenance	Referrals and linkages (identifying, establishing and managing)	Advocacy skills and strategies Managing community committees Forming and managing SHGs	Community mobilisation and collectivisation for service uptake	Fund flow Budget management Financial guidelines of NACO/SACS	Programme indicators MIS formats Best practice documentation (case studies) Data management and decision-making skills	Team management (coordination, communication and supervision)	Stakeholder management	Condom and lube gap analysis Effective stock maintenance Evidence-based supply chain management

¹¹ Based on a review of MSM TI evaluation reports in NACP-III.

MIS Officer-cum-Accountant			Documentation relating to referrals and linkages				Data entry skills MIS formats Programme indicators Data validation Data analysis for decision-making			Feedback for supply chain management based on MIS
						NACP-IV financial guidelines Bookkeeping TI budget-line items of NACP-IV Grant management Financial report preparation (formats)		Financial analysis and decision-making skills		Budgeting and forecasting relating to supply chain management
Doctor		STI/RTI management Training on clinical operational guidelines Abscess management	Documentation relating to referrals					Managing clinical team		



Counselor	BCC strategies Counselling techniques and skills Counselling related to marriage Issues of married MSM Positive living Care, support, and treatment needs of PLHIV/continuum of care Sex, gender, and sexuality Alcohol and substance use	STI/RTI management COGS implementation	Referrals and linkages (identifying, establishing and managing)	Stakeholder management			M&E formats Programme indicators	Reporting and coordination skills Field supervision skills (managing ORWs and PEs)	Stakeholder management	Basics of supply chain management and its operations Stock maintenance and documentation skills
ANM		STI treatment protocols Counseling								
ORW	Outreach planning Outreach strategies BCC activities Sex, gender, and sexuality		Referrals and linkages (identifying, establishing and managing)	Non-health needs (knowledge) Social entitlements to communities (knowledge and operations) Stakeholder analysis	Community mobilisation skills	Activity planning within financial framework	Programme indicators Documentation skills (PE level)	Reporting and coordinating skills Field supervision (managing PEs)		Condom and lube gap analysis
PE	Basics of HIV/STIs Outreach strategies Sex, gender, and sexuality Microplanning	Positive prevention Barefoot counseling and communication					Documentation skills (Daily/peer dairy)	Reporting skills		Condom and lube gap analysis

2.3.3 Programme Monitoring

The project lifecycle of the TI follows a few phases of scaling up, which should be reflected in the monitoring and management of these TIs:

1. Scaling-up coverage
 - Mapping of MSM and defining where interventions need to be launched
 - Commissioning TIs to ensure saturated coverage of MSM at state level
2. Scaling-up infrastructure (0–3 months)
 - Improving infrastructure with respect to clinics and DIC (safe places).
3. Scaling-up intensity of service delivery (3–12 months)
 - Ensuring regular outreach contacts with >80 per cent of the population on a monthly basis
 - Ensuring regular STI uptake for the population on a monthly basis
 - Ensuring condom and lube availability and accessibility
 - Creating an enabling environment—crisis response, power structure mapping and analysis
 - Strengthening community initiatives—formation of community committees, seeding collectives, etc.
4. Scaling-up quality of service delivery (9–18 months)
 - Improving service delivery
Strengthening monitoring and evaluation of TI
Improving linkages with DAPCU and other local administration
 - Strengthening fund utilisation
Strengthening referrals to TB units and other OI/ICTC/ART referrals

- Building CBO systems

The process of monitoring takes place at three different levels:

- National level, by NACO/National Technical Support Unit
 - State level, by SACS and TSU
 - TI level, by NGO/CBO implementing the project
- National level
 - Analysis of SIMS data
 - Analysis of 31 indicators report (typology-wise)
 - Analysis of six monthly assessment of TIs
 - State review meetings
 - Support visits to TIs
 - Project Monitoring Committee meeting with SACS, TSU and NACO officials
 - Analysis of evaluation reports (once in two years)
 - State level
 - Joint visits by TSU and SACS
 - Monitoring and support visits by TSU (monthly and quarterly intensive visits)
 - SIMS and 31 indicator reports (monthly)
 - Quarterly assessment by TSUs
 - Six-monthly assessment of TIs
 - Quarterly review meetings of TIs
 - SACS conducting evaluations through third-party consultants (once in two years).
 - TI level
 - Analysis of form B (weekly basis) to plan outreach
 - Planning of outreach – form C (monthly)

- Tracking of HRGs through service tracking register
- Support visits by ORW (minimum 4/week) to PE hotspots
- Support visits by PM (minimum 10 days/month) to hotspots to monitor ORWs
- Weekly PE review meeting
- Monthly review meetings by Project Director in TI
- Visit by ANM/Counsellor/PM to DSRC/ICTC/ART centres to establish linkages

2.3.4 Programme management

A. Objectives of programme management (reviewed for second-generation TIs)

- To improve the quality and management of TI
- To effectively deliver project services to MSM
- To increase the coverage of, and uptake of services by MSM
- To provide training and handholding wherever required
- To identify and effectively fill gaps in TI implementation
- To set up efficient administrative and management systems to support these operations

B. Role of State AIDS Control Society

The overall responsibility of implementing NACP-IV in a state rests with the SACS. The SACS plans, monitors and manages TIs through partner organisations. It ensures the availability of adequate resources to accomplish goals and maintains the quality of interventions. The SACS provides support and necessary mentoring to achieve its objectives. It reviews and monitors all partner organisations to identify gaps in TIs and address them.

2.3.4.3 Role of Technical Support Unit

The TSU provides handholding support to TIs in the respective state along with SACS. It follows NACP guidelines developed by NACO and facilitates their implementation along with partner organisations. The TSU facilitates the design, planning, implementation and monitoring of sexual health interventions in the states on behalf of the respective SACS, and provides management and technical support to the SACS.

The TSU makes supportive visits to partner organisations and provides coaching and mentoring to NGOs and TI staff. It participates in periodic reviews of all partner organisations and provides necessary inputs. TSU staff includes project officers who visit TIs on a regular basis to assess the quality of STI services, outreach, and M&E.

BEING IN THE FIELD

The key to the successful programme management of TIs is field-level presence: TSU project officers should spend at least three weeks in a month visiting TIs to provide hands-on capacity building and problem solving support in three key programme areas: STI, M&E and outreach/community mobilisation.

D. Role of Nongovernmental Organisations

NGOs implement TIs in their respective project areas and achieve the objectives laid out by the project plan. The implementation of TIs follows the guidelines of NACP-IV. All NGOs report to SACS/TSU and can seek support wherever required. Each NGO prepares a project implementation plan along with its respective SACS/TSU. NGOs liaise with DAPCU, local health

authorities and other NGOs while implementing TIs. They work towards creating a CBO of MSM and strengthening it so as to build a sense of ownership of the project.

- TIs should report to SACS through SIMS every month without fail. In addition to a SIMS report, a TI is expected to send a 31 indicators report.

E. Principles of SIMS for TIs

As a result of the scale of TIs and the importance of information gathering, analysis and use by the project, NACO has developed a Computerised Strategic Information Management System (SIMS). The meaning of SIMS and its uses should be understood clearly by the community, partner NGOs/CBOs and SACS/TSUs.

- SIMS is not a means to find faults in the implementation process;
- It is not the gathering of information to be used only for research purposes;

It is not the gathering of quantitative information only;

- It is diagnostic, i.e., meant to identify opportunity gaps in project implementation;
- It is supportive, i.e., helps bridge opportunity gaps for optimum implementation of the project;
- It is participatory, i.e., the community, NGOs/CBOs and SACS/TSU are equal partners in monitoring;

F. Timelines and key indicators

Programme management occurs at the levels of the SACS, TSU, Joint Assessment Team, and TI/NGO. Teams from each of these groups play a role in monitoring project progress against indicators.

Annexure 10, 'Programme Management', lays out the inputs, outputs, timelines, and monitoring guidelines for each of the programme areas.

An example of the programme management framework, the 'Master Plan for TIs', is outlined below. This is for the programme component of BCC. Each other programme area (e.g., mapping, STIs, condoms, community mobilisation, peer engagement) has its own table like the one below.

Tools

Annexure 5: Dialogue based Interpersonal Communication by and with MSM

Annexure 10: Programme Management

Programme Component	Behaviour Change Communication / Interpersonal Communications
Prerequisites	<ol style="list-style-type: none"> 1. TI coverage area and denominator fixed 2. TSU contracted and fully staffed 3. NGO contracted and funded as per NACO guidelines 4. NGO outreach staff (esp. project coordinator, outreach workers, advocacy officer) recruited to cover intervention area as per staffing guidelines 5. Site validation process completed 6. Peer educators from HRG recruited to cover all sites as per peer selection guidelines
Input	1. Annexure 6a, <i>Tool for Dialogue Based Interpersonal Communication (IPC) By and With HRGs</i>
Output	1. IPC packages for risk reduction

GLOSSARY¹²

Men who have Sex with Men (MSM)

This term is used to denote all men who have sex with other men, regardless of their sexual identity or sexual orientation. This is because a man may have sex with other men but still consider himself heterosexual or may not have any particular sexual identity at all.

Hard-to-reach MSM

Hard-to-reach MSM are those MSM who are difficult to reach through traditional outreach strategies (cruising site- or hotspot-based) due to a variety of reasons that include constraints in the current programmatic approaches (e.g., lack of peer ORWs from other subgroups except predominantly kothi-identified ORWs). Hard-to-reach MSM include (but are not limited to) gay and bisexual-identified men, married MSM (irrespective of their sexual identity), same-sex attracted legal minors, older MSM, and non-self-identified MSM. Thus, non-self-identified MSM who practice same-sex sexualities but who do not self-identify with any sense of sexuality from such practices are also hard-to-reach MSM, because they do not identify with the social milieu and messages of much of the MSM-focused outreach and health promotion.

Non-self-identified MSM

A significant proportion of MSM who practice same-sex sexualities do not have a self-identity

related to those practices and can be referred to as 'non-self-identified MSM'. In general, the term 'MSM' refers to both MSM with self-identities such as gay, bisexual and kothis, as well as MSM who do not self-identify with any of these terms. However, in India, these days the term is frequently equated with feminine self-identified same-sex attracted males such as kothis and used as a euphemism to refer to same-sex oriented/attracted men. Hence, the current situation necessitates the introduction of the term 'non-self-identified MSM' to refer to those MSM who do not have any sense of identity related to their same-sexual practices. The introduction of this term is not intended to promote an idea that all MSM should self-identify with a sexual category or label. Rather this term is used to raise awareness among policymakers and national/state HIV programme managers that a significant proportion of MSM may not self-identify with terms such as kothi and gay, and importantly, they may not even think of themselves as 'men who have sex with men'. Complementary HIV prevention strategies are needed to provide safe sex messages and other services to this vulnerable population.

Kothi

Kothis are a heterogeneous sub-group of MSM. They can be described as biological males who show varying degrees of 'femininity', which may be situational (only expressed in specific contexts). Some kothis have sex with or are married to women. Kothis are generally from lower socio-economic backgrounds and some engage in sex work for survival. A proportion of hijra-identified people may also identify themselves as kothi but not all kothi-identified people identify themselves as hijras or even TG.

12 **Most of the above definitions have been adapted from:** Chakrapani, V; Kavi, A R; Ramakrishnan, R L; Gupta, R; Rappoport, C; and Raghavan, S S (2002). *HIV prevention among men who have sex with men (MSM) in India: Review of current scenario and recommendations*. SAATHII, Chennai, India. Available at: www.indianLGBThealth.info; Chakrapani, V; Newman, P A; Mhaprolkar, H; Kavi, A R (2007). *Sexual and social networks of men who have sex with men (MSM) and Hijras in India: A qualitative study*. The Humsafar Trust, Mumbai, India. Available at: http://www.indianlgbthealth.info/Authors/Downloads/Report_SxlNetworks_MSM_Hijras_Apr_07.pdf

Panthi

In most states of India, the term 'panthi' is used by kothis and hijras to refer to their masculine insertive male (regular or casual) sexual partners or anyone who is masculine and seems to be a potential sexual (insertive) partner. The equivalent terms used in different states are Gadiyo (Gujarat), Parikh (West Bengal), and Giriya (Delhi).

Double Decker

Kothis and hijras label men who insert and receive during penetrative sexual encounters (anal or oral sex) with other men as 'Double' or 'Double Decker' or even 'DD'. These days, some proportion of such persons also self-identify as 'Double' or 'DD'. Other terms that are used in some states include 'Dupli' or 'Dho Paratha'.

Gay man (here 'gay' is a self-identity)

A gay man may be understood as someone who has significant (to oneself) sexual or romantic attractions primarily to members of the same gender or sex, or who identifies as a member of the gay community. One may identify as gay without identifying as a member of the gay community and vice versa. Though 'gay' is a common term for male and female same-sex attracted persons, it is more often used to denote same-sex oriented men. Self-identified gay men do not necessarily have sex only with men, but occasionally may engage in sex with women, especially in countries such as India where adult men face considerable social pressure to marry and/or practice heterosexuality.

Bi-sexual man (here 'bisexual' is a self-identity)

A bisexual man may be understood as someone who has significant (to oneself) sexual or romantic attractions to members of the same gender and/or sex and another gender and/or sex. People who are attracted to members of both genders or sexes may be monogamous, polyfidelitous or non-monogamous.

Sexual orientation

One's erotic, romantic, and affectional attraction. It could be to people of the same sex/gender, to the opposite sex/gender, or to both sexes/genders.

- **Heterosexuality:** Erotic, romantic, and affectional attraction to people of the opposite sex/gender.
- **Bisexuality:** Erotic, romantic, and affectional attraction to people of both sexes/gender.
- **Homosexuality:** Erotic, romantic, and affectional attraction to people of the same sex/gender.

Identity

How one thinks of oneself, as opposed to what others observe or think about one. However, there is a close symbiosis in societies between the formation of a sense of self-identity and the social and cultural application of labels to describe people. Identities are not acquired in isolation and are profoundly social in character.

Sexual minorities or sexual minority community

Refers to lesbian, gay, bisexual and TG/transsexual persons as well as persons with other identities (such as kothis and hijras) as a minority group in a predominantly heterosexual population. These days, the terms 'sexual minority communities' or 'sexual minority populations' are used to stress that, like the people they comprise, these communities or populations are diverse.

Annexure 1: Site and Needs Assessment

Exercises for site assessment

1.a Number and Trend Map ('How Hot is the Spot?')

Respondents: Visible and self-identified MSM

Location: All hotspots identified through broad mapping, and any other hotspot that might be subsequently identified through the course of the mapping exercise at the site

Process

1. Settle respondents in with an icebreaker.
2. Ask the group to draw a map of the local area, including local landmarks to orient the map. Ask them to mark the hotspots they themselves frequent, in reference to the landmarks.
3. Ask the group to rank the hotspots using symbols for high, medium and low according to the level of risk practice that puts key populations (KPs) at risk of HIV/STI infection at different hotspots.
4. Ask the respondents why they have marked different hotspots differently—is it according to the numbers of MSM who frequent each hotspot or the particular risk practice usually carried out at the hotspot which may carry more or less risk of HIV/STI transmission, or the frequency of risk practice, or any other reason? Let the KPs suggest their own reasons rather than asking them leading questions. Do not contradict unless you have to clear misconceptions and myths.
5. Ask respondents to look at the hotspots ranked as high. Ask them to discuss what kind of change is required to make the location medium or low ranking. Then ask what individual KPs or small peer groups could do to reduce risk practice in these locations. Again, do not contradict unless you need to clear misconceptions and myths.
6. Ask respondents to estimate the numbers of

MSM of different categories (e.g., kothi, double decker, panthi, etc.) who usually frequent each hotspot on an average day. Let respondents debate among themselves to arrive at figures that most members of the group are happy with. Against each hotspot on the chart, ask respondents to use different symbols for different categories of MSM and add the corresponding number next to each symbol (numbers can be represented through symbols too).

7. Ask respondents to draw a clock (or a line representing 24 hours of a day) and indicate on it the time of the day that the numbers they have mentioned are to be found at the hotspot. Ask them to mark (with + and – signs, or with spots or bindis) different hours of the day to indicate how that number might fluctuate during the day.
8. Ask participants to draw a line indicating the seven days of a week and make them similarly mark it to indicate fluctuations observed during the week.
9. Ask them to add symbols against the hotspot to indicate events or festivals in a year when the number might significantly go up or down.
10. Finish the session by asking the group to reflect on what they have shared and learned during the session which would be useful for them.
11. At the end of the session, note down the date, place, number of respondents (disaggregated by MSM categories) and mapping team number on the back of the chart paper.

Outputs

1. Estimated numbers of different MSM categories in different hotspots
2. Timings when the MSM are available at the hotspots (daily, weekly and special annual events or festivals)

1.b Seva Chitram (Services Map)

Purpose: To assess availability and accessibility of different services for KPs at the site

Respondents: Visible and self-identified MSM

Location: All hotspots identified through broad mapping, and any other hotspot that might be subsequently identified through the course of the mapping exercise at the site

Process

1. Ask the participants to draw a map of the site, including a few main landmarks, and ask them to indicate the hotspot where the KP mapping team contacted them.
2. Ask the participants to include in the map any places or people that their HRG group could go to, to get support for HIV/STI prevention and treatment.
3. Ask the participants to add against each intervention:
 - What each service provides
 - How each service helps reduce risk of HIV/STIs
4. Now ask the participants to rank the services high, medium, or low according to how accessible they are to KPs like themselves (how often they access or utilise the services—often, sometimes, never).
5. Ask them to identify factors that make them use the services marked high or medium (such as distance, cost, behaviour of service providers, confidentiality, effectiveness of services provided, availability and timing, and so on).
6. Now ask them to discuss the services ranked with low accessibility. What could be done to make these important services more accessible to MSM like themselves?
7. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.
8. At the end of the session, note down the date, place, number of respondents (disaggregated by MSM categories) and your mapping team number on the back of the chart paper.

Outputs

1. Location of different HIV/STI related services in the site
2. Range of services offered by each service provider
3. Criteria by which KPs judge a service to be accessible and available
4. Recommendations from KPs on how to make services accessible and available to them

1.c Why is it so?

Purpose: To help KPs analyse the range of risk and vulnerability factors they experience that increase their susceptibility to HIV/STI transmission. This is will help identify the strategies and intervention components that have to be put in place to enable them to avert the risks.

Respondents: Visible and self-identified MSM

Location: All hotspots identified through broad mapping, and any other hotspot that might be subsequently identified through the course of the mapping exercise at the site

Process

1. Ask participants to name the different kinds of behaviours that put people at risk of HIV/STI infection. Correct any misconceptions.
2. Pick one of the risk behaviours.
3. Ask them to draw a symbol of this risk behaviour in the centre of the flipchart inside a circle.
4. Ask 'Why is it so?' and ask them to draw and or write the reasons for the risk behaviour in balloons.
5. Keep asking 'Why is it so', adding further reasons in connecting balloons until they can think of no more.
6. Ask the participants what the diagram says about the following questions:
 - What are the most important reasons (vulnerability factors) for risk behaviour?
 - What are the ways in which HRGs already try and reduce risk behaviour?

- What would further help the HRG avoid the risk behaviour mentioned in the diagram?

7. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.

8. At the end of the session, note down the date, place, number of respondents (disaggregated by KPs and non-KPs) and your mapping team number on the back of the chart paper.

Outputs

1. The factors that make particular categories of KPs vulnerable to HIV/STI risks
2. Recommendations from KPs about how to address some of these factors and risk reduction strategies

1.d Sex Life

Purpose: To explore the range of sexual partners of KPs. This method will also indicate the kinds of sex acts usually practised by MSM with their sexual partners, which will help estimate the volume of penetrative/ receptive sex, and therefore project needs for condom supplies.

Respondents: Visible and self-identified KPs

Location: All hotspots identified through broad mapping, and any other hotspot that might be subsequently identified through the course of the mapping exercise in the site

Process

1. Administer this method on a one-to-one basis with an individual HRG.
2. Ask the KP to put themselves at the centre of the chart.
3. Ask him to draw pictures of his sexual partners all around his own picture in the middle and describe the partners (without naming them)—who they are, what they do, how old they are, how they are related to the individual, how they met, etc.

4. Then ask the HRG to indicate against each partner's picture or symbol what kind of sex he had had with the partner in the last one week, and how many times.

5. At the end of the session, note down the date, place and mapping team number at the back of the chart paper.

Outputs

1. The range of sexual partners KPs have—clients (for MSM in sex work), panthis, boyfriend/ husband, fellow kothis, wife (in case of married MSM), other women (MSM having female sexual partners), etc.
2. The proportion and frequency of penetrative sex acts they engage in and with which category of sexual partners

Capacity Standards for Participatory Site Assessment with KPs

Rather than use site assessment as a one-off process to begin a project, many organisations carry out site assessment on a regular basis to review their programmes. For this reason, capacity standards have been developed in a way that organisations can continually improve their site assessment implementation, outputs and outcomes.

The site assessment capacity standards mentioned below are not indicators which can be objectively measured; rather they are designed to stimulate discussion in the organisation so that creative ways to optimise the site assessment process can be found. The capacity standards should be used in planning, and then checked throughout the site assessment. The scores are intended to indicate where an organisation needs to take action to maximise the impact of their site assessment. The basic capacity standards in this guide are useful only to the extent that users are committed to honest and critical reflection, and they can be

used by organisations (with or without an external facilitator) to identify their own capacity-building needs, plan technical support and monitor and evaluate their site assessment progress.

Scoring of capacity standards can be carried out using the scores below:

DK = Don't know or not applicable

1 = Needs urgent attention

2 = Needs major improvement

3 = Satisfactory, room for some improvement

4 = Satisfactory, room for a little improvement

5 = Exemplary, cannot be improved

Although difficult, a frank and critical approach will mean that the final scores are more meaningful and useful to the organisation. In particular, participants should think carefully before assigning a '5'—is there really no room for improvement? Even if the standard is being reached, are there opportunities to improve the quality of the work?

Capacity Standards for Site Assessment with KPs	DK	1	2	3	4	5
1. Methods used in site assessment should be dialogue-based, highly participatory and give the KPs in the site the opportunity to analyse barriers to reducing HIV risk and find solutions. In other words, in addition to generating information, site assessment should mobilise KPs and strengthen their ability to critically reflect on reducing HIV risk.						
2. Reporting formats should be developed which are easy for site assessment team members to use. The team should meet at the end of each day to assess the information generated, look at what gaps still remain and to plan site assessment activities for the following day.						
3. During site assessment, the teams need to be very careful to keep information secure and confidential. They must also take care not to make false promises or raise unrealistic expectations about what will happen after the site assessment.						
4. At the end of site assessment, a feedback and project design or planning meeting needs to be held immediately afterwards. All the main stakeholders, including the site assessment team members and HRG representatives from the site, should be present. The site assessment team members should have time before this meeting to organise and decide how to present findings to make sure that confidentiality is maintained.						
5. If nothing happens or there are no changes in the site after site assessment, the momentum will be lost. Prior to site assessment, funding must be secured for follow-up activities. Any activities initiated by the KPs themselves as a result of site assessment should be applauded and supported.						

Annexure 2: Terms of reference for TI staff

2.a (Project Director)

One representative from the executive body/ governing body of the agency contracted with SACS is to be designated as Project Director.

The project director will be the sole person responsible for any communication with the State/District/Municipal AIDS Control Society. He/She will be one of the signatories to the contract and bank account designated for the project. In addition, a project director must:

- Ensure the appointment of all staff and PEs according to the proposal approved by SACS and be responsible for all documents pertaining to the staff in the project office;
- Conduct monthly project progress review meeting and attend other project level meetings as often as possible;
- Attend SACS meetings as and when required;
- Take the lead in networking with key district level officials such as district

magistrate, superintendent of police, and other department officials to sensitise them about the project activities, HIV/AIDS and the role of community;

- Participate in advocacy efforts with key stakeholders at the district level (political and religious leaders, other service providers, social welfare schemes, etc.);
- Ensure coordination of project activities with other HIV/AIDS services in the district by engaging DAPCUs and District Health Society;
- Supervise project activities and ensure financial integrity of the project;
- Ensure safekeeping of purchased assets and project documents in the project office and their maintenance as per guidelines.
- Ensure handover of unspent balances of the project account, assets and all other documents/records related to the project within 15 days of closure of the contract, or intimate the SACS in case of delay. Obtain a No Objection Certificate from the competent authority of SACS after handing over and settle all accounts of staff and SACS to avoid legal action as per requirements under the contract.

2.b (Project Manager)

Recruitment Qualifications	
Education	<p>Postgraduate degree in any social science discipline (preferably) with 1 year experience of working with district level programmes related to health, livelihood programmes, rural development, microfinance, and HIV/AIDS programmes.</p> <p>Graduate degree in any social science discipline with minimum three years' experience in the development/health sector at district level programmes related to health, livelihood programmes, rural development, microfinance and HIV/AIDS programmes.</p>
Knowledge and skills	<ul style="list-style-type: none"> <input type="checkbox"/> Familiarity with government health policies and programmes <input type="checkbox"/> Strong communications skills <input type="checkbox"/> Ability to work in small teams, flexible ways of working <input type="checkbox"/> Proficiency in data analysis, report writing, case study compilation <input type="checkbox"/> At least 10 days of field visits required <input type="checkbox"/> Overall management capacity, ability to monitor, report and guide a team
<p>Summary of key functions:</p> <p>The project manager will be responsible for managing the overall programme in close coordination with the SACS and implementing agency. He/she is to liaise closely with government departments at the district level, SACS and TSU; conduct data analysis and prepare monthly reports for review and reporting to SACS; review the performance of TI staff; prepare need-based monthly action plans and follow-up on action points; facilitate SACS and TSU visits.</p>	
<p>Duties and responsibilities:</p> <p>Programme Management</p> <ol style="list-style-type: none"> Overall in-charge of the TI; responsible for ensuring the functioning of the project as per NACO operational guidelines; Achieve project deliverables as per project targets; Work out of the field office, organising weekly review meetings and supervising the work of all other staff; Establish linkages with other referral services, stakeholder meetings and advocacy; Organise in-house capacity-building of the project staff; Travel to the project area/hotspots for purposes related to TI programme implementation like supervision of PE/ORWs and interaction with KPs. Field visits should last about 10–15 days in a month, and records of the field visit should be maintained; Assist PD to organise advocacy and linkage activities; Analyse the progress of project activities and share it with action points during the monthly project staff meeting; Assess the capacity-building requirements of project staff and share them with action points during the monthly project staff meeting; Monitor the transit intervention activities wherever applicable; Conduct weekly/biweekly/monthly review meetings with project staff and PEs. <p>Reporting</p> <ul style="list-style-type: none"> <input type="checkbox"/> Report to the PD on the project and TI nodal officer at SACS and/or PO at TSU; <input type="checkbox"/> Timely submission of monthly programme performance data in SIMS/CMIS or other reporting format; <input type="checkbox"/> Submission of SOEs; <input type="checkbox"/> Provide data/information required for preparation of reports. 	
<p>Training requirements</p> <p>Programme management, supervision and monitoring skills, team building skills, data analysis, community-based monitoring and rapport building, advocacy and networking.</p>	

2.c (Monitoring & Evaluation Assistant cum accountant)

Recruitment Qualifications	
Education	Graduate degree in mathematics, economics, statistics or commerce, trained in basic computer software applications
Experience	<p>Minimum of 2 years of work experience which includes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Experience in data management, monitoring and evaluation tools, data quality checks, analysis and interpretation of data on programme performance <input type="checkbox"/> Maintaining financial records/accounts <input type="checkbox"/> Knowledge and experience in health and social development sector will be an added advantage
Knowledge and skills	<ul style="list-style-type: none"> <input type="checkbox"/> Proficiency in computer data management and analysis using computer software <input type="checkbox"/> Familiarity with government health policies and programmes, strong communication skills <input type="checkbox"/> Ability to work in small teams and flexible way of working
Summary of key functions Responsible for managing all programme, physical and financial data; updating of information on daily basis; computerisation of outreach and project level data and consistency and quality checks of data; conducting data analysis; preparing monthly reports for review and reporting to SACS.	
Duties and responsibilities Under the direct supervision of the PM of the TI, the M&E cum accountant will be responsible for performing the following functions:	
Monitoring & Quality Assurance: <ul style="list-style-type: none"> <input type="checkbox"/> Computerisation of outreach, clinical and project level data on a daily basis; <input type="checkbox"/> Conduct continuous analysis of data and provide analytical reports for weekly and monthly review; <input type="checkbox"/> Individual tracking of KPs for project services; <input type="checkbox"/> Identify potential problems in reported data to improve data quality; <input type="checkbox"/> Conduct field visits to ensure data quality along with handholding of outreach teams on MIS formats; <input type="checkbox"/> Liaise with SACS and TSU teams for programme performance reporting; <input type="checkbox"/> Prepare SOEs and submit them to the PM and PD. 	
Reporting <ul style="list-style-type: none"> <input type="checkbox"/> Report to the PM; <input type="checkbox"/> Timely submission of monthly programme performance data in SIMS/CMIS or other reporting format; <input type="checkbox"/> Preparation and submission of SOEs; <input type="checkbox"/> Provide data/information required for preparation of reports; <input type="checkbox"/> Compile field level information for operational reports when required by SACS; <input type="checkbox"/> Assist in the preparation, writing, and editing of all reports required by SACS or TI project—e.g., specific annual report, field study reports, event reports, etc.; <input type="checkbox"/> M&E assistant to travel to the project area/hotspots for purposes related to the TI programme; <input type="checkbox"/> Implementation work with PE/ORW and interaction with KPs to ensure quality data capture. M&E assistant should visit the field for about 8–10 days in a month. 	
Training requirements <ul style="list-style-type: none"> <input type="checkbox"/> Basics of financial accounting and financial documentation; <input type="checkbox"/> Basics of SIMS reporting, performance indicators; <input type="checkbox"/> Knowledge of MS Office—Excel, Power Point—for preparation of analytical reports, presentations; <input type="checkbox"/> Data quality assessment at the field level, triangulation with different sets of data for data validation and quality checks. 	

2.d (Counsellor)

Recruitment Qualifications	
Education and experience	<p>Postgraduate in psychology or social work with a regular course</p> <p>In case a person with the above qualifications is not available, a candidate with the following qualifications and experience may be considered: Graduate in psychology or social work (only with regular course) with minimum two years' work experience in counselling or working with TIs/Adolescent Health Programme/mental health setting/substance abuse.</p> <p>Candidates who have obtained correspondence course degrees will not be eligible for this post.</p>
Knowledge and skills	<ul style="list-style-type: none"><input type="checkbox"/> Familiarity with issues related to MSM and their families;<input type="checkbox"/> Strong communication and mobilisation skills;<input type="checkbox"/> Ability to work in small teams, and flexible way of working;<input type="checkbox"/> Proficiency in report writing, case study compilation;<input type="checkbox"/> At least 10 days of field visits required;<input type="checkbox"/> Overall management capacity to monitor, report and guide a team in the absence of a project manager or any other task provided by the team.
Summary of position	
<p>Key functions</p> <p>Responsible for managing, providing counselling and communication support to the programme in identifying individual or group behaviour including opportunities or challenges which have implications on the HIV/AIDS programme; identifying motivating and inhibiting factors among individuals or their family members and among groups which need to be addressed through BCC sessions by outreach team as well as through one-on-one or one-to-group counselling sessions; ensuring confidentiality while dealing with individual cases; ensuring participation in project based clinics, preferred provider clinic, health camps; and maintaining patient registers, dispensing medicines, demonstrating condom use, counselling on condom negotiation skills and use of lubricants, etc.</p>	

Duties and responsibilities

Counselling and BCC:

1. Conduct individual and group sessions on HIV/AIDS, STIs, safer sex practices, etc.
2. Engage in family counselling
3. Demonstrate condom use, provide counselling on condom negotiation skills
4. Motivate clients towards regular general medical check-ups, referral of clients to ICTC, STI clinic, ART, etc.
5. Conduct orientation for ORWs on counselling techniques and coordinate the outreach based BCC and psychosocial support activities
6. Look into the counselling requirements of the female sex partners, wives of MSM and motivate them to avail HIV-related services (ICTC, STI treatment, etc.)
7. Develop BCC materials that are suitable for the local context, follow-up with clients both in the DIC and in the field, and maintain records as per prescribed formats
8. Identify individual or group motivating or inhibiting factors which need to be addressed for health seeking behaviours, condom use, decline in domestic or group violence, addressing issues related to self-esteem, communitisation of groups, etc.
9. Use the above areas to guide the outreach team to address these issues through specific need-based BCC sessions
10. Management of the clinic, especially recordkeeping, management of patient flow, visits to the clinic sites or preferred providers and dispensing of medicines.
11. Coordinate with the M&E assistant cum accountant to identify the hotspots/sites with low service uptake, increasing number of defaulters.
12. Prepare a plan along with ORWs to improve linkages with ICTCs and ensure sharing of line listing of referred clients from TI to ICTC, maintenance of referral cards and referral registers
13. Along with M&E assistant cum accountant, ensure timely reporting of condom stocks, STI and other general medicine stocks to DAPCU, SACS, TSU or TSG as per requirement
14. Participate in the site validation process and update site validation and quarterly line listing of KPs of the project along with the M&E assistant cum accountant
15. Participate in stakeholder meetings and prepare a stakeholder engagement plan to ensure that the issues related to BCC and service uptake are addressed
16. Travel to the project area to ensure provision of services in the field—field visits should extend to about 10–12 days in a month
17. Engage with providers of social welfare services and facilitate linkages with social welfare services

Reporting

- ☐ Report to the PM
- ☐ Provide the data/information required for the preparation of reports
- ☐ Prepare at least 12 case records in the prescribed format and create a risk management plan for KPs or their regular clients
- ☐ Maintain records on referrals to other services, patient register, follow-up register, referral cards, reconciliation of referral cards, patient cards, condom stock and issue register, bio-medical waste management register, medicine stock and issue register, social marketing of condoms register or any other documents as per requirement

Training requirements

- ☐ Supervision and monitoring skills, team building skills, good listening skills, case-record compilation, risk assessment and management plan, condom demo and re-demo, lubricants, basics of STI and HIV/AIDS, community based monitoring and rapport building, advocacy and networking, clinical record maintenance.

2.e (Outreach workers)

Recruitment Qualifications	
Education and experience	<ul style="list-style-type: none"> <input type="checkbox"/> Education at least up to 8th standard with good knowledge of the local community and local language <input type="checkbox"/> Preferably from the MSM community <input type="checkbox"/> In the case of candidates from the community, PEs who have performed well for at least the last 3 years and can read and write may also be considered for the post of ORW
Knowledge and skills	<ul style="list-style-type: none"> <input type="checkbox"/> Strong communications skills <input type="checkbox"/> Ability to work in small teams, and flexible way of working <input type="checkbox"/> Proficiency in data analysis, report writing, case study compilation <input type="checkbox"/> At least 20 days of field visits required <input type="checkbox"/> Capacity to monitor, report and guide a team
Summary of position	
<p>Key functions</p> <p>Responsible for overall planning of service delivery in the field for behaviour change or service uptake; along with PEs and ORWs, planning counselling sessions by counsellor, clinic services by visiting physician or preferred providers, advocacy and networking with stakeholders; supporting the PEs and facilitating their work for efficient and effective coverage of KPs; maintenance of records of the outreach team and reporting to the project; Building rapport with the target population, and mobilising them for various services; working with M&E assistant for data recording; and ensuring field training of PEs.</p>	
<p>Duties and responsibilities:</p> <p>Planning and management</p> <ol style="list-style-type: none"> 1. Prepare micro-plans for each hotspot, monitor the implementation and review of the plans 2. Facilitate and build capacity of PEs to implement outreach activities as per the required norms of the project 3. Ensure micro-plans and line listing are updated on a quarterly basis and are shared with the project for MSM 4. Prepare a monthly action plan for each hotspot, ensure adequate supply of condoms, lubricants and BCC materials for each hotspot 5. Hold discussions with the counsellor on a monthly basis to understand the hotspots or sites with poor service uptake, increasing number of dues and overdue so that necessary follow-ups can take place and micro-plans can be updated 6. Hold discussions with community members and other stakeholders while preparing the micro-plan and ensure field level support for the smooth implementation of the project 7. Identify potential volunteers and use their services for the programme. Competent volunteers fulfilling necessary criteria may be engaged as PEs after complying with necessary guidelines <p>Supervision and monitoring</p> <ol style="list-style-type: none"> 1. Take charge of outreach and supportive supervision of PEs, counselling, linkages, etc. 2. Ensure at least 20 days of field visits in a month to assigned areas and to the nearest preferred providers, ICTC/ FICTC where referrals are made 3. Ensure maintenance of weekly peer diaries, monthly report collection from PEs, submission of own reports to the project office 4. Facilitate crisis response activities 5. Ensure all new contacts of each PE are being covered by him/her 	

Advocacy and networking

- ☐ Take charge of stakeholder management—involve and take support from stakeholders in the implementation of the programme in the area
- ☐ Maintain records of free condoms and lubes received from the project and distributed by self or PEs or outlets
- ☐ Identify and manage condom social marketing outlets as per guidelines
- ☐ Ensure supply and management of IEC materials for use in outreach sessions
- ☐ Prepare the clinic site or health camp sites by mobilising the community for health check-ups or HIV testing and counselling

Commodity supply and management

- ☐ Be responsible for demand analysis of condoms and lubes in the field and ensure distribution by peers or through social marketing outlets in the field
- ☐ Maintain records of free condoms or lubes received from the project and distributed by self or PEs or outlets
- ☐ Identify and manage condom social marketing outlets as per guidelines
- ☐ Ensure supply and management of IEC materials for use in outreach sessions
- ☐ Prepare the clinic site or health camp sites by mobilising the community for health check-ups or HIV testing and counselling

Reporting

- ☐ Report to PM
- ☐ Provide data/information required for preparation of reports
- ☐ Maintain records on referrals to other services, follow-up register, reconciliation of referral cards, patient cards, condom and lube stock and issue register for distribution in the field, medicine stock and issue register if required, list of social marketing outlets and their follow-up, and other documentation as per requirement.

Norms: For MSM TIs = 1: 150 – 250 KPs; for cor composite TIs with MSM component = 1: 100 – 300 KPs

Training requirements

- ☐ Supervision and monitoring skills, team building skills, good listening skills, condom demo and re-demo, basics of STI and HIV/AIDS, advocacy and networking, crisis management, clinical record management.

2.f PEs

Recruitment Qualifications	
Criteria and experience	<ul style="list-style-type: none"><input type="checkbox"/> Preferably literate with good knowledge of the local community, and in the case of MSM community, should be from the same target group<input type="checkbox"/> Selection should be done through a process of peer progression among the volunteers associated with the project by way of helping in community sensitisation, clinic services<input type="checkbox"/> Should be from the community in terms of their occupation, typology and age group<input type="checkbox"/> Stakeholders, pressure groups, or members of power structures, family members of the KPs should preferably not be engaged with PEs.
Knowledge and skills	<ul style="list-style-type: none"><input type="checkbox"/> Strong communication skills and knowledge of community structures, community dynamics, power structures within and outside the community that control the community<input type="checkbox"/> Ability to work in small teams, and flexible way of working<input type="checkbox"/> Ability to maintain simple field records and work in a team to complete pending works<input type="checkbox"/> Identifying with issues of the community and not idolising their behaviours<input type="checkbox"/> Good motivation and rapport-building skills

Duties and responsibilities:**Planning and management**

- ☐ Along with other project staff, prepare micro-plans, calculate demand analysis of various commodities
- ☐ Prepare weekly/monthly action plans for each hotspot, ensure adequate supply of condoms, lubes and BCC materials at each hotspot
- ☐ Hold discussions with community members and other stakeholders while preparing micro-plan to ensure field level support for the smooth implementation of the project
- ☐ Ensure follow-up of STI and HIV-positive cases, home visits to KPs who have not turned up for RMC or HIV testing

Advocacy and Networking

- ☐ Hold discussions with and take support from the stakeholders to ensure smooth implementation of the programme in the area
- ☐ Work with various power structures within and outside the community and ensure their effective participation in the programme
- ☐ Identify and use preferred providers for delivering project services after due training by SACS, DAPCU or TSU, STRC

Commodity supply and management

- ☐ Support ORWs in maintaining records of free condoms and lubes received from the project and distributed by self or PEs

Reporting

- ☐ Provide data/information required for the preparation of reports

Norms for MSM TIs = 1: 60 KP

Training Requirements

- ☐ Micro-plan preparation and updation, condom demo and re-demo, basics of STI and HIV/AIDS, advocacy and networking

2.g Visiting physician

Recruitment Qualifications

Criteria	<ul style="list-style-type: none"><input type="checkbox"/> Preferably MBBS<input type="checkbox"/> The right attitude to work with KPs and their partners<input type="checkbox"/> Provide consent to handle and manage stock of medicines purchased or stored by the project as per the requirements of the Drugs and Cosmetics Act<input type="checkbox"/> Willingness to commit at least 4–6 hours, 6 days a week in MSM TIs. (The norms for MSM TIs also apply for core composite TIs)
Knowledge and skills	<ul style="list-style-type: none"><input type="checkbox"/> Strong communication skills and knowledge about community issues and their risk patterns<input type="checkbox"/> Ability to work in small teams, and flexible way of working<input type="checkbox"/> Ability to maintain simple field records and work in given field conditions, including travelling to various sites<input type="checkbox"/> Community motivation skills and rapport-building skills

Duties and responsibilities:

- ☐ Ensure audio and visual privacy of patients
- ☐ Ensure that the clinic is equipped with:
 - Examination bed with bed sheets
 - Sufficient light for examination
 - Instruments—proctoscope, etc.
- ☐ Follow syndromic case management (SCM) while treating STIs
- ☐ Ensure that case records are maintained by the physician him/herself, whereas the patients register may be maintained by project staff
- ☐ Focus on prevention, with special reference to partner management, condom use, follow-ups and management of side effects
- ☐ Lay emphasise on treatment compliance and better treatment outcomes
- ☐ Provide counselling to patients to improve their knowledge of causation, transmission and prevention of STIs
- ☐ Offer counselling services for HIV/AIDS testing and establish linkages with ART centres with respect to persons who are detected as HIV-positive
- ☐ Refer clients to ICTC, PPTCT, DMC, ART, PLHIV networks, based on need
- ☐ Hold meetings with all TI staff at least once in a month
- ☐ Regularly attend, without fail, trainings on advanced STI management
- ☐ Share relevant clinical records or reports or data maintained whenever required
- ☐ Motivate KPs to use government facilities for health services and lab tests

Annexure 3: Peer-led Outreach and Planning

Outreach planning is a tool that facilitates a PE's individual-level planning and follow-up of prevention service uptake, based on individual risk and vulnerability profiles of at-risk MSM.

Outreach planning at each site is managed by PEs. An outreach plan provides a visual picture of the site, which helps the PE to understand the extent to which programme services have reached the MSM, and to identify and monitor problem areas.

Benefits of Outreach Planning

- **Defined area of operation for PE:** Helps avoid duplication of effort and diffusion of responsibility by demarcating the site, the responsibility for which rests with the individual PE
- **Repeat visits for monthly screening:** Enable the PE to monitor clinic visits for the monthly screening of MSMs in the given site
- **Individual tracking:** Enables the PE to track

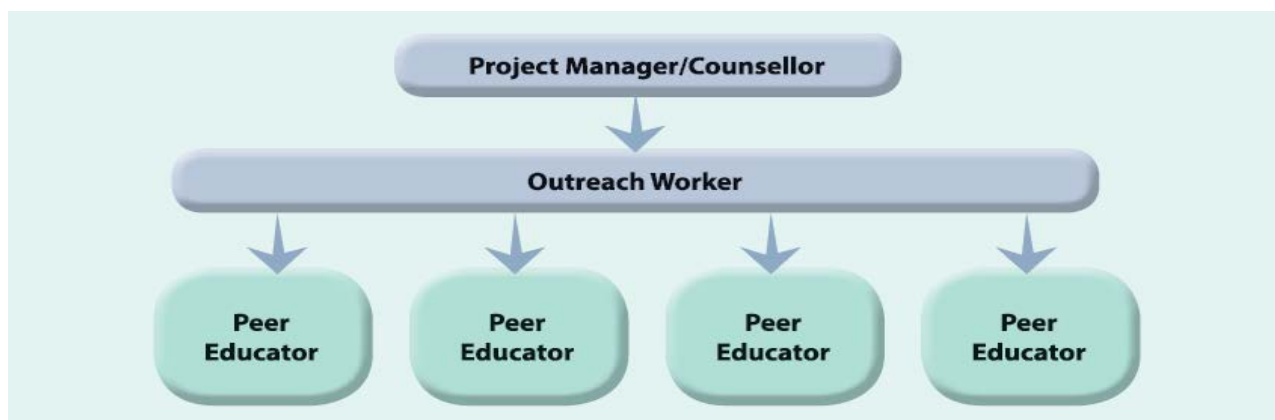
the number of MSM being reached during a given month for various services (clinic/camp attendance, one-on-one sessions, contacts, group sessions, and condom distribution).

- **PE able to collect, analyse and act upon data:** Using the PE daily activity report, the PE is able to generate data and use it to provide minimum services to all MSM in the site
- **PE becomes the site manager:** The PE can define and budget for activities to be conducted in the site and take responsibility to ensure service provision for all MSM in the site
- **Community ownership:** By addressing felt needs of the community and encouraging active involvement and decision-making by the MSM in all aspects of the programme, a sense of belongingness and ownership is cultivated.
- **Shift from delivering services (push) to meeting community's demand for services (pull):** Ownership by the community generates demand for services. The project services will be community-driven rather than IP-driven.

Outreach Planning in the Organisational Context

To ensure effective implementation of outreach planning, a particular flow system should be put in place to manage the outreach activities, with defined responsibilities for each member.

The typical structure for an ORW is given below:



Outreach planning exercises help PEs plan their outreach services, including health camps, events, communication sessions, condom distribution and crisis management for MSM in their zone. As managers, PEs monitor their own performance and the delivery of monthly services in consultation with project staff to ensure that the minimum package of health, communication and HIV prevention services reaches MSM in their respective zone. This approach has demonstrated that MSM from low literacy and economically challenged backgrounds have the capacity to take up various challenging tasks, including managing HIV/STI prevention services.

Elements of the Outreach Plan

A PE creates an outreach plan for her own site and updates and analyses it every month. The essential elements of an outreach plan include:

- Pictorial depiction of the site
- Number of registered MSM in the site

- Number of new and dropout MSM
- Number of MSM accessing services
- Number of MSM who are members of NGOs/CBOs
- Key stakeholders
- Locations of condom depots, clinic and health camp areas and other relevant local resources

Section II Outreach Planning Processes

Outreach planning is a participatory and interactive process. Following are a set of processes that can be facilitated by ORWs to help PEs create their own outreach plan. The processes are presented below in a training format, which is designed for ORWs to train a group of PEs, who will then be able to repeat the processes on their own as they update and revise their outreach plans.

Process 1: Spot Analysis

Aim: To help participants compile information collected during the urban situation and needs assessment related to each high-risk spot/site in their respective project areas to facilitate planning

Description: Participants, through group work, will compile spotwise information for planning

Suggested teaching method: Large group discussion

Materials/Preparation required: Spotwise information collected in urban SNA, chart paper, pens, and handout (*Planning Outreach for MSM Interventions*)

Duration: 120 minutes

Process:

1. Begin the session by asking participants what they learned during the urban situation and needs assessment process. Allot time for sharing of key findings.
2. Clarify the importance and need for outreach planning with respect to HIV prevention programmes. Use the following reasoning:
 - In a programme such as ours, a spot is the smallest geographic location for intervention, and it is important to plan for each and every spot at the taluk level.
 - Each spot is different; therefore, plans have to be spot specific.
 - Other characteristics such as client volume and typology of MSM (visiting site) have to be factored into planning.
 - Spotwise planning should facilitate outreach to maximum number of MSM.
3. Ask participants what information they require about MSM cruising/visiting in a spot that would help them develop a plan for that spot. Make sure the following is included:
 - Volume of partners: high volume (more than 15 partners per month), medium volume (5–9 partners/month), low volume (less than 4 partners/month)
 - Typology of MSM: kothi, panthi, double decker, bisexual
 - Age of MSM: below 20 years, 20–30 years, 30–40 years, above 40 years
 - Time of cruising: morning (6 a.m.–10 a.m.), afternoon (10 a.m.–2 p.m.), evening (2 p.m.–8 p.m.) and night (8 p.m.–6 a.m.)
- Frequency of cruising: daily, weekly, monthly
4. Ask participants to divide themselves into groups—group size should reflect the number of taluks they represent. Ask each group to identify a well known spot in their taluk and conduct Exercise 1, Spot Analysis.
5. Give participants 45 minutes to finish Exercise 1. Make sure peers in the group participate actively.
6. After everyone has completed the exercise, ask each group to present their spot analysis. Encourage peers to make this presentation.
7. After each group has presented its spot analysis, ask the following questions:
 - What was the process that each group adopted to do this exercise?
 - What is the analysis for the spot?
 - As a result of the analysis, what is the spot plan?
8. Before concluding, stress the following:
 - **Volume of partners:** Planning should ensure that MSM with a higher volume of clients are reached as a priority.
 - **Typology:** Planning should include the typology of MSM and needs to be specific to each type.
 - **Age:** MSM needs differ with respect to age, therefore planning should address that.
 - **Time/day of operation:** Understanding the time and day of operation will help plan outreach with respect to those times. For example, there are certain days in a month when MSM visit particular spots, such as the market. During those days of the month, outreach needs to be strengthened. Similarly, evenings and nights may be very busy in certain spots. Hence, the project needs to ensure that outreach is planned during those times of the day.

- Note:** During this workshop, analysis of only one spot/group can be done due to time constraints. Make sure that by end of the day, participants have developed a plan and timeline to complete this exercise for all spots. This analysis can be adapted for understanding characteristics of each location, each taluk as well as each district.

Exercise 1: Spot Analysis Tool (<20, 20-40, 40+)

District :		, Taluk :						, Location :						, Spot :						, Date of analysis :							
High Volume	Typology																										
	Street						Home						Brothel						Lodge								
	Age						Age						Age						Age								
	<20		20-40		40+		<20		20-40		40+		<20		20-40		40+		<20		20-40		40+				
	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly			
	Time		Time		Time		Time		Time		Time		Time		Time		Time		Time		Time		Time				
	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N
Medium Volume	Typology																										
	Street						Home						Brothel						Lodge								
	Age						Age						Age						Age								
	<20		20-40		40+		<20		20-40		40+		<20		20-40		40+		<20		20-40		40+				
	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly			
	Time		Time		Time		Time		Time		Time		Time		Time		Time		Time		Time		Time				
	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N
Low Volume	Typology																										
	Street						Home						Brothel						Lodge								
	Age						Age						Age						Age								
	<20		20-40		40+		<20		20-40		40+		<20		20-40		40+		<20		20-40		40+				
	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly			
	Time		Time		Time		Time		Time		Time		Time		Time		Time		Time		Time		Time				
	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N	M	A	N

HANDOUT: PLANNING OUTREACH FOR MSM INTERVENTIONS

The main objective of outreach, in the HIV intervention context, is to impart behaviour change among targeted populations. The project attempts to do the following:

- Encourage timely and complete treatment of STIs
- Encourage correct and consistent condom use

The project will work with MSM, their regular partners, spouse and female partners/wives. However, the outreach strategy will differ with respect to different typologies of MSM. The objectives of outreach are to provide knowledge about STIs/HIV, develop better health seeking behaviour, build skills to negotiate condom use, provide condoms and referrals for services. In short, the objective is to facilitate safer sexual relationships.

Key elements of the outreach:

- Geographical coverage: Outreach needs to be planned for each location/site where same-sex behaviour takes place. Each location has its own characteristics and needs, which the outreach strategy must address.
- Partner volume: Understanding the volume of partners and sex work is important to develop a good outreach strategy.
- The outreach strategy should ensure that high-risk MSM (high volume = more than 15 partners/month, medium volume = 5–9 partners/month, low volume = 4 or fewer/month) are reached with specific purpose and at specific periods. This is important because, in the context of HIV, MSM with more partners are most vulnerable and at most risk.

- Type of sex: This influences risk and vulnerability of MSM. Anal sex is more risky than oral sex. Therefore, the outreach strategy must address those who are involved in higher risk activities.
- Typology of MSM: This is very important to understand because outreach strategies differ based on typology of MSM and must reflect these typologies within the location, with a focus on high-risk MSM.
- Age: The age of MSM is also crucial for designing outreach strategies. Interests and needs of MSM differ depending on age. Vulnerability to risk also differs as a result of age.
- Time: It is important to identify the time when cruising/solicitation occur in a location so that outreach strategies reflect this understanding. For example, male sex workers may normally work in the evening at a specific location, hence outreach to them needs to be planned during that time in those locations.
- MSM interventions cannot work on a specific timetable. They have to adapt to field realities.

Process 2.1: Contact Mapping (Part 1)

Aim: To help participants map their MSM contacts in each spot and plan for outreach based on these contacts

Description: The participants, through group work, map the contacts they have in each of the spots and analyse needs

Suggested teaching method: Large group discussion

Materials/Preparation required: Maps of each town in the site, chart paper and pens

Duration: 105 minutes

Process:

1. Begin the session by asking the participants to divide themselves again into groups based on site.
2. Ask each group to draw a map of the town and mark all identifiable locations and spots on the map. Mark the estimated number of MSM in each spot.
3. Ask the participants to colour-code all ORWs and peers.
4. Using the different colour codes, mark the number of MSM each ORW and peer knows in the spot. For example, assign the colour red to Rohan, a PE, and mark all his MSM contacts in each spot using red.
5. Allot 30 minutes to complete mapping. Ask each group to present their maps. Encourage peers to make presentations.
6. After each peer has presented, ask the following questions:
 - ☐ What does the map show?
 - ☐ In which spots are the contacts limited? Why?
 - ☐ Where is the outreach not happening?
 - ☐ What should be done in specific locations where MSM are not being reached?

Note: Colour-coded maps are easy to understand by all participants, independent of literacy level.

Process 2.2: Contact Mapping (Part 2)

Aim: To help participants understand who the contacts are after mapping them in each spot

Description: The participants, through group work, list out contacts that they mapped in the previous exercise

Suggested teaching method: Large group discussion

Materials/Preparation required: Chart paper and pens

Duration: 90 minutes

Process:

1. Ask the groups to get together and look at their map again.
2. Ask each group to select the three spots with the maximum number of contacts.
3. Give the groups 30 minutes to make a list of contacts in each of the spots as stated in Exercises 2 & 3 (Contact Mapping)
4. Ask each group to answer and record the following:
 - ☐ Which contacts does each ORW know very well?
 - ☐ How many and who are the contacts that are known by more than one ORW?
5. After 30 minutes, ask each of the groups to present their work. Again encourage the peers to make the presentations.
6. Ask participants what they learned and how it will help them in planning outreach. Ensure that the following points are covered:
 - It is important to understand how many contacts we have in each spot and how to increase the number of contacts so that maximum MSM can be reached.
 - It is important to know who these contacts are so that we understand whom we are not reaching. That way, we can plan to reach those not yet reached.
 - It is important to understand that ORWs, especially peers, have contacts in more than one spot.
 - It is important to understand that peers have their own social network, including certain MSM who they are friends with and have influence over.
7. Conclude by informing the groups that both geographic networks and social networks of peers play an important role in planning outreach to MSM.
8. Also inform the group that mobility is a factor, therefore it is important to conduct Exercises 2&3 every six months. This way the project can ensure that both new and continuing MSM in each spot are being reached.

Note: Due to workshop time constraints, it may not be possible to conduct this exercise for all the spots. Hence a timeline needs to be planned for the completion of this exercise for the rest of the spots.

Exercise 2: Contact Mapping

District: Taluk: Name of Town: Date of exercise:

Estimated number of MSM in the town:

Contacted number of MSM in the town:

S. No.	Name of spot	Peer 1 Number of contacts	Peer 2 Number of contacts	Peer 3 Number of contacts	Peer 4 Number of contacts

Exercise 3: Contact Mapping

District: Taluk: Name of Town: Date of exercise:

Estimated number of MSM in the town:

Contacted number of MSM in the town:

S. No.	Peer 1 Name of contacts	Peer 2 Name of contacts	Peer 3 Name of contacts	Outreach 1 Name of contacts	Outreach 2 Name of contacts
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
No. of contacts that are known very well					
	# of contacts	# of con- tacts	# of contacts	# of contacts	# of contacts

Colour-code the contacts that are common to more than one list.

Process 3: Networks

Aim: To help participants understand the geographic and social networks of MSM and advantages and disadvantages associated with both

Description: The participants, through a debate, discuss the advantages and disadvantages of geographic and social networks and include the same in planning outreach

Suggested teaching method: Debate and discussion

Materials/Preparation required: Chart paper and pens, handout (*Geographical and Social Networking*)

Duration: 90 minutes

Process:

1. Deliver a mini-lecture on MSM networks. Clarify that MSM can have contacts in a particular geographical location, a particular social circuit, and also among network operators. It is important to understand these networks because both 'frequency of meeting' and 'peer influence' have a great impact on MSM. Hence, it is important to ensure that peers are selected from all networks so that the project can maximise reach.
2. Distribute handouts (*Geographical and Social Networking*). Ask one participant to read the case study out loud to the group. Ask them to stop where the case study ends. Make sure that they do not read the definitions.
3. After ensuring that every participant has understood the case study, divide the participants into two groups using a group-forming energiser.
4. Ask the groups to discuss the following:
 - Group 1 – Advantages of selecting peers from a particular geographical location and disadvantages of selecting them from a certain social circuit.
 - Group 2 – Advantages of selecting peers from a certain social circuit and disadvantages of selecting them from a particular geographical location.

5. Give the participants 30 minutes to prepare for the debate.

6. Appoint a referee for the debate and allot 10 minutes to each group to share their viewpoints.

7. Highlight the key advantages and disadvantages of each network and conclude that both networks are important to consider while selecting peers. Peer selection depends on the situation, and a combination of both strategies may be required. In the early stages of the project a social network may be more efficient even though it is time consuming. Once all the social contacts of each peer/volunteer have been introduced to the project and rapport has been built by each peer with others in her group, the project should move to geographic networks. At times, depending on the situation, the project may have to use geo-social networks in order to ensure effective outreach. The project should decide which one to adapt and determine this based on the project needs and reach at that time.

8. Conclude by reading out the definitions of geographic networking and social networking from the handouts.

9. Announce that both teams have worked hard and both have won. Distribute small prizes (if possible) to all the team members.

Handout: Geographical and Social Networks

Case Study of Harish

1. Harish is a kothi who has been cruising in 'X' city for the past seven years. He is 26 years old. In his early years, he used to cruise at the bus-stand with his friend Sonu. Over a period of time he developed friendship with 15 other MSM who came to the same area. He comes from his area every day at 6 p.m. after work and remains here till 10.30 p.m.

2. Harish knows that there are around 25 to 30 MSM who also come to this bus stand. Some of them come in the morning hours (6 a.m. to 10 a.m.), some in the evening (6 p.m. to 10 p.m.) and some in the night (10 p.m. to 1 a.m.). Harish has seen many of them but not all are his close friends. He knows about 15 MSM who come to the bus stand at the same time as him, i.e. (6 p.m. to 10.30 p.m.). Of the MSM who cruise at the same time as him, five are his close friends and 10 are acquaintances. In the last 7 years of working in city 'X', Harish has moved to different locations within the city, such as the railway station and the market, to meet partners due to various reasons. Over the years, he has cruised in the top 10 locations within the city. He has developed close friendships with 80 MSM in those locations (including 15 at the bus stand). He also knows 40 other MSM who operate in those locations regularly.

The SNA and spot analysis estimates 500 MSM in those eight locations. These MSM are known to operate at different times. The project has developed a good rapport with Harish. Furthermore, he is willing to work as a PE since he understands that STI/HIV is a serious threat to the MSM community, especially to his friends who he loves and is concerned about. The project staff recognises that Harish is an asset to the project. They are interested in involving him in the project. The staff has to decide on how to incorporate Harish into the project.

4. The project has two options:

Option One:

Harish can be assigned a particular geographical area (one or more locations) and be asked to reach all the MSM who operate in that area and also identify new

MSM. This would mean that he will have to build rapport with all the MSM in the assigned location, give them information and condoms and bring them to the clinic.

Option Two:

Harish can be given the responsibility of reaching out to his 15 close friends on a regular basis, whom he knows very well and has good rapport with, in 10 different locations within the city.

The Questions:

1. Which option is the most effective and efficient?
2. What are the advantages and disadvantages of each option?

Definitions

Geo-Networking Concept (Option One)

Geo-networking is defined as networking/ reaching out to MSM within a fixed geography. Using this concept, a PE/community volunteer is given the responsibility of reaching all the MSM operating in a particular geography irrespective of his rapport or relationship with them.

This, in practical terms, means that the peer has to go and make friends with all the MSM in the particular spot (geography) irrespective of age, time of operation, etc. For this he may have to work beyond his cruising time, make an effort to meet the other MSM or be introduced to them in a different way.

Social Networking Concept (Option Two)

Social networking is defined as networking/ reaching out to MSM within a social circuit. Using this concept, the PE/community volunteer is given the responsibility of reaching out to his friends irrespective of a defined geographical area.

This, in practical terms, may mean that the peer may have to travel to a few spots, do his work and also work for the project. The project may have to appoint more than one peer in one spot/ geography.

Handout III: Opportunity Gaps

Opportunity gaps are obstacles that disable an individual/community from moving from one level to the next in the behaviour change processes. MSM have to undergo different stages/levels of the outreach cycle for effective behaviour change to occur. The project should work on removing any obstacles on the way and on creating a

conducive environment, at every stage/level, for the individual/community to move from one level to the next level easily.

The factors/reasons that cause opportunity gaps may vary from individual to individual in a community. The project should develop systems to assess opportunity gaps at every level by using qualitative/quantitative information.

Example of Opportunity Gaps

A spot-wise analysis must be done and an overall analysis for the town must be completed to gain both a spot-wise and an overall understanding, since the opportunity gaps may vary from spot to spot.

Level 1 Estimated MSM in the project area Opportunity gap (Level 2–Level 1)	- -	0	218
Level 2 MSM who have been contacted at least once by the project Opportunity gap (Level 3–Level 2)	- -	79	218
Level 3 MSM who have been registered Opportunity gap (Level 4–Level 3)	- -	34	139
Level 4 MSM who are in regular contact with the project Opportunity gap (Level 5–Level 4)	- -	47	105
Level 5 MSM who visited the clinic for STI treatment Opportunity gap (Level 6–Level 5)	- -	12	58
Level 6 MSM who completed the treatment Opportunity gap (Level 7–Level 6)	- -	46	46
Level 7 MSM who had regular health check-ups	-		0

See example for details. The reason for opportunity gaps at each level has to be identified and an action plan needs to be developed to overcome these opportunity gaps. The reasons for gaps may be internal factors (where the project has direct control, as in work timing of ORWs and PEs) or external factors (for example, high mobility of MSM on a daily basis). The internal factors can be addressed immediately so that the quality of input from the project can be strengthened. Proper networking and advocacy with other government and non-governmental organisations can solve most external factors.

Definitions

Contact	Identification of MSM. Purposeful interaction with the KP
Registration with the Project	After building rapport with the MSM, they are registered by filling the registration form. This provides each person a number and makes it easy for the project to track the outreach provided to him. Registration can be initiated with 1–8 contacts in the field.
Regular Contact	MSM who have been receiving education regularly (once every 15 days), over a period of one year or until the MSM is no longer in that location (total 24 interactions a year). MSM is receiving condoms for 90 per cent of her estimated/reported client interaction. Condom distribution is accompanied by demonstration and training in negotiation skills if needed.
Referral to clinic for STI related Services	<p>Referral is done by outreach workers or peers. Referral should include STI information, condom information and demonstration, and distribution of at least four condoms. The address of the clinic should also be shared.</p> <p>The doctor provides syndromic case treatment for STIs. STI treatment includes understanding the symptoms of the MSM, clinical examination, prescription/distribution of drugs to MSM and partner notification/treatment.</p> <p>STI treatment also includes risk assessment and risk reduction counselling, condom demonstration and distribution. Either the doctor or the counsellor can provide counselling.</p> <p>Referral to the clinic needs to be done whenever MSM display symptoms. Every 6 months, the KP is referred for presumptive treatment.</p>
Regular health check-up	<p>MSM receiving STI/health care services every three months from the programme clinic or through referral doctors (aiming for four check-ups in a year).</p> <p>The objective is to promote regular health seeking behaviour among MSM. They should be referred every quarter even if they do not have symptoms.</p>

Example: Opportunity Gap Analysis

Activities	Status	Opportunity Gaps	Reasons		What should we do?
			Internal	External	
Estimate	218				
Contact	218				
Registration	139	79	Lack of rapport with the 79 MSM	Low number of MSM Out of fear of being identified, KP come to town only once in 15 days	Understand the time when MSM come and plan accordingly Build their trust by contacting them through other MSM or stakeholders
Regular Contact	105	34	Have not been able to generate interest	Higher mobility of MSM Few MSM come only once in a month	Link up with other services in the taluk so that MSM can be offered varied services Reach MSM through their social networks
STI Treatment	47	58	Referral clinic is new Clinic is available only on fixed days Lack of trust in the project	No symptoms MSM consume alcohol	Build trust through peers Inform KPs about advantages of check-ups

Process 5: Participatory Site Load Mapping

Aim: To understand the gaps between estimates of MSM, the number of unique contacts and the number of regular contacts by studying the MSM load in a day, a week and a month in different sites. Participatory site load maps also give information on potential regular contacts, i.e. the potential number of MSM a site team can contact in a month

Description: The participants develop site maps to understand the turnout of MSM at a given site in a day, week and month and compare the same with the number of unique contacts and the number of regular contacts at these sites

Materials Required: Charts, pens

Duration: 120 minutes

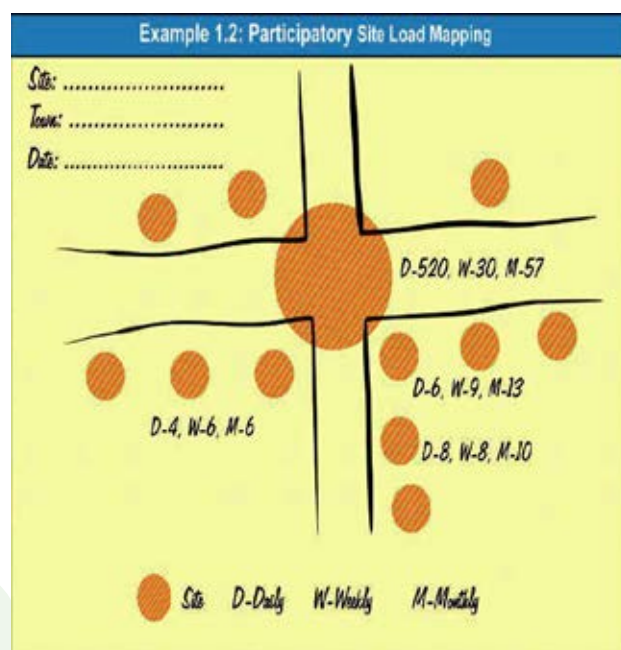
Process:

1. Explain to the participants that in order to reach out to MSM it is important to know where and how many MSM are available on a given day, week and month.
2. Divide the participants area-wise and ask them to draw a map of their area, clearly depicting sites where MSM cruise/solicit their clients. Ask them to colour-code the sites based on MSM typology.
3. Check with the participants if they have marked all the sites based on typology. Once all the sites have been marked, ask the participants to write down next to the site name the number of MSM who are always available on a normal day.
4. Next, ask the participants to write the number of MSM available at these sites in a week. Check with the participants if there are any specific days in a week when the number of MSM peaks and reasons for the same.
5. Once the above exercise is done, ask the participants to mark the number of MSM available at these sites on a monthly basis and also ask if there are specific days in a month

when the turnout is high and the reasons for the same; for example, more MSM are available on weekends.

6. Then ask the participants to add the daily, weekly and monthly turnout at all the sites and draw a picture of the MSM turnout at a site.
7. Now ask the participants to compare these figures with their estimate, unique contact and regular contact figures for these sites and analyse in the following way:
 - ☐ Are the total MSM available at these sites more or less than the unique contacts and regular contacts? Why?
 - ☐ Is high weekly and monthly turnout linked with any specific typology of MSM? Why?
 - ☐ Are there specific sites where the number of unique contacts and regular contacts is less than the monthly turnout? Why?
 - ☐ Which are the sites and the typology of MSM that need focused outreach? Which outreach team is responsible for these specific sites? What should they do to improve outreach to include more contacts?

Note: Participatory site load mapping is a visual exercise done along with outreach workers, peers and volunteers. This exercise requires a thorough understanding of the geography of the town.





Sample site load map

Process 6: Seasonality Diagramming

Aim: To understand peaks and troughs of sex work at a given place in a year and its impact on outreach planning

Description: The participants, through a seasonality map, attempt to understand the peaks and troughs in sex work based on typology in a taluk and the reasons for the same. They learn to plan outreach based on this seasonal variation

Materials Required: Pens, chart paper

Duration: 120 minutes

Process:

1. Inform the participants that the exercise is an attempt to understand how the sex work scene changes over a year in their town.
2. Divide the participants into site-wise groups and start by asking them which month/s sees the maximum number of MSM cruise/solicit. Ask the participants to have a group discussion in order to arrive at an answer.
3. Next, ask them to write the approximate number of MSM in high and low months and the reasons for the same.
4. Then identify the next busiest or peak month, the number of MSM and the reasons. Document the results. Similarly, continue doing this exercise for all the months in a year.
5. Make sure that the discussions are intensive and all the participants are involved. Make the exercise visual by using chart paper, coloured pens, etc.
6. Finally, when the seasonal calendar is complete, verify the results with the

participants to ensure that everybody agrees with what the calendar depicts.

7. Ask the group the following questions:

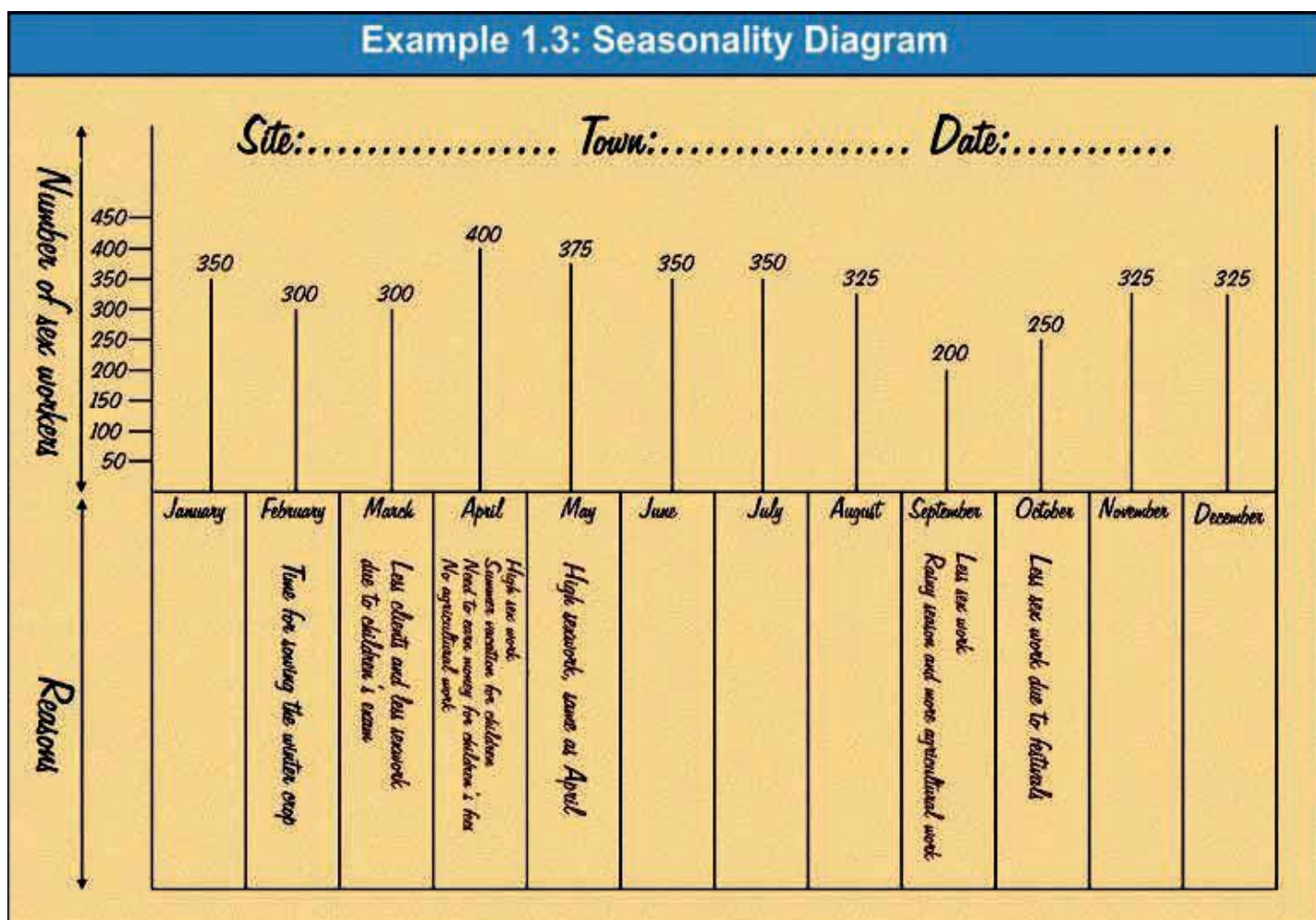
- ☐ During peak months do we find MSM from other towns coming to our town (e.g., around Ganesh visarjan in Mumbai)?
- ☐ Is the peak season specific to our site or is it valid in other sites as well?
- ☐ How does our outreach plan change based on these seasonal variations?

Note: A seasonal calendar can also be created for a month or even a week to understand the

peaks and troughs over a given period. Pay close attention to how the participants understand the different months in a year. Sometimes the participants may be more familiar with seasons in a year or different festivals in a year. In that case ask them to follow that calendar. Ensure that you check the peaks and troughs based on festivals, specific events, etc. A seasonality diagram can be also created to understand seasonal variations in other factors, such as STIs or police violence.

Note: Instead of sex workers, the above sheet may be adapted for MSM

Example 1.3: Seasonality Diagram



Process 7: Force Field Analysis

Aim: To understand the reasons for gaps in contacts and regular contacts, and to plan outreach to reduce the gaps

Description: Through this exercise, participants analyse the reasons for gaps in contacts and regular contacts, and develop plans to address these reasons

Materials Required: Pens, chart paper

Duration: 120 minutes

Process:

1. Divide the participants into taluk-wise groups and ask each group to identify the reasons for the difference between the number of unique contacts and regular contacts.
2. Ask each group to pictorially depict these reasons in small charts.
3. Ask the participants to rank the reasons in order of priority. Ensure that there is a lively debate and everyone participates.
4. Once these reasons or constraints have been

identified, ask the participants for ways in which these constraints can be overcome. Ask them to go through each constraining factor and ask the participants to list down ways to overcome it. Discuss the various ways listed out to overcome constraints and identify the ones that are easy to carry out.

5. Finally, compile all results on a chart paper and check with the group for any disagreements.
6. Ask the groups to present the results of their discussions and ask them the following questions: Were they aware of these constraints and the ways to overcome them? How will this knowledge help them in planning outreach?

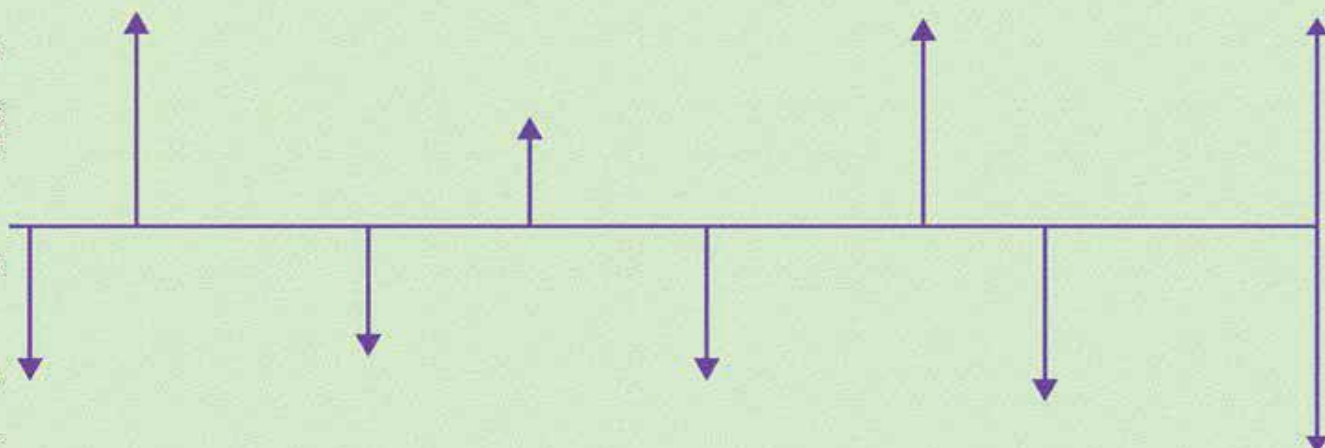
Note: This is a technique to identify and analyse the forces that restrain and facilitate a particular situation, process or outcome. The assumption is that for a given situation, there will be restraining factors and similarly there will also be factors that help improve the situation. When it comes to finding reasons for opportunity gaps, this exercise can be used for gaps at any level.

Example 1.4: Force Field Analysis

Site:..... Town:..... Date:.....

Driving Forces/Solutions

Restraining Factors/Constraints



Process 8: Preference Ranking

Aim: To identify the reasons for gaps between the numbers of regular contacts and clinic attendance and prioritise the same

Description: The participants use the preference ranking tool to analyse the reasons for gaps between the numbers of regular contact and clinic attendance, prioritise the same and make plans to address them

Materials Required: Chart paper and pens

Duration: 120 minutes

Process:

1. Begin by discussing the general reasons why MSM do not come forward to access clinical services.
2. After the initial discussions, ask the participants to list out the reasons why MSM in their town do not access clinical services. Give each of the participants a flash card and ask them to depict the reasons pictorially on the card.
3. Ask the participants to discuss these reasons in groups, prioritise them and select the

five most important reasons for low clinic attendance.

4. Then ask the participants to do a preference ranking of each of these five reasons and identify the most important reason.

□ Ask the participants to make presentations and ask them the following questions:

- What are the most important reasons for MSM not coming to the clinic?
- What are the plans to address these reasons?
- How can outreach or services be improved based on this exercise?

5. Conclude by developing an outreach plan to address these priorities.

Note: This exercise can also be carried out to develop a community understanding of a good service. We can ask the community/MSM to list the elements of a good service and do a preference ranking to understand their priorities. Compare whether the existing services meet these priorities. If not, then develop a plan to make the existing services better.

Example 1.5: Preference Ranking					
Site: Town: Date:	Reason why women are not coming to the clinic 	Reason 1 	Reason 2 	Reason 3 	Reason 4
	Reason 1 	X	X		
	Reason 2 	X	X		
	Reason 3 	X	X	X	
	Reason 4 	X	X	X	

Process 9: Condom Accessibility and Availability Mapping

Aim: To map the condom availability points and to understand if they are easily accessible to MSM population

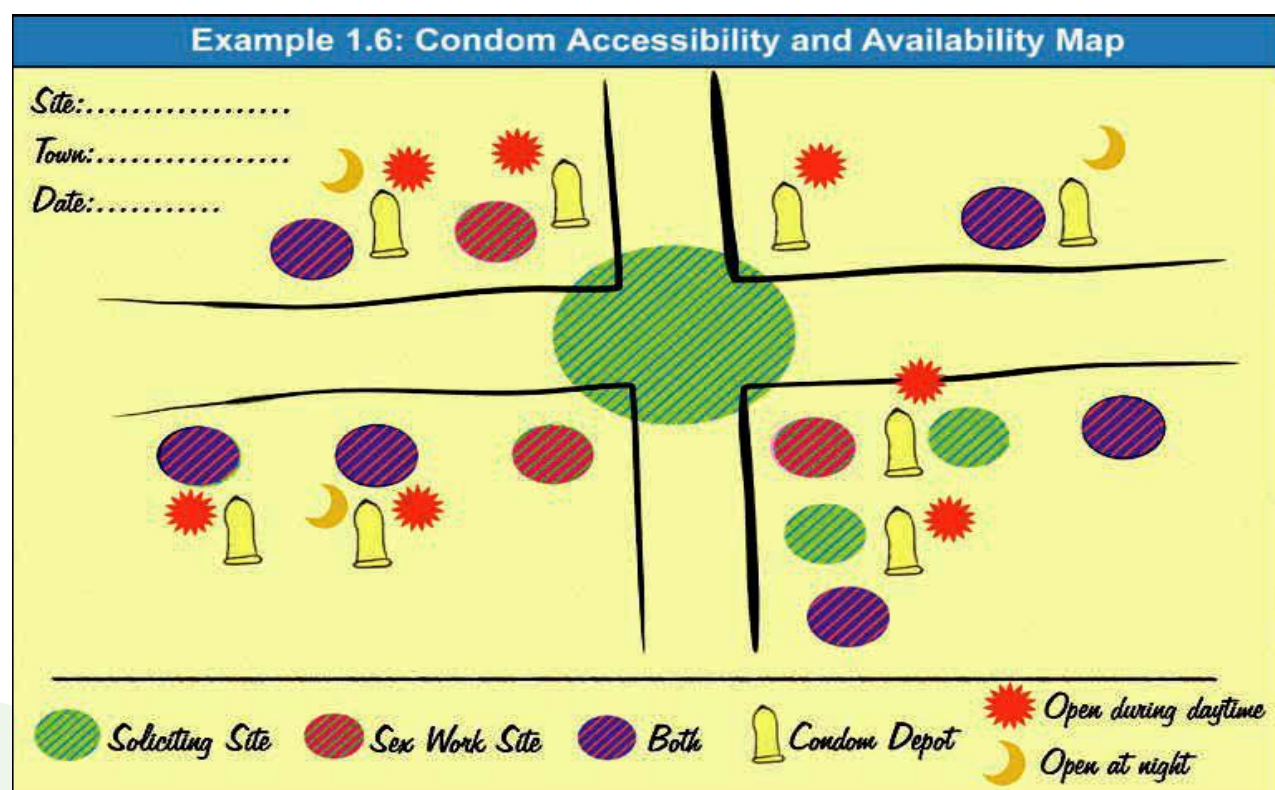
Description: The participants use maps to identify condom availability points and analyse their accessibility to the MSM population

Materials Required: Maps and pens

Duration: 120 minutes

Process:

1. Begin by discussing with the participants the importance of condoms to prevent HIV. Also explain that in condom programming the first priority is to make condoms accessible and available and that this exercise is meant to do so.
2. Ask the participants to draw a map of their town or use an existing map.
3. Ask the participants to mark all the places where MSM cruise/solicit clients. Also ask them where the sexual act takes place. Mark all these places on the map using *bindis* of two different colours—one to indicate sites where cruising/solicitation takes place, and the other to indicate sites where the actual sexual act takes place.
4. Then ask the participants to discuss each site to see when it is active (soliciting and cruising) and at what time of the day. Use markings to delineate whether the site is active only during the day or at night or at both times.
5. Then ask the participants to mark the condom depots on the map symbolically to indicate whether the depots function during the day or at night or round the clock.
6. Once the map is complete ask the following questions:
 - ☐ Are there condoms depots at all the sites where soliciting or cruising takes place? If not, what are the reasons?
 - ☐ Do all the sites that are active during the day or night or round the clock have condom depots that are open at the same time as the sites are active?
 - ☐ Are condom depots accessible to MSM?
7. Conclude by stating the importance of access to condoms at the right time and place. Draw up a plan to fill the gaps if any.



Process 10: Peer Maps

Aim: To understand the nature of outreach done by PEs with the MSM they work with

Description: The participants use maps to understand and analyse the outreach with MSM that they are accountable for

Materials Required: Chart paper and pens

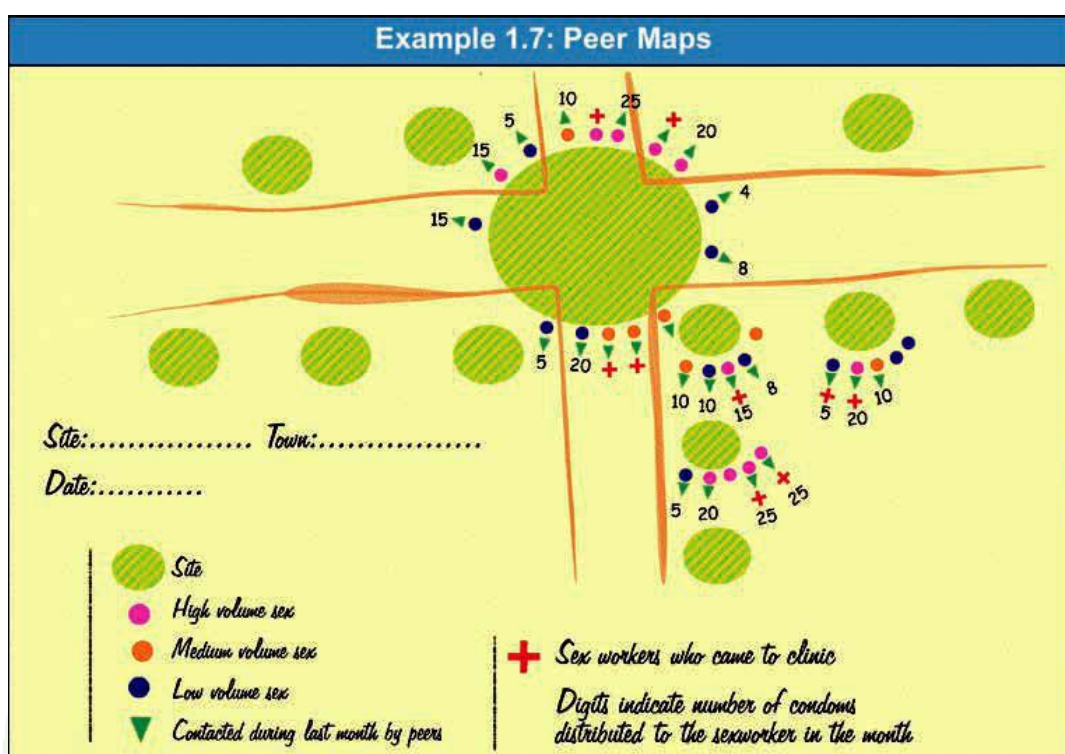
Duration: 120 minutes

Process:

1. Ask the PEs to map the sites in the town where they work and meet their community members. In these sites ask the PEs to map the MSM that they are accountable for. Ask them to depict the high volume, medium volume and low volume MSM population in these sites using different colour codes.
2. Now ask the PEs to indicate the number of times each of them met the MSM they are working with, in the last month.
3. Then ask each of them how many condoms were distributed to each of the MSM contacted.
4. Also ask each PE to mark the condom outlet boxes in these sites.
5. Now ask each of the PEs to analyse the map by answering the following questions:

- ☐ In the previous month, did the peer meet all the MSM that he is working with? If not, why?
- ☐ Based on the volume of partners/clients, was there any difference in the kind of outreach done by the peer? Did he meet high volume MSM more often and the low volume MSM less often?
- ☐ Were the condoms distributed based on the number of partners? Were enough condoms distributed to cover all the sexual acts of each of the MSM? Is there a shortfall? How is this shortfall in condom distribution being filled? Is it through the depots? Are the clients bringing condoms?
6. Conclude by saying that it is important to understand the need of each of the MSM, that a peer is accountable for planning regular contact and condom distribution accordingly. This will ensure that condoms are available for MSM whenever they are required and, at the same time, avoid dumping of condoms where there is no need.

Note: These maps can be adapted to include other indicators like clinic attendance, access to crisis support, access to entitlements, etc.



Process 11: Typology-wise Outreach Planning

Aim: To understand the link between typology of population and outreach

Description: The participants, through discussion and analysis of peer outreach, understand the link between outreach and typology of MSM

Materials Required: None

Duration: 120 minutes

Process:



























1. Explain to the participants that it is important to recognise and understand the link between outreach, typology of population and timing of soliciting and cruising.
2. Ask the participants to list the MSM they are accountable for but have not met in the last two months. This information can be generated from the peer calendars.
3. For each of the MSM listed above, ask the peers to provide the following information:
 - ☐ Place of residence
 - ☐ Place of soliciting
 - ☐ Place of cruising
 - ☐ Ideal timing for outreach (morning,

afternoon, evening, night)

4. When the participants complete this information, ask them to identify commonalities in typology and timing of outreach in those mentioned in the list. Bring out the characteristics of these.
5. Then ask the following questions:
 - ☐ Is there a link between the number of MSM who are not contacted and typology of MSM?
 - ☐ Which typology of MSM population tends to be left out from the outreach most often?
 - ☐ Is there a link between those who are left out and the timing of outreach? Are MSM cruising late at night or at a specific time of day excluded from outreach?
6. Now ask the participants to develop a strategy reach out to the typology of MSM population that tends to get left out. Ask the participants to plan how to contact, provide services and give condoms to these MSM. Conclude by asking if there are any questions.

Note: The participants can use pictures

Example 1.8: STOP

Name of sex worker/Symbol denoting sex worker	Place of residence	Place of soliciting	Place of sex	Time when available			
				Morning	Afternoon	Evening	Night
	Home/Street Brothel/Lodge	Home/Street Brothel/Lodge	Home/Street Brothel/Lodge				
 Gowdamma							
 Eshwaramma							
 Gangamma							
 Kalamma							

Section III - Tools for Monitoring Project Outreach Planning

The following tools can be used by PEs and ORWs to evaluate progress in outreach and delivery of a minimum package of services to MSM in their area.

PE Daily Activity Report

A PE records new and repeat contacts, one-to-one sessions, one-to-group sessions, referrals to clinic, condom demonstrations, condom distribution and one-to-one sessions with regular partners in a daily diary, which uses visuals to make it user-friendly for low-literate PEs. The data in the PE daily diary is used by the ORW to update the individual tracking sheet.

Sample PE Daily Activity Report

Name of the PE		District		Name of the hot spot/s		Week									
Name of the Supervising ORW		For the month				Date (end of the week)									
SI No	Name of the HRS	PE's Symbol (for identifying HRS)	Referral due/over due	Risk Assessment				Services							
		UID Number	STI	ICPC	Risk	Vulnerability	Condoms required	No. of condoms in distribution	No. of Male condoms sold	No. of Female condoms sold	Type of contacts	Referrals (STI & to others)	Reported Condom use during last week		
					Low condom use (not used)	High condom use (more than 2 per sex act)	Recent sex work	Sex work with a client	Sex work with a client	Sex work with a client	1-1	1-Group	STI	ICPC	ART
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															

Individual Tracking Sheet

The individual tracking sheet provides a list of all the MSM in a given site managed by a given PE/ORW. The services provided to each MSM every week are marked against her name. This helps to monitor the number of MSM who were provided with the minimum packet of services during the month. Every month the ORW fills the individual tracking sheet and analyses it along with the PE. The ORW discusses with the PE any difficulties in providing services to the MSM and makes a plan for the future.

Sample Individual Tracking Sheet

Outcomes of Outreach: The 'Minimum Package'

Each MSM covered by a TI is entitled to a 'Minimum Package'. An effective outreach strategy ensures that everyone gets one. The package includes the following services:

- ☐ One quality IPC session provided
- ☐ Clinical services offered
- ☐ Membership in NGO/CBO
- ☐ Quality condoms provided every week
- ☐ At least one project-related service (clinic, counselling, IPC session, condoms, regular meetings, etc.)

The delivery of Minimum Packages can be summarised using information from the PE Daily Activity Report and the Individual Tracking Sheet.

Name of the ORW				District				Name of the PE				For the Month				Monthly Tracking on core parameters																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																										
Sl No	Name of the HRG	UID Number	Referral due/over due		Risk Assessment							Services						Reported condom use during last sex	Risk not reduced	Monthly individual met	Regular condom use (yes / No)	Condoms distributed as per requirement	Referrals to ICTC and tested																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																			
					Risk				Vulnerability			Condom requirement per month (condom gap analysis)	No. of condom distributed	No. of male condom sold	No. of female condom sold	Type of contacts								Referrals (STI & others centers)																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																		
			STI	ICTC	At number of places (workplace, school, etc.)	Are condom free (not sold separately) who use of last 1000 sex	First year of sex work and below age 25 years	STI reported in last three months	Alcohol use	Unstable residence (more than one)	Violence risk					S-1	1-Group							STI	ICTC	ART																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																
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FORM C-1: Monthly summary sheet for FSW, MSM, TG and IDU (filled in by ORW)																					
Name of the ORW									For Month								Tracking on core parameters				
Sl No	Name of the PE	Week	Condom requirement per week (as per condom gap analysis)	No. of condom distributed	Type of contacts		Needles/Syringes requirement per week	No. of syringes distributed	No. of syringes returned	Referrals (STI & others centers)				No. of individuals reported not sharing needles/syringes during last injecting episode	No. of individuals reported condom use during last sex	No. of individual met each week	No. of regular contacts	No. of individuals provided needle/Syringe as per requirement	No. of individuals distributed condoms as per demand	No. of individuals referred to ICTC and tested	
					1-1	1-Group				STI	Abcess treatment	ICTC	ART								
1	PE 1	Week 1																			
		Week 2																			
		Week 3																			
		Week 4																			
		Total																			
2	PE 2	Week 1																			
		Week 2																			
		Week 3																			
		Week 4																			
		Total																			
3	PE 3	Week 1																			
		Week 2																			
		Week 3																			
		Week 4																			
		Total																			

Annexure 4: Peer progression

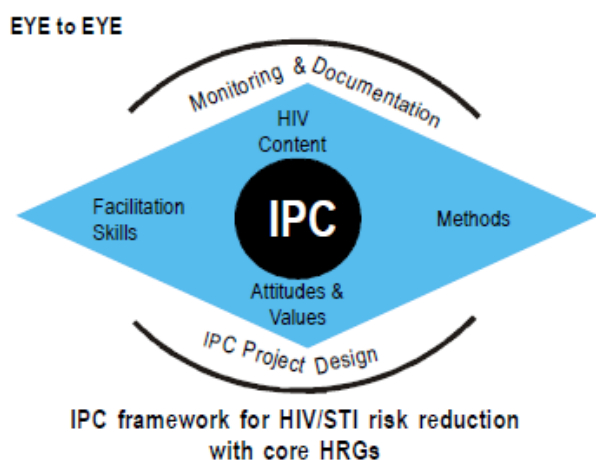
Type	Definition/ Selection Criteria	Sele- tion Process	Role	Remu- neration	Possible Next Step (Career Path)	Possible Capaci- ty-building Inputs	Performance Indicators for Consideration for Next Level (Qualitative aspects are more important than quantitative)
Com- munity member actively sup- porting the TI	MSM Operates from specific geographic area Self-identifies as MSM	Recom- menda- tion by group of MSM from a locality	Partici- pates in the pro- cess of the project Selects PEs Supports PEs in fulfilling their responsi- bilities Flags is- sues	No remuner- ation offered	Active member of the local group (Guide) PE Member of CBO Member of SHG Member of HRG Commit- tees	Orientation to the project IPC for safe sex practices Discussions on rights of MSM Build advocacy skills	Participates actively in project activities for at least three months Articulates community needs in meetings Demand for health services, condoms increases Responds to the common cause (e.g., intervenes in case of violence against MSM , helps other MSM access services)

Type	Definition/ Selection Criteria	Selection Process	Role	Remunera- tion	Possible Next Step (Career Path)	Possible Capacity- building Inputs	Performance Indicators for Consideration for Next Level (Qualitative aspects are more important than quantitative)
Active member of the egroup (Guide)	<ul style="list-style-type: none"> *Supports all the activities of the project locally *Comparatively long experience in the community *Commands respect 	*Consultation with community members	<ul style="list-style-type: none"> *Guides community members and PEs on critical issues * Motivates community members to participate in the project process *Mediates in local conflict resolution 	No remuneration offered except TA and nominal compensation for wage loss	PE	<ul style="list-style-type: none"> Community mobilisation skills Opportunities to participate in formal and informal district level activities Develops understanding of issues and structures pertaining to MSM Develops advocacy skills Develops crisis management skills 	<ul style="list-style-type: none"> Continues to associate with the project for six months Motivates five community members to participate Is not burdened with self- or social Stigmatisation

Type	Definition/ Selection Criteria	Selection Process	Role	Remunera- tion	Possible Next Step (Career Path)	Possible Capacity- building Inputs	Performance Indicators for Consideration for Next Level (Qualitative aspects are more important than quantitative)
Peer Educator (PE)	<p>Selected by the community</p> <p>As representative</p> <p>Understands community issues</p> <p>Good relationship with MSM, communication skills, respect for others</p> <p>Expresses interest in representing the community</p>	<p>Through internal consultation/ election by community members</p>	<p>Link between the community and project</p> <p>Represents and addresses community grievances, problems and needs</p> <p>Attends PE meetings and workshop organised by other partners</p> <p>Participates in decision-making on the processes of projects</p> <p>Delivers services to KPs</p>	As per NACO guidelines	<p>Committee member</p> <p>ORW</p> <p>Project Manager</p>	<p>CLSI perspective</p> <p>Rights issues</p> <p>Skill development in leadership, communication</p> <p>Opportunities to participate in formal and informal district level activities</p> <p>Dealing with authorities</p> <p>Conflict resolution/ advocacy</p>	<p>Attends most PE meetings</p> <p>Understands CLSI approach and can communicate it to peers</p> <p>Brings community issues forward for discussion</p> <p>Leads/mobilises community members in crisis situations</p> <p>Confidently interacts with authorities</p>

Type	Definition/ Selection Criteria	Selection Process	Role	Remunera- tion	Pos- sible Next Step (Career Path)	Possible Capacity- building Inputs	Performance Indicators for Consideration for Next Level (Qualitative aspects are more important than quantitative)
Commit- tee Member	Member of the PE group who serves on committee	By election for a period of one or two years	Plans, supervises and guides activities of his committee, e.g., DIC, STI clinic, etc. Facilitates formation of local group/ CBO Represents PEs/ Community members in meetings and workshops and gives them feedback Addresses barriers at peripheral Level Analyses, prioritises and resolves issues	No remuneration		Management skills Assessment of project activities Advocacy skills	Identifies gaps in the Programme Assesses activities/ provides input Problem-solv- ing

Annexure 5: Dialogue-based interpersonal communication



by and with MSM

The IPC framework includes the four cornerstones of IPC—HIV content, methods, facilitation skills, and values and attitudes—as well as the two essential aspects of creating successful IPC programmes, IPC project design and on-going monitoring and documentation.

HIV/STI content covers the barriers to risk reduction for HRGs, including social and environmental factors as well as epidemiological issues.

Methods are processes used to stimulate IPC and are selected to make the best possible use of each IPC opportunity.

Facilitation skills focus on ways to promote real dialogue, discussion and debate rather than merely giving messages.

Attitudes and values deal with the appropriate attitudes and values for working with HRGs and underlie all capacity areas essential to an organisation implementing IPC projects.

Project design looks at how the project is

organised to be both efficient and effective.

Monitoring and documentation are used to improve project processes and to share learning within and beyond the IPC project.

These components of the IPC framework complement and reinforce each other, and together they enhance the sustainability, quality, integrity and impact of interventions.

Section II Methods for IPC with HRGs for Reducing STI/HIV Risk Method Typology

All IPC methods are based on participatory learning and action (PLA) approaches. They are divided into different types:

Type	IPC Methods	
Simulation	1.	Play Safe
	2.	HRG Advisors
	3.	Statues
	4.	Margolis Wheel
Visual Representation	5.	HRG Drawings
	6.	Graffiti
	7.	Body Mapping
	8.	Lovers
Diagramming	9.	Why Is It So?
	10.	Chakra Wheel
Mapping & Ranking	11.	HIV Services Map
	12.	How Hot Is the Spot?
Stories	13.	Story With a Gap
	14.	Storytelling

IPC Capacity Standards for Method Selection and Use

- IPC tools are field tested with the HRGs before being used to determine their suitability, acceptability and effectiveness in different situations (dropin centre, outreach, clinic, etc.).
- All IPC tools used have moved beyond message delivery to dialoguebased

methods that promote critical reflection and enquiry (“from seeing and reading to listening, thinking, asking and talking”).

- All IPC tools used are designed to help KPs identify and analyse barriers to risk reduction, find acceptable and realistic solutions and plan how the solution will be adopted.
- IPC tools are selected to maximise the quality of the IPC opportunity (depending, for instance, on whether they are appropriate for the type of KP, for where IPC is taking place, the time available, the skill level of the facilitator, the HIV/STI risk reduction priorities of the KPs,

number of participants, degree of privacy, whether the encounter is a oneoff or to be repeated, literacy skills of participants, level of engagement of KPs).

- IPC tools help strengthen the motivation, knowledge and skills for HIV/STI prevention among KPs. They also help KPs to access HIV/STI-related services and resources in the community and to access peer/social support for HIV/STI prevention (i.e., they help HRGs to strengthen knowledge, resource, positional and personal power).
- During IPC, KPs are always encouraged to share their own means of HIV/STI prevention.

Method 1. Play Safe		
Purpose of the method	To help participants explore different safe sex techniques	
Requirements for facilitation	Good knowledge of safe sex and safe injecting and sharing strategies and techniques, comfort with talking about using drugs, sex and with explicit demonstrations of safe sex	
Degree of privacy	High	
Material required	Enough space for participants to act out different situations	
Method	1.	Divide participants into two teams.
	2.	Ask each team to prepare and simulate a situation where they demonstrate sex acts that are safe.
	3.	One group demonstrates.
	4.	After the demonstration, the other group analyses the simulation to check: <ul style="list-style-type: none"> <input type="checkbox"/> Whether the acts demonstrated are really safe <input type="checkbox"/> Whether they are realistic and practicable <input type="checkbox"/> Whether they can be practised in any situation or would require special circumstances <input type="checkbox"/> Whether anything can be done to make the act even safer <input type="checkbox"/> The second group demonstrates and the other group analyses using the same set of criteria
	5.	Based on the assessments the groups are awarded points
	6.	Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them
Adaptation for repeat use	For repeat use, the groups can be asked to demonstrate: Sex acts of particular kinds, such as vaginal, anal, oral, physical but nonpenetrative, noncontact	

Method 2. HRG Advisors

Purpose of the method	To enable HRGs to discuss who they can go to for advice and to build skills in assessing advice given on HIV/STI risk reduction.
Requirements for facilitation	Knowledge of HRG context and social networks, also of what the group needs to gain in terms of knowledge and skills for HIV/STI risk reduction.
Degree of privacy	Medium, can be done in public depending on the nature of the dilemma being discussed.
Material required	Props or labels to remind people who the advisors are
Method	<ol style="list-style-type: none"> 1. Settle the group with an icebreaker. 2. Split the participants into small groups and ask them to come up with a barrier to HIV/STI risk reduction that is a problem for their HRG group/subgroup (e.g. police harassment, fear of HIV testing). Share the problems from each group and decide together which one is a priority to analyse. 3. Ask the participants to list "people their community group/subgroup go to for advice, people whose advice is trusted and respected". Choose 5 or 6 of these HRG advisors and ask for volunteers to role play the advisors. 4. Ask the group who came up with the problem chosen for analysis to quickly present the dilemma to the advisors. They should do this by telling a short story about a fictional character who has the problem, giving the character a name and presenting some imaginary background information. 5. Ask each advisor in turn to give solutions to the problem presented. Ask the participants to say which advisor has given the best solution. Briefly ask volunteers to act out this solution and discuss how/if it worked and if not, why not. 6. Now ask the participants if they know of anyone in real life who has faced this problem. What happened? 7. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.
Adaptation for repeat	This activity can be repeated using different dilemmas and different advisors.

	Method 3. Statues
Purpose of the method	To help KPs identify and plan ways to address barriers to HIV/STI risk reduction
Requirements for facilitation	Good knowledge of HIV/STI risk reduction strategies which KPs can realistically use within their own context
Degree of privacy	Quite high: this can attract onlookers which can inhibit participants
Material required	Polaroid cameras can be used to take snapshots of the tableaux. The pictures are for KPs to take away with them
Method	<ol style="list-style-type: none"> 1. Settle the group in with an icebreaker. 2. Ask the group to brainstorm ways in which one can contract HIV. Correct any misconceptions and challenge any prejudices. 3. Now split the group into subgroups of 3 or 4 people. Ask each sub-group to decide on a 'freeze frame' or 'tableau' (arranging themselves in a particular way then standing as still as statues, not saying anything) showing one way to reduce the risk of HIV. 4. Go round the sub-groups if necessary to clarify what you want them to do. <ol style="list-style-type: none"> 5. Now ask each sub-group to take turns to show their tableau. Facilitate a discussion amongst the remaining participants about each tableau around the following questions: <ul style="list-style-type: none"> <input type="checkbox"/> What does the tableau show? <input type="checkbox"/> Will their suggestion reduce the risk of HIV? <input type="checkbox"/> If so, how easy would it be to put into practice in real life? <input type="checkbox"/> Are there any changes that could be made to make their risk reduction suggestion more effective? 6. If there are suggestions for change that everyone agrees on, let the group amend their tableau arrangement accordingly. 7. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.
Adaptation for repeat	Alternatively, ask for tableaux that depict risk behaviours and then ask the participants to rearrange each tableau to show how the risk of HIV/STI infection can be reduced.

Method 4. Margolis Wheel

Purpose of the method	To help HRGs identify and plan ways to address barriers to HIV/STI risk reduction.
Requirements for facilitation	Good knowledge of what makes HRGs vulnerable to HIV in the particular context. Knowledge of strategies to reduce risk of HIV.
Degree of privacy	Low
Material required	None
Method	<ol style="list-style-type: none"> 1. Settle the group with an icebreaker. 2. Put the group into pairs. Ask each pair to brainstorm situations that might make people vulnerable to HIV/STI infection. Give an example relevant to the HRG group. Go round the pairs, correct misconceptions, challenge prejudices and make sure that each pair has a different situation. 3. Arrange the group so that there is an inner and outer circle with pairs facing each other. Explain that the inner group are “consultants” and the outer group have come to get their advice. The outer group have 2 minutes with each consultant to explain the situation that makes people vulnerable to HIV/STI infection and ask them for advice on how to change the situation to reduce the risk. 4. Start the clock. After 2 minutes ask all those in the outer circle to move round to the next consultant and ask for advice. Repeat this until those in the outer circle are in their original places. Now ask the pairs to swap round so that those in the outer circle now become the consultant. Repeat the activity. 5. Finish the session by asking people to share the best advice they got for their particular situation. Ask if anyone did not get satisfactory advice and ask the group to comment. 6. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.
Adaptation for repeat use	Ask the group to brainstorm situations in their personal life or work life. Ask the advisors to give solutions that can only be done by an individual or by a group of peers.

	Method 5. KP Drawings
Purpose of the method	To enable MSM to discuss how HIV/STI risk can be reduced in the context of their everyday lives
Requirements for facilitation	Good knowledge of HIV/STI risk behaviours and risk reduction techniques and strategies for MSM
Degree of privacy	Low
Material required	Chart paper, markers
Method	<ol style="list-style-type: none"> 1. Settle the participants in with an icebreaker. 2. Give each participant chart paper and markers. If there are many participants, split them into groups and give each group paper and markers. 3. Ask each group to draw a scene from the lives of their MSM/sub-group. It could be anything they want to portray from the time of waking up to going to bed. It could be part of their work or personal lives. 4. Ask each group to present their drawing to the rest. 5. Ask all the participants to look at the drawings and to pick out aspects of their lives that might make them vulnerable to HIV. Correct any misconceptions, challenge any prejudices. 6. Now ask the groups to take back their drawings and to make one change to their drawing that could reduce the risk of HIV/STI. 7. Discuss the changes to assess them for how realistic and acceptable they are to the MSM/sub-group. 8. End the session by asking the groups to reflect on what they have shared and learned during the session that would be useful for them. Let the community keep their drawings.
Adaptation for repeat use	This activity can be repeated by specifying the type of scene to be drawn—with relatives/family, with close friends, with figures of authority, etc.

Method 6. Graffiti

Purpose of the method	To help participants explore different kinds of sex acts that the HRGs usually engage in with their sexual partners (whether intimate partners or paying ones) and the HIV/STI risks associated with them, so that they can work out ways of making sex safer.
Requirements for facilitation	Good knowledge of safe sex strategies and techniques, comfort with talking about sex in some detail.
Degree of privacy	High
Material required	Chart paper and coloured markers
Method	<ol style="list-style-type: none">1. Ask participants to draw the different sex acts they usually engage with their sexual partners on chart papers. Once the drawings are done discuss with the participants the degree of risk of HIV/STI transmission that each sex act entails. Ask them to put symbols (ticks, numbers or any other) against drawings of each sexual act to denote the degree of risk (High, Low or No risk).2. Discuss with participants if they can suggest any other way of having sex which is safer. Give examples of safe sex practices that are not mentioned by them.3. Through all the steps ensure that the participants are not feeling inhibited or uncomfortable.4. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.
Adaptation for repeat use	On different occasions ask participants to draw either intimate sexual partners, or paying partners.

Method 7. Body Mapping

Purpose of the method	To enable HRGs to explore HIV/STI vulnerability factors relating to the body and to discuss nonpenetrative sex techniques
Requirements for facilitation	Good knowledge of HIV/STI vulnerability factors relating to the body
Degree of privacy	Medium to high
Material required	Chart paper and markers, or chalk for drawing on concrete
Method	<ol style="list-style-type: none"> 1. Settle the participants in with an icebreaker. 2. Ask for a volunteer in each group to lie on the ground and have someone trace the outline of his/her body on the ground or on the chart paper. 2. Ask participants to treat the outline as a naked body and to draw in the details. 3. Now ask participants to discuss the following questions: <ul style="list-style-type: none"> <input type="checkbox"/> Which are the places on the body that feel good when touched? <input type="checkbox"/> Which parts of the body are vulnerable to HIV? How can the virus enter the body? What makes it easier for the virus to enter the body? Correct any misconceptions. <input type="checkbox"/> What options exist for safer sex, particularly non penetrative sex? <input type="checkbox"/> End the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them. <input type="checkbox"/> Let the HRGs keep their drawings.
Adaptation for repeat Use	Body mapping can be repeated to look at the symptoms of different STIs or to focus on what gives pleasure during sex

Method 8. Lovers

Purpose of the method	To enable HRGs to explore HIV/STI vulnerability factors relating to sexual partners and to discuss risky and less risky sexual behaviours
Requirements for facilitation	Good knowledge of HIV/STI risk factors.
Degree of privacy	Medium
Material required	Chart paper and markers
Method	<ol style="list-style-type: none"> 1. Settle the participants in with an icebreaker. 2. Ask participants to draw a picture of an HRG member from their own category at the centre of the chart. 3. Ask them to draw pictures of his/her sexual partners all around the picture and describe the partners (without naming them)—who are they? What do they do? How old are they? How are they related to the person? How did they meet, etc.? 4. Ask participants to indicate against each partner's picture or symbol what kind of sex (penetrative or nonpenetrative) the HRG member in question had with the partner in the last one week, and how many times. 5. Ask participants to deliberate on: <ul style="list-style-type: none"> <input type="checkbox"/> How safe each act was <input type="checkbox"/> What would the HRG have to do to make the unsafe sex acts safer? <input type="checkbox"/> To act on similar solutions, what practical steps would the participants have to take? 5. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them. Let the HRGs keep their drawings.
Adaptation for repeat use	Lovers can be repeated to look at different categories of KPs and different behaviours

Method 9. Why Is It So?

Purpose of the method	To help MSM analyse why risk behaviour occurs and what can be done to reduce them
Requirements for facilitation	Knowledge of risk behaviours and the difference between risk behaviours and vulnerability factors, knowledge of MSM context
Degree of privacy	Low
Material required	Chart paper and coloured markers
Method	<ol style="list-style-type: none"> 1. Ask participants to name the different kinds of behaviours that put people at risk of HIV/STIs. Correct any misconceptions. 2. Pick one of the risk behaviours. 3. Ask them to draw a symbol of this risk behaviour at the centre of the flipchart inside a circle. 4. Ask 'Why is it so?' and ask them to draw and or write the reasons for the risk behaviour in balloons. 5. Keep asking 'Why is it so?', adding further reasons in connecting balloons until they can think of no more. 6. Ask the participants what the diagram says about the following questions: <ul style="list-style-type: none"> <input type="checkbox"/> What are the most important reasons (vulnerability factors) for risk behaviour? <input type="checkbox"/> What are the ways that MSM already try and reduce risk behaviour? <input type="checkbox"/> What would further help MSM avoid the risk behaviour portrayed in the diagram? 6. End the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.
Adaptation for repeat use	Pick different risk behaviours (e.g., unprotected anal sex, unprotected oral sex)

Method 10. Chakra Wheel

Purpose of the method	To help HRGs identify and plan ways to address barriers to HIV/STI risk reduction.
Requirements for facilitation	Knowledge of HIV/STI prevention methods and of HRG context in relation to HIV/STI risk reduction.
Degree of privacy	Can be done outdoors in impromptu locations if the location is not right within the public domain.
Material required	The wheel can be drawn in the dust with a stick or with chalk on concrete, alternatively use markers and flipchart.
Method	<ol style="list-style-type: none"> 1. Settle the group with an icebreaker. 2. Ask the group to brainstorm ways in which their HRG group or sub-group can reduce the risk of HIV/STIs. Correct any misconceptions, challenge any prejudices. Get the group to settle on 8 important risk reduction methods or strategies. 3. Ask the group to draw a circle and divide it into 8. Assign one risk reduction method or strategy to each segment of the wheel using a symbol or object agreed by the group. Now ask the group to discuss how easy it is for their HRG group or sub-group to use these methods or strategies and shade in the segment accordingly. If it is very difficult for the HRG group to use the method or strategy then only a small part of the segment is shaded in. 4. When the wheel is complete, ask the group to reflect on the segments that have least shading. What action would need to happen to make it easier for the HRG group to use that risk reduction method or strategy? Who would need to be involved in that action? What first steps could be taken immediately and by whom? 5. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them. If necessary, offer one-to-one work with people who may have specific and personal concerns.
Adaptation for repeat use	Keep the original charts or ask the HRGs to keep them and work on a different risk reduction method at each meeting.

Method 11. HIV/STI Services Map	
Purpose of the method	To help participants map, assess and learn how to access formal and informal HIV/STI services available to HRGs in the project site.
Requirements for facilitation	Knowledge of types of formal and informal services important for HRG use in HIV/STI prevention.
Degree of privacy	Low
Material required	Chart paper and coloured markers
Method	<ol style="list-style-type: none"> 1. Ask the participants to draw a map of the site including a few main landmarks. 2. Ask the participants to include in the map any places or people that their HRG group could go to get support for HIV/STI prevention and treatment. 3. Ask the participants to put against each intervention: <ul style="list-style-type: none"> ■ What each service provides ■ How each service helps reduce risk of HIV/STI infection ■ A symbol if the service is very important in HIV/STI prevention 4. Ask them to identify factors that make a particular service attractive to them (such as, distance, cost, behaviour of service providers, confidentiality, effectiveness of services provided, availability and timing, etc). 5. Now ask the participants to rank the services marked as important in terms of how accessible they are to HRGs like themselves (high, medium, low). 6. Now ask them to discuss the services ranked with low accessibility. What could be done to make these important services more accessible to HRGs like themselves? 7. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.
Adaptation for repeat use	<p>This activity is long and can be broken up with repeat use. Keep the chart papers to continue the discussion in the next session.</p> <p>Use original papers after some time and ask participants how site has changed.</p>

Method 12. How Hot is the Spot?

Purpose of the method	To help HRGs identify and plan ways to address barriers to HIV/STI risk reduction.
Requirements for facilitation	Knowledge of HRG context and of relative risk of particular behaviours.
Degree of privacy	This activity generates information that may cause sensitivities between HRGs and the authorities, so some privacy is required.
Material required	Marker pens and chart paper
Method	<ol style="list-style-type: none">1. Settle the group with an icebreaker.2. Ask the group to draw a map of the local area, including any local landmarks to orient the map. Now ask them to use a symbol to indicate on the map the locations where behaviour occurs that puts their HRG group at risk of HIV/STI infection.3. Now ask the group to rank the locations using symbols for “high”, “medium” or “low” according to the level of risk behaviour in each location (in terms of numbers of people or frequency of risk behaviour occurring).4. Ask the group to look at the locations ranked as high. Ask them to discuss what change needs to happen generally to make the location into a medium or low rank. Then ask what individual HRGs or small peer groups could do to reduce risk behaviour in these locations.5. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.
Adaptation for repeat use	This activity is long and can be broken up with repeat use. Keep the chart papers to continue the discussion in the next session. Use original papers after some time and ask participants what may have changed in the site.

Method 13. Story With a Gap

Purpose of the method	To help MSM plan ways to address barriers to HIV/STI risk reduction
Requirements for facilitation	Knowledge of MSM HIV/STI vulnerability factors and risk reduction strategies, ability to facilitate planning
Degree of privacy	Low
Material required	Markers and chart paper when using the variation with drawing
Method	<p>1. Ask the group to quickly draw two different pictures of someone like themselves. After they have finished these drawings, tell the group that one drawing represents someone who has risk behaviours and is vulnerable to HIV. If necessary, explain what is meant by risk behaviour. Ask them to choose which drawing this will be.</p> <p>2. Now ask them details about the imaginary person in the drawing. Help them to build up a story around the drawing by asking them questions like:</p> <ul style="list-style-type: none"> <input type="checkbox"/> What is the name of the imaginary person? <input type="checkbox"/> Where does he/she live? <input type="checkbox"/> What is his/her life like? <input type="checkbox"/> Why is he/she vulnerable to HIV? <p>3. Tell them the other drawing is of someone who does not engage in any risk behaviour and is not very vulnerable to HIV. Ask them similar questions and help them to build a separate story around the imaginary person in the second drawing. This time ask them why the person is not vulnerable to HIV.</p> <p>4. After the two stories have been completed, ask the group to think about things that would help the person in the first drawing become more like the person in the second drawing. After some discussion, ask them to settle on one change (or more than one, depending on the time available) that would really help the person reduce his/her HIV risk. It does not necessarily have to be a change that the person in the drawing would make himself; it might be a change that other people have to make.</p> <p>5. Now ask the group to make a series of brief drawings outlining the steps necessary for the change to happen.</p> <p>6. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.</p>

Method 14. HRG Storytelling	
Purpose of the method	To enable HRGs to reflect on options and choices in particular situations that may reduce the risk of HIV/STI infection.
Requirements for facilitation	Good knowledge of situations which may lead to HRGs having HIV/STI risk behaviours, and knowledge of realistic strategies to reduce this risk for HRGs.
Degree of privacy	Medium, can be done in public depending on the nature of the situation chosen by participants for the story.
Material required	Any prop that can act as a “trigger” for the story
Method	<ol style="list-style-type: none"> 1. Settle the participants with an energizer. 2. Ask participants to list situations in their daily lives that might lead to behaviour that puts them at risk of HIV/STI infection. Discuss priorities and settle on a particular situation for the story. 3. Use the trigger, saying that the <i>object</i> (book, watch, shoe, etc.) belonged to someone who was in the <i>potentially risky situation</i> chosen (e.g. having group sex, etc.) 4. Ask the participants to come up with a short story (in groups or in plenary) about a person in the potentially risky situation they have chosen. They should give the story characters names, describe them, and explain events leading up to the potentially risky situation. 5. Now ask participants to volunteer to role play the story. Just before the risk behaviour occurs, ask them to “freeze” the action. Make sure that the volunteers are frozen in a comfortable position. Ask the participants if they know of anyone who has been in a similar situation and ask them to describe what happened next. 6. Now ask: What options did the people in the story have at the freeze point to avert or reduce the risk of HIV/STI infection? Once the group has agreed on some realistic options, ask different volunteers to role play them to see how they might work in practice. Discuss the outcomes: did the options help to reduce risk of HIV/STI? If not, why not? 7. Now ask: Is there anything different people could have done to avoid the potentially risky situation altogether? Discuss these options for acceptability and for how realistic they might be for HRGs to put into practice. 8. Finish the session by asking the group to reflect on what they have shared and learned during the session that would be useful for them.
Adaptation for repeat use	This activity can be interrupted and continued when the group next meet, starting with participants being asked to summarise the story and discussion from the previous meeting.

Section III SelfAnalysis Process

Self analysis of IPC capacity standards allows those directly involved in IPC outreach to MSM to assess the strengths and weaknesses of their work in the context of the NGO/CBO. The analysis has five steps:

Step 1: Building the right environment for discussion.

Step 2: Facilitating a discussion of the IPC capacity standards.

Step 3: Facilitating the group to determine scores for the basic IPC capacity standards.

Step 4: Facilitating the group to analyse capacity needs and identify priorities to be addressed.

Step 5: Preparing a report on the outcomes of the process.

Prior to the first step, the following questions should be considered:

- ☐ Who will manage and facilitate the process?
- ☐ Will external facilitators be used? If yes, how will they be identified?
- ☐ Who will participate in the capacity standards analysis?
- ☐ What logistical considerations need to be addressed (scheduling, costs, venue)?
- ☐ How will the process be documented? And how will the documentation be used?

Materials needed for the process: A4 paper, marker pens, writing pens, flip charts, photocopies of the basic IPC capacity standards and a copy of the reports from any previous analyses of IPC capacity.

Step 1 Building the right environment for discussion

To get the most out of the self analysis process outlined in this guide, users must be committed to honest and critical reflection. To foster this, a safe environment for discussion needs to be created. This includes the following:

- ☐ The analysis should take place at a time convenient to all participants.
- ☐ An environment must be created where participants feel they can be openly critical without fear of negative consequences.
- ☐ The facilitator should seek to generate a range of opinions; no one person should dominate the group.
- ☐ Participants should be encouraged to give high and low scores when it is warranted rather than just rating everything as average.
- ☐ The venue should be quiet and private. Participants should not be allowed to wander in and out to answer phone calls or to leave and rejoin sessions.
- ☐ If it is not possible to have all the staff involved in the analysis, the group should at least reflect a range of views, experiences and roles within the organisation. It should involve senior staff, field coordinators, outreach

workers, IPC facilitators and PEs. Participants should be familiar enough with the capacity area to contribute to the discussion in an informed way.

Representatives from SACS, TSU and capacity building partner could be invited as observers, but this is not mandatory and may constrain the group.

An objective facilitator with strong knowledge of the IPC process should be appointed either from within the organisation or externally. The facilitator is central to the success of the session. They *should not take part* in the discussion, but rather guide it.

Someone should also be appointed to record the key points of the discussion. This can be used for the final report.

Step 2 Facilitating the discussion

The responsibilities of the facilitator include:

- Introducing the concept of self analysis and explaining the process that will be followed.
- Ensuring that each of the basic IPC capacity standards is discussed, deliberated on and challenged within the group.
- Ensuring that all views are heard and respected. This includes being sensitive to existing hierarchies and ensuring that some members do not intimidate others.
- Ensuring that all questions get appropriate attention and not letting

participants become embroiled in a side issue or on going disagreement.

- Generating positive and productive group interaction. This includes probing for further information and asking the group to respond to statements by an individual (using questions such as ‘What do the others feel about that?’).
- Encouraging critical reflection and guarding against the group tendency to provide only positive responses.

Facilitator’s Guide

The facilitator should provide the capacity standards scoring sheet to the participants and explain how to use it. The facilitator should then use the questions provided against each standard to facilitate clearer understanding of the standards to enable proper scoring.

Basic IPC Capacity Standards for HIV/STI Risk Reduction With HRGs	Questions for the Facilitator
<p>1. All IPC sessions have moved beyond giving messages to the HRGs, and IPC facilitators now involve HRGs in discussion, debate and critical reflection about reducing their risk of HIV/STIs.</p> <p>2. In all IPC sessions, HRGs are helped by the IPC facilitator to:</p> <p>(1) Analyse their barriers to risk reduction</p> <p>(2) Find acceptable and realistic solutions to these barriers (3) Plan how they will put the solutions into practice.</p>	<ul style="list-style-type: none"> ■ Do the IPC facilitators provide enough space, security and stimulation to enable HRGs to discuss “their” issues for HIV/STI risk reduction? How? ■ Do the IPC facilitators take the participants through the 4 stages of IPC – <ul style="list-style-type: none"> ● Do they pick barriers for analysis from those identified by the HRGs or provide their own list of barriers? ● Do they suggest solutions and have discussion on what is acceptable and practical for the HRGs?



Basic IPC Capacity Standards for HIV/STI Risk Reduction With HRGs	Questions for the Facilitator
	<ul style="list-style-type: none"> Do they discuss individual/group plans to take the solutions to action? Do the HRGs share their risk reduction techniques?
3. During IPC sessions, HRGs are always encouraged by the IPC facilitators to share their own practical risk reduction techniques and assess the effectiveness of these techniques.	<ul style="list-style-type: none"> How often do the IPC facilitators need to “push” the discussion rather than facilitate it?
4. The organisation promotes and sustains appropriate values and attitudes for working with HRGs amongst all staff, and particularly amongst IPC facilitators (e.g. they are sensitive to HRG’s vulnerabilities, are non-judgmental about sexual practices and lifestyles of HRGs, and work on behalf of the HRGs).	<ul style="list-style-type: none"> Have there been any incidents of IPC facilitators being treated “differently” by the organisation because they belong to a particular HRG? Do the IPC facilitators hesitate in introducing themselves as HRGs? Do they find some of the sexual behaviours practiced by a HRG member unacceptable? Do they feel “different” from other HRG members being in the role of IPC facilitators?
5. IPC facilitators who are selected are acceptable and credible to the HRGs in the site.	<ul style="list-style-type: none"> How does the organisation select, train and support IPC facilitators? Is the process of selection transparent and capable of selecting the desired IPC facilitators? Do the IPC facilitators face difficulty in mobilising a group for a session? Do they enjoy the credibility in the group because HRGs respect them, or is there any other reason for this? How many IPC facilitators are true HRGs?
6. IPC facilitators meet regularly to share information and are able to access regular training, supervision and feedback to update their skills and knowledge.	<ul style="list-style-type: none"> Is there a mechanism by which regular interactions take place between the IPC facilitators? What is it? How does the organisation identify training needs of IPC facilitators? How often are training programmes organised for them? How does the organisation provide feedback and supervision?

Basic IPC Capacity Standards for HIV/STI Risk Reduction With HRGs	Questions for the Facilitator
<p>7. IPC facilitators have consistent supplies of condoms and lubricants and other risk reduction commodities and information for demonstration and discussion purposes. They also have sufficient supplies of paper and markers and other materials needed for IPC methods.</p>	<ul style="list-style-type: none"> ■ Do IPC facilitators have adequate supplies to enable smooth implementation of IPC? ■ If there is a shortage, what do they do?
<p>8. IPC facilitators are able to make a safe space for the maximum number of HRGs to participate in IPC sessions. They can facilitate sessions in which HRGs feel comfortable to share sensitive issues. They use methods which help HRGs be creative in finding solutions to problems. They work at times convenient to HRGs, and which do not interfere with income generation.</p>	<ul style="list-style-type: none"> ■ Do they know how and when and where to work with HRGs? ■ Have there been instances of public interference or opposition or violence during or after the IPC sessions? ■ Are the HRGs comfortable discussing sex and sexuality with the IPC facilitators? ■ What is the proportion of sessions where the facilitator “does” the method for the group?
<p>9. IPC facilitators keep informed about key HIV/STI risk reduction issues that are relevant for the HRGs in the site. They are able to respond to the hierarchy of HRG needs (e.g. on a continuum from basic prevention skills and knowledge for new entrants to the HRGS community, to VCTC and positive prevention for those who have been around longer).</p>	<ul style="list-style-type: none"> ■ Do the IPC facilitators have a knowledge of most (if not all) of the HIV/STI prevention services available in their site? ■ Do the IPC facilitators have a knowledge of most (if not all) of other (than HIV/STI prevention) services available in their site? ■ How many referrals do they make every month (average)?
<p>10. IPC facilitators can link HRGs with other prevention services in the site (e.g. STI treatment, VCTC, condoms, lubricant, injecting equipment, counselling, mutual support opportunities, etc.). They are also able to refer HRGs to other services that are important to them (e.g. credit, childcare, education, etc.).</p>	

Basic IPC Capacity Standards for HIV/STI Risk Reduction With HRGs	Questions for the Facilitator
11. The organisation is aware of and able to reach HRGs who are hardest to reach with IPC methods and actively targets new HRGs and those HRGs most at risk.	<ul style="list-style-type: none"> ■ What are the ways by which the IPC facilitators get information about new HRGs? ■ What is the ratio of new to old participants in a session?
12. Regular feedback from IPC work in the field helps the organisation to understand the changing needs of HRGs in terms of risk reduction and to adapt other intervention strategies accordingly.	<ul style="list-style-type: none"> ■ How does the organisation learn about changes in the site and about issues that affect the vulnerability of different HRGs? ■ How often do the IPC facilitators meet with the NGO coordinator? ■ Does the organisation have committees with significant HRGS representation on them?
13. The organisation contributes to, and learns from, the implementation of a State-level communication strategy using information collected on a regular basis from their IPC monitoring.	<ul style="list-style-type: none"> ■ How is the information gathered from IPC sessions collected from the IPC facilitators and documented by the organisation? ■ How has the information collected from the implementation of IPC helped the organisation in tuning their programmes/interventions to the needs of the HRGs? ■ How often does the organisation share the information generated from IPC sessions to other stakeholders, policy makers, etc.?

Step 3 Facilitating the group to determine scores for the basic capacity standards

Copies of the IPC standards should be made for participants to refer to. After the group discussion, participants should form pairs or small groups and determine a score for each IPC capacity standard. When they have done this, the whole group can come together and agree on a final score.

Where there are big differences in scoring between the small groups or pairs, each small group should explain why they gave the score they did. It is important that they then try and reach a consensus on a final score, but where it is not possible, an average of the different small group scores can be taken. Keep a final copy of the standards reflecting the scores after the whole group has shared their thoughts and the discussion has taken place.

Basic IPC Capacity Standards for HIV/STI Risk Reduction with KPs

Scoring Sheet

These standards are not ‘indicators’ which can be objectively measured; rather they are designed to stimulate discussion in the organisation so that creative ways to improve IPC for HRGs can be found. This means that although an organisation can use the standards to see where it has strengthened its own IPC for risk reduction, the score of one organisation cannot be compared with the score of another organisation.

Scores are designed to indicate the degree of action required in order for each statement to be completely true for the organisation:

DK =Don’t know or not applicable

1 = Needs urgent attention

2 = Needs major improvement

3 = Satisfactory, needs some improvement.

4 = Satisfactory, needs a little improvement.

5 = Exemplary, cannot be improved

Although difficult, a frank and critical approach will mean that the final scores are more meaningful and useful to the organisation. In particular, participants should think carefully before assigning a ‘5’—is there *really* no room for improvement? Even if the standard is being reached, are there opportunities to improve the *quality* of the work?

Basic IPC Capacity Standards for HIV/STI risk reduction with HRGS	DK	1	2	3	4	5
1. All IPC sessions have moved beyond giving messages to the HRGs, and IPC facilitators now involve HRGs in discussion, debate and critical reflection about reducing their risk of HIV/STIs.						
2. In all IPC sessions, HRGs are helped by the IPC facilitator to: (1) Analyse their barriers to risk reduction (2) Find acceptable and realistic solutions to these barriers (3) Plan how they will put the solutions into practice						
3. During IPC sessions, HRGs are always encouraged by the IPC facilitators to share their own practical risk reduction techniques and assess the effectiveness of these techniques.						
4. The organisation promotes and sustains appropriate values and attitudes for working with HRGs amongst all staff, and particularly amongst IPC facilitators (e.g. they are sensitive to HRG's vulnerabilities, are non-judgmental about sexual practices and lifestyles of HRGs, and work on behalf of the HRGs).						
5. IPC facilitators who are selected are acceptable and credible to the HRGs in the site.						
6. IPC facilitators meet regularly to share information and are able to access regular training, supervision and feedback to update their skills and knowledge.						
7. IPC facilitators have consistent supplies of condoms and lubricants and other risk reduction commodities and information for demonstration and discussion purposes. They also have sufficient supplies of paper and markers and other materials needed for IPC methods.						
8. IPC facilitators are able to make a safe space for the maximum number of HRGs to participate in IPC sessions. They can facilitate sessions in which HRGs feel comfortable to share sensitive issues. They use methods which help HRGs be creative in finding solutions to problems. They work at times convenient to HRGs, and which do not interfere with income generation.						

9.	IPC facilitators keep informed about key HIV/STI risk reduction issues that are relevant for the HRGs in the site. They are able to respond to the hierarchy of HRG needs (e.g. on a continuum from basic prevention skills and knowledge for new entrants to the HRG community, to VCTC and positive prevention for those who have been around longer).					
10.	IPC facilitators can link HRGs with other prevention services in the site (e.g. STI treatment, VCTC, condoms, lubricant, injecting equipment, counselling, mutual support opportunities, etc.). They are also able to refer HRGs to other services that are important to them (e.g. credit, childcare, education, etc.).					
11.	The organisation is aware of and able to reach HRGs who are hardest to reach with IPC methods and actively targets new HRGs and those HRGs most at risk.					
12.	Regular feedback from IPC work in the field helps the organisation to understand the changing needs of HRGs in terms of risk reduction and to adapt other intervention strategies accordingly.					
13.	The organisation contributes to, and learns from, the implementation of a state-level communication strategy using information collected on a regular basis from their IPC monitoring.					

Step 4: Facilitating the group to analyse capacity needs

After the scoring against standards has taken place, participants should identify the areas where the organisation is strong, and areas where capacity needs to be strengthened.

Ask the participants to focus their attention on the capacity standards which have been scored between 1 and 3:

Think about capacity gaps that need immediate/urgent attention (score 1).

Think about the low capacity areas that need major improvement (score 2).

Think about the average capacity areas that need some improvement (score 3).

Discuss:

- ☐ What action can be taken?
- ☐ How can that action be taken?
- ☐ How urgent is the action?
- ☐ Who will take responsibility for this?
- ☐ Do we need external help or is this something we can do ourselves?
- ☐ Are there any resources that could help us with this?
- ☐ Write down the findings using the planning table format below. Include any actions carried over from the previous plan if one was made.
- ☐ Discuss what the next steps should be.
- ☐ Fix a deadline for the finalisation and distribution of the report (SACS/PSU, other partners, etc).
- ☐ Follow up on the actions that have been agreed on.
- ☐ Discuss how the findings of the analysis will be shared with other staff and stakeholders. Decide when the next biannual analysis of IPC capacity will take place.

Need	What?	When?	Who?	Resources
Capacity gap identified	Action needed	Now/in the next 2 months/in the next 6 months	List people to be involved	required

Step 5 Compiling a report of the basic IPC capacity analysis

The basic IPC capacity standards report should include the following sections:

- ☐ Organisation name and date of report
- ☐ Overall conclusions from the session
- ☐ Final capacity standards score sheet
- ☐ What has improved in the last 6 months? (If a similar exercise was done in the past)
- ☐ Capacity strengthening plan
- ☐ Signature of NGO director or representative

The report should provide a succinct and clear summary of the findings of the capacity analysis and include as attachments the final capacity standards scores and the capacity strengthening plan for review during the next selfanalysis.

A copy of the report should be kept in the organisation and one should be sent to the SACS/TSU. The organisation may or may not want to share it with other partner organisations.

Annexure 6: Crisis Response System

Rationale for Crisis Management

Harassment and violence directed against sexual minorities is common and is a significant barrier to targeted interventions for key HIV-affected populations. Harassment may include verbal abuse, arrest on false charges (e.g., of solicitation or for

carrying condoms), beatings and even sexual assault.

Harassment and abuse may come from the general public, police, goondas, local leaders, clients, or from within the KP itself.

In order to create an environment that supports members of the HRG in building their self-esteem, such violence and harassment must be eliminated through timely and proper crisis response and regular sensitisation and advocacy programmes. This, in turn, will help HRGs focus more on their health and, specifically, on issues relating to STIs, including HIV/AIDS. As part of a TI, crisis response interventions increase outreach to members of the HRG, thereby strengthening the NGO's or CBO's relationship with them and gaining their trust. Crisis response also helps build rapport between field workers and members of the KP, which facilitates communication about prevention and treatments of STIs.

Essential Ingredients of Effective Crisis Management

- Trained and committed staff members who are willing to be 'on call' 24 hours a day and to respond immediately when a crisis happens;
- Effective communication mechanisms (i.e. crisis phone helplines) that the community can contact;
- Availability of information about crisis response among community members;
- Experienced and committed lawyers who are willing to provide assistance 24 hours a day;
- Networking, alliance building, and sensitisation work with local stakeholders (especially the HRG) through regular meetings and education as appropriate;
- This includes community-level legal literacy sessions in close alliance with other CSOs, activists and local media contacts who can advocate on behalf of the community when necessary;

- Reflections on crisis management cases to improve and build internal capacities.

Establishing a Crisis Response System

The following steps can be taken to establish a crisis response system:

1. A crisis management team is established. This should consist of PEs, outreach workers, senior project staff, and legal resource persons familiar with the legal issues surrounding harassment of MSM. The team establishes detailed protocols for staffing and procedures of the crisis response system, and is responsible for implementing these.
2. Mobile phones are obtained to be used exclusively for community members to call in case of a crisis. The project should have at least 1–2 mobile phones available, although in a large urban setting the ideal ratio is at least 1 phone for ~1,000 population.
3. Nominated community members volunteer to manage these phone lines for crisis management. These members may change every month so that a pool of crisis managers develops and no volunteer is over-burdened.
4. Crisis mobiles are never switched off. Volunteers undertake to be available 24 hours a day to respond to a crisis. Many crises happen at night, and the crisis team and project staff should be ready to respond even at odd hours.
5. All crisis mobile numbers are widely circulated within the community through practical, pocket-sized crisis cards printed in the local language as well as English. The card lists the mobile phone numbers and describes the kind of crisis management that the NGO/CBO offers to the community.

The Crisis Response System in Action

1. When a community member calls the crisis number on her own behalf or on behalf of another member who has been harassed or abused, the member of the crisis management team responding to the call immediately gets in touch with other crisis team members to apprise them of the situation. Depending on the nature of the crisis, and according to the criteria for senior staff and legal response established by the team, the crisis team members may inform senior project staff, including the project coordinator and legal resource person.
2. The team ensures that at least one person from the crisis team goes to the spot where the crisis has happened and meets the person concerned. Any crisis should be responded to within 30 minutes of it being reported. It is important to provide immediate moral support and give the message that the person is not alone in this situation and that the person has support from the project.
3. If a police report needs to be filed, or if the situation involves arrest or the person affected is at the police station for any other reason, a team member, along with a legal resource person, should reach the police station within 30 minutes.
4. Every crisis is documented to record the kind of crisis, perpetrators and response. A formal documentation system can be used to show an increase or decrease in the number or type of crisis cases, and the nature of responses to crises. This information can be used both to strategise for improving crisis response, and for public advocacy.
5. Weekly debriefing meetings are held with the crisis management teams to discuss any crises that have happened during the week, followed by collective brainstorming on strategies for improving the crisis response. Examples of Crisis Intervention Materials are reproduced below— an information card and documentation form for a crisis intervention programme targeting MSM and TG in Bangalore, operated by the NGO Sangama.

Flat No.13, Royal Park Apartment,
3rd Floor, 34, Park Road, Tasker Town,
Bangalore - 560 081
Ph. : 080 - 22868680 / 121,
Fax : 080 - 22868191
E-mail : sangama@sangama.org
www.sangama.org

☉ Are you a homosexual / bisexual / hijra /
lesbian / gay / kothi / double decker /
transsexual / transgender ?

☉ Do you face harassment / violence from
family, police, goondas, public,
work place ?

Please feel free to contact
**Sangama's 24 hour
HELPLINES**

99456 01651/52

99456 01653/54

99452 31493

99452 31494 (Samara)

Format:

Situation Report on Community Harrassment/Abuse

This situation report allows for simple and comprehensive documentation of incidents of harassment or abuse against MSM. Full documentation is essential for the purposes of legal response and community advocacy. Following the format of the situation report ensures that the crisis intervention volunteer does not omit information that needs to be collected while the memory of events is still fresh.

Situation Report on Community Harrassment / Abuse

Report Serial #

District

Abuse against: Individual: Yes/ No

Group: Yes/ No

Who was harrassed / abused? (Type)

Hijra	Yes	No	Panthi	Yes	No
Kothi	Yes	No	Pimps	Yes	No
DD	Yes	No	Partners/lovers	Yes	No
Clients	Yes	No	Other (Please Specify)	Yes	No

Who harrassed / abused the above? (If possible record the name(s) of the abuser.)

Rowdies	Yes	No	Community members	Yes	No
Police	Yes	No	Family	Yes	No
General Public	Yes	No	Partner	Yes	No
Clients	Yes	No	Others (Please Specify)	Yes	No

Date of Incident Date Month Year

Time of Incident Time AM/ PM

If an individual was harrassed/abused, please record their name/registration number.

If Group, please fill in the number of people who were abused and their type, and if possible their names/registration number.

Incident Details (Include kind of abuse and extent of damage. Where did the incident happen (Location, police station area etc.)? If physical injuries were sustained, please record.

Date and time the project made its first response to the incident through its staff.

Date	Month	Year	Time	AM/ PM
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Action taken by the office/staff (was a report filed, was the abused person taken to hospital, etc.?).

Follow-up actions to be taken

Date the issue was resolved completely

Date	Month	Year
------	-------	------

Report filed by

Date

Any incident should be recorded in which the target community, staff and the associates of sexual networks, etc. were beaten up, arrested, raided or suffered any other form of abuse, including extortion and forced sex, whether by the police, rowdies, clients or the general public.

This report must be filed on the day the incident happens. Best practice is that the report is shared immediately with the programme manager. It is expected that if the case is genuine, partner will take necessary response in coordination with the District HIV/AIDS committee or any other relevant committee/individual. Responses could include an FIR, personal visit to the affected person/group, and in the case of beatings the provision of medical aid, medical report, evidence gathering, photographs etc., as well as discussions with the community and building of response strategies. The underlying principle is to make abuse reporting and action a routine activity and ensure that the response is not ad hoc.

Annexure 7: Indicators for assessing and evaluating community mobilisation

http://www.praxisindia.org/files/Measuring_Community_Mobilisation_June_10.pdf

Annexure 8: Broad Mapping (Overview)

MAPPING MSM - GEOGRAPHIC MAPPING, SIZE ESTIMATION AND SITE ASSESSMENT (Physical and Virtual)

Background

A. Mapping in the context of HIV intervention for physical sites

Mapping, in the context of NACP-III TIs (and for this document), refers to the following three exercises:

1. Review of secondary data;
2. 'Broad mapping', to estimate size, identify MSM typology and locations of risk; and
3. 'Site assessment,' to derive basic insights into factors that make MSM particularly vulnerable to HIV, and to initiate interventions MSM will be 'mapped' in each state in two distinct phases:

1. In the first phase mapping is to be carried out:
 - In areas where TIs addressing MSM are in operation
 - Any other areas where TIs are not in operation but MSM are known to be present in significant numbers

2. The second phase of mapping is implemented when SACS and TSUs identify major geographic areas in the state which have been left out of TI coverage. This could be done through a review of TI data against state geography.

The objective of mapping in the second phase is to ensure that such gaps in coverage are 'mopped up' through commissioning of new TIs or reconfiguration of existing TIs. Mapping in the second phase will follow the same methodologies as in the first phase. These guidelines describe mapping in the first phase.

Key Terms

- A geographical area demarcated by a definite boundary (e.g. town, city, village) is referred to as a 'physical site'.
- Areas within a site where there is significant concentration of MSM are referred to as 'hotspots'. Within hotspots, MSM may solicit, cruise, and interact with their peers and even other groups at risk for HIV, or have sex. Hotspots may be starting points for virtual networks, especially cell phone networks, and a need assessment of addressing virtual networks should be carried out.

The overarching goal of mapping MSM is to put appropriate and effective interventions in place. Therefore, it is important to remember:

1. Mapping must be rapid—based on its results the TIs have to be designed and services have to reach these populations urgently.
2. Those who are mapping MSM must know how to find them. They must be credible and acceptable to the MSM and, most importantly, must be respectful towards the norms, practices and rights of MSM. This is because a significant proportion of MSM are hard to reach or hidden or physically scattered. The stigma, discrimination and violence they experience from mainstream society often make them even more inaccessible, as they are usually reluctant to share personal information with outsiders.
3. Methodologies must be usable, ethical and MSM friendly.

B. Objectives

To identify or confirm locations within states and districts where TIs ought to be placed to reach MSM who are most vulnerable.

TIs will address only those MSM who are most at

risk, by assessing their risk behaviour. Accordingly, it will be essential to immediately address the needs of individuals within the MSM community who practise high risk behaviour.

Validate estimates of size.

- Generate estimates of the size of the MSM population in each physical site, by different categories (on the basis of risk and typology);
- Provide locations of hotspots where HIV risk activities predominantly take place;
- Generate information to help understand the mobility patterns of MSM within and outside the site and linkages to virtual networks;
- Explore the HIV/STI risks that MSM face and the vulnerability factors that exacerbate such risks;
- Characterise MSM in terms of risk profile to facilitate subsequent programming;
- Identify their HIV related needs, existing HIV interventions and key gaps;
- Begin the process of mobilising MSM for HIV/STI prevention;
- Build awareness about HIV;
- Increase knowledge about risk reduction strategies;
- Increase knowledge about existing HIV/STI prevention interventions for MSM;
- Build social capital and solidarity amongst MSM—a collective voice;
- Explore safe and private spaces for MSM to meet and work together;
- Build a core group of MSM from the site who will serve as an important resource for project implementation by recruiting and training local MSM to implement mapping.

C. Guiding Principles

Pay attention to definitions of MSM (including sub-categories).

We must clearly define the MSM whom we are mapping. Otherwise, those conducting the exercise will not know whom to count and whom to leave out. That is, define who constitutes MSM and who among them are at high risk or exhibit high risk behaviour.

Involve MSM in the mapping exercise.

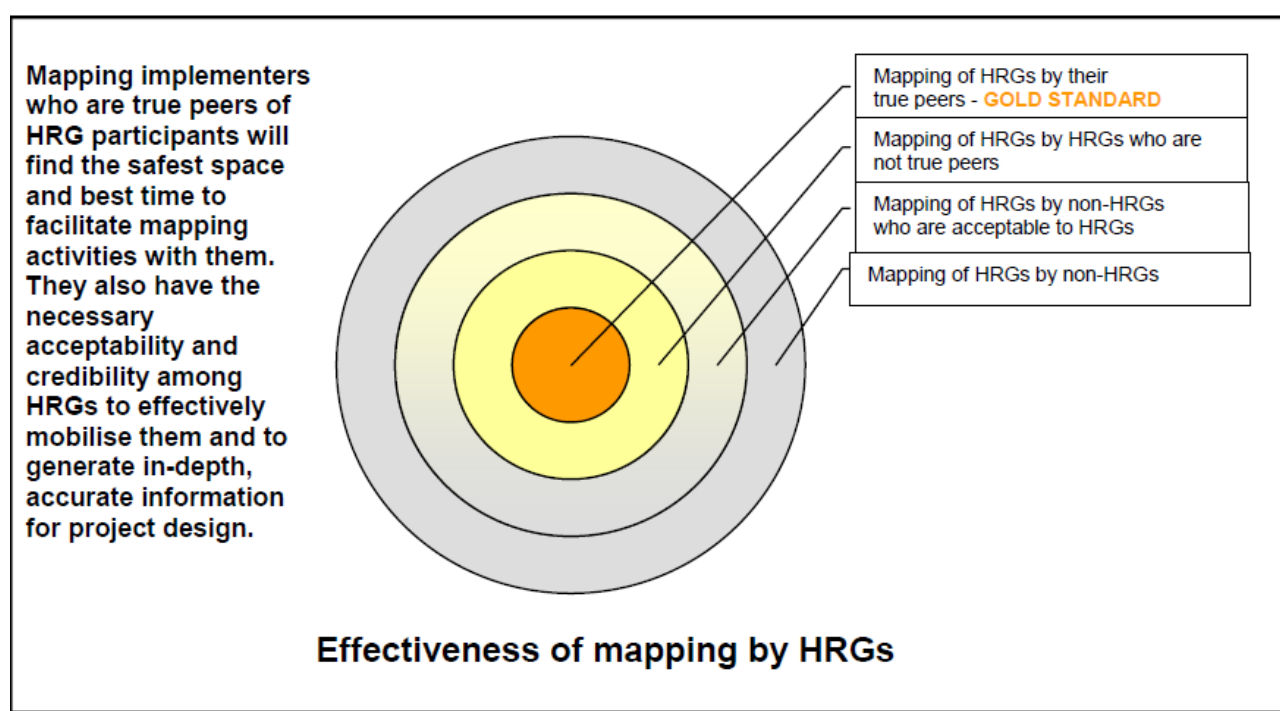
- Experience shows that if MSM themselves are recruited to conduct the mapping the results will be more accurate. It is also important to recruit representatives from all sub-categories of MSM that are available in a site—community dynamics within MSM groups can vary depending on the typology, and MSM community members can be relied upon to provide their expertise to address these issues.
- Since mapping involves getting people to provide sensitive information about their sexual behaviours, their partners, locations, networks, etc., MSM members are more likely to share information without fear or prejudice if it is solicited by people from the same group, who are acceptable and credible to them.
- When MSM members are responsible for it, the process of mapping becomes an intervention in itself—it mobilises local MSM communities to understand and address HIV risks and creates a demand for HIV services. So, while the mapping is being carried out, the intervention simultaneously gets underway.
- Of course, like all other researchers, the MSM field research team must be trained to do the mapping and will also require administrative and technical support throughout the process. This additional

support will be provided by professional but community-friendly members in the mapping team.

Some critical criteria for selecting people responsible for carrying out the mapping:

- Must be true peers of and be able to represent different categories of MSM in the areas being mapped
- Must be credible and acceptable to MSM
- Must know and be well known in the site

- Must be motivated to work along with peers on HIV/STI risk reduction
- Must be available throughout the mapping process—from training, field level implementation, feedback and analysis of data, to dissemination, i.e. must agree to take time off from their regular occupation for a considerable period of time (for which they will be financially compensated)



Gather information from multiple sources.

Triangulation is a critical component of any mapping exercise. Information gathered from one source needs to be verified against information from other sources. In order to triangulate the data, it is important to have multiple sources of information for mapping:

1. Primary key informants are MSM.
2. Secondary key informants are those who are part of or close to the occupational or sexual lives of MSM—shopkeepers near risk sites, and auto rickshaw drivers near sex sites.
3. Tertiary key informants are those who are well-informed about MSM in a town/district/state, e.g.,

NGOs, government officials, pharmacy owners, local journalists.

It is advisable not to consult groups that are known to have adversarial relationships with the particular MSM, such as ruffians, as this might jeopardise the trust of local MSM in the mapping exercise or cause them actual harm.

A rule of thumb

Although secondary or tertiary stakeholders are often aware about MSM, they never have the complete or same picture as MSM themselves. Therefore, in any mapping exercise, more than 60 per cent of respondents—i.e., people who are

consulted for information—must be among the MSM being mapped.

Understand the limitations of the mapping process

Mapping is not the same as formal research or ethnographic study. So the information it generates can, (a) be limited to informing the design or review of HIV interventions; and (b) be site-specific and therefore not generalisable to other sites. Keep in mind that size estimates are just that—they are not an exact headcount of individual MSM members. Moreover, there is constant movement and mobility, and therefore estimates arrived at from mapping must be regularly revised and updated through the course of TI implementation.

Do no harm, be ethical

As mapping is an integral part of NACP-IV, it must be implemented in a way that reflects and reinforces the core values and approaches of NACP-IV—ensuring the wellbeing and protecting the rights and interests of MSM. While mapping it is important to remember the secret, socially marginalised, and also formally criminalised status of most MSM and the practices that they engage in. To protect MSM participants, the following key guidelines are to be followed:

- Do not breach the confidentiality of MSM
- Seek the consent of MSM before involving them in the mapping exercise
- Be prepared to handle the negative consequences of mapping for the MSM—have a harm reduction plan
- Do not raise false expectations (e.g., promise services, jobs or remuneration)

Steps to ensure protection of MSM during mapping

1. Gaining access to MSM may require going through various gatekeepers such as employers. Mapping teams must hold discussions with gatekeepers and clarify the purpose of the exercise—size estimation, providers of services to MSM, places where MSM

members operate and obtaining information to guide the design of HIV interventions or improved implementation of ongoing projects. Gatekeepers should be told that all information gathered by the mapping team will be kept anonymous and confidential, and will not be shared even with them.

2. Specific efforts should be taken to inform the NGOs/CBOs working with the populations covered by the mapping, as well as community leaders, about the purpose, risks and benefits of the mapping exercise.

3. The mapping exercise is anonymous. No names or personal identifiers should be recorded. Mapping teams and others associated with the exercise must ensure that mapping records are kept secure throughout the process and afterwards.

4. Mapping teams must take witnessed verbal consent from each participant before they involve her/him in the process. All mapping documents and information should be labelled in such a way that the participants remain anonymous. Prior to the implementation of any mapping procedure or method, those who are implementing it must explain the procedure in detail to potential participants, and answer all questions to the full satisfaction of the participants. The mapping team should emphasise that participation is voluntary and should participants decide not to participate or withdraw from the procedure at any time, their decision will not affect any services from the NGO/CBO or the clinic that they normally receive.

5. Mapping teams, SACS, TSU and NACO should closely monitor the consent procedure through spot checks.

6. Discussions should be held between SACS, TSU, NACO, the mapping team, local NGO/CBO staff and community leaders on the potential use of information for programming when the mapping is complete or before any dissemination of mapping data.

7. Those implementing the mapping exercise

should adopt stringent measures to ensure that participation does not expose MSM to any risk or cause them any harm. However, it is also essential to spell out the specific steps to be taken to mitigate the harm that MSM participants might still be exposed to, despite such precautionary measures, and how MSM participants will be supported by the implementers of mapping following such incidence of harm.

These steps are necessary not just to mitigate any harm caused materially (such as money to compensate for loss of work or other support like legal aid, safe custody, etc.), but also to establish that NACP-IV respects the rights and entitlements of MSM and acknowledges that any harm to them ought to be substantively redressed.

Steps	Programmatic Objective	Where to be Implemented	Output Expected	Timeframe
1. Review of available information	To determine the sites where mapping will be carried out	At state level	List of sites to be mapped <ul style="list-style-type: none"> ▪ All sites where there are TIs ▪ Sites where there are no TIs but are obvious and/or reported concentrations of HRGs such as cities/towns, trading centres, religious centres 	2 weeks
2. Broad mapping and feedback and analysis of data	To determine where to place the TIs (which district)	At site level	<ul style="list-style-type: none"> ▪ List of reported hotspots ▪ Size estimation by subcategories ▪ HIV/STI services available for HRGs 	4–12 weeks, depending on the size of the state
3. Site assessment, including feedback, data analysis	To determine the site-specific design of TIs	Within a site at hotspot level	<ul style="list-style-type: none"> ▪ Confirmed list of hotspots in the site ▪ Fine-tuning of estimated numbers by sub-category in the site ▪ Mobility pattern of HRGs ▪ Availability of HRGs ▪ Risk profile of HRGs 	6–12 weeks

(The shaded area represents activities which are a part of TI processes.)

Internet site mapping			
	Activity	Tool	Result
Step 1	Conduct FGD among local groups	1	Most used internet site in that district
Step 2	Estimate no. of internet profiles in a district	2	Identification of high density districts
Step 3	Time-based mapping of a district	3	Peak hours of online activity and presence
Step 4	Annual monitoring of a district	4	Tracks district density throughout the year
Step 5	Quarterly tracking of all districts	4	Identification of new high-density districts
Step 6	Steps 1, 2, 3 for new districts		

E. Involvement of TIs

As far as possible, NGOs and CBOs implementing TIs should be engaged in the process of mapping: they should understand the process and realise why such close participation of MSM is critical for successful mapping. Only when they know how and why information is being gathered will they trust the information and use it to shape their intervention design. In addition, involvement in the mapping process enables NGOs, CBOs or networks running TIs to fully understand the complex realities of the lives of MSM. Witnessing the competence with which MSM implement mapping also convinces NGOs of their full potential as partners in interventions.

While TI involvement in mapping is ideal, TIs are likely to be at different stages of maturity, and coverage of MSM by TIs may vary from state to state. As a rule of thumb:

1. In all cases where a TI has been in operation for some time and has an extensive and effective intervention programme, the NGO/CBO running it should ideally be involved in every step of mapping.

However, it is recommended that MSM members who are not being paid or working with the existing TI (as PEs, outreach workers or in any other paid or voluntary position) be selected to do the mapping. Of course, if the TI in question has already mapped the MSM they work with, with substantive participation of MSM themselves, and the data they have is reliable and credible, there is no need to repeat the mapping in their operation site/s.

2. In areas where TIs have been commissioned but the intervention is new, mapping should be carried out as the first step of the intervention, and if necessary, the design, location or composition of those TIs should be reconfigured based on the mapping information.

3. In areas where MSM presence is reported but TIs are not yet in place, mapping needs to be carried out first, and TIs are then to be contracted depending on the number of MSM present. Since it takes considerable time to advertise for, select and contract TIs, advertisements can be placed based on the information generated through the review, and TIs can be selected from among those who apply, based on the information from the broad mapping exercise.

Steps	Involvement of TIs
1. Review of available information	Existing TIs to be consulted
2. Broad mapping	Ideal but not imperative
3. Site assessment	Close involvement recommended
4. Feedback and data analysis	Close involvement recommended
5. Report writing	Not necessary
6. Dissemination	Close involvement recommended

Based on information from the review, the requirement of new TIs can be estimated and accordingly Expressions of Interest can be advertised.

Based on information from broad mapping, organisations can be selected, and if possible within the time, contracted, to run TIs

Selected organisations can be involved, and if already contracted, can implement site assessment as the first step of intervention

What is mapping?

Mapping is the process used to depict the distribution of specific characteristics over a geographical area.

Approaches of broad mapping

Broad approaches:

- Enumerating the risk groups, i.e. risk group approach
- Identifying and typifying locales where risk activities occur, i.e., geographical approach

Key elements

- Clearly defining risk activities and asking strategic questions
- Staged approach and complete trawling of locations, spots
- Direct contact with stakeholders—secondary and primary
- Direct spot validation and triangulation

Scope of Mapping

Information will be collected on the prevalence of high risk activities (HRA) in towns.

- HRA in the case of MSM refers to:
 - Male to male commercial sex work
 - Men who have sex with men (inclusive of all typologies)
- Geographic location profile
- Estimation of HRG group numbers
- Variations in the KP volume
 - Weekly
 - Seasonal
- Number of KPs
 - Belonging to the same town
 - Coming from outside town

Source of information

Information for the study is gathered from Key Informants (KI):

- Primary stakeholders
- Secondary stakeholders
- Tertiary stakeholders

Methodology

- The study will adopt a geographical mapping approach, which has been developed and tested in Karnataka, Kerala and Maharashtra
- Step 1: 30 to 75 field interviews of KIs of tertiary and secondary stakeholders to identify places of HRA
- Step 2: Ranking of places based on HRA, frequency of mention; consolidation
- Step 3: Visits to all the spots with activity of >3, and mapping to be carried out through at least five interviews (3 primary and 2 secondary stakeholders)
- Step 4: One group discussion with each HRG in the town. The GD will validate information from interviews and also provide information about cross-cutting issues like STI providers, movement of MSM, timing, etc.
- Step 5: Compilation, analysis, qualitative reflections

Tools used in the study

A combination of the following tools and methods will be used

- In-depth individual interviews (lead through checklists)
- Group discussions
- Observations

Techniques used in the study

- Clean slate method
- Snowballing technique

- Reaching saturation point

Terms used in the study

- KI (Key Informant)
- Primary stakeholder
- Secondary stakeholder
- Tertiary stakeholder
- Location
- Spot
- HRA: HRG, MSM
- Estimates

Annexure 9: Tools for Virtual/ Internet mapping

Virtual site mapping

SACS must initiate a process of mapping virtual sites for the state. NACP has, so far, maintained a larger focus on physical sites and site-based outreach. Our current TIs are geared to the idea of physical outreach and providing services to these sites. While even today this may be the most relevant mode of outreach, it is being increasingly observed that there is a trend among MSM resorting to communication technology to access other MSM and thereby sexual encounters. These sexual encounters do not necessarily take place in identified hotspots and sex sites, and therefore cannot be addressed by the current outreach strategy alone. Communication technology used by MSM mainly includes the internet as well as mobile phone networks. While mobile phone networks may still have connections with hotspots and physical sites, internet-based encounters do not have any rigid geographical basis. Interactions and meetings can happen amongst MSM irrespective of the city, state or even country they are located in. Hence, within a TI paradigm, we may need to redefine 'site' as a physical site or a virtual site.

Similar to the physical mapping of sites, it is important to map the number of internet users who 'cruise' on the internet and are visiting a particular location, in order to assess the need for mapping and further detailing of an internet-based outreach programme for a particular location. Mumbai, for instance, may be more suited for an internet-based outreach programme compared to Nanded (a semi-urban site) in Maharashtra, based on our primary and secondary data analysis of MSM populations and internet users.

Total number of active virtual sites

Similar to the process of listing down physical sites and the distribution of MSM across sites, virtual sites must also be documented. Although the MSM community may give feedback on the most used internet sites for a specific location it is important to have an evidence-based decision making process. Most MSM/gay websites give location-wise data of individual profiles. Thus, the number of files for a specific location can be aggregated. In order to overcome the issue of websites having different formats of sharing data, it is important to have a data gathering tool ready to standardise data from different sites. This will facilitate drawing of comparisons of MSM data within and across states.

Ethical concerns: Many MSM share their personal data and information on websites. Such data should be strictly used for academic purposes of mapping and determining efficacy of an internet-based outreach programme. Consultants, policy makers and SACs should in no way interfere in community dynamics by creating profiles on these sites to engage the community. Community engagement should be strictly restricted to CBOs and community-appointed staff after conducting thorough research on effective BCC and messaging through the internet.

Steps for virtual mapping:

Determine the number of MSM/gay websites in use in a state/city by conducting FGDs

- Use an existing community profile to log on to various internet sites.
- Go to the 'Users' section (remember that website layouts differ and hence it may be advisable to take the services of an individual from the community who can navigate them easily) and note the aggregate data of profiles registered under various locations. (Note: Details will be aggregated on the basis of state, city or even district. Note the number of profiles on a district-wise basis, or to the extent of smallest geographical unit available.) It is also important to look at travelling advertisements of profiles into a particular location (e.g., some locations may not have any local MSM, but have a huge population travelling from outside).
- Another aspect of mapping is tracking the online profiles of MSM/gay men on internet sites in a 24-hour cycle. (E.g., most people are active online from early evening till late night.) This exercise will be key to understanding internet outreach times for effective message delivery for BCC and outreach.
- A similar exercise for travelling profiles can be tracked for a year to understand the annual cycle of individuals travelling to particular locations. E.g., Darjeeling and Goa may have local MSM populations but may show a spiked increase during their respective tourist seasons.
- Mapping for a particular location can be done purely on the basis of primary data from these internet sites. This can be further corroborated by secondary indicators such as internet coverage, and the number of internet subscribers on city/district basis. A high concentration of cyber cafes could also be considered an indicator as some

towns/districts may have fewer personal internet connections but a strong cyber cafe subscriber base.

Determine the size of population that is accessing the sites in a certain state

It is important to note that the actual number of profiles need not necessarily translate into the actual number of MSM/gay individuals in a particular location. Many men have more than one profile on these sites and the result may be an inflated account of the actual numbers. Since there is no evidence based data on the number of profiles maintained by MSM/gay men on an average, it would be safe to discount the number of profiles by 20–30 per cent after a small dipstick survey of 100 individuals in a location. Moreover, very often people in smaller towns and districts park their profiles under the heads of larger towns and cities for anonymity, but continue to access and message individuals connected to their locations.

Prioritise the cities with 250 profiles and more

After discounting, any town/district/city that has more than 250 profiles should be considered for an internet-based outreach programme. At this stage it would always be wise to understand the composition of the profiles in terms of local/travelling profiles to give further inputs for outreach and BCC strategy.

Select the most appropriate TI and allocate the virtual TI to them

Ideally, it would be necessary to pilot the project in a particular location and further strengthen outreach and BCC strategy. Any internet-based intervention would require the following:

- Staff that is trained to use computers and has knowledge of internet and basic navigation on internet sites;
- All internet-based ORWs need to go through basic counselling modules to effectively handle internet communication;

- A dedicated computer for internet-based outreach at each TI;
- Good understanding of services within the TI, a strong physical site-based TI, and strong linkages and referrals to direct internet populations towards health seeking behaviour;
- A preferred private practitioner at each TI to refer internet walk-ins to paid services, decide indicators, targets, etc.

Plan a single-point intervention for the rest of the members of the state to be linked to one-point service with links to the local TI

Each SACS needs to take a decision on whether the internet outreach programme needs to be operated through a single-point contact put in place by the state or as an additional service provided by a TI. Initially, during the pilot it will be necessary to implement the programme rigorously. In areas where CBOs have adequate capacity, internet based outreach can be implemented through the CBO TI itself. At locations where such capacities are missing the SACS can take the onus of initially running the programme with recruitment from within the community and then transferring skills to the CBO TI.

Negotiating with websites to not be considered as spam

The site administration can be requested to give specific messaging rights to outreach profile IDs. This will allow these IDs to send out BCC messages about HIV and access services without being labelled as spam. NACO needs to negotiate with the website owners at the national level.

Annexure 10: Programme management

Programme Component	1. Mapping and Enumeration	Primary Responsibility		
		SACS	TSU	NGO
Prerequisites	1. Mapping budgets released to SACS 2. TSU established and staffed 3. NGO contracted and staffed (project coordinator, outreach workers, community guides) - only for site validation			
Input	1. NIACO participatory mapping protocols 2. NIACO site verification and profiling tools			
Output:	1. State mapping report with estimated numbers of each HRG with population split by District, site, hotspot and typology (in Year 1 and Year 3) 2. HRG denominator targets for each TI in the State (targets to be revised annually based on validation process)			
	Activities			
Secondary data review to identify locations where mapping is required				
Along with Mapping TRG and State level mapping agency, conduct broad mapping of State and sites identified in desk review				
Oversee agency field work during mapping exercise and provide technical / management support				
Collate mapping data to identify a) potential intervention sites, b) list of hotspots within sites, c) size of HRG population at each site and hotspot by typology (female sex workers, MSM, TG, IDU) and sub-type (e.g. FSW could be brothel-based, street-based, lodge-based, home-based, bar-based, MSM could be kothi, double decker, panthi, etc.)				
Review findings of mapping exercise				
Approve and publish mapping data for the State in collaboration with State level mapping agency				
	Site Validation (from month 1 onward)			
Validation and profiling of each intervention site by joint team of outreach worker and community guides (max of 2-4 weeks / site). Key outcomes include: 1) Finalised intervention denominator and risk profile by site - HRG population size, typology split, hotspot distribution, client volume and condom use estimates 2) One-on-one meetings with at least 50% of HRG denominator at site 3) Create familiarity and acceptability for the project among HRG 4) Identify potential peer educators				
Collate site validation results to finalise NGO-level denominator (size estimates for intervention)				
Periodically (at least every year) update TI coverage targets in the State based on current validated data available from TI NGOs				
Fix denominators for all TIs in the State (review and update at least every year)				

Major Milestones/ Targets	H1	H2
Year 1	1. State and District mapping covering entire State completed, reports finalised and published 2. 100% of NGOs validate mapping numbers for all sites through HRG-led process 3. Denominators fixed for all TIs in the State (basis mapping data and subsequent validation)	
Year 2	1. Mapping numbers at all sites validated by TI NGOs and denominators for TIs revised accordingly	
Year 3	1. State and District re-mapping covering entire State completed, reports finalised and published 2. 100% of NGOs validate re-mapping numbers for all sites through HRG-led process 3. Denominators for TIs revised basis new numbers 4. TIs added / reduced as required based on new information	
Year 4	1. Mapping numbers at all sites validated by TI NGOs and denominators for TIs revised accordingly	
Year 5	1. Mapping numbers at all sites validated by TI NGOs and denominators for TIs revised accordingly	

2. Staff Recruitment and Intervention Start-up (STI clinic staff covered under STI section)		Primary Responsibility		
Programme Component		SACS	TSU	NGO
Prerequisites	1. TI coverage area and denominator fixed 2. TSU contracted and fully staffed 3. NGO contracted and funded as per NACO guidelines			
Input	1. NACO NGO HR Policy 2. Annexure 3, <i>Peer Educator Training</i> 3. Annexure 2, <i>Site Assessment</i>			
Output	1. Validated site profiles 2. NGO staff and peers fully staffed and trained			
Activities				
Recruit NGO project staff (non-clinic staff) 1) Project coordinator - 1 per intervention 2) Outreach workers in the ratio 1 per 250 HRG to be covered by the interventions (TSU support for recruitment, optional) 3) Accountant - 1 per intervention 4) Office support staff - 1-2 per intervention 5) Community guides - 1 HRG member per outreach worker (temporary position only purpose to conduct site validation before peers are hired)				
Training of NGO staff on introductory topics for intervention 1) Basic induction on HIV/AIDS 2) Understanding FSW/community dynamics of sex work 3) Skills in identifying and building rapport with FSW 4) Site validation methodology				
Site Validation (from month 1 onward)				
Validation and profiling of each intervention site by joint team of outreach worker and community guides (max of 2-4 weeks / site). Key outcomes include: 1) Finalised intervention denominator and risk profile by site - HRG population size, typology split, hotspot distribution, client volume and condom use estimates 2) One-to-one meetings with at least 50% of HRG denominator at site 3) Create familiarity and acceptability for the project among HRG 4) Identify potential peer educators				
Collate site validation results to finalise NGO-level denominator (size estimates for intervention)				

Peer Recruitment (from month 3 onward)				
	SACS	TSU	NGO	
Recruit peer educators from the HRG community (as per NACO peer selection guidelines) in the ratio of 1 peer per 60 HRG under intervention coverage. A few critical considerations for peer selection (see section 3.3.1.D for a detailed list): 1) Should be active HRG members 2) Should belong to the predominant typology of HRG at the hotspot 3) Should have responsibility to cover hotspots within one site 4) Should have wide networks in the site to be covered 5) Will receive an honorarium for time commitment to project				
Selected peers trained as per peer capacity building curriculum identified in TI guidelines				
Major Milestones/ Targets	H1			
Year 1	1. 100% of NGO staff recruited and trained as per TI guidelines 2. 100% of sites validated by outreach worker - community guide team			
Year 2	Maintain previous levels			
Year 3	Maintain previous levels			
Year 4	Maintain previous levels			
Year 5	Maintain previous levels			
	H2			
	1. 100% of sites have recruited and trained peer educators as per NACO peer selection guidelines			

Programme Component	3. Infrastructure Set-up (STI clinic setup covered under STI section)			
Prerequisites	1. TI coverage area and denominator fixed 2. TSU contracted and fully staffed 3. NGO contracted and funded as per NACO guidelines			
Input	1. Validated site profile information			
Output	1. Basic infrastructure established			
	Activities	Primary responsibility		
		SACS	TSU	NGO
	Basic infrastructure setup (during first three months prior to peer identification)			
Conduct community consultations to identify suitable location and premises for safe spaces or drop in centers (DIC) at all locations with HRG size >=500				
Provide free condom distribution through outreach workers and community guides to HRG met during consultations and other meetings				
Establish short-term referral services to STI doctors (to fill service vacuum until full-fledged services are set up)				
	Infrastructure Scale-up (after peer recruitment)			
Conduct community consultations to identify suitable location and premises for safe spaces or drop-in centres (DIC) at all locations with HRG size >=100 (At smaller locations safe space can be rented for partial duration of a day if full-time facilities not available)				
Major Milestones/ Targets	H1	H2		
Year 1	1. Safe spaces established in consultation with HRG at 100% of sites with HRG population >=500 2. Outreach workers and guides delivering basic outreach (free condom supply and STI referrals) at 100% of sites with HRG population >=500	1. Safe spaces established in consultation with HRG at 100% of sites with HRG population >=100		
Year 2	Maintain previous levels			
Year 3	Maintain previous levels			
Year 4	Maintain previous levels			
Year 5	Maintain previous levels			

4. Outreach Planning		Primary Responsibility		
Programme Component	Activities	SACS	TSU	NGO
Prerequisites	1. TI coverage area and denominator fixed (including sites, hotspots and target group) per mapping report 2. NGO contracted and funded as per NACO guidelines 3. NGO outreach staff (project coordinator, outreach workers, community guides) recruited to cover intervention area as per staffing guidelines 4. Site validation process completed 5. Basic project infrastructure established (project offices, drop-in centres, clinics) 6. Critical commodities available (Condoms, STI drugs, BCC material) 7. Peer educators from HRG recruited to cover all sites as per peer selection guidelines			
Input	Annexure 5, <i>Peer Led Outreach and Planning</i>			
Output	1. Hotspot level microplans for each peer 2. Site level work plans for outreach workers			
Adapt NACO specified microplanning tools and guidelines for local use				
Train TI project staff (project coordinator, field officers, outreach workers and peer educators) to use microplanning tools				
Implement Phase 1 of microplanning (spot analysis, contact mapping, geographic and social networks) at all sites to initiate first-time contact with target HRG population and identify the "most at risk" individuals in each peer's network				
Weekly/bi-weekly review meetings with peers to develop individual plans for regular contact (Phase 2 of microplanning) based on information collected through Phase 1 tools and peer formats (peer education card, calendar and individual-level tracking)				
Monthly meetings between outreach staff and peers to 1) plan for raising service levels using Phase 3 microplanning tools and 2) update information captured in Phase 1 and Phase 2 tools as per any changes in the field				
Six-monthly "opportunity gaps" analysis to improve service delivery and coverage of HRG				
Review quality (accuracy, up to date) of peer microplanning tools and formats and provide technical support to raise peer capacity to use and analyse data from peer formats (Outreach workers to do joint outreach and analysis of formats with each peer at least two days every week)				
Review quality of microplans and provide on-site technical support to peers and outreach workers to implement microplanning and use information to prioritise outreach and service delivery to "most at-risk" and "least served" populations (TSU staff to do joint field outreach and analysis of formats for at least five days per NGO per month)				

Major Milestones/ Targets	H1	H2
	1. 50% of TINGO staff and peers trained on use of microplanning for outreach	1. 100% of TINGO staff and peers trained on use of microplanning for outreach 2. At least 50% of sites implemented Phase 1 and Phase 2 microplanning tools and peer formats with acceptable quality as per TSU review (i.e. peers are able to identify and direct services to the riskiest and neediest individuals in their respective networks) 3. 100% of NGOs contact at least 40% of target denominator through peers every month (each contact to consist of at least 1 to 1 BCC session and condom distribution)
Year 1		
Year 2	1. 100% of sites implemented Phase 1 and Phase 2 microplanning tools and peer formats with acceptable quality as per TSU review 2. 100% of NGOs meeting at least 60% of target denominator through peers every month	1. 100% of sites implemented full suite of microplanning tools (Phase 1, 2 and 3) and peer formats with acceptable quality as per TSU review 2. 100% of NGOs meeting at least 80% of their target denominator through peers every month 3. 100% of NGOs have completed opportunity gap analysis to improve service delivery and coverage
Year 3	1. 100% of NGOs have robust microplanning systems in place to identify and meet new HRG individuals within three months of entering a site 2. Maintain previous levels on all other aspects	1. Maintain previous levels on all other aspects
Year 4	1. Maintain previous levels	1. Maintain previous levels
Year 5	1. Maintain previous levels	1. Maintain previous levels

Programme Component	5. STI Services (includes staffing and infrastructure setup)	Primary responsibility		
		SACS	TSU	NGO
Prerequisites	1. TI coverage area and denominator fixed (including sites, hotspots and target group) per mapping report 2. NGO contracted and funded as per NACO guidelines 3. NGO outreach staff (project coordinator, field officers, outreach workers, community guides) recruited to cover intervention area as per staffing guidelines 4. Site validation process completed 5. Peer educators from HRG recruited to cover all sites as per peer selection guidelines			
Input	NACO STI Guidelines and Tool for STI Approach			
Output	1) STI service coverage plans for each TI 2) STI service delivery to HRG as per plans 3) STI technical support and quality monitoring systems established to cover all TIs			
Adapt NACO specified STI guidelines and tools for local use				
Staffing and establishing infrastructure for STI services				
Recruit STI technical officers at TSU-level to provide technical support and quality monitoring for STI services delivered by TIs (At least 1 STI technical officer for every 20 clinics or every 3 Districts - whichever is smaller)				
Conduct consultations with HRG groups at all sites to: 1) determine current health seeking practices 2) identify list of preferred physicians for each HRG 3) decide optimal mode for STI service delivery at the site (intervention clinics - static or outreach, referrals to public or private sector)				
Establish physical infrastructure (premises, equipment, utility connections) for clinics after consultations with HRG to identify convenient, accessible sites 1) Static intervention clinics at all sites with ≥ 1000 HRG/site or with high risk profile as determined by the TSU 2) Outreach clinics - fixed day, fixed time - for smaller sites with high-risk profiles				
Recruit adequate staff at intervention clinics (STI physicians, counsellors and ANM) as per NACO STI management guidelines (Where feasible select qualified HRG members for appropriate roles)				
Establish referral clinic services (with public or private sector as preferred by HRG) to cover smaller sites (≤ 200 HRG/site)				
Establish logistics network for supply of STI drugs, condoms and other consumables to all clinics				

Linkages (NGOs to establish linkages with technical support from TSU; TSU to monitor quality of linkages)				
Establish working referral linkages at each clinic (ideally HRG members accompanied by NGO staff or peers) for ICTC, care and support and ART services				
Establish working referral linkages at all clinics with District RNTCP for TB screening and treatment				
Establish working referral linkages at all clinics with laboratories for syphilis screening and testing with appropriate quality assurance systems (Sites with >2000 HRG should set up facilities for serologic testing of syphilis at intervention clinics)				
Establish working linkages for other services prioritised by the HRG community (medical termination of pregnancy, child delivery etc) subject to availability of budgets				
Training				
Finalise STI capacity building requirements and establish linkages with NACO-approved national/regional institutions for training				
Train intervention clinic staff (physicians, counsellors, ANM) and key NGO staff on STI management, clinic operation and reporting as per NACO guidelines - to be repeated every year with updated curriculum as required (special emphasis on attitudinal orientation while delivering services to marginalised HRG)				
Train referral clinic physicians and other key staff on STI management, clinic operation and reporting as per NACO guidelines - to be repeated every year with updated curriculum as required (special emphasis on attitudinal orientation while delivering services to marginalised HRG)				
Monitoring				
Finalise STI clinic reporting formats and train clinic staff and key NGO staff (project coordinator, field officers, outreach workers) on clinic data collection, analysis and reporting into CMIS				
Periodic data entry of clinic forms into CMIS				
Weekly coordination meetings between clinic and outreach staff at all sites to analyse clinic service data and plan for raising service utilisation and monitor follow-ups (Clinic data critical input for effective microplanning)				
Regular visits - at least every two months - to each clinic by TSU STI technical officers (at least 2 days/visit to intervention clinics, 1 day/visit to referral clinics) to assess:				
1) Adherence to technical standards 2) Quality of services and linkages 3) Clinic utilisation and coordination with outreach services 4) Reporting compliance 5) Community orientation of clinic staff (especially to prevent stigmatising behavior toward HRG by clinic staff) 6) Community representation in clinic staffing (to be increased over time as community capacity increases)				
Quarterly analysis of STI data to track at least the following				
1) Utilisation trends by clinic, 2) STI syndrome profiles and appropriate treatment 3) Uptake of regular checkups				
Random review visits to major clinics by SACS STI officer every six months				

Major Milestones/ Targets	H1	H2
Year 1	<p>Clinic functioning</p> <ol style="list-style-type: none"> 1. 100% of required STI technical officers (as assessed by NACO guideline of 1 STI officer every 20 clinics or 3 Districts) recruited and trained by TSU 2. Regional capacity building institutions identified and contracted 3. NACO STI guidelines adapted for State use 4. Health-seeking behaviour consultations with HRG conducted at 100% of sites 5. Intervention static clinics established - including infrastructure, staff recruitment and training and commodity provision - at all suitable sites identified by TSU team and NGOs 	<p>Clinic utilisation</p> <ol style="list-style-type: none"> 1. 5 % of HRG denominator accessing clinic services every month <p>Clinic functioning</p> <ol style="list-style-type: none"> 2. Outreach clinics established - including infrastructure, staff recruitment and training and commodity provision - to cover all suitable sites identified by TSU team and NGOs 3. 100% of static clinics following syndromic case management as assessed by TSU STI technical officer visits 4. 100% of static clinics developed referral directories and established referral linkages for a) voluntary HIV testing and counselling (with full confidentiality) and b) care and support 5. 100% of static and outreach clinics have functioning paper-based reporting formats (data updated and reported every month) <p>Clinic monitoring</p> <ol style="list-style-type: none"> 6. 100% clinics visited by TSU STI technical team at least thrice during the six month period and provided with technical support and guidance as required (to be continued for the rest of the project cycle)
Year 2	<p>Clinic utilisation</p> <ol style="list-style-type: none"> 1. 10% of HRG denominator accessing clinic services every month <p>Clinic functioning - Maintain previous levels. In addition:</p> <ol style="list-style-type: none"> 2. Referral clinics established - providers contracted, trained and commodity provision - at all suitable sites identified by TSU team and NGOs 3. 100% of outreach clinics following syndromic case management as assessed by TSU STI technical officer visits 4. 100% of outreach clinics developed referral directories and established referral linkages for a) voluntary HIV testing and counselling (with full confidentiality) and b) care and support <p>Clinic monitoring. Maintain previous levels. In addition</p> <ol style="list-style-type: none"> 5. At least 5% clinics visited by NACO/SACS team for random quality checks (to be repeated every six months) 	<p>Clinic utilisation</p> <ol style="list-style-type: none"> 1. 15% of HRG denominator accessing clinic services every month <p>Clinic functioning</p> <ol style="list-style-type: none"> 2. 100% of clinics (static, outreach and referral) have functioning paper-based formats (data updated and reported every month) 3. 100% of static and outreach clinics and at least 50% of referral clinic data entered into CMIS every month 4. 100% of referral clinics established referral linkages for a) voluntary HIV testing and counselling (with full confidentiality) and b) care and support 5. 70% of referral clinics following syndromic case management as assessed by TSU STI technical officer visits 6. 100% of static and outreach clinics established linkages for TB screening and treatment and OI, ART provision 7. Annual quality audits rolled out at 100% clinics by TSU staff 8. 100% of clinic staff (including physicians, counsellors, ANM) covered by refresher trainings during the year (to be repeated every year) <p>Clinic monitoring. Maintain previous levels</p>

Year 3	<p>Clinic utilisation</p> <ol style="list-style-type: none"> At least 20% of HRG denominator accessing services every month At least 50% of HRG denominator underwent regular STI check-up during these six months <p>Clinic functioning. Maintain previous levels. In addition:</p> <ol style="list-style-type: none"> 100% of clinics established mechanisms for syphilis screening and treatment 100% of clinics providing asymptomatic treatment as specified in NACO guidelines 100% of clinics have at least one HRG member on their staff 100% of NGOs established clinic committees with HRG representation to oversee quality and function of clinics <p>Clinic monitoring. Maintain previous levels</p>	<p>Clinic utilisation</p> <ol style="list-style-type: none"> At least 25% of HRG denominator accessing STI services every month At least 75% of HRG denominator underwent regular STI check-up during these six months At least 50% of HRG denominator screened for syphilis (and all positive treated) <p>Clinic functioning</p> <ol style="list-style-type: none"> 100% of referral clinics established linkages for TB screening and treatment and OI, ART provision 100% of clinics conduct repeat annual quality audit and show improvements on key parameters 100% of all clinics entered data into CMS every month <p>Clinic monitoring. Maintain previous levels</p>
	<p>Clinic utilisation. Maintain previous levels. In addition</p> <ol style="list-style-type: none"> At least 80% of HRG denominator screened for syphilis during these six months (and all positive treated) At least 80% of HRG denominator undergo verbal screening for TB symptoms (and all identified as potential candidates referred for sputum screening and follow up treatment) <p>Clinic functioning. Maintain previous levels.</p> <p>Clinic monitoring. Maintain previous levels</p>	<p>Clinic utilisation</p> <ol style="list-style-type: none"> At least 30% of HRG denominator accessing STI services every month At least 90% of HRG denominator underwent regular STI check-up during these six months At least 90% of HRG denominator screened for syphilis (and all positive treated) At least 90% of HRG denominator undergo verbal screening for TB symptoms (and all identified as potential candidates referred for sputum screening and follow up treatment) <p>Clinic functioning. Maintain previous levels.</p> <p>Clinic monitoring. Maintain previous levels</p>
	<p>Clinic utilisation. Maintain previous levels</p> <p>Clinic functioning. Maintain previous levels</p> <p>Clinic monitoring. Maintain previous levels</p>	<p>Clinic utilisation. Maintain previous levels</p> <p>Clinic functioning. Maintain previous levels</p> <p>Clinic monitoring. Maintain previous levels</p>

Programme Component	6. Condom Distribution			
Prerequisites	1. TI coverage area and denominator fixed 2. TSU contracted and fully staffed 3. NGOs contracted and funded as per NACO guidelines 5. NGO outreach staff (project coordinator, outreach workers, community guides) recruited to cover intervention area as per staffing guidelines 6. Site validation process completed 7. Peer educators from HRG recruited to cover all sites as per peer selection guidelines 8. Outreach planning tools implemented by peers by site (especially to assess numbers of sex workers in a site, average number of clients in a month and days working in the month)			
Input	1. FSW Annexure 5, <i>Tool for Peer-Led Outreach and Planning</i> , and <i>NACO Tool for Condom Programming</i> 2. Site-wise information on sex worker distribution, client volume and transaction frequency from outreach planning tools			
Output	1. Condom demand estimates by NGO and site 2. Free condom distribution plan 3. Social marketing plan (if necessary)			
		Primary responsibility		
		SACS	TSU	NGO
Collate at NGO level condom availability information from site validation exercise				
Provide NGOs with survey results on number/proportion of condoms directly bought by clients (required for condom estimation formula)				
Calculate "site-wise" condom requirement figures using the estimation formula provided in the TI Guidelines document (Condom programming section) for each site under coverage by NGO				
Train outreach workers, peer educators and clinic staff on accurate methods for condom demonstrations				
Submit indents to SACS for estimated annual condom demand (after factoring in requirements for condom demonstrations, promotion events and all free distribution (peer, clinic and DIC))				
Consolidate NGO-wise demand estimates to arrive at State-level free condom requirement				
Submit indents to NACO for free condom supplies				
Establish logistics networks to deliver condom supplies to each NGO site				

Free distribution of condoms					
Set condom distribution targets for individual peers based on demand calculation for their respective networks					
Identify indirect outlets for stocking free condoms in and around hotspots based on consultations with community to establish outlet timings are suitable (especially for hotspots that operate late at night) and the outlets are accessible and community friendly					
Provide adequate condom stocks to peers for weekly distribution and reconcile stock balance with condom distribution records from peer cards/outreach registers at least every week					
Ensure adequate condom supplies and stock tracking mechanisms at all STI clinics and DICs (records should show number of condoms distributed to each HRG member who avails the service)					
Monitor condom stock levels at indirect outlets twice every week and replenish as required					
Prepare monthly condom utilisation report and submit to SACS/TSU showing distribution through each channel and consumption for other activities (demos, promotions, breakage etc)					
Social marketing of condoms (CBO-led social marketing not recommended unless warranted because of strong demand from HRGs; suggested role of NGOs/CBOs to provide information and feedback to existing SMOs to help improve their distribution)					
Establish linkages with social marketing organisations (SMOs) operating in the same geographical areas (with TSU support as required) to ensure distribution of socially marketed condoms around hotspots					
Share updated list of hotspots, key outlets (especially outlets that operate late at night) and incidents of stock outs with SMOs to improve distribution at hotspots					
Create awareness among clients and regular partners about the availability of socially marketed condoms at hotspots					
Monitoring					
Commission research to assess condom availability around hotspots at all times (special focus on availability at night) (Target availability is at least 80% at all times)					
Assess adequacy of direct and indirect distribution to cover all acts estimated (based on outreach planning calculations) within each peer's network and modify distribution channels and quantity to fill gaps					
Perform monthly condom accessibility audits at hotspots through peers (using outreach planning tool) (Modify distribution plan to address any issues identified)					
Periodic tracking of condom usage by HRG through peer educators or through clinic counsellors (validate reported usage based on actual condom distribution numbers) (Other assessment through NACO BSS in Year 1, Year 3 and Year 5)					

Major Milestones/ Targets	H1	H2
Year 1	<ol style="list-style-type: none"> 1. Condom demand estimation exercise completed for 100% of sites 2. 100% NGOs complete annual demand estimation and submit to SACS 3. State-level consolidated demand calculated and indent raised to NACO (Steps 1-3 repeated at the start of every subsequent year based on updated information) 	<ol style="list-style-type: none"> 1. Free condom distribution meeting at least 60% of estimated demand across all NGOs 2. Indirect condom outlets established at 60% of hotspots where need identified 3. No stockouts of more than five days at any NGO 4. Baseline condom availability study conducted across State
Year 2	<ol style="list-style-type: none"> 1. Free condom distribution meeting at least 80% of estimated demand across all NGOs 2. Indirect condom outlets established at 80% of hotspots where need identified 3. No stockouts reported at any NGO 4. Linkages established with SMOs to improve distribution of SM condoms at 80% of hotspots 	<ol style="list-style-type: none"> 1. 80% of hotspots report condom availability in excess of 80% (as assessed through condom availability research) 2. Reported condom usage by HRG at least 60% in sex with commercial partners and 30% in sex with regular partners (as assessed through peer surveys)
Year 3	<ol style="list-style-type: none"> 1. Indirect condom outlets established at 100% of hotspots 	<ol style="list-style-type: none"> 1. Reported condom usage by HRG at least 70% in sex with commercial partners and 40% in sex with regular partners (as assessed through peer surveys)
Year 4	Maintain previous levels	Maintain previous levels
Year 5	Maintain previous levels	<ol style="list-style-type: none"> 1. Reported condom usage by HRG at least 80% in sex with commercial partners and at least 50% in sex with regular partners (as assessed through peer surveys)

Programme Component	7. Behaviour Change Communication / Inter Personal Communications			
Prerequisites	1. TI coverage area and denominator fixed 2. TSU contracted and fully staffed 3. NGO contracted and funded as per NACO guidelines 4. NGO outreach staff (esp. project coordinator, outreach workers, advocacy officer) recruited to cover intervention area as per staffing guidelines 5. Site validation process completed 6. Peer educators from HRG recruited to cover all sites as per peer selection guidelines			
Input	1. FSW Annexure 6a, <i>Tool for Dialogue Based Interpersonal Communication (IPC) By and With HRGs</i>			
Output	1. IPC packages for risk reduction			
	Activities	Primary responsibility		
		SACS	TSU	NGO
Adapt IPC and BCC toolkits for local use				
Train NGO staff and peer educators on IPC methods - especially the value of analytical thinking and problem solving among community members to arrive at local solutions to HIV/AIDS risk and vulnerability issues				
Train NGO staff and peer educators on strategic planning for BCC message development				
Review NGO-developed BCC materials and NACO/SACS materials for message consistency / message reinforcement				
Conduct IPC capacity standards jointly with NGO staff and peer educators every six months to assess quality of IPC and identify areas for improvement				
Major Milestones/ Targets	H1	H2		
Year 1		1. 100% of NGO staff and peers trained on IPC methods and strategic planning for BCC message development		
Year 2	1. IPC capacity standards conducted at 100% of NGOs	1. 100% NGOs implementing IPC methods		
Year 3	1. At least 80% NGOs show improvement on IPC capacity standards in second round of assessment			
Year 4	1. 100% NGOs show improvement on IPC capacity standards in third round of assessment			
Year 5	Maintain previous levels			

Programme Component	8. Enabling Environment	Primary Responsibility		
		SACS	TSU	NGO
Prerequisites	1. TI coverage area and denominator fixed 2. TSU contracted and fully staffed (including advocacy officer) 3. NGO contracted and funded as per NACO guidelines 4. NGO outreach staff (esp. project coordinator, outreach workers, advocacy officer) recruited to cover intervention area as per staffing guidelines 5. Site validation process completed 6. Peer educators from HRG recruited to cover all sites as per peer selection guidelines 7. Service roll-out (STI, BCC, condoms, enabling environment) commenced			
Input	1. Annexure 9, Power Analysis 2. Annexure 7, Crisis Response System			
Output	1. Site-level advocacy plans 2. Site-level power structure analysis 3. Well defined crisis response systems			
Activities				
Adapt power analysis and crisis response tools for local use				
Train NGO staff and peer educators on the use of power analysis and crisis response tools				
Conduct peer-led power structure analysis at each site to determine local power structures/stakeholders and their influence on the HRGs environment				
Establish crisis response systems at each site to track and address community crisis incidents within minimum elapsed time				
1) Prioritise sites that have a high concentration of stakeholders with "disabling" or "negative" influence				
2) Train community members to perform critical roles				
3) Identify and build linkages legal support teams at each site to assist community during crises				
4) Setup 24-hour helpline support systems				
Advocacy with State police leadership (DGP and/or ADGP(training)) to support TI activities in all Districts including identification of nodal officers at State and District levels				
Conduct District-level meetings				
1) With SP and Deputy SP level officials to raise awareness and support for HRG interventions and HIV issues with specific support requests (examples listed in Section 3.3.5.D)				
2) TOT workshops to train District nodal officers for subsequent police station-level activities				
Conduct police sensitisations at District and town levels through multi-disciplinary teams (consisting of trained District police officers, lawyers, NGO staff, peers) (Should be handled with TSU support so activity will not seem like an NGO-only local initiative)				
Conduct legal literacy sessions for peers and community members to inform them of legal provisions and their rights				
Set up advocacy and crisis response committees at each site consisting of community members who are identified and trained for this specific role (also mentioned under community mobilisation section)				

Major Milestones/ Targets	H1	H2
Year 1	1. 100% of NGO staff trained on power analysis and crisis response tools	1. 60% of NGO sites complete power structure analysis and develop local advocacy plans 2. State-level advocacy workshop completed with DGP / AD GP level officer and support obtained for District activities 3. 100% of peers covered by legal literacy training sessions
Year 2	1. 100% of NGO sites complete power structure analysis and develop local advocacy plans 2. 60% sites set up crisis management systems to respond to incidents affecting HRG community within 24 hours 3. District-level police workshop and TOT covering SP and Deputy SP level officers completed in 60% Districts	1. 100% sites have set up crisis management systems to respond to incidents affecting HRG community within 24 hours 2. District-level police workshop and TOT covering SP and DySP level officers completed in 100% Districts 3. 100% Districts have police signed / police issued ID cards for 3. 40% of towns covered by police sensitisation workshops during the year 4. Advocacy committees with full community representation setup at 100% of NGOs
Year 3	1. At least 80% incidents being responded to within 24 hours in all sites	1. 100% of towns covered by police sensitisation workshops during the year (ongoing activity to be conducted every year)
Year 4	Maintain previous levels	Maintain previous levels
Year 5	Maintain previous levels	Maintain previous levels

Programme Component	9. Community Mobilisation (excludes CBO formation and transition from NGO to CBO, which are addressed elsewhere)	Primary responsibility		
		SACS	TSU	NGO
Prerequisites	1. TI coverage area and denominator fixed 2. NGO contracted and funded as per NACO guidelines 3. NGO outreach staff (project coordinator, field officers, outreach workers, community guides) recruited to cover intervention area as per staffing guidelines 4. Site validation process completed 5. Peer educators from HRG recruited to cover all sites as per peer selection guidelines 6. At least 70% of HRG denominator contacted at least once, ideally within six to nine months of intervention start (This is critical to ensure that representative community members are involved in the project and not just the ones who are contacted first)			
Input	Community committees examples from TAI - VHS and Annexure 8, Community Committees Chapter 5			
Output	1) Functioning community committees for project implementation and oversight 2) Functioning community networks across all sites			
Activities				
Adapt NACO specified guidelines and tools for formation of community committees and CBOs for local use				
Raising community engagement and involvement in project service delivery (typically from month 3 of project)				
Ensure peer selection guidelines are adhered to while recruiting peers for outreach				
Define clear role separation between peers and outreach workers to ensure that from initiation peers handle over 80% of 1 - 1 outreach contacts and condom distribution (role of outreach workers is to manage/monitor peers and provide technical support)				
Identify list of community leaders from each site (jointly with peers and community guides)				
Involve community members (through group discussions facilitated by community leaders) in				
1) selection of DIC and clinics (location, building, facilities)				
2) selection of clinic staff - especially doctors and counsellors				
(Critical that peer involvement not be treated as a proxy for wider community involvement because peers, who draw remuneration, are usually seen as affiliated to the project by other community members)				
Define ToRs for key committees with community representation (areas include project management, clinic services, DIC management, advocacy and crisis response, event management)				
Constitute community committees with membership from HRG community (not including peers) with following key guidelines - all typologies of HRG should be represented, and community members should be rotated every six months to ensure wide participation from community. Indicate numbers of committees as follows:				
1) Project management committee - 1 per TI				
2) Clinic committee - 1 per static and outreach clinic, 1 per site for referral clinics (i.e. to cover all referral clinics in that site)				
3) DIC committee - 1 per DIC				
4) Advocacy and crisis management committee - At least 1 per site (all hotspots with > 100 HRG should have representation on the site committee)				
5) Event management committee - 1 per TI				

Networking within the community (typically from month 6 the project)							
Organise quarterly "info-lainment" events to gather all the contacts in a peers network (approximately 60 contacts / peer as per NACO guideline)							
Identify and train community members from each hotspot as designated contacts for "crisis management" - to respond to violence or harassment							
Develop directory of welfare and livelihood schemes available from government for which HRG community members meet eligibility criteria due to economic or social status							
Train all peers on SHG/community groups (CGs) formation methods by end of month 18							
Foster development of SHGs or community groups (in groups of 10-15 community members) across all sites to address economic and vulnerability issues							
Develop directory of literacy, welfare and livelihood schemes available from government for which HRG community members meet eligibility criteria due to economic or social status							
Build capacity of peers and community leaders to manage linkages for eligible SHG/CG members to access relevant schemes (NGO should not manage linkages directly - except in the first three months - and should instead build capacity of community members to perform this role) (Priority for developing linkages should be decided in consultation with community members, not by NGO alone)							
Increasing community ownership of the programme (typically from month 12 of project)							
Finalise and publish transparent performance assessment criteria for NGO staff and peers							
Conduct annual NGO staff performance assessment (including peers) with community input							
Annual progression of selected peer to roles with enhanced responsibilities, based on performance assessment and peer progression criteria (NGO-led but with community input)							
At the minimum by the end of Year 1:							
1) all DICs to have a DIC manager from the community							
2) all static and outreach clinics to have a clinic staff member (counsellor, ANM or administrator) from the community							
Improving governance / initiating CBOs (typically from month 18 of project)							
Initiate community consultations to institute democratic processes for:							
1) electing and rotating members of community committees (to be led by community leaders)							
2) peer progression (to be led by peers)							
Organise six monthly District-level and annual State-level meetings of peers, community leaders and SHG members to facilitate networking							
Monitoring of community mobilisation							
Conduct group discussions with community members during monthly TSU field visits to assess:							
1) community understanding of project roles and objectives							
2) acceptance of project by community							
3) attitudes of NGO staff towards community							
4) relationship of peers with community members, especially to assess if peers are members of HRG							
5) If community priorities are being addressed by project							

Major Milestones/ Targets	H1	H2
Year 1	<ol style="list-style-type: none"> 1. 100% of NGOs recruited peer educators from respective HRG groups (in the overall ratio of 1 peer for 60 HRG members) as per NACO peer selection guidelines 2. 100% static clinics selected and finalised based on group consultations with community members (similar guideline for all DICs set up by the project) 	<ol style="list-style-type: none"> 1. 100% NGOs finalise and publish peer performance assessment and peer progression guidelines 2. At least 80% of outreach contacts and condom distribution occurring through peer educators 3. At least 50% of NGOs have constituted at least two community committees with clear ToRs and monthly meeting records 4. At least 70% of DICs managed by community member 5. At least 50% of static and outreach clinics have at least one staff member from the community
Year 2	<ol style="list-style-type: none"> 1. At least 80% NGOs have constituted at least three community committees with clear ToRs and monthly meeting records 2. 100% of DICs managed by community members 3. At least 80% of static and outreach clinics have at least one staff member from the community 4. 100% peers trained on SHG formation processes 5. 100% of NGOs complete performance assessments per guidelines for all their peers (to be repeated annually in subsequent years) 6. At least 50% of peer educators organise quarterly events that bring together their outreach network 	<ol style="list-style-type: none"> 1. 100% NGOs have constituted at least four community committees (including advocacy and clinic committees) with clear ToRs and monthly meeting records 2. 100% of static and outreach clinics have at least one staff member from the community 3. At least 50% NGOs elevate at least one peer to a role of higher responsibility based on peer progression guidelines 4. At least 10% of community members are members of SHGs 5. At least 70% of NGOs have established linkages with literacy, welfare and livelihood schemes in their sites 6. 100% Districts organise community networking events that bring together community leaders and peers for all TI NGOs in the District (subsequently held every six months)
Year 3	<ol style="list-style-type: none"> 1. At least 25% of community are members of SHGs/CGs 2. State-level community networking event for members from all TI NGOs (subsequently held every year) 3. 100% of NGOs have established linkages with literacy, welfare and livelihood schemes in their sites 	<ol style="list-style-type: none"> 1. 100% of community committees electing and rotating members through democratic processes 2. 100% of NGO elevating suitable peers to higher levels based on transparent performance assessments and peer consultations
Year 4	<ol style="list-style-type: none"> 1. At least 50% of community members are members of SHGs 2. At least 80% sites have a functioning SHG with bank account and monthly meeting records 	<ol style="list-style-type: none"> 1. At least 20% of NGO staff drawn from community members
Year 5	<ol style="list-style-type: none"> 1. At least 80% of community members are members of SHGs 	

Programme Component	10. Programme Monitoring (STI monitoring covered in the STI services section)	Primary responsibility		
		SACS	TSU	NGO
Prerequisites	1. TI coverage area and denominator fixed 2. TSU contracted and fully staffed (especially programme team and M&E officers) so that each <u>TSU project officer covers a maximum of 6 NGOs or 3 Districts</u> - whichever is smaller 3. SACS and TSU M&E and programme staff trained by NACO on TI monitoring and evaluation framework, including TI indicators and CMIS formats 4. NGO contracted, funded and equipped (including with a dedicated computer) as per NACO guidelines 5. NGO outreach staff (project coordinator, field officers, outreach workers, community guides) recruited to cover intervention area as per staffing guidelines 6. Site validation process completed 7. Peer educators from HRG recruited to cover all sites as per peer selection guidelines 8. Service roll out (STI, BCC, Condoms, enabling environment) commenced			
Input	1. NACO TI Indicators 2. CMIS TI formats 3. Outreach planning formats for peer data capture			
Output	1. TI data input into CMIS 2. Monthly MIS analysis reports for State, District, NGO, site 3. Monthly peer-level data analysis and workplans			
Activities				
Adapt NACO TI indicators and paper-based formats for local use				
Finalise graphical data capture and analysis tools for use of non-literate peer educators				
Train all NGO staff (project coordinators, outreach workers, accountant/data entry operators) on TI monitoring indicators and formats				
Collate site-wise data every month and submit updated paper-based TI indicators reports to SACS and TSU by 15th of following month (e.g. data for Mar 2007 should be reported to SACS by 15th Apr 2007)				
Enter monthly NGO data into NACO CMIS by 22nd of next month and generate monthly feedback reports for sharing with NGOs by 25th of following month (e.g. NGO paper-based formats for Mar 2007 should be entered into CMIS by 22nd Apr 2007 and feedback reports sent to NGOs by 25th Apr 2007)				

Monitoring by outreach workers	SACS	TSU	NGO
<p>Monthly review meeting with peers to:</p> <ol style="list-style-type: none"> 1) Collate and review monthly outreach progress vs. goals for the month 2) Support peers to update microplan formats - especially social and geographic networks to reflect population changes (new individuals, individuals leaving project area) 3) Support peers to increase service focus (BCC, condom and clinic services) on the most at risk individuals in their network (those with highest client loads, low condom use or high incidence of violence) 4) Set outreach, clinic and condom distribution goals for the month based on above considerations 5) Plan thematic BCC campaigns and community mobilisation initiatives and events planned for the month 6) Finalise monthly advocacy plan to address key stakeholders (madams, pimps, policemen, regular partners) 7) Review clinic service uptake by peers (very critical area because peers must serve as models for behaviour change through personal example) 8) Develop personal workplan for the next month to support peers whose performance is sub par <p>Weekly review meetings with peers (those linked to the outreach worker's monitoring cycle) to:</p> <ol style="list-style-type: none"> 1) Collate and report to NGO weekly peer contact data using paper - based formats 2) Review outreach progress within peer's network (how many ever met, how many never met and reasons for the same, how many contacts planned during the week, how many achieved, problems faced) 3) Coordinate outreach with clinic service uptake (referrals made by peers, how many referrals actually converted to visits, plans to address failed referrals, tracking individuals with follow up visits to clinic, repeat STI cases) 4) Review accuracy and completeness of data records maintained by peers 5) Assist peers to develop peer workplans (daily and weekly) based on progress in the field (to focus services on most at risk and least served populations) 6) Document incidents of violence/harassment reported by community members and track follow up action taken, if any <p>Conduct outreach work and review and analyse peer data cards/registers at least twice a week with every peer to ensure:</p> <ol style="list-style-type: none"> 1) Knowledge of basic BCC and skills (HIV transmission methods, myths, condom demos) 2) Outreach planning is implemented per quality standards 3) All peers conduct outreach based on a daily work plan (peer should have planned in advance the individuals from her network that must be met on a particular day and the purpose of each meeting) 4) Peers transcribe outreach information (individuals met, issues discussed, services provided, number of condoms distributed, enabling environment issues detected) into peer cards at least every two days <p>Random field visits (unaccompanied by peer educators) every week to assess if peers conducting outreach in the field as per work plan</p>			
Monitoring by project coordinators			
<p>Bi-weekly visits to each outreach worker's area for field observations and technical support on:</p> <ol style="list-style-type: none"> 1) Clarity of project objectives 2) Clarity and accuracy of BCC messages and condom demonstrations 3) Accuracy and completeness of peer and outreach worker data formats/registers 4) Proper use of microplanning tools to raise service reach 5) Availability of communication materials, condoms and clinic commodities <p>Review and analyse weekly peer contact formats submitted by outreach workers to assess:</p> <ol style="list-style-type: none"> 1) Trends in outreach contacts and condom distribution across sites 2) Identify sites with performance issues and plan diagnostic support field visits within two weeks 			

Monthly review meetings with outreach staff and clinic staff to:				
1) Review monthly outreach and clinic performance vs. goals				
2) Coordinate communication and planning between outreach and clinic teams				
3) Identify and address enabling environment issues (violence, stakeholder problems, peer conflicts) affecting service delivery or uptake				
4) Set goals for next month by site and by outreach worker area				
Review and collate NGO-level information on NACO TI indicators for reporting to SACS / TSU and data entry into CMIS				
Oversee monthly data entry into CMIS (data entry could be accomplished through accountant or part time staff)				
Monitoring by TSU TI programme staff				
Monthly visits to each NGO of at least three days by TSU team of at least 1 Project Officer and 1 technical officer (STI/M&E/Advocacy/BCC/Condom/Community mobilisation/Finance) to conduct field based support to outreach workers and peers to				
1) Develop the diagnostic and problem solving skills of outreach staff when confronted by field level issues				
2) Strengthen skills for data analysis and use for planning / diagnosing problems				
3) Assess quality of microplanning				
4) Provide on-site technical mentoring (including BCC methods and condom demonstration methods)				
During such visits the TSU team should aim to meet all outreach workers and at least 50% of peer educators				
Monthly analysis of CMIS data reported by all NGOs to assess				
1) Timeliness of submission and completeness and consistency of reported data				
2) Perform trend analysis for each NGO on all NACO TI indicators vs targets (where applicable) and share feedback reports with each NGO				
3) State-wise performance by consolidating data from all NGOs				
Bi-monthly random field interviews with individuals who have accessed programme services (based on outreach or STI records) to assess				
1) whether project is actually serving HRG members				
2) track user experience of project services				
3) record attitudinal issues reported about any project staff (NGO, clinic, peers)				
Quarterly review of each NGO by TSU Project Officer and TSU technical team to assess project performance vs goals and quality of implementation on all major elements - outreach, BCC, condom, STI, enabling environment, community mobilisation, M&E, finance - with all major findings and key action points for next quarter reported in a formal project feedback note				
Note: A customised version of milestones contained in each section of the programme management guidelines could be used to set NGO goals				
Monitoring by SACS/JAT				
Six-monthly visit by SACS NGO advisor to each NGO to assess financial systems and overall project implementation quality (including field visits to at least two implementation sites and meeting with 50% outreach workers and 25% peers)				
Annual NGO performance assessment by SACS Project Director and TSU project and technical team (could be conducted jointly for all NGOs or individually by NGO based on SACS preference)				

Major Milestones/ Targets	H1	H2
Year 1	<ol style="list-style-type: none"> 100% of NGO staff trained on TI monitoring framework including indicators and paper-based formats 100% NGOs visited by TSU M&E staff every month for field level follow up on monitoring systems 100% of NGOs visited by TSU Project Officer for at least three days every month Clear annual milestones set on a comparable set of parameters for 100% of NGOs (process repeated every year) 	<ol style="list-style-type: none"> At least 50% NGOs reporting monthly MIS data by 15th of following month and 100% reporting by 25th Monthly CMIS data entry for 100% NGOs completed by 30th of next month (e.g. Mar 07 data entered by 30 Apr 07) 100% NGOs being covered by quarterly review meetings with TSU project and technical team to assess progress vs. milestones 100% of NGOs visited by SACS NGO advisor during the six month period 100% of peers met by TSU staff during monitoring visits able to do accurate and correct condom demonstrations
Year 2	<p>Maintain previous levels. In addition:</p> <ol style="list-style-type: none"> At least 80% NGOs reporting monthly MIS data by 15th of following month and 100% reporting by 22nd Monthly CMIS data entry for 100% NGOs completed by 25th of next month (e.g. Mar 07 data entered by 25 Apr 07) At least 40% NGOs meet Year 1 milestones as set during H1 of Year1 	<ol style="list-style-type: none"> 100% NGOs reporting monthly MIS data by 15th of following month Monthly CMIS data entry for 100% NGOs completed by 22nd of next month and feedback reports sent by 25th of next month
Year 3	<p>Maintain previous levels. In addition:</p> <ol style="list-style-type: none"> At least 70% NGOs meet Year 2 milestones set during H1 of Year2 	Maintain previous levels
Year 4	<p>Maintain previous levels. In addition:</p> <ol style="list-style-type: none"> At least 80% NGOs meet Year 3 milestones set during H1 of Year 3 	Maintain previous levels
Year 5	<p>Maintain previous levels. In addition:</p> <ol style="list-style-type: none"> 100% NGOs meet Year 4 milestones set during H1 of Year 3 	Maintain previous levels

Annexure 11: Mandatory Community Committees and their Composition, Roles, Responsibilities

S. No.	Name of the committee	Roles and Responsibilities	Composition
1	Outreach and Communication Committee	<p>Primary responsibility: Providing feedback on outreach services</p> <ul style="list-style-type: none"> <input type="checkbox"/> Generating demand for 100 per cent quality outreach services to the most vulnerable KPs <input type="checkbox"/> Periodically collecting feedback on outreach service delivery from KPs in their respective hotspots and sharing it with the EC body <input type="checkbox"/> Assisting PEs in mobilising hard-to-reach HRGs <input type="checkbox"/> Participating in monthly meetings of the committee and sharing feedback generated from the field with committee members <input type="checkbox"/> Maintaining the minutes of committee meetings 	<p>i. Project Manager ii. Executive body member (CBO): 1 iii. Community Leaders: 4</p> <p>Total members: 6 Community: 5 Non-Community: 1</p>
2	Clinic/Health Committee	<p>Primary responsibility: ensuring proper delivery of quality health services</p> <ul style="list-style-type: none"> <input type="checkbox"/> Generating demand for quality health services <input type="checkbox"/> Collecting feedback on all kinds of health facilities and service delivery, such as STI/RMC/ICTC, PPP and government health functionaries <input type="checkbox"/> Sensitising government Health Service Providers <input type="checkbox"/> Sharing community feedback on health service delivery during CC meetings <input type="checkbox"/> Referring partners for partner treatment/check-ups <input type="checkbox"/> Discussing the status of positive referrals and provide feedback on the status based on data provided by ANM <input type="checkbox"/> Regularly conducting meetings and maintaining minutes 	<p>iv. Project Manager v. Doctor: 1 vi. Nurse/Counsellor: 1 vii. Executive body member (CBO): 1 viii. Community Leaders: 4</p> <p>Total members: 8 Community: 5 Non-Community: 3</p>

S. No.	Name of the committee	Roles and Responsibilities	Composition
3	Crisis and Advocacy Committee	<p>Primary responsibility: Managing the crisis response system and advocacy with key stakeholders to effectively address the vulnerabilities of the community</p> <ul style="list-style-type: none"> <input type="checkbox"/> Strategising the crisis response system and ensuring crisis and emergency response within 2 hours <input type="checkbox"/> Identifying unreported crisis cases and sensitising the community to report crisis cases <input type="checkbox"/> Periodically participating in systematic stakeholder analysis <input type="checkbox"/> Participating in advocacy programmes on a regular basis, i.e., proactive advocacy <input type="checkbox"/> Sensitisation of key stakeholders such as police, media, lawyers, political leaders, health service providers and other government and non- government agencies and establishing linkages with relevant stakeholders <input type="checkbox"/> Participating, sharing feedback and suggesting ways to improve the crisis response system 	<ul style="list-style-type: none"> i. Project Manager ii. Project Director iii. Advocate: 1 iv. Executive body member (CBO) (preferably President or Secretary): 1 v. Community leaders (and/or paralegal volunteers): 4 <p>Committee may include police officials, human rights activists, social workers, based upon the need for and support from these stakeholders. Their role is limited to providing support to the active functioning of the committee and not in monitoring aspects</p> <p>The local crisis response team comprises 2 community leaders and PEs</p> <p>Total members: 8 Community: 5 Non-Community: 3</p> <p>One of the Community leaders from the committee will be designated as Committee Coordinator.</p>

S. No.	Name of the committee	Roles and Responsibilities	Composition
4	DIC Committee	<p>Primary responsibility: Ensuring the proper maintenance and effective utilisation of DICs by the community. Hence, the committee has considerable functional roles.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ensuring that the DIC is kept clean and hygienic <input type="checkbox"/> Facilitating utilisation of DIC as means for community mobilisation by conducting events <input type="checkbox"/> Pool up recreation facilities required for DIC <input type="checkbox"/> Arranging facilities for meetings <input type="checkbox"/> Evolving strategies to increase DIC attendance (such as celebrating birthdays, etc.) <input type="checkbox"/> Establishing DIC norms and ensuring that all KPs follow the norms <input type="checkbox"/> Maintenance of assets and attendance register <input type="checkbox"/> Ensuring info-inventory and useful displays at the DIC <input type="checkbox"/> Ensuring the availability of BCC/IEC material at the DIC <input type="checkbox"/> Ensuring proper maintenance and updating of books and records of the committee 	<p>i. Executive body member (CBO): 1 ii. Community leaders: 4</p> <p>Total members: 5 Community: 5 Non-Community: 0</p>
5	Condom Committee	<p>Primary responsibility: Overseeing condom promotion activities. Hence, the committee has both functional and monitoring roles.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Collecting feedback from KPs about the availability, accessibility and utilisation of condoms <input type="checkbox"/> Identifying and proposing condom outlets for improving accessibility as per the need <input type="checkbox"/> Ensuring condom outlets are adequately stocked <input type="checkbox"/> Collecting feedback from ANM regarding reporting of STI cases according to hotspot, and improving condom usage activity in high STI reporting areas <input type="checkbox"/> Monitoring condom stock procurement as per requirement <input type="checkbox"/> Ensuring proper condom demonstration by PEs <input type="checkbox"/> Ensuring proper maintenance and updating of books and records of the committee 	<p>i. Project Manager ii. Executive body member (CBO): 1 iii. Community leaders: 4</p> <p>Total members: 6 Community: 5 Non-Community: 1</p>

6	Project Advisory Committee	<p>Primary responsibility: Providing strategic direction to the project in terms of project performance, ethical standards and sustainability of the programme. The NGO board is responsible for ensuring the implementation of decisions taken by the project advisory committee.</p> <p>Functional roles:</p> <ul style="list-style-type: none"><input type="checkbox"/> Framing and ensuring ethical guidelines and policies (confidentiality, ethical standards of the staff, etc.)<input type="checkbox"/> Developing grievance redressal mechanisms<input type="checkbox"/> Developing project recruitment policy within the flexible limits of standard guidelines <p>Monitoring roles:</p> <ul style="list-style-type: none"><input type="checkbox"/> Reviewing the functioning of all committees<input type="checkbox"/> Reviewing core quarterly targets; identifying gaps in achieving quarterly targets and planning strategies to overcome them<input type="checkbox"/> Reviewing budgetary aspects<input type="checkbox"/> Reviewing staff recruitments<input type="checkbox"/> Ensuring that meeting minutes are shared with the community	<ul style="list-style-type: none">i. Project Directorii. Project Manageriii. Any external professionals favourable to community: 1iv. Executive body member (CBO) (preferably President/Secretary): 1v. Community leaders: 3vi. (For composite interventions) MSM: 1, TG: 1vii. PLHA: 1 (preferably hotspot community leader) <p>Total members: 7–8 Community: 5 Non-Community: 2–3</p>
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Annexure 11: NACP-IV MSM Strategy Paper

National AIDS Control Programme

Phase IV

Strategic Approach for Targeted Intervention among Men who have Sex with Men (MSM)

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Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CBO	Community Based Organisation
DAPCU	District AIDS Prevention and Control Unit
GIPA	Greater Involvement of People Living with HIV/AIDS
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
ICTC	Integrated Counselling and Testing Centre
IEC	Information, Education and Communication
MHP	Mental Health Professional
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non-governmental Organisation
PLHIV	People Living with HIV
SACS	State AIDS Control Society
STI	Sexually Transmitted Infection
STRC	State Training and Resource Centre
TI	(STI/HIV) Targeted Intervention
TSU	Technical Support Unit

A. BACKGROUND

Under the National AIDS Control Programme Phase IV (NACP-IV), MSM continue to be featured as a high priority group. The prevalence of HIV among MSM in India is estimated at 7.3 per cent,¹ which is more than 20 times the general population rate (NACO, 2010). The prevalence of sexually transmitted infections (STIs) is also high among MSM (e.g., Syphilis: 5.8 per cent² to 14 per cent³).

The achievements of NACP-III in relation to MSM (and TG) populations include:

- Expanded coverage: 2,74,000 (out of an estimated 4,12,000 population)—a seven-fold increase from NACP-II;
- More TIs: 180 exclusive and around 200 composite TIs, which achieved 67 per cent coverage of most-at-risk MSM and TG populations;
- About 150 surveillance sites for MSM/TG populations;
- Initiation of reporting on discrimination/violence against MSM;
- Presence of MSM TIs in almost all states (based on information from the mid-term review report of NACP-III)

NACP-IV intends to build on these achievements and intensify efforts to prevent HIV infection among MSM, while offering a range of necessary comprehensive services.

B. GOAL AND GUIDING PRINCIPLES

Goal

Zero new infections among MSM by the end of 2017; and universal access to HIV prevention, care, support and treatment services for all at-risk MSM.

Guiding Principles

- Universal access—inclusion of **all** high-risk MSM,⁴ regardless of sexual identity, marital status, age or presumed/stated sexual practices (receptive or penetrative or both);

1 NACO (National AIDS Control Organisation). (2010). UNGASS Country Progress Report – India.

2 Gupta, A et al. 'Same-sex behavior and high rates of HIV among men attending sexually transmitted infection clinics in Pune, India (1993–2002)', *Journal of Acquired Immune Deficiency Syndromes*, 2006, 43: 483–490.

3 Newman, PA et al. 'Correlates of paid sex among men who have sex with men in Chennai, India', *Sexually Transmitted Infections*, 2008, 84: 434–438.

4 Not all individuals in a given sub-group of MSM are at high risk of HIV. For example, MSM in a mutually monogamous relationship with an HIV-negative partner are at a much lower risk of HIV infection. Also, there is overlapping risk between being MSM and also being an injecting drug user or sex worker. See the glossary for a definition of 'high risk MSM' and size estimation.

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- Rights-based approach⁵ to health care in order to ensure that NACP-IV provides all comprehensive and necessary HIV-related services for MSM and continues with its national policy of voluntary HIV testing and clinical screening;
 - Elimination of stigma and discrimination against sexual minorities in various settings (health care settings, workplace, family, and society);
 - Strengthening of community systems—investing in the formation and strengthening of MSM community groups and networks to promote community ownership of the HIV programme;
 - Addressing multiple vulnerabilities as associated with sex work, marital status, multiple stigmas and lower socio-economic status;
 - Emphasis on both the scale of services as well as on the quality of messages and services to maximise effectiveness and ensure that interventions and services are, to a large extent, evidence-based.
 - Ensuring that MSM TIs not only focus on providing services to MSM who already enjoy access to their services, but also focus on prevention of HIV/STIs among their steady partners—male and female;
 - Providing a comprehensive service package with a continuum of prevention, care, support and treatment services;
 - Flexibility to allow for adapting TI design and implementation to suit the local context (urban/rural, concentrated vs. dispersed MSM communities, etc.);
 - Transition of certain services (such as STI clinical services) to NRHM/NUHM,⁶ which becomes possible after ensuring proper sensitisation of government health care providers about the issues faced by sexual minorities and improving their competency to provide optimal clinical and counselling services.

A Rights-based Approach to HIV Programming for MSM in India

A comprehensive and effective response to HIV and AIDS requires addressing human rights. Since the early days of the epidemic, social, legal and economic marginalisation have been associated with vulnerability to HIV. A rights-based approach to HIV endeavours to address these disparities and improve the overall performance and impact of programming would be the best way to contain the HIV epidemic and move towards zero prevalence among MSM.

MSM have been heavily affected by HIV and AIDS from the start. Evidence indicates that their vulnerability to HIV is contingent on the degree to which their rights are recognised and addressed.

5 A rights-based approach to health is normatively based on international human rights standards and operationally directed to promoting and protecting human rights, and where governments and donors work to implement respect for, protection of, and realisation of rights.

6 NRHM: National Rural Health Mission; NUHM: National Urban Health Mission

The 1948 Universal Declaration on Human Rights codified this connection between health and rights in Article 25 of the document. India voted in favour of this declaration and has affirmed its strong support of human rights over the years, along with its support to several other international commitments and agreements.

The interconnections between human rights and health became more obvious and urgent as the AIDS pandemic emerged. A human rights-based approach to health looks beyond a clinical services model of disease control and provides a framework to address the contextual and structural factors that contribute to health and well-being.

India needs to adopt the human right to health as a guiding principle of NACP-IV and address critical barriers that increase the vulnerability of MSM and other most-at-risk populations. By protecting and affirming the right to health among these populations and by ensuring that they are able to access services without experiencing discrimination, legal sanctions, social stigma, or violence, India will be able to effectively build on the foundation of its earlier national AIDS strategies and help sustain the momentum of these efforts.

C. STRATEGIC OBJECTIVES

The goal can be achieved through the following strategic objectives:

1. To reach diverse sub-groups of MSM through complementary outreach strategies by contacting all at-risk MSM and providing behaviour change communication (to promote safer sex and access to services);
2. To offer a comprehensive package of prevention, care, support and treatment services to meet the specific needs of various sub-groups of MSM (and to ensure a continuum of prevention, care and treatment);
3. To create and sustain an enabling environment that promotes human rights and access to services for MSM;
4. To mobilise and strengthen MSM communities to effectively contribute to national responses to the HIV epidemic.

STRATEGIC OBJECTIVE-1: OUTREACH STRATEGIES TO PROVIDE BEHAVIOUR CHANGE COMMUNICATION

To reach diverse sub-groups of MSM through complementary outreach strategies by contacting all at-risk MSM and providing behaviour change communication (to promote safer sex and access to services)

Traditionally, outreach has been conducted in hotspots or cruising sites. However, the number of traditional such sites has been decreasing due to urban/rural development, and more and more MSM have started using mobile phones and the internet to seek sexual partners, thereby increasingly rendering these sites redundant. Thus, outreach strategies will have to include both physical/traditional outreach strategies and virtual or technology-based outreach strategies.

Expanding the traditional outreach strategies to reach diverse sub-groups of MSM (See Diagram 1)

Under NACP-IV, the traditional outreach model of conducting outreach at hotspots or cruising sites will be expanded. The changes include: 1. employing outreach workers belonging to different sub-groups or typologies of MSM; 2. moving to sub-group-specific venues (e.g., bars for gay men, massage clubs that cater to same-sex attracted men); and 3. outreach during events for communities (e.g., Pride March) or at occasions or events where a high number of MSM come together (e.g., certain festivals). These are explained further below.

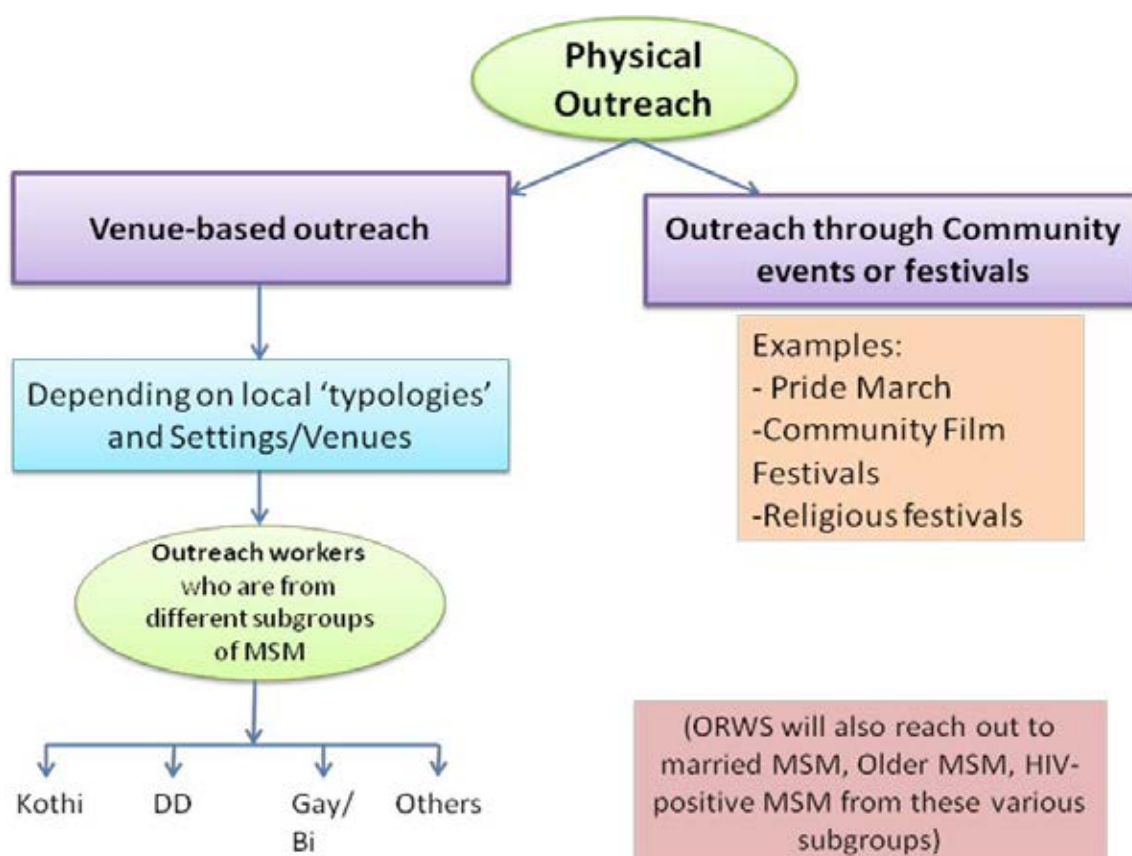
Under NACP-III, a significant majority of the ORWs in most TIs have been kothi-identified MSM,⁷ who could primarily only reach out to their peers—that is, other kothi-identified MSM. Kothi ORWs found it difficult to reach and talk to masculine-looking MSM, who may be double-decker-identified MSM or gay-identified MSM. Accordingly, depending on the proportion of the local typologies of MSM, ORWs need to be identified from those key MSM sub-groups and employed for traditional outreach. In addition, sub-group-specific outreach strategies need to be developed and implemented. For example, in metros, where there is a sizeable proportion of gay-identified MSM, a gay-identified MSM can be recruited by the TI as an ORW to work with gay communities, preferably through nomination, or being acceptable to the local gay community groups. He can then reach out to gay-identified men at gay parties, gay-specific bars or other gay-specific venues.

Certain community-based events, such as LGBT Pride Marches and LGBT film festivals, can also be venues for reaching some at-risk MSM, at least to provide basic information on safe sex and services available for MSM. Sometimes community events organised by MSM agencies can be venues to

⁷ **Kothi-identified MSM** generally present with feminine gender expression and are primarily receptive partners during anal sex with panthis. **Panthis** is usually a label given by kothis to their masculine partners and usually is not a separate identity. Kothis label MSM who engage in both insertive and receptive sex as **'double-deckers'** (some may also self-identify as double-deckers. (Note: There are regional variations in the terms used.) **Gay- and bisexual-identified MSM** are primarily from the middle and upper socio-economic classes and are relatively better educated as compared to kothi-identified MSM, who are primarily from lower socio-economic classes and tend to be less educated. (For more details, please refer to the *Glossary*.)

provide such information. Certain festivals like Ganesh Chaturthi (Maharashtra) and Dhandiya Ras (Gujarat) may attract large congregations of MSM; HIV-related messages and condoms could be provided at such events.

Diagram 1. Expanding physical outreach strategies



While the presence of local typology-based ORWs is recommended, it may not be possible to provide an ORW for each category of MSM, such as married MSM, HIV-positive MSM, and older MSM. To effectively reach out to these sub-groups, existing ORWs need to be sensitised on the issues of married MSM, HIV-positive MSM and older MSM, so that these sub-groups can also be addressed and are not discriminated against or left out. More details on potential strategies to reach currently hard-to-reach MSM are listed in **Table 1**.

Appropriate TI models need to be developed in rural areas/districts where there are not too many hotspots and where MSM are not concentrated. One possible model –is one with urban-based TI with satellite or sub-offices in interior parts of districts that have ‘clusters’ of MSM, and employing local peers to reach rural MSM and refer them to nearby health services. However, documentation of existing TI models for rural MSM and pilot-testing is required to determine the feasibility, acceptability and cost-effectiveness of one or more TI models for rural areas.

Technology-based Outreach or Virtual Outreach (See Diagram 2) Mobile Phones

Increasingly, mobile phones are being used by people from all socio-economic classes, and especially among MSM (irrespective of socio-economic class), mobile phones are also being used to contact potential sexual partners through sharing of numbers amongst friends. Thus, health promotion messages could be sent via mobile networks to MSM (who are line-listed in TI projects or whose numbers are obtained with their explicit permission/consent to send such messages). For HIV-positive MSM who explicitly provide consent for getting messages and reminders, treatment-related messages and reminders for ART adherence and follow-up could be conveyed through texting and making calls. Adequate mechanisms need to be developed to keep these mobile numbers confidential.

Phone helplines

Many CBOs working with MSM have been using phone helplines to provide information and counselling to MSM who may want to remain anonymous and who may not want to visit drop-in centres. Sometimes, in crisis situations, these helplines can be used to get rapid response. Phone helplines could be made a part of NGO/CBO-run TIs depending upon the perceived demand/need and the capacity of the agency to implement it. In cases where there is less capacity but adequate demand, the capacity of the TI implementing partner needs to be built.

Internet-based interventions

More and more MSM, especially those who are not currently accessing TI services, are using websites (national and international) for same-sex attracted men to meet potential sexual partners. It is important to identify such websites, reach out and build a rapport with them (and talk about corporate social responsibility), place advertisements and post links to HIV-related websites. Another strategy is to operate a state-specific website (in both local language and English) for same-sex attracted men on which information about HIV, sexual and other health-related matters is provided to decrease sexual risk behaviours and increase uptake of HIV and STI testing and counselling among MSM, with a provision for online counselling by peers. These websites can be operated by an experienced TI implementing agency or by a separate agency exclusively hired for this purpose.

Diagram 2. Technology-based Outreach Strategies

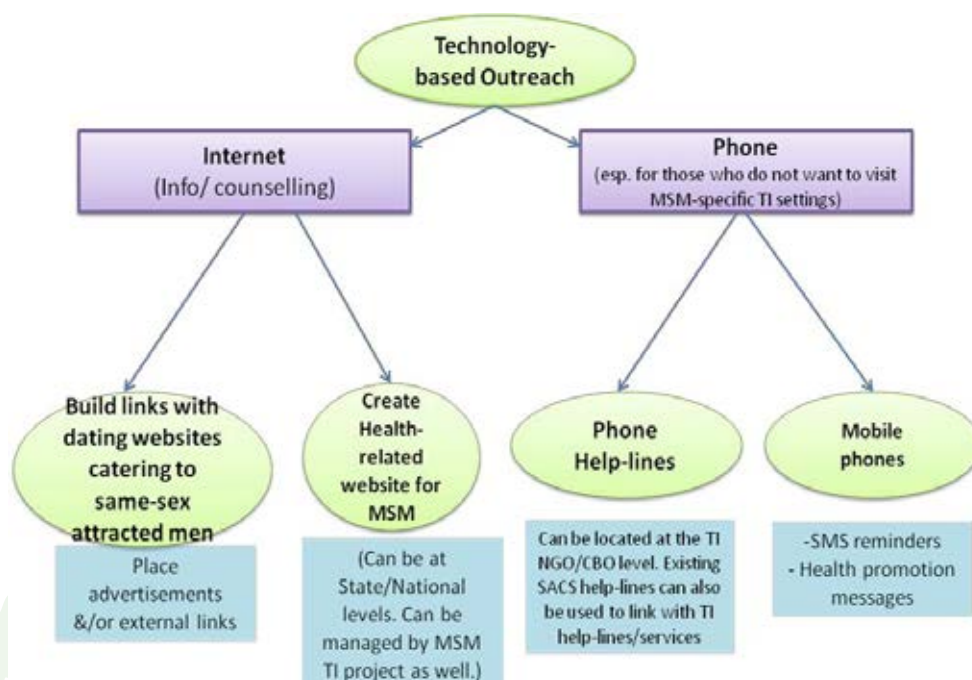


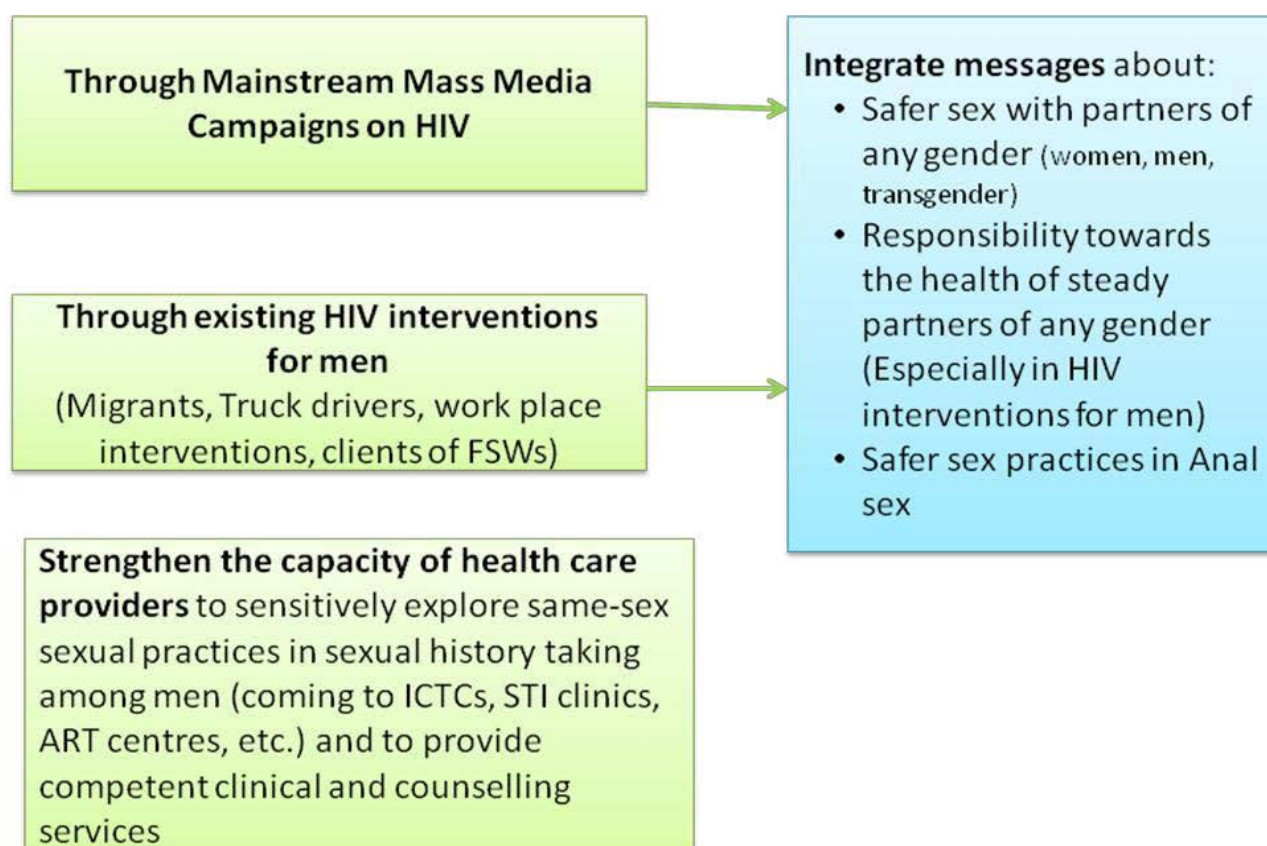
Table 1. Strategies to reach ‘Hard-to-reach’ MSM⁸

Sub-groups of hard-to-reach MSM	Barriers to reach	Potential strategies to reach <i>(to provide info/counselling and link with services)</i>
Gay or bisexual-identified MSM	<ul style="list-style-type: none"> - Do not visit current hotspots of TIs - Socio-economic class differences between current TI outreach workers - Do not want to be seen talking to kothi-identified/feminine persons in public places or even allow kothi ORWs from TIs at gay parties or other gay-specific venues - Do not want to visit DICs located within CBOs/NGOs which are seen as predominantly kothi-oriented 	<ul style="list-style-type: none"> - Sensitise existing gay-specific local groups (e-groups) or other social groups on the importance of HIV interventions for gay-identified men and get their support. Gay peer ORWs can be identified with the help of these local gay groups - Employ gay-identified ORW acceptable to the gay community, depending on the settings (e.g., urban areas), who can then facilitate access to gay-specific venues (parties, bars, etc.)
Married MSM	<ul style="list-style-type: none"> - Community stigma (kothi/ gay) related to marital status - Fear of disclosure of sexuality to wives and its negative 	<ul style="list-style-type: none"> - Create a conducive environment for married MSM in TIs by addressing community stigma around married status of self-identified MSM - Anonymous referral and FU services

⁸ For a definition and explanation of ‘hard-to-reach MSM’ please refer to the *Glossary*.

Self-identified MSM who do not visit DICs/TIs and cruising sites 'Older' MSM (> 50 years of age)	consequences	(phone/internet) for married MSM who do not want to visit TI sites/DICs
	Want to receive anonymous services	<ul style="list-style-type: none"> - Helpline-based service referrals/follow-up - Internet-based interventions
	Not prioritised by HIV agencies, especially agencies with mostly young MSM ORWs	<ul style="list-style-type: none"> - Need to educate TI staff about the importance of reaching out to older MSM
	Legal barrier to the provision of services in the current TIs	<p>Sensitise existing youth/adolescent-friendly clinics on issues of same-sex attracted legal minors and establish linkages with the relevant government or non-governmental agencies. There is a need to develop guidelines to address this issue (i.e., being a legal minor as an access barrier)</p>
Same-sex attracted legal minors (below 18 years of age)		
Non-self-identified MSM <i>(See Diagram 3)</i>	Not coming to cruising sites and TI projects; and not even using MSM-specific internet sites	<ul style="list-style-type: none"> - Integrate messages/counselling in existing HIV interventions for men (migrants, college youth, drug users, prisoners, truck drivers, etc.) in mainstream mass media campaigns on HIV, along with generic messages on safer sex with partners of any gender. Strengthen the capacity of health care providers to sensitively enquire about same-sex sexual histories when men visit government health care settings (STI clinics, ICTCs, ART centres, etc.)

Diagram 3. Reaching Non-self-identified MSM



STRATEGIC OBJECTIVE-2: (COMPREHENSIVE PACKAGE OF SERVICES AND CONTINUUM OF CARE)

To provide a comprehensive package of prevention, care, support and treatment services to meet the needs of various subgroups of MSM while ensuring a continuum of care

MSM must be provided with a range of HIV-related services—directly, through TIs, and by linking them with government (and sometimes, private/non-governmental) health facilities. These include the essential package of services to be made available by TIs (on-site services and essential referrals) and an additional package of

services (a suggested list of referrals). Both these packages are elaborated below. Together, they form the comprehensive package of services.

Table 2. Comprehensive package of services (includes referral services)

Essential package of services (See Table 2)

Most of the following services are provided either through TIs or by linking with appropriate health care services (e.g., HIV testing and STI treatment).

1. Outreach and Behaviour-change communication

The various physical and virtual outreach strategies have been elaborated earlier. Their aim is to provide information/counselling on HIV/STIs and sexual health, provide services

Essential Package of Services	Additional package of services (Usually referral services)
<ol style="list-style-type: none"> 1. Outreach And Behaviour Change Communication 2. Condoms and lubricants 3. Drop-in Centre (DIC) 4. STI screening (Syphilis/Other STIs, HBV) And management (including partner referrals) 5. Voluntary HIV testing and counselling, and risk reduction counselling 6. Crisis/Violence prevention and mitigation (Crisis Response Team) 7. Positive living and positive prevention 	<ol style="list-style-type: none"> 1. Counselling related to sexuality and mental health issues and/or marital issues 2. Anal cancer screening for HIV-positive MSM 3. Social protection/entitlements 4. Alcohol dependency treatment and drug-dependent treatment programmes 5. Treatment of Hepatitis-B 6. Screening for Hepatitis-C, in the case of a history of injecting drug use

Table 2.

for HIV/STI screening and treatment, promote condom and lube use, and uphold human and legal rights. Depending on the nature of information/counselling, outreach workers or counsellors will be the key staff involved in providing information and behaviour change communication. Appropriate tools to assist in behaviour change will be developed in local languages. These tools will cater to the specific needs of diverse sub-groups of MSM while taking into account the diversity in sexual identities, socio-economic and educational status, marital status and HIV status.

2. Condoms and Lubricants

Condoms and lubricants will continue to be provided free through TIs to cover all the estimated anal sex episodes of the beneficiaries they reach. Supply of free condoms and lubes will be timely and distribution will be made more efficient. Training will be provided to TI staff to calculate condom and lube requirements. This training is of particular importance because water-based lubricants have relatively low shelf life (six months)

and thus their usage within the stipulated period becomes essential. Methods of observing lube uptake and corresponding adjustments on lube indents will be fine-tuned to prevent wastage or stock-outs at the TI level, in parallel to the stocking of condoms (both super-lubricated and flavoured).

3. Drop-in Centre

DICs will be treated as a service to focus on and strengthen collectivisation that enhances community ownership of the TI. This will also ensure service uptake through TIs. The concepts of community ownership and collectivisation will be defined through tangible activities or modules that help in fostering community spirit (e.g., by offering training on self-development and leadership skill development). DICs will focus on providing services to the community and will orient itself in terms of service quality and standards. The DIC will serve as the focal point that channelises community synergy towards uptake of services both internal and external to TI. DIC protocols will be strengthened to ensure efficient use of space. DICs will be of a size to

accommodate enough people to hold meetings and other related community activities. Hence, budgets for DICs will be commensurate with the city tier (category of the city/town) and the needs of the specific MSM community typology.

4. STI screening (Syphilis/Other STIs, HBV) and management (including partner referrals)

Not all TIs have clinics located within their office premises. Some have established linkages with local government hospitals for STI screening and treatment while others have their own clinics. Wherever there are TIs for MSM, the local government health care providers will be sensitised and trained on the needs of MSM. An appropriate time-period (about three to five years) will be allowed for transition of STI care of MSM from TI-based clinics to the nearest government health care facilities. Referrals to government facilities will also help MSM gain access to general health facilities that TIs presently do not provide. The national STI guidelines, which include guidelines for anal and oral STIs, will be followed. Health care providers in the government STI clinics will be trained on these guidelines and on the issues of MSM and transgender people.

Anal and oral STI screening will continue to form a part of the current STI prevention strategies. Proctoscopy, a procedure for detecting symptomatic anal STIs, requires the explicit consent of the patient after taking his sexual history. Only on the basis of such oral sexual history (e.g., history of unprotected anal sex in the past three months or condom breakage/slippage) should any invasive procedure be conducted. These are crucial steps to prevent human rights violations such as the forcible use of invasive proctoscopic examination, which drives away other potential beneficiaries from seeking such services.

Testing for syphilis is recommended at a six-month interval for both individuals with HIV-negative/unknown status and those who are HIV-positive. Presumptive treatment for STIs among MSM will be provided after evidence for the same is available. If required, operational research on the efficacy of presumptive treatment will be conducted.

Because unprotected anal sex may result in transmission of Hepatitis-B (HBV) infection, screening for HBV is recommended as a routine practice when MSM are screened for STIs. HBV screening of MSM is a standard international practice. Hepatitis-B vaccination should be offered to those who are HBV-negative.

5. Voluntary HIV testing and counselling

While HIV screening for MSM at quarterly intervals is recommended, in consistency with NACO's policy this will not be made mandatory. MSM will be provided proper counselling on HIV testing and only those who consent for testing will be sent for HIV testing and counselling.

6. Crisis/Violence prevention and mitigation (Crisis Response Team)

Crisis forms a part of any outreach work and rapid response to crisis builds the faith and confidence of a marginalised community that often finds itself on the receiving end of stigma and violence. Every TI needs to not only react to crisis but also look at preventive actions that can avert any unpleasant situations. Crisis response is part of creating an enabling environment and hence needs to be addressed by all TIs. A crisis response team usually includes a project manager, counsellor, ORWs and local (area) peers. Each TI should also take up proactive

advocacy strategies to prevent future crises. The prevention of sexual and physical violence should be part of such proactive strategies. Crisis response teams should also take care of the service needs of victims of sexual violence by connecting them with medical services, helping them in filing cases and linking them to free legal aid. NACO will develop mechanisms to offer sexual post-exposure prophylaxis (S-PEP) in the government hospitals for victims (men, women and transgender) of sexual violence.

7. Positive living and Positive Prevention

MSM living with HIV need to be offered certain essential services. These include:

- Treatment literacy and effective communication for better knowledge to access services;
- Assistance in disclosure to steady partners and providing information about where to refer their steady partners (men and women) for HIV screening and treatment;
- Counselling on safer sex with sexual partners and reducing the risk of sexual transmission (correct and consistent use of condom during any sexual encounter, condom negotiation and sexual communication skills);
- Prevention of transmission through non-sexual routes (injecting drug use);
- Advice on how to prevent other infections such as STIs and TB;
- Supporting and monitoring MSM on care, support and adherence to ART;
- Referral to ART centres and TB DOTS centres;
- ART preparation, initiation and adherence support;

- Nutrition support and encouraging physical activity;
- Supporting the formation of support groups of MSM living with HIV;
- Referral to mainstream PLHIV networks and proper sensitisation of network staff/members;
- Buddy system for MSM living with HIV, where one or more staff members are given the responsibility of providing necessary referral services (Note: Some MSM living with HIV may need to be accompanied by a staff member to the government services at least initially).

Additional package of services

(Referral services)

Some of the referral services that can be offered through TIs include:

- Counselling services pertaining to sexuality and mental health (these can even be offered at TI site level), issues arising out of marital status (like legal aid);
- Anorectal cancer screening for HIV-positive MSM (especially those who have a history of anal warts);
- Social protection/entitlements;
- Alcohol dependency treatment and drug-dependent treatment programmes (needle syringe programmes, opioid substitution treatment, etc.);
- Treatment of Hepatitis-B infection;
- Screening for Hepatitis-C, in case of history of injecting drug use.

STRATEGIC OBJECTIVE-3: ENABLING ENVIRONMENT

To create and sustain an enabling environment to promote human rights and access to services for MSM

A supportive or enabling environment, which includes policies and legislations that address stigma, discrimination and violence, and psychosocial vulnerabilities, is critical to achieving universal access to HIV prevention, treatment, care and support. Activities to promote such an enabling environment, thus, will not be limited to advocacy with the immediate stakeholders around the TI implementing sites but include changing the negative attitude of the general public and health care providers towards same-sex attracted people. Both proactive and reactive advocacy strategies will be used by key stakeholders towards this end. Depending on the nature of the issue, the activities could involve training and sensitisation, legal reform, and partnerships with agencies working on human rights issues. Also, some of these advocacy activities will take place at the national level, some at the state level, district level or TI site level.

Table 3. Key advocacy activities to create an enabling environment

No.	Advocacy Issues	Activities	Agencies to be involved			
			NACO	SACS	TIs	Other agencies
1	Mental health concerns of MSM	a) Training TI staff (especially the outreach team) on mental health concerns of MSM	Developing training module on 'Mental health concerns of MSM' for TI staff	Taking lead in these trainings at the state level	Outreach team (including additional in-depth training to counsellors) to use this knowledge to provide mental health counselling	
		b) Training of Health Care Providers (HCPs), including Mental Health Professionals (MHPs)	Advocating with Ministry of Health to include health concerns of sexual minorities (including mental health concerns) in the medical and nursing curriculum	--	--	Ministry of Health; Indian Psychiatric Society (IPS), Indian Association of Clinical Psychologists
			Developing a module for orientating/ sensitising existing HCPs and MHPs on these issues	To forge collaborations with state level medical and psychiatrist associations in conducting these orientation sessions	To assist STRC in selecting participants for such orientation sessions	Training agency to use supportive mental health experts as resource persons for these trainings

2	<p>Enabling MSM (especially MSM involved in sex work) to access social entitlements (identity documents, economic schemes)</p>	<p>Training TI staff (especially the outreach team) on these issues so that they can enable (through information dissemination, and guidance) their project beneficiaries to access such social entitlements. Although these issues are not specific to MSM, this approach could be used to attract the population (especially un-reached MSM from economically/ socially disadvantaged backgrounds) to TI services</p>	<p>Developing a module / information pack on the following :</p> <ul style="list-style-type: none"> □ Where and how to get these social identity documents □ What kind of social protection schemes are available and how to access them 	<p>SACS to conduct these trainings</p>	<p>Outreach team to use this knowledge to enable project beneficiaries to access social entitlements</p>	<p>In some cases referrals could be made to the National Legal Services Authority (NALSA), State Legal Services Authority (SALSA), District Legal Services Authority (DALSA), and SACS legal aid cells, where those exist</p>
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3	Advocacy with Police	<p>Training police personnel at all levels (using the Tamil Nadu model/ UNAIDS nodal points)</p> <p>Note: Each training to have personnel from the same level to ensure a more open discussion and better interaction among the trainees</p>	Developing an appropriate training module (the Tamil Nadu model to be adapted/further developed)	<p>SACS to train a group of Master Trainers (selected from TI staff/ community members)</p> <p>SACS to collaborate with state police authorities to conduct these trainings</p>	Master Trainers to be selected from the communities among other experts	DIG Police, Police Academies and other relevant government departments
		Orientation/ sensitisation of police personnel at the local Police Station level	<p>Developing a training module for TI staff on legal rights, various laws that can/are being used against MSM and how to deal with police harassment/ rights violations faced MSM</p> <p>Motivating SACS to initiate/scale up/strengthen their legal aid cells</p>	<p>SACS to train TI staff on these issues</p> <p>SACS to initiate/scale up/strengthen their legal aid cells and pro-actively take up cases of rights violations/ police harassment</p>	To build rapport with the police stations within their project area	Human Rights Commissions, various organisations and agencies working on human rights issues, local lawyers (who have been sensitised regarding these issues)
4	Advocacy with Judiciary	<p>Sensitising judges (at the national, state and district levels) and lawyers</p> <p>Using Alternate Dispute Resolution (ADR), Lok Adalat for resolving conflicts/rights violations at the local level/rural settings</p>	To collaborate with relevant government ministries and departments, and other development partners to facilitate such sensitisation sessions	Facilitating sensitisation sessions at the state and district levels	<p>Sensitising local lawyers/referring them to such sensitisation sessions carried out by SACS</p>	<p>Judicial Academies, Ministry of Social Justice and Empowerment and Ministry of Law, HR Commission</p> <p>Development partners (such as UNDP), Human Rights Commission</p> <p>NALSA, SALSA and DALSA</p>

5	Advocacy with people representatives	Advocating with MPs and MLAs, towards getting support from relevant ministries Ensuring community representation at the National AIDS Committee	Advocating with MPs regarding the need for NACO to work with MSM populations Advocating with the Parliamentary Forum on HIV/AIDS	Advocating with MLAs and with the State Level Legislative Forum Training TI staff/ CBO board members to advocate with MLAs	TIs to support SACS in advocating with MLAs	National AIDS Committee, Parliamentarian Forum on HIV/AIDS, state level legislative forums
6	Crisis management at the TI level	Strengthening Crisis Management Cells (CMCs) with the TI to deal with crisis	Developing a training module for TI staff for the efficient management of CMCs	SACS to carry out these trainings	To involve CBO board members/ community members to strengthen their CMCs	

MSM communities are quite diverse. Not all MSM want to be part of informal or formal groups of MSM. Similarly, there may be various reasons behind the formation of MSM community agencies. Some of these are formed to address the health needs and advocacy issues of same-sex attracted men. Some other community groups are informal (non-registered), and possibly even primarily e-group-based, and they may focus on issues of importance to same-sex attracted communities and/or to socialise and meet with potential sexual or life partners.

Some of the MSM community agencies have formed national and state level networks. There are experienced national and state level networks of sexual minorities (such as Integrated Network for Sexual Minorities, INFOSEM—a national network, and Manas Bangla—a state level network in West Bengal). In addition, state level networks of MSM and transgender people are being formed and strengthened in Avahan-supported programmes as well.

Thus, community mobilisation and strengthening processes need to take into account all these existing and emerging community structures. Community mobilisation and strengthening, in general, will thus not only be focused on building the capacities of the communities to address HIV-related issues among the diverse communities but also to address the broader health-related issues and rights issues. The goal of community mobilisation and strengthening from the national government's perspective is to strengthen the communities so that they can eventually take ownership of programmes addressing HIV/health-related issues and rights issues of their communities.

At the TI level, community mobilisation may refer to mobilising community members at the grass-root level to understand their health-related issues and rights, improve their access to services and to help them collectivise and enjoy/realise their rights. This, in turn, will greatly assist in moving towards the national goal of zero new infections

by 2017 through developing and strengthening community ownership of the programme.

Thus, community strengthening strategies include:

1. Community mobilisation at the TI level (established CBO/NGO);
2. Support for formation and strengthening of formal and informal community groups;
3. Support for strengthening of existing national and state level networks of sexual minorities, and formation of new state level networks of sexual minorities;
4. Linking and docking these networks with other government agencies to facilitate their mainstreaming into national goals of progressive, rational and scientific thinking.

Community mobilisation at the TI level (established CBO/NGO)

TI-based community ownership building activities include (but are not limited to):

- Conducting events of importance and attraction to the communities with larger representation from the grass-root level community members (not just PEs or CBO/NGO staff). For example, community events like ‘Melukolupu’ in Andhra Pradesh, and Ghutiari Sharif Mela in West Bengal.
- Mixing information with entertainment (‘Infotainment’) during DIC activities and in the field.
- Encouraging community members to actively provide periodic feedback to check and ascertain whether the services meet the needs of the beneficiaries and are of acceptable quality.

- Community participation in planning of outreach at hotspot and cluster levels, and crisis management groups at intervention sites.
- Participation of community members in planning, implementing and monitoring activities at TI level.
- Community involvement in the designing of various capacity building modules and communication materials

Support for formation, and strengthening of formal and informal community groups

Under NACP-III, community strengthening primarily supported the formation of formal (registered) CBOs under the guidance of NGOs and transition of TIs from NGOs to CBOs. Also, capacity building support from SACS was provided only to CBOs funded by NACO/SACS. The strategy under NACP-IV will be to support the formation of formal (registered) CBOs wherever necessary and to support capacity-building of existing CBOs in order to address the health and rights-related issues of MSM. Capacity-building support will not be limited to NACO/SACS-funded CBOs but also for new/emerging formal and informal community groups (including e-group-based groups), based on their needs and the stage/experience of the community groups/agencies.

Support for strengthening of existing national and state level networks of sexual minorities, and formation of new state level networks of sexual minorities

Support, either through NACO or through donor partner agencies must be offered to build the capacities of the secretariats of existing national and state level networks of sexual minorities (such as INFOSEM and Manas Bangla) by NACO/SACS.

In addition, support must be offered by SACS or other donor partners for the formation and strengthening of state level networks or federations of sexual minorities to build their advocacy capacities. In some cases, the secretariats of such networks may also serve as hubs for overseeing and extending support to TIs implemented by CBOs at the state level (for example, WBSACS currently supports the secretariat of Manas Bangla to oversee and provide support to TIs implemented by its CBO members).

Community engagement in the decision-making processes

The government is committed to the principle of greater involvement of people infected and affected by HIV/AIDS (GIPA). Accordingly, MSM communities will be involved in the designing, implementation and evaluation of GIPA programmes and policies.

The formation of NACP-IV strategies for MSM involved the active participation of community representatives from various parts of India. This shows the commitment of the government to involve affected communities in programme/policy designing. Similarly, the support for the formation and strengthening of CBOs (and networks) to implement TIs shows the active involvement of the communities in the implementation of the programme by taking ownership. Community representatives will also be involved in the review and evaluation of national and state HIV programmes.

The recently approved national GIPA policy is also applicable to affected communities such as MSM (whether HIV-positive or not), and procedures set in the national policy will be adapted to involve the MSM communities in the design, implementation and evaluation of HIV programmes.

D. CAPACITY BUILDING

The process of capacity building and creation of an enabling environment for the successful implementation of the programme will take place at several levels—NACO, SACS and TI, along with key stakeholders. For this purpose, a resource pool is to be developed at the district, state and national levels, with professional and community experts in HIV interventions for MSM.

Capacity-building of SACS

Capacity building measures targeted at SACS officials will include, but not be limited to, the creation of state-specific scale-up plans (including mapping and size estimation); tailoring of the HIV programme for MSM according to the local context; development of an advocacy strategy; implementation in collaboration with other partners; and the involvement of MSM communities in the designing, implementation and evaluation of the state MSM programme.

Capacity-building of TI-implementing partners

TI staff and management will be trained on all aspects for the successful implementation of the project. These include management and technical aspects, and providing ongoing technical support for implementing TIs.

Capacity-building of community groups and networks

Capacity-building will not be limited to CBOs funded by NACO/SACS, but active capacity building support will be provided for new/emerging formal and informal community groups (including e-group-based groups), based on their needs and experience.

Capacities of national and state networks of sexual minorities will be built to enable them to effectively advocate with key stakeholders (health care providers, police, judiciary, etc.), thereby reducing stigma and discrimination in various settings, and to promote access to health services including HIV and sexual health services.

There is a need for a situation assessment of the capacity of TI service providers in delivering MSM-specific interventions and the identification of areas for capacity-building. The current capacity and resources of NGOs/CBOs implementing TIs are insufficient for them to comprehensively provide care and support. There is an urgent need for treatment literacy and effective communication so that MSM are better aware about available services. HIV-positive MSM need to be supported to build their own self-help groups as a capacity-building measure towards enhancing care, support and adherence to ART.

Capacity-building of health care providers

Training will be provided to health care providers in government hospitals (STI clinics, ICTC, ART centres, General Medicine and Surgery, Psychiatry, etc.) on:

- Human rights-related issues of sexual minorities and to better understand sexual minorities as fellow humans;
- Ensuring competent clinical and counselling services for MSM and their steady partners (men and women); and
- Developing cross-linkages with agencies working with MSM.

E. MONITORING AND EVALUATION, AND

STRATEGIC INFORMATION

a. Programme planning and implementation

Formative research will help in designing the national/state programme as well as projects according to the local context (TI level). For example, at the national/state level, the type of information required in relation to HIV programme for MSM involves answering the following questions:

- Who are MSM? What are the various sub-groups/typologies of MSM? Who is at high risk for HIV?
- What are the various strategies to reach diverse sub-groups of high-risk and at-risk MSM?
- Where are the various sub-groups of MSM located (mapping) and what is the estimated size of these sub-groups (size estimation)?
- What are the driving factors for HIV transmission risk among MSM and how should these be addressed? (This may require structural level interventions.)
- In what ways can individual level interventions help address risk and promote behaviour change?

Operations Research

Among other benefits, operations research can be useful to find out what works and why; and what did not work and why. This can help improve the programme/project. Operations research can be conducted at different stages of the programme/project to identify the need for mid-course correction or the need to modify or expand the strategies.

Sometimes, where there is limited information about developing intervention models for particular sub-groups of MSM in certain settings (example, rural), *feasibility studies* to test potential intervention models may be necessary. Models

that have worked in one part of the country may require modification before being implemented in another part of the country, in keeping with the local context. Operations research studies will help in addressing these kinds of questions.

b. Programme monitoring and evaluation

Input/Output Monitoring and Process Evaluation

Programme/project monitoring requires using quantitative and qualitative indicators to find out whether the required outputs are being achieved within the stipulated time-period, and whether they are of acceptable quality. Process evaluation consists of checking the process involved in arriving (or not arriving) at the required outputs of a project.

Outcomes and Impact Evaluation

Programmes/projects can be evaluated by finding out whether they have resulted in the intended outcomes/impact. This requires baseline, mid-line and end-line assessments (using mixed methods—both quantitative and qualitative). However, the impact is often visible only after several years and not during the programme period.

In order to measure some of the short-term outcomes, such as change in the behaviour and biological outcomes (HIV/STI prevalence), there is a need for biological and behavioural. Periodic second-generation HIV/STI serosurveillance among diverse subgroups of MSM is necessary. An Integrated Behavioural and Biological Survey among MSM in different parts of India needs to be undertaken and its results should be disaggregated by age and MSM sub-group to help identify differences in burden of disease, risk behaviours and dynamics of the epidemic.

SUGGESTED TARGETS AND INDICATORS AT THE NATIONAL LEVEL

- Saturation of coverage of all high-risk MSM accessing outreach sites (cruising sites or hotspots) in terms of providing essential HIV prevention, care, support and treatment services. The number of high-risk MSM accessing cruising sites has been estimated at around 3.5 million
- Annual validation of MSM populations at physical outreach sites (and emerging virtual sites)
- All 'A' and 'B' category districts (in terms of HIV prevalence) should be covered with one or more MSM TI to saturate the coverage of estimated number of MSM
- All metro cities (national and state) must have one or more MSM TI to saturate the coverage of estimated number of MSM
- All current MSM TIs with adequate capacity should be upgraded to enable them to provide a comprehensive package of services (include lubricants, vulnerability reduction interventions and linkages for social support)
- 70 per cent of exclusive MSM TIs to be transitioned from NGOs to CBOs (higher than the NACP-III aim of 50 per cent)
- 100 per cent of anal sex acts to be protected by condoms and lubes

