

Capacity Building of Communities, Community Networks, and CSOs

Module - 6 **CLM and Knowledge Management**

Community System Strengthening under NACP - V



Module - 6

CLM and Knowledge Management



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Foreword



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स्वास्थ्य और परिवार कल्याण मंत्रालय
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NACP Phase-V envisages "Keep beneficiary and community in center" of HIV/AIDS epidemic as one of the key guiding principles. This aims to maximum the benefits to its diverse target population in a friendly ecosystem, offering a basket of tailored integrated services across prevention-detection-treatment spectrum. The National AIDS Control Program acknowledges the collaboration and involvement of the communities, people living with HIV/AIDS and civil society organizations as key to elimination of HIV/AIDS related stigma and discrimination and strengthening the HIV response in the country. Under NACP V, Community Systems Strengthening (CSS) as an approach complements NACO's overall vision where every person who is highly vulnerable to HIV is heard and reached out to and every person living with HIV is treated with dignity with access to quality care.

Under CSS, the aim is to identify and build the capacity of the communities, community networks and community organisations to ensure greater meaningful involvement of communities (and their organisations) in planning, implementing, monitoring, and evaluation of NACP. It is expected that these individuals, groups and networks from the community will complement the program through mobilizing the community, increasing demand for NACP services and support in improving the quality of care. NACO, through the model of social contracting already partners with Non-Governmental Organisation (NGOs) and Community Based Organisations (CBOs) for provision of HIV services to our priority populations, and hence, it is envisioned that through further capacity building efforts more community-based organisations will be able to take this partnership to the next level.

The capacity building modules developed under CSS, are designed to equip community, community networks and community-based organisations with the necessary knowledge, skills and tools to augment the HIV response in India. I believe these modules will play a valuable role in increasing the capacities of our communities to work in partnership with the National Program towards achieving the goal of elimination of HIV as a public health threat by 2023.


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सत्यमेव जयते



Preface



राष्ट्रीय एड्स नियंत्रण संगठन
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NACP recognizes the need for community-engaged responses, not just as beneficiaries, but as key partners in action for improving health and well-being. It aims towards elimination of HIV/AIDS related stigma and discrimination. NACP Phase-V, therefore aims to institutionalize the community engagement and meaningful participation at the most granular level in the form of community system strengthening (CSS). CSS will catalase improved health outcomes specifically through strengthening targeted interventions (TI) program, advocacy and rapid response to reducing stigma and discrimination, enhancing treatment literacy, greater involvement of communities in decision making and finally developing structured systems of community-led monitoring (CLM).

Under CSS, creation of the community resource pool at the national and sub-national level is given priority wherein focus is to increase capacities of community, community networks and community based organisations. This is done with the objective to enhance engagement and participation of the community in all aspects of the national program from planning, implementation and monitoring. More recently, substantial contribution is added by the community when engaged through community advisory boards at the district level. While conducting Programmatic Mapping and Size Estimation. Through the principles of GIPA, NACP also recognizes the involvement of PLHIV and affected communities by enabling individuals and communities to draw on their life experiences; thus contributing to reducing stigma and discrimination. Communities also play a pivotal role in enactment of the HIV/AIDS Act 2017 by increasing awareness and creating accountability for furthering the HIV response in the country.

Aligned with the above, the modules have been developed for "Capacity Building of Communities, Community Networks and CSOs" under CSS as part of the Global Fund grant, 2021 – 24. It is intended to intensifies efforts for building capacity and human resources, with the aim of enabling communities and community actors to play a full and effective role alongside health and social welfare systems. The modules are useful not only for the HIV program but can also be referenced by the larger public health programs towards effective community engagement in the country.

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सत्यमेव जयते



Message

The fifth phase of the National AIDS Control Programme, aims to attain the United Nations' Sustainable Development Goals 3.3 of ending the HIV/AIDS epidemic as a public health threat by 2030. This has warranted a focused and stronger attention to community involvement in the HIV response in India. Therefore, community system strengthening lays strong emphasis on building capacity and human resources, with the aim of enabling communities and community actors into full partnership with national health and social welfare systems.

There are new overarching strategies that are employed under NACP phase V which complement ensuring access to testing, treatment and care services. There is attention on developing new generation and integrated communication strategy for prevention, testing, and treatment of HIV and STIs. Focus is also laid on promoting launch and scale-up of social protection schemes by Central/State Governments to mainstream people infected and affected with HIV, including the vulnerable population, towards reducing inequalities and promoting inclusions. To reduce HIV related stigma and discrimination, emphasis is on accelerating the notification of State rules in context of the HIV and AIDS (Prevention and Control) Act, 2017, which is the primary legislation protecting and promoting the rights of people infected and affected with HIV. The community of key population and PLHIV will play an important role by spreading awareness, generating demand and supporting in creating an enabling environment for implementation of these strategies, especially by strengthening the process of grievance redressal mechanism.

These modules support in ensuring that information regarding the rights of the community, access to correct and relevant information regarding the programs under NACP and information on social welfare and protection schemes reaches our priority population. Under CSS, the creation of a community resource pool will complement the National level efforts to accelerate and sustain the national HIV response.

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Message

Under NACP phase V, NACO's vision for community system strengthening (CSS) is to ensure meaningful involvement of PLHIV and Key Populations to support the ongoing HIV interventions by building communities capacities and their systems. It is envisioned as an important strategy to improve the program's impact; effectiveness, efficiency, and accountability through better collaboration. It is envisioned for building capacities for reaching the unreached and hidden groups, dissemination of information, and creating an enabling environment for the reduction of stigma and discrimination.

One of the main components of CSS, is to identify and build the capacities of communities, community networks and organizations, it was envisioned to develop capacity building modules based on the needs of the community. As NACO has always involved the community through constant consultation and conversation, the same process has been followed for the development of the above. The topics covered were identified through the mechanism of community needs assessment and finalized through consultation meetings. The 6 thematic areas identified for the modules are: Advocacy; Community networks, linkages, partnerships, and coordination; Resources Mobilization; Demand Generation; Organizational and leadership strengthening; and CLM & Knowledge Management.

The modules for "Capacity Building of Communities, Community Networks and CSOs" are developed covering a range of topics that can be utilised by stakeholders like SACS and implementing partners working with community, community groups and organisations but also for the communities themselves to increase their knowledge and skills to contribute towards the National HIV program. I believe these modules will contribute to strengthening the roles of our priority populations to achieve the highest attainable standards of health, no matter who they are or where they live.


(Dr. Shobini Rajan)

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Acknowledgment

We strongly believe that the modules developed for "Capacity Building of Communities, Community Networks and CSOs" under CSS as part of the Global Fund grant (2021 – 24) under NACP V will intensify NACO's efforts towards meaningful engagement of the communities in the National HIV response in India.

We are grateful for the valuable guidance provided by Ms. V. Hekali Zhimomi (Additional Secretary & Director General, NACO). Ms. Nidhi Kesarwani (Director, NACO) provided her valuable experience in defining the content for the modules. Dr. Anoop Kumar Puri, (DDG – CST, IEC & MS, NACO), Dr. Uday Bhanu Das (DDG – PMR & Lab Services, NACO) Dr. Shobini Rajan (DDG – TI, BSD and STI, NACO), Dr. Chinmoyee Das (ADG – CST, SI & IT, NACO), Dr. Bhawna Rao (DD – IEC & MS & Lab Services, NACO) and Dr. Saiprasad Bhavsar (DD – CST, PMR & SCM, NACO) and SACS officials for their technical inputs and contribution in developing the modules.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CBO	Community-Based Organization
CC	Community Champions
CSC	Care and Support Centres
CSS	Community Systems Strengthening
CHW	Community Health Worker
CMS	Community Monitoring System
CLM	Community Led Monitoring
CRG	Community Resource Group
DAPCU	District AIDS Prevention and Control Unit
DSRC	Designated STI/RTI Clinics
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
H/TG	Hijra/ Transgender
HRG	High-Risk Group
HCPs	Health Care Providers
ICTC	Integrated Counselling and Testing Centres
IEC	Information, Education and Communication
KM	Knowledge Management
KP	Key Populations
MSM	Men Having Sex with Men
NACO	National AIDS Control Organization
NACP	National AIDS & STD Control Programme
NGO	Non-Government Organization
OST	Opioid Substitution Therapy
PLHIV	People Living with HIV
PWID	People Who Injects Drug
SACS	State AIDS Control Society
STI	Sexually Transmitted Infection
TI	Targeted Intervention

CHAPTER - 1.0

Introduction, Background and Overview

India is one of the countries in the Asia Pacific region that have recorded significant decreases in new infections among the key populations (KP) and significant increase in providing access to treatment among people living with HIV infection. The strategies adopted by the National AIDS Control Organization (NACO) for prevention, treatment and care have predominantly worked because the National AIDS & STD Control Programme has kept the key populations (KP) and people living with HIV (PLHIV) at the center of its response. Working with the key groups, consulting and respecting them as the stakeholders have supported immensely in advancing the response to combat HIV/AIDS and the social ramifications of the epidemic. India in its' fight to end AIDS is at a critical juncture as the fast-track targets and India's commitment to end AIDS by 2030, warrants focused and stronger response from the key players. The key players in this regard are the community members from the key populations such as the female sex workers (FSW), men having sex with men (MSM) and PLHIV. Participation and leadership of the key players from KPs in tandem with a well-integrated national program will take India towards achieving the global goals of ending AIDS by 2030. Towards this purpose the NACP V focuses on Community System Strengthening (CSS) and empowerment and calls for community engagement at different level including cadre of health delivery system, at both NACO and State AIDS Control Society (SACS) level. Community System Strengthening aims to achieve improved health outcomes of NACP specifically for strengthening targeted interventions (TI) program, reducing stigma and discrimination, enhancing treatment literacy, greater involvement of communities in decision making and finally developing structured systems of community-led monitoring (CLM).

One of the main approaches under Community System Strengthening is to develop the capacities of communities and Community Based Organizations (CBO) and Non-Government Organization (NGO). In the year 2021, NACO conducted a series of consultations with the community members and national level stakeholders. These consultations pointed out towards the capacity strengthening needs of the community. The national level consultation also brought out the thematic areas on which training could be imparted. Therefore, in order to develop the capacities of individuals and community-based organizations, module-based trainings have been envisaged. This module and other five modules have been created to address the related learning needs of the Community Champions (CCs) and CBOs/NGOs in the field of HIV/AIDS prevention program.

CHAPTER - 2.0

Purpose of Module: 6

CLM and Knowledge Management

This module pertains to CLM and knowledge management (KM) which contributes to the advocacy which in turn strengthens the service delivery systems. An aware and informed communities that engage in CLM serve as a bridge between people and the systems. Engaging knowledge management can contribute to use of existing knowledge or the creation and transfer of new knowledge by the Community Champions, CBO/ NGO for the better programmatic, health and rights related outcomes.

Target Audience of this module

The target audience of this module are the Community Champions and CBOs/NGOs representing and/ or working for the Key Populations (KPs). The key populations who are defined under the Global Fund CSS framework are those groups that meet all three of the criteria below:

1. The population experiences increased risk or burden of disease due to a combination of biological, socio-economic and structural factors;
2. Access to health services that prevent, diagnose, treatment or care for these diseases is lower than for the general population; and
3. The population experiences human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization.

Based on the above criteria, the KPs are defined by NACO as under:

Female Sex Worker (FSW)

Adult women who engaged in consensual sex in exchange for money/ payment in kind at least once as a means of livelihood in the last six months.

Men Having Sex With Men (MSM)

Adult men who had anal or oral sex with more than one male/hijra partner at least once in the last six months.

Hijra/ Transgender People (H/TG)

Sexually active adult person having more than one sexual partner in the last six months and whose self-identity does not confirm unambiguously to conventional notions of male or female gender roles but combines or moves between these.

People who inject drugs (PWID)

Adult men and women who use addictive substances for recreational or non- medical reasons, through injections, at least once in the last six months.

People Living with HIV (PLHIV)

who require anti-retroviral therapy (ART) to live a healthy life.

The Community Champions and representatives of CBO/NGO may be from these KPs and some of them may also from the general population. They will constitute the training participants whose capacities will be strengthened under the CSS.

CHAPTER - 3.0

Objectives of Training Module 6

CLM and Knowledge Management

The master trainers need to bear in mind that the participants are Community Champions and the representatives of a CBO/NGO and need to learn about the CLM and KM practices. Therefore the objective of this training module are as under:

1. To Strengthen Community Led Monitoring and Knowledge Management at the grassroots level

CHAPTER - 4.0

Expected Outcomes

It is expected that after the training, workshop participants will engage in CLM and knowledge management activities. The overall outcomes are as under:

1. Under the CLM, relevant programmatic qualitative and quantitative data are collected, analyzed, used, and shared. Appropriate mechanisms for data quality, feedback and supervision are in place.
2. Knowledge management practices are adopted at the grassroots level.

CHAPTER - 5.0

Principles of the Training Program

The participants of the workshop will be CBO/NGO professionals, activists and community resource persons with varying experience and education. The approaches used for the module cannot be a mere class room lectures kind of one-way interaction; it has to be an approach that respects as well as incorporates their experience, pre-existing knowledge and motivates them to adapt the new learning. Hence, the adult learning approach known as the Andragogy will be utilized for developing these modules. According to Malcom Knowles, an eminent exponent of the adult learning enunciated following core principles of andragogy are:

1. Adults ***need to know*** why they need to learn something before learning it.
2. The ***self-concept of adult*** is heavily dependent upon a move towards ***self-direction***.
3. ***Prior experiences*** of the learner provide a ***rich resource for learning***.
4. Adults typically become ***ready to learn*** when they ***experience a need to cope*** with a life situation or perform a task.
5. Adult orientation to learning is life centered and they see ***education as a process of developing increased competency levels to achieve their full potential***.
6. The ***motivation for adult learners is internal*** rather than external.

Andragogy reorients adult educators from “educating people to helping them learn”. The methods used may range from isolated instruction within a curriculum or integrated instruction. It may also encompass intentional and unintentional learning situations. The instructions need to be organized by task and present in a manner similar to how it will be used. The learner needs to know why the concept to be learned is important in order for the learner to remain motivated. Despite the learner ultimately having control of learning through self-directed means, the trainer needs to facilitate the opportunities for the learner to experience growth.

CHAPTER - 6.0

Methods of the Training Program

The module covers the subject in great details. The facilitator is required to study the content and if need be research it further and prepare themselves thoroughly. The facilitator can modify presentation to meet the regional need.

This module is further divided into sub-modules with the activities and direct instructions which can be used to explain concepts. During the activity, the facilitator is expected to explain the practical implications of that activity and link it with the content. The facilitator is expected to address specific topics of immediate concern and then expand to how it can be applied in real life situations as well as for various key populations. Much of the content will be applicable to the experiences of the learners therefore a facilitator is expected to engage in active learning, use the learner experience and incorporate key learning on the spot for the better understanding of participants. Facilitator may also engage in cross learning for example learning from the successes of a particular KP group and identifying key strategies that could be incorporated towards other key groups.

CHAPTER - 7.0

Ethics of the Facilitator

Respect for participants

The workshop participants may come from different geographies, life experiences and diverse KP groups. The facilitator needs to be aware about this diversity and respect is the participants. The respect should translate into his/her/their way of verbal and non-verbal communication. A participant's agency should be fully respected by the facilitator.

Being non-judgemental

The facilitator should make him/her/themselves aware about the diversity of their workshop participants and must be non-judgemental towards them. No participant should be judged on the basis of their sexuality, gender identity, sexual behavior, being in sex work and their vulnerability to HIV/AIDS.

Equality towards participants

Over and above being sensitive to the diverse participants, a facilitator is also expected to treat all the participants equally. All participants need to be given equal opportunity participate and express their views. Participants can be of varied personality such as introverts and extroverts, sensors and intuiters, thinkers and feelers, judges and perceptors. People from all of these personality type needs be given equal opportunities to participate in the workshop.

Respecting confidentiality

Team building and group work creates a comfort zone for the participants in which participants may share their deeply personal insights and stories. The facilitator has to ensure that post training, they are not sharing these insights by naming any participant. Maintaining confidentiality of the participants and proceedings is an important ethic to be followed by the facilitator.

Module 6	Community Led Monitoring and Knowledge Management
Module Objectives	To Strengthen Community Led Monitoring and Knowledge Management at the grassroots level
Expected Learning Outcomes	(1) Under the CLM, relevant programmatic qualitative and quantitative data are collected, analyzed, used, and shared. Appropriate mechanisms for data quality, feedback and supervision are in place. (2) Knowledge management practices are adopted at the grassroots level



Andragogy - Malcolm Knowles Submitted by Steven R. Crawford, scrawf@odu.edu at <http://academic.regis.edu/ed205/Knowles.pdf>

CHAPTER - 8.0

6.1 Community Led Monitoring

Session: 2.1	Session: 6.1 Community Led Monitoring
Learning objectives of this session	Participants learn about: 1. Meaning and importance of Community Led Monitoring 2. Methods of conducting CLM
Duration	2 Hours
Tools	Power Point Presentation, Chart Paper and Pen
Methodology	Discussion



Activity: 1**10 Minutes**

Participants learn about:

In a KP community, a handpump for drinking water was installed by the local authorities. This pump provided clean drinking water to the community 24/7 and eased severe water shortages. Within six months, the handle of this community handpump broke down resulting into severe water shortages and immense hardships for women who had to fetch water from far off. A meeting was called to discuss this situation and after much discussion, reasons behind why the handpump handle broke were identified as:

1. Youths in the community often fiddled with handpump to test its’ strength, especially past 11 pm when most members in the Basti were in their respective houses.
2. When no one was filling up water, children treated handpump handle like a See-Saw, placed a child on it and moved up and down on almost on daily basis, several times a day.

The community agreed that the handpump was being misused by youths and children alike. While they decided to pool money and repair the handpump, they also decided to take up some action towards not letting this happen again.

Questions:

What actions can be taken by the community?
Will it be a one-time activity or a regular activity?
What would be the result of these activities?

Activity: 2**10 Minutes**

District BNM has one government district hospital where people are referred for advanced medical consultation and surgeries. Many of the KP and PLHIV community members visit this hospital for their health care. They are experiencing a peculiar problem which they feel amounts to discrimination. The problem is like this: whenever a PLHIV patient has to seek either a surgery or go for child birth, such a person is scheduled as a last patient which means that the PLHIV client has to wait for hours. Whenever some of the Community Health Workers (CHWs) have raised this issue, doctors and medical staff of the surgery department have often dismissed them by saying that this scheduling is done due to sero-positive status of the patient. Any efforts to talk about universal precautions by HCPs has not worked and has not yielded any result. Now the Community Health Workers and the local KP CBOs have taken up this matter with the Civil Surgeon as well as DAPCU. These authorities have promised sensitization of staff of the surgery department within a week on the universal precautions and HIV/AIDS Act, 2017. Authorities have also asked KP community to share **their observations on the functioning of this department and their staff on a monthly basis.**

Questions

What could be the points of observations for the community?
 From where will they collect these observations?
 What will they do with these observations?
 How will they present these observations?
 What can they possibly expect out of this exercise?

Instruction: Facilitator has to first assign one activity and then discuss the action as "monitoring". In the second activity, the observations are certain actions which are conducted by the community therefore it is community based monitoring. These activities set the tone for community based monitoring.

**Lecture Content for the Facilitator****What is Community Led Monitoring (CLM)?**

In the context of our work, Community led means community of FSWs, MSM, H/TG, PWID and PLHIV have their groups, networks and CBOs which may be registered or unregistered and represent the communities vulnerable to and affected by HIV/AIDS. Monitoring means to watch a check a situation carefully for a period of time in order to discover something about it (dictionary.cambridge.org). Therefore, CLM means monitoring by a community of people to check/ observe a situation then gain understanding of that situation, its' implications and suggest an action/ policy changes to the appropriate stakeholders.

HIV community-led monitoring (CLM) is an accountability mechanism for HIV responses at different levels, led and implemented by local community level organizations of people living with HIV, networks of key populations, other affected groups or other community entities.

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

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

UNAIDS 2021, Establishing community-led monitoring of HIV services

Under the CLM, experiences and inputs of all types of clients such as the PPTCT, ICTC, ART, OST, DIC, STI/RTI, DMC/DOTS and the facilities used by them are collected and analysed in a comprehensive manner. This information is then used to identify the gaps and further improvise the HIV program for better user experience. Thus CLM is a highly constructive exercise. HIV affected community members plan, lead, train and implement in CLM

Community Led Monitoring

CLIENT FEEDBACK

PPTCT Clients

ICTC Clients

ART Clients

OST Clients

DIC Clients

STI/RTI Clients

DMC/DOTS Clients

FACILITY/ASSESSMENT

PPTCT Facility

ICTC Facility

ART Facility

TI Facility

STI/RTI Facility

DMC/DOTS Facility

Why engage in Community Led Monitoring?

Many successes in the field of HIV are a result of continuous community participation, ownership and leadership. CLM is the next step forward where other than the routine programmatic monitoring, the user experience is key to improve the programs which in turn will encourage people to seek services and being retained in care. This is the space for community to express what is the level of access, information on treatment literacy, experience pertaining to testing and treatment desired by them. CLM also pave the way for community having a say in the decision-making, planning, implementation, monitoring and evaluation of services.

CLM should not be confused for project monitoring which is based on input-output and process monitoring which enables an organization to effectively monitor the progress of the project and outcomes.

Case Study: HIV Treatment Access in West and Central Africa

Regional Community Treatment Observatory in West Africa (RCTO-WA)

To better understand gaps and challenges in HIV treatment service delivery, 11 local civil society groups across 11 countries in West and Central Africa with support and coordination from the International Treatment Preparedness Coalition (ITPC) rolled out community treatment observatories (CTO) to improve access to ARVs for people living with HIV.

Implementation: The project ran between January 2017 and December 2019 and recruited and trained data collectors (84 in all across 11 countries) who then reviewed available data and surveyed clients and health workers to fill in periodic reports. Both quantitative and qualitative data were gathered, with the quantitative tool including more than 100 indicators relevant to assessing the overall quality of service delivery. Over the course of the project, data collectors and other personnel conducted more than 1500 interviews, organized 143 focus group discussions, and visited 125 health facilities. They reached nearly 100,000 young people, more than 35,000 key populations and engaged a total of 105,435 people on ART.

Results: Among the biggest on-going challenges noted was the lengthy gap in returning viral load test results to clients, as only 25% of results were returned within two weeks. Positive trends were seen in several key indicators as the project progressed, developments due in part to community groups' advocacy based on observatory findings.

For example, the frequency of recorded stock-outs at facilities monitored across the project was 15.2% in period three (January-June 2019) compared with 23.6% over the same period the previous year.

The rate of viral load suppression improved even more substantially, rising from 48.4% in January-June 2018 to 77.4 during period three the following year.

Several notable country-level changes were observed as well in response to the monitoring findings and subsequent advocacy, including improvements in quality of care in health facilities in Mali and the removal of user fees in Nigeria.



Source: *The Global Fund, Community-based monitoring: An overview, May 2020*
https://www.theglobalfund.org/media/9622/core_css_overview_en.pdf

5 Keys to Effective Community - Led Monitoring

1. **Conducted by communities:** HIV/AIDS affected communities take charge of the conducting CLM.
2. **Routine:** Community led monitoring is routine and done over time.
3. **Rigorous:** Data is verifiable reliable and collected under human rights principles that ensure informed consent confidentiality security and no harm.
4. **Independent:** CLM is independent of govt. systems and data is owned by communities.
5. **Actionable:** CLM leads to advocacy wins that improve services from the ground up.

Community - Led Monitoring is NOT

- **CLM is not the Monitoring of People:** CLM is about the quality of prevention, treatment and care service systems therefore not about monitoring people.
- **CLM is not conducted by Governments:** Government programs have M&E systems that include some community indicators but CLM is independent of the Govt. M&E systems.
- **CLM is not conducted by Facilities:** Facilities also conduct periodic assessments to ensure service effectiveness, however CLM which also has facility assessment is conducted by the community members.



Source:

Community Led Monitoring Brief, https://itpcglobal.org/wp-content/uploads/2020/02/Community-Led-Monitoring-Brief_full.pdf

Stages of Community Led Monitoring

Activity: 2

3 Minutes per stage, total 15 minutes

Facilitator has to keep a chart paper ready. After they share each stage, they have to ask audience, what in their view are the preparations/ activities required for each of these stages. Stage wise note down these responses and answers.

The five stages of CLM

Stage 0: Assessment of community resources , context and implementation of CLM

1. Presentation of CLM aims and objectives by and to community members.
2. Deliberative process that may include a formal or informal situation analysis of strengths, weaknesses, opportunities and threats.
3. Include information and assessment of existing and potential CLM related funds and other resources available or likely to become available.
4. Finalize and confirm funding and other available resources. Engage with the department of health at the highest possible level.



Stage 1: Establish the budgetary, workplan and collaborative foundations for CLM

1. Create a coalition of community-led groups to lay the foundations for CLM. (Identifying and including various groups and organizations representing various KP groups, identifying the coalition lead and other staff and agree upon a common agenda).
2. Develop a workplan and draw up terms of reference for different posts. (Those posts that require special skills and are not filled by the community, they can be filled by external recruitment).
3. Develop a clear budget in consultation with key stakeholders.
4. Secure political engagement (local, district and national level) in a memorandum of understanding.

Stage 2: Develop a robust data and information framework with trained monitors

1. Identify issues of concern from affected communities.
2. Recruit and train those conducting CLM.
3. Design and test the data collection tools.
4. Be informed how data are collected and used in service evaluation.

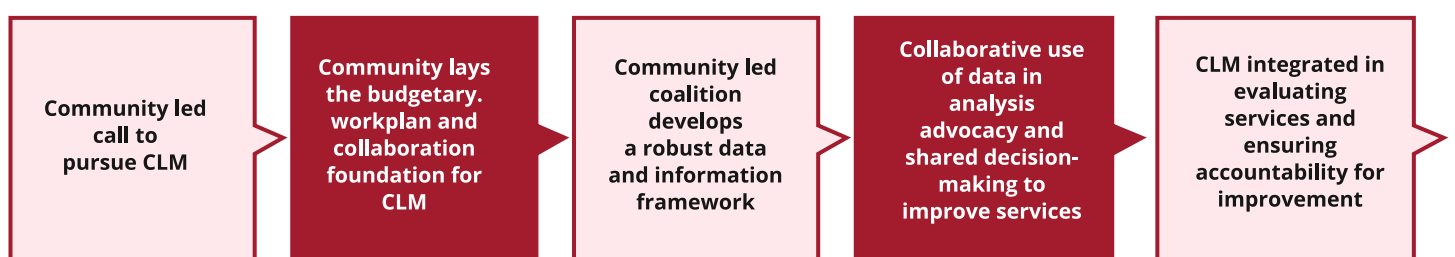
Stage 3: Community members use analysis, advocacy and shared decision-making to improve services

1. Finalise the data collection and analysis plan.
2. Pilot routine monitoring with standardized questions at the facility and community levels.
3. Move to routine data collection. Analyse data and develop advocacy messages.
4. Work with partners to establish a dedicated seat at the relevant forums where related health sector data are presented and discussed.
5. Present data in the service review and improvement process.

Stage 4: CLM transparently integrated with the health service evaluation and decision-making process

1. Monitor the commitments to change, looking for links between intervention and impact.
2. Provide regular feedback to the clinic and the community.
3. Continue listening, gathering and acting on points of concern.
4. Consolidate capacity and strengthen available expertise.

Stages of Community Led Monitoring



Tools of Community Led Monitoring

Based in affected communities

Community dialogue: Meeting of community members to discuss and assess an issue or need that was identified as requiring routine evaluation.

User survey: Conducted among people living with HIV who attend or do not attend the service in question. Structured questionnaires tailored to underlying factors in health-seeking behaviour, such as experiences of stigma and discrimination and health provider attitudes.

Focus group discussion: Group discussion that is conducted among selected service users or those who are not engaging with the service. This should be structured around an agreed framework with consistent topics to identify solutions and trends.

Door-to-door survey: A more open-ended approach that is designed to engage people who are not using services and other members of the affected community. The survey questions may lead with the health service experience generally and proceed to cover HIV services, thus avoiding stigmatization of directly approaching people living with HIV at home.

Facility-based

Observational survey: Monitoring aspects of different types of service (e.g., fixed, drop-in or mobile) by on-site observation of specific points.

Interview of service users at facilities: Tailored quantitative and qualitative questions to assess user experience (e.g., waiting times, safety at different times, sufficiency of staff, and availability of medicines and diagnostics for HIV, other sexually transmitted infections and tuberculosis).

HIV treatment facility leader survey: As the previous point, with additional questions about the context of any identified problems.

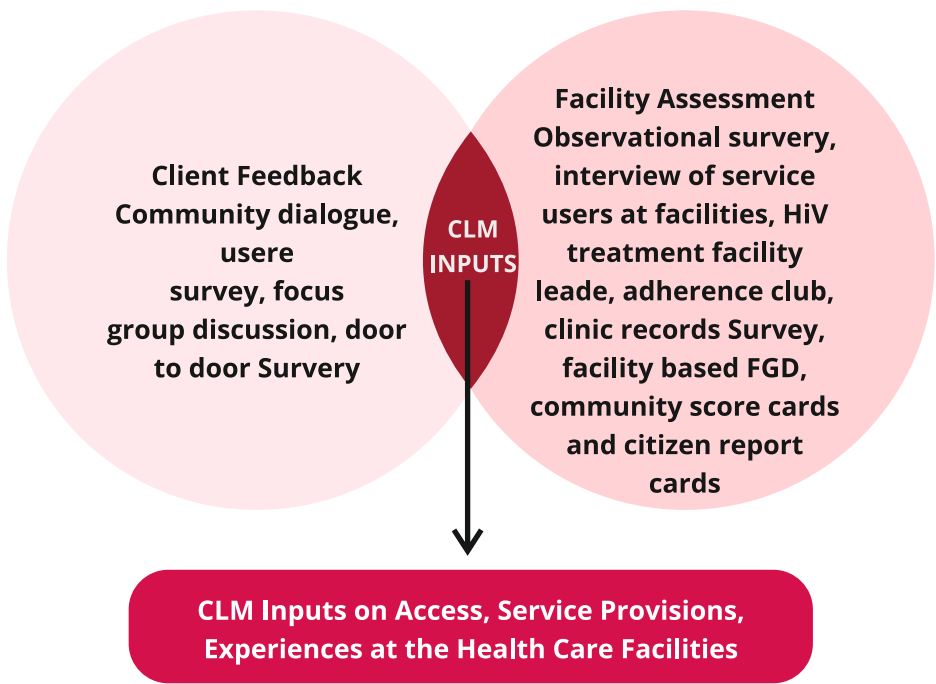
Facility-supported adherence club survey: Baseline data on the number of clubs and individual members, the frequency of meetings and the assessment of functionality. Supplemented by individual or focus group discussions.

Clinic records survey: Covers specific points of service quality. This information supports and triangulates with other CLM data rather than replicating pre-existing monitoring. This is only possible if data anonymity is assured, and after clearance by a recognized ethics authority.

Facility-based focus group discussion: Group discussion that is conducted among selected service users and/or providers. This should be structured around an agreed framework with consistent topics.

Community scorecards and citizen report cards: These monitoring and feedback tools, developed by communities and their health-care providers, are already in use in many settings and are a forerunner of CLM. They can be adopted into the routine CLM process.

Tools of Community Led Monitoring



Topics of Community Led Monitoring

Some examples:

Service Quality Aspects that can be monitored:

Availability	Accessibility	Acceptability	Affordability	Any other
Medicines.	Accessibility of services.	Services.	Unofficial user fees.	Security at the facility.
Diagnostics.	Time taken to reach the facility.	Staff appropriate attitudes and behaviors.	Hidden charges.	Waiting time.
HIV prevention tools.	Opening Hours.			

Service Provision Aspects that can be monitored:

Prevention Services	Testing	Viral Load and CD4	ART	Integrated services
People are receiving prevention services according to their need.	Availability and standards of returning results.	Availability and standards of returning results and further action.	Multi-month dispensing roll-out.	Integration of other services such as tuberculosis or sexual health services.

Things to remember:

- CLM is not a one-time project hence support of all stakeholders at local, district, state and national level in its' implementation is critical.
- Participant confidentiality and data security is an important obligation of the members involved in CLM.
- Community members involved in CLM risk inadvertent outing of their identity or status and experience backlash in social settings.
- CLM is an organized exercise which requires data collection, management and analytical skills. Members having some of these skill-set can be trained in this organized exercise. Outsourcing CLM to non-community members should be minimal however technical experts may be required for guiding the processes of research.

Should Community Champions and CBOs/NGOs take on CLM?

After the successful experience of West Africa, CLM is being recommended as critical step in enhancing the on-going quality of HIV program. Removal of barriers in service delivery and further improvements will go a long way to achieve the goal of 95-95-95. Along with the stakeholders, communities will also play a key role in ending AIDS by 2030. CLM is an opportunity for the HIV affected communities to have a greater say in the critical health matters affecting their life. Participation in CLM also offers an opportunity to strengthen their own capacity towards their rights and advocacy.

Generating Evidence by CLM

Collection of CLM Data

Collection of data is done on a simple form which has survey questions that assess the situation on certain parameters. You are required to ask the question and then either encircle or tick mark the answers of a particular survey form.

For example:

Q. 1 Was it easy for you to access / reach the TI office / DIC / OST center?

☐ Very difficult ☐ Somewhat difficult ☐ Easy

Q. 2 How did you find the environment / cleanliness of the TI Office / DIC, during time of your visit?

☐ Unfriendly and unhygienic ☐ Average ☐ Welcoming and hygienic

Note: Share any one CLM form for the better understanding of the participants.

Collating, data organizing, analysing and interpreting your CLM Data

Once you have collected community led monitoring in a location across various facilities and people, you need to take following collation steps:

Step: 1 Organise your forms by subcategories as under:

Client Feedback Questionnaire

- Form 1: Feedback on TI for example FSW/MSM/TG Typology
- Form 2: Feedback on Integrated Counselling and Testing Center (ICTC)
- Form 2a: Feedback on Designated STI/RTI Clinics (DSRC) / Suraksha Clinics

Step: 2 For collation, take a sheet of paper and write down questions and responses. For example:

Q.1 Was it easy for you to access / reach the TI office / DIC / OST center?	
Very difficult	
Somewhat difficult	
Easy	

Q. 2 Was it easy for you to access / reach the TI office / DIC / OST center?	
Unfriendly and unhygienic	
Average	
Welcoming and hygienic	

Step: 3 Then conduct the tally marking exercise for each question's response.

Tally Marks

Tally marks are a quick way of keeping track of numbers in groups of five. One vertical line is made for each of the first four numbers; the fifth number is represented by a diagonal line across the previous four.

1	I	6	IIII I
2	II	7	IIII II
3	III	8	IIII III
4	IIII	9	IIII IIII
5	IIII	10	IIII IIII



Source: <https://www.enchantedlearning.com/math/tally/>

Suppose you collected data from 10 KPs, you will make a tally table like this:

Q.1 Was it easy for you to access / reach the TI office / DIC / OST center?	
Very difficult	I (1)
Somewhat difficult	II (2)
Easy	IIII II (7)

Q. 2 Was it easy for you to access / reach the TI office / DIC / OST center?	
Unfriendly and unhygienic	
Average	III (3)
Welcoming and hygienic	IIII II (7)

Step: 4 Analysis and interpretation of Tally Table of your CLM form.

Analysis of Q. 1 - Out of 10 participant surveyed, a majority (7) have found it easy to access TI office.

Interpretation: In town XYZ, location of ABC TI is easily accessible to the KP community.

Analysis of Q. 2 - Out of 10 participant surveyed, a majority (7) have found it welcoming and hygienic

Interpretation: The ABC TI is welcoming and hygienic

Your report will be based on the analysis of all the parameters of a CLM form. With this report, you can conduct advocacy with the local authorities and community members.



Source:

Establishing community-led monitoring of HIV services-Principles and Process, UNAIDS 2021
https://www.unaids.org/sites/default/files/media_asset/establishing-community-led-monitoring-hiv-services_en.pdf

Community Monitoring System as envisaged by NACO

In India, NACO has envisaged a strong Community Monitoring System (CMS) of which CLM is an integral part.

Proposed Structure: The Community Monitoring System is proposed to be a multi-layered structure spanning across districts, states and national level.

State Level

At state level “Community Resource Group” or CRG will be constituted through nominations from the communities, community networks (Key Populations such as FSW, MSM, H/TG, PWID), PLHIV and Youth from KP. Every three months (once in a quarter) respective SACS will organise State-CRG meeting to share redressal plan for service delivery improvement, aligning with the compiled feedback received from communities.

District Level

District – Community Resource Group representatives will, in turn, support respective DAPCU/ TSU officer for compilation of feedback along with effective implementation of redressal plan. This comprehensive system will have mechanism for feedback collection, compilation and redressal of concerns related to commodity, service delivery and stigma / discrimination in public health set-ups.

Collection of feedback: A tool will be devised in form of questionnaires to collect community feedback from field. This tool will have two distinctive self-administrative and facilitated versions. Both the questionnaires will have indicators to capture feedback on accessibility, availability and quality pertaining to all NACP related service deliveries at field level.

Self-administration version on virtual platform: The self-administration version will be implemented mainly through virtual platform with integration of existing grievance redressal portal to capture precise feedback and to provide quick response.

Offline -anonymous feedback: The offline /hard copy version of the same questionnaire will also be available at respective servicecentres and will be collected as anonymous polling / drop box mode. This kind of feedback is envisioned to becollected on a daily basis at respective service centres.

Descriptive feedback from the Community: With respect to collecting detailed and descriptive feedback from the community, it is proposed that a facilitated version will be executed at Targeted Intervention / Service delivery point (to be finalised) with support from the designated staff either through individual or focus group discussions. The descriptive feedback is envisioned to be collected on a weekly basis.

Compilation of feedback: The DAPCU / TSU officer will be responsible to compile the feedback at monthly interval and submitted to respective State AIDS Control Society (SACS) / District AIDS Control Society (DACS). Corresponding CRG member specific to each district will support DAPCU / TSU in this process.

Redressal of feedback: It is envisaged that this Community Monitoring System will assess level of satisfaction experienced by the community, which will lead to an improved and sustained uptake of services at NACP facilities. Every SACS / DAPCU is expected to conduct quarterly CRG meetings and develop a clear plan for redressal of the feedback received from community keeping in mind that the plan should comprise timely corrective action to the grievance received from the community.

CHAPTER - 9.0

6.2 Process of Knowledge Creation and Management

Session: 6.2	Process of Knowledge Creation and Management
Learning objectives of this session	• What is Knowledge creation and its rationale? • Generating evidence for evidence-based practice and data management • Capability enhancement through developing community researchers and alliances
Duration	2 Hours
Tools	Power Point Presentation, Flipcharts, Sketch pen
Methodology	Participative

Instructions to the Facilitators

This session will involve participative learning. The facilitator is expected to engage the participants to brainstorm and present their experiential understanding of process of knowledge creation. This module has pre-decided content which the facilitator is expected to revise beforehand and if need be, refer to the resources mentioned. Activities are conducted before the knowledge sharing via presentation. The facilitator is expected to weave the activity learning in the content.

Activity: 1**15 Minutes**

Divide your class by Community Champions and CBOs. Give them following question to discuss:

1. What is knowledge?
2. What do we know about HIV/AIDS in the KP community?
3. How do we know it?

Ask them to write their responses and discuss this in the class and simultaneously note down their responses as categories “heard, know” and “knowledge source”. Use these responses to explain the concept of knowledge and the categories to explain tacit and explicit knowledge in the later part.

Lecture Content for the Facilitator**What is knowledge?**

As per various dictionaries, knowledge is:

- Knowledge (of about something) information, understanding and skills you have gained through learning or experience.
- The state of knowing about a particular fact or situation.

What is knowledge creation?

- A continuous combination, transfer, and conversion of different kinds of knowledge.
- Making personal knowledge available to others is the core.
- Knowledge can be at individual or social level. Link between individual and social knowledge is governed by culture of interaction.
- New knowledge always begins with the individual and organization amplifies it in context.
- ‘Commitment’ for promoting the formation of new knowledge within an organization is important.
- New knowledge helps in performance, innovation.

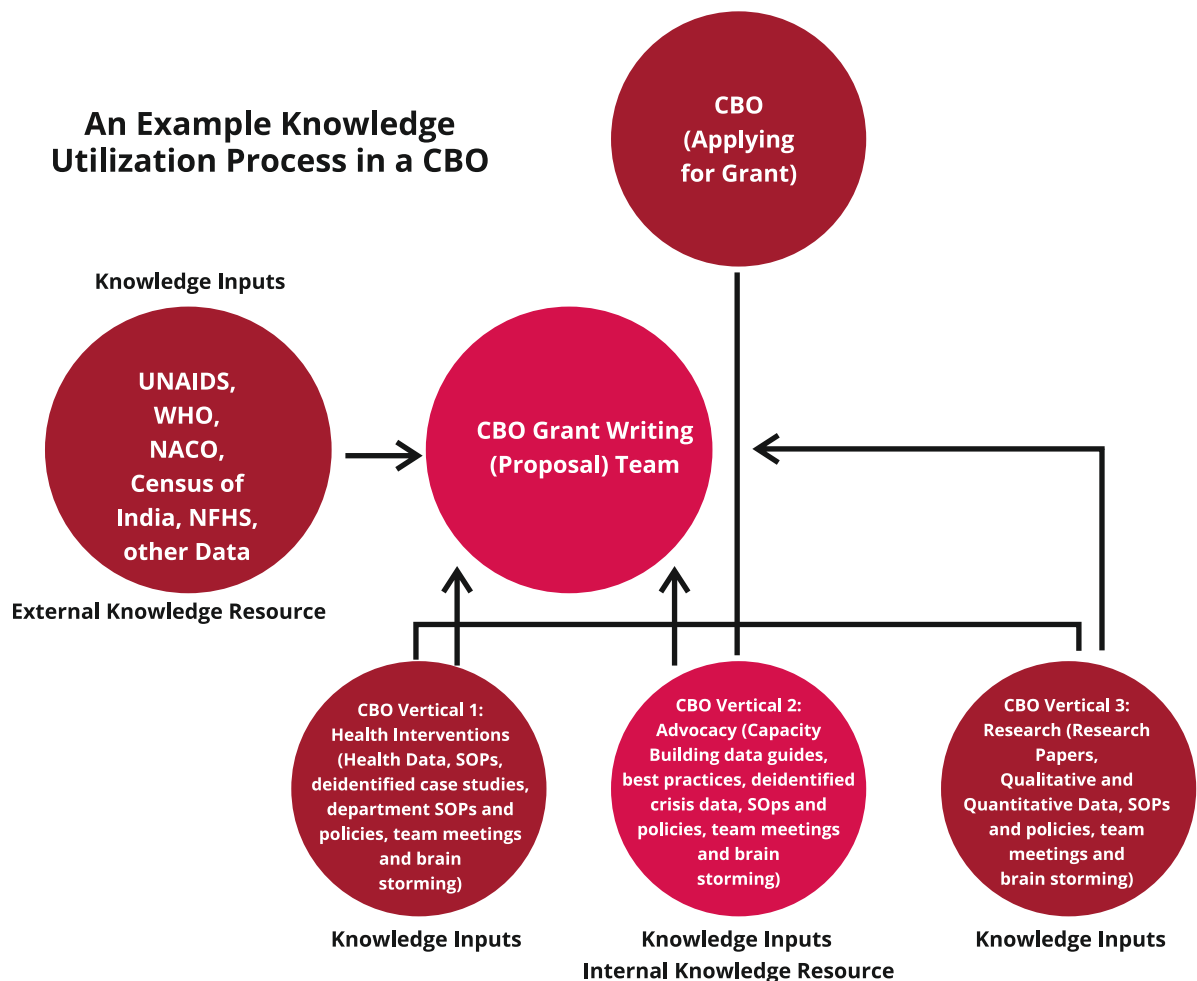


Activity: 2**3 Minutes**

Have a small discussion on why is knowledge important for Community Champions and CBOs. Write down the key points for discussion.

What is Knowledge Management?

All the forms of knowledge and information that exists within a CBO is organized, stored, distributed and used effectively is known as the knowledge management. A CBO engaged continuously in implementing programs typically makes use of program knowledge, its' data and key achievements in further planning. By using available knowledge such as the program and reach data, research findings and ground experiences, CBOs can write winning proposals. While most CBOs lack knowledge management systems, some of them are able to effectively utilise their existing knowledge because they have well organised verticals. These well-established verticals have relevant information, data and research studies which they are able to mutually share therefore make a compelling argument about the proposed project's relevance hence they are able to win a major grant. Same is applicable in case of legal efforts and policy briefs prepared by a CBO. An example of knowledge utilization process in a CBO is as follows:

**An Example Knowledge Utilization Process in a CBO**

What happens when the CBOs do not have a Knowledge Management system?

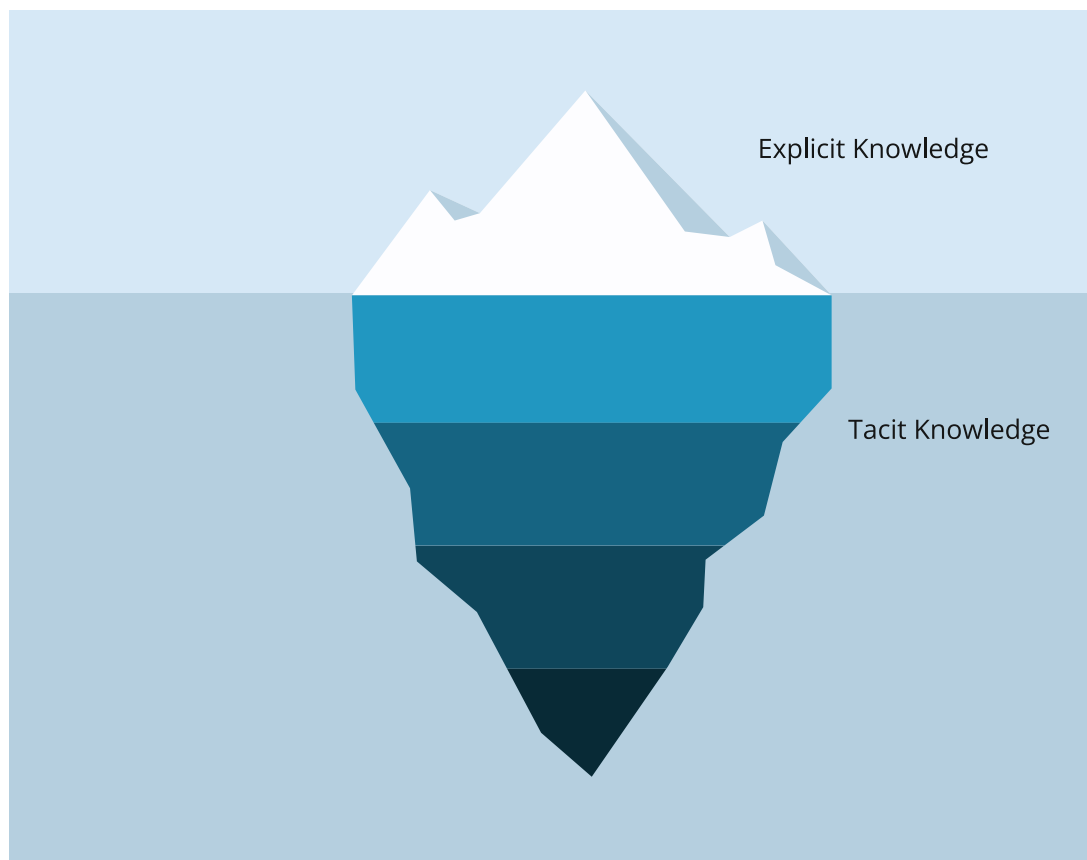
- **Inconsistency in narrative:** Within a CBO, different versions of the same work lead to reduced credibility of the work. For example, the data on how many people were helped by an intervention or even organizational mission may be presented differently by people thereby creating a question in the minds of the donors.
- **Missing out on most relevant information:** CBO personnel may miss out on most relevant information that needs to be shared/ presented. Duplication
- **Replication of work is hampered:** Lessons learnt and best practices will go unnoticed thereby leading to reinventing the wheel rather than drawing from the past experiences.

Types of Knowledge

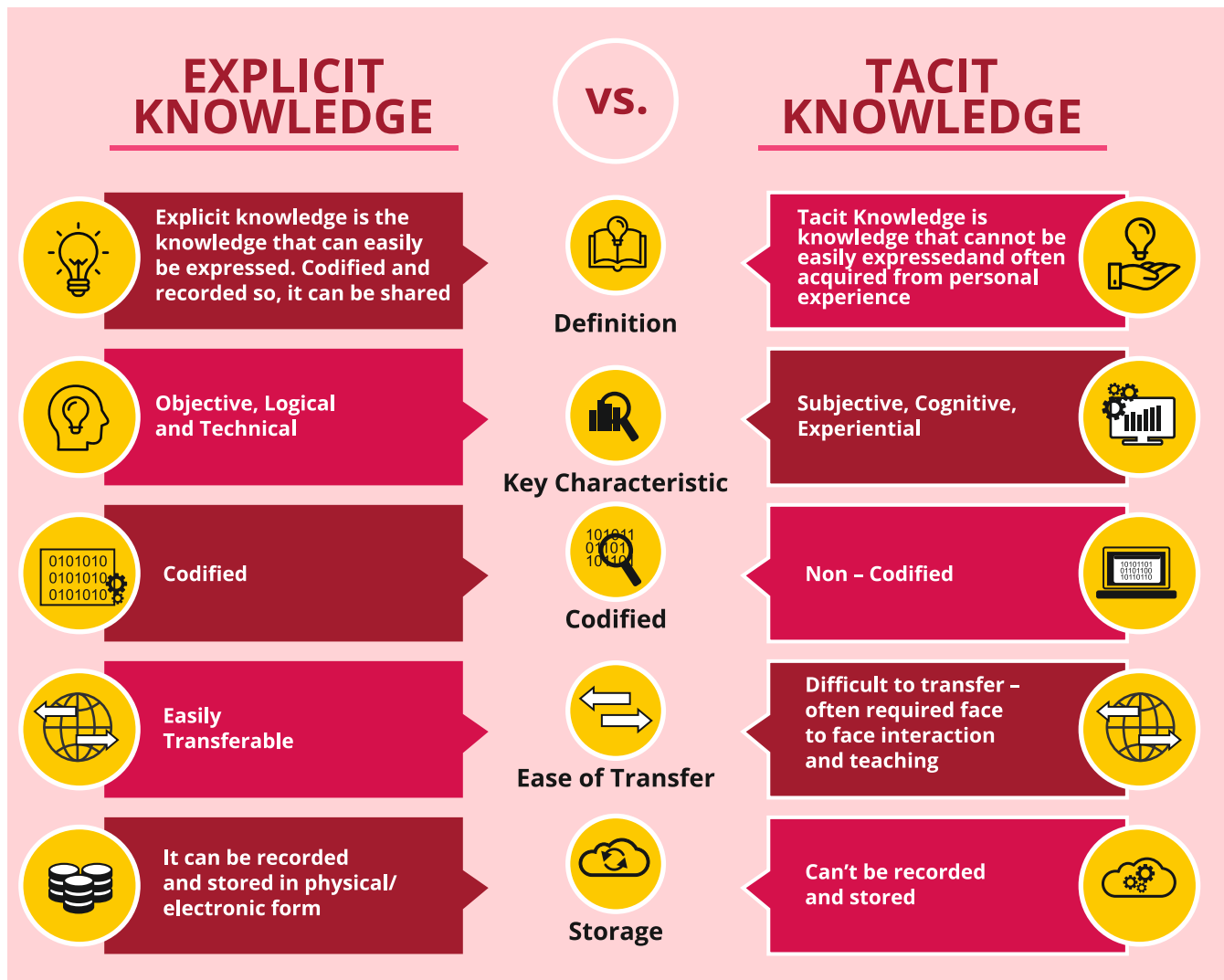
There are two types of knowledge, tacit and explicit:

- Tacit knowledge is highly personal, thinking, feeling, informal, experiential, relatively hard to communicate. Tacit knowledge is at core of knowledge creation.
- Explicit knowledge is formal, written, systematic, codified and easy to articulate.

The Knowledge Iceberg



The process of knowledge transfer happens formally and informally via community and stakeholder meetings, consultations, presentations, internal report sharing and via social media. Various tools aid and support knowledge transfer.



Picture source: <https://document360.com/blog/tacit-knowledge/>

The cycle of Knowledge Management

The cycle of knowledge management has seven stages:

- 1. Acquisition-**The process of acquiring knowledge either through research, training, and education (explicit knowledge) or through daily experiences and know-how (tacit knowledge) should be done across the organization — individually or as a group. Most CBOs do not have adequate resources or do not have time to document the knowledge therefore knowledge is passed on verbally. It would help an organization to document and systematize the acquired knowledge.
- 2. Codification-**This is the process of putting the knowledge that's acquired into words. Not all knowledge can be translated into verbal or written language, however. This step involves creating job aids, training materials, write-ups, tests and other printed or written material or any form of media for consumption.
- 3. Storage-**This step is where repositories come in. These can be databases or manuals where people can go to access codified knowledge.
- 4. Retrieval-**This is the act of accessing stored knowledge. Retrieval should be simple and efficient.
- 5. Distribution and presentation-**This is making all that knowledge accessible to the people who need it. Knowledge can be presented in different formats and in different ways. This could come in the form of reports or training modules and presentations.
- 6. Application-**After knowledge is gained through distribution and presentation, it is now time to apply what was learned. This is where an CBO will plan its activities according to the knowledge it has gained.
- 7. Creation-**Because of the application of knowledge, an CBO can now gain new experiences that will give way to the creation of new knowledge from the new experiences and the cycle starts all over again.



Source:

<https://www.socialbrite.org/2021/01/15/how-nonprofits-can-benefit-from-knowledge-management/>

Utilization of Knowledge available to Community Champions and CBOs

S.N.	Knowledge Type	Source of Knowledge	How to utilize? Community Champions	CBOs
1.	Tacit	Oral history	Self-advocacy	Building organizational culture
		Ground experiences	Providing program inputs, systems level advocacy	Designing strategies
2.	Explicit	Experiences documented as case studies.	To be used in legal petitions or communicating with DAPCU/SACS	
		Community Led Monitoring data	CLM reports shared with DAPCU, SACS for improvements at the health care systems level	
		Available Research Data	Advocacy	Advocacy Policy inputs Program planning
		Program data	Advocacy	Advocacy Policy inputs Program planning
		SOPs and Policies	Not applicable for an individual	Day to day operations of the organization

Externalization of Tacit to Explicit Knowledge

External means outside and internal means inside. In the context of knowledge management when the knowledge which is tacit (inside) becomes visible, explicit, then this process is called externalization. The tacit and explicit knowledge continuously interact with each other and influence it greatly.

In the field of HIV prevention, the public health experts, scientific community and policy planners engaged with the communities to learn from them (tacit knowledge) and apply scientific research methods on those experiences. The outcome led to many research methods, research, policy papers, innovations and guides/manuals (explicit knowledge).

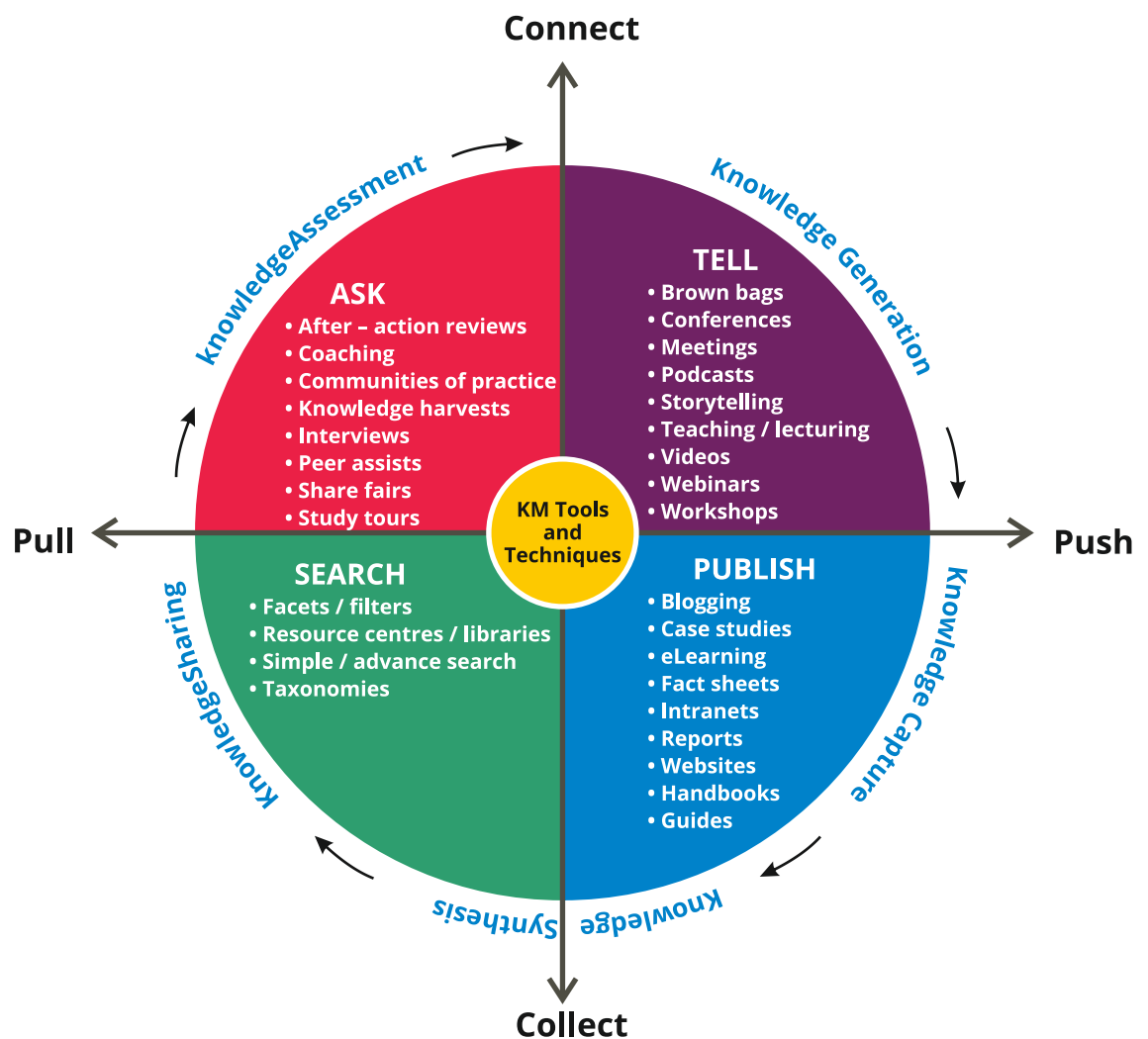
Externalization of Tacit to Explicit Knowledge

	Tacit Knowledge held by KP and PLHIV community	When is it an Explicit knowledge?	Why the need to convert Tacit knowledge into Explicit knowledge?	Who moderates this conversion?
1.	Knowledge about people meeting potential sex partners/clients/injecting partners/ adherence factors.	Mapping Report	Generating evidence for CBOs implementing TI	Trained researchers, community members and CBOs
2.	KPs knowledge, attitude and perception of HIV/AIDS. KPs engage in sexual practices which can put them at risk for HIV transmission.	Knowledge, Attitude, Behavior and Practices (KABP) studies Integrated Bio-Behavioral Surveillance (IBBS)	Generating evidence for intervention programs, BCC	Trained researchers, community members and CBOs NACO, SACS, DSAC
3.	Experiences and stories of stigma in family, community, employment, education and health care set up.	People living with HIV stigma index Written narrative accounts.	Generating evidence for stigma reduction and advocacy program, institutional capacity building, rights	CBOs, NACO, SACS, DAPCU
4.	Compared to general population, KPs are at higher risk of HIV.	HIV Sentinel Surveillance (HSS)	Generating evidence for NACP	CBOs, NACO, SACS, DAPCU
5.	KP and PLHIV community members have stress, tensions and feel low.	Mental Health Studies	Generating evidence for specific intervention programs, advocacy, rights	CBOs, NACO, SACS, DSACS
6.	In general people do not have a discipline when it comes to taking medication; they often stop ART medication at will. Some people do that for ART medication as well. There are community barriers in adherence.	ART adherence studies	Generating evidence for ART education and adherence support program	CBOs, NACO, SACS, DSACS

Knowledge Management Tools and Techniques

The Knowledge Management tools and techniques are divided into four parts:

- Knowledge assessment
- Knowledge generation
- Knowledge Capture
- Knowledge Synthesis
- Knowledge Sharing
- Knowledge Assessment



Picture Source: <http://knowledgesuccess.org/wp-content/uploads/2019/09/km-matrix-updated-1-1024x939.png>

How to Capture and Promote Knowledge

Type of Knowledge	Capturing Knowledge (What?)	Capturing Knowledge (How?)	Promoting Knowledge (Where)
Tacit		Written Tools	
	People, events and new developments within the CBO.	News letter	Sharing within the organization.
	Personal narrative, experiences.	Case studies	Experience sharing within the organization. Media, systems level (including legal) and individual advocacy. Rights related advocacy.
	Work, event, crisis related experiences.	Documentation	
	Rights related issues.	Email list/ email campaign	
		Verbal Tools	
	People, events and new developments within the CBO.	Meetings, Town hall	Sharing within the organization.
	Personal narrative, experiences, organizational history.	Podcast Radio Talks	Advocacy at the media, systems and society level.
		Visual Tools	
	Personal narrative, experiences, organizational history, rights related issues, events.	Video Blogs	Social Media Advocacy
		Youtube	
		Video sharing apps	
		Social networking sites and apps	
Explicit		Written Tools	
	Functioning of CBOs.	SOPs, Policies, Code of Conduct	Sharing within the organization.
	Trainings.	Training modules, job aides, handbooks, training programs and exposure visits	People within the organization and outside the organization
	How well projects are doing.	Monitoring reports	Sharing at the project, organization and donor level.
	Has the project achieved its' outcome?	Evaluation studies	Sharing at the project, organization and donor level.
	What are the current trends, situation in the community?	Research studies, monographs, published papers and factsheets	Sharing at the project, community, organization and donor level, scientific community at the national and international level
		Verbal Tools	
	Experience sharing, project achievements, situation assessments, what needs to be planned?	Conferences, symposiums	Local, regional and national level stakeholders, international donor agency.
		Brown bag seminars	Local, regional and national level stakeholders.
		Visual Tools	
	How to (for example) counsel Kps	Video training modules	Sharing at the project, organization and donor level.
	Know and demand your rights	Facebook live Webinar	Sharing at the project, CBO and community level.

Knowledge Management Tips for Community Champions and CBOs



Activity: 2

12 Minutes

Divide participants into 3 groups. Distribute chart papers and sketch pens to each group. Have groups discuss and write answers to following questions – one question for each group.

- What is evidence?
- Why is it important to generate evidence in a CBO?
- How will you manage data/ evidence generated?

Discussion time 5 minutes and presentation 2 minutes per group.



Alternate Activity: 2

12 Minutes

Based on who you are- whether you are a Community Champion, CBO or NGO, what Knowledge will you generate, how will you capture and promote it?

Lecture Content for the Facilitator

Community champions can use these simple tips to manage knowledge in their own way:

- Bring out tacit knowledge as much as possible by different audio and visual mediums.
- Document or get someone to document and disseminate experiences and learnings.
- Access data on NACO web-site (publications); in case of clarity/ better understanding seek support from a known CBO/ resource person who is able to simplify information for you.
- Attend meetings, conferences and seminars as much as possible. Make a habit to write down key learnings.
- Access web based open resources. Keep a folder for all the downloaded information and read it from time to time.

CBOs can engage in knowledge management in the following way:

- Identifying and assessing all the data generation in various departments.
- Managing data by establishing a system.
- Creating a centralised data repository which can be easily accessed by various teams.
- Accessing and sharing web based resources and maintaining a folder of relevant information, documents and research papers.
- Access data on NACO web-site (publications); in case of clarity/ better understanding seek support from a known resource person who is able to simplify information or interpret the data for you.

- Attend meetings, conferences and seminars as much as possible and store and share key learnings, presentations and explicit knowledge.
- CBOs should establish knowledge management systems and also appoint a knowledge manager in their respective organizations.

Activity: 3

12 Minutes

Divide the participants into 3 groups and discuss the opportunity and challenges to create knowledge in the organization. Participants are to be given chart papers and colors.

Facilitator can summarise the group discussion on the following points:

- Appreciating and recognizing the importance of knowledge creation.
- What are the existing challenges/ gaps in creating knowledge?
- Identifying various possible options to fill the identified gaps in organizational context.
- Evaluating feasibility of implementation.
- Implementation considerations.
- Efficacy measurement and learning strategy.

Reflection

Reflect on what this learning means to you and how can you apply it in your context of knowledge creation.



CHAPTER - 10.0

6.3 Documentation

Session: 6.3	Documentation
Learning objectives of this session	Participants learn about: •Importance of documentation, types and ways of documentation. •Learn to document projects, programs, good practices, cross learning's, replications and resource directories.
Duration	1 Hour
Tools	Power Point Presentation, Flipcharts, Sketch pen
Methodology	Participative

Instructions to Facilitators

This session will involve participative learning. The facilitator is expected to engage the participants to brainstorm and present their experiential understanding of process of documentation. This module has pre-decided content which the facilitator is expected to revise beforehand and if need be, refer to the resources mentioned. Activities are conducted before the knowledge sharing via presentation. The facilitator is expected to weave the activity learning in the content.

Activity: 1**15 Minutes**

Participants are grouped in 4 parts. Each group represents a community-based organization working on public healthcare. In 10 minutes, each team to write on flip charts which are the activities and elements to be documented and why they think so. After the allocated time, each group share the additional points they conceptualized

Facilitator's role:

The facilitator leads the discussion after the activity. Pick up the key word and phrases. Then, facilitator ignite thoughts of participants saying that:

- (1) What came to their mind when the term documentation was uttered for the first time
- (2) Which activities were on top of mind? What next?
- (3) What were the challenges they faced in documenting activities/elements

Important Documents for CBO members:

- Membership register
- All statutory Books of accounts including cash book, ledger, petty cash book, assets registers, salary registers, etc
- Accounting items like cash memos, receipt book
- Minutes of meetings register
- Inward and outward register of the correspondence
- Correspondence
- Visitor and complain book
- Work reports, impact reports

**Lecture Content for the Facilitator****Why is documentation needed?**

For an NGO/CBO involved in HIV/AIDS, documentation and communication is about recording, learning from and sharing its experiences, results and lessons learned – for the benefit of its own organisation and others.

- **How documentation is different from IEC?**

Documentation is different from Information, Education and Communication (IEC) – which an NGO/CBO might carry out as part of its programme work to raise awareness about HIV/AIDS among community members.

Ensure that participants have a clear view of documentation right from the start. To support this, it may help to facilitate a discussion about the difference between some words that are often confused. **These include:**

- "Documentation" and "documents".
- "Reporting" and "report writing".
- "Data" and "information".

Why is it a systematic process?

What are the various types of documentation?

What are the advantages of documentation?

- Helps raising credentials of CBO.
- Planning and monitoring their work.
- Good for internal communication- knowledge transfer is facilitated.

B. What makes a good documentation?

- Provides information from different sources.
- Provides brief and concise information.
- Uses quotes from the participants in the project.
- Has a "catchy" title.
- Has a good balance between text and visuals, including symbols, drawings and graphics.
- Looks interesting and is colorful and attractive.
- Is informative for the target audience
- Uses simple language.
- Is well organized and laid out.
- Keeping the documents at safe place



Activity: 2

10 Minutes

Ask participants to identify two good experiences and two bad experiences from their past documentation work and to consider what they learned from them

- **What were the good experiences?**
- **Why are they termed as good?**
- **What were the bad experiences?**
- **Why are they termed as bad?**
- **What are the lessons learnt?**

Thinking time 5 minutes and Discussion time 5 minutes

C. Skills needed for documentation

Documentation and communication skills include:

- Listening
- Recording
- Word processing
- Analysing
- Observing
- Writing
- Planning
- Collecting data
- Prioritising
- Drawing
- Editing
- Designing

Key considerations for documenting in HIV/AIDS work:

- Be gender and culture sensitive.
- Use appropriate language with correct pronouns.
- Always check the accuracy of information and data.
- Uphold and promote human rights.
- Keeping documents confidential
- Use local and simple language that cannot be misinterpreted.
- Ensure that whoever is producing our documentation is knowledgeable about HIV/AIDS.

D. Steps in documentation

Step 1: Deciding an Aim and objectives (SMART)

Step 2: Identifying priority audiences

Step 3: Choosing key messages

- Inspiring
- Memorable
- Positive
- Attention-grabbing
- Clear
- Taken from practical experience

Step 4: Selecting the mode and type

- Case studies
- Newsletters
- Leaflets
- Photo-story books
- Websites
- Videos
- Policy reports
- Workshop reports
- Presentations
- Abstracts
- Annual reports
- Radio programmes

Step 5: Developing the document

- Structure and contents outline
- Title and cover page
- Table of contents
- List of abbreviations
- Executive summary
- Introduction
- Aim and objectives
- Activity report for each project
- Recommendations
- Conclusion
- Annexes
- References

Step 6: Disseminating the document**Step 7: Monitoring and evaluating the document****E. What is a 'good practice'?**

A technique or methodology that through experience and research has proven reliably to lead to the desired result.

Criteria of 'good practice'

- Effectiveness
- Efficiency
- Relevance
- Ethical soundness
- Sustainability
- Replicability
- Involvement of partnerships
- Community involvement
- Political commitment

Documenting 'good practice'

- Title of the best practice
- Introduction (context and justification)
- Implementation of the practice
- Results of the practice – outputs and outcomes
- Lessons learnt
- Conclusion
- Further reading

F. Cross learning criteria for organizations

- gained knowledge and practical skills which led to changes in techniques / methods, increasing the impact and effectiveness of their work
- identified their own strengths and sharing good practice to the benefit of other organisations
- identified solutions to some of their challenges and taken positive action to address these
- extended their networks to draw on in the future.

Leveraging from cross learning platforms

- Uniformity in reporting formats
- Accessibility in principle of shared knowledge
- accuracy and accountability

G. Resources directories

- **Organization level**
 - Personnel
 - Stakeholders
 - Donors (individual and institutional)
 - Facilities
- **External resources (local, Block, district, state, national, regional and global)**
 - Govt offices
 - Other nonprofits
 - Influencers
 - Media
 - Apex bodies
 - Facilities

Activity: 3

10 Minutes

Divide the participants into 3 groups and discuss the opportunity and challenges to create systematic documentation in the organization. Participants are to be given chart papers and colors.

Facilitator can summarise the group discussion on the following points:

- Appreciating and recognizing the importance of documentation
- What are the existing challenges/ gaps in documentation?
- Identifying various possible options to fill the identified gaps in organizational context
- Evaluating feasibility of implementation
- Implementation considerations
- Efficacy measurement and learning strategy

Reflection

Reflect on what this learning means to you and how can you apply it in your context of documentation.



Annexures

S.N.	Reporting Items	Basic Reporting Format for Staff Narrative
1	Report Date	
1.1	Event Date	
2	Reporting Person	
3	Designation	
4	Department	
5	What is being reported?	
5.1	Meeting/ Conference	
5.2	Events: Rally/Walks/Protest March/ Street Play/ Any other Play (share details and numbers like people attending)	
5.3	Sensitization / Training (share number of people attending)	
5.4	Crisis Management	
5.5	Visitors Interaction	
5.6	Field Supervision	
6	Venue/Site/Place	
7	Who did you meet/interact with?	
8	Any facilitator/ sponsors (add name and organization)	
9	Name of Staff (s) attending this	
10	No. of Stakeholders present	(with name, designation and organization name)
11	Agenda/Topic/Activity	
12	Key points discussed / Minutes	
13	List any resources used	
14	Key decisions taken/ Meeting Outcomes	
15	Your Key Take Away	

Annexure: Photos or any other relevant document.

Documenting a Project

Name of the Project	Cover Page with Logo
	Acknowledgements
	Key terms
	Acronyms
	Table of Content
Implementing CBO	
Funding Agency	
Project KP	
Targeted Reach	
Geographical Area of the project	
Duration	
Objectives	
Strategies	
Objective-wise activities, outputs, outcomes	
Objective: 1	
Activities	
Outputs	
Key outcome under this objective	
Objective: 2	
Activities	
Outputs	
Key outcome under this objective	
Objective: 3	
Activities	
Outputs	
Key outcome under this objective	
Stakeholder enagement	
Key networks	
Leveraging linkages under this project	
Key successes and failures	
Key challenges	
Way forward	
Financial report	
Annexures	
Project Team Details	
Photographs of activities	
Any IEC/BCC	
Case Studies	
Training Modules	
Letter of appreciation	
Letter of support	

Annexure:
Community Led Monitoring Formats by NACO
Community Monitoring System
Client Feedback Questionnaire

Form 1: Feedback on Targeted Intervention (TI) for FSW, MSM and TG typology

Name of the Client: _____

Name and address of the center: _____

Client UID (optional): _____

Client Contact Number / Email Id (optional): _____

Date of feedback: _____

Filled by - Client / TI staff (please mention who): _____

i. Was it easy for you to access / reach the TI Office / DIC?

☐ Very difficult ☐ Somewhat difficult ☐ Easy

ii. Was the timing of the TI Office / DIC convenient with you?

☐ Not convenient ☐ Somewhat convenient ☐ Very convenient

iii. How did you find the environment / cleanliness of the TI Office / DIC, during time of your visit?

☐ Unfriendly and unhygienic ☐ Average ☐ Welcoming and hygienic

iv. When you have visited the TI Office / DIC, were the staffs present

☐ None present ☐ Only Counsellor /
Lab-Technician were present ☐ Counsellor, Lab-Technician
and Doctor all present

v. Were the staffs in TI Office / DIC, sensitive with you?

☐ No ☐ No response ☐ Yes

vi. Did you feel comfortable during counselling session? (in context with the counselling space and confidentiality)

☐ Did not feel comfortable ☐ Somewhat felt comfortable ☐ Felt comfortable.

vii. Did you find the information shared by the counsellor on safer sex, STI symptoms, STI / HIV prevention relevant?

☐ Not relevant ☐ Somewhat relevant ☐ Relevant.

viii. Was condom available at the time of your visit?

☐ Never available ☐ Not available during the
time of my visit ☐ Adequately available

ix. Did you ever receive any crisis management support from this TI?

☐ Requested but never received ☐ Never requested ☐ Requested and received

x. Overall, how satisfied are you with the TI service?

☐ Not satisfied ☐ Somewhat satisfied ☐ Very much satisfied

xi. Please share any specific area / issue in the TI that you would like to see improvement - (in areas of facility, services, staff, commodity, any other)

Ans:

Community Monitoring System

Client Feedback Questionnaire

Form 1a: Feedback on Targeted Intervention (TI) for PWID typology / Opioid Substitution Therapy (OST) centre

Name of the Client: _____

Name and address of the center: _____

Client UID (optional): _____

Client Contact Number / Email Id (optional): _____

Date of feedback: _____

Filled by - Client / TI staff (please mention who): _____

I. Was it easy for you to access / reach the TI office / DIC / OST center?

☐ Very difficult ☐ Somewhat difficult ☐ Easy

ii. How did you find the environment / cleanliness of the TI office / DIC / OST center, during time of your visit?

☐ Unfriendly and unhygienic ☐ Average ☐ Welcoming and hygienic

iii. When you have visited the TI office / DIC, were the staffs present?

☐ None present ☐ Only ORW present ☐ ORW and Counsellor present

iv. When you have visited the OST center, were the staffs present?

☐ None present ☐ Only ANM / Counsellor / ORW ☐ ANM / Counsellor, ORW and
present (whichever applicable) Doctor present (whichever applicable)

v. Were the staffs in TI Office / DIC, sensitive with you?

☐ No ☐ No response ☐ Yes

vi. Are you satisfied with the STI / HIV prevention, safe injection practice information shared by the counsellor?

☐ Not satisfied ☐ Somewhat satisfied ☐ Very much satisfied

vii. Did you find the information shared by the counsellor on safer sex, STI symptoms, STI / HIV prevention relevant?

☐ Not relevant ☐ Somewhat relevant ☐ Relevant.

viii. Have you received abscess management support?

☐ Have requested but never received ☐ Never requested ☐ Received support when requested

ix. Was condom available at the time of your visit?

☐ Never available ☐ Not available during the time of my visit ☐ Adequately available

x. Was needle & syringe available at the time of your visit?

☐ Never available ☐ Not available during the time of my visit ☐ Adequately available

xi. Was OST service available at the time of your visit?

☐ Never adequately available ☐ Not available adequately during the time of my visit ☐ Adequately available

xii. Have you ever received support related to grievance / crisis from the TI / OST staffs?

☐ Have requested but never received ☐ Never requested ☐ Received support when requested

xiii. Overall, how satisfied are you with the TI / OST service?

☐ Not satisfied ☐ Somewhat satisfied ☐ Very much satisfied

xiv. Please share any specific area / issue in the TI / OST that you would like to see improvement – (in areas of facility, services, staff, commodity, any other)

Ans:

Community Monitoring System

Client Feedback Questionnaire

Form 2: Feedback on Integrated Counselling and Testing Center (ICTC)

Name of the Client: _____

Name and address of the center: _____

Client UID (optional): _____

Client Contact Number / Email Id (optional): _____

Date of feedback: _____

Filled by - Client / ICTC staff (please mention who): _____

i. Was it easy for you to access / reach the TI office / DIC / OST center?

☐ Very difficult ☐ Somewhat difficult ☐ Easy

ii. Was the timing of the ICTC convenient with you?

☐ Not convenient ☐ Somewhat convenient ☐ Very convenient

iii. How did you find the environment / cleanliness of the ICTC, during time of your visit?

☐ Unfriendly and unhygienic ☐ Average ☐ Welcoming and hygienic

iv. When you have visited the ICTC, were the staffs present

☐ None present ☐ Only Counsellor / Lab-Technician were present ☐ Counsellor, Lab-Technician and Doctor all present

v. Were the staffs in ICTC, sensitive with you?

☐ No ☐ No response ☐ Yes

vii. Did you find the information shared by counsellor in ICTC, relevant or useful?

☐ Not relevant ☐ Somewhat relevant ☐ Relevant.

viii. Have you been informed about partner / spouse notification by the counsellor?

☐ Not informed ☐ No response ☐ Informed.

ix. Have you received testing result within the timeline informed by the counsellor?

☐ Counsellor didn't shared any timeline ☐ Haven't received result in time as shared by counsellor ☐ Received in time

x. Have you received support from the counsellor / ICTC staff to navigate other essential Out-Patient Department (OPD) services / DSRC / ART clinic?

☐ No ☐ No response ☐ Yes

xi. Was condom available at the time of your visit?

☐ Never available ☐ Not available during the time of my visit ☐ Adequately available

xii. Overall, how satisfied are you with the ICTC service?

☐ Not satisfied ☐ Somewhat satisfied ☐ Very much satisfied

xiii. Please share any specific area / issue in the ICTC that you would like to see improvement - (in areas of facility, services, staff, commodity, any other)

Ans

Community Monitoring System

Client Feedback Questionnaire

Form 2a: Feedback on Designated STI/RTI Clinics (DSRC) / Suraksha Clinics

Name of the Client: _____

Name and address of the center: _____

Client UID (optional): _____

Client Contact Number / Email Id (optional): _____

Date of feedback: _____

Filled by - Client/DSRC-Suraksha (please mention who): _____

I. Was it easy for you to access / reach the DSRC / Suraksha Clinic?

☐ Very difficult ☐ Somewhat difficult ☐ Easy

II. Was the timing of the DSRC / Suraksha Clinic convenient with you?

☐ Not convenient ☐ Somewhat convenient ☐ Very convenient

iii. How did you find the environment / cleanliness of the DSRC / Suraksha Clinic, during time of your visit?

☐ Unfriendly and unhygienic ☐ Average ☐ Welcoming and hygienic

iv. When you have visited the DSRC / Suraksha Clinic, were the staffs present

☐ None present ☐ Only Counsellor / Lab-Technician ☐ Counsellor, Lab-Technician and
were present (whichever applicable) Doctor all present (whichever applicable)

v. Were the staffs in DSRC / Suraksha Clinic, sensitive with you?

☐ Bad ☐ Average ☐ Good

vii. Did you find the informationshared by counsellor in DSRC / Suraksha Clinic, relevant or useful?

☐ Not relevant ☐ Somewhat relevant ☐ Relevant.

viii. Was condom available at the time of your visit?

☐ Never available ☐ Not available during ☐ Adequately available
the time of my visit

ix. Have you requested and/ or received medicine from DSRC / Suraksha Clinic?

☐ Have requested but never received ☐ Never requested ☐ Received support when requested

x. Did you find navigation to locate other essential Out-Patient Department (OPD) services from DSRC / Suraksha Clinic convenient?

☐ Not convenient ☐ Somewhat convenient ☐ Very convenient

xi. Overall, how satisfied are your with the DSRC / Suraksha Clinic service?

☐ Not satisfied ☐ Somewhat satisfied ☐ Very much satisfied

xii. Please share any specific area / issue in the DSRC / Suraksha Clinic that you would like to see improvement - (in areas of facility, services, staff, commodity, any other)

Ans:

Community Monitoring System

Client Feedback Questionnaire

Form 2: Feedback on Integrated Counselling and Testing Center (ICTC)

Name of the Client: _____

Name and address of the center: _____

Client UID (optional): _____

Client Contact Number / Email Id (optional): _____

Date of feedback: _____

Filled by - Client / ART Clinic staff (please mention who): _____

i. Was it easy for you to access / reach the ART clinic / Link ART center?

☐ Very difficult ☐ Somewhat difficult ☐ Easy

ii. Was the timing of the ART clinic / Link ART center convenient with you?

☐ Not convenient ☐ Somewhat convenient ☐ Very convenient

iii. How did you find the environment / cleanliness of the ART clinic / Link ART center, during time of your visit?

☐ Unfriendly and unhygienic ☐ Average ☐ Welcoming and hygienic

iv. When you have visited the ART clinic / Link ART center, were the staffs present

☐ None present ☐ Only Counsellor / Lab-Technician were present ☐ Counsellor, Lab-Technician and Doctor all present

v. Were the staffs in ART clinic / Link ART center, sensitive with you?

☐ No ☐ No response ☐ Yes

vi. Did you feel comfortable during counselling session? (in context with the counselling space and confidentiality)

☐ Did not feel comfortable ☐ Somewhat Comfortable ☐ Felt Comfortable

vii. Did you find the informationshared by counsellor / doctor in ART clinic / Link ART center, related to ART regiment, adherence, side-effects / Opportunistic Infection (OI), relevant or useful?

☐ Notrelevant ☐ Somewhat relevant ☐ relevant

viii. Did you receive support for periodic (in last six months) CD4 and viral load testing from the ART clinic / Link ART center?

☐ Have requested but never received ☐ Never requested ☐ Received support when requested

ix. Was ART medicine available at the time of your visit?

☐ Never adequately available ☐ Not available adequately during the time of my visit ☐ Adequately available

x. Did you find navigation to locate other essential Out-Patient Department (OPD) services from ART Clinic convenient?

☐ Not convenient ☐ Somewhat convenient ☐ Very convenient

xi. Overall, how satisfied are your with the ART clinic / Link ART center service?

☐ Not satisfied ☐ Somewhat satisfied ☐ Very much satisfied

xii. Please share any specific area / issue in the ART clinic / Link ART center that you would like to see improvement - (in areas of facility, services, staff, commodity, any other)

Ans

Notes



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