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Civil society at the centre of HIV responses: lessons from the DFID Programme Management Office, India

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Starting in 2005, and until 2007, HLSP managed the DFID-funded programme of support to India's National AIDS Control Programme through the Programme Management Office (PMO). This paper explores the wider lessons emerging from the programme, and how the overall approach, management and commissioning processes contributed to its success.

In spite of the short timeframe, the PMO achieved a number of important results, including some with potential longer term impact. It developed a 'challenge fund' to encourage community-based innovation, it emphasised fostering links between civil society and government, and building organisationally sustainable approaches. The projects it commissioned, delivered by 39 partners and their networks, helped to introduce and scale up approaches to harm reduction for injecting drug users and support for men having sex with men, people living with HIV and women. Both policy level and frontline acceptance of the harm reduction approach increased.

Lessons from the approach remain of value to national efforts to scale up and institutionalise evidence-based and inclusive approaches with civil society and affected groups. The PMO has shown that government activities can be successfully complemented by community-based programmes and services that are well designed and supported.

Acronyms and abbreviations

AIDS	Acquired immunodeficiency syndrome
BCC	Behaviour change communication
CASP	Communication and Advocacy Support Programme
CBO	Community-based organisation
CF	Challenge Fund
DFID	Department for International Development
GIPA	Greater involvement of people living with or affected by AIDS
HIV	Human immunodeficiency virus
IDU	Injecting drug user
IEC	Information, education and communication
M&E	Monitoring and evaluation
MSM	Men who have sex with men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non-governmental organisation
OST	Opioid substitution therapy
RALF	Research and Learning Fund
SRH	Sexual and reproductive health
SACS	State AIDS Control Society
TG	Transgendered people

1. Introduction

In recent years the number of people with HIV in India has grown to the third largest in the world – behind only South Africa and Nigeria – and the largest in Asia. During India's National AIDS Control Programme Phase II (NACP II), HIV infections were on the increase among vulnerable groups such as injecting drug users (IDUs), men who have sex with men (MSM), transgendered (TG) people, and women, but there was no comprehensive programme of relevant targeted interventions.

Through the Programme Management Office (PMO), HLSP managed the DFID-funded programme of support to NACP-II, covering HIV prevention, treatment, care and support. The PMO developed a 'challenge fund' to encourage community-based innovation, and emphasised fostering links between civil society and government, and building organisationally sustainable approaches. The 61 projects, delivered by 39 partners and their networks in 2006/07, helped to introduce and scale up approaches to harm reduction for IDUs, and support for MSM, people living with HIV, and women.

This paper explores the wider lessons emerging from the programme, and how the overall approach, management and commissioning processes contributed to its success.

In this brief programme, completed during the final year of NACP-II, the PMO produced a number of important results, including some with potential longer term impact. The focus on IDUs and MSM increased with both policy level and frontline acceptance of the harm reduction approach in relation to injecting drug use and HIV. Other achievements were: improved communication and networking among groups working with and for both MSM and IDUs; increased capacity in community-based and national HIV organisations; development of models to reach marginalised women at risk of HIV; and new research on HIV issues in the Indian context.

2. The context

HIV in India

During the early 2000s, data suggested that India was globally second in terms of the number of people living with HIV, at around 5.1 million adults and children in 2003.[1] These figures generated much publicity and calls for action. Following changes in surveillance, the figures were revised down, suggesting a relatively low national adult HIV prevalence (0.36%), or approximately 2.5 million HIV-positive persons – less than half the previous estimate.[2]

In India more men are HIV positive than women. Heterosexual transmission is the greatest cause of HIV infection, although injecting drug users and men who have sex with men are at significant risk. In north-eastern India, injecting drug use is the major cause for the epidemic spread, and sexual transmission the second. While the estimated percentage of adult population affected by HIV may have dropped, in absolute numbers India still ranks third highest in the world behind South Africa and Nigeria, and the highest in Asia.[3]

The response

The Government of India response centres on its National AIDS Control Programme (NACP), now in phase III. NACP-II (1999-2006) increased targeted interventions with a focus on populations at higher risk – sex workers, MSM, IDUs and bridge populations (truckers and migrants). Policy initiatives included a strategy for greater involvement of people living with or affected by AIDS (GIPA).

NACP-III aims to halt and reverse the epidemic in India over the five year programme through interventions which include: saturation of targeted intervention coverage for key populations and strengthened systems in prevention; treatment (including antiretroviral therapy), care and support at district, state and national levels; as well as opportunities for income generation for affected people.

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[1] UNAIDS, UNICEF, WHO (2004) Epidemiological factsheets on HIV/AIDS and sexually transmitted infections: India. The low estimate was 2.5m, the high estimate was 8.5m.
[2] http://data.unaids.org/pub/PressRelease/2007/070706_indiapressrelease_en.pdf
[3] NACO website http://www.nacoonline.org/, accessed December 2008.

Although NACP-II and -III have increasingly prioritised targeted interventions, there is still much to be done. Scaling up – during the time of the PMO and now – remains a critical issue, in terms of prevention and access to treatment and care. While there are some effective programmes across the country, the resources, skills, infrastructure and networks are not fully in place to deliver to scale in the necessary timeframe. Lessons from the PMO's way of working remain of value to national efforts to scale up and institutionalise evidence-based and inclusive approaches with civil society and affected groups.

Key players

The National AIDS Control Organisation (NACO) was constituted in 1992 as a division of the Ministry of Health and Family Welfare, with a remit across government. State AIDS Control Societies (SACS) – autonomous state bodies – are in place across the country. Their functions include medical, public health and social sector services, and communication. SACS boards have representation from key government departments, civil society, trade and industry, private health sector and networks of people living with HIV. With the setting up of District AIDS Prevention and Control Units under NACP-III, there will be increased emphasis on improving coordination functions at state level in supporting implementation at the district level.[4]

The AIDS non-governmental sector in India is extensive – the *NGO Gateway*[5] lists hundreds of bodies working in the field. Aside from the Government, funding comes from international bilateral and multilateral donors as well as foundations and international NGOs.

In 2006, as now, capacity and resources varied, from well-established international and national NGOs with relatively secure funding, a strategic approach and strong links to government, to local community-based organisations (CBOs) providing virtually unfunded services and outreach in areas of greatest risk. National networks were not always in place for key risk issues; lack of communication or disagreement about a common approach or remit prevented effective working. Cross-sectoral partnerships (for example linkages between HIV organisations and poverty reduction programmes) were needed from national government to project level. In particular there were untapped opportunities for government collaboration with non-governmental sectors.

Many organisations at national and state levels – and particularly at frontline level – were in need of capacity building across the project cycle: data collection and analysis, project and financial management, strategic and action planning, partnership building and maintaining, communications, service delivery, and monitoring and evaluation.

DFID support to the Government of India

The UK Department for International Development (DFID) has provided support to NACO since it was established. Support was in line with DFID's strategic commitment to a unified HIV response involving all sectors of government and society.[6] The Government of India channelled a significant portion of the money to state level, via support to the SACS of eight states. Outside government, DFID funded a package of support including a Sexual Health Resource Centre, a Healthy Highways Project, mass media campaigns by the BBC World Service Trust and condom promotion strategies in the focus states, as well as other projects.

Towards the end of NACP-II, DFID commissioned HLSP to administer its support to NACO and to projects outside government, in order to address its lack of management capacity to deal with a large number of projects. The Project Management Office was thus established.

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[4] NACO website, accessed December 2008.
[5] Supported by the NACO and UNAIDS. http://www.ngogateway.org/
[6] Set out in the 2004 AIDS strategy *Taking Action*.

3. The DFID Project Management Office (PMO)

Early challenges

The remit of the PMO was to commission and ensure the delivery of a portfolio of new and existing projects across India. Specific tasks included: commissioning projects; managing and monitoring all projects and funding streams; fund disbursement; technical assistance; evaluation; disseminating results, experiences and best practice; providing a secretariat function for all partners for networking, coordination and advocacy.

This was a potentially daunting task given the timeframe – 21 months from inception in mid-May 2005 to completion in March 2007.[7] Deliverables were to include a 'challenge fund', condom distribution and promotion; information and behaviour change communications, and a proactive communications and programme development role. A small team was established in Delhi, with access to Indian and international technical assistance.

Identifying and commissioning a range of projects in such a complex environment and short time-frame generated a number of challenges, for example, how to generate awareness of the programme among the vast Indian HIV community, without raising undue expectations of what might be accomplished during the timeframe, or scepticism about a one-year project at the end of NACP-II. Then there were the issues of managing a transparent tendering and commissioning process with a very tight schedule and a potentially unmanageable number of bids, and of balancing the desire for innovation with the need for evidence-based initiatives.

Core principles and management approaches

The PMO established a number of principles to aid commissioning, including:

- the importance of partnership and engaging those most affected by HIV –which were used as criteria for assessing proposals
- transparency – as a DFID requirement, and to gain trust and demonstrate appropriate processes to the field
- speed and responsiveness – as organisations needed a minimum of a year to deliver challenging outputs
- capability to 'hit the ground running' once bids were approved – as there would be little time for staff recruitment process or development of entirely new approaches and initiatives
- the existence of a certain infrastructure – staff, skills, financial stability to the end of the project period, experience in delivery, computer based monitoring systems, and the systems to accept funding from an international donor.

To reduce the potential for an unmanageable number of bids from small organisations without the infrastructure to deliver – and in keeping with the PMO principles – partnership or 'umbrella' bids were encouraged, with larger organisations bidding on behalf of their current or new networks. To discourage 'more of what we're doing now', organisations were asked to build on their experience of 'what works', but also to explore the innovative potential of their work or extend initiatives to new areas (such as harm reduction for drug users in areas where NGOs had previously been committed to an abstinence approach).

Recognising that it was not possible to deliver outcomes in the time available, tendering terms of reference asked for outputs and aimed to define the programme as time-limited, innovative and complementary to NACP-II. To contribute to transparency, expert panels reviewed applications. Priority geographical regions and groups (MSM, IDUs, people living with HIV, and women) aimed to complement NACP-II. 'Influencers' were a priority for advocacy-based initiatives.

In total, the PMO commissioned[8] 61 projects, delivered by 39 partners and their networks across India. These included the DFID contracts already in place as well as projects tackling prevention and service

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[7] The programme was then extended to the end of June 2007.
[8] In line with DFID and European tendering guidelines, bidding tiers were established to allow a quick approval process for small amounts. An expression of interest phase for larger amounts allowed the PMO to estimate the volume of final bids, and to eliminate organisations without the infrastructure to deliver.

delivery for prioritised groups, states and districts, covering challenge fund, communication, research and social marketing.

The PMO portfolio included:

- Challenge Fund: for civil society (NGOs/CBOs), designed to promote innovation and partnership and covering a wide range of HIV-related priorities.
- Communication and Advocacy Support Programme (CASP): to strengthen IEC and BCC through innovative approaches, and to increase the role of civil society and key groups in the advocacy/policy dialogue. The NACO Newsletter was part of this portfolio.
- Research and Learning Fund (RALF): to complement existing data (often quantitative and state specific) with more qualitative elements.
- Social Marketing Fund (SMF): to build on existing condom promotion activities, funding development and social marketing of new and niche sexual health products.
- Support to the United Nations (UN): support to UN agencies engaged in HIV programming, with a focus on cross-UN coordination.

Scaling up: the 'Projects to Programme' approach

As the projects got up and running, it was time to consider how to live up to the PMO's name: how to create a 'programme' out of a number of disparate projects? How to generate something strategically useful, beyond the PMO's short lifetime?

A range of mechanisms were put in place to create a more programmatic approach.

Communication and networking. Improved communication and networking were critical to a programmatic approach and to making a 'step change' in a number of areas. Where groups had been working in isolation, efforts were made to establish wider networks for priority topics. As a result, PMO partners established a national network for harm reduction and IDUs (see Box 1); MSM and TG networks and organisations came together – initially in a mediated process – to agree a national strategy; organisations working on sexual and reproductive health (SRH) shared learning about methods. Local networking improved regional communication. The PMO website served as a focus for communication about progress and solutions to common problems. The NACO newsletter provided updates on wider NACP-II activities.

Strategic approaches. While national plans were in place to inform NACP-II, some key priority areas were working without specialist strategies. This is particularly important in relation to scale-up. The PMO brought together networks of MSM and TG to develop a national strategy (see Box 2); strategic planning was supported for the Indian Network for People living with HIV/AIDS (INP+), with a focus on realistic means of achieving national scale-up of the network; the International HIV/AIDS Alliance took up support offered on strategic approaches to advocacy.

Capacity building. The PMO provided needs-based support (such as training, toolkits, checklists, and technical assistance to PMO partners). This included in-depth regional working sessions on project and financial management as well as support on a range of technical issues, such as:

- needs assessment; data collection, analysis and use
- strategic and action planning
- stakeholder engagement
- capacity building
- communications (effective partnership communication, IEC/BCC, media)
- advocacy / 'making things happen'
- networking
- project and financial management
- partnership to deliver core and wider programme elements (e.g. income generation, legal issues)
- service delivery (prevention, treatment, care, rehabilitation (for harm reduction), referral to wider programmes and services
- M&E, review, research

Achievements

The PMO regularly monitored projects, which self assessed against their original logframe, and PMO managers agreed final assessments with partners. In-depth reviews were undertaken for major programme areas, including harm reduction for IDUs, MSM and TG, social marketing and PMO management itself.

There were achievements and products from across the programme. Two areas that showed considerable innovation and the potential for sustainable developments are harm reduction for IDUs (and work with women within this) and men who have sex with men (see boxes 1 and 2).

Box 1: Harm reduction for IDUs

Injecting drug use is a major route of transmission in India; in the north east of the country it is *the* primary cause of HIV infection. Despite this, there has been uneven commitment – politically and among service providers – to harm reduction for IDUs. The PMO provided opportunities to focus on this important issue. Projects were commissioned with a range of providers – drug specialists, providers of primary health care, of SRH services, and of general HIV prevention – for prevention, treatment and care services, as well as policy and advocacy work. Information sharing about best practice and advocacy work by NGOs committed to the harm reduction approach influenced a change in attitude in both government and NGOs previously committed to an 'abstinence' approach.

Results
- Harm reduction projects from four networks reached out to more than 100,000 IDUs across India.
- Opioid substitution therapy (OST) was established in four urban and three rural sites across the north east states of Manipur and Nagaland, and in eight further states and three union territories. OST was attractive to drug users and acceptable to all stakeholders – families, the community, religious leaders and policy makers. More than 4,500 IDUs benefited from OST and over two thirds successfully completed treatment or were in treatment at the end of the project. OST has subsequently been implemented by the Indian Government.
- The establishment of the Indian Harm Reduction Network is a milestone in India's harm reduction history.
- Integrated models for providing access to women partners of male IDUs and female IDUs were established, including SRH and harm reduction services. Peer-led interventions (including those led by women) have been shown to be effective in gaining access to this key population.

Lessons
- Engagement of those most affected is critical to the effectiveness and sustainability of programmes. 'Nothing for us without us' emerged as a strong principle for future action.
- Further key principles include: 'reaching the unreached', and 'need based services'.
- Generic services do not attract women clients, and generic service providers do not have the necessary skills to deal with women's needs. Women-centred services – such as combined SRH/harm reduction provision – can improve access for women. Women staff and outreach workers were critical to the success of the services.
- As with MSM and TG, sustained funding is needed to support prevention, treatment and care, as well as links with related programmes such as income generation.

Other examples of achievements were in the areas of **women**, **social marketing** and **emerging priorities**. A number of projects focused on improving engagement of women affected by HIV. The programme demonstrated the effectiveness of an integrated approach to access through SRH services, for example for women drug users/partners of IDUs. One project looked at trafficking of girls and women and its relationship to HIV. Research looked at increasing uptake of voluntary counselling and testing by women. The social marketing programme had success in increasing condom use among vulnerable groups and fed information to the SACS to strengthen their social marketing strategies. The research and challenge fund projects produced new evidence on emerging priorities, including: migration; children; disability and HIV; discrimination; capacity building issues; and communication and networking.

Box 2: MSM and TG

India has a large population of MSM and transgendered (TG) people – both visible and hidden. A historical division between MSM and TG organisations and networks, for reasons of geography and difference in approach, had led to fragmentation of community voice at the national level. Many small grassroots organisations did not have the skills, connections, capacity and resources to meet the needs of their communities.

Results
The MSM project review found that the projects together developed a number of products, some beyond the scope of the original project, including:
- *Evidence to Action: Strategic Plan for Scaling Up Interventions for MSM and Transgender Populations in India* (the 'National Strategy'), with a five-year institutional home in NACP-III.
- Toolkits (in four languages) and training manuals on advocacy, grant writing, programme development and M&E.
- Research on social and sexual networks of MSM/TG, prevention and human rights abuses.

Lessons
- Great strides have been made in uniting MSM and TG groups and strengthening communities' voice. However, there is still a focus on local needs and issues among many groups, requiring an external catalyst to support the development of a national network and platform.
- More medical and behavioural data for MSM and particularly for TG populations are needed for effective HIV prevention, treatment and care.
- Lack of professional skills among grassroots groups remains a significant challenge.
- Development of a national community-led strategy was a major achievement; the crucial next step will be engagement with SACS to scale up the proposals.
- There is an imperative to ensure longer term funding for both prevention and treatment programmes – and particularly in the case of access to antiretroviral therapy.

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4. Lessons learned across the PMO

The PMO ethos helped ensure that it was a developmental and learning programme. Central to this approach was listening. In a project with as limited a timeframe and such ambitious outputs as the PMO, it would be tempting to be prescriptive in driving progress, but the PMO developed through listening to partner needs and engaging fully with them. Of particular importance was ensuring that the demands of people affected by HIV were heard; this is best expressed by the principle emerging from the Indian Harm Reduction Network – *nothing for us without us.*

Throughout the PMO, efforts were made to be a learning organisation – to identify 'what works' along with the challenges and their solutions. A number of lessons were learned about the key components that helped to contribute to the PMO's effectiveness.

Box 3: Lessons learned. Key elements for building effectiveness and working towards sustainability

1. A focus on data, lesson learning, research and M&E
2. Strategic planning and delivering services in partnership
3. Engagement of stakeholders
4. Effective networking, communication and advocacy
5. Coordinated capacity building based on need
6. A focus on both outputs and outcomes
7. Generating buy-in and 'quick wins'

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1. **A focus on data, research and M&E increased lesson learning and the potential for sustainability and scale-up**. Research initiatives complemented available quantitative data with qualitative information on emerging issues. Lesson learning – through review, networking, workshops and use of the website – helped to build awareness of effective interventions. Publications and resources emerging from the programme were disseminated widely.

2. **Emphasis on strategic planning and delivering services in partnership – across NGOs and civil society organisations, with government and the private sector – helped widen the impact of the programme**. Tendering criteria for projects encouraged partnership bids, which resulted in a range of joint projects as well as a partnership approach across the PMO.

3. **Engagement of stakeholders – from service users to national government – increased the potential for buy-in, effectiveness of targeted interventions and sustainability**. The PMO was successful at engaging stakeholders across sectors and across India, with a focus on prioritised groups. Engagement of service providers and users also increased the effectiveness of projects, as the views of these stakeholders informed delivery to meet need.

4. **Effective networking, communication and advocacy helped to bring about significant breakthroughs across the country and across sectors**. The size of India – in terms of population, geography and the scale of the epidemic – requires effective communication among policy makers, providers and priority group members. The stigma associated with HIV, and in relation to populations at higher risk, means that effective, open means of communication can be a challenge. The PMO instituted a range of approaches to improve communication. Alliance building – across government, NGOs, CBOs and development partners – was a critical factor in the PMO's accomplishments. DFID gave the PMO the authority to make links across NACO and NACP-II, allowing the PMO and its programme to influence agendas and organisations.

5. **Coordinated capacity building based on needs assessment contributed to speedy start-up and effective delivery of initiatives**. The short timescale of the project meant that it was essential that providers had the capacity to deliver. A first step was prioritising bids by organisations that could demonstrate such capacity. Needs based capacity building supported delivery.

6. **A focus on outputs and outcomes contributed to value for money and the potential for scaling up**. While it was not possible for most of the projects to generate longer term outcomes, the programme overall aimed to contribute to sustainability and future scale-up. Outputs included tools, resources, research, and increased access to services.

7. **Generating buy-in and quick wins helped contribute to institutionalisation and integration of innovative approaches into law, policy and programming**. Advocacy among partners, networking, and demonstrating evidence of effective action contributed to buy-in across the programme. Longer term institutionalisation of approaches and activities across government and organisations will have to be assessed in the longer term, but early indications at the end of the programme suggested some progress had been made.

Importantly, factors also included tight, professional project management; efficient procurement, from setting up systems to selecting the organisations; close, hands-on contact between PMO staff and contract-holders; and robust financial management. Without a strong focus on these systems throughout the programme, the PMO would not have succeeded.

A communications strategy helped promote and build ownership for the evidence of effectiveness and lessons learned. SACS received tailored reports of progress in their area with discussions about future implementation and scale-up. Partners and stakeholders received a dissemination pack on advocacy, emerging priorities, harm reduction, MSM/TG, social marketing and women. In-depth evaluations were carried out on harm reduction, MSM and TG, social marketing, and the PMO approach; these were disseminated to participating partners and other bodies. *Our Story and our responses to HIV/AIDS in India*[9] documented the views of PLHA and project workers.

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[9] Published by DFID India, 2007 http://www.dfid.gov.uk/pubs/files/hiv-india.pdf

5. Conclusions

Changes in policy and practice during NACP-III suggest that a number of PMO-supported initiatives will continue. NACP-III adopted and scaled up work on peer education, including with young people. The harm reduction network continues to grow and develop. Research results and abstracts continue to be presented at conferences. Perhaps most important has been the effectiveness of the PMO-supported work with MSM and IDUs, which helped inform the direction of NACP-III. This is evidenced, for example, by the Government supporting scale-up of opioid substitution therapy for 40,000 people. In addition, DFID intends to provide funding for a programme support with a focus on MSM/TGs and harm reduction for IDUs.

A one-year programme is not always considered 'best practice' and is often difficult for organisations to manage. As part of the harm reduction review, close to 100 PMO partners and participants were asked if the one-year programme had been 'worth it'. All but one of the participants said – with great enthusiasm – that it had been more than worth it. The widespread view was that the participatory, listening, responsive and developmental approach had made partners feel valued and had encouraged these already engaged and committed participants to push themselves and their organisations to achieve more. The one participant who said no, explained that it was because the programme had been so beneficial; she could not stand to see it end.

A further benefit of the PMO is the development of a replicable model (see diagram on page 10) that can be used to channel large sums of money effectively through a variety of contractual arrangements. In addition, the approach has shown that government activities can be successfully complemented by community-based programmes and services that are well designed and supported.

The authors

Barbara James provided support to the PMO on strategic planning, performance management and review, and gender issues.

Gordon Mortimore headed the DFID's Programme Management Office, 2006/07.
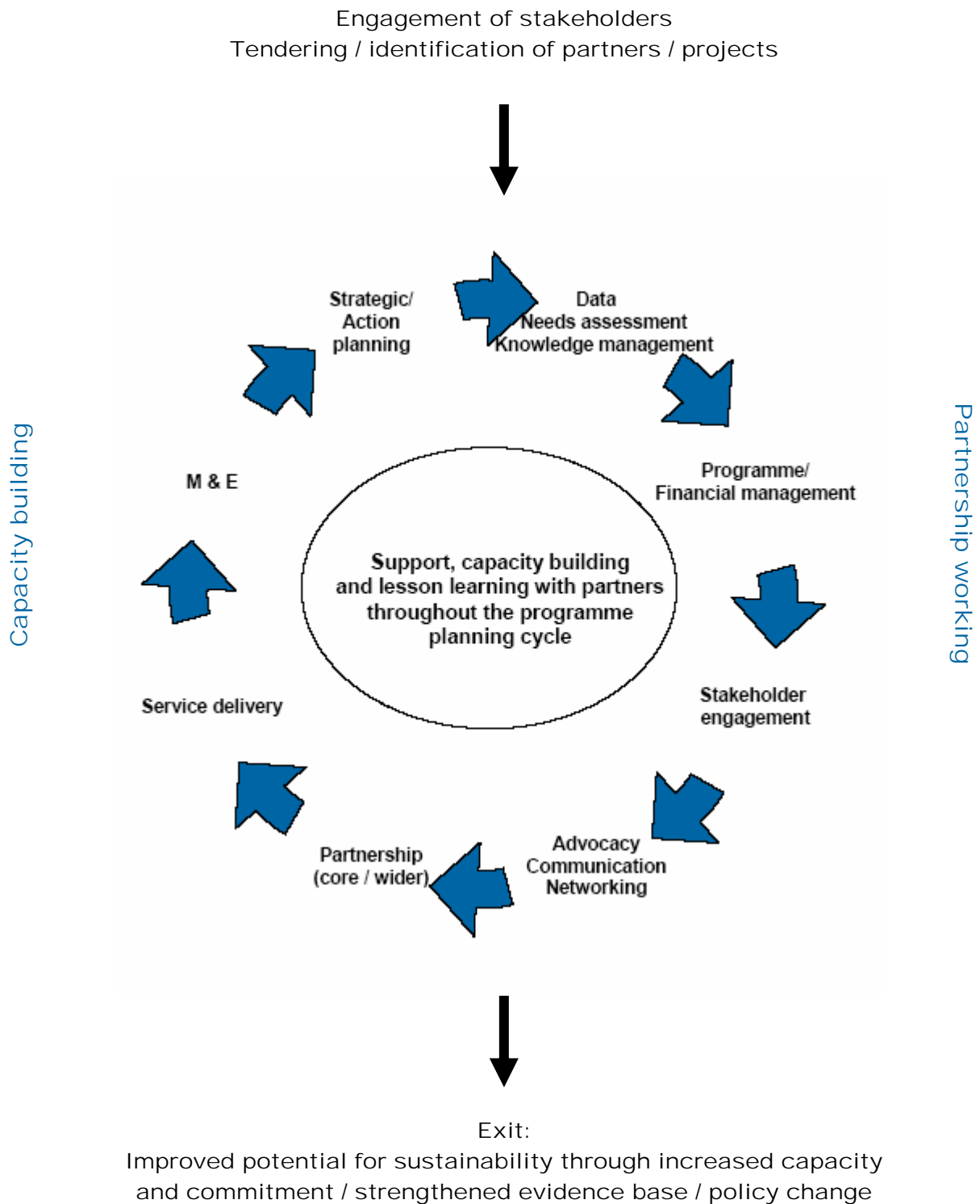
Sources of information

DFID PMO Briefing Papers (June 2007)*:* Advocacy; Emerging priorities; Harm reduction; Men who have sex with men; Social marketing; Women; The PMO management model.
PMO Reports: Assessment of the projects for MSM and TG persons; Harm reduction for drug using populations; Condom social marketing: a review.

From projects to programmes: contracting for HIV/AIDS in India. HLSP Institute, November 2006
http://www.hlspinstitute.org/projects/?mode=type&id=121235

For further information about HIV/AIDS in India, see the NACO website: http://www.nacoonline.org/

The PMO Approach

Engagement of stakeholders
Tendering / identification of partners / projects

Exit:
Improved potential for sustainability through increased capacity
and commitment / strengthened evidence base / policy change

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