AIDS
Community

AIDS COMMUNITY
Consolidated Reply

Query: Building management capacities of CBOs, from TCIF, (Comparative Experiences)

Compiled by E. Mohamed Rafique, Resource Person; research provided by Seema Kochhar, Research Associate.
28 February, 2006

Original Query: Vibha Singh, Transport Corporation of India Foundation, Gurgaon, Haryana
Posted: 01 February 2006

Transport Corporation of India Foundation (TCIF) is implementing an HIV intervention program for Truckers along the National Highways 2 to 8 since 2004. One of the factors for the program's eventual success will depend on how best TCIF is able to build Community Based Organizations (CBOs) among the Trucking population of these Highways.

CBOs be they among the High Risk Behaviour Groups like CSWs, MSM, IDUs, or in bridge populations like Truckers and Worker Groups or among PLHIV, have their main strength in Community Mobilization. They build on this strong point and through Community Led Structural Interventions (CLSI) have been able to launch good programs in the fight against HIV. CBOs generally in their initial years of existence require a lot of capacity building and tacit hand-holding by the NGO or implementing organization building up the CBO. Over the years depending on the capacity of the CBO, the management of the program and its ownership is taken over by the CBO. This strategy also makes better sustainability sense.

I would like to learn about the experiences (successful or otherwise) from any of our members who have attempted to build up CBO management capacities. What were the difficulties faced by implementing organizations while forming, capacity-building and hand-holding CBOs and how were they overcome? Did the implementing organizations feel left out once the CBOs had enough capacity and were able to run the program by themselves? What did CBOs and implementing organization feel was the ideal time-line for CBOs to own and lead the intervention? What was the new role of implementing organizations once the CBO was full-fledged?

Responses were received, with thanks, from:

1. **Shivananda DG Khan, Naz Foundation International, Lucknow.**
2. **S. Hashim Aadil, PRAGATI, Hyderabad.**
3. **Ashok Row Kavi, Humsafar Trust, Mumbai. (Response 1) (Response 2)**
4. **Santosh Bagali, Bijapur, Karnataka.**
5. **Mohamed Shafi, Gowri Sha Hospital, Thiruvananthapuram**
6. **Sunil Menon, SAHODARAN, Chennai.**
7. **E. M. Sreejit, London school of Hygiene & Tropical Medicine, London, UK.**
8. **Amrita Bhende, Committed Communities Development Trust (CCDT), Mumbai.**
9. **Shyamala Ashok, SFDRT, Pondicherry**
10. **Anandi Yuvaraj, India HIV/AIDS Alliance, New Delhi.**
11. **Sandeep Kumar, UHRC- Indore.**
12. **P. N. Vasanti, Centre for Media Studies (CMS), New Delhi.**
13. **Seema Kurup, Media Matters, Ambernath, Maharashtra.**
14. **Sonal Zaveri, Mumbai.**
15. **Tarit Chakraborty, Bengal Network for PLHIV (BNP+), Kolkata.**
16. **Kaveesher Krishnan, SAATHII, Hyderabad.**
17. **Alka Gogate, Mumbai.**
18. **Xavier Raj, SERC, Synovate Ltd.,**

Summary of Responses

Responding to the query on strategies for building sustainable management capacities of CBOs, members presented a rich mosaic of experiences and examples to buttress their suggestions. Endorsing various elements of the **Community Led Structural Intervention** (CLSI) approach for building CBOs, members examined the empowerment issues, monitoring and evaluation needs, constraints and possible ways to overcome these.

One interesting **strategy** described by a member, was a multi-pronged one - involving community mobilization, income generation, and capacity building to strengthen local NGOs and CBOs while promoting gender equity and working for poverty reduction. Starting a newspaper and a message centre for MSM helped a CBO to begin a process that eventually led to its becoming one of the largest network of MSM in Asia. Scaling up to ten states in India proved to be a successful strategy to work with positive networks for another NGO.

Responders agreed that one of the measures of success of NGOs, in the development of a CBO, is how best they run interventions and represent the interests of the community. Some **elements of the CLSI approach** as retold by members include:

- viewing community members as agents of change - instead of deviants, or victims;
- in a community of sex workers, respecting their choice to continue in sex work;
- building a sustainability component from the beginning of the program;
- involving the partners as much as possible in the development of work plans and goals;
- facilitating their empowerment to demand rights and justice; and
- building linkages, and negotiating with health care providers, government and donors for an increase in access to services/ prevention methods, and to ensure their safety.

The **lessons learned** as reported by CBOs include the importance of programs to:

a) build capacity of community workers to run their own programs;
b) develop their identities as peer educators; as well as

c) develop their collective strength in mobilizing people/resources to improve their work and living conditions.

Members stated that NGOs and CBOs agree that **Capacity Building** of a CBO in common, simple but essential areas are vital in the early stages of its growth. These areas include: how to form and manage groups, hold meetings, form committees, appoint office bearers, define and demarcate roles of members, keep accounts, manage tenders, formulate rules and byelaws, organize events, and other such activities which are relevant to the objectives of the organization. Prior to registration of the CBO, such training and handholding is organized.

Experience so far suggests that CBOs or NGOs working towards their **rights** have been able to acquire the skills and build their capacities rather quickly (Hamsafar Trust). Responders stated that a rights based approach provides space for participation of marginalized individuals, sharing of information, developing appropriate systems, institutionalization of process within the group, and forming a network for solidarity. **Networking**, at the community level offers stability for focusing on building capacities. Members also felt that a sensitized and visionary team in a CBO firms up the commitment and quickens the pace.

Agreement prevailed that a policy towards **sustainability** is essential. It was felt that both NGOs and CBOs from the beginning should understand that the support from NGOs would decrease gradually. As the phase-out begins, facilitation of CBO's dialogue with government and local charitable organizations is required. Members shared that Positive Networks that ran their organizational activities with donations, coupon collection, honorarium earned through training programs, membership fees, and tickets from cultural programs, etc. reported better sustainability. Positive Networks also often benefited through financial and technical support from volunteering agencies (VSOs), UN agencies, the National Network, and the SACS.

Responders stated that an almost universal **constraint** was fund sustainability. The members cited examples of donors having to reorient the project activities and staffing pattern of CBOs to make the project sustainable, as an interim measure, before others took over. Another issue pointed out was that of overlaps and duplication of work at cruising sites allocated to different projects. An added difficulty stated was that SACS does not pay the peer educators (among the communities where their NGO's are the implementing agencies), whereas International Donors do so. Therefore, the observation was that the peer educators were less responsive to NGOs funded by SACS. Conversely, some responses showed how CBOs have successfully dealt with structural blockages, such as lack of skills, lack of access to macro-institutions and credits, and have resolved situations involving some forms of discrimination.

Another important contribution made was on **Monitoring and Evaluating** NGOs working with CBOs. Instead of fulfilling quantitative measure indicators, members felt that focus could shift to processes undertaken and to the impact made. Similarly, regarding **Empowerment** of a development initiative, it was felt that it's better spelt when the community itself builds ownership of the programme component and is enabled to deliver organizational tasks. All the stakeholders should take part in the administrative and management functions, if they themselves run the CBO. Members emphasised that enhancing active participation of the community is also a pre-requisite to ensure empowerment.

Finally, as one member summed up: "Looking at this continuum of local response, CBOs, federations and NGOs we can conclude that the degree of expertise required; and, therefore, the management capabilities may vary across this continuum. It would be useful to keep procedures simple and appropriate. This is learning by doing. This means handholding support. Well-conceived materials that could be accessed and used should complement it. Balance between internal capabilities and external support or control is desirable".

Uttar Pradesh

Naz Foundation International Shivananda KhanNFI, Lucknow

NFI's specific remit is to provide technical assistance to local 'MSM' networks, collectives, groups and community-based organizations towards developing and implementing their own HIV/AIDS prevention, care and support services.

ActionAid (From Santosh Bagali Belgaum, Karnataka)

In Lucknow ActionAid is part of the HIV&AIDS Citizen's Forum (formed with joint efforts of few individuals in Lucknow in solidarity with +ve people). ActionAid is also collaborating with the upcoming UP network of positive people whom we are supporting for community mobilization. They have been successful in removing discriminatory hoardings put up by the state AIDS Prevention Society and UNICEF. Efforts are also onto set up the Allahabad Positive Peoples Network, to do a study on the prevalence of HIV in UP and to review the IEC materials available and being used in UP to address HIV and AIDS related issues.

Gujarat

Self - Employed Women's Association (From Hashim Aadil, PRAGATI, Hyderabad)

SEWA itself is made up of several branches: the Union, the SEWA bank, the Economic Wing, and the Rural Wing. The Economic Wing provides skills training, forming production units, obtaining new materials, and improving marketing skills. The Rural Wing focuses on mobilizing agriculture labourers, including non-farm activities during the off-season months. The union is modelled after trade unions where members are grouped by trade or occupation. No longer part of the TLA, SEWA works as an institution representing the women with whom it works.

ActionAid (From Santosh Bagali Belgaum, Karnataka)

has initiated its work on care by identifying positive people from the Kutch Network of Positive People and Lakshya - a CBO working with MSMs in Baroda for fellowships. They collaborate very closely with the Gujarat SAPS, GNP + and SAHAS- a care and support NGO.

Maharashtra

Humsafar Trust (From Ashok Row Kavi, Humsafar Trust, Mumbai)

Humsafar Trust offers a wide array of community services. It got Mumbai's first VCCTC within a community based organization, the first STI clinic exclusively for homosexuals, transgendered and bisexual men, a modest library used by a minimum of three research scholars every week, a drop-in-centre open from noon to 8.30 P.M. on weekdays, help-lines for tele-counselling and rooms for one-on-one counselling for sexually distressed people. It also has a huge citywide street outreach program spread over 45 beats covering 155 sex sites in the Mumbai Metropolitan Region (MMR), health camps at truck spots for transgendered sex workers. It has special drop-in centres and clinics for male sex workers, especially film extras and young males trying to make a living in Bollywood and the fashion world, special outreach into virtual networks working through cyber space and internet sex, condom distribution at sex parties and backroom sex.

ActionAid (From Santosh Bagali Belgaum, Karnataka)

SAMVAAD is a resource centre initiated at ActionAid in Mumbai. The centre trains community leaders and CBO functionaries on the Stepping Stones module. The region partners with CYDA,

an NGO which has taken SS to 14 districts of Maharashtra which uses it as a powerful behavioural change tool among youths. Maharashtra Association of SS Trainers (MAAST) was established and the Marathi Manual was produced.

Tamil Nadu

SAHODARAN (From Sunil Menon SAHODARAN)

It is the pioneering MSM CBO in the city of Chennai, with eight years of implementing experience to its credit, in the field of HIV/AIDS and STI. The project has planned a detailed Advocacy approach, involving Railway Police as well as Health Care providers to sensitize them on the various issues related to MSM. Besides, workshops for the Media and Reporters are also planned, to encourage more sensitive reporting on various issues related to Sexuality and Gender. The drop-in center has been shifted to a new place

ActionAid (From Santosh Bagali Belgaum, Karnataka)

ActionAid has started working with a positive network (SIPN) with about 1700 positive people from the Hijra community in Tamil Nadu. The focus is on understanding their needs, advocating for free ARVs, treatment and care for PLWHAs. They also work with an initiative for 1600 sex workers and their children in 3 districts where the focus is on advocating for safe sex and creating awareness on the high risk behaviour aspect.

Manipur

ActionAid (From Santosh Bagali Belgaum, Karnataka)

The first region to initiate HIV and AIDS work in India . Supports the Manipur Network of Positive People (MNP+) working towards positive living with its branches in all the nine districts of Manipur. 'Nothing about us...without us' is their slogan. The focus is on home-based care, counseling for positive living, formation of mutual support groups, with thrust on medical needs as well as social issues such as life skill development. Injecting Drug Use is the major cause of HIV in this area where there is a large number of AIDS widows and HIV orphans. Foster Care of orphans within the communities is promoted where 100 positive children are supported through an ActionAid programme here.

Andhra Pradesh

Lepra India (From Xavier Raj, SERC, Synovate Ltd.,)

A Targeted Intervention for truck drivers was implemented by Lepra India in Andhra Pradesh. Transport owners and brokers at halt points were mobilized over a period of time to be the peer educators. Lepra India helped these transport owners and brokers to form their own CBO.

ActionAid (From Santosh Bagali Belgaum, Karnataka)

ActionAid supports WINS, a local organization to form collectives of sex workers and positive people. It has led to the formation of Chittoor Network of Positive people to provide support in times of distress to the families of PLWHAs. Alternate livelihood options and legal aid is provided to fight stigma and discrimination faced by women. Support has been mobilized from government hospitals for medical assistance. Positive children and children vulnerable to HIV are a special focus of the programme. WINS provides support to 100 positive children supported by ActionAid Italy .

Madhya Pradesh

UHRC(From Sandeep Kumar UHRC – Indore)

Strengthening the Management capacity of CBOs of slums to take up bigger challenges is one of the programs of UHRC. Although the Program is broad-based and is focusing on RCH issues and not directly to HIV and AIDS, yet it has been instrumental in giving a wide range of learning which have been documented as a Multi-stakeholder Urban Health Program with sections on the

three-tier NGO-CBO Partnership Model, the Ward Coordination Model, as well as the Lessons Learned.

Karnataka

ActionAid (From Santosh Bagali Belgaum, Karnataka)
AAI supports MILANA a Family support Network of PLWHAs which works with about 250 +ve women, 100 positive children and their families. ActionAid has also initiated Abhaya- a health initiative of ActionAid Karnataka Projects, a five year focused HIV prevention project with more than 2000 women in Sex work and MSMs in Davangere and Shimoga districts. PLWHA Networks are also being formed both in Davangere and Shimoga districts. The regional office produced the Indian Adapted version of Stepping Stones which was released in December 2004. Stepping Stones is being implemented with PLHAS and Sex workers. The region has put in efforts of integrating HIV and AIDS work within their programmes working on issues of Violence Against Women and in other larger development initiatives.

West Bengal

Bengal Network for PLHIV (From Tarit Chakraborty, BNP+, Kolkata)
Formed initially with a few members of Kolkata Network of Positives, BNP+ stepped into the districts and formed the district level network in Howrah with the formation of the Howrah Network for People Living with HIV (HNP+). Soon, South 24 Pgs Network for People Living with HIV (SNP+), North 24 Pgs Network for People Living with HIV (NNP+) and the Network of Hoogly for People Living with HIV (NHP+) were formed. Recognized as the Positive Network for West Bengal, BNP+ liaised with West Bengal State AIDS Prevention and Control Society, Indian Network of Positives, Voluntary Services Organization and UNICEF for building its network of CBOs.

ActionAid (From Santosh Bagali Belgaum, Karnataka)
The Kolkotta regional office supports the Bhorukha Charitable Trust. The partner organization, Bhalobasa works on three levels: The first level is with the individual, Bhalobasa (a care centre) provides institutional care and support. Second, they work with the family, sensitizing them on how they can support their family member. Thirdly, they work with the community, aiming to create an enabling and caring environment for positive people so that they can remain in their communities and continue to be as productive as possible.

Delhi

Centre for Media Studies (From P. N. Vasanti, CMS)
CMS has the experience of interaction and orientation with almost 500 CBOs and NGOs as civil society groups working on different aspects of health, mostly HIV, from among specific pockets and specific groups or communities in and around Delhi. Short modules on various topics for training community members are available.

ActionAid (From Santosh Bagali Belgaum, Karnataka)
In Delhi ActionAid India provides Fellowship to two people from the Delhi Network of Positive People to develop their capacities and form a Network of Positive people.

Orissa

ActionAid (From Santosh Bagali Belgaum, Karnataka)
The Bhubaneswar regional office too has identified positive people for fellowships to initiate their work on HIV and AIDS.

Related Resources

Recommended Organizations

Voluntary Services Organization *(From Tarit Chakraborty, BNP+)*
http://www.vso.org.uk/ E-mail: infoservices@vso.org.uk
Carlton House, 85 Upper Richmond Road, London, SW15 2BS Tel: +44 (0)20 8780 7600

Voted top international development charity in 2004 for its work in promoting innovative approaches to globalising volunteering with 2000 professionals in 40 countries.

Humsafar Trust*Ashok Row Kavi**Humsafar Trust*
http://www.webbingsystems.com/humsafar/index.html arowkavi@vsnl.in
Second Floor, Old BMC Building, Nehru Road, Vakola, Mumbai-400 055 Tel: +91 22 26673800

A non-denominational foundation focusing on Male Sexual Health, issues concerning gay men and men-who-have-sex-with-men (MSM).

SAHODARAN*Sunil Menon**SAHODARAN, Chennai*
http://www.yogachicago.com/nov05/sahodaran.shtml E-mail: sahodara@md3.vsnl.net.in
127, Sterling Road, First Floor, Nungambakkam, Chennai 34.

A CBO for Men who have sex with Men, work with Hijras, transgendered men and Male sex workers in Chennai.

Prakriti *Sunil Menon**SAHODARAN, Chennai*
6, Jagannathan Road,Nungambakkam, Chennai 600 034 E-mail: Prakritichennai@hotmail.com

This NGO is the umbrella organization of which Sahodaran is a part. They work with other at-risk youth

SFDRT *(From Shyamala Ashok SFDRT, Pondichery)*
http://www.sfdrt.org/ E-mail: aabinand@satyam.net.in
34, Chetty Street, Pondicherry 605 001 Phone : 91 - 413 - 2349284, 2220058

Provides Sexual Health services for Sex workers and clients in the brothel, Bar tenders, workers and clients at the liquor bars as well as Truckers in the Truck Halt Points

Dr. Samarjit Jana
Contact: Sjana@careindia.org CARE India, 27, Hauz Khas Village, New Delhi-110 016

He is the Assistant Country Director in CARE India. He developed the CLSI approach based on the "Sonagachi model" in the early 1990s.

Recommended Documents

CHANGE/ Risk, Morality, and Blame, *(*From *Dr. Mohamed Shafi, Thiruvananthapuram)*
http://www.genderhealth.org/pubs/AminHIVAmongSexWorkersinIndiaJan2004.pdf [432 KB]

Page 21 and 22 gives the first steps of how to use a gender and rights-based participatory strategy to build community based organizations of sex workers

Experience in Scaling Up Support to Local Response in Multi-Country AIDS Programs (MAP) in Africa, *(From Xavier Raj, SERC, Synovate Ltd.,)*
http://www1.worldbank.org/hiv_aids/docs/ScalingUp.pdf [KB]

This is a World Bank report which documents some of the valuable reports that has been prepared by Jean Delion, Pia Peters, Ann Klofkorn Bloome

CARE India - Role of Community Led Structural Interventions in working with Sub-populations vulnerable to HIV/AIDS
http://www.careindia.org:8080/concept2004.doc [95.5 KB]

A concept paper on CLSI for the Targeted Interventions in India among various High Risk Behaviour Groups and Bridge Populations like Truckers.

CARE India - Understanding Power and creating spaces: Sex Workers? Voices in HIV Prevention
http://www.careindia.org:8080/understanding.pdf [40.2 KB]

A lucid document that shows the dynamics of power relations in relations to varied spaces and places and its implications in sex work

Recommended Websites

Urban Health Resource Centre *(From Sandeep Kumar, UHRC- Indore)*
http://www.uhrc.in/module-ContentExpress-display-ceid-4.html

Gives a glimpse of the Multi-stakeholder Urban Health Program in Indore, with sections on the three-tier NGO-CBO Partnership Model, the Ward Coordination Model, as well as the Lessons Learned.

aidsmap - Supporting NGOs and CBOs *(From Dr. E. M. Sreejit, LSHTM, London, UK)*
http://www.aidsmap.com/en/docs/7B5A3CA3-4785-4EDA-8165-CB434FB5D8BC.asp

This page justifies support to NGOs and CBOs, gives reasons, defines what constitutes support, what are the key lessons learnt as well as who provides NGO/CBO support.

The International HIV/AIDS Alliance (*From Anandi Yuvaraj, India HIV/AIDS Alliance)*
http://www.aidsalliance.org/sw7442.asp

Contains links to 24 publications that help to create an enabling policy, legal and institutional environment so that civil society can be actively and influentially involved in AIDS responses.

(From Dr. E. Mohamed Rafique UNAIDS, Delhi)

CARE India
http://www.careindia.org:8080/displaySector.jsp?sCode=CIS23

The page has details of CARE's SAKSHAM program, supported by the Bill and Melinda Gates Foundation, India AIDS Initiative (AVAHAN) to learn and apply Community Led Structural Interventions (CLSI).

Parivartan
http://cira.med.yale.edu/parivartan/aboutus.html

This is a project of Yale University that is supported by the Bill and Melinda Gates Foundation's Avahan India AIDS Initiative to conduct research on implementing CLSI among high-risk groups in six Indian states

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Shivananda DG Khan, Naz Foundation International, Lucknow.

You may want to check out Naz Foundation International's website www.nfi.net for a range of resources and NFI's strategy is at http://www.nfi.net/strategy.htm NFI's specific remit is to provide technical assistance to local 'MSM' networks, collectives, groups and community-based organizations towards developing and implementing their own HIV/AIDS prevention, care and support services.

S. Hashim Aadil, PRAGATI, Hyderabad

While surfing I came across this page on an organization called SEWA at http://magnet.undp.org/Docs/dec/monograph/GenderEquity-INDIA.htm which is a fitting answer to your query on CBO and Management capacity. Reproduced below is the text from that web page showing how it has used a multi-pronged strategy of community mobilization, Income Generation and capacity building to achieve Local NGO and CBO strengthening, Gender Equity as well as Poverty reduction.

Region: Asia
Thematic Focus: Local NGO/CBO strengthening, Gender Equity, Poverty reduction
Country: India

Context
The Self - Employed Women's Association (SEWA) was legally registered as a trade union of self-employed women with the support of the nationally recognized Textile Labour Association of Ahmadabad (TLA) in India. Divided into three groups – small-scale sellers, home-based producers, and labourers - the "invisible" women who were brought into SEWA found themselves outside the framework of labour laws and thus benefits (e.g., health insurance, retirement, and pensions). To remedy this problem, hundreds of meetings were organized in Ahmadabad's working class neighbourhoods in order to establish "trade groups" whose leaders provided the link between SEWA and other workers throughout the city. Major issues faced by the workers included: lack of capital, harassment by the police and municipal authorities, and poverty - induced family problems.

Key Factors

Following a three pronged strategy, SEWA has now turned into a major local intermediary organization. The strategy includes the following dimensions:

1. Increasing the women's profile as workers;
2. Raising women's income; and
3. Increasing women's control over assets (income and property).

SEWA is credited with advocacy for self-employed women, mobilizing women entrepreneurs, networking with other organizations, organizing cooperatives, setting up a cooperative bank for women, and other achievements. In a unique approach, SEWA has been able to mix labour unions and cooperatives. In doing so, the organization first forms trade unions among traditionally unorganized women workers and subsequently assists them to set up cooperatives.

SEWA itself is made up of several branches: the Union, the SEWA bank, the Economic Wing, and the Rural Wing. The union is modelled after trade unions where members are grouped by trade or occupation. Leaders that emerge from these groupings are supposed to participate in decision making through a system of committees. However, in reality a fairly "top-down" approach was inherited from the TLA with rest decision making with the president and the general secretary.

In contrast to the union, activities in other SEWA operations are development oriented. The first of these was a credit programme, which began with SEWA serving as an intermediary for national banks. Difficulties experienced in this process resulted in the creation of the SEWA Bank. The Bank mobilized savings, while continuing to function as an intermediary for the nationalized banks for two years. Later, SEWA began disbursing money that the banks deposited in a saving account of the SEWA Bank. Now, SEWA lends out its own funds, because of difficulties with repayments to the banks and also due to its current sufficient resources.

The Economic Wing provides skills training, forming production units, obtaining new materials, and improving marketing skills. The Rural Wing focuses on mobilizing agriculture labourers, including non-farm activities during the off-season months. No longer part of the TLA, SEWA works as an institution representing the women with whom it works.

Main Lessons

Key lessons from this study are:

SEWA was first established as an organization to mobilize forces against discrimination and inequality towards poor and marginalized women was transformed to become a development oriented institutions;

Despite a split from a sponsoring organization, SEWA has been able to maintain its status as a local institution. The specialization nature of SEWA's work has helped this organization remain active, even though it no longer works under the umbrella of its sponsoring institution; and

SEWA's membership fluctuates as economic condition changes. This demonstrates that the organization serves a function in women's economic lives, but that active participation is not always necessary or possible.

This case study is originally written by Norman Uphoff and it appears in his book: Local Institutional Development: An Analytical Sourcebook, (1986), Kumarian Press

Ashok Row Kavi, Humsafar Trust, Mumbai.

This is an account of how difficult it is to build community-based organizations (CBOs). I can only recount, as an example, our struggle as homosexuals to become part of mainstream society

with dignity. From 1985 onwards many of us self-identified homosexuals or same-sex loving men, realized that with large families breaking up, rapid industrialization and urbanization and women's emancipation, many of us would have no place in our society if we did not organize in some way. That's how some of my friends and I started a newsletter called 'Bombay Dost', which was a momentous event in giving a voice to an hitherto invisible community. We were not even sure there was a community of such homosexuals at all in India. But we were over-whelmed by the response of over 800 letters a week at its peak in 1992/93.

It was unfortunate that the HIV epidemic came in at the same time. So not only were we fighting stigma and discrimination but realized that soon we would die in droves as was happening to whole communities of homosexuals in America. It was my first visit to an International AIDS Conference at Montreal in 1989 that frightened me out of my wits. I saw a desperate community fighting for its very life; with over 80 per cent of the HIV infections happening among gay men in the USA, hardly 8 per cent of the funding for HIV preventions was going to gay groups. If that was the condition in the world's most visible and powerful gay community, what chance did we men-having-sex-with-men (MSM) have in India where we were not just invisible but totally scattered and unorganized.

Towards that end, I remember we started meetings in parks, hotels rooms, private homes, small community halls from 1989 onwards. The birth of 'Bombay Dost', a quarterly news magazine, elicited heart-breaking stories: lonely and scared men and women not knowing where to turn for counselling, trapped in unhappy marriages to innocent spouses who had no clue what was happening to them. Many men were already infected by anal and oral STIs, most joined dysfunctional religious groups or tried suicide or ridiculous cures to rid themselves of this unwanted sexuality. It was tough: we started a message service where people would ask for street counselling. We met our clients on railway platforms, near well-lit landmarks so we were not set upon by goondas and police, we tried to talk of condoms near public toilets only to be beaten up by cops and finally realized that a newsletter would never solve a community's problems.

That's how in April 1994, Humsafar Trust was registered. Only three men were willing to sign on the MOU filed with the Charity Commissioner at Bombay. Our first job was to take the subscription list of Bombay Dost and contact 74 men who we thought were peer leaders. In this I have to specially thank the contribution made by Shivananda Khan, a British citizen of Indian descent, in London, for partnering us in the first gay men's conference in India in December 1994. After that conference, five groups of homosexuals quickly formed all over India. Just before that event, an activist lawyer Siddharth Gautam, brought out the first 'situational report' on homosexuality in India. "Less Than Gay', is a classic in its own right, still one of the best compiled and written reports on the subject. He died soon after and is sorely missed.

Humsafar Trust was allotted a space in a municipal bazaar from where it still functions. This decision was by two incredible progressive health officials of the Bombay Municipal Corporation namely Dr. Alka Karande, the then Executive Health Officer and her dynamic deputy Dr. Jairaj Thanekar, the pioneer who set up Asha Prakalpa, the first civic effort to offer exclusive health services to women in prostitution in Mumbai's red-light area of Kamathipura. We again bow down our heads to these two who had also gone into Mumbai's very heartland of teeming slums and immunized 99 per cent of the children against polio which was a miracle in those days. We must mention the strong support and encouragement in those early days from Dr. Prasada Rao and Dr. Alka Gogate who gave us our first pilot project from the Mumbai District AIDS Control Society (MDACS).

Humsafar Trust today offers a wide array of community services. It got Mumbai's first VCCTC within a community based organization, the first STI clinic exclusively for homosexuals,

transgendered and bisexual men, a modest library used by a minimum of three research scholars every week, a drop-in-centre open from noon to 8.30 P.M. on weekdays, help-lines for tele-counseling and rooms for one-on-one counseling for sexually distressed people, a huge city-wide street outreach program spread over 45 beats covering 155 sex sites in the Mumbai Metropolitan Region (MMR) courtesy of MDACS who gave us the first pilot MSM intervention in 1999, health camps at truck spots for transgendered sex workers, the first special drop-in centers and clinics for male sex workers, especially film Xtras and young males trying to make a living in Bollywood and the fashion world, special outreach into virtual networks working through cyber space and internet sex, condom distribution at sex parties and backroom sex, thanks to the Avahan-Aaastha Project.

In many ways, we are proud that we have gone and 'discovered our own', we have formed families and networks with hijra gharanas, we have proudly fought the moral and culture policing groups in the streets over lesbian issues, we have stopped TV shows when we were not heard by conservative stubborn homophobic people, we have talked on college campus, had stalls to draw tattoos and make friends with people who have learnt to appreciate that we too had a right to live in dignity.

In fact last year alone, Humsafar's Outreach Workers (ORWs) have distributed over nine lakh condoms in one-to-one outreach because we like to have daily meetings with our clients to collect feedback and gossip of what's happening where. We have done presentations in temples, and masjids, talking quietly to both pundits on political platforms and with mullahs and imams in their masjids, in that we too want to be blessed by God.

And the people have opened their hearts to us for, however bad they may think we are, we are their sons, brothers, uncles, neighbours. We are everywhere and we intend to be very proud and productive members of this great and ancient land which has never persecuted homosexuals -- ever!! In other words, we will make sure that through our community based organizations we will never let our people be ashamed of us. During the floods last year in Mumbai, our Humsafar boys were given a big pat on the back by the Municipal Health Service because we distributed over 30,000 water purification tablets, got in the young and old for health check-ups in Vakola, took sick people to hospitals and taught the illiterate how to fill in their admission papers in civic hospitals. In fact, Humsafar Trust's linkages with over five public hospitals, especially our linkage with Sion Hospital in North-Central Mumbai is noted as a model public-private initiative by UNICEF and has been documented as such. As hard working citizens of this land we insist that we have a right to health like every other citizen of this country and we shall strive to upgrade what the Government has built up from scratch. And we urge you all; the young and old of every caste, community and creed to do the same. For community based organizations (CBOs) are the only way we can really work with the Government to deliver. Nay CBOs are the very interface between the Community and the Government. We are like the two hands that must come together and do the namaskar for the world outside to know about the achievements of our people.

This effort of forming CBOs is now new at all. Chanakya refers to 'Shrenis" or guilds of various kinds in Mauryan India of 300 BCE to 200 AD approximately. The Arthashastra talks of various community-based groups who built dams, tanks, roads, common pasture lands, community halls through joint efforts called 'visthi'. The Temple at Madurai talks of meetings of villages to mobilize taxes to build tanks and roads. The Sanskrit word 'Sangrama" or battle actually means a meeting of villages for 'San' is meeting and 'Grama' is Village. So, that really meant an argument but then became battle for obvious reasons of conflicting interests of water sharing mostly.

Dr. Santosh Bagali, Bijapur, Karnataka.

Part of the web page of ActionAid at http://www.actionaidindia.org/camp_hiv.htm provides experiences of their work in different states of India with community based organizations which is quoted below:

WORK WITH COMMUNITIES:
Though in its nascent stage the HIV and AIDS thematic has deepened its work to 10 states in India , which has initiated programmes with People Living with HIV and AIDS.

Guwahati: The first region to initiate HIV and AIDS work in India . Supports the Manipur Network of Positive People (MNP+) working towards positive living with its branches in all the nine districts of Manipur. 'Nothing about us...without us' is their slogan. The focus is on home-based care, counseling for positive living, formation of mutual support groups, with thrust on medical needs as well as social issues such as life skill development. Injecting Drug Use is the major cause of HIV in this area where there is a large number of AIDS widows and HIV orphans. Foster Care of orphans within the communities is promoted where 100 positive children are supported through an ActionAid programme here.

Andhra Pradesh: ActionAid supports WINS, a local organization to form collectives of sex workers and positive people. It has led to the formation of Chittoor Network of Positive people to provide support in times of distress to the families of PLWHAs. Alternate livelihood options and legal aid is provided to fight stigma and discrimination faced by women. Support has been mobilized from government hospitals for medical assistance. Positive children and children vulnerable to HIV are a special focus of the programme. WINS provides support to 100 positive children supported by ActionAid Italy .

Tamil Nadu: ActionAid has started working with a positive network (SIPN) with about 1700 positive people from the Hijra community in Tamil Nadu. The focus is on understanding their needs, advocating for free ARVs, treatment and care for PLWHAs. They also work with an initiative for 1600 sex workers and their children in 3 districts where the focus is on advocating for safe sex and creating awareness on the high risk behaviour aspect.

Karnataka: AAI supports MILANA a Family support Network of PLWHAs which works with about 250 +ve women, 100 positive children and their families. ActionAid has also initiated Abhaya- a health initiative of ActionAid Karnataka Projects, a five year focused HIV prevention project with more than 2000 women in Sex work and MSMs in Davangere and Shimoga districts. PLWHA Networks are also being formed both in Davangere and Shimoga districts. The regional office produced the Indian Adapted version of Stepping Stones which was released in December 2004. Stepping Stones is being implemented with PLHAS and Sex workers. The region has put in efforts of integrating HIV and AIDS work within their programmes working on issues of Violence Against Women and in other larger development initiatives.

Maharashtra : SAMVAAD is a resource centre initiated at ActionAid in Mumbai. The centre trains community leaders and CBO functionaries on the Stepping Stones module. The region partners with CYDA, an NGO which has taken SS to 14 districts of Maharashtra which uses it as a powerful behavioural change tool among youths. Maharashtra Association of SS Trainers (MAAST) was established and the Marathi Manual was produced.

Uttar Pradesh: In Lucknow ActionAid is part of the HIV&AIDS Citizen's Forum (formed with joint efforts of few individuals in Lucknow in solidarity with +ve people). ActionAid is also collaborating with the upcoming UP network of positive people whom we are supporting for

community mobilization. They have been successful in removing discriminatory hoardings put up by the state AIDS Prevention Society and UNICEF. Efforts are also onto set up the Allahabad Positive Peoples Network, to do a study on the prevalence of HIV in UP and also to review the IEC materials available and being used in UP to address HIV and AIDS related issues.

West Bengal : The Kolkotta regional office supports the Bhorukha Charitable Trust. The partner organization, Bhalobasa works on three levels: The first level is with the individual, Bhalobasa (a care centre) provides institutional care and support. Second, they work with the family, sensitizing them on how they can support their family member. Thirdly, they work with the community, aiming to create an enabling and caring environment for positive people so that they can remain in their communities and continue to be as productive as possible.

Delhi : In Delhi ActionAid India provides Fellowship to two people from the Delhi Network of Positive People to develop their capacities and form a Network of Positive people.

Gujarat : In Gujarat ActionAid has initiated its work on care by identifying positive people from the Kutch Network of Positive People and Lakshya - a CBO working with MSMs in Baroda for fellowships. They collaborate very closely with the Gujarat SAPS, GNP + and SAHAS- a care and support NGO.

Bhubaneswar : The Bhubaneswar regional office too has identified positive people for fellowships to initiate their work on HIV and AIDS.

Dr. Mohamed Shafi, Gowri Sha Hospital, Thiruvananthapuram

Page 21 and 22 of, Centre for Health and Gender Equity's (CHANGE) Publication: **Risk, Morality, and Blame: A Critical Analysis of Government and U.S. Donor Responses to HIV Infections Among Sex Workers in India**, available at http://www.genderhealth.org/pubs/AminHIVAmongSexWorkersinIndiaJan2004.pdf gives the first steps of how to use a gender and rights-based participatory strategy to build community based organizations of sex workers. An excerpt of the strategy from this publication is appended:

NGO case study: identifying elements of a gender and rights-based approach

This analysis also sought to understand how a gender- and rights-based approach could be implemented in a practical setting by examining the approach of one NGO in Maharashtra that participated in the research. The NGO was formed to respond to the needs of women in prostitution. Starting from an initial focus on improving the lives of sex workers through participatory and peer-driven strategies, the NGO now implements several programs including an advocacy campaign to improve accountability of the primary health system in providing HIV services and an intervention with truckers. The sex worker intervention has a peer education strategy that includes one-to-one counselling, condom distribution, and referrals to health facilities for STI and other health problems. The most distinguishing characteristic of their approach is its emphasis on participatory processes in developing and managing the interventions. The director of the NGO described their approach as the following:

"We are firm believers in the participatory approach. Our approach with the sex workers has been to develop their capacity and make them the primary focus in everything. I insisted that there would only be sex workers for project coordination and as outreach workers. I would rather have the sex workers as outreach workers in their own communities than have outsiders working with the community. In keeping with the principles of our participatory approach, we insisted that the project coordinator and outreach workers be from the community, get paid the same amount, and have the opportunity to be promoted. From the very outset, we decided not to see sex workers as vectors or victims of the disease, but as agents of change. Our aim was not to target

sex workers in order to stop transmission to clients or their spouses. Instead our aim was to get the sex workers to protect themselves and their lives. Their [i.e. sex worker's] needs placed first. Therefore, our approach has worked. Otherwise everyone else's approach has been that sex workers need to be targeted because they are doing the society a favour by protecting their clients from HIV. Here we tell the sex workers to put their life and that of their children first, before anyone else. The other NGOs haven't been able to negotiate spaces and also negotiate with providers, the government, and donors as we have done. From the very outset, I was very clear that prostitution was not a moral issue for me. They are doing work, performing a service like any other person in society. That is why I was able to make the kind of inroads I did into this community. The problem is that sex work is never part of the mainstream, so sex workers are very suspicious of those people who want to work with them. Therefore, when working with the sex workers, you have to first address that. Improving their image and acceptance in the mainstream is important."

As one measure of success of this NGO's unique approach, it has resulted, albeit not without considerable struggles, in the development of a collective—a community of sex workers, leaders, volunteers who have formed a community-based organization (CBO) to run interventions for their own community and represent their interests in various ways including lobbying with the police and helping sex workers access government services. Some of the elements of a gender-sensitive strategy based on this NGO's approach include:

- viewing sex workers as agents of change instead of passive target groups, deviants or victims;
- giving priority to their needs;
- respecting their choice to continue in sex work;
- improving their own image and acceptance into the mainstream;
- facilitating their empowerment to demand rights and justice; and
- building linkages and negotiating with health care providers, government and donors to increase their access to services and prevention methods, and to ensure their safety.

Other lessons learned included the importance of programs to
a) build capacity of sex workers to run their own programs;
b) develop their identities as peer educators; and
c) develop their collective strength in mobilizing to improve their work and living conditions.

Sunil Menon, SAHODARAN, Chennai.

Here are some lines on our experience as a CBO in Chennai for MSM and of the NGOs we had for support.

Many constraints and difficulties both financial and technical were faced during the present term of the project, which lead to SAHODARAN becoming an independent unit from October of 2004. Prior to this its previous collaboration was with the NGO Prakriti. Due to major financial restrictions, FHI/USAID had to stream-line the project activities and staffing to make the project sustainable and feasible to fund, as an interim process, before APAC took over as the main funding agency. APAC had earlier on in the same year, taken over another MSM project in Chennai, namely SWAM.

Originally, SAHODARAN was part of the larger NGO when it came under the funding scheme of FHI/USAID. But after nine months, it became a separate CBO, and started functioning as an

Independent organization with funding through INP+. The group was newly registered and had not till date received its FCRA to be able to receive funding directly. In this phase, the project activities were reduced to Outreach and Drop-in Center based intervention as the funding was considerably reduced due to financial constraints. To keep the CBO running, it was agreed that the funding will continue till APAC took over at a later stage, when the CBO became fully functional as an Independent organization.

Thanks to the support received SAHODARAN was the pioneering MSM CBO in the city of Chennai, with eight years of implementing experience to its credit, in the field of HIV/AIDS and STI prevention. So, it was crucial to continue the services that were being provided to the MSM community since 1998. A disruption in the project would have put to waste, the invaluable services the project team had been offering to the community, in a consistent and systematic way

A big constraint, which is universal to all effective programs doing interventions, is sustained funding. Fortunately, funding was received without a break for just sustaining the basic project activities and hence the community received continued services in the field by the outreach team. However the setback caused by the budget constraint was the streamlining of the existing staff structure that lead to five staff members having to seek work elsewhere. This also increased the work load on the remaining staff and they had to adapt and adjust their job responsibilities from before.

The project had planned a detailed Advocacy approach, within the course of eighteen months, involving Railway Police as well as Health Care providers to sensitize them on the various issues related to MSM. Besides, workshops for the Media and Reporters were also planned during this period, to encourage more sensitive reporting on various issues related to Sexuality and Gender. All this fell through, when the program was downsized to ensure the continuity of the Basic services to the community and to prevent a temporary break. Advocacy work could not be taken up at all as there was no fund allocated for project activities. The only funds available were for salaries and basic amenities. Despite this, media advocacy continued, with the Project Director interacting with the Print Media and was quoted frequently in the press.

Budgetary constraints also prevented any advocacy work with both the Railway Police and the health care providers. Outreach staff sensitized HCPs on their own on an individual basis, whenever they had an opportunity to interact with them, while accompanying a referral. Staff also had to 'make peace' with the RPF on duty, and tried to avoid any confrontation with their personnel to ensure sustained and smooth outreach activities. Health care providers seemed a lot more sensitized to MSM, and this could also be due to the interaction of the staff with the Government and Non-government agencies offering services, over a period of seven years.

The drop-in center could not function continuously, as the project had to shift from its previous office/drop-in center premises where it was residing for the past two years, to a new place nearby. This was due to the cut in the overall budget for Project activities and amenities, to that of the previously received amount and hence the rent allocated was reduced considerably leading to the renting of a newer and smaller space. The drop-ins had to be told of the new place and some of the outreach work had to focus on bringing to notice to the community, the change in the office/drop-in center address. Therefore, for a month or to, drop-in center attendance was very low and at a bare minimum. The facilities at the drop-in center were the same, though the space available was very limited. Slowly but steadily, the drop in center attendees increased, once they got used to the new route to get to the center.

Political issues and constraints were reported sporadically, as MSM were harassed at the cruising sites, and even arrested in some cases. Eleven male sex workers were arrested from the Marina Beach and remanded to an NGO for counselling and 'rehabilitation'.

Yet another issue was overlap and duplication of work at cruising sites allocated to different MSM projects. As both SAHODARAN and SWAM had been carrying out Outreach in seventy-seven sites in the city of Chennai under the FHI/USAID funding scheme for the past seven years, it was suggested that the outreach teams of both the Gates Funded projects of ARM and CHES, work in other areas, outside of theses seventy-seven sites. To some extent, it was resolved through dialogue and a mutual understanding of the respective Outreach teams at the Field level, though efforts by INP+ to bring all the key players and stake-holders to the table, didn't come through. The Drop-in Center faced issues of attendance as the other projects vied in an unhealthy manner to woo MSM into their centers. The Drop-in Centers at the TAI projects gave monetary benefits for the drop-in to come by the center. So as the word spread, more people started going there, though they went by only once. Giving benefits to come to a Drop-in Center will only make it more difficult for the existing older MSM projects to get MSM to come to their centers. What was also questionable was the sexual identity of these males who came to the centers.

Dr. E. M. Sreejit, London school of Hygiene & Tropical Medicine, London, U.K.

You may want to visit http://www.aidsmap.com/en/docs/7B5A3CA3-4785-4EDA-8165-CB434FB5D8BC.asp the aidsmap HIV Worldwide's web page on 'Supporting NGOs and CBOs responding to HIV/AIDS'. This page justifies support to NGOs and CBOs, gives reasons, defines what constitutes support, what are the key lessons learnt as well as who provides NGO/CBO support.

Amrita Bhende, Committed Communities Development Trust (CCDT), Mumbai.

From my own humble experience I can offer this bit of information: one of the programs I head called, 'Dancing Feat', provides support services which include life skills education and counselling for children at risk to HIV. Committed Communities Development Trust (CCDT), the organization I work for, has provided these services to about 1,600 children over a four-year period through thirteen partner NGOs.

We did this program with NGOs with varying backgrounds, some of which didn't and still don't do any separate work related to HIV and AIDS. Getting these NGOs/CBOs onboard at first and then to successfully contribute to the running of the program has been a challenge. Some of the systems I put in place were as follows:

1. Involving the partners as much as possible in the development of work plans and goals.
2. Involving the heads of the organizations in the running of the program like asking them to supervise certain aspects; as well as holding regular meetings with them to determine the direction of the program
3. Putting in systems where those nominated for any training had to immediately conduct similar programs in the organization
4. I have to admit that team-building efforts were sometimes in vain since everyone has their own targets and own organizational pressures but we attempted to foster a spirit of comradeship between every representative, including celebrating birthdays, going for

picnics. I consider this as the single most important aspect that anyone heading a partnership needs to take care of. Making individuals from different organizations feel part of another team.

5. Constantly pointing out the benefits of the program to that organization is the only way to actually get that CBO to give it some priority. Though of course it helps if they actually believe in the program.
6. It also helps if the program has some visibility. If research is part of the process or if the program has some mechanism through which information related to the program can be disseminated. For example, we have a film, a song and our program involves dance, so we also have public performances. This makes partners feel even more that they are part of something important and beneficial to them.
7. A sustainability component should be inbuilt from the beginning of the program and the CBOs should be aware of the expectations.

It has taken us four years after which I can confidently say that certain partners are ready to take on the program themselves. Some have committed themselves financially as well. The emphasis here is on the word 'partner'. If the CBO truly believes they are... in every sense of the term, then they will act like it. The only support that we provide now is technical guidance as and when needed.

The main concern is whether the vision of the program is shared or imposed by all those involved. Hope this helps.

Shyamala Ashok, SFDRT, Pondicherry

Building management capacities of CBO's – our experiences and the Issues with current interventions:

The funding pattern for targeted interventions are not the same for all organizations. For instance SACS does not pay the peer educators among the Communities where their NGO's are the implementing agencies. However, when International donors fund the same program, the peers within the Communities are paid by the respective NGO's. Such disparities between the implementing NGOs due to the difference in who is funding for the same groups, causes a difference in the trust that the Communities have for the NGO. The NGO who does not pay the Community's peer educators are questioned and looked down upon how ever good their field work may be. Some of the community members who are originally part of one implementing NGO subsequently also become part of another, which causes overlaps and accounts for duplication. This is very true of sex workers and truckers. During such situations there are comparisons done once again based on money, depending on which NGO preferences are made, which gives rise to heart burns among NGOs funded by agencies that do not allow payments to peer educators.

One of the ways of rendering capacity to the CBO's over the period is to raise them as volunteers. However, over time this kind of volunteers from the communities, demand money. Then, again the concept of volunteering is totally lost. It is definitely said that education moulds character and therefore communities that we work with like the sex workers and MSM etc. are by and large less educated and with less or no skills. Such persons spend most of their time in sex work and every aspect with the related NGO is seen as an opportunity for a monetary benefit with a false rationalization that the NGO has earned the name and fame by association and experiences contributed from the community.

Well, while the above factors pose as barriers to our efforts in converting mobilization to community participation and collectivism, there is a very important aspect that has been left out and are set backs in the current interventions, that being the mental health status of those whom we mean as communities. Sex Work and MSM is yet another barrier that clashes or confuses. Most of us forget and think that all MSM's are sex workers because of the fact that NACO has MSM as a core group. The word MSM is associated with a moralistic attitude that sex is the pertinent factor of this group. Where as there are people who are biologically made to be a gay and lives with one partner, who are educated and well employed etc.

Also, one thing of importance is for us to understand that our Intelligence Quotient (IQ) has to match our Emotional Quotient (EQ). Only then we will have the know how to convert our skills for our betterment. In case our IQ does not match with the EQ and this may be seen in sex workers or any other marginalized communities, then they not only have a set back on skills but will have a very low self esteem along with characteristics such as depression, anxiety etc. which comes in the way of their daily life. Have we all thought of this factor in our current interventions? Have they been addressed within the current national interventions be it national or international donors working with the sex workers, MSM etc. If there are no consistencies with the head and the heart how would sustainability within programs be worked out? We only add to activities such as giving knowledge on STDs, identifying STDs, treating them etc. This is only a very small component of their entire quality of life, although if left will end up with serious consequences such as HIV infections etc. With these large circumstances such as the "mental health" still unfed into the current scenario of work we are still left with a big, question mark as to "how and are communities mobilized"? Only if there are strong community mobilizations can we then render capacity to them on specific tasks.

Anandi Yuvaraj, India HIV/AIDS Alliance, New Delhi.

The International HIV/AIDS Alliance web page at http://www.aidsalliance.org/sw7442.asp is on Civil society development. The Publications in this section are intended to support the technical and financial capacity of civil society organizations, their ability to network and co-ordinate civil society responses effectively and efficiently, and to create and maintain an enabling policy, legal and institutional environment so that they can be actively and influentially involved in HIV/AIDS responses. The publications include toolkits, lessons learnt reports and studies and policy briefings and papers. Of these, the Publications appended are those relevant to building management capacities of CBOs.

The titles listed below are by date of publication:

1. Tools together now: participatory tools to facilitate mobilizing communities for HIV/AIDS http://www.aidsalliance.org/sw31815.asp
2. CBO/FBO Capacity Analysis: A tool for assessing and building capacities for high quality responses to HIV/AIDS http://www.aidsalliance.org/sw31738.asp
3. CBO/NGO support – The role and added value of NGO-based CBO/NGO support providers in the response to HIV and AIDS in southern and eastern Africa http://www.aidsalliance.org/sw14338.asp
4. NGO capacity analysis – A toolkit for assessing and building capacities for high quality responses to HIV/AIDS http://www.aidsalliance.org/sw7443.asp
5. Participation, Hope, Action – Mobilizing communities to respond to HIV/AIDS http://www.aidsalliance.org/sw7407.asp

6. The involvement of people living with HIV/AIDS in community-based prevention, care and support programs in developing countries – A multi-country diagnostic study http://www.aidsalliance.org/sw8420.asp
7. NGO Support Toolkit version 2.0 – supporting document http://www.aidsalliance.org/sw7447.asp
8. Greater Involvement of PLHA in NGO Service Delivery: Findings from a four-country study http://www.aidsalliance.org/sw8421.asp
9. Participation and Empowerment in HIV/AIDS Programming – Policy briefing No. 2 http://www.aidsalliance.org/sw9754.asp
10. Supporting NGOs and CBOs Responding to HIV/AIDS – Policy briefing No. 1 http://www.aidsalliance.org/sw9758.asp
11. Advocacy in Action – A toolkit to support NGOs and CBOs responding to HIV/AIDS http://www.aidsalliance.org/sw7451.asp
12. Raising funds and mobilizing resources for HIV/AIDS work – A toolkit to support NGOs/CBOs http://www.aidsalliance.org/sw7448.asp
13. The involvement of people living with HIV/AIDS in the delivery of community-based prevention, care and support services in Maharashtra, India – A diagnostic study http://www.aidsalliance.org/sw8494.asp
14. The involvement of people living with HIV/AIDS in the delivery of community-based prevention, care and support services in Zambia – A diagnostic study http://www.aidsalliance.org/sw8501.asp
15. A Facilitator's guide to participatory workshops with NGOs/CBOs responding to HIV/AIDS http://www.aidsalliance.org/sw7455.asp
16. The Involvement of People Living with HIV/AIDS in the Society of Friends of Sassoon Hospitals (SOFOSH), Maharashtra, India: Diagnostic study on the involvement of PLHA in the delivery of community-based prevention, care and support services http://www.aidsalliance.org/sw8495.asp
17. The Involvement of PLHA in the Maharashtra Network for Positive People (MNP+), Maharashtra, India: Diagnostic study on the involvement of PLHA in the delivery of community-based prevention, care and support services http://www.aidsalliance.org/sw8497.asp
18. The involvement of PLHA in the Project Child of Committed Communities Development Trust (CCDT), Maharashtra, India – Diagnostic study on the involvement of PLHA in the delivery of community-based prevention, care and support services http://www.aidsalliance.org/sw8499.asp
19. The Involvement of PLHA in the Salvation Army Mumbai HIV/AIDS Community Development Programme, Maharashtra, India – Summary of Findings: Diagnostic study on the involvement of PLHA in the delivery of community-based prevention, care and support services http://www.aidsalliance.org/sw8496.asp
20. Documenting and communicating HIV/AIDS Work – A toolkit to support NGOs/CBOs http://www.aidsalliance.org/sw7458.asp
21. Expanding community action on HIV/AIDS – NGO/CBO strategies for scaling up http://www.aidsalliance.org/sw8366.asp
22. Building Partnerships: Sustaining and expanding community action on HIV/AIDS http://www.aidsalliance.org/sw8415.asp
23. Positive, Engaged, Involved – The participation of people living with HIV/AIDS (PLHA) in community-based organizations http://www.aidsalliance.org/sw8423.asp
24. Pathways to Partnerships – A toolkit to support NGOs/CBOs responding to HIV/AIDS http://www.aidsalliance.org/sw7461.asp

Sandeep Kumar, UHRC- Indore.

UHRC the Urban Health Resource Centre, previously known as EHP, is working for last four years on Urban Health issues at different levels with field sites in different cities. One of the core areas where we have focused in implementing programs is strengthening the Management capacity of CBOs of slums to take up bigger challenges. Although the Program is broad-based and is focusing on RCH issues and not directly to HIV and AIDS, yet it has been instrumental in giving a wide range of learning which have been properly documented. You can visit our Webpage http://www.uhrc.in/module-ContentExpress-display-ceid-4.html to get a glimpse of the Multi-stakeholder Urban Health Program in Indore, with sections on the three-tier NGO-CBO Partnership Model, the Ward Coordination Model, as well as the Lessons Learned. You are most welcome to Indore to learn more on field.

P. N. Vasanti, Centre for Media Studies (CMS), New Delhi.

Here is a brief of our experience on capacity building with CBOs and NGOs:

During the last few years we have had the experience of interaction and orientation with almost 500 CBOs and NGOs as civil society groups working on different aspects of health, mostly HIV, from among specific pockets and specific groups or communities in and around Delhi. This was in a particular capacity building program conducted in collaboration with the Population Foundation of India (PFI) and our Centre for Media Studies (CMS) Academy. This capacity building was specifically on Behavior change Communication and Management. In our initial discussions and formative study we found many request for specific management issues including fund raising, proposal writing, hiring and retaining staff, etc. Based on this, we prepared dynamic short modules for different levels like:

FINANCIAL MANAGEMENT
for Accounts Officers and Accounts Managers
FCRA, Deduction of Tax at Source, TDS returns (Specific to NGOs), Financial Policies, procedures and systems

PROJECT MANAGEMENT
for Project/Program Managers/Officers & Coordinators
Identification and design of Projects, Project Planning, Project Proposal, Team building, Project Implementation, Project Control & Monitoring, Project Closing

HUMAN RESOURCE MANAGEMENT
for HR professional/Project/Program Managers/Officers & Coordinators
HRM Overview, Performance Management, Hiring & Retaining staff, Employee Relation, Succession Planning, Formal Appraisal & Counseling, Compensation Management, Training, Organizational Culture, Leadership, Building Moral, Human Resource System

EFFECTIVE COMMUNICATION SKILLS
for Middle Level Program Managers/Officers
Faster & Effective Reading, Effective Written Communication, Effective Business Presentation, Effective Listening

MEDIA HANDLING
for Program Officers/Public Relation Officers/Personnel in Media Division

Media Management, Press information, Understanding media Pattern outcome, Media selection, Different forms of media (print, audio visual), Trends (media handling), Identify audience, selecting messages, Cultivating relationship

All of these were dynamic in the sense we knew who all were coming in advance for a particular module and prepared to suit their needs and answer their questions. The response to our pilot was tremendous. Over the three years we managed to cover once 643 professionals at various levels by having small groups (max 25 min 10) interactions. Field level professionals in such organization hardly get any exposure or capacity enhancement opportunities. They are the contact points and yet the efforts and resources spent on them are the least. Therefore, learning from our experience was to focus on these front line workers and yet keep the overall management and organization in perspective and in the same line of thinking.

With so much happening and new concepts and tools available today, these need to be continuously shared with these professionals for behaviours change to be possible while managing their projects effectively. But such programs need to be sustainable and dynamic. For middle and senior professionals, strategies for capacity enhancement are also critical for effective program management and organizational development. Interestingly even in Delhi, we saw how organizations were working in isolated pockets with no interactions and exchange of learning, solutions or resources even with other organizations in the same community. One outcome, which emerged from our experience, is a common platform for regular interaction and exchange of information and experience.

Seema Kurup, Media Matters, Ambernath, Maharashtra.

Vibha's query and the many responses to it have brought in a whole lot of information. Thanks everyone for the same. Was enthralled by what Ashok wrote in about Humsafar. The organization has progressively moved on with support and non-support, to stand on its own. Also noteworthy is the fact that the trust has built a support mechanism which extends beyond its "own" community. Am sure we draw lots of inspiration from the work.

This entire dialogue also triggers off a whole lot of questions for me. Kindly permit me to do some loud thinking as I try to place the questions that concern me a development worker.

In a recent visit, we had the opportunity to interact with a community of truckers in an urban setting. Being a highly mobile population, it is a truly challenging task to mobilize truckers into groups. The local NGO works hard day, night and overtime to get them organized. They have met with a lot of success it seems. At a cultural program organized by the NGO for the community, truckers not only showed up in hundreds, but also participated actively in making the program a "success". However, this enthusiasm is not reflected in the smaller group meetings that the NGO convenes regularly. So, it is then said that a particular weekly meeting of a "potential" CBO did not happen, because "enough" number of people were not present. Enough to create a CBO which will go on to take over the intervention on lowering risky behavior among truckers. Around five-six truckers had attended the meeting.

My question is, how does one define a community group? If there are group of say five truckers who average their meeting time to about twice a month at a common space, if they have common issues to discuss and sort out, if they respond to any one particular situation as a group --- is this a community group? As I understand, many of us would scoff at the number. Five is too small. Too small to make a "difference", as I am told by many discerning people - not from the

community. What I would like to understand is: Small, according to whom? For what? What is this "difference" that we are talking about? Who defines what should be the ideal number of a community based group and the "difference" that they should be bringing about? Perhaps five is too small a number for us to put into our compiled monthly, quarterly and annual reports! But for the community, especially for a highly mobile community like the truckers, isn't five a great number to begin with and carry on for a couple of months?

For truckers, a small group of five can be an ideal group to being work on a common agenda and sustain it too. But it is when we intervene with our projects on forming groups, committees, getting people organized, that the entire issue of numbers creeps in. "Scaling up" becomes the priority, work should be "seen" is the prime concern. Which is a great approach, I think. Only if we remember not to skip processes. To give an example of what I mean to say: in a week so and so outreach worker HAS to reach out to a decided number of the community. (Decided by who??!!) In order to complete the "target" the outreach worker rushes through his/her work / job. Also s/he has certain records to fill and show. The project coordinator then turns this array of numbers into a qualitative analytical study / report / document which is then sent to the organization heads or the funding agencies as a representative of the work done so far. Of the many such reports / documents one gets to read, most are well written, well presented, and much admired. If collated with a graphical representation, a table or two, some pie-charts and photographs it becomes a truly amazing document. Also adding to the "usefulness" of this document is a case study or two of "success stories".

While this process is truly remarkable in the way it gathers data from the field, it also throws up some interesting questions for us to consider. Who reads this report? What are the outcomes of this report? Who brings about the "change" as inspired by this report? Is there a sharing of these kind of reports with the community? Does the community even know that such reports are made, sent and shared with people elsewhere? What is their say, their contribution in this? If a community group exists, what is the group's contribution to it? Does the qualitative and quantitative information hold any good with the very community it talks about? Tell me, if we say that around 1000 truckers were reached out in a month, by a staff of three and they all now know about risky behaviour, and that they have agreed to use the condom, and that around 1000 condoms have been distributed…. How does one relate the data to the desired change? Is distribution of 1000 condoms = 1000 protected sexual encounters? I may listen to you, accept a condom from you, but you will never know if I have used it or not! How does one measure up to this challenge of the number phenomena that we have created ourselves?

What if the stress on the outreach at the grassroots is to BUILD people as communicators, even as they learn to adopt safe behaviors themselves? What if my outreach worker spends time to build trust, rapport and understanding of a group of five truckers who go on to build trust, rapport and understanding of others …? What if we put numbers to rest for a while? Will we not open up a whole lot of opportunities for interaction with communities if we re-look at our grouping criteria and say: "five is a group"?

Dr. Sonal Zaveri, Mumbai.

Initiating, strengthening, sustaining CBOs is a complex and painstaking effort but absolutely doable. Although I am currently involved with HIV and AIDS issues, as a social worker, I have worked with community development organizations in health, water, sanitation, education and poverty alleviation - the classical 'development' issues - for over two decades.

Most of the CBOs that we helped form began as groups of youth or women or men who had come together on an issue - either mahila mandals, credit groups, habitat groups and others. What helps tremendously in the early stages is a lot of capacity building on simple but essential areas - how to form and manage groups, hold meetings, form committees, appoint office bearers, roles of members, keep accounts, manage tenders, how to prepare rules and byelaws, organize events and other such activities which were relevant to the objectives of the organization. Such training and handholding was organized prior to registration. Getting CBOs registered was usually a milestone. In some cases, dormant or existing CBOs were also involved but all went through a process of capacity building and reformation. Most CBOs after registration do go through ups and downs and NGOs need to be prepared to provide support, which includes continued capacity building, monitoring and other technical support. Some common problems are - a few take on all leadership positions, group conflict, lack of interest, problems in procuring work/managing/ or whatever the CBO was formed to do. Once some money enters the kitty, other problems may emerge in managing funds - in places where we had more than 50-100 CBOs we introduced a system of internal audit. As CBOs matured we also put in a grading system. CBOs got a 'A', 'B' or C grade according to criteria which were shared with CBOs - this helped to direct our efforts towards selective strengthening. In some cases, CBOs even after a great deal of support over a long period of time were not able to make the necessary changes, in which case some difficult decisions had to be taken.

When CBOs are formed as a policy of NGOs towards sustainability, both NGOs and CBOs understand that the support from NGOs will decrease gradually. As Phase-out began in certain communities, we also helped CBOs dialogue with government, local charitable organizations - like in sustaining health centers. In order to manage the funds that were being generated in CBOs through community contributions, we also set up a revolving fund. The members of this revolving fund included the managing NGO (donor to the CBO), as well as CBO representative and other trusted community leaders. Again this hand holding was done to ensure that transparency and honesty in managing affairs could be streamlined. The handover to the community took several years but was definitely carried out. It is also useful to help CBOs form a federation - this helps them in lobbying on issues and also is a self regulatory mechanism. It is also helpful to associate CBOs with available relevant legal entities such as registering with credit cooperatives and other such bodies - in this way, they are mainstreamed and follow guidelines and regulations.

A word of caution - our funding cycles were longer - 5 years at a time and this did not put the pressure to artificially create, strengthen and sustain CBOs. India has a rich history in the CBO movement but as much of the experiences lie outside the HIV and AIDS realm, it would be useful to dialogue with other sectors.

Tarit Chakraborty Bengal Network for PLHIV (BNP+), Kolkata.

I want to share our experience on forming our CBO, named Bengal Network for People Living With HIV (PLHIV). I think from this story you can easily understand how we faced challenges and how we overcame it.

Up to 2004, PLHIV were dispersed and not organized and they could not get them together in one group. On 26th August 2004, seven infected people formed a common platform in collaboration with INP+ to bring HIV positive people in West Bengal under one umbrella – named Bengal Network for People Living With HIV (BNP+). At that time, BNP+ was dependent upon Kolkata Network of HIV Positive, which was the only one district level network in Kolkata at that time for manpower and financial support. Those days the organizational activities were run by

donation, coupon collection, honorarium got from training programs, membership fees, sold ticket from cultural programs and other such collections. Initially, members of BNP+ was from Kolkata only because of lack of social recognition and acceptance of other NGOs working on HIV and AIDS in the state districts.

In the month of January 2005, BNP+ stepped into the districts and formed the district level network in Howrah with the formation of the Howrah Network for People Living with HIV (HNP+). Soon, South 24 Pgs Network for People Living with HIV (SNP+), North 24 Pgs Network for People Living with HIV (NNP+) and the Network of Hoogly for People Living with HIV (NHP+) were formed. The PLHIV members from the districts were automatically listed as members of BNP+ and thus BNP+ became strong in the number of positive networks it had spawned and so its recognition spread in West Bengal.

VSO (Voluntary Services Overseas) sent Volunteers from foreign countries to guide BNP+. Need assessment survey had been done on PLHIV of North Bengal, East & West Midnapore, Nadia and Burdwan to assess needs of HIV positive people under supervision of West Bengal State AIDS Prevention and Control Society (WBSAP&CS).

Lastly on the basis of recognition and manpower, UNICEF funded a Care and Prevention synergy program to BNP+ for the districts Birbhum, Purulia and Murshidabad.

At present, BNP+ has come a long way and is able to get acceptance, respect and recognition from the society. It independently runs the activities. In future, BNP+ hopes to enhance the area of its work for improvement of life of PLHIV in West Bengal. BNP+ is what it is today thanks to the technical and financial help arranged by WBSAP&CS and INP+. No doubt this helped us very much. Especially Mr. Abraham, the President of INP+ and Mr. Suresh Kumar, the Project Director of WBSAP&CS were instrumental in foreseeing our difficulties. On behalf of BNP+ thanks to both of you.

Kaveesher Krishnan, SAATHII, Hyderabad.

Community based Organizations has been a recent buzz word in most community mobilization initiatives specifically among vulnerable sections through NGOs. It has been a trend since early eighties in community development programmes with sections like women, farmers, persons with disability, tribal groups, users groups of natural resources like water, soil conservation groups etc. The challenge in building and strengthening these organizations is not of fulfilling quantitative measure indicators, rather in terms of processes undertaken and impact made.

Empowerment of a development initiative is better spelt when the community themselves build ownership of the programme component and is enabled to deliver organizational tasks. Also, empowering a community like that of truck drivers through the formation of an organization shouldn't be a hastily taken decision. For any organization to build capacity and entrust the responsibility to its primary stakeholders and then phase out, requires adherence to certain cautiously built up steps (kindly refer to Friar, Paulo; Pedagogy of the Oppressed; 1970). Group formation and strengthening process need to be given adequate pace otherwise would result in a state of unbearable crisis.

Enhancing active participation of the community in the development cycle is also a pre-requisite to ensure empowerment. It shouldn't be the NGO representatives who periodically get invitations for meetings who have a bearing upon the community. Even in such circumstances the

communication shouldn't be in the language that is alien to them. This tends to ensure a more effective and more need-based programmes. Different NGOs need to be coordinated based on their common vision to their efforts and persuaded to think more strategically on their long-term goals. There is need for a common platform between similar NGOs, elected representatives and government to agree, share and meet the common objectives.

In the CBOs if run by the stakeholders themselves, the administrative and management roles should be delegated to all. The members' role shouldn't be confined to mere participation in the meetings, mass gatherings, meeting people or visiting agencies. These hardly secure any space that enhances skills in management and coordination in the organization.

Ashok Row Kavi, Humsafar Trust, Mumbai.

I have been waiting for well over a week to read an answer to complement my first posting on how CBOs identify their problems and then work around issues with different gate-keepers, mentors and Funding Agencies functioning in different capacities.

Now I shall write how these inherent energies, once identified, can be encouraged and enhanced by different players. For this I have taken many inputs from my staff, among them is our CEO Vivek Anand, our HOD Counseling Pretti Prabhughade and our Program Coordinator Ernest Noronha along with our other admin staff. This has taken some time and I'm going to make this as brief yet informative as possible.

Once a CBO/NGO has identified issues and problems around which it starts working, a totally different paradigm comes into play. Now it is no more just a community based organization (CBO) or NGO, for it has to start learning corporate methodologies by dissection of its various functional components to become a successful delivery agent.

This is what happened to the Humsafar Trust in 2000 as a new millennium dawned. We tried to prepare ourselves by organizing a consultation with 32 sexual minority groups across India. A modest report describes how difficult the path was going to be. Anybody wishing to read it can ask for 'Looking into the Next Millennium – How Can Sexual Minorities Face the Future in India'. This report first looked at the inherent strengths and weakness of the LGBT movement in India. It was funded by a host of private donations from our foreign "family" like Richard Winger and Joseph McCormack in the USA to SIDA, MDACS, DFID and others. It became our guidebook to go ahead bravely into the future.

In that year something momentous happened. Knowing how we were sitting on the cusp of a crisis, FHI stepped in with USAID-IMPACT with an intensive assessment initiated by Bethanne Moskov, the then head of USAID in India. I still remember Bethanne visiting sex sites along with us and shaking her head anxiously asking: "When can you get this off the ground?" This multi-faceted woman is a huge (literally) bundle of energy and I saw her working at close quarters in the establishment of Avert Society, the USAID arm in Maharashtra.

But I would be failing in my duty if I did not explain the amazing way that Family Health International (FHI) went about identifying our inherent strengths, building them up and turning even our weaknesses into our future strengths. It was FHI which decided that the two TIs (2,000) that had been awarded by MDACS-NACO were just not enough to reflect any kind of evidence-based behaviors change within the MSM sector in India. What this means is that if there is an estimated population at high risk or high-risk group (HRG) of X in a certain locale, it is no use just giving one or two TIs if that does not cover even 10 per cent of the X estimated HRG.

If anybody would like to read more about the history of the emerging sexual minorities in India, I recommend Ruth Vanitha and Saleem Kidwai's "Same Sex Love in India – Readings from History and Literature" to see how effervescent and culturally energetic India's homosexuals have been throughout Indian history.

The first step USAID-FHI, under its IMPACT program, took was up-scaling the MSM project in Mumbai metro to 14 TIs, a quantum jump as it were. Simultaneously MDACS-NACO not only gave us an STI clinic but also embedded a VCCTC within it. This would dock the expanded outreach program to feed our clinic/VCCTC and also link up the public health system through our understanding with the LTMG Sion Teaching Hospital.

We are indebted to Dr. Hemangi Jerajani, HOD, Skin and Dermatology, LTMG Hospital who sent in the first MD interns to understand the issues faced by homosexuals and MSM. We also realized that many MSM would not feel comfortable coming to an openly identified homosexual space and for those MSM who did not wish to come to our VCCTC/STI clinic could utilize our services at the LTMG hospital in Sion. Today we have 6 such referral centers in Mumbai and two in Thane District. The public private partnerships with these hospitals started working effectively when Humsafar Trust posted their health workers and Counsellors in their referral linkages and a two way partnership began.

To bring things on an even kneel, FHI brought in the low profile hard task-master Sharad Malhotra, the present finance Director of FHI in the Delhi head office. He whipped us into shape by teaching us hands-on financial management from scratch. I still shudder at his sharp remarks on the one major weakness of CBOs – our lack of financial management skills.

Ms. Kathleen Kay, the Country Director of FHI India sent in an international evaluation team of epidemiologists, scientists, finance guys along with an Indian expert, who have all become dear friends and well wishers today. What they taught us in capacity building is still irreplaceable. – a CBO must build upon its own strengths and make a general effort to turn its weaknesses around by looking inwards and training its own, even if took a long time. I still remember Lou Macullum telling us: "Look guys, it's for you to set up your systems yourself. Don't expect to be spoon-fed like babies all the time". That led us to set up our own MIS which is till today our greatest strength and has made Humsafar Trust a highly documented NGO.

The ruthless way Dr. Chris dissected our clinical process and methods are still in writing, whereas Senthil, a dear friend and critic even whacked our outreach into a working army today. Thus comforting without compromise was what we got, sympathy with support, mentoring with methodologies were Ms. Kay's contribution that helped us in identifying first our weaknesses, converting them through concerted action into our strengths.

In early 2002, the entire team of Humsafar Trust brainstormed for three days and deconstructed our entire work into 11 components like Community work, Outreach and Condom Distribution, STI Services and HIV testing facility, Care and Support, Advocacy, Networking, BCC strategy (IEC development and Distribution) Research, Training and Project Management. These components were thoroughly reviewed and set of indicators (around 100) were split into 15 formats and MIS using excel sheets were developed. Each component was tackled through a concerted effort from within the organization itself. Outside help was discouraged. Today our recruitment policies, even our behaviour change strategy and our human resource policy was pushed into place by our CEO Vivek Anand

Also, it was in the second phase of the programme that we learnt how to sharpen our vision and get back to goal oriented programmatic planning. What started as a haphazard condom

distribution program in the early 1990s become a sophisticated social marketing instrument and daily outreach forms, describing in detail how a 'initial contact' became a 'client' and how that 'client' would be tracked to a clinic to be followed up, became Humsafar Trust constructs and specialties which we have now taught to numerous others..

In the second phase of the USAID-FHI-IMPACT a whole care and support program evolved (that was not there in our initial proposals) even as the pool of MSM we reached out to returned through the clinic as HIV+ and sick men needing treatment for OIs and help in hospital settings. Today the Humsafar Trust is well equipped not only to back its positive person's group "Safe Sailors Club" but has accessed the government rollout of ART and is dovetailed into the layered paid treatment program of the Global Fund.

Wherever USAID-FHI-IMPACT could not possibly fund us, like in buying STI drugs, condoms etc we were supported by MDACS. Thus our Condoms, STI drugs, HIV test kits came from MDACS-NACO whereas USAID-FHI- IMPACT money paid for the doctors, additional Lab Technicians and consumables offering our clients a holistic treatment program. The Humsafar Trust VCCTC / STI clinic is an example of collaborative efforts of MDACS and USAID–FHI, three agencies. Today Humsafar Trust has trained more than two dozen doctors in medical issues around MSM.

Our own IEC materials, pre-testing the print material and bringing out high quality behavior change material is something we have now got slightly addicted to and will sorely miss as the IMPACT program comes to an end this year.

My advice to all CBOs and NGOs is not only do you need to strive to stand on your feet but you have to manage support of the right Funding Agencies and mentors to hold your hand at the right time. I would like to personally say a big thank you to Bethanne Moskov and Meri Sennit and their team in USAID, Kathleen Kay and her team in FHI, Dr. J.V.R Prasad Rao, Dr. P.L. Joshi, Ms. Meenakshi Dutta Ghosh, Dr. Qureshi, Sadhana Rout and the present PD of NACO, Sujatha Rao, the PD and the entire team of Goa SACS, PD Dr. Sapatnekar, Add PD Koliwad and the entire team of Avert Society, Mr. Ashok Alexander and his team at BMGF, the Maharashtra Director Dr. Sanjeev Singh Gaekwad and the entire team of FHI Mumbai, the team at FPAI Mumbai and finally our first mentor, the ex PD of MDACS Dr. Alka Gogate and the current PD Ms. Nirupa Borgess. We also take this opportunity to thank every person who helped us during our journey and whom we may not mention this on an everyday basis but would like to convey to them that we are what we are because of them and their unflinching support.

Lastly it's very strange but worth mentioning that the greatest friends of us hapless male homosexuals, infected hugely by STIs and HIV – nowhere are prevalence rates below the critical five per cent – dying by the drove, silently, the wives and female partners of MSM who are themselves hopelessly unaware of their partners sexuality, our greatest friends have been women! Whatever would we do without them?

Dr. Alka Gogate, Erstwhile Project Director, MDACS, Mumbai.

This is Alka Gogate and its nice to know that our first MSM project has come to this stage. I must admit that when we decided to give one Targeted Intervention (TI) unit to Humsafar many were uncomfortable as at that time as MSM was not considered to be group for TI. However we were encouraged by Mr. Prasad Rao the then Project Director of NACO. Not only that but our unconventional idea then of setting up a VCCTC and STI clinic outside the Hospital has now worked well.

At the same time we need to appreciate the tireless efforts taken by Ashok Row Kavi and his team, who were always willing to do some new things. They were one of our NGOs who decided to find out baselines for condom usage, hotspots, the mapping for the numbers etc. So, when we at MDACS floated the idea of having evaluation on an yearly basis they were the only NGO in the first year to undergo an evaluation. So, if the self help group wants to become CBO, and CBO wishes to become an NGO and in the end have a self supporting unit, you can do so, if there is a will. The will to change and accept the challenges of the world where the only permanent thing is CHANGE. There is never a dearth for Donors nor the support you need, but one has to take up the challenge to work for the community.

Xavier Raj, SERC, Synovate Ltd.,

Reading Ashok Row Kavi's email brought back memories of our association with FHI, USAID, and DFID. Though we are not in the same league of Hamsafar, credit for discovering Social and Environmental Research Centre (SERC) goes to these three agencies, especially FHI. Individuals in these organizations Tobi Saidel, Sharad Malhotra, Barbara Franklin, Thomas Philip, Vergese Thekkan, J.K. Basu of FHI, with support from Vathani and Bethanne Moskov of USAID shaped our capabilities during the initial years. Even our recent assignment with FHI (Kathleen Kay, Rajiv Dua, Rajat Adhikari and of course Sharad, who walked into our Mumbai Office to meet the team and accounts) was a learning ground for us. Many of the NGOs / CBOs supported by FHI / PMUs of DFID would vouch for this. Many NGOs / CBOs in Tamil Nadu owe their capabilities and strengths to APAC. This must be true of NGOs / CBOs support through SACS, BMGF or OXFAM. Dr. Suresh Kumar in West Bengal has been pursuing the path of building the capacities of NGOs and through them CBOs. He definitely has reduced external dependence for M & E, if not completely eliminated it. Similar examples could be found in Andhra Pradesh as well. I am limited by my exposure, therefore, other states also must have their best practices in this area.

There are also other examples of building capacities of NGOs and CBOs. Community based care and support programme implemented by HIV/AIDS Alliance International through lead partners in India has come up with effective system and procedures for building capacities of CBOs. I personally had an opportunity to study closely PWDS – Alliance project in Tamil Nadu, which has been quite effective in building management capacities of CBOs and NGOs.

So, as it may appear, these agencies pursue the path of building management and technical capabilities of organizations – private, NGOs or CBOs. All these individuals practice capacity building of organizations, in their own way. They have been doing this in a variety of settings and with organizations of varying capabilities and capacities. If we can get all these individuals from these various organizations in one place to deliberate on building management capacities of CBOs, we definitely could up with a workable framework.

One example, which is relevant for TCIF is the TI for truck drivers implemented by Lepra India in Andhra Pradesh. Transport owners / brokers at halt points were mobilized over a period of time to be the peer educators. Lepra India helped these transport owners / brokers to form their own CBO. How did Lepra India team go about mobilizing these brokers / owners, build their capacity, and come up with an exit plan would be useful to look at.

Inputs and handholding from supporting agencies are essential, so are CBOs' initiative and drive to acquire new skills. Experience so far suggest that community led CBOs or NGOs working towards their rights have been able to acquire the skills and build their capacities quickly (Hamsafar Trust). A rights based approach provides space for participation of marginalized

individuals, share information, develop appropriate systems, institutionalization of process within the group and network for solidarity. Networking, especially in the case of community led CBOs, at the community level offers a stability for focusing on building capacities. Being part of a network of CBOs supported by an agency in a geographically contiguous areas also known to contribute to effective capacity building. A sensitized and visionary team in a CBO firms up the commitment and quickens the pace.

Perhaps, we are looking at a continuum of Local Response (LR), CBOs, Federations and NGOs. Degree of expertise required, therefore management capabilities, may vary across this continuum. It would be useful to keep procedures simple and appropriate. Much of this could be learnt by doing. This would mean handholding support. This should be complemented by well conceived materials that could be accessed and used. Balance between internal capabilities and external support or control is desirable.

A World Bank report documents some of the valuable Experience in Scaling Up Support to Local Response in Multi-Country AIDS Programs (MAP) in Africa. This report has been prepared by Jean Delion, Pia Peters, Ann Klofkorn Bloome.

There are also other examples such as Actionaid, Poorest District Area Programme, Self Help Groups (in some instances) and Micro-enterprises, where in CBOs have managed to acquire management capabilities. The difference could lie in the fact that common unifying factor is external to the individual and non-stigmatizing. However, many of these CBOs have successfully challenged structural blockages, such as lack of skills, access to macro-institutions and access to credits as well as some forms of discrimination.

UNICEF is currently documenting programmes for working with young people in vulnerable communities. This also provides some insights in how to build capacities of individuals and groups.

Positive people's networks, especially the growth of District Level Networks, are also good case studies for understanding capacity building of CBOs.

Many thanks to all who contributed to this query!

*If you have further information to share on this topic, please send it to Solution Exchange for the AIDS Community in India at aids-se@solutionexchange-un.net.in with the subject heading '**Query: Building management capacities of CBOs, from TCIF, (Comparative Experiences)***