MEETING MINUTES

Fifth CCM Steering Committee Meeting
Project DIVA (Diversity in Action)
Global Fund Round 9 South Asia HIV Programme (MSA-910-G01-H)

Dusit Thani Hotel
Bangkok, Thailand
June 6 – 7, 2013

DAY 1: JUNE 6, 2013

2 – 3 P.M. session

Thirty-five participants from South Asian Global Fund Country Coordinating Mechanisms (CCM), the United Nations Development Programme, Asia-Pacific Regional Center (UNDP-APRC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), Population Services International (PSI) Nepal, Project DIVA (Diversity in Action) country partners, and other invitees attended the 5th CCM Steering Committee (SC) meeting in Bangkok, Thailand on 6-7 June 6 2013.

Edmund Settle, Policy Advisor (HIV, Health and Development), UNDP APRC, started the session by discussing the second round Project DIVA proposal that was re-submitted by UNDP to the Global Fund to Fight AIDS, TB and Malaria (GFATM) on April 15, 2013. In December 2012, the South Asia CCM SC took the decision to recommend the role of Principal Recipient (PR) to UNDP APRC, following the announcement that PSI, the Nepal-based PR of the Grant had opted out of the implementation of Phase II. UNDP communicated to the CCM SC its availability and interest in taking on this interim PR role. The GFATM stated it had no objection to UNDP APRC submitting the Request for Renewal as the proposed PR for Phase II, subject to the satisfactory outcome of the Phase II assessment. In view of UNDP's global experience on implementing GFATM grants; regional experience on HIV, Human Rights Governance and Sexual Diversity; its partnerships with regional governments, multilateral institutions and civil society organizations; and its capacity building know-how, the CCM SC had recommended that UNDP submit the Request for Renewal as the potential PR for Phase II. UNDP is cautiously optimistic that GFATM will approve the proposal and that UNDP will takeover as the PR for Phase II starting in July 2013.

UNDP thanked sub-recipients (SR) and PSI Nepal for helping UNDP re-conceptualize and re-submit the Phase II proposal with significant budget savings.

The major changes in Phase II are that there will be a greater effort to engage the local health sector in addressing issues related to discrimination. Discriminatory practices at health services continues to be a barrier to healthcare access for gay men and other men who have sex with men (MSM) and transgender people (TG). The World Health Organization and EPRO have developed a training package tested in five countries with 200+ healthcare providers that will be deployed in this effort.

All sub-recipients have been re-assessed prior to Phase II, with only the Pakistan SR remaining to be assessed in June 2013. Qasim Iqbal of Naz Male Health Alliance (NMHA) of Pakistan will present on Day 2 on the importance of service delivery for DIVA. Imran of Pakistan was specially recognized for recommending UNDP APRC as the Phase II principal recipient to GFATM.

Rajiv Dua, Regional Program Director (Project DIVA), PSI Nepal, shared the progress report, key accomplishments, and major activities of Project DIVA in Phase I, until the end of the no cost extension (NCE) period in June 2013. He also touched on the activities that PSI Nepal would undertake during the Phase I closeout period of July-September 2013. Rajiv paid tribute to the recently deceased Shivananda Khan whom he credited with being the person who crafted Project DIVA.

PSI discussed the highlights of Phase I till December 2012. The levels of achievement ranged from 0% to 133% for the top ten indicators. Two indicators in which achievement was 0% was because of lack of action on the part of Naz Foundation International (NFI), which withdrew from Phase I. The withdrawal of the India and Sri Lanka SRs from Phase I also accounted for the non-achievement or low achievement in several indicators.

PSI said that its grant rating till the two years ending December 2012 had fallen to B1 due to management issues while the programmatic rating had remained the same. Of the individual SRs, it was noted that Bandhu Social Welfare Society (Bangladesh) has an A1 rating, Blue Diamond Society (Nepal) had an A2 rating, NMHA (Pakistan) and Bhutan had B1 ratings, while Afghanistan had a B2 rating.

Regarding the delays in providing condoms and lube to SRs, PSI accepted there have been issues around procurement and with stock-outs of HIV test kits. PSI shared that condoms and lube donated by USAID not counted earlier in programme achievement due to insistence that USAID provide quality assurance letters for supplies will also be counted now as the certification letters had been received from USAID.

A major challenge PSI had to deal with was the constant struggle with the Local Fund Agent (LFA). Issues in which the LFA caused problems were faulty calculations, tendency to remove committed amounts off the cash balance (instead of amounts actually spent), and reduction in planned on-site supervision visits designed to support SRs. Other challenges were the failure of some SRs to follow systems and processes, an example being that of Companions on a Journey (CoJ) of Sri Lanka. In terms of lessons learned, PSI advised those present that the use of fund balance for other, non-DIVA related costs should be strictly avoided as the GFATM shows no flexibility ('no mercy') on this issue.

On the NCE and closeout, PSI reported that once the NCE period ends on June 30, there will be a four month close out period until October 31, 2013 during which PSI Nepal will assist SRs and partners as required and conduct audits of all of them. The final PU/DR will be submitted on August 14. A final audit report will be submitted on September 30. Savings will be directed into Phase II as cash balance. Final report will be submitted to GFATM on October 30. PSI shared that SR obligations are to terminate contracts of staff that will not be needed in Phase II and to maintain all program and finance records for seven years.

Following PSI's presentation, **Edmund** of UNDP thanked Rajiv's leadership and the dedicated work of the PSI program manager's during a turbulent period. Appreciation was expressed for PSI's willingness to professionally deal with GFATM and LFA queries. Following this statement, the minutes from the 4th CCM Steering Committee Meeting were presented, certified and endorsed.

The **participants** then discussed the Terms of Reference for the CCM SC including whether to keep the structure intact, whether to continue meeting twice a year or to do so just once a year, the usefulness of appointing a coordinator, and whether the current CCM set up has achieved desired results. **Imran Zali** of Pakistan flagged the issue of government representatives at CCM SC meetings changing often, reducing the effectiveness of the Steering Committee. He said it would be better if government representatives could change as little as possible so that they actually gain capacity and use it. **Edmund** remarked that the CCM SC meetings are expensive

and entail a huge amount of administrative work and urged participants to consider whether two annual meetings are necessary or if one might suffice.

A representative from **Bhutan** opined that the CCM SC should be given greater responsibilities and be made more accountable. A **Pakistani** representative said that his team is optimistic that the Phase II plan submitted by UNDP will be approved by GFATM Technical Review Panel (TRP) but that participants need to be prepared in case GFATM wants Project DIVA to be merged into existing country programs. A representative from **Nepal** called on GFATM to change the implementing modality of grants by including UNAIDS and other external development partners in the planning and execution processes to augment the work of MSM/TG communities.

Dr. Ruben F. del Prado, UNAIDS Country Coordinator for Nepal and Bhutan, said that with a shift in focus from 'national' to 'regional' it would be a big mistake if this opportunity (Project DIVA) is not filling gaps and supplementing and improving essential national competencies of both government and civil society actors. The UNAIDS Secretariat is not a donor nor an implementer, and a UNAIDS Country Office is the best-positioned UN entity to ensure Project DIVA, in-country, is optimally aligned with national HIV strategies and plans where these exist. This must be done in close collaboration with the UNDP Country Offices through the Joint UN HIV Teams. The UNAIDS Secretariat, usually with the World Health Organization (WHO), is the main supporter of national governments to report on HIV program implementation progress and achievement of country targets and participates in national CCMs. It is expected, therefore, that Phase II will establish a much more formal engagement with the UNAIDS Secretariat – especially with the country offices.

Edmund responded to Dr. del Prado's comments by stating that relations between UNDP APRC and UNAIDS Regional Support Team (RST) – both based in Bangkok – are strong and will be enhanced in order to provide Phase II with the necessary support from the UN system should UNDP be selected as the PR for Phase II.

A representative from **Bangladesh** stressed the importance of developing a simplified reporting format so that all in-country communications between CCM and Project DIVA partners can be tracked. The representative from **Nepal** said that a forum of PRs should be created so that they can share experiences and that UNDP should be added to this forum. He also called on the SRs to invite CCM oversight in annual or biannual review meetings for added effectiveness.

To wrap up the first session, **Edmund** discussed the current modality of the CCM SC meetings. He said that having three people from each country – the CCM coordinator, a government representative, and a community representative – attend each SC meeting may need to be re-examined given the constant change in representatives and the reduced effectiveness due to that. Afghanistan provides a good example of representation as the government person is from the national AIDS authority. It would be useful to have the MSM/TG focal person from the AIDS control bodies attend instead of government officials with a tenuous connection to the project.

Edmund again touched on the importance of having a focal person or chair of the CCM SC. Otherwise the PR will have difficulty communicating its message effectively across to SRs. Given that this is a community systems strengthening (CSS) programme at heart, it was recommended that the focal point or chair be a community person. Finally, UNDP stressed that it values continuity between Phase I and Phase II to ensure a seamless transition. For this, UNDP has

hired Bhushan Shrestha (formerly with PSI Nepal) and Rajesh Jha (formerly with NFI) as consultants to assist with the transition process.

3:15 – 5 P.M. session

CCM SC meeting reconvened after a short tea break. **Edmund** of UNDP started off by sharing key information about the Phase II request for renewal submitted to GFATM on April 15, 2013.

UNDP re-conceptualized its Phase II submission by getting inputs from its offices in Iran and Haiti and at headquarters in New York, as all of them have had experience as PR in handling and/or turning around other GFATM grants of this type. Key stakeholders from the South Asian region also participated in this process. UNDP emphasized that it does not want implementation to happen in a silo and that it wants sharing and synergies to happen with national HIV programs for and with MSM and TG populations.

In terms of country partner SRs, India and Sri Lanka do not have any for Phase II, as none were selected by PSI within the April 15 deadline. These countries also do not have country activities scheduled, although they will be invited to participate in regional activities. A representative from **Sri Lanka** clarified why her country did not seek to participate with an SR in Phase II. She said that the MSM/TG movement was demolished after the collapse of CoJ. There are new organizations working on these issues but they did not apply as they need time to mature.

Pakistan, Bangladesh and Nepal will host one regional consultation each during Phase II. Maldives will be invited to participate in regional training and advocacy activities with a minimal cost implications. Maldives also qualifies for funding under the GFATM New Funding Model coming online in 2014.

The objectives of Phase II remain the same as Phase I with the addition of an objective to improve strategic information. Time period for Phase II will be 2.5 years instead of three years. The grant rating was B2 when PSI made the original submission to GFATM hence the total budget was reduced to $16.2 million, which is 40% less than expected. UNDP has streamlined the budget and thanked SRs for consolidating activities.

UNDP shared that four CBO SRs from Phase I have left Project DIVA. GFATM has no objections to the recommendation from the CCM SC that UNDP be the new PR for this grant. They have asked for more information on projected results and for contextual information. In addition to input from UNDP's global staff and from national SR partners, input was also sought from stakeholders such as ESCAP, SAARC, SAARCLAW, IDLO, UNAIDS and others before the re-submission of the Phase II proposal.

CSS, advocacy, and improving the knowledge base about HIV in MSM/TG populations will be activities that will be continued in Phase II. Coordination with local health authorities in SR partner countries will be a major new focus. Resources will be devoted to enable the strengthening of health referral systems and providing healthcare in an discrimination-free environment.

In Phase II, UNDP will seek to achieve high impact by giving greater access to services for beneficiaries. Promoting regional advocacy will be a central objective along with capacity

building through CSS and health systems strengthening (HSS). A technical assistance strategy will be developed by involving APN+ and other regional organizations working for the HIV affected communities. No new regional networks will be created and existing networks will be utilized. UNDP will seek to improve the management of the grant in order to preempt temptations that led to multiple failures in Phase I as there was no systematic supervision plan.

UNDP will also seek to work more with transgender people and with youth. At the end of Phase II, the overarching objective is to make sure that local governments will take over and fund HIV services for MSM/TG. This project should be a model for what the government can do for the health of these communities and how it can be done. CSS approach will be retained as this is a community-led grant at its core. The guiding principles for the revision of the Phase II submission were that what was good will be retained, what did not work will be discontinued, good activities will be added, and that all GFATM GRP concerns will be addressed.

The Phase II strategy is based on the USAID Treatment Cascade. This cascade identifies the cascade as involving ten steps, namely 1. Hidden Populations, 2. Identified, 3. Targeted, 4. Reached, 5. Tested, 6. Informed, 7. Diagnosed, 8. Evaluated, 9. Treated, and finally 10. Retained. Step 5 (tested) is the most important link between governments and MSM/TG communities so UNDP will be emphasizing that. But this is a leaky cascade as most beneficiaries identified and targeted slip through the cracks and never make it to the final and crucial treatment and retention (adherence) steps so UNDP will design activities to prevent 'leakage.' To achieve this, UNDP will shift the strategic focus to addressing male to male transmission within cities, providing HIV services at city and municipal levels, improving coordination, and enhancing research and policy. It will seek high impact by getting the maximum number of beneficiaries to treatment as early as possible, lower the viral load through Treatment as Prevention (TasP), and facilitate more VCT access and treatment retention. The main goal of reducing the impact of HIV on MSM and TG populations will remain central to all of this.

The main advocacy activities in Phase II will happen in Bangladesh, Bhutan and Nepal. Workable service delivery models in Afghanistan and Pakistan will be a goal even though service delivery cannot be expanded because of GFATM's instructions. Operational research will be a new priority both at the national and regional levels. A budget has not been set aside for cooperation with SAARC but they will be invited to participate in regional activities where possible in order to influence their regional work on issues relevant to Project DIVA.

Dr. del Prado of UNAIDS said that the South Asian region is broad and that challenges and issues faced are very different. He called upon Phase II to provide added value to national plans. How Project DIVA will contribute to the achievement of national targets should be made clearer. Ticking off project activities should not overtake the bigger goal. **Edmund** agreed with Dr. del Prado's comments on the larger goals and said that UNDP wishes to ensure that local capacity is built on the ground. The performance framework has also been cut in half in order to reduce time spent on ticking off boxes and instead shifting focus to enhancing the quality of activities.

<u>Presentation on UNDP and the Global Fund</u>

Dr. Mandeep Dhaliwal, Director (HIV, Health and Development Practice), UNDP, presented on what the global partnership between UNDP and GFATM looks like. UNDP's main activities with GFATM grants are on implementation support, capacity development, and policy engagement.

For implementation support, UNDP is usually the principal recipient of last resort for GFATM grants. UNDP will take over grants only under exceptional circumstances and does so on an interim basis until national entities are ready to take over. Exceptional circumstances are when no national entity can take on a PR role. This is often the case in conflict affected, post-conflict, or unstable countries. It is also the case when grants have been suspended due to corruption.

As the UN Development Group's lead convener on issues such as development and gender, UNDP is well placed to take over troubled GFATM grants. UNDP was interim PR in 24 countries for signed grants worth US$1.6 billion in 2012, accounting for 11% of GFATM's portfolio. UNDP has managed grants for GFATM in 35 countries since 2003. Only 13% of UNDP-managed GFATM grants had ratings of B2 or C, which is significantly less than that of grants managed by other PRs. Twelve million beneficiaries around the world have been reached by HIV counseling and testing under GFATM grants managed by UNDP.

Among the value additions UNDP brings to managing GFATM grants are the sharing of good practices and lessons across regions. UNDP as PR will help open conversations that NGOs might have had trouble bringing up with governments. As an example of what her organization has done, Mandeep discussed the harm reduction services provided in an eastern European country where national frameworks did not protect sexual and gender minorities. UNDP's interventions eventually led to a change in national policies to protect these groups. Similarly, in South Asia, UNDP could change policies down to the municipal level with effective interventions in order to benefit MSM/TG and enhance their access to HIV testing, care and treatment.

UNDP and UNAIDS jointly helped GFATM develop its sexual orientation and gender identity (SOGI) strategy and its gender strategy. Furthermore, UNDP sits on the GFATM's human rights reference group and prioritizes human rights in all its work, which would be in line with the latter's recent move to mainstream human rights issues in its grants. If it takes on the PR role, UNDP can deploy its web based toolkit for capacity development and enabling legal environments to maximize the impact and value of this grant. The toolkit will enable country SR partners to access a rich collection of resources such as sample ToRs and other useful tools. CCM strengthening will be a priority and UNDP will bring its significant resources to enable that.

Presentation of video prepared by Bandhu Social Welfare Society (Bangladesh)

At the end of the day's proceedings, BSWS presented a video that was broadcast on the International Day Against Homophobia and Transphobia (IDAHO) 2013 on the private Bangla Vision channel. The video showed discussions between experts such as Shale Ahmed, Executive Director of BSWS, Prof. Shah Alam, Chairman of Bangladesh Law Commission, Prof. Mehtab Khanam, Clinical Psychology Department, Dhaka University, and A.N. Badraruja, Additional Secretary, Ministry of Health and Family Welfare.

Issues discussed were that of the size estimation of MSM and TG/Hijra population in Bangladesh; the tendency of society to confuse MSM with TG/hijra; the high HIV risk faced by MSM and TG; patterns of stigma and discrimination against this population in employment and in accessing healthcare; the normality of being gay or transgender; and causes of homophobia and internalized homophobia.

DAY 2: JUNE 7, 2013

9 – 10:20 A.M. session

Edmund of UNDP gave an outline of the agenda for the day and invited **Lou McCallum, Director, AIDS Project Management Group (APMG)** to present on the draft regional and national level advocacy frameworks. Lou said that the advocacy framework on MSM and TG populations for Bangladesh, Bhutan, Nepal and Sri Lanka have been finalized and the framework for India is under discussion. UNDP has partnered with SAARCLAW to prepare the regional advocacy framework and resource guide. The regional advocacy framework is backed up by the resource guide, which contains useful advocacy documents and information on SOGI issues. The hard copy of the guide is an easily accessible alternative to trawling the Internet looking for information and it will be updated regularly. UNDP, UNAIDS, WHO and other UN system resources on HIV and on MSM/TG have been included in the guide. The guide will make it easier for activists and policymakers to write policy briefs and pull up references. APMG welcomes comments for improvement.

The national advocacy framework's list country priorities and provides assistance on improving policy and laws. The frameworks address legal and policy issues, healthcare challenges, police and justice systems, community structures and the media. Phase II envisions anticipating the technical assistance needs of country partner SRs and addressing those. The frameworks have been developed to facilitate this process and they were developed by soliciting country partners feedback on the drafts.

Dr. del Prado of UNAIDS said that in-country we must look beyond official legal frameworks. Interpretation, traditions, cultures and powerful elements in society have ways to override the official legal frameworks and still make the lives of marginalized populations difficult. Actions of key decision makers and services (e.g. uniformed services, etc.) can have an adverse impact on the work of community-based organizations. He further suggested that government officials should be approached with an attitude of cooperation and working collaboratively rather than as an adversary.

Lou suggested that SR tactics should spread beyond just *quoting* rights such as the Universal Declaration of Human Rights or other international legal instruments. These tactics can be of limited use on the ground if, for instance, a person providing HIV care is homophobic. APMG concluded by saying that these frameworks are a guide to engaging various stakeholders. He said that it is essential for activists to be more knowledgeable and sophisticated than just announcing their rights. Quoting relevant local laws might be more helpful.

Next, **Naomi Burke-Shyne, International Development Law Organization (IDLO)** presented on national human rights institutions (NHRIs) and SOGI initiatives. It is essential to improve enabling environments by starting a dialogue between SOGI communities and NHRIs as the latter have a mandate to protect human rights. IDLO has a project on NHRIs and SOGIs in which it seeks to assess the capacity of South and Southeast Asian human rights institutions in order to address SOGI related human rights issues and to strengthen NHRI capacities. Countries where this project is operational are Bangladesh, India, Nepal and Pakistan in South Asia and Indonesia,

the Philippines, and Timor Leste in Southeast Asia. IDLO has engaged with non-governmental organizations such as BSWS, BDS, NMHA, INFOSEM, Equal Ground (Sri Lanka), Center for Legal Aid and Rights (India) and with UNAIDS and SAARCLAW in this project.

The engagement with NGO/community partners has enabled IDLO to get a better sense of where national laws and policies are focused. For instance, the NHRIs of Bangladesh and Nepal are very involved in SOGI issues whereas that of Sri Lanka and India are only somewhat or occasionally engaged. Naomi said that Bangladesh for the first time in its second Universal Periodic Review in Geneva advocated for SOGI rights and protecting LGBT people from discrimination. In Nepal, the National Human Rights Commission (NHRC) has appointed a focal point on LGBT issues and BDS sends a paid intern to work full-time at the Commission every six months. The Commissioner of the NHRC of Nepal has in fact approached BDS to send a staff member at a level higher than intern to work within the organization, while NHRC has also written to the Election Commission to protect the rights of LGBT people during elections.

A parallel study was carried out by the National Rights Commission of Pakistan (NRCP), a well-known human rights organization, on transgender rights. This is a very sensitive topic but the research was nevertheless carried out without hindrance.

The majority of LGBT people throughout South Asia reported experiencing rights violations based on their sexual orientation or HIV status. IDLO seeks to increase the confidence of community members so that they can advocate more effectively for their rights with NHRIs. Phase II will look at NHRIs and engagement of communities with them and follow up with realistic ground level activities to engage relevant ministries, police, and others.

Following Naomi's presentation, **Dr. del Prado** said that something that must be included in Phase II is engagement with the gatekeepers within the key religions of the five or six countries, who are powerful promulgators of animosity against sexual minorities, and who shape the mores of nations, cultures and even re-write traditions. Historically, Hinduism, Buddhism, Islam, and Christianity were accepting and inclusive of transgender people and of those engaging in male-to-male sexuality, without discrimination of these persons. On the contrary, such persons, albeit clearly minorities, were respected. We must be able to trace back to the times in the not-so-distant past when 'religious' men re-wrote traditions and cultures that resulted in the current 'mores' that condone and sustain homophobia and transphobia, and the widespread, accepted animosity, against fellow humans. Phase II provides the opportunity to officially engage with anthropologists and historians of the major religions to obtain evidence for well-informed engagement with those who can be made to 'see and spread the light'. Phase II must have a well designed and implemented approach to human rights and the law and on anthropology and history for answers and evidence-informed engagement with these gatekeepers.

The final presentation of the morning session was by **Brianna Harrison, UNAIDS**, who presented on 'Enabling legal and social environments for effective HIV responses – maximizing impact of global, regional and national processes.' Brianna discussed the Global Commission on HIV and the Law convened in 2010 by UNDP for UNAIDS to see how legal responses help or hinder HIV responses. This undertaking ran for 18 months and had regional and country level impact culminating in a February 2011 Asia-Pacific Regional Dialogue. The main takeaway of the Global Commission was that if we continue with current legal and policy environments, HIV infection rates will stay as high as they are today. On the other hand, a million infections can be averted

by 2030 if we make the required changes to law and policy. The recommendations include decriminalizing populations, ensuring rights of transgender people, investing in evidence and rights based laws, and communities should build coalitions for reforming laws, cultures, and traditions that are homophobic or transphobic. In this regional effort, the commitments made in ESCAP resolutions 66/10, 67/9, and the Roadmap endorsed at the 68th Commission will provide guidance. Emphasis will also be placed on interlinking regional and national activities.

10:45 A.M. – 12:30 P.M. Session

Following a tea break, **Edmund** presented on UNDP/WHO SEARO, EMRO Health Sector Engagement. The value addition of this grant is that regional and national experiences inform and assist each other. Community people who were previously objects of pity are now well-informed advocates who are resource persons. The progress from 2008 to 2013 has been remarkable, as it has made community activists equal to staff in international organizations and donor agencies. This grant is a good example of how a community mobilized to secure funds and empower itself and Phase II will seek to continue this.

It is crucial to engage the health sector as the risk of a man acquiring HIV from another man, through unprotected anal sexual intercourse is significantly higher than through heterosexual, non-anal intercourse. This also the case for TG persons, engaging in unprotected anal intercourse. Regional health sector engagement will be key in this grant through a two-track approach of CSS and HSS. A clear technical assistance strategy will be adapted and rolled out based on WHO guidelines. The 'test and treat and retain' strategy will be given priority, and the use of regional networks will be stressed, and a human rights component will be introduced.

Other crucial activities in Phase II will be the TasP initiative, encouraging South-South (peer) learning, 'community life competence,' conducting regional operations research, and developing a sustainability strategy that will involve a discussion of the transfer of resources and knowledge to governments at the end of the grant in 2015. Regional health sector initiatives will be rolled out regionally then moved to countries and about 15% of the grant budget in Phase II will be directed towards engaging with national and local health authorities. WHO and UNDP will jointly conduct these regional initiatives with support from regional networks. Activities will be interlinked and mutually reinforcing.

Dr. del Prado of UNAIDS called on all participants to return to their respective countries and organizations, fully energized to move this important initiative. The funds, through this grant must be strategically invested to directly benefit gay men, other MSM and TG. He also advised strongly that, for practical reasons, the LFA for Phase II must be based in Thailand and not in Nepal.

Presentation of video prepared by Blue Diamond Society (Nepal)

The morning session ended with a video presentation titled *I am not what you see* produced by Blue Diamond Society of Nepal in 2009. The 30-minute video highlighted the situation and challenges faced by LGBT people who have made major strides in securing their rights and healthcare access in the past decade and a half. Pivotal events such as the Supreme Court decision of December 2007 which ordered that all laws discriminating against LGBT people be scrapped and that the government work to legalize gay marriage were highlighted.

Notwithstanding major legal and political gains, the video highlighted how LGBT people in Nepal still face major obstacles to participating as full members of society due to conservative social mores and cultural norms.

2 – 3:30 P.M. Session

Rajesh Jha, UNDP consultant and formerly with NFI, shared information about the SR assessments he has been conducting over the past few months and the capacity development opportunities that have been identified in SRs. This is the third assessment under Project DIVA. All SR assessments with the exception of that of Pakistan have been completed (Pakistan will be completed in June). The SR capacity assessment tool utilized for the assessments is based on UNDP's master Capacity Development Toolkit and was customized and adapted to the needs of South Asian SRs. By the end of Phase II, country partners will be expected to have made significant gains in capacity by leveraging UNDP resources.

Fifty-nine components were diagnosed using 168 indicators during this assessment exercise. The assessment covers steps two and three of the UNDP capacity development plans – common understanding of capacity development needs and a shared vision of capacity goals.[1]

The assessment exercise sought to understand what systems exist and what needs to be improved in terms of organizational and management performance; programme management; financial management and systems (for instance strengthening oversight capacity); risk management and prevention of fraud and corruption; monitoring and evaluation; and pharmaceutical and health product management. It also identified capacity development objectives for the institutional and technical capacity of SRs. The methods by which UNDP in Phase II will provide technical support to SR partners will be through on-site support, mutual learning, systems and tools, and training by on-site UNDP staff. Capacity development plans for individual SRs with a budget, time frame, and a strategy are being prepared.

Edmund shared that different countries have varying priorities due to their unique situations. For example in Nepal and Bangladesh, BDS and BSWS have links with many donors whereas the situation in Afghanistan and Pakistan is more urgent as basic service delivery is needed. UNDP will tailor individual SR capacity building plans keeping in mind the needs of each.

The final presentation on the challenges and opportunities in Phase I was done by **Qasim Iqbal, Executive Director, Naz Male Health Alliance, Pakistan**. As the SR with the largest programme in the grant, Pakistan had the opportunity to make the model work and show how it can be scaled up. However, due to its complete reliance on Project DIVA for funding, it caused serious issues for NMHA. Qasim acknowledged the role of the late Shivananda Khan in founding the organization, being the "architect of Project DIVA," and for including Afghanistan and Pakistan in the grant when no one thought an organization working for MSM/TG could exist in these countries.

[1] Step 1 is complete ownership and steps 4 and 5 are political leadership of senior management and desire to change/improve.

Prior to the start of Project DIVA in 2010, the situation of MSM/TG in Pakistan was bad – there was limited data, widespread S&D, no livelihood options for the communities, and a lack of information about HIV. Project DIVA has created self-esteem for people who are gay men and other MSM, while not necessarily open about it or feminine in appearance and behavior. NMHA registered 33,918 MSM in less than a year, exceeding the target for this objective and most other targets were met or exceeded. Of the 99 staff hired, 94 are from the MSM/TG community.

In 2012, the Supreme Court of Pakistan gave equal citizenship rights to transgender people with a third category called *panjeshara*. Seven TG ran for Pakistan's recently concluded general elections and Chief Justice Iftikhar Chaudhary was instrumental in helping this happen.

Despite the achievements of NMHA and the gains made by MSM/TG in Pakistan, severe challenges affected the organization's work. The long delay in project signing, approval delays, bureaucratic delays, socio-cultural challenges, poor security, lack of technical support when NFI left – all disrupted NMHA's work. The PR, PSI Nepal, did not communicate well or provide regular updates, especially after April 2011. NMHA was also minimally involved in the original proposal submission by PSI for Phase II.

The situation with the UNDP Phase II proposal re-submission has been a vast improvement. NMHA has had significant input including 10 days in Pattaya, Thailand where its senior staff went over the whole proposal and planned everything in collaboration with UNDP APRC.

Other Phase I challenges included late disbursements by PSI. This had adverse repercussions for programme implementation, target achievement, and led to staff turnover. NMHA branch offices were evicted from three locations due to late payment of rents. Assets in Karachi were unusable due to landlord lockout. Huge delays in procurement led to HIV testing being suspended or no drugs being available for STI patients due to stock outs. Condoms and lubricants were often not available for six months at a time and NMHA was unable to organize national level meetings. No funds available for seven months between August 2011 and June 2013.

Despite these challenges, NMHA was able to establish a national technical working group on MSM and TG, establish a head office, establish six CBOs in two provinces, and create excellent linkages with APCOM, APN+, MSMGF, IDLO and other organizations. NMHA is concerned about sustainability and signed a new project with the World Bank last month and is exploring funding options with APN+ and the U.S. Department of State.

Dr. del Prado of UNAIDS reported that he had a discussion with UNDP's Edmund and Mandeep to highlight a few areas in the proposal that may need some fine-tuning and clarification to better pass the scrutiny of the GFATM Technical Review Panel. He will submit these in writing before June 21, 2013.

After this presentation on Phase I challenges and opportunities, **Edmund** led a brief wrap-up session. He announced that UNDP will seek to continue hosting two CCM SC meetings a year due to its obvious value. Composition of participants will remain as is, and CCM coordinators and MSM/TG focal persons in the national AIDS authorities will be encouraged to attend along with a community representative. Management meetings will occur in coordination with CCM

meetings. All future meetings will most likely be held in Bangkok as it is the cheapest option and there are no visa issues and direct flights from all SR partner countries. The grant Fund Portfolio Manager from GFATM is also based in Thailand, making Bangkok meetings the best option logistically as well.

Finally, **Gokarna Bhatt, CCM Coordinator for Nepal**, nominated Imran Zali of Pakistan to be the CCM SC focal person/chair for the next 12 months. UNAIDS and UNDP along with Pakistan CCM endorsed this nomination and it was finalized. Edmund then declared the last CCM SC meeting of Phase I over. The next one, which will be the first for Phase II, will most likely be held around October or November 2013 in Bangkok, Thailand.

Note: Minutes were endorsed by Imran Zali, CCM Steering Committee Chair, via email on June 18, 2013.