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SAMASTHA PROJECT, USAID/INDIA
FINAL EVALUATION

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SAMASTHA PROJECT

FINAL EVALUATION OF COMPREHENSIVE HIV AND AIDS PROGRAM

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ACRONYMS

AP	Andhra Pradesh
ANC	Antenatal clinic
ANM	Auxiliary Nurse Midwife
APAC	AIDS Prevention Control Project (of USAID, based in Tamil Nadu)
APSACS	Andhra Pradesh State AIDS Control Society
ARVs/ART	Antiretroviral Drugs/Antiretroviral Treatment
ASHA	Accredited Social Health Activist (community outreach worker in NRHM)
AWW	Anganwadi Worker (community health worker focused on children 0-6, adolescent girls, pregnant women and nursing mothers)
BIRDS	Belgaum Integrated Rural Development Society
BMGF	Bill & Melinda Gates Foundation
CABA	Children Affected by AIDS
CBO	Community-Based Organization
CCC	Community Care Centre
CDC	Centers for Disease Control and Prevention
CDPO	Child Development Project Officer
CHBC	Community home-based care
CHC	Community Health Centre
CIDA	Canadian International Development Agency
CMIS	Computerized Management Information System
COPE	Client Oriented Provider Efficient (Tool)
CST	Care, support and treatment
CTX	Cotrimoxazole
DAPCU	District AIDS Prevention and Control Unit
DIC	Drop-in Center
DLN+	District Level Networks of PLHIV
DRP	District Resource Person
FBO	Faith-Based Organization
FSW	Female Sex Worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People living with or affected by HIV/AIDS
GOI	Government of India
HIV	Human Immunodeficiency Virus
HRG	High-risk Groups/Populations (also referred to as Key Population)
HSS	HIV Sentinel Surveillance
IBBA	Integrated Behavioral and Behavioral Assessment
ICHAP	India-Canada HIV/AIDS Project (2001-2006)
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User/Use
IEC	Information, Education and Communication
IMAI	Integrated Management of Adult and Adolescent Illnesses, WHO
INP+	Indian Network of Positive People
IP	Implementing Partners
IPPCC	Integrated Positive Prevention Care Center
IPPCC-DIC	Integrated Positive Prevention and Care Drop-In Center
KNP+	Karnataka Network of Positive People
KHPT	Karnataka Health Promotion Trust
KSAPS	Karnataka State AIDS Prevention Society

LFU	Lost-to-Follow Up
LSE	Life-Skills Education (for OVC)
LWS	Link Worker Scheme
M&E	Monitoring and Evaluation
MARP	Most At-Risk Population
MSM	Men Having Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non-Governmental Organization
NIMHANS	National Institute of Mental Health and Neuro Science
NRHM	National Rural Health Mission
OI	Opportunistic Infection(s)
OVC	Orphans and Other Vulnerable Children
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PHC	Primary Health Centre
PLHIV	People Living with HIV (preferred in India to PLWHA or PLHA)
PLWHA	or PLHA: People living with HIV/AIDS, often interchanged with PLHIV
POWR	Positive Outreach Worker
PPTCT	Prevention of Parent-to-Child Transmission (called PMTCT in other countries)
PSI	Population Services International
PSV	Participatory Site Visits
RCCM	Regional Center for Clinical Mentoring
RCH	Reproductive and Child Health
RGUHS	Rajiv Gandhi University of Health Sciences
RNTCP	Revised National TB Control Programme
RRC	Red Ribbon Club
RRP	Regional Resource Person
RTI	Reproductive Tract Infection
SABLA	"Empowerment" (Hindi), a central government program for adolescent girls
SACS	State AIDS Control Society
SIHFW	State Institute of Health and Family Welfare
SIMS	Strategic Information Management Systems
SIMU	Strategic Information Management Unit
SIRD	State Institute of Rural Development
SJMC	St. John's Medical College, St. John's National Academy of Health Sciences
SRH	Sexual and Reproductive Health
STI	Sexually-Transmitted Infection
SVYM	Swami Vivekananda Youth Movement
TA	Technical Assistance
Taluka	Sub-District geographic and Administrative Unit
TB	Tuberculosis
TG	Transgender
TI	Targeted Intervention
TRG	Technical Resource Group
TSG	Technical Support Group
TSU	Technical Support Unit (with State AIDS Control Society)
USAID	United States Agency for International Development
VHSC	Village Health and Sanitation Committee
WCD	Department of Women and Child Development
WHO	World Health Organization

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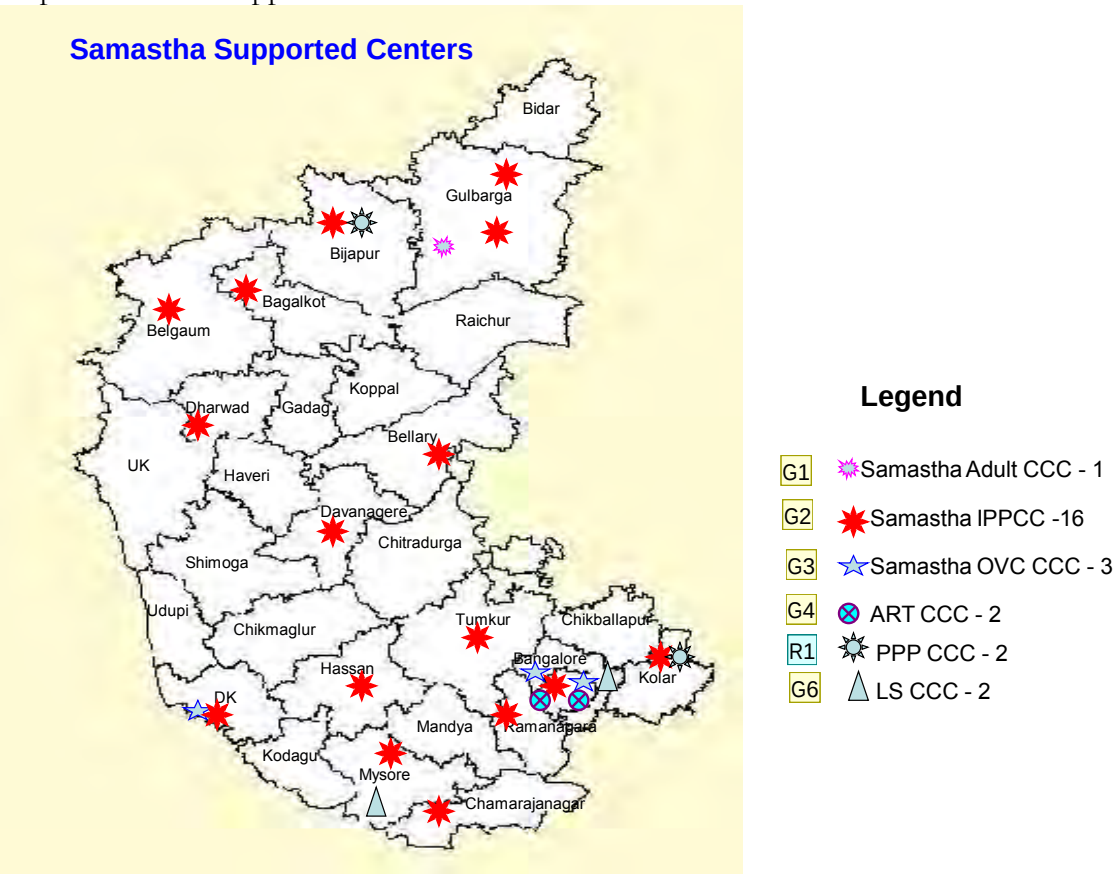

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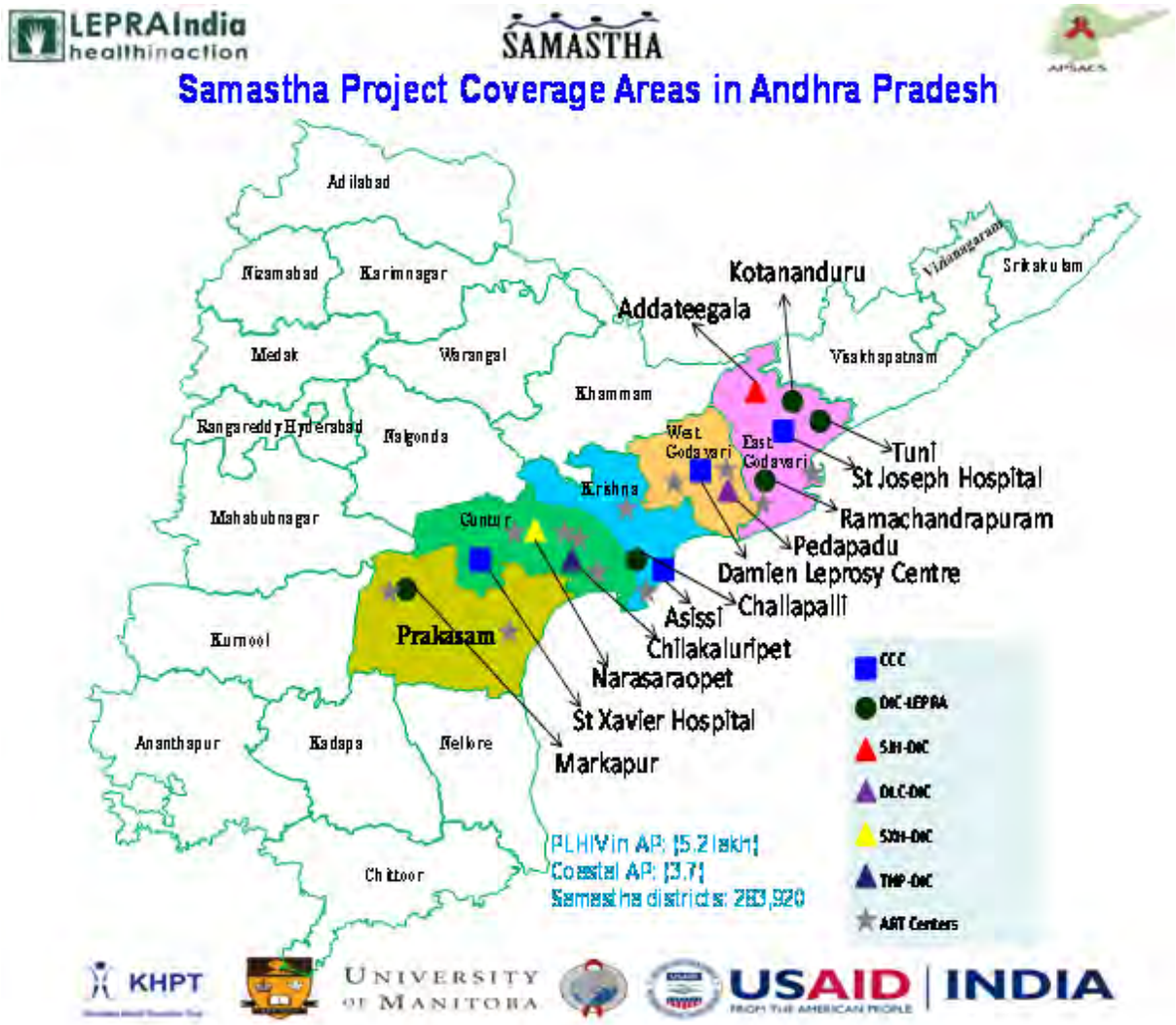

EXECUTIVE SUMMARY

India has one of the greatest HIV and AIDS burdens in the world, third globally in terms of numbers infected: 2.3 million persons. Nationwide 0.34% of adults, age fifteen to forty-nine, are HIV-positive. However, these statistics mask the variation in HIV prevalence among the states of India, several of which contain concentrated epidemics of more than 1%, and even 2%, HIV prevalence. USAID/India, as part of the President's Emergency Plan for AIDS Relief (PEPFAR), supports the government of India's efforts to reduce HIV/AIDS prevalence and mitigate the impact of the disease in the country. USAID's response to the epidemic has focused on the four high-prevalence southern states with concentrated epidemics: Tamil Nadu (from 1992), Maharashtra (from 1999) and, through Samastha since 2006, Karnataka and Andhra Pradesh. The USAID/India portfolio totals about $22 million annually, with all current activities scheduled to end in 2011 or 2012.

THE SAMASTHA PROJECT

Samastha = "Comprehensive" in Sanskrit

Samastha is a five-year project (2006–2011) with a total budget of $22 million. This is about 20% of the annual USAID/India HIV portfolio. Samastha is a comprehensive HIV/AIDS prevention, care, support and treatment project in two states, Karnataka and Andhra Pradesh, both with high HIV prevalence and with populations larger than most countries in the world. The project goal is to reduce transmission and mitigate the impact of HIV in selected districts of these two states, with a focus on rural, previously under-served areas. Samastha provides system strengthening at the state level and also focuses on thirteen high-prevalence districts in Karnataka, and makes more limited contributions in five high-prevalence districts in coastal Andhra Pradesh.

In both states, the epidemic is driven by sexual transmission, especially by men who are clients of sex workers—women driven, primarily by poverty, into this work. The situation is made especially acute by a high level of work migration. In northern Karnataka, the epicenter of Karnataka's epidemic, transmission is also propelled by the age-old Devadasi tradition that encourages daughters to be given to the local temple and into sex work.

Samastha is funded through a cooperative agreement with the University of Manitoba, which has worked in Karnataka since 2001 under a project of the Canadian International Development Agency (CIDA). The Karnataka Health Promotion Trust (KHPT), a partnership between the University of Manitoba and the Karnataka State AIDS Prevention Society (KSAPS), is the lead implementing agency. EngenderHealth is a prime technical partner on issues relating to quality of care, orphans and vulnerable children (OVC), and HIV-TB. Population Services International (PSI) provided technical support on strategic communication and condom social marketing during the initial three years.

ABOUT THIS EVALUATION: PURPOSE AND METHODOLOGY

The purpose of this evaluation has been to evaluate performance, impact, and lessons learned under Samastha and to highlight recommendations for USAID/India for the future direction of HIV/AIDS support. Methodology included document review, stakeholder interviews with government officials and others at multiple levels, development of questionnaires and clinical assessment tools for site visits, interviews and group discussions with key populations at the community level (people living with HIV [PLHIV]; female sex workers and various cadres of outreach workers; and observations at hospitals, testing centers, and support centers for PLHIV. The five-person evaluation team divided into two sub-teams for eight days of field visits in seven districts of Karnataka, and two in coastal Andhra Pradesh. Districts were selected based on population representation and taking into consideration of the large amount of travel time required. Annex D-2 summarizes districts, implementing organizations, populations and facilities

covered. The team conducted a mid-evaluation briefing with USAID, then a debriefing-and-validation session with KHPT, and a final briefing with USAID.

MAJOR CONCLUSIONS

General Overall Conclusions

1. Samastha has met the project objectives, met and surpassed most original targets and indicators, and been highly effective. Samastha has made major critical contributions in each program area of HIV prevention, care, support and treatment and in strengthening government health systems. It is very appreciated by local government.
2. There are indications, from recent antenatal clinic (ANC) data, that the epidemic may be turning a corner in Karnataka; if so, Samastha and USAID definitely have been part of the force bringing the epidemic under control.
3. Because Samastha was designed to be "gap-filling," it is difficult to consistently quantify and attribute impact to Samastha alone. Rather, achievements are due to the inputs of Samastha that have strengthened the government system and, in Karnataka, complemented those of the only other donor (Gates Foundation, whose Avahan projects are also implemented by KHPT).
4. Achievements in Andhra Pradesh have been important, especially in care and support, but less dramatic than in Karnataka (as Andhra received only about $1.5 million of Samastha's $22-million budget.)
5. The project has contributed significantly to strengthening health systems and building capacity of staff. (See Capacity Building conclusions below).
6. Clinical services supported by Samastha (testing and treatment centers and hospital-based care) will continue after Samastha ends, but it is very likely that the quality of services will be adversely affected without Samastha inputs. Equally—or more—seriously, without Samastha's outreach workers, community mobilization to access and use services will cease, and the Integrated Positive Prevention and Care Centers (IPPCs) and drop-in centers serving positive people will no longer have adequate resources to assist PLHIV with treatment adherence support and related benefits.

Prevention

Samastha has been very effective in scaling up prevention outreach to rural populations, along with mobilization for services and care. Samastha's rural prevention model is appropriate, evidence-based, feasible and replicable. It has contributed to the national response. Particularly in high-prevalence districts, such as northern Karnataka, Samastha's intensive rural outreach approach has proven effective. Behavior has changed significantly in the areas of increased HIV and STI testing and increased condom use, but the job is not yet done. Promotion activities must continue if transmission is to be halted.

Care, Support, and Treatment

- Samastha has significantly *strengthened health systems* and contributed to *scaling up* and *improved quality* of care, support and treatment services, through technical assistance to the State AIDS Control Societies and technical strengthening, including: integrated counseling and testing centers (ICTCs), anti-retroviral therapy (ART) Centers, integrated positive prevention and care centers (IPPCCs), "Link-ART centers" (in Karnataka), community care centers (CCCs), counseling services, and district-level officials' management and supervision.

- Samastha has *increased access to and utilization of services* primarily by training, deploying and supporting essential cadres of field-based outreach workers (Link workers, female sex worker (FSW) peer educators and peer outreach workers) who have mobilized and supported community members to go for HIV testing and, if positive, to follow through with ART services.
- Indicators of improvement include: steady increases in service utilization, no drug stock-outs and, in Karnataka, a very low lost-to-follow-up (LFU) rate of only about 3.5%—perhaps the lowest in all India. However many challenges remain.
- TB-HIV integration has not been a significant focus for Samastha. Clinical management is an issue that requires system changes. Nevertheless, KHPT reports that its TA to the intensified TB-HIV program has resulted in Karnataka becoming one of the best performing states in the country.

Link Workers

The Samastha Link Worker model has been well designed and implemented, with important elements that improved its reach and effectiveness to specific high-risk populations. The model appears most effective in very-high-prevalence rural districts. Samastha has provided important technical assistance (TA) to the National AIDS Control Organisation (NACO) for the nationwide scale-up of Link workers.

Capacity Building and Health System Strengthening

Samastha has contributed significantly to strengthening the health system response to HIV/AIDS in Karnataka and Andhra Pradesh. Capacity building of implementers and health systems strengthening have been priorities of Samastha from the outset (about 25% of budget). Samastha has been successful in building the capacity of the government's AIDS control bodies (the State AIDS Control Societies [SACS] and the District AIDS Prevention and Control Units [DAPCU]), especially in Karnataka. Samastha has also been very active and quite successful in providing TA to NACO to meet many nationalneeds. Evidence of success in capacity building exists in the numerous achievements in prevention, care, support and treatment described below.

Strategic Information

Strategic information capacity has been successfully built throughout Samastha. The Samastha project is an outstanding example of how data generated by well-designed monitoring and evaluation (M&E) systems can contribute significantly to successful interventions and overall impact. In this regard, Samastha/KHPT, by all international standards, is outstanding in the field of health improvement programming at the public health level.

Cooperative Agreement (Unilateral Funding)

As a program management arrangement, the Cooperative Agreement between USAID and the University of Manitoba/KHPT for work at the state level provides a very good model for USAID. It has allowed Samastha/KHPT to be flexible and innovative and to respond well to the rapidly changing nature of the epidemic and the local response. Working through a bilateral project between USAID and the national government would almost certainly have led to undesirable delays in getting inputs to the state level, rigidity, and less successful results. For these two states, each with populations larger than many countries (Andhra Pradesh, at about eighty-three million, has a population larger than Germany; Karnataka, at fifty-three million, is larger than South Africa), "unilateral" funding through the Cooperative Agreement has yielded highly successful results. Additionally, KHPT's strategy of working with fewer, but stronger and better established, NGOs has made project management easier for USAID.

COMPARISON TO NATIONAL STATISTICS

Karnataka is one of only two states in south India with an HIV prevalence of more than 0.6% and is currently the only state in the country in which every district has been classified as "A" category (ANC HIV prevalence of 1% and above). In response to the epidemic, it is also the only state that, by 2010, had saturated *every district* with targeted interventions, Link worker schemes for rural areas, ART centers, community care-centers, drop-in centers for people living with HIV and AIDS, and a functional District AIDS Prevention and Control Unit (DAPCU).

The Samastha project has catalyzed, strengthened and supported the Karnataka State AIDS Control Society (KSAPS)—with Samastha consultants co-located at KSAPS—to achieve significant levels of coverage for counseling and testing and for care, support and treatment. Noteworthy are the following comparisons (see also Annex F-4):

- **ART**. In Karnataka, between 2008 and 2010, there was a three-fold increase in the numbers of people put on ART. Yet the loss to follow-up rates have reduced from 5.5% (2008) to 3.4% (2010), about a third of the national figure (9.3% in 2010).
- **PPTCT, counseling and testing.** Among Karnataka's estimated 1.2 million pregnant women annually, the proportion who received counseling and testing services for HIV increased from 20.1% in 2008 to more than 67% in 2010. This coverage is about three times higher than the national average of 20.1% in 2010. Similarly, the proportion of HIV-positive pregnant women who delivered in hospitals and received single-dose Nevirapine increased, from 40.3% in 2008 to 62.1%, to marginally exceed the national average of 59.3% in 2010.
- **TB-HIV**. Significant achievements are seen in relation to TB and HIV cross-referrals. Coverage of HIV testing among an estimated annual incidence of 55,000 newly-detected TB patients in Karnataka increased from 50% in 2008 to 82% in 2010, against the national average of 65% (2010). Of these TB patients, 13% were found to be HIV-infected, in contrast to a national average of less than 5%. The proportion of clients referred from HIV counseling and testing (ICTC) for TB diagnoses increased from 6% in 2008 to 9% in 2010, also exceeding the national average of 7.4% (2010).
- **CABA.** The Samastha project has significantly increased coverage of care for children affected by HIV and AIDS to about 54.5% of the estimated 33,000 children in the state. This is almost ten times the national-level coverage, which is estimated at around 6.7%.

RECOMMENDATIONS TO USAID/INDIA FOR NATIONAL IMPLEMENTATION

As USAID had earlier determined that the Samastha Project should end on its initial completion date (September 2011), USAID/India requested that the Evaluation Team provide recommendations for the future direction of HIV/AIDS support by USAID/India, based on lessons learned under the Samastha Project. Below are fourteen recommendations addressed to USAID/India. Section III of this report provides the rationale for these recommendations, along with a few modest recommendations to Project Samastha.

1. For health system strengthening, the HIV/AIDS program (policies, guidelines and services) should be incorporated into state health services for greater participation of government providers and facilities, while at the same time retaining the focus and capacity to address local HIV/AIDS priorities.

2. As the AIDS epidemic has matured, NACO should seriously consider revising its current A, B, C classification of districts, adding an A+ classification to better reflect the rapidly increasing burden of need and ongoing care required in high-prevalence districts.
3. Institutional care of PLHIV should be integrated within existing government health structures. Separate wards are of no benefit, but rather increase stigma and discrimination.
4. A standard, comprehensive module for HIV/AIDS care, including stigma and discrimination reduction, should be included in all medical and nursing pre-service curricula.
5. Pediatric HIV care and treatment for children should be strengthened through in-service training for primary providers at all government health facilities.
6. A state-of-the-art laboratory—with capacity for assessing viral load and ARV and TB drug resistance—should be available in each state to support the growing burden of the epidemic. Satellite labs, based on prevalence and need, should also be developed.
7. Learning centers, best-practice sites and cross-sharing of lessons learned, between and within states, should be supported for capacity building at all levels.
8. The intensive rural outreach model with Link workers should focus specifically on high-prevalence districts (e.g., ANC> 1.25, high ART burden).
9. Samastha's experience with Link workers should be studied by those responsible for the national Link Worker Scheme, giving special attention to Samastha design elements that have made for its effectiveness (and its cost-effectiveness).
10. Interventions for female sex workers should be led by female sex worker community-based organizations and provide outreach throughout the district, urban and rural, as required.
11. District-level networks of PLHIV (DLN+) should be strengthened, consistent with GIPA (Greater Involvement of Positive People). Positive people should be employed in government ICTCs, ART centers, link-ARTs and primary health centers.
12. Technical assistance should be provided through strong, experienced partners who base their TA on evidence gained from field-level implementation.
13. The placement and financial support of very competent and appropriate personnel within a priority government agency, such as the State AIDS Control Society (SACS), is an effective approach to providing technical assistance that should be continued in the future, especially for weak agencies.
14. Effective priority interventions developed under Samastha should continue for an additional period of time. USAID should consider continuation of Samastha support in alignment with the GOI and NACO fiscal year while the means are found to mainstream its successful interventions into state and/or national programs.

SCOPE OF WORK QUESTIONS, CONCLUSIONS AND FINDINGS

SOW Questions

As you proceed through this report, you will see questions that are indented and bold, like this text.

These are the key questions asked in the evaluation's Scope of Work (SOW). Each SOW question is followed by a conclusion that answers the question, and then by detailed findings, which present the evidence on which the conclusion is based.

I. INTRODUCTION

The Problem: Serious HIV Epidemic in Karnataka but Weak Capacity to Respond

Karnataka is one of four large, southern-India states with a relatively advanced HIV epidemic. Many factors contribute to Karnataka's severe HIV epidemic, including extensive in- and out-migration and the presence of major transportation routes. High poverty levels create economic pressures that drive commercial sex work and force migration and social dislocation of laborers (primarily men) seeking work. The situation is particularly acute in northern Karnataka, which is drought-prone and suffers substantial poverty. Low literacy, especially among women, hinders effective and widespread behavior change communication.[1]

A PEPFAR review team assessed Karnataka to be a "weak state. . . struggling to respond to the epidemic":

> Amongst the four southern high-prevalence states, Karnataka has the second largest [number of] HIV infections. However, it has been slow in responding to the epidemic, with frequently changing leadership for the state AIDS program and delays in implementation of critical operationalization components under NACP-3. . . .[2]

Background to the USAID Response

The Karnataka Health Promotion Trust (KHPT), registered as a charitable trust under the Indian Trusts Act, formed in 2003 as a collaborative partnership between the University of Manitoba and the Karnataka State AIDS Prevention Society (KSAPS).[3] KHPT works closely with KSAPS to deliver HIV/AIDS services in Karnataka, neighboring Maharashtra and Andhra Pradesh.

In 2001, the Canadian International Development Agency (CIDA) launched the first comprehensive district-wide HIV prevention and care project in rural Karnataka, the "India-Canada Collaborative HIV/AIDS Project" (ICHAP). This was led by the University of Manitoba, working with and through KSAPS. The strategy, launched in the Bagalkot district in northern Karnataka—considered the epicenter of Karnataka's epidemic—centered on deploying a cadre of Link workers and peers to mobilize communities and provide services.

Shortly thereafter, in December 2003, the Bill & Melinda Gates Foundation (Avahan Initiative) funded KHPT to launch the *Sankalp* Project, a targeted, HIV-prevention project focusing on vulnerable and at-risk populations, including men and women in sex work, men who have sex with men [MSM] and transgender populations in thirteen districts. In December 2005, KHPT began a second Gates-funded project, *Corridors*, focused on a belt of districts in northern Karnataka and southern Maharashtra with some of India's highest HIV-prevalence rates, primarily due to high levels of migration and interconnecting sexual networks. *Corridors* works to reduce HIV and STI transmission among women in sex work, MSM and transgender populations who live and migrate across these districts.

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[1]USAID/India. Cooperative Agreement # 386-A-00-06-0014 4, with University of Manitoba. "Enhance Karnataka Project," September 20, 2006, pp. B1-B2.

[2] PEPFAR Review Team. "State of Affairs: Karnataka.," No date, probably 2006/07.

[3] KHPT's governing structure is two-tiered. A Board of Trustees includes senior officials of KSAPS, the University of Manitoba and other stakeholders. A Project Steering Committee, chaired by the Health Secretary, Government of Karnataka, includes other government officials, representatives from leading organizations and technical consultants. KHPT has its headquarters in Bangalore and works through its NGO grantees' regional and field offices in Karnataka and Andhra Pradesh (e.g., LEPRA Society in Andrah Pradesh).

2004 opened a new chapter in India's response to the epidemic with the provision of antiretroviral drugs (ARVs) and introduction of antiretroviral therapy (ART). In Karnataka, ART services rolled out on April 1, 2004 at eight institutions.

Samastha: 2006–2011

It is within this context that Samastha was created: the first comprehensive (prevention-care-treatment-social support) response to the epidemic. It was designed to complement other efforts, both those ongoing through Gates funding as well as ART expansion by the government through NACO and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Intended to "fill gaps," Samastha prioritized outreach and services for Karnataka's many *rural* female sex workers (FSWs)—one major gap Samastha should fill. The Cooperative Agreement set forth the following objectives (emphases added):

Main objectives:

1. Prevent transmission of HIV in rural areas of selected districts of Karnataka.
2. Improve health and social outcomes for people living with and affected by HIV and AIDS in selected districts of Karnataka and Andhra Pradesh

Four main components:

1. HIV prevention for *vulnerable populations* in rural areas (Karnataka only)
2. HIV prevention among *high-risk groups* in rural areas (Karnataka only)
3. Community-based care, support and treatment (Karnataka and coastal Andhra Pradesh)
4. Capacity building and health systems strengthening (especially Karnataka).[4]

NGO partners, including community-based organizations (CBOs) and sex-worker collectives, implement activities. Samastha's focus districts are the following (based on need and government request):

Northern Karnataka	Central & South Karnataka	Coastal Andhra Pradesh
Belgaum, Bijapur, Bagalkot, Bellary, Gulbarga	Dharwad, Davangere, Tumkur, Kolar/Chikballpur, Mysore, Hassan, Ramanagaram	East Godavari, West Godavari, Krishna, Prakasam, Guntur

KHPT currently receives about one third of its annual budget from Samastha, another third from the Avahan program (the Sankalp and Corridors projects), and about one-third from the Global Fund (GFATM) through NACO and the State AIDS Control programs. Of Samastha's total $22-million project budget, $1.5 million has gone to Andhra Pradesh.

Samastha is the only USAID-funded activity in both Karnataka and Andhra Pradesh. The Center for Disease Control (CDC) has some activities in both states, but they are minor in scope compared with Samastha.

[4] USAID/India. Cooperative Agreement for "Enhance Karnataka Project". 20 September 2006.

II. FINDINGS AND CONCLUSIONS

1. EFFECTIVENESS

a. Prevention

SOW question #1:

Is the rural prevention model adopted by the Samastha Project appropriate, evidence-based, feasible and replicable? Did it contribute to the national response and, if so, how?

Conclusion

Samastha's rural prevention model is appropriate, evidence-based, feasible and replicable. It has contributed to the national response (see below and in Section III, Link Workers). Samastha has been very effective in scaling up prevention outreach to rural populations, along with mobilization for services and care. While more work remains to be done, behavior has changed: increased use of HIV and STI testing and some increase in condom use among female sex workers, as described below.

Detailed findings

The four main components of the Samastha rural prevention model are: (1) promotion of risk reduction; (2) service promotion and referral; (3) community mobilization; and (4) stigma reduction.

The "strategic shift." In 2008, Samastha made a major "strategic shift" from its original proposal. The proposal envisaged implementing a uniform approach in all Samastha-assisted districts, designed to closely follow National AIDS Control Program III (NACP-3) guidelines for all A-category districts.[5] The strategic shift meant a major change to tailor Samastha's prevention model and interventions to local conditions in the districts.

In accord with the variability in HIV prevalence, rural transmission and the burden of the disease, Samastha was restructured in five high-prevalence districts in northern Karnataka and seven lower- prevalence districts in central and southern Karnataka. Advantages of this strategic shift include: (1) resources invested based on need; (2) districts with a possibility of greater impact have received more intensive interventions; and (3) all planning and implementation is evidence-based. Through this shift, the strategies for prevention and care were redefined based on the specific need of each district**.**

Since the 2008 strategic shift, the rural prevention model involves:

- In the high-prevalence Northern districts: Intensified outreach by a large number of field-based outreach workers (FSW peers, Link workers, and PLHIV community outreach workers) to a diverse population including rural FSW, pregnant women, PLHIV, OVC, and high-risk men and women.

[5] NACO has classified districts according to HIV prevalence. "A" represents the highest prevalence, indicating ANC HIV prevalence of 1% and above. All Samastha districts in Karnataka are "A" districts. Districts well above 1% are: Bagalkot (2.13%), Bijapur and Davangere at 2%, Belgaum (1.5%) and Tumkur (1.3%). In Andhra Pradesh, West Godavari is highest at 2.08% (2008 data).

- In the Central and Southern Districts: Reduction in number of Link workers, and greater prevention outreach to rural FSWs through FSW networks and to rural PLHIV by peer community outreach workers.

The feasibility and replicability of the Samastha model depends on well-defined criteria for selection of villages and target populations. Initial work by Samastha, using one model for all twelve districts, had limited impact. In 2008, by refocusing on the needs and epidemic dynamics of each district, greater results were achieved. Training and supplying all cadres of outreach staff with teaching tools and the ability to document their work will also be important for replicating Samastha's intensive, rural-prevention model.

The Samastha rural-prevention model, especially the use of Link workers in high-prevalence rural areas, has been adopted by NACO for the National Link Worker Scheme, although with some modifications (see Section 2 below for more detail on the Link Worker Scheme).

SOW question #2:

How effective and efficient were the Samastha Project prevention strategies in saturating the coverage of rural MARPS [FSWs] 6, especially in northern Karnataka? What were the strengths and weaknesses of the prevention strategies?

Conclusion

Samastha project data show excellent coverage of rural FSWs for HIV testing and STI services (an increase from 15% of a modest target in FY 2007 to 113 % of an expanded, more ambitious target in FY 2010).

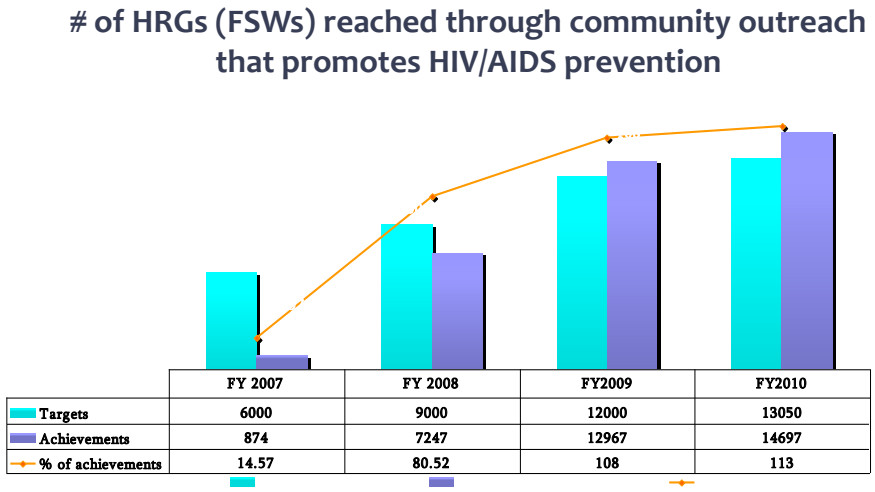
Detailed findings

In FY 2010, almost 15,000 FSWs were contacted by Samastha outreach workers. Among these, 67% of FSWs were referred to ICTCs for HIV testing and received their test results, and 81% were referred for and received sexually transmitted infection (STI) services (see Figure 1, below).

Figure 2 (next page) shows strong evidence that high-risk populations increasingly are using the services. For example, although it is not always possible to identify FSWs at ART centers, the gap is closing between the numbers of persons identified (at ICTCs) as HIV-positive and the percentage of those persons actually going for CD4 testing. In 2007–2008, only 47% of people testing positive went for CD4 testing (shown as Pre-ART Registration); two years later, this had increased dramatically to 88%. Only three months later, it had mounted to 91%.

[6] Samastha's focus here re. "MARPs" is only on female sex workers (FSWs). It did not include MSM or IDUs (the latter being extremely few in rural Karnataka).

Figure 1: FSWs reached through community outreach that promotes HIV/AIDS prevention[7]



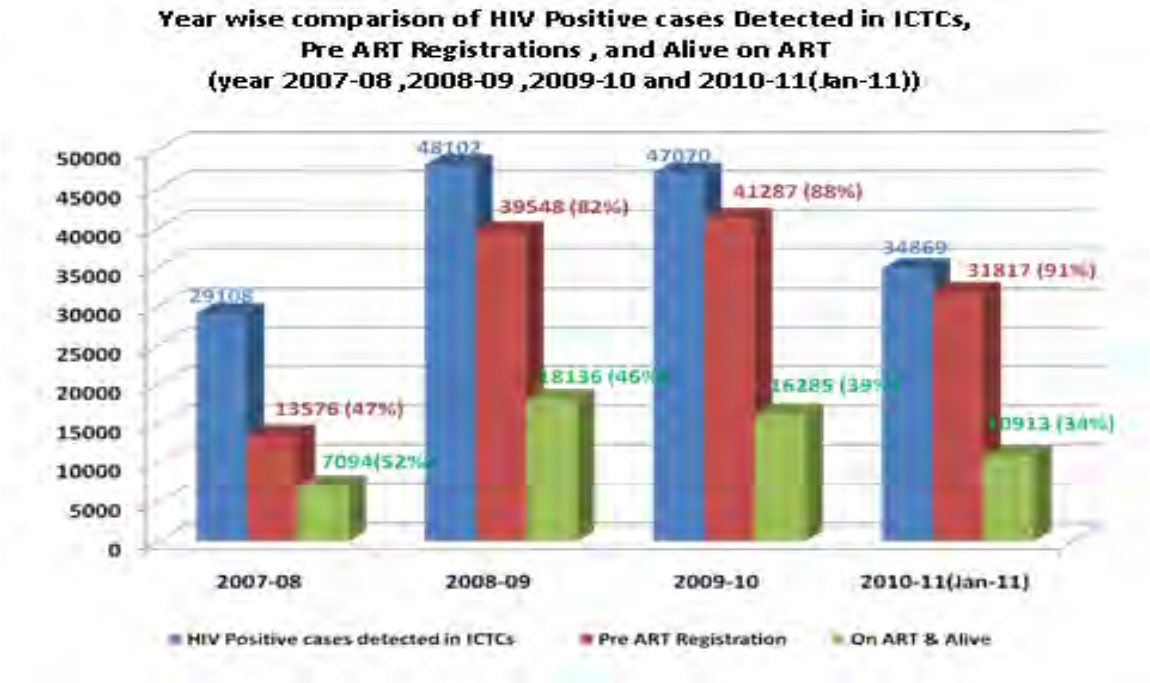
	FY 2007	FY 2008	FY2009	FY2010
Targets	6000	9000	12000	13050
Achievements	874	7247	12967	14697
% of achievements	14.57	80.52	108	113

Significant increase in the coverage of rural FSWs from 15% in FY2007 to 113 % in FY2010.

In the last year, 14,697 FSWs contacted:

- **11,907 (81%) FSWs received STI consultation**
- **9,777 (67%) FSWs were referred to ICTC and obtained their test results.**

Figure 2: Yearly comparison of HIV-positive cases detected in ICTCs, pre-ART registration, and alive on ART



[7] Samastha Annual Work Plan, October 2010–September 2011.

The districts of northern Karnataka are known for high HIV prevalence,[8] primarily driven by poverty, seasonal work migration, men who are clients of sex workers, and by the cultural traditions of Devadasi[9] and early marriage.[10] Both support widespread pre-marital and extra-marital sex with multiple partners. Here KHPT is implementing prevention activities through both Samastha and Avahan. In three of the five northern districts (Bagalkot, Belgaum and Bijapur), outreach to FSWs, urban and rural, has been through Avahan-supported, targeted interventions. In the remaining districts, mobilization and support by sex worker collectives, Samastha's Link workers and its many PLHIV community outreach workers have assisted with saturation coverage of rural sex workers.

In the seven southern and central Karnataka districts, collaboration with sex worker collectives has increased outreach to rural FSWs. During outreach, Samastha peer FSW educators provide information, demonstrate condom use, distribute condoms, and help sex workers develop skills to negotiate condom use. The FSW peer educators also motivate FSWs to go for regular HIV and STI testing and care services, and provide follow-up support. Table 1 below shows an increase in the number of female sex workers visiting the STI clinics, reflecting the impact of FSW peer educators. Table 2 summarizes field data concerning strengths and weaknesses in prevention.

Table 1: female sex workers who have gone to an STI clinic for services

Year	2007	2008	2009	2010
# FSWs	1,660	5,864	11,899	8,997

While the prevention strategy has been efficient at reaching out to the large numbers of at-risk individuals, poverty throughout rural Karnataka creates a need to focus specifically on HIV-positive widows, single women and OVC.

[8] Prevalence of 2% or above in Bagalkot, Bijapur and Davangere, according to 2008 data.
[9] Devadasi, traditionally, are women who, as young girls, were given to the temple by their families to provide services ranging from temple cleaning to sex with the priest. This has gradually emerged as "traditional communities engaged in sex work." See Annex E.
[10] "A 25-year-old man explained it simply: 'My parents have selected a seven-year-old girl for me to marry. I have been sexually active since the age of 14 and will continue to do so till my wife comes to stay with me [after she attains puberty]'." ICHAP, *The Hidden Epidemic*, p.13.

Table 2: Prevention—Strengths and Weaknesses

Prevention Strategy Element	Strengths	Weaknesses
Focus population		
FSW	Link to FSW collective	Two FSW organizations in Bellary district
Pregnant women	Initially a priority for link workers	May be issues/some overlap in transition of services to ASHAs
Youth	Stepping Stones program	
PLHIV	Decreasing village-level stigma and discrimination	Potential breach of confidentiality by outreach workers at village level
Criteria for village selection	Evidence based on prevalence	
Cadres of outreach workers		
FSW	Able to reach and find FSWs	
Link workers	Good utilization of monitoring tools	Too much work and large areas of population to cover
Community outreach Workers (HIV+ peers)	Most effective at communicating, offering support and personal experience	Expected to cover large areas with limited resources, training, fragile health
Training approach and materials	Very strategic and detailed; fine-tuned for each target population[11]	
Integration with village structures	• Collaboration and strengthening of VHSC; development of village resources; development of community volunteers	• Potential breach of confidentiality

SOW question #3:

Did the Samastha Project achieve scale/coverage of MARPs [FSWs] with quality of services? Is the coverage and intensity of coverage adequate? Has there been an increase in consistent condom use in the target population?

Conclusion

From both quantitative data as well as the perspective of patients interviewed during the evaluation, the quality of services has improved in most facilities (IPPCCs, drop-in centers, andCCCs such as the Cardinal Gracias Hospital in Belgaum). Samastha has contributed significantly to this improvement (see "Care, Support, And Treatment," below). Coverage has increased, as has condom use.

[11] For example: KHPT, "Prevention of HIV and AIDS & Care for People Living with HIV and AIDS: A toolkit for Program Managers."

Detailed findings

ART patients and FSWs interviewed in the three northern districts visited praised counselors, doctors and nurses for their quality of care. [12] The evaluation team found the same thing in Andhra Pradesh. "I love my doctor," said a woman on ART in Vegavarum, West Godavari.

The individual cases that follow here and elsewhere in this report are presented to give voice and face to the persons and lives behind the statistics.

> *"Chekicala is illiterate, thirty-five years old with two children, abandoned by her husband twelve years ago. She came to the hospital Cardinal Gracias in Belgaum from a distant village (110 kilometers away), recommended by a friend who had a good experience previously at the hospital. Chekicala came because she had diarrhea for several days. She was tested for HIV while at the hospital. Her test turned out to be positive and she began ART treatment (five days' hospitalization in order to monitor side-effects of the drugs). She did not really comprehend what HIV was about, but praised the medical staff and the counselor for their care and compassion.*
>
> *"Remka is a pre-ART patient, twenty-two years old; she has no children. She was diagnosed HIV positive after she got married as a second wife. Her husband is dying of AIDS and not working. She works in a factory and the first wife is a farm laborer. Remka goes for her CD4 count and check-ups every six months and is very pleased with the services at the hospital and the counseling about her health.*
>
> *"Dengema is a Devadasi in Bagalkot. She is about forty-five years old and illiterate. She had been given to the temple when she was thirteen. She is also a madam and recruits young girls for clients, who then meet in her home. She conducts her business by cell phone and charges twenty rupees per client for the use of her home. Dengema goes regularly to the ICTC for HIV testing and STI check-ups. She praised the quality of the services and the friendly medical staff."*

HIV-positive persons (PLHIV) serving as community outreach workers and based primarily at integrated positive prevention care centers (IPPCC-DIC) have played a critical role in reaching out to their peers and encouraging them to use ART and CCC services. ART patients interviewed reported that the counseling provided was useful.

> *"Mattri lives in Mudol. She is a farm worker, illiterate, thirty years old with three children, a widow following her husband's death of AIDS three years ago. She is very poor and afraid to die and abandon her children. She started ART nine months ago. She goes to the Bagalkot Hospital ART center for treatment. She likes the medical staff and explains that they are very friendly and reassure her about her sickness. The link worker who accompanies her to the hospital is helping her to get a government ration card by filling out the forms for her."*

(See Annex E for additional profiles from field interviews in northern Karnataka.)

Condom Use

Only a few years ago, over a third of men in some of these rural areas had never even seen a condom.[13] Today, with support from Samastha and its partners, there are 4,737 active condom outlets in 2,302 villages for the general population and for FSWs, and increased and more consistent condom use by sex workers with their clients. According to reasonably reliable survey

[12] The Samastha evaluation team visited Bagalkot, Belgaum and Bellary and conducted interviews with FSW and other vulnerable populations regarding their satisfaction with quality of care.

[13] In Bagalkot in 2003, 51% of married men and 38% of unmarried men said they had never seen a condom. ICHAP, "The Hidden Epidemic: HIV/AIDS in Rural Karnataka." 2003, p. 16.

data, in 2008–2009 the percentage of men who used a condom with FSWs at their last sexual encounter was reported to have increased to between 65% and 100% (the variation has to do with age and marital status).[14] Condom use with lovers/regular partners and in the general population, however, remains more sporadic. In group discussions with a total of fifty-seven FSWs during this evaluation, most said they use a condom with their clients. However, with lovers/regular partners and husbands, they admitted there is very little use of condoms. A main reason, they reported, is their inability to negotiate condom use with their lovers.

While the evaluation team initially had doubts that sex workers would succeed in using condoms with their clients, data from other interventions (not Samastha) in five Karnataka districts testify that use is increasing. [15] Two rounds of integrated biological and behavioral assessments (IBBA) among FSWs show significant increase in reported condom use, but also this pattern: condoms most frequently used with occasional commercial (paying) clients in contrast to repeat commercial clients and regular lovers/partners.[16] The second round of IBBA showed an increase in reported condom use with occasional clients (condom use at last sexual encounter increased from 81% to 89%; condom use all the time from 62% to 77%). There were larger increases in reported condom use with repeat commercial clients (condom use at last sexual encounter increased from 63% to 88%; condom use all the time from 40% to 77%), and in the proportion of FSWs reporting zero unprotected sex in the previous month with commercial clients (increased from 58% to 76%). Reported condom use with lovers/regular partners remained much lower, but also increased (condom use at last sexual encounter increased from 31% to 38%; condom use all the time from 15% to 28%).

> *"Maychuak is a Devadasi and works as a FSW peer educator in Housur village. She explained that high-volume sex workers have about thirty clients a week, middle range about twenty-two clients, and low range, five or six clients. Young women are usually in the high-volume range. Maychuak explained that she faces a real challenge with her lovers, because they do not want to use condoms. She asked to be trained with additional communication skills in dealing with intimate partners."*

It is significant that data show younger men increasingly using condoms.[17] The main challenge appears to remain with middle-aged, married men.

Lessons learned

- An intensive, individualized, rural-outreach model, such as Samastha employs in northern Karnataka, is able to change behavior. Similar achievements could not have been produced through mass media campaigns.
- A strong, *centralized and individualized M&E system*, including tools for documenting and tracking work, has been a critical component for effective prevention and behavior change. Behavior change communication, without individualized tracking, would have been much less effective.
- The *peer-to-peer approach* for FSWs and PLHIV is the most effective strategy for prevention and for offering support and guidance that can be readily accepted.

[14] KHPT and University of Manitoba. "Knowledge, behaviour and attitude towards HIV/AIDS-related issues: Findings from *Samastha* Polling Booth Survey in general population groups." 2008–2009, PPt.
[15] KSAPS. *Annual Action Plan 2009 –2010,* February 26, 2009, p.13.
[16] The first round took place between 2004–2006, varying by community. The second round, again community-specific, took place about two to three years later: 2006–2009.
[17] KHPT and University of Manitoba. "Polling Booth Survey" 2008–2009. PPt, e.g., slide 10.

- *Outreach to FSWs*, both urban and rural, should remain in the hands of the female sex workers themselves, including FSW collectives. An unfortunate tendency observed is that results of the FSW collectives are typically taken over by NGOs dominated by male employees.
- *Field-based outreach workers* (Link workers, FSW peer educators, PLHIV outreach workers, ASHA, ANM, and Anganwadi) require adequate training, tools, compensation, monitoring and support for their work to be effective and sustainable.
- *ASHAs* (Accredited Social Health Activists, the newly created cadre of community outreach workers under NRHM, the National Rural Health Mission), as currently recruited and deployed, are very unlikely to achieve what the Samastha outreach workers accomplish. Coming from relatively elite status, the ASHAs are not likely to bridge caste and class differences with ease. Furthermore, their few hours of classroom training on HIV do not prepare them to discuss sexual matters with comfort. Discussions with the NRHM mission director revealed his strong belief that the ASHAs are not ready to take on the roles that Samastha's link workers and peer outreach workers play.
- There is need to develop *empowerment strategies for FSWs and PLHIV* (including vocational training and literacy classes) and for greater integration of women in network and support organizations. Many HIV-positive widows and single mothers need special support, including nutritional and financial support.
- *Condom-use findings from surveys* should be triangulated with data on STI increase or decrease.

b. Care, Support and Treatment

Samastha views HIV care, support and treatment as integral to an overall HIV control strategy, linked seamlessly with prevention programs, advocacy and other activities to reduce stigma and discrimination, and to a broader set of social services for persons living with and affected by HIV. The Samastha approach is client-centered, with services oriented to the needs of PLHIV and their families.[18] The project presents a continuum-of-care model that addresses the dynamic care needs of individuals at risk/vulnerable to, or infected with, HIV, and their families and communities during the progression of the disease.[19] It progresses, from awareness/prevention and STI management; to testing and counseling; to diagnosis and treatment of simple and then complex opportunistic infections; to palliative care; through death and bereavement.

The care, support and treatment component of Samastha represents more than 50% of budget expenditures. This includes direct monies to care and support facilities such as the CCCs and the IPPCC-DICs, where outpatient medical services and psychosocial services, even nutrition education and supplementation, are offered to PLHIV and their families. In addition to facility-based care, community, home-based care is provided through field workers, including link workers in northern Karnataka and peer outreach workers in central and southern Karnataka, focused on women and children. Technical assistance for care and support is also included in this component.

All work in Andhra Pradesh is funded under Samastha's care, support and treatment budget.

[18] "Care and Support Strategy and Conceptual Framework," USAID/India Cooperative Agreement with University of Manitoba, September 20, 2006, page 24.
[19] Ibid, page 26.

SOW question #1:

How has the Samastha Project in KN and AP contributed to increasing access to and utilization of services, especially care, support and treatment and access to ART among target groups such as rural-based female sex workers and people living with HIV/AIDS?

Conclusion

Samastha has significantly *increased access to and utilization of services* through TA and other inputs. Building on the Samastha continuum-of-care model, multiple, effective health delivery systems and structures have been supported, including:

- Home-based care training for Link workers and PLHIV
- Integrated Counseling and Testing Centers (ICTCs) or HIV testing and referral to ART
- Integrated Positive Prevention and Care Centers (IPPCCs), which provide outpatient treatment services, including for minor opportunistic infections (OIs)
- Support and counseling services
- Referrals and facilitation for government-provided social entitlements
- Linkages to + Networks
- CCCs, which provide both outpatient and inpatient care
- Technical assistance:
    - To ART centers, providing ART and outpatient care (including CTX prophylaxis for OIs)[20]
    - Implementation of the intensified TB-HIV program
    - For integration of the PPTCT-NRHM program
    - Mainstreaming OVC care with the department of Women and Child Development (WCD).

In addition, Samastha has significantly *strengthened the systems* within these institutions, including:

- Links to outreach through Link Workers, Peer Educators and Outreach Workers
- Record-keeping systems that employ a user-friendly computer-based management information system (CMIS)
- Quality-of-care improvements through training and mentoring of all cadres of staff
- Coordination with District Level officials through regular training and supervision
- Leveraging infrastructure, manpower and equipment/medical supplies—for example, obtaining drugs and equipment through alternate sources.

Detailed findings

The two figures below show the increase in the availability of ART and CD4 testing facilities in Karnataka. The presence of a Samastha employee embedded at KSAPS was instrumental in bringing about these notable accomplishments.

[20] ART centers are financed by the GOI. What they receive from Samastha is important technical support, focused specifically on developing quality services at the ART centers throughout Karnataka.

Figure 3: Increase of ART centers, 2004–2010

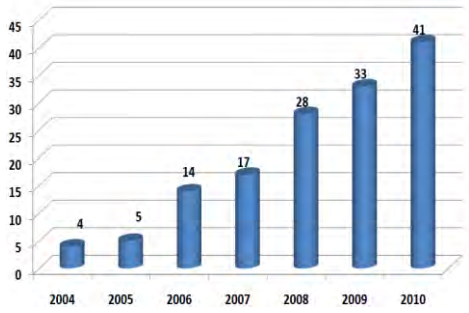
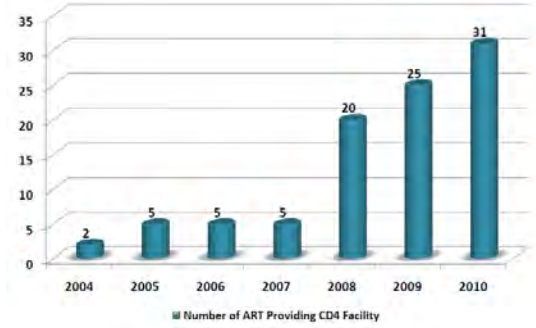


Figure 4: Increase of CD4 Testing Facilities, 2004–2010

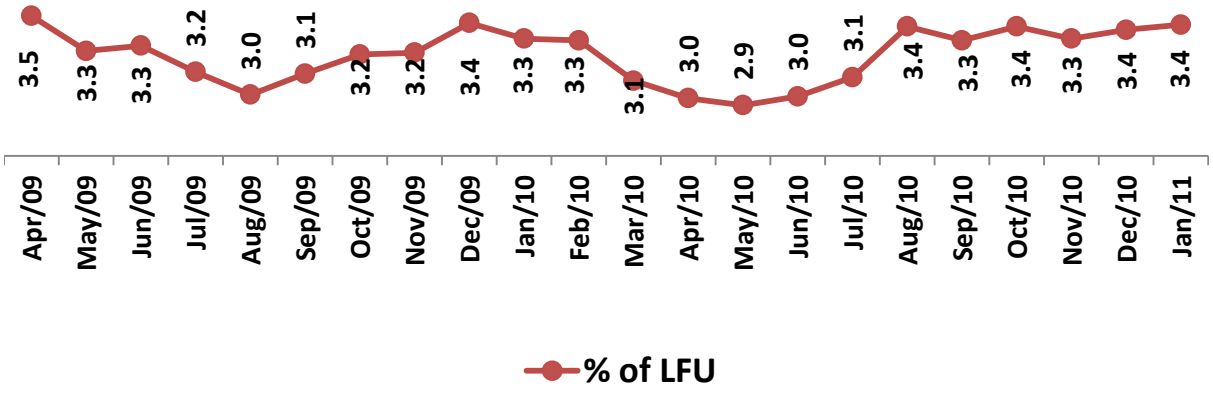


While the scale up of ART centers is significant, 25% of the centers unfortunately are without CD4 testing machines (of the forty-one ART centers, only thirty-one have CD4 machines and related facilities). As a result, the lab technician from these ten ART centers must transport blood to a district-level center for processing. Many patients who travel a great distance—up to 300 km.—for CD4 testing are thus forced to make a second trip back to the ART center to get their results and medications.

To reduce the barriers of travel time and distance, ninety-three Link-ART centers have been created, where patients can go for their monthly drug distribution. As the number of people on ART continues to mount, more Link-ART centers will be required. However, for CD4 counts, people on ART must still visit an ART center at least twice a year.

Karnataka has one of the best treatment adherence rates in India. Monthly data on LFU reveal a consistently low level of 3.5% or less (down from 5.5%) among ART patients (see Figure 5, below). This is the lowest in India[21] and much less than in many African countries. This is a major achievement. It is the result of the improved quality of services (appreciated by all ART patients interviewed) and by the individualized tracking, outreach and treatment support to people on ART.

Figure 5: Monthly ART Lost-to-Follow-Up, Karnataka, April 2009–January 2011



SOW question #2

How successful were the various models on care, support and treatment (CST) developed by the Samastha Project, including referrals and the linkages established by the Project, in providing a prevention-to-care continuum program?

Conclusion

Samastha has been successful in establishing an effective prevention-to-care continuum, which has resulted in increased access to and use of HIV testing (ICTCs) and treatment (ART centers) and, as a result, the high treatment adherence rates. Some components have been successful (ART centers) while other components (e.g., CCCs) have been less effective.

[21] "Samastha Contribution to Care, Support and Treatment in Karnataka." Excel document provided by Samastha, February 2011.

Detailed findings

Community Care Centers (CCCs)

In 2006, Samastha proposed to work through Snehadaan[22] and its networks of affiliated, faith-based institutions to support expanded services at care and support centers. Many of these faith-based hospitals already provided institutional, palliative, hospice and foster care for men, women and children living with or affected by HIV, as well as to other patients requiring similar care. Support from the project was intended to build the capacity of the staff of these centers through training and mentorship (from EngenderHealth, St. John's Medical College, National Institute of Mental Health and Neurosciences [NIMHANS], Snehadaan, LEPRA Society, Swami Vivekananda Youth Movement [SVYM] and other regional centers). In addition, targeted funding, based on need, to expand the scope and quality of their care and support activities was proposed. The support included provision for increased medical and counseling staff and integrated outreach worker teams. A particular role of these centers was to provide support for OVCs and vulnerable women, including widows and those living in extreme poverty. [23]

Integrated Positive Prevention and Care Centers (IPPCCs). An innovative concept based on KHPT's experiences in extending services through drop-in centers, these IPPCCs were designed by Samastha to be managed by PLHIV networks where feasible and, when not, by implementing NGOs. Services provided included: HIV prevention and treatment counseling; ART treatment management; prophylaxis and treatment of OIs; general care and nutritional support; fertility and sexuality counseling; safe sex education and condom distribution; home visits; and referrals for treatment of alcohol addiction and to CBOs that provide home-based care.[24]
Different CCC-IPPCC models. In some settings, the IPPCC is located directly inside or adjacent to the CCC. In others, it is at a distance. Although originally designed to work collaboratively, IPPCC proximity to the CCC has not always been possible (see Annex F-1 for specific examples). Some CCCs provide outpatient services, while others only offer inpatient admissions. Some CCCs are free standing units housing only ten beds, intended solely for PLHIV, while others are functioning hospitals where the ten to twenty beds designated for PLHIV are either integrated within the wards or housed in separate and isolated parts of the hospital.

To Samastha's credit, selecting faith-based facilities as CCCs appears to have been a good decision, as these independent hospitals have high potential for service sustainability. However, the differences among the CCCs make it difficult to assess accurately the value (quality and cost) of these different models of care and support.

Between 2006–2008, Samastha invested in nine CCCs in nine Karnataka districts (including one combined Adult/OVC) and in two Bangalore CCCs (both combined with OVCs). In 2008, nine of the eleven CCCs were transferred over to NACO/GFATM-6 funding. Similarly, the four Andhra Pradesh CCCs are supported by APSACS, with NACO/GFATM funding. Samastha continued to train and mentor staff of all facilities as well as to provide TA and monitoring by the Snehadan Learning Site team. Through GFATM-6, NACO provided a fixed, annual subsidy (no longer need-based). Two of the Karnataka Adult CCCs (transferred to GFATM-6 funding) were designated as "learning sites" (Snehadan and SYVM Mysore) and continued to receive Samastha funding for their learning-site roles. Since 2008, Samastha has also supported two innovative Public-Private Partnership-CCC models (PPP-CCC) based in district hospitals in Kolar and Bijapur. The three Karnataka OVC-CCC facilities are receiving support for the duration of the Samastha project (Annex F-2 lays out these details in table form).

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[22] A Catholic philanthropic institution In Bangalore with a long history in providing medical care to the needy.
[23] USAID/India Cooperative Agreement with University of Manitoba, September 20, 2006, p. 41.
[24] Ibid, September 20, 2006, p. 40.

In August 2009, shortly after this transition to GFATM-6 funding, NACO issued new guidelines for CCCs. During this transition period, GFATM-funded CCCs were required to follow NACO guidelines or risk losing funding. As a result, the Samastha team was obliged to focus substantial efforts on a model that KHPT acknowledges as discriminatory, not reflective of best practices, and not sustainable. Some of the challenges include:

1. The separation of HIV patients (by creating separate HIV/AIDS wards in hospitals) increases and perpetuates stigma and discrimination (example: Cardinal Gracias Hospital in Belgaum having to separate its wards when they were previously integrating HIV patients into normal wards).

2. Guidelines designed to limit the number of in-patient days for patients who are terminally ill and have no other place to go (example: St. Mary's Hospital in Bellary was obliged to move a patient into its general hospital and then back into the HIV unit to avoid being downgraded by NACO's monitoring system).

"In the district hospital in Hassan we have a fully integrated CCC model, with HIV+ patients throughout the wards and an IPPCC and an ART center—all located in the same facility. When a representative of NACO visited, he fully appreciated the model as the best way to avoid stigma and discrimination to PLHIV. At the same time he said, 'But you are five years ahead of NACO and this does not fit to NACO's CCC guidelines—and therefore we will need to withdraw funding'."

As relayed by Manoj Sebastien, SVYM

Outreach Services

Like the CCCs, outreach services also have been developed using multiple models and multiple cadres of workers, discussed in the prevention model (above). One of the primary roles of the Link Workers was to raise awareness about the need for and availability of testing and ART services; FSW peer educators and HIV+ outreach workers are encouraged to mobilize members of their community to use ICTC, ART and CCC services as needed. Samastha has developed an excellent system of referral linkages (including duplicate-paper-referral forms) that easily allow an individual to be tracked from the village to the ICTC, ART or CCC site. HIV+ outreach workers have also been placed at IPPCCs, ART centers and at CCCs to follow-up on patients who have not returned for services or to follow-up on their status post-hospitalization.

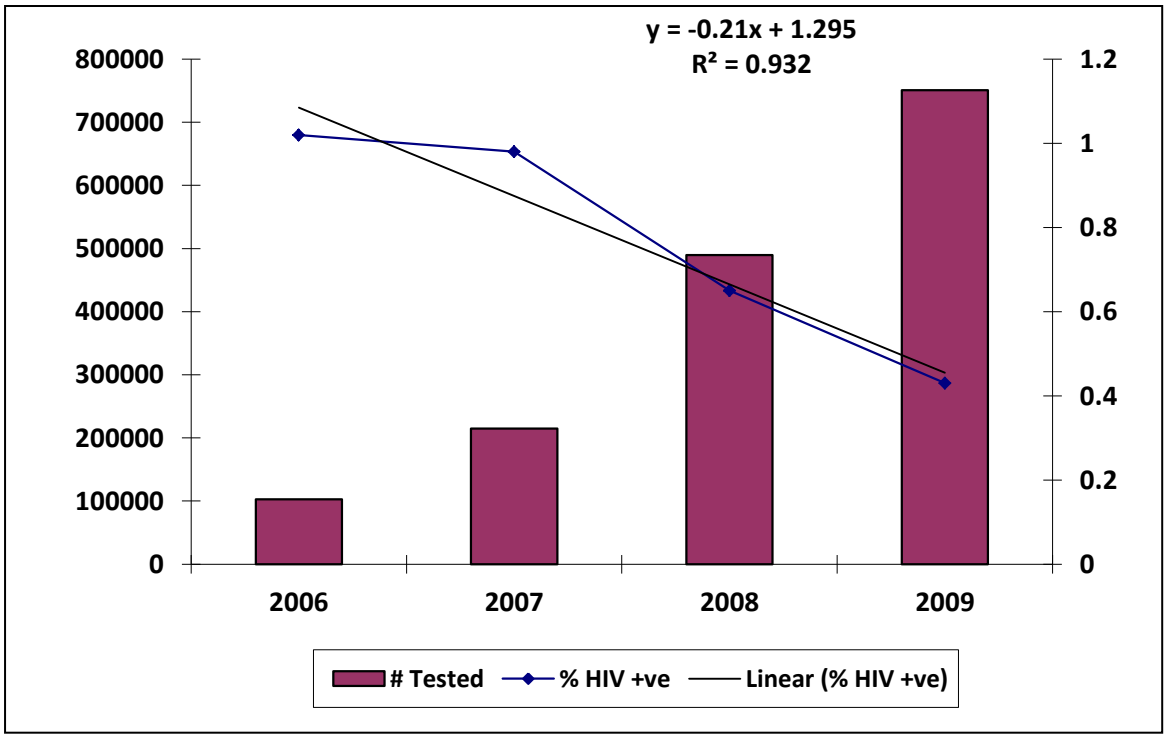
Figure 2 on page five of this report ("Yearly comparison of HIV-positive cases detected in ICTCs, Pre-ART registration, and alive on ART") shows improvements in linking PLHIV to ART services across Karnataka. The gap between people identified as positive and people who actually register for ART services continues to narrow each year. This is due to the increased availability and acceptability of ART services as well as the effective contribution by outreach workers who are actively tracking all identified PLHIV.

Prevention of Parent-to-Child Transmission (PPTCT)

Across the twelve Samastha districts, the numbers of women attending PPTCT clinics has significantly increased—from about 5,000 women in 2007 to 35,000 women in 2009. This increased uptake is shown in Figure 6 below (the dark vertical bars). As with ART, this improvement is due to the larger number of sites where pregnant women can now receive HIV testing, to the expanded outreach to pregnant women, and to reduction in stigma. The additional HIV-testing sites include the ICTC centers currently available as well as specially designated, 24/7 primary health care centers (PHCs). The active role and focus of Link workers on pregnant women, plus the presence of ASHAs, has significantly increased referrals for PPTCT. The

presence of a Samastha-supported staff member embedded at KSAPS and specifically focused on PPTCT has undoubtedly contributed to this increase as well. (Note: The descending trend lines in Figure 6 refer to decreasing HIV prevalence among the pregnant women being tested.)

Figure 6: Uptake of PPTCT services in Karnataka, Samastha districts, and decreasing HIV trends (2006-2009)



SOW question #3:

What were the strengths and weaknesses of structures and processes, including quality of services, supported by the project for providing care, support and treatment to PLHIV and OVC?

Conclusion:

Structures and processes developed and supported by Samastha for providing care and treatment to PLHIV are much stronger than when Samastha began. Achievements are also noteworthy in comparison with the national data, as is summarized above (Executive Summary) and in Annex F-4. OVC was a lower priority in the project design, but Samastha has shown some leadership in this area as well.

Detailed findings:

Structures and processes were developed with a logical flow of services, beginning with outreach workers who identify at-risk populations either in their villages or through other entry mechanisms (e.g., at Primary Health Centers) and then bring them to an ICTC for HIV testing. If identified as positive, the outreach worker accompanies this person to the ART center where he or she receives a referral to a local IPPCC-DIC or district-level network (DLN+) of positive people for on-going support and, if needed, treatment of minor OIs. More severe illnesses are referred to the CCC or to the hospital.

With regard to the care, support and treatment systems, the following strengths and weaknesses have been identified:

Table 3: Care, Support and Treatment: Major Strengths and Weaknesses

Description	Major Strengths	Major Weaknesses
Samastha partners for capacity-building	Having strong partners as resources (e.g., EngenderHealth, St. Johns Medical College, Snehadaan, SVYM)	Some of the products developed are not user-friendly nor cost-effective (e.g., eLearning, glossy publications)
Training	Stigma & Discrimination module very useful for CCC staff	Limited exposure to and practice of Home-Based Care
Medical care provided	• Increasing access to and use of ART services • Quality of care improvements – through training and mentoring of all cadres of staff • Initiation of care and support of OVC/pediatric HIV as a special service • Initiation of efforts to extend social support and entitlements to PLHIV/CLHIV • Comprehensive (sequence of care under IMAI, competent clinical mentorship and learning sites, experiential learning and Expert Patient trainers)	• Limited pediatric care; tracking of CABA to be further developed • Weak TB management • Weak diagnostic facilities for clinical cases • No monitoring of drug resistance among HIV-TB co-infected people • Further attention needed to discordant couples/partners[25] • Nursing care for pediatric HIV has not yet been addressed
Infection Control	• Good infection control module developed by EngenderHealth • Positive attitude of staff to learn	Some infection control practices in CCCs are unsafe and not yet as per standard (esp. as related to use of gloves and disposal systems)
Program Management	• Good CMIS • Efficient tracking system of LFU	• Limited CMIS feedback to CCCs • Role of outreach worker at CCC not well defined
Linkage (community to health facilities)	Effective community outreach bringing people to services	Limited success with linkage to district-level networks of HIV+ people

Concerns

Limited pediatric AIDS care

In light of the growing burden of pediatric HIV cases,[26] most CCCs are not equipped to handle HIV infected children with common medical problems. Both medical and nursing officers require additional training and support to effectively manage and care for the growing number of children living with and affected by HIV and AIDS.

[25] However, more than 1000 sero-discordant couples have remained sero-discordant after 2 years of outreach (Reynold Washington, email communication).

[26] Through January 2011 in Karnataka, a total of 12,220 children have ever been registered for pre-ART and 3,695 are currently alive and on ART.

HIV-TB co-infection and integration of services

TB is part of Samastha's care continuum but clinical management remains an issue, which needs system changes. Samastha has helped build the state's response toward improving TB coverage and TB-HIV integration (including joint training with the Revised National TB Control Programme [RNTCP] and procurement of CTX supplies, joint planning at the state level and joint visits to high priority districts). However, TB diagnosis often is missed in northern Karnataka, due to inadequate diagnostic facilities for sputum testing and the lack of facilities for diagnosis of extrapulmonary TB. The current procedures, usually implemented at initial diagnosis, need to be followed longitudinally for all asymptomatic HIV positive cases and become an integral part of regular screening.

The challenge nationally. TB is the most prominent disease in India. About 95% of the population is infected, with the disease killing more than 1,000 people a day. Every year, TB results in some 100,000 women being rejected from their families, some 300,000 children dropping out of school, and economic costs to society of approximately $3 billion. TB is the main opportunistic infection suffered by HIV-infected persons. HIV-TB co-infection is already a very serious problem that could easily become worse with the spread of HIV and multi-drug resistant tuberculosis. India accounts for about one third of the global burden of TB. (Source: USAID/India *Partners Guide* 2008)

Growing burden of HIV care

Not to be ignored, especially in high prevalence districts, is the growing burden of HIV care as AIDS moves from crisis to chronic disease. With the increased availability and acceptability of ART services, ART centers are now serving as the focal point for referrals, linking PLHIV and their families to this facility (for CD4 testing for the HIV+ person and encouragement of family members to go to the ICTC for HIV screening). They also serve as the primary "point of care;" because of developed relationships, PLHIV feel comfortable coming here for treatment of OIs and other problems.

In the future, this will pose an overwhelming burden of care for the ART centers. It will therefore be necessary to continue to strengthen the PHCs, *taluka* (sub-district) and district-level facilities, and all providers in order to meet the ever-growing need for non-AIDS care for PLHIV who are now surviving thanks to ART. This burden of care will be felt even more acutely in high-prevalence districts (see Annex F-3).

Support for Living: More Than Tests and Drugs

> *"ART and OI medicines add years to life, but the counseling and supportive care offered through the Jeevana Jyothi adds life to those years."*[27]

"Improve health and social outcomes for people living with and affected by HIV and AIDS in selected districts of Karnataka and Andhra Pradesh." This is one of the Samastha's two main objectives agreed upon in the USAID Cooperative Agreement. In Samastha, support does not mean just disease-related care. On the contrary, the project planned from the start to provide support to improve the quality of life for people found HIV+. While the humanitarian dimension in this work is profound, programmatically, this component also has a direct impact on disease reduction. Giving hope to people who get on ART and reducing stigma encourages others who may suspect they have been infected to go for testing.

[27] KHPT. "Clinical Services, Jeevana Jyothi - Learning from Communities," Bagalkot Project, No date, p.15.

It was profoundly clear during field visits in distant communities that people living with HIV and AIDS are immensely grateful for the support that they see coming to them directly from Samastha, via outreach workers who, in many cases have made a difference between life and death.

Melanga is a peer counselor at the Mysore Hospital IPPCC. She is positive, about thirty years old. She is in charge of ninety-eight villages with about 300 PLHIV. She visits their homes weekly or monthly, depending on their condition, and keeps in touch with them by telephone in case of crisis. In addition to giving information about hygiene, ART adherence and CD4 counts, she accompanies PLHIV for care and services when needed. She also provides information about family planning.

Testimonials in Andhra Pradesh

Crowded together, sitting on mats in the small space of the Challapalli Drop-in Center for Positive People, one positive person after another—many of them AIDS widows—wanted to tell their story of how an outreach worker had pulled them back from the abyss. All spoke passionately, often with tears.

"When my husband died of AIDS, my family threw me out, with my little daughter. I had nowhere to go and was desperate. I didn't have enough food and stopped taking my medicines. Then Suparti (she beams and gesture to an outreach worker) saved me. She persuaded my family to take me back in. Now I am earning some money in day labor and am taking my medicines again.

"I was a cook in a school. My husband died of AIDS. When they learned that I was HIV-positive, they would not let me continue. For days, weeks, I was desperate. Then Jyoti (peer outreach worker) saved me. She took others, of higher status, and went to the school and explained that my condition could not enter the food. Many other people from Samastha talked too, explaining many times. Finally it was agreed that this disease cannot enter the food. Now, thankfully, I am back cooking again at the school. I am a good cook.

"I am owning a small plot of land, very small. When the neighbors learned I had this disease, AIDS, they believed they could take my land. I fought, but no avail. Then the outreach worker saved me. The officials called it "Land Encroachment." But the outreach worker proved that neighbor had no right. Now I have my small land again."

The Government of India provides many social entitlements for poor and disadvantaged populations and people living with HIV: food rations, widow pensions, and more. Many poor PLHIV, however, perhaps the majority, do not know about these benefits or are illiterate and cannot fill in required forms. Samastha-supported outreach workers have been linking PLHIV and OVC to such benefits, and supporting them against stigma and discrimination. The positive beneficiaries thank Samastha and plea that it does not end: "This support group is my life."

Self-Help Groups for People Living with HIV

The creation of PLHIV self-help saving groups under Samastha has also been very successful; participants praised their monthly meetings in which they discuss adherence, nutrition, social entitlements and join in group saving.

"This is meeting day for one of the Mysore Positive Self-Help Savings Groups. A total twenty-five members are registered and twelve have arrived at the Integrated Positive Prevention Care Center (IPPCC) which serves as a community drop-in-center and office for the supporting NGO, Swami Vivekananda Youth Movement (SVYM). Located near the district hospital and ART center, the IPPCC offers counseling, support and medical services to PLHIV registered with Samastha. The eight

women and four men present have been living with HIV for as little as five months to as long as eleven years. All four men are on ART, as are two of the women. All of the women have a husband who is positive and three are widowed. Twelve of thirteen children from eight participants are negative and the positive child, whose positive parents were identified during pregnancy seven years ago, has been coming to the center for four years. The woman who has been HIV+ for 11 years is not on ART, has a positive husband and no children. She first visited the IPPCC one year ago. One married couple is present; both are positive and the husband is on ART.

"One of the men learned about Samastha and the support group meetings from a peer counselor at the ART center. He gets his medicines at the IPPCC but has learned about home-based care and the importance of hygiene and clean drinking water at the meetings. As a member of this Savings Group, he saves about 150Rs per month and feels that in an emergency, if he needs money, this group and the savings will assist him. One mother spoke about the OVC program through which her child regularly receives a bag of protein powder as well as school bags, books and even special organized excursions. One woman mentioned that, while she was hospitalized at the Samastha/GFATM supported Community Care Center, Asha Kiran, she met someone from "Anand Jyoti" (the District Level Network of Positive People) who referred her to the IPPCC, where she has been getting medical care. The IPPCC has also been very helpful for linking participants to other government services such as ration cards and special programs for PLHIV.

"The participants agreed that the primary value of the support group was meeting and sharing on a regular basis. A few mentioned that they want to reach out to others to share their stories and to give people living with HIV hope and courage. Fear and stigma remain barriers to people coming forward, and building self-esteem was deemed critical. They felt the best place to meet other PLHIV was at the ART center or at the care and treatment center (ICTC) when people are first identified. That is when the fear is the greatest.

"All the participants who are on ART use the nearby ART center for most of their medical care. They are very satisfied with the doctors and counselors. They say the technician is very good at drawing blood and always wears gloves. They usually wait at least one hour and often longer to get CD4 test results. They travel between two to twelve km. to reach the center and pay about ten to twenty rupees each way, which is considered an acceptable price."

A foster care family for OVC. *Vikram sits on his foster sister's lap, timidly glancing at the strangers who have entered his tidy one-room home in Vannur Village, Belgaum. Eight years old and HIV+, he is small for his age. His father died of AIDS and his HIV+ mother is a sex worker who was unable to care for him due to her own health problems. With the assistance of BIRDS, Samastha, the Link worker and village health and sanitation committee (VHSC), Vikram found a new home with another family also affected by AIDS. Vikram's foster parents lost their daughter to AIDS and were raising their two teenage granddaughters. At age sixty-five, grandpa is an agricultural worker, and grandma is occasionally able to do manual labor earning twelve rupees per day. This was never enough, so the granddaughters had to leave school and do manual labor to help the family survive. The foster parents have three sons in addition to the daughter they lost, but none is able to provide any support and one son refuses to have anything to do with the family due to the stigma of HIV/AIDS.*

Today, assisted by the Samastha Foster Care program through the VHSC, the family has been linked to government assistance programs that have been directly facilitated through Samastha. They currently receive 500 Rs per month and 1,000 Rs annually for educational costs. In addition, Samastha has linked Vikram's thirteen- and fourteen-year-old foster sisters to the Sabla program, which provides them with nutrition delivered monthly by the Aganwadi worker coming from the Department of Family Welfare. Both girls have returned to school, and Vikram is in school too. Every three to six months

Vikram travels with his foster mother to the ART center in Belgaum. Travel costs, forty rupees each way, are supported by the VHSC. His height and weight, checked regularly by the Samastha Link Worker, remain below the third percentile, but his CD4 count is now 544 and he is normally full of energy. The foster program encourages any surviving parent or relative to stay in touch with the child. Vikram's mother visited once last year. Her health has improved but she is currently living and working in far-away Goa. The Samastha OVC/CABA initiative operates in all districts in Karnataka and Samastha districts in Andhra. A total of 17,898 children are registered in the program, 28% of them living with HIV.

c. CAPACITY BUILDING AND HEALTH SYSTEM STRENGTHENING

Samastha has built good capacity and strengthened the health systems of Karnataka and AP at many levels, from individual and grass roots levels (link workers, outreach workers, peer educators, etc.) to institutional levels (SACS, DAPCUs, NGOs, training institutes, etc.). Important health-system strengthening has occurred, but to develop sustainability, time is needed to nurture, strengthen and adopt effective measures at the local, state and national levels. The project period is too short to scale up, consolidate and close out—while also sustaining all interventions and behavior change at the present level of accomplishment—without further support. The risk is that the investment made and good work achieved during the short years of Samastha implementation[28] is otherwise likely to dissipate without additional time, during which activities can be absorbed into and funded through the government structures. KHPT and KSAPS have worked together to include key elements from the Samastha project into KSAPS' Annual Action Plan for FY 2011–2012 (April 1, 2011–March 31, 2012) and Karnataka's secretary of health reports having urged NACO to sustain the Samastha interventions.[29] It is very unlikely, however, that all Samastha work can be mainstreamed into the government's 2011–2012 plans. The effective interventions developed under Samastha should be continued for an additional period, with USAID support and/or support from other agencies, while structures are found or developed for mainstreaming into state and/or national programs.

SOW question #1:

How has the Samastha Project contributed toward the strengthening of the health systemic response to HIV/AIDS in Karnataka and Andhra Pradesh? What challenges were faced in Karnataka and Andhra Pradesh?

Conclusion

Samastha has contributed significantly to strengthening the health system response to HIV/AIDS in Karnataka and Andhra Pradesh. Capacity building of implementers (individuals and organizations) and health systems strengthening have been priorities of the Samastha project (about 25% of budget dedicated to this objective). Where Samastha has worked, capacity has been built and the health system has been strengthened, top to bottom.

Detailed findings

Evidence of success in capacity-building exists in the numerous achievements described in this report (see Sections II.1.a., II.1.b., and II..3., "Prevention" , "Care, Support and Treatment" and "Strategic Information").

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[28] Although Samastha is a five-year project, it has had only about three-and-a-half years of implementation to date, following an initial start-up period during which partnerships were established, investigative ground work took place (village mapping, etc.), and implementation plans were prepared.

[29] Discussion at Karnataka Statehouse with health secretary, NRHM mission director, Department of Women and Child Development, and other state officials, February 5, 2011.

For example, Samastha's information system provides the following evidence on Samastha capacity building inputs strengthening the health system:

Component: Link-ART centers

- Problem addressed: Distance to the ART centers was a barrier, hindering use and weakening treatment adherence.
- Input: Samastha provided on-site training for establishment of Link-ART centers closer to patients' homes; mentorship provided by senior counselors in the ART centers; created a Yahoo group for networking on clinical issues.
- Output: Number of Link-ART centers increased from zero to ninety-three.
- Outcome: Access to treatment improved dramatically.
- Attribution: Essential training would not have occurred without Samastha.

The Karnataka health system's ability to provide ART to some 52,993 persons in FY 2010[30] with so few LFU is further evidence of the strength of the system that Samastha has helped to build (refer to Figure 6). Similarly, the system's ability to motivate female sex workers to be tested for HIV and to go for regular STI check-ups is evidence effective capacity building.

In Andhra Pradesh, the $1.5 million in project funds for those coastal districts come from Samastha's care and support budget line. Much of this, however, has focused on capacity building and strengthening of systems for care, support and treatment.

How has Samastha accomplished these achievements?

Following are the yearly steps Samastha has taken towards strengthening of the health systemic response to HIV/AIDS:

1st year	• Preparing the foundation: Inductions (orientation of government and others) , Situation Needs Assessment, Monitoring Information Systems, Outreach Dialogue Skills
2nd year	• Strengthening Service Delivery: Basic Care Skills Training, Counseling skills, Stepping Stones, Team building training, Home-Based Care, ART adherence, HIV/TB, OVC Program , Infection Prevention/Stigma & Discrimination, BCC Materials Use and Training Phase 1, etc.
3rd year	• Consolidation of Services and Extension into Community Action; • Government services and support - Institution building
4th year	• Health systems strengthening of Karnataka Health Systems, • Strengthening CBOs for ownership; Mentoring visits to CCCs, IPPCCs, • Client Oriented Provider Efficient (COPE) pilot in ART centers
5th year	• TA to KSAPS; GIPA Trainings: Induction/Community HBC/Positive Prevention Tool Kit and Rollout, Strengthening Counseling services, Training Support Groups , Social Entitlements

Training, well-planned and delivered

To build capacity, Samastha has conducted a large amount of training for health care providers, managers, counselors and outreach workers see box, below). Of course, "numbers trained" is not an indicator of quality of training, or of outcomes and impact. Training quality, however, has been high. This is evidenced by the program outputs and impacts discussed above. Furthermore, site visits offered first-hand observation of the competence with which staff are doing their work and the satisfaction, and even enthusiasm, expressed by field-level personnel about the Samastha training they have received.

Samastha training, 2006-2010

- 3,318 persons trained under Care & Support
- 5,527 persons trained in Prevention

[30] S. Shastri, "Care, Support and Treatment in Karnataka." PPt, KHPT, December 2010.

"May I show you my micro-planning?" asks Prasana, a supervisor of outreach workers at the Challapalli Drop-in Center in Krishna District, Andhra Pradesh. Face glowing, she proudly displays her hand-drawn "priority wheel," her review of village mapping by the outreach workers, her field diary and records. Likewise her four outreach workers, all HIV+ but appearing full of energy, vie too to display their micro-planning and colorfully-drawn priority wheels plus field diaries of their home visits. Each of them is responsible for twelve to twenty-five villages, depending on the geographic spread; each has about sixty PLHIV and a few HIV+ children. Soon one outreach worker pulls from her bag a wooden penis model, wanting to demonstrate its use. Another jumps in, eager to show her Positive Prevention Toolkit, telling how it is so important in facilitating successful visits to village homes. "People with HIV used to feel ashamed and hide from others. Now they like to see us coming with our flipchart and gather neighbors to learn about AIDS. It makes stigma fading away." On a bulletin board are photographs of events they've organized. "There's a large HIV community here," explains Prasana, "because of the truck route. In 2007, there was nobody to help PLHIV. Now we help, accompany people to ART, hold Support Group Meetings, leverage school books and supplies for their children. We've even arranged 'positive marriage' for couples both who are positive. This program cannot stop. It must continue. It is changing the lives of so many.

"Similarly at a CCC in West Godavari district (where prevalence is calculated at 2.08%), seven PORWs (positive outreach workers) vie to show their tools and books. The colorful priority wheel, part of micro-planning. "The project taught us how to plan and use our time, and we teach this to our PLHIV too." Each proudly shows her neatly-kept ledgers. One book for patient follow-up. One book with village maps. One field diary. IEC materials, condoms and the wooden penis model. "Samastha has increased our confidence. We have learned so much. But many don't have this; they need it too." Their supervisor (a man, also positive) eagerly explains: "We use the CMIS and its data for our monthly meeting with the PORWs. This helps them plan; it's really very useful. And the quarterly analysis from KHPT, also useful for planning. Plus we use it, the CMIS, for our NACO reports. Previously we had to do it all by hand. Now in just a click we have our report to send to NACO, and to Samastha too. The CMIS is beautiful."

The same level of confidence and competence among outreach workers was observed at each of the community-level site visits (about fifteen) during this evaluation.

Samastha's training generally has been well designed, delivered by competent teams with high-quality materials, systems, experience and skill. The approach is interactive and hands-on (e.g., roleplay, rather than lecture-based). Training has been designed with, in most cases, frequent reinforcement through mentoring, "hand-holding," supportive supervision, an effective M&E system and strengthening backward, forward and lateral referral links (see Annex H-1).

Prevention training for reaching at-risk rural populations

Aimed at reducing HIV transmission among for most-at-risk rural populations, training for reaching and mobilizing at-risk rural populations has been intensive and multi-faceted: foundation course, Stepping Stones, life skills education, outreach communication skills, counseling, ideology building for PLHIV, STIs, organization development, social entitlements, micro-planning, M&E, training for field researchers and supervisors, enabling environment, and training for VHSC (see Annex H-2).

Care, Support and Treatment

Samastha's capacity-development strategy for care and support is based on a multi-tiered training program: basic training followed by clinical mentoring, hands-on experiential training at learning sites (Bagalkot, Swasti and Snehadaan); and advanced-topic training packages developed by EngenderHealth (TB/HIV; pediatric HIV and OVC care; infection prevention, and stigma and

discrimination; the Client Oriented Provider Efficient [COPE] tool; and home-based and palliative care). Samastha has also provided ongoing capacity development through continuing medical education programs.[31] (See Annex H-2.)

Effective Tools
Results-oriented tools and job aids for the various cadres of workers have been a high priority, going hand in hand with the training. Samastha wisely adopted already existing tools where appropriate, rather than developing new ones. Examples include EngenderHealth's very effective COPE tool and the Positive Prevention Toolkit developed by CDC. Samastha/KHPT have also developed some excellent tools to fill the gaps. For example, the *Prevention of HIV and AIDS & Care for People Living with HIV and AIDS: A Toolkit for Program Managers* usefully explains distinctions among target groups to government officials and others, and the rationale for reaching and fine-tuning approaches to each.

Challenges. These have included:

- Samastha's need to follow national guidelines that neither reflect best practices nor latest knowledge concerning effectiveness (e.g., LWS, CCC structure)
- The ongoing issue of operating under a system (i.e., NACO) parallel to the State Health Department, rather than being integrated into the existing health delivery system.
- Despite efforts, limited success in collaboration with and strengthening the positive networks (DLN+ and KNP+), as was envisaged in the Cooperative Agreement
- Training limitations: very good modules, but some training (e.g., IMAI, COPE, Infection Prevention, Stigma and Discrimination) has only begun or been provided to only a limited number of individuals and institutions
- Difficulties in meeting PLHIV requests for social entitlements (food rations, widow pensions, and other social and economic benefits)

SOW question #2:

How successful has the Project been in building the capacity of local institutions for rural prevention, care, support and treatment—such as the State AIDS Control Societies (SACS), District AIDS Prevention Control units (DAPCUs), and technical partners? What have been the opportunities and challenges?

Conclusion

Samastha has been successful in building the capacity of SACS and DAPCUs, providing substantial training and technical assistance—especially in Karnataka, where it benefits from KHPT's close, organic relationship with KSAPS.[32] In response to requests from SACS and NACO to provide technical assistance in the areas of capacity building, field level mentoring, module development, and best-practices documentation, Samastha established its Strategic Initiative and Knowledge Translation Unit (SIKT), which now facilitates TA and capacity building support.[33]

[31] Source: Samastha "Technical Brief on Capacity Building Strategy." KHPT, 2011.
[32] Samastha *Annual Progress Report, 2010*; and "Capacity Building through Care & Prevention Trainings, 2011," matrix provided by Samastha.
[33] "Strategic Initiative and Knowledge Translation Unit (SIKT)." PPt presentation, February 3, 2011.

Detailed findings

Support to the state AIDS control societies—KSAPS and APSACS:

- TA that improved quality and access in the rolling out of ART and Link-ART centers.
- TA that increased access to and use of PPTCT services.
- TA in the development, planning and implementation of training for outreach workers, health workers and counselors of IPPCC and drop-in centers for community and home-based care and positive prevention.
- Capacity building of counselors at ART centers through sex and sexuality sensitization training for ART counselors, mentorship, and training of pharmacists.

TA to develop the state's annual action plans.Support at the district level:

- Capacity building for the DAPCUs: capacity has been well built and DAPCUs have been actively supported by Samastha. Samastha-initiated, district-level coordination meetings are now institutionalized under DAPCU. Samastha staff supported the mainstreaming training under the DAPCUs. [34]
- To facilitate decentralization of HIV prevention management, Samastha (in consultation with KSAPS, the KSAPS Technical Support Unit [TSU], and NGO representatives), conducted perspective-building workshops with key stakeholders in all districts of Karnataka. The sensitization process consistently emphasized reduction of stigma and discrimination to create an enabling environment that empowers PLHIV to access their social entitlements.
- Development of a training curriculum/module for the strengthening of supportive supervision and monitoring by district supervisors.
- TA in planning, module adaptation, and systems for implementation, monitoring and reporting to the implementation partners.
- TA and handholding support in adapting the life skills education module for KHPT's Migration Project in the districts of Bagalkot, Belgaum and Bijapur and support to the training of the district teams. A midterm review of LSE programs identified gaps and strengthened the programs with refresher training.

Strengths

- Embedding five key Samastha personnel within KSAPS has been a very effective way to effect change. For example, for Samastha's ART consultant, sitting and working within KSAPS, focused on development of ART services, has allowed him to identify additional areas that KSAPS can also address. This embedment has built greater ownership of the HIV/AIDS program within KSAPS than if these five Samastha staff had not been physically at KSAPS.
- Samastha's strong CMIS system facilitated the work of the SACS (Karnataka and AP).

Challenges

- Effecting change within district-level hospitals is a challenge, especially because SACS operate outside the State Health Department
- Building capacity for large-scale comprehensive interventions with multiple institutions, staff turnover, scheduling conflicts (periodic meetings, training, etc.)

[34] KHPT. *Mainstreaming District AIDS Prevention & Control Units (DAPCU): Karnataka Experience*. 2010.

- Andhra Pradesh. In the project proposal, health system strengthening and capacity building was an objective only in Karnataka. AP's project budget of was only $1.5 million and planned for Care and Support. Samastha had no embedded key personnel in APSACS. Thus, capacity building occurred in Andhra, but not at the same scale as in Karnataka.

SOW question #3:

How successful has the Project been in providing TA at the national level? What have been the opportunities and challenges?

Conclusion

Samastha has been very active and quite successful in providing TA to meet many national-level needs.

Detailed findings

- Samastha has actively assisted NACO in developing guidelines for targeted interventions (TIs), orphans and vulnerable children/CABA.
- The Link Worker Scheme has been a major area of TA to the national level (see details in Section II.2 below).
- In most of these areas, Samastha has been represented on the Technical Resource Group (TRG) at NACO, has supported NACO to conduct experience-sharing and training, and has influenced the M&E framework.
- In response to NACO requests, Samastha has also participated in site-level evaluations (of targeted interventions and CCCs).
- Samastha established a Strategic Initiative and Knowledge Translation Unit at KHPT to provide TA and capacity building support to the SACS and NACO in areas such as capacity building, module development, and documenting best practices.
- Samastha has discussed its CMIS and M&E framework with NACO at length. Some Samastha reporting formats and indicators have been included in national guidelines.
- Samastha provided TA to NACO in developing a curriculum/module for strengthening of supportive supervision and monitoring by district supervisors and rolled out training for district supervisors across India.
- Samastha and partners have provided training for Village Health and Sanitation Committees, ANMs, ASHAs and Anganwadi workers, which has been appreciated and acknowledged by NACO, NRHM and RNTCP.

Samastha leadership judges that it has been "partially successful" in having all its technical offerings *adopted* by NACO. "The LWS and rural programming scaled up across the country; M&E was partially implemented; outreach planning and some modules have been used for training. . . . Bagalkot district is not easily accessible and this poses challenges for learners to visit. Besides, the LWS needs to be fit into the local socio-cultural and sexual context…."[35]

Challenge

NACO, as the lead for HIV work in all India's diverse states, sets guidelines that apply nationwide. Because some states' health work is quite weak, the NACO guidelines tend to be very prescriptive and do not allow for the fine-tuning to local situations that has become the hallmark of the Samastha approach. This has been a major challenge.

[35] Reynold Washington, February 17, 2011, by email.

SOW question #4: Convergence

In the context of integration of HIV and AIDS services under flagship national health programs [NACO and NRHM], how has the Samastha Project contributed to implementation of a comprehensive and integrated package of services for vulnerable populations?

Conclusion:

"Implementation of a comprehensive and integrated package of services for vulnerable populations" is an aspiration for the future. Decades of USAID experience with vertical programs (e.g., BKKBN in Indonesia) and efforts to subsequently integrate them into the normative structures of the Ministry of Health teach that integration does not happen overnight.

Detailed findings:

Many Samastha activities have contributed to laying the foundation for convergence and integration:[36]

- *Expanded the capacity* of many doctors and other health workers to address the STI, HIV and AIDS needs of vulnerable populations
- *Systems established* in government facilities for HIV and AIDS testing, care and treatment
- *Integration of the PPTCT program with NRHM*: TA for guidelines for integration; configuration of outreach ICTC services to expand coverage; nurses and laboratory technicians training in 24x7 PHC for counseling and testing services; drafting government circulars for increasing access to ART services; early infant diagnosis and infant feeding.
- *Integration of TB-HIV* cross-referrals.
- *Integration of OVC / CABA initiative into DWCD*: concept notes for leveraging resources; satellite training workshops for all DWCD staff; drafting government circulars for guideline implementation; support to implementation of CABA scheme; linking with social schemes through involving district commissioners and chief executive officers of Zilla Panchayats, as well as village health and sanitation committees.
- *Approaches for serving orphaned and vulnerable children (OVC)*: Community-based OVC program training; OVC programming for district-level functionaries (deputy director of the Women and Child Department, Child Development Project officers, supervisors and Anganwadi workers).
- *Integration of training for STI and ICTC components with State Institute of Health and Family Welfare (SIHFW):* Development of training materials, job aids, and contribution of resource persons for the training.
- *Training-of-trainers programs for infection prevention and reduction of stigma and discrimination in health care settings:* This training is now being rolled out in all community health centers and government PHCs through the SIHFW and its institutions, supported by Samastha.
- *Counseling skills training*: Samastha has developed and institutionalized the role of counselor in district health facilities. Developed initially to service HIV patients, this important new role and skillset enables health facilities to respond to the needs of vulnerable populations who, previously, often feared going to a health facility—due in large part to negative treatment by the medical staff. Samastha has provided TA in

[36] Source: "Convergence for HIV Care: National Best Practices Workshop," November 5–6, 2009, Bangalore; "Samastha Annual Progress Report 2010"; and other Samastha project documents.

developing a national curriculum and training module for counselors in targeted interventions. This training has been institutionalized in NIMHANS.

- *A pediatric counseling skills manual* has recently been developed by Samastha (EngenderHealth) and is being rolled out by Clinton Foundation in Andra Pradesh.
- *Building HIV perspectives among VHSCs* to ensure mainstreaming of HIV. Trainings for VHSC members were conducted across the twelve Samastha districts. Objective was to build perspectives about NRHM, VHSC and HIV, and to understand the composition, importance and role of VHSC in HIV prevention.
- *TA to NRHM's VHSC Project* - included infection prevention/stigma and discrimination reduction training, satellite-based trainings, CMIS.
- *Improved health knowledge and response at the village level*, through support for the VHSCs and establishment of village resource centers (e.g., Mysore district)
- *Institutionalizing training*, strengthening village response through development of well-trained cadres of outreach workers serving vulnerable populations.
- *Development of materials that support outreach and services among vulnerable populations* (e.g., "Enhancing Outreach Communications Skills": training modules for community outreach workers on dialogue skills, messaging on prevention and care, etc.)
- *Two CCCs established in district hospitals under Public Private Partnership.*

Samastha's care team and its learning and training partners (EngenderHealth, St. John's Medical College/ National Academy of Health Sciences, Swami Vivekananda Youth Movement and Snehadaan) have the potential to provide TA across all four high-prevalence states in south India (Maharashtra, Tamil Nadu, Karnataka, and AP). St. John's is nationally recognized, Snehadaan has branches in Maharashtra and AP, and SVYM was a training center under EngenderHealth for PLHIV networks, under Global Fund Round 4, for Karnataka and Maharashtra.[37]

2. LINK WORKERS

SOW question #1:

What have been the contributions of Samastha to the design, implementation and monitoring of Link Workers in Karnataka?

Conclusion

Samastha has been the clear pioneer in developing, refining and implementing the Link Worker Program in Karnataka, which has subsequently been studied by NACO and many other states. Following Samastha's lead and deployment of link workers in twelve districts, NACO developed its national Link Worker Scheme, which KHPT implements in eight districts of Karnataka.[38] CDC and UNICEF also sponsor variants of Link worker programs in four districts each, based on the Samastha model and implemented by Myrada, an NGO. KHPT trained all teams.[39]

Detailed findings:

Samastha based its Link Worker component on the "ICHAP model" developed and implemented from 2001–2006 in Bagalkot District under the India-Canada HIV/AIDS Project.

[37] Reynold Washington, by email.
[38] Samastha's initial, twelve districts are now thirteen, as Gulbarga district has been divided into Gulbarga and Yadgir.
[39] For complex reasons, the other districts do not include the critical design improvements of Samastha listed on this page.

Originally, the Link Worker program was designed as a "community-based rural HIV/AIDS prevention and care model" for high-prevalence districts.

The Samastha program design centered on HIV prevention, referral and follow-up services to high-risk groups and vulnerable populations in rural areas. Specifically this included (1) prevention with rural FSWs, (2) prevention among the rural general population, village youth, pregnant women and high-risk men and women, and (3) care and support for PLHIV and OVC. The strategy was to train a village-level workforce of link workers, supervisors and volunteers on the various issues of HIV/AIDS, gender, sexuality and STIs and on how to mobilize high-risk individuals, youth and women to go to public health facilities for STI, HIV, and ART services and to follow through on service recommendations.

The program design in the first two years of Samastha was similar for all twelve districts irrespective of the burden of the epidemic, as this fit with NACP III guidelines for 'A' category districts. [40]

In 2008, emerging evidence suggested that the program required a "strategic shift," finely tuned to accommodate the varying conditions within Karnataka. As a result, the decision was made to focus in central and south Karnataka districts on female sex workers only. In contrast, for northern Karnataka it was decided to include the general population in districts (five in north Karnataka) with evidence of active local sexual networks (high rates of multi-partner sex and high HIV prevalence among men, clients of sex workers), and to include community home-based care, thus integrating prevention and care.

Under Samastha, the original model has undergone further refinement, with specific design elements included that have been shown to improve effectiveness and impact. These include:

- Selecting for participation only those villages with a substantial presence of the target vulnerable populations (PLHIV and FSW);
- As per Samastha's 2008 strategic shift, defining key target populations to reflect the needs of local geographical and contextual settings
- Using an individualized monitoring and evaluation system (to track individuals)
- Training and mobilizing village volunteers through the "Stepping Stones" program
- Providing expanded health services through 24/7, primary health care centers; and
- Allowing flexibility for responding to changing local environments and needs.

These design elements allow tailoring of the Samastha Link Worker model to respond most cost-efficiently to the critical needs and gaps identified in each district; this has been found to be effective, especially in the very high-prevalence districts of northern Karnataka.

The work required of all Link workers is significant. Their primary responsibilities include home visits to high-risk groups (including FSWs, PLHIV, pregnant women and OVC), reaching out to men and women judged to be at risk, accompanying persons at risk to service sites (ICTC, ART, etc.), conducting training programs for youth and OVC, working with village health and sanitation committees, and installing condom depots and village resource centers.

Pregnant women were a target population during the first two years of the program. Since the PPTCT-NRHM integration and after ASHA workers came into existence, Link workers focus

[40] NACO has classified districts according to HIV prevalence, "A" representing the highest prevalence: ANC prevalence of 1% and above.

specifically on linking positive pregnant women and their children to ongoing PPTCT and care initiatives.

Some of the many challenges faced by the Link workers include: how to address the psychosocial needs of doubly-orphaned children; infected adolescents asking for marriage solutions; HIV-positive women asking for medical help for childbirth and surgeries (tubectomy, appendicitis, kidney stone removal, etc., as many doctors are still hesitant to handle their cases); and PLHIV reluctant to reveal their positive status and thus giving wrong contact information.

> ***A link worker's story.*** *"When Nagama was twenty-seven, her husband became very ill. He was taken to the local hospital and she was told that he had AIDS. She decided to take her two children back to her parents' home so she could better care for her husband. Within a few months, he died and she found herself a widow with two small children, living in her parents' home. A member of the village health committee proposed her name as a link worker, a new cadre of village-level health worker that soon to be introduced in the village. Nagama gratefully assumed this role and soon became the primary earner for her parents and children. She has committed the last four years of her life to help others in her village who are affected or infected by HIV. She works daily, nine to four, moving around her village and two other villages visiting the homes of PLHIV or meeting with adolescents and women who are at risk. She works side by side with a male counterpart link worker and also accompanies people from her village to the HIV Counseling and Testing Centers (ICTC) and to ART centers for CD4 testing and treatment. She proudly shared that she recently accompanied thirty pregnant women to the ICTC. Each of the pregnant women paid her own transportation. All were proud they were doing their best to prevent their unborn children from being infected."*

Samastha now works in 2008 villages selected through a mapping exercise that identified villages where HIV prevention and care needs were greatest. There is flexibility to adjust the program, complementing other existing programs and avoiding duplication in each district, keeping in view optimum use of funds and person-power.

Sustaining this level of work—while maintaining the quality of the interactions, plus substantial documentation requirements—with limited training, remuneration and travel compensation presents many challenges. In the five northern high-prevalence districts of Karnataka[41], Samastha currently employs 381 outreach workers (this includes Link workers, FSW peer educators and peer outreach workers) who cover the rural population.

For the future success of the AIDS response in Karnataka, it will be crucial to assess the impact of the NACO versus the Samastha Link Worker models to determine how the Link Worker Scheme should best be continued. This assessment should include consideration of the many other village level workers, including FSW Peer Educators from Targeted Interventions, ANMs, ASHAs, and Anganwadi workers. It should also be determined if this level of intensive rural intervention is really required in all currently-designated "A" districts—or, for cost-effectiveness, if Link workers would be best utilized only in extremely high-prevalence districts (e.g., Bagalkot and Belgaum). Such extremely high-prevalence districts might best be reclassified as A+ districts.

[41] Five high-prevalence districts are, Bagalkot, Belgaum, Bijapur, Gulbarga, and Bellary.

SOW question #2:

What specific TA has Samastha provided to NACO for the nation-wide scale-up of the Link Worker Scheme?

Conclusion

Samastha has provided important TA to NACO for the nationwide scale up of the LWS. Scaling up the original ICHAP Bagalkot Link Worker intervention to the twelve Samastha districts in Karnataka allowed the Samastha team to learn many lessons. After Samastha established Bagalkot as a learning site, many officials at the national level visited to learn from it.

Detailed findings

National-level officials included the DG, NACO (Ms Sujata Rao, June, 2007), who endorsed Bagalkot as a learning site for rural programming. NACO then sent three senior technical officers to review and learn from Samastha's link worker training. Many others have used the Samastha learning site -- not only officials from NACO, but also from CDC, UNICEF, UNAIDS, APAC, LEPRA Society, etc., implementing the LWS. Other states were then encouraged at NACO level to visit the Bagalkot learning site, and Samastha trainers spent about four weeks in neighboring Maharashtra to provide TA to build capacity for LWS implementation in that state. NACO Deputy Director Dr. Khera spent three days with Samastha/KHPT in Bangalore to rewrite the LWS operational guidelines; they include Samastha's rural mapping approach and Bagalkot as a learning site. Nine training modules, developed under Samastha, are now being redeveloped for NACO with support from UNDP. The Samastha CMIS and M&E framework have been discussed at length with NACO and some reporting formats and indicators have been included in NACO's LWS. The National TSU has visited northern Karnataka almost every quarter since June 2010. In 2010, NACO asked the Samastha team to facilitate three regional experience-sharing and learning workshops on the LWS. These *Vinimaya* ("exchange") workshops convened at Kolkata, Jaipur and Bangalore. Samastha staff facilitated most of the technical sessions.

Unfortunately, it appears that many of the important elements of the Samastha LWS have not been incorporated in the national Link Worker design and guidelines.[42] A recent (2010) multi-state evaluation of the national Link Worker Scheme highlights numerous limitations of the national program that could have been avoided.[43] See Annex G for a comparative assessment of the Samastha and the national schemes.

> ***PPTCT and the link worker.*** *"With a six-month-old smiling child cradled in her arms, Laxmi proudly shares that her baby is HIV negative. As the baby begins to cry, Laxmi lifts the palu of her sari and feeds her. "The doctor said I can only breastfeed for six months, and then I need to stop and give her other food," she says. When Laxmi was four months pregnant, she was visited by a local link worker. The link worker encouraged Laxmi to go to the ANC clinic for care and to the ICTC to make sure that she could help her baby to stay healthy. At the ICTC, Laxmi learned the shocking news that she was HIV positive. Because Laxmi had no major risk factors, the link worker encouraged her to disclose her status to her husband and encourage him to go for testing, as well. With the support of the male and female link workers, he was also tested. Both were positive, but neither currently requires*

[42] Reasons these critical elements were not included appear to be cost savings and NACO's preference for a single template that can apply to all states and contexts.

[43] Important findings include: inadequate training, lack of comprehensive village level planning, lack of infrastructure and job aids for Link workers, weak monitoring in the field, weak institutional arrangements, lack of awareness, and inadequate supplies especially regarding condoms. See ICRA Management Consulting Services Limited (IMACS) and International HIV/AIDS Alliance, August 2010.

ART. To date, Laxmi's baby is HIV negative, but she knows that the baby needs to be checked again. She also knows that she needs to check her CD4 again, but she doesn't know the date and will wait for the link worker to tell her when she needs to go."

Transformation of a Stepping Stones member. *"Durgappa is an unmarried man of twenty-five in Simikeri village, Bagalkot District. When asked about his experience in the Stepping Stones training program, he passionately declared that the weekly, hour-long training he participated in for three months last year changed his lifestyle completely. He is now very knowledgeable about sex and sexuality, no longer indulges in high-risk, random sexual behavior, and leads a confident, fear-free, peaceful life. He has told to his friends in the village how he benefitted from the program and has spread the message far and wide of reducing risk through unprotected sex by using a condom, not only in his own village but also at his work place, and prompted others to also undergo the Stepping Stones training. He openly praised the Link worker of his village for the inspiration he received to take the training. Dr. Gadad, medical officer of Kaladagi PHC, who provided good support as a resource person in the training program, was present. He said young people in the village are now equipped with the required HIV knowledge and life skills, and that the incidence of HIV has substantially come down in the village following the Stepping Stones training. The twenty-eight people in the training April–June, 2010 included volunteers, youth, VHSC members, and adolescent children of FSWs. They have now formed a Red Ribbon Club, following the NACO model."*

3. STRATEGIC INFORMATION

Overall conclusion

Strategic information capacity has been built successfully throughout all parts of Samastha. The collection of data and the strategic use of information for design and ongoing improvement have been a very high priority and one of Samastha's greatest strengths. For many years, USAID has emphasized the importance of data for decision-making.[44] The Samastha project is an outstanding example of how data generated by well-designed M&E systems can contribute significantly to successful interventions and overall impact. In this regard, Samastha/KHPT, by all international standards, is outstanding in the field of health improvement programming at the public health level.

SOW question #1:

What evidence was utilized or generated in the project to design results-based strategies and interventions?

Conclusion

Evidence in the design phase KHPT based its 2006 proposal to USAID on lessons learned during the ICHAP project in Bagalkot and its Avahan/Gates Foundation-funded Sankalp and Corridors projects.[45] During the Avahan projects, KHPT had used a two-stage approach—situation assessment and outreach planning—which enabled KHPT to rapidly scale up targeted prevention programs. "Within eighteen months our program partners contacted more than 40,000 (90%) of the estimated FSW population across 200 towns and cities, most of [whom] had

[44] USAID's centrally funded Data for Decision-Making project, in the early 1980s, tried hard to push this, but had only limited success.

[45] USAID/India. Cooperative Agreement # 386-A-00-06-0014 4, with University of Manitoba for "Enhance Karnataka Project". 20 September 2006, pp. B1-65, Program Description.

never had any previous HIV programming." [46] A modification of this approach was adapted for Samastha.

Detailed findings

Much of Samastha's first year went into detailed preparatory work. Deciding for cost-efficiency's sake to focus only on villages with populations of 500 or more, Samastha teams gathered data on all those villages in 2007, by means of social mapping, facility and network assessments. Final selection of the target villages considered geographic clustering and denominators for (numbers of persons in) the project target groups: FSWs, PLHIV, OVC and other high-risk individuals. Following the selection of the villages, a common intervention was initiated in all of them, introducing Link workers as the principal outreach workers.

Mid-term modification of the design

In late 2008, after almost two years of experience, the Samastha team conducted a district-wie review and reflection exercise. On the basis of evidence and results to date, the team decided a major "strategic shift" should be made. Accordingly, the project was redesigned to implement custom interventions in different parts of the state, based on variation in HIV prevalence, rural transmission dynamics and the burden of the epidemic. Thus, a major strategic distinction was made for the five high-prevalence districts in northern Karnataka versus the seven lower-prevalence districts in central and southern Karnataka. This evidence-based customization of interventions has made for greater cost-efficiency and effectiveness.

SOW question #2:

What M&E systems have helped the project in monitoring and tracking quality and progress at district and sub-district levels?

Conclusion

Samastha excels in monitoring and evaluation. Its M&E systems are summarized in the figure 7 below.

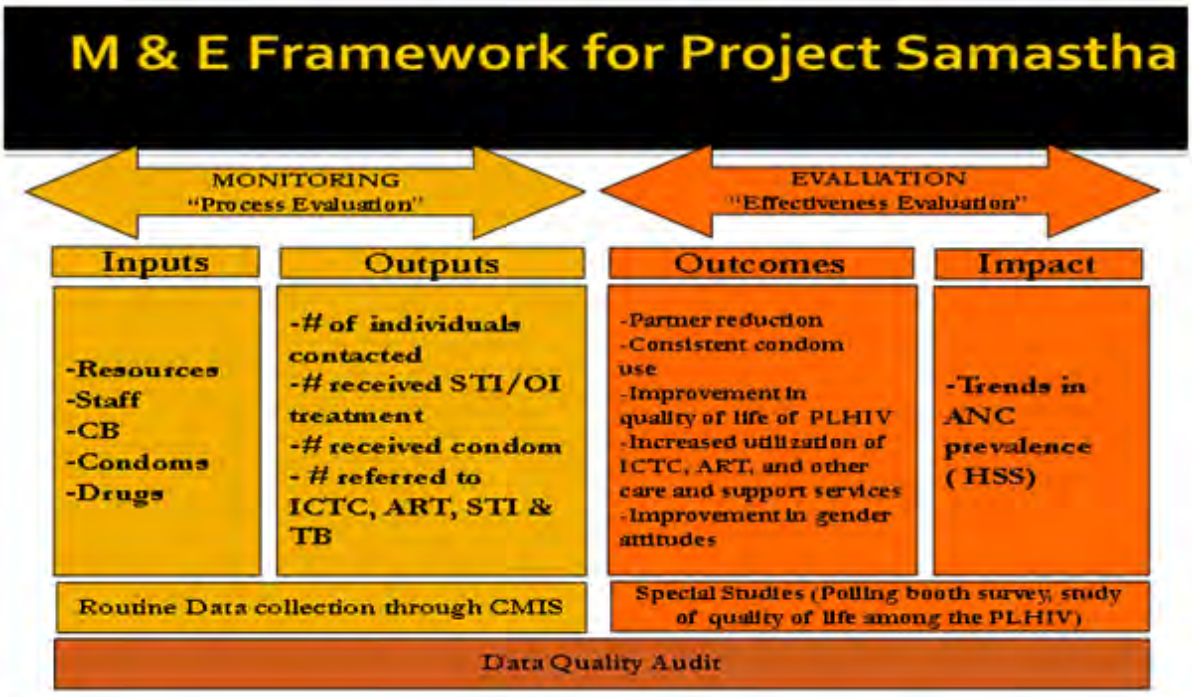
Detailed findings

A set of input and output process indicators is used for monitoring progress. A set of outcome indicators is used for evaluation. Some of these—such as utilization of the testing centers (ICTCs) and ART centers, and lost-to-follow-up (LFU) rates—indicate project quality and effectiveness. Impact on trends in HIV is assessed through data on HIV prevalence among pregnant women attending antenatal clinics, taken as the best possible reflection of HIV in the general population. Impact cannot be attributed to Samastha alone, as it is the result of inputs from various sources in both Karnataka and Andhra Pradesh—as KHPT emphasizes.[47]

[46] Ibid, p. B-62.

[47] For more discussion of the attribution challenge, see Question 3 in the following section, Management.

Figure 7: M&E Framework for Project Samastha



An illustration of use of indicators and attribution is the following, taken from a Samastha strategic information tool.

Strategic Information - Care and Support

Inputs	Processes	Outputs	Outcomes	Attribution
Logistic Management Information System	Official request from PD-KSAPS - Software developed, personnel recruited to install software in all ART centres and manage the system	Drug procurement, distribution and supplies are monitored and managed on a daily basis	No stock-out in Karnataka in the last two years	LMIS is Samastha contribution

Samastha reports to USAID only on PEPFAR indicators. However, for its own internal quality and process monitoring, it uses a different set of milestones and program indicators, which have evolved over time as more is understood about project dynamics (see Annexes I-1 and I-2).

The following M&E system components have helped Samastha to monitor and track quality and progress at district and sub-district levels:

Computerized MIS (CMIS): Aiming for prevention, care and support, and capacity development following PEPFAR indicators and program indicators, developed software having features of master files to register villages, service centers, staff, data entry modules on different components. The CMIS data is used for identifying program gaps, lost to follow-up cases and disaggregating target groups in terms of their needs.

Analysis and desk review of program coverage and gaps: Analysis of district-wide monthly, quarterly and annual reports, as well as additional analysis of the CMIS data, is conducted and shared periodically with the implementing partners (IPs) on program coverage and gaps therein. Analysis focuses extensively on high-risk individuals, particularly for HIV testing, referrals to ART and care services (e.g., for TB and other opportunistic infections).

Review meetings: monthly, semi-annual and thematic meetings: Each IP organizes monthly review meetings. Samastha/KHPT organizes program review meetings with all the IPs twice a year, and special meetings are organized with the IPs focusing on separate priority themes. Similarly, a semi-annual zone-level workshop involving all the IPs is organized to identify program gaps using CMIS data and program strategy review.

Field visits are undertaken frequently to project sites (by regional managers, MIS officers, M&E managers, senior project managers, etc.) to provide support to the IPs on field strategies, analyze the extent and quality of coverage, review data quality, and to support record-keeping.

Data quality checks strengthen the quality of data collected at various program levels. The CMIS data is tallied with the source document to ensure data quality and to identify gaps in the data. Internal consistency is checked against the source documents for completeness and accuracy of data. A data quality audit takes place on regular basis with the support from zonal and central M&E team.

Annual review assesses in detail the achievement of various program components with reference to annual targets and finalizing targets for the coming year. This also includes review of technical assistance, capacity building, program coverage, and fund utilization.

"Polling Booth Surveys"[48] have been carried out to study changes in sexual behavior in the general population and among female sex workers.

A cohort study of PLHIV assessed Samastha's impact on PLHIV's quality of life in terms of physical, social and psychological well-being, access to and effectiveness of services provided, experience of stigma and discrimination and other relevant factors.

Monitoring of training ensures that each training activity includes specific learning objective(s), a course outline or curriculum, and knowledge, skills and/or competencies expected to be gained by the participants (to be sampled through pre- and post-test evaluation).

Recommendation

The results-based strategies, M&E systems, and related approaches to strategic information developed or refined under Samastha should be mainstreamed into government systems. This should be a priority during the remaining period of the Samastha project.

4. MANAGEMENT

SOW question #1:

How effective are the Samastha management systems -- including project planning and review, grants management, financial and procurement systems -- in scaling up project activities?

Conclusion

Samastha management systems, especially the annual and quarterly program and budget review process, have been very effective for implementing and scaling up activities. Detailed and quality M&E data have proven fundamental to solid management.

[48] This is an innovative methodology that gets responses anonymously, thus with likelihood of greater accuracy than through individual interviews.

Detailed findings

The Samastha management team meets quarterly with each of its sub-grantees to assess implementation and financial progress to date. These quarterly meetings are a critical tool for the on-going assessment of progress toward milestones as well as of spending. *The Annual Participatory Program Reflection* was also cited as a valuable opportunity for sharing experiences and planning future strategies.

Funds are released quarterly, based on proposed activities and budgetary spending. All grantees report timely provision of funds and excellent support from the KHPT financial and program teams. The spending of all sub-grantees averaged 80% of budget, which is excellent in the India NGO sector. Facilities requiring procurement of medical supplies, such as the CCCs and IPPCCs, also reported timely delivery of supplies and a logical and efficient procurement system. Samastha has also been consistently spending 98% of its planned annual budget. (Initially, Samastha represented 35% of KHPT's annual operating budget; today it represents 30%.)

SOW question #2:

What are the strengths and weaknesses of the NGO funding model adopted by the Samastha Project (e.g., fewer sub-grants with large funding to strong partners)?

Conclusion

The Samastha model of a *smaller* number sub-grants, but to relatively *stronger* partners, has been beneficial for management purposes and relative speed of implementation. The main weakness of the model is that smaller, local NGOs that might have benefited from KHPT's capacity building were not actively engaged.

Detailed findings

KHPT/University of Manitoba have been actively working in Karnataka for the past ten years. Through this work and their close collaboration with the KSAPS, KHPT has developed strong working relationships with numerous local NGOs. Using an extensive review process, KHPT carefully selected its NGO partners for Samastha based on their work to date, ability to effectively implement projects, and fiscal accountability. The KHPT team consciously chose strong local partners who were established, experienced and well regarded in their geographic regions. By working with larger NGOs, such as BIRDS in northern Karnataka, MYRADA in central Karnataka, SVYM in southern Karnataka, and LEPRA Society in Andhra Pradesh, Samastha has avoided what could have potentially been an enormous management burden for a project working across substantial distances in more than seventeen districts in two different states. Because of the strength of these larger groups, they did not require large amounts of TA for organization development purposes as is common with newer and smaller NGOs. KHPT also chose partners who were involved with its Avahan project (MYRADA, Swasti) or with KSAPS (CARDTS in Tumkur), both for greater economies of scale and to avoid potential conflict among competing local NGOs. In a few districts (e.g., Bagalkot, Bijapur and Davanagere) where KHPT was unable to find suitable local partners, KHPT itself assumed responsibility for implementing Samastha activities.

The primary weakness of this model is that smaller, local NGOs who might have benefited from KHPT's strong capacity building and technical assistance skills were not actively engaged in the Samastha project. Sex worker collectives, which are being "strengthened" under the Avahan-supported Sankalp and Corridors projects, also appear to have received only limited inputs from

KHPT/Samastha. Given that the Avahan project was deemed capable of fully covering all FSWs (urban and rural) in Bagalkot, Belgaum, Bijapur and Mysore districts, we may question why this same coverage was not possible—or preferable—in all districts. For example, Vimukthi, a sex worker collective based in Bellary district and supported under the Avahan intervention, is one of the smaller NGOs directly contracted by Samastha for outreach to rural sex workers in that district. To implement Samastha in Bellary, however, a male staff was hired to support Vimukthi, rather than Samastha working to build the capacity of Vimukthi itself to carry out the work.[49]

SOW question #3:

What were the strengths and weaknesses of the implementation arrangements in the complex organogram adopted by the Project (e.g., staff sharing between projects, inter-partner staffing arrangements between technical partners, cost, clarity of roles and challenges in financial tracking and allocation of funding)?

Conclusion

Samastha benefits from the KHPT/Samastha institutional arrangement, which gives it access to the broader expertise of all KHPT personnel. On the other hand, numerous people wear multiple hats, which may pose a challenge in accurately tracking their time to Samastha versus another of the KHPT projects.

Detailed findings

The KHPT/UOM/Samastha organogram is complex (see Annex J). On the one hand, it shows the breadth and strength of the team to which the Samastha project has access, including all of the KHPT Directors. [50] On the other hand, a number of people wear multiple hats, which may pose a challenge in accurately tracking their time to Samastha or to one of the other KHPT projects. Fortunately, because the majority of KHPT projects focus on HIV/AIDS, the different project activities appear to be more complementary than not. In addition, some staff time, especially of regional supervisors, gets billed fifty-fifty to both Avahan- and Samastha-supported activities. Staff time sheets reflect the percentage of billing to each project but, given the field realities, there is bound to be some overlap. At the same time, because KHPT is the principal implementer on almost every HIV-related project in Karnataka (not only Samastha but also CCCs funded by the Global Fund through NACO, Link workers funded by NACO, Avahan-funded targeted interventions, and KSAPS-funded targeted interventions), there is little scope for conflict and competition at the ground level, which is frequently the case when multiple implementing agencies are working in the same geographic area.

Attribution of costs and impact is also a challenge in this current structure. For example, in a district such as Bellary, where Samastha is working with rural FSWs and KHPT's and Avahan-funded Sankalp project is conducting an FSW Targeted Intervention—both activities in collaboration with Vimukthi, the local FSW collective—how much of the increased utilization of the ICTC can be attributed to one project or the other? Finally, of greater importance is the increased uptake of ICTC services by all FSWs—for which full credit can be given to Vimukthi, KHPT and both USAID's Samastha and Gate's Avahan projects.

[49] KHPT states that the male staff is planned to support the FSW CBO only for the initial period, that Samastha has made repeated attempts to find the appropriate female staff/community member to take over the role, that Samastha is also sincerely trying to build the capacity of Vimukthi itself to carry out the work, and that decisions have also been made keeping in mind the NACO guidelines into which these interventions will transition.
[50] This is essentially the same model as within USAID's traditional "cooperating agencies": staff for a USAID project draw on the expertise of the larger organization.

SOW question #4:

How effective was the coordination among the various partners in maximizing resources through complementary planning and avoiding duplication of efforts, particularly with the Government agencies and key donors?

Conclusion

In Karnataka, relationships among partners, notably government and key donors, is unique and coordination very effective, given few actors and KHPT's central role.

Detailed findings

As noted above, the relationship of KHPT with state government is organically close (see Footnote 1), and the only other key donor working in the state is Avahan/Gates, for whom KHPT is prime implementer. Samastha and its mutual working relationships were praised by government stakeholders (in Karnataka, the health secretary, the KSAPS director, NRHM mission director and others[51]; in Andhra the APSACS director and DAPCU district program managers). An Avahan/Gates senior program officer was also very positive about the mutual reinforcement of the Gates and USAID funding.[52]

Importantly, KHPT, by placing five key, full-time Samastha staff members inside KSAPS (for ART, HIV-TB, IT, IEC and mainstreaming/integration with NRHM) has been able to achieve near-seamless coordination with KSAPS. Through these five embedded staff, evidence from Samastha's field implementation could be fed directly into KSAPS planning and decision-making. For example, the Samastha team members noted that the costs and time required for ART patients to travel monthly to district-level ART centers for their drugs was a major factor in ART discontinuation. The Samastha staff member posted at KSAPS with responsibility for ART was able to advocate *internally* for "ink-ART centers to bring ART services closer to community members. The resulting huge scale-up—from zero Link-ART centers in 2006 to ninety-three in 2010—contributed significantly to increased access to ART services and thus, treatment adherence.

During Samastha's 2008 strategic shift, evidence also showed that population segments, such as village youth and pregnant women—initially key target populations for the link workers—were being adequately covered by other community-level government workers such as ANM, Anganwadi and the newly created ASHA workers. To avoid overlap, Samastha proceeded, district by district, to make critical, evidence-based decisions regarding outreach to target populations.

The OVC component is another key area where Samastha has coordinated with partners (EngenderHealth, Snehadaan and LEPRA Society), government agencies and existing village structures. Through Samastha, a total of 17,598 OVC (28% HIV-positive) were identified in Karnataka and Andhra Pradesh work, resulting in the creation of a Karnataka State Children Affected by AIDS (CABA) program. The Samastha/KHPT team has also played an active role in creating the national guidelines for CABA and was chosen as the district lead agency to pilot the NACO-CABA scheme in Bagalkot and Belgaum districts. By developing different models for care, ranging from a community-based, link worker OVC intervention to local village

[51] Interview at Karnataka Statehouse, February 5, 2011.

[52] Interview with Ms. Aparajita Ramakrishnan, Gates/Avahan senior program officer, formerly responsible for Karnataka, February 2, 2011.

committees supporting temporary residential homes and foster care, or by linking to government schemes for education and residential care, each of these 17,598 children has received some form of support through Samastha, their local communities and the Government of India.[53] These models of care are the fruit of close and sustained work with community stakeholders, government officials at local, district and state levels, community volunteers and other private donors (including the Clinton Foundation in Andhra). This is a notable example of Samastha's leveraging power. [54]

What about Gender?

Samastha lists, "Address gender issues" as one of its guiding principles. "Be gender sensitive and inclusive," begins the excellent guidance in KHPT's *Toolkit for Program Managers*.[55] Indeed, Samastha has maintained a focus on reaching out to increase women's access to treatment, care and support. Among ART clients registered with Samastha, 54% are female.[56] However, there is a major discrepancy between stated principles and Samastha's own staffing. At all levels of KHPT and Samastha management, the number of men far exceeds women. While more women are employed by Samastha than men, this is only because there are so many women in the lower-level positions. At the field level, many women are employed for outreach work. Especially in two categories of field personnel—peer educators and peer outreach workers—women greatly outnumber men. However, in management roles, even at the district level and below, men still disproportionately outnumber women. Among district coordinators, district project coordinators and DIC+ coordinators, 93% are men. Among supervisors and Taluka coordinators, 83% are men.[57]

The challenges of working and traveling in the districts and rural areas are significant. Female literacy, especially in rural areas, is lower than male literacy,[58] and cultural biases subjugating women are deep-rooted, especially in rural areas. Nevertheless, as an important leader in Indian public health, it will be important for KHPT to work toward greater gender balance in its management teams and to demonstrate leadership in overcoming this aspect of traditional cultural discrimination.

[53] USAID-supported Samastha project, Orphan and Vulnerable Children (OVC). KHPT presentation, February 3, 2011.
[54] See the OVC foster family profile at the end of the section above titled, "Support for Quality of Living".
[55] KHPT. "Prevention of HIV and AIDS & Care for People Living with HIV and AIDS: A Toolkit for Program Managers," p. 25.
[56] Samastha Project. "Annual Progress Report, October 2009–September 2010."
[57] KHPT, Samastha Staff Details as of February 28, 2011—Karnataka and Andra Pradesh.
[58] Statewide in Karnataka, male literacy is 76% to 57% female literacy, with significantly lower levels for both in rural areas. (*HIV/AIDS Situation and Response in Karnataka: Epidemiologial Appraisal Using Data Triangulation*, 2010 [Table 1: State background, December 2009, Karnataka]).

III. CONCLUSIONS

1. GENERAL OVERALL CONCLUSIONS

1. Samastha has met the project objectives, met and surpassed most original targets and indicators, and been highly effective. Samastha has made major critical contributions in each program area of HIV prevention, care and treatment, and in strengthening government health systems. It is very appreciated by local government.
2. There are indications, from recent ANC data, that the epidemic may be turning a corner in Karnataka; if so, Samastha and USAID have definitely been part of the force bringing the epidemic under control.
3. Because Samastha was designed to fill gaps, it is difficult to consistently quantify and attribute impact to Samastha alone. Rather, achievements are due to Samastha inputs that have strengthened the government system and, in Karnataka, complemented those of the only other major donor (Gates Foundation, whose Avahan projects are also implemented by KHPT).
4. Achievements in Andhra Pradesh have been important, but on a lesser scale than in Karnataka (Andhra Pradesh received only $1.5 million of Samastha's $22 million budget).
5. Samastha-supported clinical services (testing and treatment centers and hospital-based care) will continue after Samastha ends, but it is very likely that the quality of services will be adversely affected without Samastha inputs. Equally or more seriously, without Samastha's outreach workers (Link Workers and others), community mobilization to access and use services will end, and the IPPCC-DICs serving positive people will no longer have adequate resources to assist PLHIV with treatment adherence support and related benefits.

2. TECHNICAL AREA CONCLUSIONS

a. Prevention

1. Samastha has been very effective in scaling up prevention outreach to rural populations, as well as mobilization for services and care. Samastha's rural prevention model is appropriate, evidence-based, feasible and replicable. It has contributed to the national response. Particularly in high-prevalence districts, such as northern Karnataka, Samastha's *intensive* rural outreach approach has proven effective. While more remains to be done, behavior has changed in the areas of HIV and STI testing and increased condom use.
2. Samastha has achieved excellent "saturation" or coverage of rural female sex workers for HIV testing and STI services. In 2010, almost 15,000 FSWs were contacted by Samastha outreach workers. Among these, 67% were referred for HIV testing and received their test results, and 81% were referred for and received STI services.
3. Data show significant increase in reported condom use, but also this pattern: condoms most frequently used with occasional commercial (paying) clients while repeat commercial clients and regular lovers/partners continue to be more resistant.
4. Essential elements include: field-based outreach workers using a peer-to-peer approach, supported by good training, compensation, and supportive supervision; and a strong individualized M&E system for tracking FSWs, PLHIV and other service recipients.

b. Care, Support and Treatment

1. Samastha has *significantly strengthened health systems* and contributed to *scaling up* and *improved quality* of care, support and treatment services, through technical assistance to the State AIDS Control Societies and related inputs for technical strengthening of:
    - Integrated Counseling & Testing Centers (ICTCs) for HIV testing and referral to ART
    - ART centers, providing ART and outpatient care (including CTX prophylaxis for OIs)
    - IPPCCs, providing outpatient treatment services, including for minor OIs
    - Supporting the surge from zero to nearly 100 Link-ART centers (in Karnataka)
    - CCCs, providing both outpatient as well as inpatient care and service
    - Support and counseling services
    - All cadres of staff, through training and mentoring
    - Record-keeping systems, through a user-friendly CMIS
    - District-level officials' management and supervision through regular training, supervision and meetings
    - Coverage of children affected by HIV and AIDS (CABA) with the Department of Women and Child Development (WCD)
2. Samastha has *increased access to and utilization of services* primarily by training, deploying and supporting essential cadres of field-based outreach workers (Link workers, FSW peer educators and peer outreach workers) who have been able to mobilize and support community members to go for HIV testing and, if positive, to follow through with ART services. Samastha's substantial inputs have contributed specifically to:
    - Improved quality of care at the facilities
    - Improved attitudes of and treatment by medical personnel in the facilities
    - In Karnataka, bringing services closer to people by establishment of "Link-ART centers"
    - Reduced stigma and discrimination; and
    - Increased access to and use of government support services and entitlements for PLHIV
3. Improvement indicators include steady increases in service utilization and, in Karnataka, a very low lost-to-follow-up rate of only about 3.5% (may be the lowest in all India).
4. Negative findings: distance to ART centers remains a barrier to use; about 25% of ART centers lack CD4 machines; pediatric HIV care generally of limited quality; inadequate management and support of discordant couples; underutilized nurses (e.g., in ART centers, primary responsibility is completing paper work rather than providing quality nursing care); infection control often poor (Samastha improvement module welcomed, but resources for expansion are limited); inadequate attention to ARV drug resistance and TB/HIV co-infection and to the emerging threat of MDR-TB; diagnostic facilities challenged in understanding reasons for unexplained HIV deaths; the current CCC model and guidelines perpetuate stigma of PLHIV and pose additional hardships for vulnerable populations.

c. Link Workers

1. The Samastha LWS has been well designed and implemented, with important elements that improved its effectiveness and reach to specific high-risk populations. The Samastha Link worker model appears most effective and best utilized in very high-prevalence rural districts with large populations of PLHIV and other high-risk groups.
2. Samastha has provided important TA to NACO for the nationwide scale up of Link workers.

d. Capacity Building and Health System Strengthening

1. Samastha has contributed significantly to strengthening the health system response to HIV/AIDS in Karnataka and Andhra Pradesh. Capacity building of implementers (individuals and organizations) and health systems strengthening have been priorities of the Samastha project (about 25% of budget dedicated to this objective). Where Samastha has worked, capacity has been built and the health system has been strengthened, top to bottom. Evidence of success in capacity-building exists in the numerous achievements described in "Prevention" and "Care, Support, and Treatment" sections.
2. Evidence shows that training has been well planned and delivered. To build capacity, Samastha has conducted a large amount of training for health care providers, managers, counselors and outreach workers. The training has generally been well designed and delivered by competent teams with high-quality materials, systems, experience and skill. The approach is interactive and hands on (e.g., role-play, rather than lecture-based). Training has been designed with, in most cases, frequent reinforcement through mentoring, "hand-holding," supportive supervision, an effective M&E system, and strengthening backward, forward and lateral referral links. Results-oriented tools and job aids for the various cadres of workers have been a high priority, going hand in hand with the training.
3. Samastha has been successful in building capacity of SACS and DAPCUs, providing substantial training and technical assistance. It has been especially successful in Karnataka, where it benefits from KHPT's close, organic relationship with KSAPS**.** Samastha has also been very active and quite successful in providing TA to NACO and to meeting many needs at the national level.

e. Strategic Information

Strategic information capacity has been successfully built throughout Samastha. Data collection and the strategic use of information for design and ongoing improvement have been a very high priority. The Samastha project is an outstanding example of how data generated by well-designed M&E systems can contribute significantly to successful interventions and overall impact. In this regard, Samastha/KHPT, by all international standards, is outstanding in the field of health improvement programming at the public health level.

f. Cooperative Agreement (Unilateral Funding)

As a program management arrangement, the Cooperative Agreement between USAID/India and the University of Manitoba (with KHPT as implementing partner) provides a very good model for USAID. It has allowed KHPT and Samastha to be flexible and innovative and to respond well to the rapidly changing nature of the epidemic and the local response. Working through a bilateral project between USAID and the national government would almost certainly have involved undesirable delays and rigidity, and yielded poorer results. For these two states, each with populations larger than many countries (Andhra Pradesh, at about 83 million, is larger

than Germany; Karnataka, 53 million, is larger than South Africa), "unilateral" funding through the Cooperative Agreement has yielded highly desirable results.

Further benefits of USAID/India's partnership with University of Manitoba (UOM) and KHPT include the following:

- USAID's contribution in Karnataka and Andhra Pradesh was strengthened by leveraging the intellectual rigor and contributions of UOM and KHPT's established resources (staff and systems).
- As discussed above (see "Management"), Samastha's strategy of channeling investments through a smaller number of relatively strong and well-established NGOs offers an important model for USAID. A primary weakness of this model, however, is that smaller local NGOs that might have benefited from KHPT's strong capacity building and TA skills were not actively engaged in the Samastha project.
- As new partners of USAID funding, UOM and KHPT also benefited from systems strengthening due to PEPFAR requirements.
- KHPT rigor in the area of data quality assurance, a main focus of USAID investments, has contributed to the KHPT's credibility as a leader in M&E systems.[59]

III. RECOMMENDATIONS

1. MAJOR RECOMMENDATIONS

1. **For health system strengthening, the HIV/AIDS program (policies, guidelines and services) should be incorporated into State Health services for greater participation of government providers and facilities, while at the same time retaining focus and capacity to address local HIV/AIDS priorities.**

   USAID has an important role to play in encouraging the integration of all HIV/AIDS programming into the larger National Health Program. In the early days of the epidemic, a freestanding vertical program allowed the country to focus intensively on the impending threat. As the epidemic has matured, the care, support and treatment of PLHIV has become as critical as prevention. All levels of the existing government health system will need to be strengthened to face the ever-growing burden of care, support and treatment, for both adults and children living with HIV and AIDS.

2. **As the AIDS epidemic has matured, NACO should seriously consider revising its current A, B, C classification of districts, adding an A+ classification to better reflect the rapidly increasing burden of need and ongoing care required in high-prevalence districts.**

   NACO's current classification of districts requiring priority attention is based primarily on HIV prevalence at ANCs in the past three years and on HIV prevalence among high-risk groups (FSW, MSM, IDU). In Karnataka, twenty-six of twenty-seven districts are designated as "A". In Andhra Pradesh, all twenty-three districts are classified as "A". This classification was developed in 2006, before so many thousands were on treatment. Today the burden of HIV care, indicated by the number of PLHIV registered at ART clinics should be an

[59] Discussion with USAID technical team, February 2011.

important criterion, in addition to ANC prevalence, for determining the type of prevention, outreach, care and support required in any particular district.[60] The numbers of PLHIV requiring regular, ongoing care has the potential to overwhelm the existing health infrastructure. By including an additional "burden of care" component to the district classification system, state governments will be better able to prioritize future health system strengthening needs and receive commensurate support. Technical assistance *at the district (DAPCU level)* would be very beneficial in these A+ districts. (The policy of TA at only national or state levels may not have the same impact on human lives.)

3. **Institutional care of PLHIV should be integrated within existing government health structures. Separate wards are of no benefit, but rather increase stigma and discrimination.**

   Under Samastha, several different types of CCCs, originally intended to serve as "step-down" or palliative care (hospice) facilities for PLHIV, were created. Creating separate, freestanding facilities or placing PLHIV in separate wards tends to increase stigma and discrimination. HIV-positive patients should be integrated into existing hospitals and facilities. The Samastha Private Public Partnership Community Care Centers in Bijapur District Hospital and at Kolar District Hospital are innovate examples of the type of integration required to reduce stigma and discrimination and to provide quality health care to PLHIV.

4. **A standard, comprehensive module for HIV/AIDS care, including stigma and discrimination reduction, should be included in all medical and nursing pre-service curricula.**

   Knowledge and practices related to HIV/AIDS remain weak among many doctors, nurses and other medical personnel. Doctors continue to have a limited understanding of infection control measures (e.g., washing disposable surgical gloves for re-use by other health care personnel) and nurses express fear about their vulnerabilities when caring for HIV-infected patients and therefore often ignore or not touch them. Many health care professionals continue to be judgmental about the patient's behavior that resulted in becoming HIV+, irrespective of actually having any knowledge as to how the patient was infected. It is crucial that HIV/AIDS care, including stigma and discrimination reduction, be taught in all medical and nursing schools throughout India.[61]

5. **Pediatric HIV care and treatment for children should be strengthened through in-service training for primary providers at all government health facilities.**

   Doctors, nurses and counselors at Community Care Centers, ART centers and elsewhere generally have very little specific knowledge about caring for HIV+ children.[62] The growing number of pediatric AIDS cases will require specific training, skills and supplies to adequately provided services to this extremely vulnerable population.

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[60] For example, the Northern Karnataka states of Bagalkot and Belgaum have HSS ANC rates of 2.13% and 1.5% respectively (2008). In addition, Bagalkot's cumulative pre-ART registration (HIV-positive tested for viral load) is 14,108, of which 7,573 have started ART at some point. Belgaum's cumulative pre-ART is 14,439 with 7,001 who have ever started ART. (Final Consolidated ART data through January 2011 for Karnataka provided by Dr. S. Shastri, Samastha/KSAPS).

[61] Samastha has been working with the Rajiv Gandhi University of Health Sciences, the umbrella regulatory and academic approving authority for all medical, dental, nursing and health related courses in Karnataka. Samastha has initiated an HIV cell, aimed at developing a package for integration of HIV into pre-service curricula. Source: KHPT Technical brief on Rajiv Gandhi University of Health Sciences.

[62] In Karnataka as of January 2011, a total of 12,220 children have ever been registered for pre-ART and 3,695 are currently alive and on ART.

6. **A state-of-the-art laboratory—with capacity for assessing viral load and ARV and TB drug resistance—should be available in each state to support the growing burden of the epidemic. Satellite labs, based on prevalence and need, should also be developed.**

   With the growing burden of HIV, more TB cases with underlying HIV are expected to develop. Early detection, followed by effective treatment (particularly for open pulmonary TB cases) is necessary to prevent further transmission. This is especially important for poor communities with high HIV prevalence and because the potential for development of multi-drug resistance is greater with underlying HIV infection. With this in mind, all high-prevalence states should have a state-of-the-art laboratory to support early detection of TB and drug-resistant TB. As the HIV epidemic progresses, this will also be important for detection of emerging primary and secondary ARV-resistance.

7. **Learning centers, best-practice sites and cross-sharing of lessons learned, between and within states, should be supported for capacity building at all levels.**

   Samastha staff and beneficiaries alike have emphasized the great value of exposure to a quality learning site that includes direct hands-on opportunities. Doctors and nurses who attended training at Snehadaan emphasized how much they learned by seeing with their own eyes and by then applying thenew skills in a non-threatening learning environment. Such sites have proven very valuable for training illiterate populations, such as sex workers, who can observe their peers at work and be taught directly by people who fully comprehend the conditions they are facing. Samastha partners also praised opportunities for cross-sharing within Samastha (particularly the annual sharing/reflection of lessons learned). Similar opportunities could be supported across state lines to include field visits for enhanced learning. It will be important to assure that the learning sites are mature and truly represent the proposed intervention, and have not just been created for the purpose of serving as a learning site.[63]

8. **The intensive rural outreach model with Link workers should focus specifically on high-prevalence districts (e.g., ANC> 1.25, high ART burden).**

   As demonstrated under Samastha, the Link worker model is most effective in very high-prevalence districts, where many village people are at risk for HIV. Because the Link worker's primary role is to educate the community about HIV prevention and to encourage vulnerable villagers to visit the ICTC and to access ART services if testing positive, this approach can only be cost-effective in communities where large numbers of people are at risk. Having Link workers—with this set of responsibilities—working in areas of lower prevalence, risks overloading the health system, especially ICTCs, with counseling and testing requests from low-risk people, until it is unable to effectively serve those really in need. In addition, issues of confidentiality remain very important at the village level and intensive outreach efforts by Link workers actively seeking PLHIV or those at risk can lead to greater stigma and discrimination within the village. "A+" districts, rather than "A" districts (see Recommendation #2, above), would be the primary focus for Link workers.

9. **Samastha's experience with Link workers should be studied by those responsible for the national Link Worker Scheme, giving special attention to Samastha design elements that have contributed to its effectiveness (and cost efficiency).**

   Under Samastha, the Link worker design has been re-assessed and design elements modified (e.g., village selection criteria, mapping, M&E framework, roles and responsibilities,

[63] This is especially important when working with community-based organizations, which should be authentic representations of the community they serve as well as capable of sharing their experiences on their own with only minimal external support.

flexibility, etc.) to meet the changing local environment and progress of the epidemic. For example, when it was observed that Link workers could not be effective in villages with small numbers of PLHIV, target villages were changed. The national Link Worker Scheme has not incorporated many of these important design elements and appears to be implemented without adequate flexibility to respond to local needs, which means that those Link workers will find achieving their goals a challenge and costs may be disproportionate to benefits. In light of the negative findings of the recent evaluation of the national Link Worker Scheme[64] and the probability of its redesign, that redesign process should study the lessons that Samastha has learned.

10. **Interventions for female sex workers should be led by FSW CBOs and provide outreach throughout the district, urban and rural as required.**

    Under Samastha, the terminology "targeted intervention" has been interpreted as only an urban intervention (outreach to urban sex workers). Therefore, in some Samastha districts the Link workers' role included outreach to *rural* female sex workers. Female sex workers, however, assured the Samastha evaluation team that they are best suited to reach out to their peers, wherever they are located, because of their personal, in-depth understanding of the issues faced. Their capacities should be built and supported, rather than eclipsed by male project staff. Positive outreach workers likewise felt that they could most effectively speak to and support their positive peers.

11. **District Level Networks of PLHIV (DLN+) should be strengthened, consistent with GIPA. Positive people should be employed in government ICTCs, ART centers, link-ARTs and Primary Health Centers.**

    The original Samastha proposal described a primary role for state- and district-level PLHIV networks. Achieving this objective was one of the project's major challenges. Network representatives made cogent arguments to the Samastha Evaluation Team stressing the need for GOI, USAID, and other donors to support the positive networks for their important role as local advocates and as providers of peer-to-peer support. The Evaluation Team believes support would yield greatest results directed to the state and especially district-level networks. It would also be beneficial for government to create and fund positions at government health facilities to employ PLHIV as peer counselors, who could also assist in tracking lost-to-follow-up. At the national level, there should be increased participation of PLHIV networks in NACO policy planning, including the technical resource groups and the working groups, for an eventual NACP IV.

12. **Technical assistance should be provided through strong experienced partners who base their TA on evidence gained from field-level implementation.**

    The Samastha project had very strong partners who supported work in the field as well as in developing program materials. As USAID moves forward with emphasis on technical assistance and health systems strengthening, it will be important to select strong partners with the requisite skills and the ability to effectively share those skills with others. Organizations such as KHPT, with a proven record of accomplishment, practical on-the-ground experience and sound management skills, should be considered as potential partners.

13. **The placement and financial support of very competent and appropriate personnel within a priority government agency, such as the SACS, is an effective approach to**

[64] IMACS and International HIV/AIDS Alliance, 2010.

providing technical assistance which should be continued in the future, especially for weak agencies.

Samastha has shown that the model of embedding qualified personnel within an existing government structure, such as KSAPS, has been very effective. The selection of five highly competent individuals with specific areas of expertise, paying their salaries, and having them collaborate and participate in Samastha activities while actually sitting at and working through a government agency, had a significant impact on improving that part of the health system. While KSAPS had a reputation a few years back for being very weak, the KSAPS project director has stated that, "Since things are now running so well, we will no longer require this technical assistance from KHPT."[65]

14. **Effective priority interventions developed under Samastha should continue for an additional period. USAID should consider continuation of support to Samastha, to align with the GOI and NACO fiscal year,[66] while means are found to mainstream its successful interventions into state and/or national programs.**

It is recommended that the community-focused work on prevention, care, support and treatment should be continued, particularly in the high-prevalence districts in Karnataka and coastal Andhra Pradesh. While much progress has been made and there are signs that the epidemic is finally turning a corner in Karnataka, without additional outreach support, especially in highest-prevalence districts, there is a serious chance that these gains could be lost. Interventions that should continue include: (1) Link workers in high-prevalence districts of northern Karnataka; (2) integrated positive prevention and care centers/drop-in centers, while treatment of opportunistic infections is transitioned over to primary health centers (24/7 PHCs), ART centers or other local practitioners; (3) peer outreach workers elsewhere, supporting PLHIV and the positive self-help and support groups, and including Andhra Pradesh, until its outreach workers can be incorporated into APSACS budget; (4) work with the Department of Women and Child Development to mainstream HIV care for women and children within WCD-supported institutions; and (5) maintain the innovative PPPCCC model with attention to determining its impact on stigma and discrimination of PLHIV and quality of care. It is important to note that KSAPS has included items (1) and (2) in its next Annual Action Plan, to begin April 1, although these are not likely to be funded, given that NACO funds are committed elsewhere.

2. ADDITIONAL RECOMMENDATIONS FOR SAMASTHA AND KHPT

1. **Gender.** KHPT's project proposal and values statements emphasize gender balance and serving most vulnerable populations, especially women. However, except for the bottom rung of personnel—the outreach workers—KHPT is seriously gender-skewed, with only a small minority of women in headquarters or field positions. KHPT, excelling in many other areas, should be a model for India in this area also.
2. **Following knowledge and conviction as to what is right.** It is not easy to work within national guidelines, especially in a country as large as India. In the Samastha districts, KHPT has followed its convictions with regard to an effective link worker model. Elsewhere it has yielded to national guidelines for link workers, which KHPT knows to be less effective than

[65] Statement by Mr. R.R. Jannu, Project Director, KSAPS, in interview with Samastha Evaluation Team, 5 February 2011, Bangalore.

[66] KHPT states that its targeted interventions (in Bagalkot and elsewhere) will transition to KSAPS by April 2012. (KHPT-KSAPS "Bagelkot District Profile." PPt presentation, February 2011.)

the Samastha Link worker model. Likewise in establishing CCCs, KHPT knew that an integrated model was most appropriate, especially for stigma reduction, yet it yielded to national guidelines for segregating HIV patients. Given its established track record, KHPT should act with greater confidence to implement what its evidence shows is best.

3. **Female sex workers.** These women are an important part of Samastha. Many have been empowered to a certain extent. Unfortunately, during this evaluation their voices were rarely heard in the presentations, which were usually PowerPoint presentations given by male staff. In presenting the work of a CCC, for example, this might be acceptable, but for the projects focused on sex workers and FSW collectives, those principals' voices should be heard. This illustrates the need for more genuine empowerment of the FSW partners by KHPT. Certainly, good opportunities exist during the remainder of the project.
4. **Networks of Positive People.** In its consolidation phase, Samastha should invest additional effort toward the strengthening of these networks. As envisaged in the project proposal, the positive networks should have been involved in all stages of project design, implementation, management and monitoring, both to respond better to the needs of PLHIV for medical, nutrition, social and other services, and to strengthen their own programs.
5. **Publications.** KHPT/Samastha is active in documentation, which is good. However:
    a) Too many publications are too glossy, too fancy. This is inappropriate for development projects that help poor people. Take, for example, the numerous publications presenting the Jeevana Jyothi experience in Bagalkot and the Avahan-funded Pragati project. This is highly inappropriate, considering that these are both collectives of poor women scraping for their daily existence. In many cases, the content ranges from good to excellent, but would be much more appropriately be presented on recycled paper. This holds for all KHPT publications, for consistency with KHPT-stated principles.
    b) *Convergence*: The good state and district overviews that KHPT/Samastha has produced and provides for visitors[67] are very useful, but these should include, along with literacy, reproductive health and MCH indicators: TFR, CPR (contraceptive prevalence rate), MMR and IMR. This would be desirable in any case, but especially with thought to convergence with NRHM and the broader health system.
    c) Dates and page numbers: all publications should have dates and page numbers. Most lack these.

[67] For example, KHPT, *State Profile: Karnataka,* no date.