Program Evaluation of the

# PRIMARY HEALTH CENTER ENHANCEMENT PROJECT

in Andhra Pradesh, India

SEPTEMBER 2012

CDC

SAATHII
Solidarity and Action Against The HIV Infection in India

fhi360
THE SCIENCE OF IMPROVING LIVES

Program Evaluation of the

# PRIMARY HEALTH CENTER ENHANCEMENT PROJECT

in ANDHRA PRADESH, INDIA

September 2012

CDC

SAATHII
Solidarity and Action Against The HIV Infection in India

fhi360
THE SCIENCE OF IMPROVING LIVES

# ACKNOWLEDGEMENTS


| Names and Organizations | Key Contributions |
|---|---|
| **Solidarity and Action Against The HIV Infection in India (SAATHII) – Consulting Agency** | |
| Dr. L. Ramakrishnan (Project Lead) | Pretesting of Tools, Data Collection, Data Analysis and Report Writing |
| Ms. Aparna Addala (Data Collection Supervisor) | |
| Dr. Ravikanth and Mr. David Ettl (Evaluation Experts) | |
| Mr. G. Anil Kumar and Ms. Somisetti Sowjanya (Data Analysts) | |
| Mr. K. Pedababu, Mr. Markandeya Prasad, Mr. Siva Parvathi, Ms. Padma Renuka, Mr. Ramesh, Mr. K. Manaiah, Mr. M. Shiva Kumar, Mr. Sai Satya Dev, Ms. Sumathi (Field Investigators) | |
| Mr. Mastan Babu, Mr. Vincent Madhukar, Ms. S. Poorna Babu Rao, Mr. Naga Babu, Ms. D. Renuka Babu, Mr. B. Sridhar, Mr. Y. B. Harish, Mr. S. Durga Prasad, Mr. B. Nehru Babu (Data Abstractors) | |
| **Catholic Health Association of India (CHAI)** | |
| Rev Dr. Tomi Thomas | Protocol Development, Data Collection Training, Coordination and Report Review |
| Rev Dr. Sebastian Ousepparampil (Former CHAI Staff) | |
| Mr. Mohammed Mateen | |
| Mr. Sundar Bunga | |
| Mr. Sukumar Akkamsetty (Former CHAI Staff) | |
| **LEPRA Society** | |
| Mr. N. M. Chandrasekara | Protocol Development and Report Review |
| Mr. Michael Sukumar | |
| **FHI 360-DAKSH** | |
| Dr. Ashok Agarwal (Principal Investigator) | Protocol Development, Data Collection Training, Monitoring and Supervision, Data Analysis and Report Writing |
| Dr. Satya Ranjan Lenka | |
| Mr. Nitin Datta (Former FHI 360 Staff) | |
| Dr. Sharmistha Basu | |
| Dr. Suvakanta Swain | |
| Mr. S. Siluvadas | |
| Dr. Mahaboob Subhani | |
| **Telugu Network for People Living with HIV/AIDS** | |
| Mr. Ramesh Babu | Inputs in Protocol Development |

| Names and Organizations | Key Contributions |
|---|---|
| **Centers for Disease Control and Prevention (CDC) – India** | |
| Ms. Srilatha Sivalenka (Principal Investigator) | Protocol Development, Data Collection Training, Supervision, Data Analysis and Report Writing |
| Ms. Deepika Joshi (Public Health Specialist) | |
| **CDC– Atlanta** | |
| Dr. Yamir Salabarría-Peña | Mentoring Support in Protocol Development, Data Collection Training, Data Analysis and Report Writing |
| Ms. Nadia Solehdin | |
| **Andhra Pradesh State AIDS Control Society (APSACS)** | |
| Mr. C. Parthasarathy, IAS | Support in Protocol Development and Report Finalization |
| Mr. R. V. Chandravadan, IAS (Former APSACS Project Director) | |
| Dr. J. C. Reddy | |
| **National AIDS Control Organization (NACO)** | |
| Mr. Suresh Mohammed (Former NACO Staff) | Support in Protocol Development |
| Mr. Ugra Mohan Jha (Program Officer, Statistics) | |

# CONTENTS

# ACRONYMS

| | |
|---|---|
| ADM & HO | Additional District Medical and Health Officer |
| AH | Area Hospital |
| ANC | Antenatal Case and Antenatal Care |
| AP | Andhra Pradesh |
| APSACS | Andhra Pradesh State AIDS Control Society |
| ART | Anti-Retroviral Therapy |
| ARTC | Anti-Retroviral Therapy Centre |
| CCC | Community Care Centre |
| CDC | Centers for Disease Control and Prevention |
| CDC-DGHA | Centers for Disease Control and Prevention-Division of Global HIV/AIDS |
| CHAI | Catholic Health Association of India |
| CMIS | Computerized Management Information System |
| CT | Counseling & Testing |
| DAC | Department of AIDS Control |
| DAPCU | District AIDS Prevention and Control Unit |
| DG | Director General |
| DHS | Directorate of Health Services |
| DIC | Drop-In-Centre |
| DOHFW | Department of Health and Family Welfare |
| DPM | District Project Manager |
| FGD | Focus Group Discussion |
| FICTC | Facility Integrated Counseling and Testing Centre |
| HBC | Home-Based Care |
| HIV | Human Immuno-deficiency Virus |
| HSS | HIV Sentinel Surveillance |
| ICTC | Integrated Counseling and Testing Centre |
| IDI | In-depth Interview |
| IEC | Information, Education, Communication |
| INC | Indian Nursing Council |
| IRB | Institutional Review Board |
| MO | Medical Officer |
| M&E | Monitoring & Evaluation |
| NACO | National AIDS Control Organization |
| NRHM | National Rural Health Mission |
| NS | Nurse Supervisor |
| NVP | Nevirapine |
| OR | Outreach |
| PCI | Project Concern International |
| PD | Project Director |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PHC | Primary Health Center |
| PHCEP | Primary Health Center (PHC) Enhancement Project |
| PLHIV | People Living with HIV/AIDS |
| PPP | Public Private Partnership |
| PPTCT | Prevention of Parent to Child Transmission |
| QC | Quality Control |
| PM | Project Manager |
| RNTCP | Revised National Tuberculosis Control Program |
| SHG | Self Help Group |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| TI | Targeted Intervention |

# EXECUTIVE SUMMARY

## Background

In the fiscal year 2004-2005, the United States' Centers for Disease Control and Prevention–Division of Global HIV/AIDS (CDC-DGHA), previously the CDC Global AIDS Program- in collaboration with Andhra Pradesh State AIDS Control Society (APSACS), and two non-governmental organizations i.e., Catholic Health Association of India (CHAI) and Project Concern International (PCI), initiated a one-year pilot in 20 Primary Health Centers (PHCs) in two districts, to respond to the burgeoning HIV/AIDS epidemic in the state. A pilot of the PHC Enhancement Project (PHCEP) was initiated with the purpose of making HIV/AIDS-related services available and accessible to the rural population seeking primary health care, including antenatal services, in the state. CHAI, as the implementing sub-partner of PCI and subsequently of LEPRA Society, assumed the responsibility for implementation.

Through this pilot, nurses outside the government system were recruited and trained in providing comprehensive HIV/AIDS services within the primary health care system. Each nurse, referred to as a PHCEP nurse in this document, was posted at a PHC under the Medical Officer (MO) in-charge. The PHCEP nurses were trained and skilled to provide HIV counseling and testing and Prevention of Parent to Child Transmission (PPTCT) (identification of positive pregnant women, counseling, delivery, ARV prophylaxis for mother and child, infant feeding counseling, infant diagnosis, follow-up) services and conduct community outreach to promote uptake of services. PHCEP Nurse Supervisors (NS) were recruited and trained to coordinate, facilitate, and supervise the work of a number of PHCEP nurses (five to eighteen).

By December 2006, the PHCEP was expanded to 266 PHCs in 10 districts by APSACS. In 2010-2011, on Department of AIDS Control (DAC's) directive, APSACS initiated Facility Integrated Counseling and Testing Centers (FICTCs), in which the existing staff nurses and lab technicians of PHCs were capacitated to provide HIV counseling and testing.

**Purpose of evaluation:** Given the uniqueness of the PHCEP and the fact that it was concluding in September 2010, the key stakeholders met in 2010 to plan an evaluation of the project with the purpose to: (1) Better understand the context in which the project took place, (2) Identify facilitating and impeding factors faced during implementation, and (3) Identify good practices, lessons learned, and success stories, if any, to inform planning and implementation of HIV/AIDS related services in rural and remote areas in India.

## Evaluation Design

A process evaluation, with a mixed methods design was conducted. The two districts with the highest (Guntur, 2.5%) and lowest (Nizamabad, 0.5%) HIV prevalence (DAC, 2009) were selected, in order to learn the most about implementation in these two scenarios. The evaluation was carried out in ten PHCEP sites, five from each district.

## Evaluation Questions

The overarching evaluation question was "*What are the key lessons learned, success stories, if any, and challenges*

*and recommendations from the PHCEP?"* Sub-evaluation questions included:

a) What services were provided to clients at PHCEP and FICTC PHCs sites?

b) What have been the good practices and innovations of the project, if any?

c) What have been the challenges encountered during the implementation of this project?

d) What are the recommendations from the project designers, funders, implementers, and beneficiaries?

# Findings Based on Evaluation Question:

## Services were provided to clients at PHCEP and FICTC PHC sites

To understand service delivery at PHCEP and FICTC PHC sites, quantitative data were abstracted (see Annex 3) from routine monitoring data on HIV counseling and testing (CT), uptake of PPTCT services, and referrals from HIV ICTC to Revised National Tuberculosis Control Program (RNTCP). Qualitative data to answer sub-questions on good practices, challenges and recommendations were collected through a total of 96 in-depth interviews (ID) and focused group discussions (FGD) from beneficiaries, service providers at PHCEP sites, district health administration, APSACS and other stakeholders such as CHAI, LEPRA SOCIETY and CDC. Qualitative data were analyzed using a grounded theory approach.

During the period Jan 2007-June 2010, 90.5% (N=31,788) of non-ANC clients received their HIV test results on the same day as their pre-test counseling and testing. Average daily client load ranged from 3 to 26 with an overall mean of 12 HIV tests per day. Among ANC clients, 80% (N=149) of positive pregnant women identified at the evaluation sites had institutional deliveries. Among the live births (N=104), nearly 86% of mother-baby pairs received Nevirapine for prevention of parent to child transmission of HIV. During the period Jan 2007-June 2009, there were 57 infants born that were still alive at 18 months: of these, 35% mother-baby pairs were followed up at 6, 12 and 18 months. Forty five percent of HIV-exposed children (N=57) were tested at the end of 18 months. Ninety one percent of clients (N=2129) referred by PHCEP reached the Designated Microscopic Center (DMC) of RNTCP for TB diagnosis.

## Good Practices and Innovations of the Project

According to key informants in the evaluation, the entire project was an innovation in terms of decentralizing HIV/AIDS services at the sub-district level by integrating them into primary health care, at a time (2005-2006) when there were no locally available services for the rural population, key informants, beneficiaries and service providers identified specific improvements in HIV service delivery such as provision of stigma-free services, availability of same-day HIV test results, maintenance of confidentiality, initiation of deliveries for HIV positive pregnant women (as opposed to referring them to higher level healthcare facilities), timely administration of nevirapine to mother-baby pair, follow-up and testing of HIV exposed child at 18 months; and enhanced access to services. Service providers and key informants reported good practices with respect to health care workforce, including PHCEP staff capacity building strategy, multi-tasking in providing HIV/AIDS services (counseling, testing, outreach, PPTCT cascade) by PHCEP nurses, and coordination between PHCEP nurses and community level workers. In terms of monitoring, processes that were established for monthly performance review were identified as a good practice. The ownership demonstrated by the government (APSACS) of this multi-stakeholder initiative was seen as a good practice.

## Challenges Encountered during the Implementation of this Project

Challenges at the PHCEP evaluation sites included getting space within the PHCs for counseling and testing during project start-up as well as, monitoring and maintaining HIV service quality during rapid scale-up. A recurrent challenge was the PHC staff members' perception of PHCEP nurses as outsiders and the program as external to the health system and routine activities. Data from in-depth interviews with

beneficiaries suggested that a few PHCEP nurses had misconceptions in the areas of breast feeding and termination of pregnancy for HIV-positive pregnant women. Project transition brought with it challenges including disruption of some of HIV/AIDS services at the PHCEP sites. Service providers including PHCEP nurses expressed strong concerns over difficulties in absorbing PHCEP nurses within the government system after completion of the project. Service providers and key informants expressed problems with supply chain management.

## Recommendations from the Project Designers, Funders, Implementers, and Beneficiaries

- Similar projects in the future should ensure buy-in from existing facility staff through sensitization, and ensure systems and processes are in place before roll-out.
- Ensure space and privacy for HIV counseling and testing, and guarantee supply of HIV test kits and condoms within sites.
- Government norms should be followed in recruitment of staff in similar projects.
- Intensify outreach activities by having training of PHC staff on community mobilization and involving additional staff and community volunteers.
- Create awareness at the facility level about the various government welfare schemes available for PLHIVs.
- Transition plan should be an integral part of the project and be considered well in advance
- Instead of continuing PHCEP project, build capacity of existing PHC staff on HIV/AIDS service provision, so that the services are fully integrated into health systems to ensure sustainability.

# I. BACKGROUND OF PHCEP

In the fiscal year 2004-2005, the United States' Centers for Disease Control and Prevention– Division of Global HIV/AIDS (CDC-DGHA), in collaboration with Andhra Pradesh State AIDS Control Society (APSACS), and two non-governmental organizations i.e., Catholic Health Association of India (CHAI) and Project Concern International (PCI), initiated a one-year pilot in 20 Primary Health Centers (PHCs) in two districts, to respond to the burgeoning HIV/AIDS epidemic in the state. A pilot of the PHC Enhancement Project (PHCEP) was initiated with the purpose of making HIV/AIDS-related services available and accessible to the rural population seeking primary health care, including ante-natal services, in the state. Catholic Health Association of India (CHAI), as the implementing sub-partner of PCI and subsequently of LEPRA SOCIETY, assumed the responsibility for implementation.

Through this pilot, nurses outside the government system were recruited and trained in providing comprehensive HIV/AIDS services within the primary health care system. Each nurse, referred to as a PHCEP nurse in this document, was posted at a PHC under the Medical Officer (MO) in-charge. Following training and skill-building, PHCEP nurses provided HIV counseling, testing and PPTCT services (identification of positive pregnant women, counseling, testing, institutional delivery, ARV prophylaxis for mother and baby, infant feeding counseling, infant follow-up and HIV diagnosis). They also conducted outreach to promote uptake of services, make PLHIV home visits, map groups at high risk for HIV at village level, decrease stigma, raise awareness of HIV/AIDS among self-help group women, school children, village youth and local self-governing bodies. PHCEP Nurse Supervisors (NS) were recruited and trained to coordinate, facilitate, and supervise the work of a number of PHCEP nurses (five to eighteen).

By December 2006, the PHCEP was expanded to 266 PHCs in ten districts by APSACS. In 2010-2011, on DAC's directive, APSACS initiated facility-integrated ICTCs (FICTCs ), in which the existing staff nurses and lab technicians of PHCs were capacitated to provide HIV counseling and testing.

For the key components, intended outputs and outcomes of the PHCEP please refer to the logic model in Annex 1.

## Evaluation Purpose

Given the uniqueness of the PHCEP and the fact that it was concluding in September 2010, the key stakeholders met in 2010 to plan an evaluation of the project. After examining the monitoring data available under the project, participating stakeholders agreed to conduct a process evaluation of the project. The purpose of the evaluation was to better understand the context in which the project took place; to identify facilitators and challenges faced during implementation, and to identify good practices, lessons learned, and success stories, if any, to inform planning and implementation of HIV/AIDS related services in rural and remote areas in India.

The evaluation is intended to inform stakeholders DAC, State AIDS Control Societies (SACS), Government of Andhra Pradesh (GoAP), National Rural Health Mission (NRHM) on future development of similar projects in the country.

# II. EVALUATION DESIGN

This was a non-experimental process evaluation which primarily used mixed data sources and methods to answer the stated evaluation questions and the indicator measures. The scope of the evaluation design was based on the availability of pre-existing information and feasibility of obtaining information from stakeholders such as beneficiaries, implementers, the technical assistance agency and the government. In the absence of baseline data of the project, the evaluation focused on project implementation rather than outcomes.

## IIa. Evaluation Questions, Indicators, Sources and Methods

### (i) Evaluation Questions:

The evaluation questions included the following:

1. *What are the key lessons learned, success stories, if any, and challenges and recommendations from the PHCEP?*

- What services were provided to clients at PHCEP and FICTC PHC sites?
- What have been the good practices and innovations, and success stories of the project, if any?
- What have been the challenges encountered and lessons learned during the implementation of this project?
- What are the recommendations from the project designers, funders, implementers, and beneficiaries?

### (ii) Indicators, Source and Methods

Indicators were developed to measure progress towards answering the evaluation questions. For each evaluation question, indicators, data sources and data collection methods are described in the Annex 2. Quantitative indicators were analyzed over time with aggregated data from January 2007 to June 2010 for PHCEP and for the FICTC which came into existence much later than the PHCEP PHCs, the time period for abstraction of data for indicators was from June 2009 to June 2010. Data abstracted from these sites were separately analyzed and presented.

## IIb. Data Collection Procedures

Solidarity and Action Against The HIV Infection in India (SAATHII), the third party agency contracted for data collection; gathered, managed, and analyzed the data. FHI 360 monitored SAATHII and oversaw quality assurance of data collection, analysis, interpretation and reporting. FHI 360 and SAATHII developed the training material and trained data collectors on data management, data analysis, interpretation and reporting with contextual inputs from CHAI.

SAATHII's field team underwent rigorous training by CDC HQ team on quantitative and qualitative methods, interview techniques and data abstraction onto excel spreadsheets prior to data collection. The field work was carried out from April to July 2011 where the field data collection team stayed in the districts of data collection and traveled to each facility. The data collection began ten months after completion of the PHCEP.

**Evaluation site and population selection:** The evaluation took place in two out of 10 districts in which the PHCEP is implemented. Given resource constraints, it was decided that the two districts with the highest (Guntur, 2.5%) and lowest (Nizamabad, 0.5%) HIV prevalence (DAC, 2009) would be chosen to learn the most about implementation in these two scenarios. Five evaluation sites (PHCs) within each district were selected purposefully to include diverse characteristics that were to be represented in the evaluation (Purposive heterogeneous sampling strategy) (Michael Quinn Patton, 2002). Characteristics included geographical spread, volume of counseling, ANC/Non-ANC clients, institutional delivery/no delivery, and population size of the PHC catchment area. An additional five FICTC PHCs from Nizamabad and four from Guntur were selected from each of these districts in order to examine services provided at PHCEP PHCs and FICTC PHCs sites, the criterion for selecting sites included (i) FICTC PHCs which are located geographically closer/ adjacent to PHCEP- PHC due to resource constraints of travel for data collectors.

**Evaluation populations included: Beneficiaries*:*** The PHCEP target population was the rural population of the 10 districts of AP in which the project was implemented. For the purpose of this evaluation, beneficiaries (rural populations) were categorized as ANC and Non-ANC. To capture responses from beneficiaries residing in the PHCEP PHC catchment area, but who accessed similar HIV/AIDS services at higher public health facilities despite the same being provided at the PHCEP PHC, PLHIV (ANC and Non-ANC) were included as data sources. **Service Providers:** PHCEP Nurse, Nurse Supervisor, Staff Nurse and Medical Officer at the facilities were included as respondents under service providers. **Key Informants:** These included the Additional District Medical and Health Officer (ADMHO), members of the CHAI and LEPRA Society, APSACS, CDC, and community members from the focal areas including village leaders, self-help group (SHG) leaders and other local informants. Facilitator guides for interviews and focus group discussions are in Annex 6 and field-testing of the entire data collection process was conducted in a non-evaluation district, and changes were made accordingly.

In-depth interviews planned with key informants from DAC and with the Project Director of APSACS could not be conducted. A total of 96 IDIs and FGDs were conducted and included in the analysis. Project-related documents were reviewed as another source of qualitative data.

Quantitative data was collected for the period Jan 2007 to June 2010 (42 months) from the PHCEP sites and for the period June 2009 to June 2010 (12 months) for the FICTC sites. As the FICTC sites were established more recently than the PHCEP sites, data were only available from 2009.

Quality in data collection, analysis and reporting was ensured by the FHI 360 and CDC teams throughout the process through mock interviews, and data abstraction during training; monitoring visits, de-briefing sessions, review of data abstraction sheets during data collection; and review of transcripts, inter-coder reliability and feedback through teleconferences post-data collection. A series of meetings and workshops (related to data collection, data analysis and report writing) were held between the period March and Sept 2011.

## Data Management and Analysis

**Quantitative data:** Numerical data were abstracted from registers at the sites, and analyzed using MS Excel™ to produce descriptive statistics and display results. The flow chart below (Figure 1) illustrates the process including quality control (QC) at each stage.

**Qualitative data:** Qualitative data collection was undertaken in the local language (Telugu) to ensure understanding and participation of beneficiaries and service providers. The IDI and FGD were recorded in the field using digital audio devices (Transcend ™). Additional notes were written on each session by the assigned notetaker. Recordings were then transcribed in Telugu, and supplemented with field notes. These transcripts were translated into English.

The codebook was developed jointly by the evaluation team with mentorship support from the CDC HQ team. Twenty-four codes were defined through an inductive process based on the transcripts. These are listed in Annex 8, clustered into four broad areas: Resources, Services, Project Cycle and Management,

and Stakeholder Issues; with recommendations being a code that spanned all four areas. The flow chart (Figure 2) summarizes the process of data collection, management, analysis and quality control:

The evaluation team coded all transcripts and analyzed the data deductively to explore emerging themes. Coding and data management were computer based, facilitated by AtlasTi™ version 5.0. The approach to analysis was grounded theory, wherein theory generation evolved out of the phenomena that were captured via the coding process. No external theoretical constructs were imposed upon the data analysis.

For each code, the outputs from all transcripts were collated and analyzed in reference to the evaluation questions. Thus, for example, all the transcript segments that had been assigned the code 'Project Start-up and Scale-up' were imported into a document and classified into four themes: services provided, positive outcomes, challenges faced by the program, and respondent recommendations. In case of conflicting recommendations from different respondents, emphasis was given to those recommendations that received support across multiple categories of respondents; however, important conflicting opinions were clearly stated to demonstrate variability.

## Confidentiality and Ethical Considerations:

All those involved in data collection, analysis and report writing signed confidentiality agreements and completed the FHI 360 research ethics training curriculum. Written consent was sought from all the participants prior to in-depth interviews and focus group discussions (see recruitment form in Annex 4 and Informed consent form in Annex 5). Confidentiality and privacy were ensured throughout the process. HIV status was not disclosed to the field investigators responsible for conducting the interviews and focus group discussions. No questions related to HIV status were asked. To protect the identity of those who were HIV positive, the same questions were used for HIV positive and HIV negative clients.

Security was ensured for both quantitative and qualitative data. Daily, quantitative data were transferred from data abstractors' laptops to the data analyst's laptop, and subsequently deleted from abstractors' laptops. All data were housed in password-protected machines with weekly backups maintained by the data collection supervisor and handed over to the PI. Individual MS Excel™ files were password protected. Hard copies were housed in a safe. Signed consent forms were placed in sealed envelopes and submitted to the Principal Investigators for safe custody.

**Figure 1**

**Quantitative data collection and analysis process**

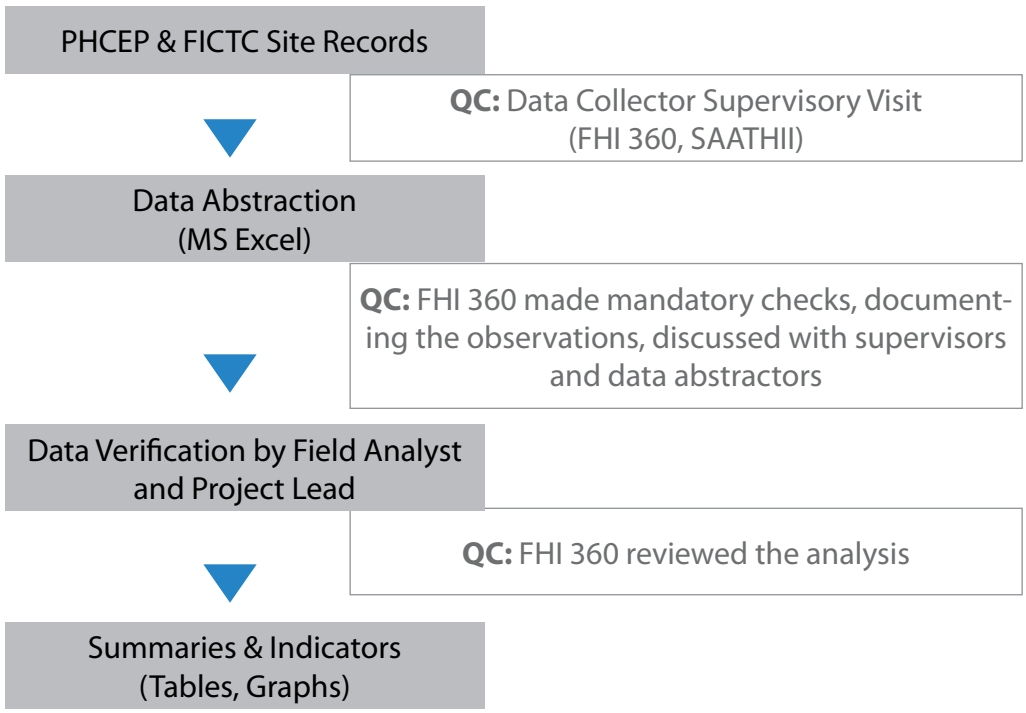
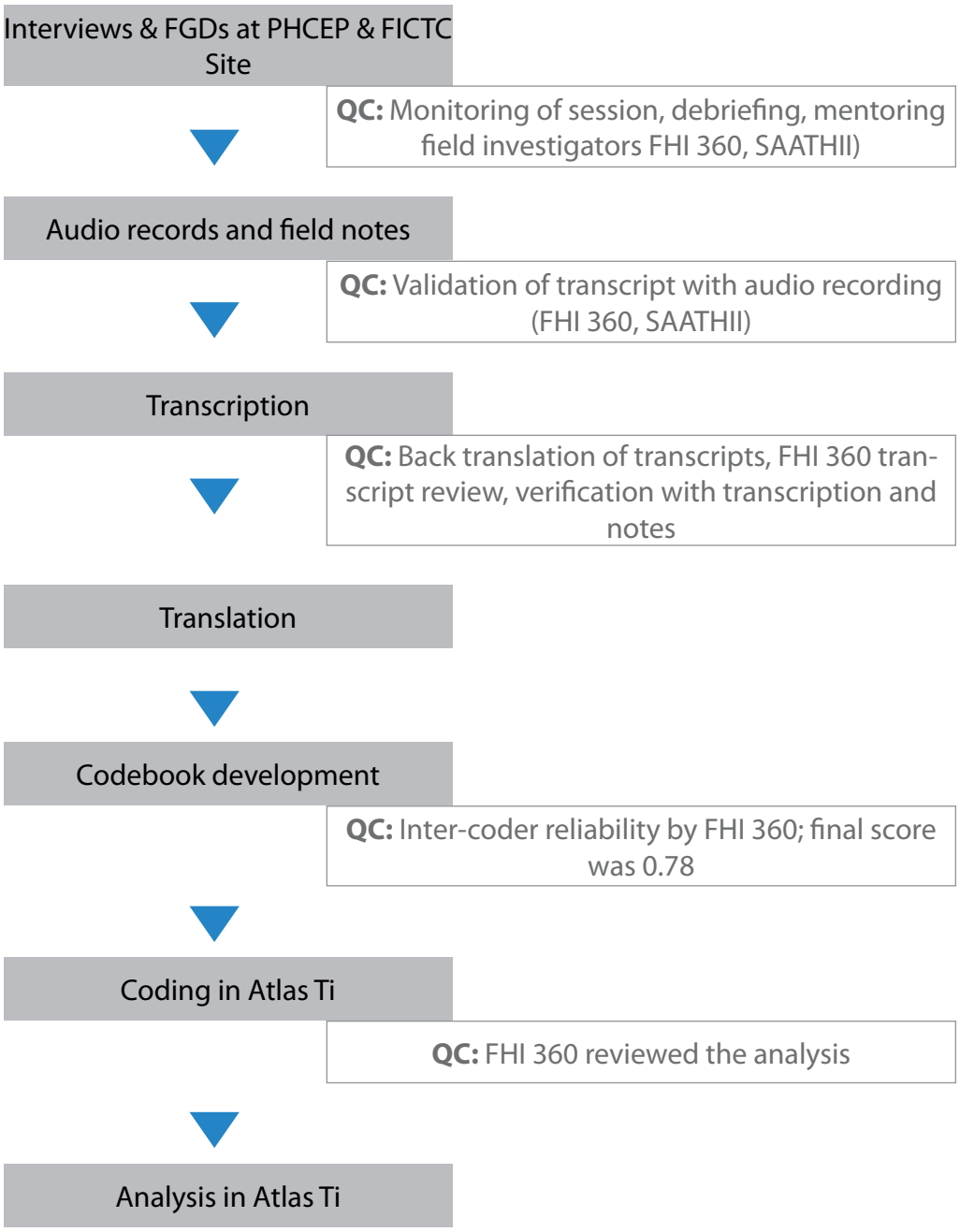


**Figure 2**

**Qualitative Data Collection Process**



# III. RESULTS

The PHCEP project was initiated to bring HIV services into the primary health care system, with a desired impact of averting new HIV infections and bringing individuals in rural areas testing positive into the continuum of HIV care, support and treatment services. While the purpose of the current evaluation was not to measure impact, its findings in the domain of the program are described below with reference to a set of quantitative and qualitative process indicators. Evaluation results are organized by evaluation question.

## III a. Services were provided to clients at PHCEP and FICTC PHC sites

Quantitative results were obtained with reference to

- HIV counseling and testing to general (non-ANC) clients (Indicators A1.1 and A1.2), and cascade of PPTCT for pregnant women and mother-baby pairs (Indicators A1.3-A1.5)
- Referrals of clients availing HIV services to TB services provided under the Revised National Tuberculosis Control Programme (RNTCP) (Indicator A2.1)

### 1. Counseling and Testing Services:

The following results describe HIV counseling and testing for Non-ANC clients across the 10 PHCEP sites from January 2007 to June 2010. Table 1 indicates 95.6% (N= 30403) of 31,788 clients counseled and tested across the sites got their result during the period Jan 2007 to June 2010. Of the total, 90.5% (N=28770) got their results on same day. As shown in Figure 3, the average daily client load ranged from 3 to 26 in Guntur sites and 5 to 21 in Nizamabad sites; with an overall mean of 12 HIV tests per day. (The calculation for each district, the daily client load

**Table 1: Percentage of individuals who know their HIV test results on the same day[1] among those counseled and tested at Guntur and Nizamabad PHCEP sites, Jan 2007-June 2010**

| PHCEP sites | GUNTUR 5 sites | | NIZAMABAD 5 sites | | TOTAL | |
|---|---|---|---|---|---|---|
| Category | Number | Percent | Number | Percent | Number | Percent |
| Pre-test date is the same as Post-test date | 14552 | 90.3 | 14218 | 90.7 | 28770 | 90.5 |
| Post-test date is after the pre-test date | 1043 | 6.5 | 590 | 3.8 | 1633 | 5.1 |
| Test result not collected | 322 | 2.0 | 725 | 4.6 | 1047 | 3.3 |
| Errors * | 195 | 1.2 | 143 | 0.9 | 338 | 1.1 |
| TOTAL | 16112 | 100.0 | 15676 | 100.0 | 31788 | 100.0 |

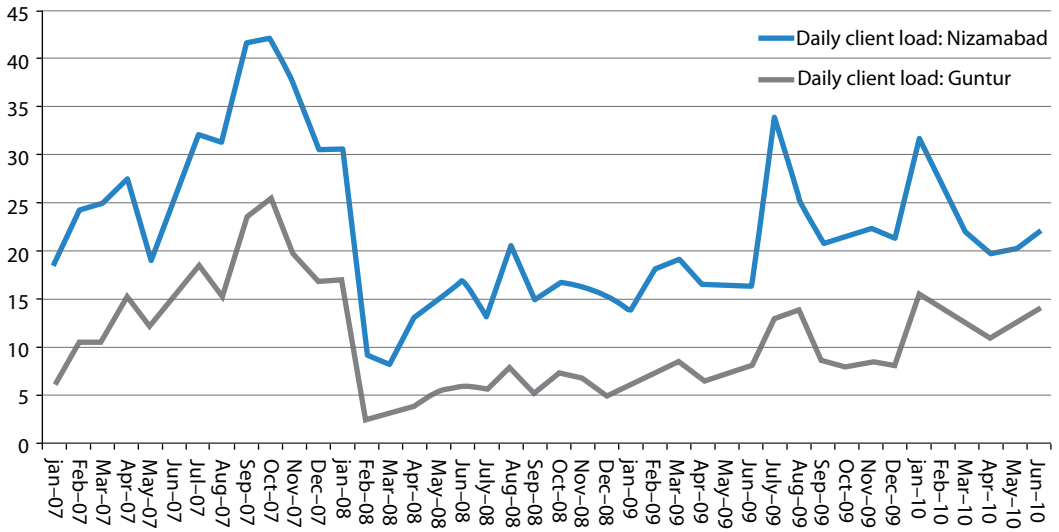
* Errors include (i) pre-test date missing, or (ii) pre-test recorded as having occurred on a later date than post-test

Source: APSACS ICTC non-ANC register

1 [Numerator = (Number of clients counseled and tested in a month
Denominator = (Number of working days in a month when HIV testing is done)

**Figure 3**

**Daily client load[2] for HIV testing at PHCEP Evaluation sites in Guntur and Nizamabad Jan 2007-June 2010**




was calculated for each month by summing the total number of tests done in all five evaluation sites, and dividing by the number of days in that month when testing was done.)

Peaks in testing coincide with various campaigns of the APSACS, such as the Be-Bold campaign to saturate PPTCT coverage (2007), and Shubham campaigns to increase referrals to counseling and testing for high risk populations (mid-2009, early 2010)[3]. Low case loads in the first half of 2008 were due to a state-wide shortage of testing kits Jan-April 2008[4]

## 2. PPTCT Cascade Services

Among ANC clients, 80% (N=149) of positive pregnant women identified at the evaluation sites had institutional deliveries (Table 2). Among the live births (N=104), 85.8% of mother-baby pairs received Nevirapine for prevention of parent to child transmission of HIV (Table 3) across the ten evaluation sites. During the period Jan 2007-June 2009, there were 57 infants born that were still alive at 18 months. Of these, 20 (35%) mother-baby pairs were followed up at 6, 12 and 18 months. Altogether 26 (45%) of HIV-exposed children (N=57) were tested at the end of 18 months including 6 children, who were not followed up for 18 months, but tested at 18 months (Table 4) of these, 35% mother-baby pairs were followed up at 18 months (Table 4). Forty five percent of HIV-exposed children (N=57) were tested at the end of 18 months (Table 4); this includes 6 children who were not followed up but tested for HIV at 18 months.

Qualitative information from both service providers and beneficiaries testified to the role of PHCEP nurse in motivating clients to give birth at PHCEP sites (institutional deliveries) and for also conducting deliveries with the support of staff nurses.

*"…she [PHCEP nurse] identifies infected pregnant women during her field visits and gathers names sub-centre wise and informs them one week before that they must come here for institutional delivery. She tells each woman that if she does not come for institutional delivery it may be dangerous in case of emergency, and if she does, her baby will also be safe."* – *Service Provider*

*"It is difficult for me to make an account of help she extended to me during delivery. Accompanying me to all the places, carrying my reports, discussing with all, helping in giving samples, collecting reports . . . the list is endless."* - *ANC client*

2 [Numerator = (Number of clients counseled and tested in a month
Denominator = (Number of working days in a month when HIV testing is done)

3 www.apsacs.org/subham.html

4 CHAI process document of PHCEP

**Table 2: Percentage of HIV positive pregnant women diagnosed at Guntur and Nizamabad PHCEP sites had institutional deliveries2 , Jan 2007-June 2010**

| PHCEP sites | Guntur (5 sites) | Nizamabad (5 sites) | Total |
|---|---|---|---|
| Number of registered positive pregnant women | 90 | 59 | 149 |
| Number of institutional deliveries | 72 | 47 | 119 |
| **Percentage of institutional deliveries** | **80.0%** | **79.9%** | **79.9%** |

Source: APSACS positive ANC line list register

**Table 3: Mother-Baby Pairs administered Nevirapine as proportion of live births to positive mothers 3 identified at Guntur and Nizamabad PHCEP sites, Jan 2007-June 2010**

| Guntur ( 5 sites) | Nizamabad ( 5 sites) |
|---|---|
| 56/62 (90.3%) | 33/42 (78.5%) |

Source: APSACS positive ANC line list register for evaluation data

**Table 4: Percentage of mother-baby pair followed-up4 and tested 5 at 18 months in Guntur and Nizamabad PHCEP sites, Jan 2007-Jan 2009**

| PHCEP Sites | Guntur (5 sites) | Nizamabad (5 sites) | Total |
|---|---|---|---|
| Number of live births to HIV-positive mothers | 39 | 18 | 57 |
| Number of MB pairs followed up at 18 months | 13 | 7 | 20 |
| Percentage of positive MB pairs followed up at 18 months | 33% | 39% | 35%(N= 57) |
| Number of HIV-exposed children tested at 18 months | 18 | 8 | 26* |
| Percentage of HIV-exposed children tested at 18 months | 46% | 44% | 45% (N= 57) |

Sources: APSACS ICTC post-natal follow-up register and ANC line-list registers at the PHC

Data on number of live births of HIV-positive mothers were considered for the period Jan 2007 to Jan 2009, in order to be able to include the full period of 18 month follow up. These constituted the denominator for the above indicators.

* Out of the 26, 6 children were not follow-up till 18 months but were just tested for HIV at 18 months

## 3. Cross-referral between Revised National Tuberculosis Program (RNTCP) and ICTC

Ninety-one percent of the clients at the ten evaluation sites were referred by the PHCEP nurse for TB testing reached RNTCP centre, as seen in Table 5.

Data on the referral were not available for TB positive referred by RNTCP and tested at the PHC.

**Table 5: Percentage of clients referred from ICTC at Guntur and Nizamabad PHCEP sites reached RNTCP 6, Jan 2007-June 2010**

| PHCEP Sites | Guntur (5 sites) | Nizamabad (5 sites) | Total |
|---|---|---|---|
| Number of clients referred from ICTC for TB testing | 1241 | 888 | 2129 |
| Number of clients reached RNTCP for TB testing | 1122 | 811 | 1933 |
| Percentage of clients referred by ICTC who reached RNTCP ( 10% has to reach RNTCP) | 90% | 91% | 91% |

Source: DAC monthly ICTC report

The FICTCs were at a nascent stage at the time of data collection, hence client load was minimal. Data from Nizamabad were available for three of the five evaluation sites during the period June 2009-June 2010 and for only one in Guntur for the same period. Information available for FICTC is given in Annex 9.

## III b. Good Practices and Innovations of the Project

Good Practices are based on codes categorized as per the health system building blocks[5] as summarized in table 6. Data for all results have been obtained from beneficiaries, service providers and key informants. Beneficiaries include ANC and non-ANC clients (both HIV-positive and HIV-negative). Service providers include PHCEP nurse and supervisor, PHC staff nurse and medical officer, and ADMHO). Key informants include community members, CHAI, LEPRA, CDC and APSACS.

**Table 6: List of codes as per health system blocks**

| Health System Building Blocks | Codes |
|---|---|
| 1. Service Delivery | Counseling and Testing, PPTCT, Referrals, Outreach, Confidentiality, Area/District Hospitals, Private facilities, Access, Start-up and Scale-up, Project Transition |
| 2. Health Workforce | Staffing, Presence/Absence of PHCEP Nurse, Monitoring and Supervision, Coordination, Capacity building, Project Transition |
| 3. Information | Reporting |
| 4. Medical Products | Infrastructure, including supplies such as test kits |
| 5. Financing | Funding |
| 6. Leadership/ Governance | Partnerships, Project Transition, Ownership |

### 1. Service Delivery

In this section we report good practices, innovations and success stories in the areas of counseling and testing, PPTCT, outreach, stigma-free services, confidentiality and access.

**PHCEP as an innovative project:** According to key informants, the project was an innovation in terms of integrating HIV into primary care service delivery, enabling services to be provided in a decentralized manner. Prior to the project, voluntary counseling and testing services were available mainly in the secondary and tertiary facilities (43 locations in the 10 PHCEP districts), with PPTCT services being even more restricted (13 locations in the 10 PHCEP districts)[6]. Through the PHCEP, HIV services became available in 266 facilities in these districts, enabling a huge scale-up of counseling, testing and PPTCT services. The benefits of comprehensive services have been seen in the quantitative data on counseling, testing and PPTCT service delivery, and in positive deliveries being performed in the PHCEP.

*"Their contribution to ICTC numbers is huge, PPTCT was also good… and some of these nurses also got awards for conducting huge number of positive deliveries"* – *Key Informant*

**Stigma-Free services:** Fear of stigma on the part of HIV-affected communities, and enacted stigma (i.e. discrimination) in health-care settings have been identified as barriers to universal access to HIV testing and treatment worldwide[7]. Multiple beneficiaries, medical officers and other service providers reported that the PHCEP sites offered stigma-free counseling and testing and outreach services.

*"They (PHC staff)… never treated me differently……..….. They used to call me by name and used to enquire about my health… they treat me well and I feel I am well taken care of here…."* – *non-ANC client living with HIV*

*"…in the beginning when stigma and discrimination were more prevalent, these PHCEP nurses really did help us in going to villages, doing the counseling at the village level, family counseling …"* – *Key Informant*

5 CDC adaptation of World Health Organization Health Systems Framework http://www.cdc.gov/globalaids/Strengthen-Health-Systems/

6 CHAI 2011 PHCEP Process Document

7 UNAIDS 2009. HIV-related Stigma and Discrimination: A Summary of Recent Literature

**Maintenance of Confidentiality:** Maintaining client confidentiality in HIV service delivery settings is an important component of quality of services[8]. Both beneficiaries and service providers mentioned confidentiality frequently in interviews and focus group discussions and while delivering test results.

*"Thinking that it was just a test report, I asked my mother to go and bring the report from there…Madam [PHCEP Nurse] told my mother to send me for collecting the reports and also told her that she wanted to talk to me exclusively. She categorically told my mother that the reports would be given there only when the patient comes in person"* – *HIV-positive ANC*

*"It is 100% confidential because when we get a [HIV] positive case except the PHCEP Nurse no one knows about it. Rest of the staff doesn't know it. Even their relatives are not told…… ….. we don't mention the names on the report"* – *Service Provider*

**Perceived quality of counseling:** Beneficiaries, both ANC and non-ANC clients, predominantly reported that the information provided to them during counseling was useful and comprehensive. This included motivating ANC clients to opt for institutional delivery; risks of HIV transmission through sexual and non-sexual routes, promoting condom use, fidelity to marital partner and importance of testing to non-ANC clients and couples. This was corroborated by the PHCEP nurses themselves. Beneficiaries and service providers mentioned that the counseling and safer sex information was given with the aid of pictures, books, films, and penis models.

**Test Results on the same day:** Having test results available on the same day is indicative of service quality as it increases the chance that clients will obtain their test results. Quantitative findings indicate that over 90% of clients got their test results on the same day as their pre-test counseling and testing at the PHCEP evaluation sites. These are substantiated by qualitative findings from both beneficiaries and service providers.

**Access and uptake:** PHCEP enhanced access and promoted uptake by individuals. Community members, service providers, and key informants mentioned that availability of services at grassroots level was beneficial as it minimized distance and reduced travel and associated experiences, resulting in large numbers counseled and tested. From project initiation until June 2010, 678,194 non-ANC individuals received HIV related counseling and 664,671 were tested for HIV[9]

*"…we thought why to go here and there, and decided to get tested when the facility is available here [PHCEP site] so we got tested here"* – *non-ANC client*

*"For a person to get himself tested [at district hospital] would be like one day going and getting himself tested and coming back, probably going another day to get reports that two day wages is lost, right? … So this was providing the services literally at their doorstep…that way services were really made accessible to the people."* – *Key informant*

Both beneficiaries and service providers mentioned outreach by the PHCEP nurse as a facilitator of HIV services uptake. Outreach activities included use of flip charts, posting banners, performing street plays, facilitating group discussions, airing televised public service announcements, and playing educational games to raise awareness about PHCEP services. As part of outreach, PHCEP nurses also identified pregnant women to promote counseling, testing, and institutional deliveries; and created linkages for positive patients with local NGOs to help them access care and treatment.

*"Generally they [PHCEP nurses] come to Anganwadi centre and keep calling everyone. They repeatedly tell everyone that they should get tested… they come to our village once in a week."* – *Non-ANC client*

*"Regarding this [outreach by PHCEP nurses] I see a lot of awareness among people. Of late, we have seen voluntary responses for testing."* – *Service provider*

8 WHO 2004. Standards for quality HIV care: a tool for quality assessment, improvement, and accreditation

9 APSACS CMIS

## 2. Good Practices relating to Health Workforce

This section identifies good practices pertaining to staff roles, capacity building, and coordination between PHCEP Nurses and frontline health workers.

**Multi-tasking by PHCEP nurses:** PHCEP nurses were able to handle both HIV counseling and testing, roles that in other ICTCs are performed by two different individuals. In addition, the PHCEP nurses provided referrals, outreach, PPTCT cascade services and maintained registers.

*"[F]or the first time a single person who is actually capacitated as a counselor, lab technician and an outreach worker… so this was like a remarkable thing, one person doing all these three different services at the grass root level."* – *FGD with key informants*

**Capacity building of health workforce:** In 2006 and 2007, the PHCEP technical assistance teams, along with APSACS, organized induction trainings for PHCEP nurses on basics of HIV, Voluntary Counseling and Testing, PPTCT, Community Outreach, Follow-up Counseling, and SHG issues. Additional training programs were organized for the Nurse Supervisors, Medical Officers, and district team members[10]. The objective of the training programs was to build capacity of service providers, particularly nurses, in providing comprehensive HIV/AIDS services. Refresher and need-based training was provided to PHCEP nurses to bridge knowledge and skill-gaps identified by the project monitoring team.

Key informants stated that these training programs improved service uptake, coordination between PHCEP Nurses and frontline health workers (ANMs, Anganwadi Workers, etc.), ownership of the program by medical officers, and supplementing in the curriculum.

*"After going through the training module that was set by DAC …PHC project team introduced these two components [nutrition and palliative care] as part of training …"* – *FGD with key informants*

*"APSACS from the beginning played a key role in training... APSACS basic services team used to come … and train in all the technical, financial issues and human resource management and how to work with other people, coordination issues…"* – *Key informant*

*"[Initially] medical officers thought that HIV/AIDS project means it is a separate project, it is only APSACS project and so they [PHCEP Nurses] only take care… So we conducted trainings for medical officers and training for the PHC staff so slowly they too started getting involved in the program…."*– *Service provider*

**Coordination between PHCEP and Frontline Health Workers:** PHCEP nurses carried out outreach and follow-up activities in the field along with frontline health workers such as ANMs, Accredited Social Health Activists (ASHA), Multi-Purpose Health Workers (MPHW), Women Health Volunteers (WHV), Outreach workers and Anganwadi workers (AWW). Multiple stakeholders reported that the coordination among these categories of frontline health workers and PHCEP nurses helped raise HIV awareness, mobilize villagers for counseling and testing and PPTCT services, and follow-up of mothers and HIV-exposed infants.

*"[PHCEP nurse] comes and goes round village once and sends message of her coming there through messengers [ANM, ASHA workers, outreach workers] usually available in village, they go and inform villagers."* – *Beneficiary*

*"Conducting meetings, they [PHCEP nurses] explain things related to HIV to them. They explain dos and don'ts to them. Anganwadi teacher facilitates such meetings with the help of PHCEP nurse"* – *FGD with beneficiaries*

*"When she went to a village, she [PHCEP nurse] would call up WHVs, ASHA workers …… With their help she would reach all people. She would make a house-to-house visit during the village visit."* – *Service provider*

*"The program is successful thanks to ASHA workers too. They gather community members, village sarpanch and other villagers anytime we request them to do."* – *Service provider*

**Monthly review:** Key informants and a service provider noted that monthly reviews were a salient feature of the monitoring and supervision system of the project. During these monthly reviews, the PHCEP performance is reviewed, evidence-based decisions are made, and support is provided to the staff to address gaps that have been identified.

10 CHAI 2011, PHCEP Process Document

### 3. Good Practices related to Information and Documentation

According to the key informants, the PHCEP project maintained detailed records of clients through registers and submitted monthly reports. The project followed national reporting guidelines, and also recorded additional information on outreach activities, successes and challenges encountered in the course of their daily work, which were reported as being useful for program improvement.

In the evaluation team's review of the ICTC non-ANC client register for the purpose of abstracting data, errors found in registers were minimal, accounting for 1.1% of 31,788 individual entries examined (Table 1)

### 4. Good Practices related to Leadership and Governance

The PHCEP involved partnerships with multiple agencies like APSACS at state and district level, district health department, primary health centres, CDC and civil society organizations-CHAI and LEPRA Society. A salient feature of the project was the leadership role played by APSACS, the nodal government agency, in owning the project, scaling it up, its involvement in capacity building, monitoring and review and its willingness to collaborate with technical partners.

*"[A senior official of APSACS] believed in innovation… gave a lot of freedom to this project to implement and then saw… nurses performing very well in the pilot and … immediately said we will go ahead [scale up]"* – *Key informant*

*"And we collaborated as one… we could go [to visit the APSACS nodal official] any time, even at 11:30 at night … and so we worked as one organization and made this project work."* - *Key informant*

## III c. Challenges encountered and Lessons Learned during the implementation of this Project

This section outlines the challenges faced during the course of PHCEP. We operationally define 'challenge' as a situation, system, or process that negatively influenced the PHCEP during start-up, scale-up, routine implementation or transition. Emphasis is given to those challenges identified by multiple individuals and those from multiple stakeholder categories.

### 1. Start-up and Scale-up related Challenges

Key informants reported challenges at the PHCEP sites when the project was starting up. These included recruiting staff to work in remote villages where suitable accommodation was scarce, getting space within the PHCs for counseling and testing, monitoring and maintaining quality during rapid scale-up.

*"…introducing the PHCEP nurses itself was a big challenge like availing the space for them at the PHC"* – *Key informant*

### 2. Implementation-related Challenges

While most respondents spoke in positive terms of the information they received during counseling sessions with the PHCEP nurse, there were some examples of misinformation or faulty advice given by them. These included one instance of advice against a second marriage given to a widower living with HIV, one instance of an HIV-positive ANC client being suggested to terminate her pregnancy and two cases of positive ANC clients advised against breast feeding.

A recurring theme among service providers within the health system was their perception of PHCEP staff as outsiders and the program as external to the health system and their routine activities. Key informants reported challenges in getting the medical officers to own the project, extend cooperation to the PHCEP nurse in allocating space and getting the activities established, and in disbursing funds for PHCEP activities. They reported that medical officers were initially not willing to attend project-related trainings, and were unwilling to undertake or permit PHCEP nurses to conduct positive deliveries.

*"Medical officers think that HIV/AIDS project [PHCEP] means it is a separate project, it is only APSACS project and they only [will] take care. The involvement of PHCs was not there"* – *Service provider*

There was also a perception among some staff nurses that HIV counseling and positive deliveries were the sole responsibility of PHCEP nurses. It was suggested that salary disparities between PHCEP nurse and other facility staff were partly responsible for the lack of ownership.

*"The PHCEP nurses were always looked upon as HIV nurses, so… no other nurse would help them… even for positive deliveries, no staff used to perform then…"* – *Key informant*

Service providers experienced problems with procuring supplies including HIV test kits and other consumables mainly due to shortages of supplies at the higher level. Moreover, consumables and kits were not delivered at service delivery points and the PHCEP nurse collects the supplies from the district.

*"….what happens at times is there will be a gap of 10-15 days to receive supply of kits. In such situations, obviously there will be gap in services also"* - *Service provider*

*"…the supply of kits would stop at district level ...going there [district headquarter] and getting test kits, surgical stuff [delivery kits], test tubes, etc is a difficult task."* – *Service provider*

### 3. Project Transition-related Challenges

Apart from project initiation, transition of the PHCEP was marked by a number of challenges. Services at many sites were disrupted during transition. As a service provider stated, *"Patients come and ask for reasons of closure… Because, so far we have provided them services, now we are unable to continue similar services [counseling, tests] to ANCs or high risk groups."*

*"A lot of excellent work has been done and all of a sudden it is stopped. So it became very much difficult for them now. Initially you wanted everyone to come to you. It was done with a lot of good intentions. Now people began coming to you and you stopped it."* – *Service provider*

*"Earlier we entrusted blood tests and these [HIV-positive] cases to the PHCEP nurse… As she was interacting with the people and gathering them, blood tests were taking place. Now the problem is unless they come to us we're not able to do it. The number of people who come particularly for HIV test is very low."* – *Service providers*

PHCEP nurses were terminated from their positions, and plans to have them absorbed by the NRHM were delayed, despite efforts by APSACS to secure such placements. According to key informants, PHCEP nurses were perceived as outsiders to the government system, and their re-hiring would have violated norms of reservation and policies of hiring local staff. The failure to continue PHCEP nurses resulted in a loss of their contribution to the HIV program in the state.

*"When it came to sustainability they [project partners] had to plan it well ahead in time. It was not done. It was not a smooth transition"* – *Key informant*

## III d. Recommendations from the Project Designers, Funders, Implementers, and Beneficiaries

This section summarizes key recommendations from the respondents, including beneficiaries, service providers, and key informants in response to questions related to improving HIV/AIDS service provision at PHC, continuation of services at the PHC, transition and suggestions for implementation of similar projects in near future.

### 1. Project Start-up

This part explains project initiation including recruitment and scale up from two districts to ten districts. One of the recommendations from the key informants was to invest more time on ensuring systems and processes are in place prior to initiation of the project e.g., allocation of separate space for counseling in the PHC and supply chain issues (equipment, HIV test kits, delivery kits and other consumables).

As mentioned under Section III referring to challenges, recruitment of PHCEP nurses by third party was a challenge in terms of their non acceptance by the PHC staff and their absorption into health system during transition. Hence it was recommended by key informants that government norms should be followed in recruitment of nurses in similar projects and prior sensitization of PHC staff is important to ensure their ownership for the project and acceptance of project staff.

*"See, initially in 2005-06 there were huge issues of supply chain management because reaching PHC and getting… I know that the nurses were not allowed to sit in the PHC because they were posted by third party … slowly they had to be convinced and they got some place in the PHC. .so first couple of years was a herculean task to get all the equipment and supply chain management. In case if this particular model leads to be rolled out again in any other place, I think these things(above)need to be kept in mind…" – Key informant*

## 2. Outreach

Both service providers and beneficiaries suggested that there was a need to intensify outreach activities so as to reach high-risk groups and underserved populations by training nurses and other staff in the PHC on community mobilization and involving additional staff and community volunteers in supporting outreach. A key informant suggested that the reporting and documentation of outreach needed to be strengthened for better monitoring.

*"…there need to be a training ……especially on community mobilization in reaching the rural population"- Key informant*

*"It will be good if the help of these persons (PLHIV) are taken for increasing awareness levels of their people….. these people can speak to them in their own language and make them understand. We need to organize awareness camps in their tandas (villages). At the same time these volunteers must be given some counselling tips also " - Service provider*

*"Outreach can be improved…by reporting and documentation of the outreach component" – Key informant*

## 3. Human Resources

Recommendations on human resources are related to presence/absence/challenges associated with required staff for HIV/AIDS related services as well as issues related to recruitment, retention and continuation of staff. Respondents including beneficiaries, community members, staff nurses and ADMHO, pointed out that if PHCEP project continues then the numbers of PHCEP nurses could be increased considering their workload and range of tasks assigned.. There was a specific recommendation from service providers to consider male staff for counseling male clients. One of the key informants also suggested that post PHCEP project the PHCEP nurses could be utilized to mentor HIV counselors and laboratory technicians at other facilities such as Public Private Partnership sites, mobile ICTCs and FICTCs .

*"As we have less man power, it is better if it is increased. Then we can achieve 100% screening levels." –Service provider*

*"…so far she [PHCEP nurse] had been alone to do the service. If one more person could assist her it could be easy for her on one hand and two people can cover more area and meet more people" - Beneficiary*

Contradictorily some of the key informants recommended that there is a need for the PHCEP activities to be transferred to existing health workforce instead of continuing the PHCEP nurses. Towards this, they recommended capacity building of existing PHC staff on HIV/AIDS service provision, so that the services are fully integrated into health systems.

*" …you cannot have a vertical system of HIV counseling and testing continued forever. ...HIV counseling and testing should become a part of system (health). The technician (laboratory) should be doing the test (HIV) as part of routine PHC lab tests..." – Key informant*

## 4. Infrastructure and Supplies:

Recommendations related to space for services, equipment, consumables such as drugs, HIV test kits and delivery kits, and supply chain issues are discussed here. Multiple respondents emphasized the need to ensure space and privacy for counseling and testing, guarantee supply of HIV test kits, condoms and other consumables at the facilities for effective service delivery.

*"...giving a good space and having some privacy for …services especially for STI/RTI related … we should have that kind of atmosphere actually." – Key informant*

*"…we need to have continuous availability of kits so that we can deliver services without time gaps" – Service provider*

*"…on the whole the supply chain has to improve from National level to state level to districts ….."* – *Key informant*

## 5. HIV/AIDS Services

This section focuses on the additional recommendations provided by stakeholders in an effort to improve HIV/AIDS services at the PHC level. One of the service providers suggested that there should be a condom box kept at an accessible location and a site point person identified to replenish it on a regular basis. Beneficiaries and community members wanted HIV counseling and testing services for ANC to be available more frequently than once a week. There were also suggestions for display of board highlighting government welfare schemes for PLHIVs at the PHC to increase awareness and utilization.

*"There should be a box (condom) in the Gram Panchayat, and one in the middle of the village."* – *Service provider*

*"Blood tests( for ANC) are done on Wednesdays only. There will be a long queue of ANC on Wednesdays. … they don't bring box [/lunch/]. They say they get tired by 5 o'clock. It would be better if we had done tests (for ANC) every day.."* - *Service provider*

*"Since it (HIV testing for ANC) is every Wednesday it may not be possible for many people (ANC) to get the test done. If it is every day they can come whenever they want."* – *Key informant*

*"They get bus pass. Mostly many people don't know. Even positive people don't know. We should arrange a board displaying these facilities. They feel they have the support of the government, and our departments."* - *Service provider*

## 6. Project Transition

Project transition referred to information pertaining to transition of PHCEP to NRHM. Though most of the beneficiaries recommended that the PHCEP nurses should be continued, some of the key informants were of the opinion that such vertical project is not viable in the long run. With reference to the transition related challenges in Section III, key informants suggested that smooth transition requires prior planning and consultation among key stakeholders.

*"…Once again we request you let them (PHCEP Nurse) continue their services here (PHC). People living here need their services…."* – *Key informants (Community members)*

*"when you start a project you also have to envision how you are going to transition … when a project is going to end after five years….."* - *Service provider*

*" .. if you want to continue the same separate model (PHCEP project), it becomes stand alone, a vertical structure, I don't think it is viable in the long run. So sooner or later it is better to integrate with the system (Health)…"*- *Key informant.*

*"we should plan first and sit together at the decision makers level ……...that consultative process was missing…….. They were (stakeholders) never talking. The implementers, the primary stakeholders and decision makers were talking (about transition) but then they were not sitting together… ."* – *Key informant*

# IV. DISCUSSION AND WAY FORWARD

The PHCEP initiative in Andhra Pradesh was the first of its kind to decentralize HIV services to the PHC level in the country. As quantitative outputs show, it enabled a rapid scale-up in counseling, testing and PPTCT-cascade services in the districts. Availability of these facility-based and outreach services at primary health center level enhanced access and uptake of HIV counseling and testing. PHCEP demonstrated how a single nurse tasked with counseling, testing, outreach, referrals and PPTCT cascade services could make positive contributions to the existing HIV program. This enhancement contributed to capacity building, while ensuring that monitoring and supervision systems were in place. Stigma reduction, maintenance of client confidentiality, and availability of test results on the same day, were among the good practices identified with respect to HV service delivery. Data on service uptake provide further support to evidence from other countries[11] demonstrating that decentralization is critical to reach PLHIV in rural areas and bring them into the continuum of care.

This evaluation suggests that challenges in service delivery were most pronounced in the phases of start-up, scale-up and transition, providing lessons for initiation of future interventions of this kind. Specifically, buy-in needs to be obtained from participating sites and key stakeholders early on in a project life cycle, as these have implications at all stages – initiation, implementation, scale-up and transition. Critical factors that impact the buy-in include the need to sensitize stakeholders on the importance of the issue, issues of placing independently hired staff versus task-expansion of existing staff,

11 Zhang 2011, Decentralization of the provision of health services to people living with HIV/AIDS in rural China: the case of three counties. Health Research Policy and systems. 2011;9:9.

## Methodological Recommendations for Future Process Evaluations

- Detailed pre-testing of all evaluation components of the evaluation, to realistically estimate field challenges and time for data collection, review, transcription, translation, data analysis and quality control.
- Intensive training and mentoring of field investigators before data collection.
- Training of field monitors during data collector training.
- Handholding by supervisors during initial data collection to ensure that data collectors are conducting interviews as per training imparted to them.
- Review for saturation during data collection and terminate when saturation has been obtained.
- Ensure field investigators familiar with dialectic variations of the local language.
- Conduct inert-coder reliability to ensure uniformity in coding.

compliance of the project with pre-existing government norms for recruitment; as well as operational issues such as mechanisms for ensuring requisite infrastructure and supply chain. Additionally transition needs to be planned well in advance, to ensure that staff and facility capacities created or enhanced during the project are leveraged beyond the project period, and resources for service continuation are in place.

While this present evaluation focused on process, future studies should also aim to assess outcome and impact of such projects through experimental and quasi-experimental methods. This will necessitate establishment of baselines, comparison sites, and identify data sources for evaluation during project initiation.

A second area of future evaluations would be to examine the cost-effectiveness of PHCEP-like models in comparison to other existing models such as the FICTC and stand-alone ICTCs.

A third area of investigation would be to examine effects of HIV/AIDS programs such as PHCEP on health systems strengthening. Though the present study has suggested there are areas in which health systems were strengthened because of the HIV program, rigorous studies are needed to explore effects of HIV programs on other health outcomes such as child immunization, family planning, TB case finding and treatment, and maternal and infant mortality. Studies in developing countries such as Zambia and Rwanda[12] (Yu et al. 2008) have identified such impacts. With the Indian government's increasing emphasis on integrating HIV with Sexual and Reproductive Health (SRH) and with the National Rural Health Mission, such studies are urgently needed.

## Limitations

Since interviews were conducted after the completion of the project, and as many respondents had accessed services more than a year ago, recall lapse was a limitation. There were some communication-related challenges relating to the different dialects that were used across the two districts. Field-level challenges existed in the area of finding respondents due to missing or incorrect addresses, relocation of respondents, and unavailability of PHCEP nurses to assist in the recruitment. It is recommended that these limitations be addressed in future evaluations, wherever possible. For instance process evaluation carried out concurrently with program implementation can reduce recall lapse, help identify and bridge gaps early on in the evaluation.

12 Yu et al. 2008. Investment in HIV/AIDS programs: Does it help strengthen health systems in developing countries? Global Health. 2008; 4: 8.

# V. ANNEXURES

## ANNEXURE 1: LOGIC MODEL AND FICTC

### Problem Statement: Lack of HIV/AIDS services in high prevalent remote rural districts of Andhra Pradesh (A)

| INPUTS | ACTIVITY | OUTPUTS | SHORT-TERM OUTCOMES | INTERMEDIATE OUTCOMES |
|---|---|---|---|---|
| **1** Human Resource: NP, NS, DPM term (DPM & MSE). State CHAI term DG, PM, ??? M&E, DOC, HR, SPC, FIN, SEC, ACC) State LEPRA (shared politics). 7,8,9,10, 11,12,13,14,15,16 | **7** Staff Recruitment 17 | **17** NPs, NS, DPM team, STATE Team recruited | **27** Increased level of awareness about HIV status and prevention of HIV among rural population 31,32,33,34 | **31** Increased health seeking behavior (HIV specific and general) among rural populatics 29,35,36,37 |
| **2** Funds: DAC through APSACS & CDC through LEPRA. 7,8,9,10, 11, 12, 13, 14, 15, 16 | **8** Induction Training: NP, NS, DPM team, 24 hrs PHC staff nurse, PPP Staff nurse Lab tech. 18 | **18** NP, NS, DPM team, 24 Hrs PHC staff nurse, PPP Staff nurse, Lab tech Trained 20,23,27,28,29,30 | **28** Increased access to HIV prevention, care & support and treatment services 31,32,33 | **32** Reduction in HIV risk behavior 33,36 |
| **3** Equipments: ICTC lab equipments, Computer, Printer, TV, DVD Player, Inverter 8,9,10,15,16 | **9** Refresher Trainings': NP, NS, NPM team, 24 Hrs PHC staff nurse, PPP Staff nurse MO 19 | **19** NP, NS, DPM team, 24 Hrs PHC staff nurse, PPP Staff nurse, MO Trained 20,23,27,28,29,30 | **29** Increased no. of positive institutional deliveries at PHC 35 | **33** Increased practice of positive prevention 34,35 |
| **4** Logistics & Consumables: HIV test kits, lab supplier, delivery kits, IEC materials, registers, condoms 10,13,14,15,16 | **10** PHC HIV/AIDS Services: CT, PPTCT (positive deliveries, NVP, FU, MB, Child text) T/t for STI, HIV, OR HIV awareness HBC, Condom 20 | **20** No. of centre operational No. of Clients tested, counseled positive deliveries conducted, NVP given, message, HBC, Condom received 27,28,29,30,31,32, 33,34,35 | **30** Improved quality of HIV services delivery by PHC 31,32,33,34 | **34** Decrease in stigma 33 |
| **5** Infrastructure: ICTC room & furniture. 8,9,10,13,15,16 | **11** Advocacy: dist, sub district and state level 18,19,21 | **21** Seale up of Pilot by APS ACS DAC after 1 year 28,29 | | |

## Problem Statement: Lack of HIV/AIDS services in high prevalent remote rural districts of Andhra Pradesh (A)

| INPUTS | ACTIVITY | OUTPUTS | SHORT-TERM OUTCOMES | INTERMEDIATE OUTCOMES |
|---|---|---|---|---|
| **6** Policies & Guidelins: DAC, APSACS, PEPEAR, LEPRA and CHAI guidelines **8,9,10,12,13,14,15** | **12** Linkages and Networking: With DHL AHCHC, ARTC, CCC, TL DIC, RNTCP, STL Networks, SHG Other NGO 22 | **22** Linkages developed 28,29 | | |
| | **13** Referrals: DH, AH, CHC, ARTC, CCC, TI, DIC. RNTCP, STL, Networks SHG Other NGO 23 | **23** No. of Clients referred 27,28,29,30 | | |
| | **14** Monitoring By APS ACS DAPCU, LEPRA and CHAI 24 | **24** No. of monitoring visits ocuducted and by APS, ACS, DAPCU, LEPRA, CHAI, quality tracking tool developed and used 30 | | |
| | **15** Reporting: CMIS data PHC to dist term DAPCU to APSACS to CHAI to CDC, PEPFAR data PHC to NS to CHAI to LEPRA to CDC, Same system for Financial Reportime | **25** Correct Monthly quarterly half yearly annual report and submitted in time 30 | | |
| | **16** Documentation: Project activities, success stories, News Letter 26 | **26** Ongoing Process documentatice No. of Success stories, Quarterly News letter other publication | | |

# ANNEXURE 2: INDICATORS, DATA SOURCE AND DATA COLLECTION METHOD BY EVALUATION QUESTION FOR PHCEP AND FICTC

| EVALUATION QUESTION | INDICATOR | DATA SOURCE | DATA COLLECTION METHOD |
|---|---|---|---|
| **1.** What have been the good practices, innovations, and success stories of the project, if any? | **A. Quantitative Indicators**<br>**A1.** Prevention services<br>PPTCT and CT Services | **A1.** Data source for indicators on quality of prevention services<br>**Note:** PHCEP and FICTC use same registers | **A1.** Document Review (Data abstraction by data collectors at the PHC) |
| 2. What services were provided to clients at PHCEP and FICTC sites? (This sub-question will be answered by examining PHCEP and FICTC program monitoring data) | **1.** % of individuals who are counseled and tested and know their results on the same day: [Numerator (# received the result on the same day); Denominator (# Counseled and tested on the same day) (How many of those who were counseled and tested received result on the same day)] | 1. APSACS ICTC non-ANC register at the PHC (Numerator – Serial No. 16, Denominator – Serial No. 11) | |
| | **2.** Daily client load for HIV testing at the PHC: [Numerator (# of clients counseled and tested in a month; Denominator (# of working days in a month when HIV testing is done) (How many clients are counseled and tested daily in a month)] | 2. DAC monthly ICTC report (Numerator – Indicator 3 of summary table, Denominator – Section A, No. of days HIV testing done in the month) | |
| | **3.** % of positive mother and baby pair (MBP) received Nevirapine (NVP) on a monthly basis (PHC/ Other health facilities): [Numerator (# of MB pairs received NVP in a month); Denominator (# of HIV positive pregnancies resulting in live births identified by the PHC nurse in the same month)] | 3. APSACS positive ANC line list register at the PHC (monthly data) (Numerator – Serial No. 15 and 16, Denominator – Serial No. 10) | |

| EVALUATION QUESTION | INDICATOR | DATA SOURCE | DATA COLLECTION METHOD |
|---|---|---|---|
| | **4.** % of positive pregnant women (identified by PHCEP nurse) had institutional delivery (PHC/Other health facilities) [Numerator (# of HIV positive pregnant women who delivered in an institution); Denominator (# of registered HIV positive pregnant women identified by the PHC nurse who delivered)] | 4. APSACS positive ANC line list register at the PHC (Numerator – Serial No. 12, Denominator – Serial No. 11) | |
| | **5.** % of positive mother and baby pairs followed for 18 months [Numerator (# of HIV positive mothers and children followed for 18 months); Denominator (# of HIV positive mothers with live births identified by the PHC nurse)] | **5.** APSACS ICTC post-natal follow-up register at the PHC (Numerator – Serial No. 16). APSACS positive ANC line list register at the PHC (Denominator – Serial No. 10) | |
| | **6.** % of HIV exposed children tested at 18 months [Numerator- No. of HIV-exposed children tested at 18 months. Denominator- No. of live births to HIV positive mothers identified by PHC nurse] | **6.** APSACS ICTC post-natal follow-up register at the PHC (Numerator – Serial No. 17). APSACS Positive ANC line list register at the PHC (Denominator – Serial No. 10). | |
| | **A2.** Cross-referral between Revised National Tuberculosis Program (RNTCP) and ICTC | **A2.** Data source for indicators on quality of cross-referral services | **A2.** Document review at RNTCP and PHCEP (Data abstraction by data collectors at the PHC) |
| | **1. Referral for TB diagnosis:**<br>% of clients referred by ICTC reached RNTCP<br>[Numerator (# of clients reached RNTCP from the PHCEP/FICTC); Denominator (# of clients referred to RNTCP PHCEP/FICTC)] | 1. DAC monthly ICTC report (Numerator – Section E, Serial No. IIb, Denominator – Section E, Serial No. IIa) | |
| | **2. Referral for HIV testing:**<br>% of newly diagnosed TB cases tested for HIV at PHC<br>[Numerator (# of newly diagnosed TB cases referred by RNTCP tested for HIV at PHC); Denominator (# of newly diagnosed TB cases at RNTCP)] | **2.** DAC monthly ICTC report (Numerator – Section E, Serial No. IIIa, Denominator – RNTCP register) | |

| EVALUATION QUESTION | INDICATOR | DATA SOURCE | DATA COLLECTION METHOD |
|---|---|---|---|
| **1.** (contd.) What have been the good practices, innovations, and success stories of the project, if any? | **B1.** Qualitative Indicators: Types of good practices, innovations and success stories, if any<br>**1.** Types of challenges/ barriers by service and data source (PHCEP nurse, PHCEP nurse supervisor, PHC MO, Additional District Medical and Health Officer-AIDS and Leprosy (ADM&HO), PHC staff nurse, beneficiaries, and key informants) | **B1. Qualitative Indicators**<br>◆ Beneficiary (please refer to Figure 1 just below this table)<br>**I. ANC**<br>1. Antenatal case, ANC who received any kind of service from PHCEP nurse between March 2010-May 2010<br>2. HIV positive ANC residing in the PHCEP PHC catchment area, received CT service from PHCEP nurse but who delivered in a higher public health facility between January 2009-May 2010<br>**II. Non-ANC**<br>1. Beneficiary who received any kind of service from PHCEP nurse between March 2010-May 2010<br>2. PLHIV beneficiary residing in the PHCEP PHC catchment area but accessed CT services at a higher public health facility between March 2010-May 2010<br>◆ PHCEP Nurse<br>◆ PHCEP Nurse supervisor (PHCEP NS)<br>◆ PHC Medical Officer (MO) where PHCEP is implemented (existing Government position)<br>◆ PHC Staff Nurse where PHCEP is implemented (existing Government position)<br>◆ Key Informants : DAC, APSCAS, ADM&HO, CDC, CHAI, LEPRA and Community Members | |

| EVALUATION QUESTION | INDICATOR | DATA SOURCE | DATA COLLECTION METHOD |
|---|---|---|---|
| 3. What have been the challenges and lessons learned during the implementation of this project?<br>4. What are the recommendations from the project designers, funders, implementers, and beneficiaries? | **B. Qualitative Indicators:**<br>2. Type of lessons learned by service and data source (PHCEP nurse, PHCEP NS, MO, ADMHO (AIDS and Leprosy), PHC staff nurse, beneficiaries, and key informants) and district<br>3. Identification of recommendations for similar interventions by service and data source (PHCEP nurse, PHCEP NS, PHC MO, PHC staff nurse, beneficiaries, and key informants) and district | **Beneficiary**<br>**I. ANC**<br>1. Antenatal case, ANC who received any kind of service from PHCEP nurse between March 2010-May 2010<br>2. HIV positive ANC residing in the PHCEP PHC catchment area, received CT service from PHCEP nurse but who delivered in a higher public health facility between January 2009-May 2010<br>**II. Non-ANC**<br>1. Beneficiary who received any kind of service from PHCEP nurse between March 2010-May 2010<br>2. PLHIV beneficiary who is residing in the PHCEP PHC catchment area but accessed CT services at a higher public health facility between March 2010-May 2010<br>◆ Nurse (PHCEP supported)<br>◆ PHCEP Nurse supervisor<br>◆ PHC Medical Officer (MO) of Primary Health Center (PHC) where PHCEP is implemented (existing Government position)<br>◆ Staff Nurse of Primary Health Center (PHC) where PHCEP is implemented (existing Government position)<br>◆ Key Informants: DAC, APSCAS, ADM&HO, CDC, CHAI, LEPRA and Community Members | Focus Groups and In-depth Interviews (FG and ID) |

# ANNEXURE 3: DATA ABSTRACTION FORMS AND GUIDELINES

**Indicator:** A1.1. % of individuals who are counseled and tested and know their results on the same day

**Source:** APSACS ICTC non-ANC registers at the PHC

| Unique ID: District (1 digit)ICTC (1digit) PHC (2 digits) Beneficiary (3 digits) | Month (Serial No.3) | Year (SerialNo.3) | Date of HIV Counseling and testing done (Serial No.11) | Date of HIV test result received (Serial.No.16) | Whether date of HIV testing and receiving is same (Y=yes, N=no) |
|---|---|---|---|---|---|
| | | | | | |

**District :** 1-Nizamabad ; 2-Guntur **ICTC:** 1-PHCEP; 2-FICTC

**Indicator:**

A1.3: % of positive mother and baby pair (MBP) received Nevirapine (NVP) on a monthly basis

A1.4: % of positive pregnant women (identified by PHC nurse) had institutional delivery (PHC/Other health facilities.

A1.5: % of positive mother and baby pairs followed for 18 months (only denominator)

A1.6: % of HIV exposed children tested at 18 months (only denominator)

**Source:** APSACS positive ANC line list register at the PHC

| Unique ID: District (1 digit)ICTC (1digit)PHC (2 digits) Beneficiary (3 digits) | Month | Year | Whether outcome of pregnancy was live birth (Serial No. 10) (Y=yes, N=no) | Whether positive pregnant woman delivered (Serial No. 11) (Y=yes, N=no) | Whether delivery was in hospital (Serial No. 12) (Y=yes, N=no) | Administration of NVP to mother (Serial No. 15) (Y=yes, N=no) | Administration of NVP to child (Serial No. 16) (Y=yes, N=no) | Whether MB pair received NVP (Y=yes, N=no) |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

**Indicator:**

A1.2: Daily client load for HIV testing at the PHC

A2.1: % of clients referred by PHCEP/FICTC reached Revised National Tuberculosis Program (RNTCP)

A2.2: % of newly diagnosed TB cases tested for HIV at PHC

**Source:** Monthly ICTC report (DAC CMIS)

| Unique ID: District (1 digit) PHC (2 digits) Beneficiary (3 digits) | Month | Year | No. of days HIV testing is done (Section A) | No. of clients counseled and tested (Indicator 3 of summary table) | No. of persons referred to RNTCP diagnostic services (Section E, Serial No. IIa) | No. of persons who have reached RNTCP diagnostic unit (Section E, Serial No. IIb) | No. of newly diagnosed TB cases at RNTCP | No. of newly diagnosed TB cases referred by RNTCP tested at ICTC |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

**Indicator:**

A1.4: % of positive mother and baby pairs followed for 18 months (only numerator)

A1.5: % of HIV exposed children tested at 18 months (only numerator)

**Source:** APSACS ICTC post-natal follow-up register at the PHC

| Unique ID: District (1 digit) ICTC (1digit)PHC (2 digits) Beneficiary (3 digits) | Month | Year | Follow-up of M-B pair at 18 months(Serial No. 16) (Y=yes, N=no) | Baby tested for HIV at 18 months (Serial No. 17) (Y=yes, N=no) |
|---|---|---|---|---|
| | | | | |
| | | | | |

# ANNEXURE 4: RESPONDENT RECRUITMENT FORM/ DEMOGRAPHIC PROFILE

## INSTRUCTION: This form will be filled out by participants before Focus Group and In-depth interview sessions

Sl. No. ☐☐☐ Day ☐☐ Month ☐☐ 2010

Name of Village/Town/PHC: _____ Taluka: _____

Name of District: _____ District Code ☐☐☐

Name of Interviewer: _____ Interview: FGD/ ID

| Source of Information | Code | Source of Information | Code |
|---|---|---|---|
| PHCEP Nurse | 1 | DAC | 6 |
| Nurse Supervisor | 2 | APSACS | 7 |
| Beneficiary:<br>a. ANC who received any kind of service from PHCEP nurse between March 2010-May 2010<br>b. HIV positive ANC residing in the PHCEP PHC catchment area, received CT service from PHCEP nurse but who delivered in a higher public health facility between January 2009-May 2010<br>c. Non-ANC beneficiary who received any kind of service from PHCEP nurse between March 2010-May 2010<br>d. PLHIV beneficiary who is residing in the PHCEP PHC catchment area but accessed CT services at a higher public health facility between March 2010-May 2010 | 3a/3b/3c/3d | ADM&HO | 8 |
| PHC Medical Officer | 4 | CDC | 9 |
| PHC Staff Nurse | 5 | CHAI | 10 |
| | | LEPRA | 11 |
| | | Community members | 12 |

1 Age of the respondent: ☐☐ Years If below 18 years - **TERMINATE**

2 Sex Male 1 Female 2

3 Marital Status: Married 1 Unmarried 2 Divorced/Separated 3 Widow/er 4

4 Highest level of education: Illiterate 1 Functional literacy 2 Up to 5th 3 Up to 8th 4 Upto10th 5 Passed 12th/ Equivalent 6 Graduate & Above 7

5 If you are a staff or other key informant (Code 1-2, 4-5, 6-11), how long (months) you are associated with the project? ☐☐☐ If less than 6 months – **TERMINATE**

6 What is your occupation? _____ Occupation code ☐☐☐

| | | | | | | |
|---|---|---|---|---|---|---|
| 7 | If you are a beneficiary (Code 3a or 3c), did you receive service between March & May 2010? | Yes | 1 | No | 2 | If No - **TERMINATE** |
| 8 | If you are a beneficiary residing in the PHCEP catchment area (Code 3b), did you deliver in higher public health facility between January 2009 & May 2010? | Yes | 1 | No | 2 | If No - **TERMINATE** |
| 9 | If you are a beneficiary residing in the PHCEP catchment area (Code 3d), did you access CT services from a higher public health facility between March 2010 & May 2010? | Yes | 1 | No | 2 | If No - **TERMINATE** |
| 10 | If you are community member (Code 12), are you a leader/member of SHG/any other leader? | Yes | 1 | No | 2 | If No - **TERMINATE** |
| 11 | Have you already been interviewed in this evaluation? | Yes | 1 | No | 2 | If No - **TERMINATE** |

# ANNEXURE 5: INFORMED CONSENT FORM

This form contains information seeking your consent for participating in this study. The study is being funded by Centers for Disease Control and Prevention (CDC). The study will help us improve HIV/AIDS services available at local government hospitals. We are asking you to read this so that you can take an informed decision. We will read it to you if you want so. We will give you a copy of this form. If you do not understand any word please ask us to explain. If you agree to participate, you will be asked questions individually or in a group. This may take 1-2 hours. We will audio record the discussion with you, to correctly capture your views.

Your participation in this study will not disadvantage you or your organization in any way.

## Possible Benefits and Compensation

You will not be given any money for taking part in this study; however, your inputs will help in making HIV/AIDS services better in the future.

## If you say no or change your mind

If you change your mind after saying yes, you may leave the study in between. In such a case, we will not use any information you shared for this study. This will not affect the services you receive at the government hospital.

## Confidentiality

We will do everything to protect the information you provide and your participation in this study. Only persons working directly on this project will have access to your interview. At the end of the day after downloading the audio recordings of the interview, we will delete the files from the recorder to make sure that no unauthorized person will have access to the data. The downloaded audio files will be password-protected and will be destroyed after use within a maximum period of six months from the date of the interview. We will use all the information you provide only for this study. Your name will not be used or mentioned anywhere in the project report.

## Possible Risks

There is a very little chance that someone else could know about your participation in this study. But we will do everything to prevent that from happening.

If you have a problem or have other questions

For any clarification about the study, please call Ms. Srilatha Sivalenka at XXXXXXXXXX or Mr. Sukumar Akkamsetty at XXXXXXXXXX.

This form has been explained to me. A copy of the form has been given to me. All my questions about the study have been answered to my satisfaction. I agree to participate in the study on my own.

_____

Name of the participant

_____ _____

Signature of the participant Date

If participant cannot read the form or does not wish to sign the form s/he can give a verbal consent to participate in the study; however, a witness must sign the form on his/her behalf.

I was present with the participant when the form was being explained. All questions asked by the participant were answered to his/her satisfaction. The participant has given verbal consent to take part in this study.

_____

Name of the witness

_____ _____

Signature of the witness Date

I have explained the reason for the study to the above person. I have also explained the possible benefits, and risks associated with participating in this study.

_____

Name of the person who obtained the consent

_____ _____

Signature of the person who obtained consent Date

# ANNEXURE 6: GUIDES FOR FOCUS GROUP DISCUSSIONS AND INTERVIEWS LIST

1. FG guide for Key Informant (Community Members)
2. FG guide for PHCEP Nurse
3. FG guide for PHCEP Nurse Supervisor
4. FG guide for CHAI Staff
5. Interview guide: Antenatal case, ANC who received any kind of service from PHCEP nurse between March 2010-May 2010
6. Interview guide: Non-ANC Beneficiary who received any kind of service from PHCEP nurse between March 2010-May 2010
7. Interview guide: HIV positive ANC residing in the PHCEP PHC catchment area, received CT service from PHCEP nurse but who delivered in a higher public health facility between January 2009-May 2010
8. Interview guide: PLHIV beneficiary who is residing in the PHCEP PHC catchment area but accessed CT services at a higher public health facility between March 2010-May 2010
9. ID guide for PHC staff nurse
10. ID guide for PHC medical officer (MO)
11. ID guide for other key informants

## 1. FOCUS GROUP DISCUSSION GUIDE – KEY INFORMANT (COMMUNITY MEMBERS)

I want to thank you for taking the time to meet with us today. Our names are _____ and I would like to talk to you about your experience in getting HIV/AIDS related services from the Primary Health Centre/ Nurse. The purpose of this focus group is to gather your opinions on how to improve services available at local government hospitals. I want to reiterate that the information you provide will be kept confidential. We will use it only for this evaluation. We may include some quotes in the evaluation report but we will not mention your details anywhere in the report. The focus group will take up to two hours.

1. How did you find out about the HIV related services at the PHC?
2. Have you ever accessed HIV-related services at the district hospital? What has been your experience in accessing HIV-related services at the PHC versus district hospital? (Probe- preference for one over the other? Why? time taken to travel now versus earlier?, satisfaction with services at PHC via a vis district hospital?)
3. What has been your experience with the HIV related services that you have accessed at the PHC? Why? (Probe- e.g. counseling and testing (e.g. satisfaction with counseling and testing provided? Why? NP sensitive to your needs? counseling and testing in private? confidentiality issues?), referral for other services, ANC services (e.g. CT, communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, After taking services from PHC have you referred/told anyone to avail services, etc.)
4. Which HIV related services at the PHC have been most beneficial ? Why? (Probe- e.g. counseling and testing (e.g. satisfaction with counseling and testing provided? Why? NP sensitive to your needs? counseling and

testing in private? confidentiality issues?), referral for other services, ANC services (e.g. CT, communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, etc.)

5. Which HIV related services at the PHC have been least beneficial ? Why? (Probe- e.g. counseling and testing (e.g. satisfaction with counseling and testing provided? Why? NP sensitive to your needs? counseling and testing in private? confidentiality issues?), referral for other services, ANC services (e.g. CT, communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, etc.)
6. Tell me about the services you received from the nurse practitioner in the community. (Probe- SHG meetings, school meetings, community risk assessments, home visits?)
7. If the nurse practitioner is not there, how will that affect your decision to avail HIV services at the PHC?
8. How do you think the HIV services at the PHC can be improved so that they would be more helpful for you?

## 2. FOCUS GROUP DISCUSSION GUIDE – PHCEP NURSE

I want to thank you for taking the time to meet with us today. Our names are _____ and I would like to talk to you about your experience in getting HIV/AIDS related services from the Primary Health Centre/ Nurse. The purpose of this focus group is to gather your opinions on how to improve services available at local government hospitals. I want to reiterate that the information you provide will be kept confidential. We will use it only for this evaluation. We may include some quotes in the evaluation report but we will not mention your details anywhere in the report. The focus group will take up to two hours.

1. Can you describe the services you provide? (Probe: HIV related services, for beneficiaries, how much time the beneficiaries need to spend in a visit, say for HIV testing?)
2. What has been your experience in providing the services? (Probe: planning the service e.g. setting up the services, supplies, logistics, field travel support; what have been your good experiences, what you think did not work well, is there something you would want to be improved/strengthened)
3. What has been the contribution of the PHCEP in HIV/AIDS services? (Probe: coverage, quality, referral for other services, good practices, innovations, if any)
4. What have been your successes? (Probe: in delivering the planned HIV/AIDS services, in integrating the HIV/ AIDS services with the other PHC services)
5. What will be the important lessons in implementing the PHCEP approach of delivering HIV/AIDS services? (Probe: added value if any of including PHCEP nurse; both for positive and negative lessons, ask to justify each lesson)
6. What will be your recommendations on providing HIV/AIDS services at PHC? (Probe: for continuation of HIV/AIDS services through PHC, the approach to be followed in service delivery, the management and supervisory support, supply and logistic support, staffing, monitoring system)

## 3. FOCUS GROUP DISCUSSION GUIDE – PHCEP NURSE SUPERVISOR

I want to thank you for taking the time to meet with us today. Our names are _____ and I would like to talk to you about your experience in getting HIV/AIDS related services from the Primary Health Centre/ Nurse. The purpose of this focus group is to gather your opinions on how to improve services available at local government hospitals. I want to reiterate that the information you provide will be kept confidential. We will use it only for this evaluation. We may include some quotes in the evaluation report but we will not mention your details anywhere in the report. The focus group will take up to two hours.

1. Can you describe the services you provide? (Probe: HIV related services, for beneficiaries, how much time the beneficiaries need to spend in a visit, say for HIV testing?)
2. What has been your experience in providing the services? (Probe: planning the service e.g. setting up the services, supplies, logistics, field travel support; what have been your good experiences, what you think did not work well, is there something you would want to be improved/strengthened)
3. What has been the contribution of the PHCEP in HIV/AIDS services? (Probe: coverage, quality, referral for other services, good practices, innovations, if any)
4. What have been your successes? (Probe: in delivering the planned HIV/AIDS services, in integrating the HIV/AIDS services with the other PHC services)
5. What will be the important lessons in implementing the PHCEP approach of delivering HIV/AIDS services? (Probe: added value if any of including PHCEP nurse; both for positive and negative lessons, ask to justify each lesson)
6. What will be your recommendations on providing HIV/AIDS services at PHC? (Probe: for continuation of HIV/AIDS services through PHC, the approach to be followed in service delivery, the management and supervisory support, supply and logistic support, staffing, monitoring system)

## 4. FOCUS GROUP DISCUSSION GUIDE – CHAI STAFF

I want to thank you for taking the time to meet with us today. Our names are _____ and I would like to talk to you about your experience in getting HIV/AIDS related services from the Primary Health Centre/ Nurse. The purpose of this focus group is to gather your opinions on how to improve services available at local government hospitals. I want to reiterate that the information you provide will be kept confidential. We will use it only for this evaluation. We may include some quotes in the evaluation report but we will not mention your details anywhere in the report. The focus group will take up to two hours.

1. What difference has this project made, if any, in the provision of HIV-related services to rural populations in Andhra Pradesh? (Probe- consider the duration of the project- evolution since 2005 when no ICTCs existed and HIV services were not available at the PHC level.)
    a. Service provision (model of project, access to rural population, availability of service at PHC)
    b. Implementation (establishing and scaling-up services at PHCs—availability of space, supply chain management, funding)
    c. Quality of services (e.g. adherence to DAC guidelines, EQAS from SRL)
    d. Reporting (timeliness of reporting, availability of data, data quality)
    e. Training (only for CHAI staff and APSACS)
    f. Partnership (advocacy, recruitment)
2. What have been the challenges in provision of HIV-related services to rural populations in Andhra Pradesh?
    a. Service provision (model of project, access to rural population, availability of service at PHC)
    b. Implementation (establishing and scaling-up services at PHCs—availability of space, supply chain management, funding)
    c. Quality of services (e.g. adherence to DAC guidelines, EQAS from SRL)
    d. Reporting (timeliness of reporting, availability of data, data quality)
    e. Training (only for CHAI staff and APSACS)
    f. Partnership (advocacy, recruitment)

3. What have been the lessons learned in provision of HIV-related services to rural populations in Andhra Pradesh?
    a. Service provision (model of project, access to rural population, availability of service at PHC)
    b. Implementation (establishing and scaling-up services at PHCs—availability of space, supply chain management, funding)
    c. Quality of services (e.g. adherence to DAC guidelines, EQAS from SRL)
    d. Reporting (timeliness of reporting, availability of data, data quality)
    e. Training (only for CHAI staff and APSACS)
    f. Partnership (advocacy, recruitment)
4. If the PHCEP project was to continue, what would be your recommendations to improve the HIV services at the PHC ? (Probe- i.e. if all elements of the model were to continue)
    a. Service provision (model of project, access to rural population, availability of service at PHC)
    b. Implementation (establishing and scaling-up services at PHCs—availability of space, supply chain management, funding)
    c. Quality of services (e.g. adherence to DAC guidelines, EQAS from SRL)
    d. Reporting (timeliness of reporting, availability of data, data quality)
    e. Training (only for CHAI staff and APSACS)
    f. Partnership (advocacy, recruitment)
5. What is the relevance, if any, of the PHCEP model from the point of view of future planning? Why?

## 5. IN-DEPTH INTERVIEW GUIDE – BENEFICIARY: ANC who received any kind of service from PHCEP nurse between March 2010-May 2010

I want to thank you for taking the time to meet with us today. Our names are _____ and I would like to talk to you about your experience in getting HIV/AIDS related services from the Primary Health Centre/ Nurse. The purpose of this interview is to gather your opinions on how to improve services available at local government hospitals. I want to reiterate that the information you provide will be kept confidential. We will use it only for this evaluation. We may include some quotes in the evaluation report but we will not mention your details anywhere in the report. The interview will take up to two hours.

1. How did you find out about the HIV related services at the PHC?
2. Have you ever accessed HIV-related services at the district hospital? What has been your experience in accessing HIV-related services at the PHC versus district hospital? (Probe- preference for one over the other? Why? time taken to travel now versus earlier? satisfaction with services at PHC via a vis district hospital?)
3. What has been your experience with the HIV services that you have accessed at the PHC? Why? (Probe- e.g. counseling and testing (e.g. what and how was the process of counseling? satisfaction with counseling and testing provided? Why? NP sensitive to your needs? counseling and testing in private? confidentiality issues?), referral for other services, ANC services (e.g. CT, communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, After taking services from PHC have you referred/told anyone to avail services, etc.)
4. Which HIV services at the PHC have been most beneficial? Why? (Probe- e.g. counseling and testing (e.g. satisfaction with counseling and testing provided? Why? NP sensitive to your needs? counseling and testing in private? confidentiality issues?), referral for other services, ANC services (e.g. CT, communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance

during labor and delivery, assistance post labor and delivery, etc.)

5. Which HIV services at the PHC have been least beneficial? Why? (Probe- e.g. counseling and testing (e.g. satisfaction with counseling and testing provided? Why? NP sensitive to your needs? counseling and testing in private? confidentiality issues?), referral for other services, ANC services (e.g. CT, communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, etc.)
6. Tell me about the services you received from the nurse practitioner in the community. (Probe- SHG meetings, school meetings, community risk assessments, home visits?)
7. If the nurse practitioner is not there, how will that affect your decision to avail HIV services at the PHC?
8. How do you think the HIV services at the PHC can be improved so that they would be more helpful for you?

## 6. IN-DEPTH INTERVIEW GUIDE – BENEFICIARY: Non-ANC who received any kind of service from PHCEP nurse between March 2010-May 2010

I want to thank you for taking the time to meet with us today. Our names are _____ and I would like to talk to you about your experience in getting HIV/AIDS related services from the Primary Health Centre/ Nurse. The purpose of this interview is to gather your opinions on how to improve services available at local government hospitals. I want to reiterate that the information you provide will be kept confidential. We will use it only for this evaluation. We may include some quotes in the evaluation report but we will not mention your details anywhere in the report. The interview will take up to two hours.

1. How did you find out about the HIV related services at the PHC?
2. Have you ever accessed HIV-related services at the district hospital? What has been your experience in accessing HIV-related services at the PHC versus district hospital? (Probe- preference for one over the other? Why? time taken to travel now versus earlier? satisfaction with services at PHC via a vis district hospital?)
3. What has been your experience with the HIV services that you have accessed at the PHC? Why? (Probe- e.g. counseling and testing (e.g. what and how was the process of counseling? satisfaction with counseling and testing provided? Why? NP sensitive to your needs? counseling and testing in private? confidentiality issues?), referral for other services, ANC services (e.g. CT, communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, After taking services from PHC have you referred/told anyone to avail services, etc.)
4. Which HIV services at the PHC have been most beneficial? Why? (Probe- e.g. counseling and testing (e.g. satisfaction with counseling and testing provided? Why? NP sensitive to your needs? counseling and testing in private? confidentiality issues?), referral for other services, ANC services (e.g. CT, communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, etc.)
5. Which HIV services at the PHC have been least beneficial? Why? (Probe- e.g. counseling and testing (e.g. satisfaction with counseling and testing provided? Why? NP sensitive to your needs? counseling and testing in private? confidentiality issues?), referral for other services, ANC services (e.g. CT, communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, etc.)
6. Tell me about the services you received from the nurse practitioner in the community. (Probe- SHG meetings, school meetings, community risk assessments, home visits?)
7. If the nurse practitioner is not there, how will that affect your decision to avail HIV services at the PHC?
8. How do you think the HIV services at the PHC can be improved so that they would be more helpful for you?

## 7. IN-DEPTH INTERVIEW GUIDE – BENEFICIARY: HIV positive ANC residing in the PHCEP PHC catchment area, received CT service from PHCEP nurse but who delivered in a higher public health facility between January 2009-May 2010

I want to thank you for taking the time to meet with us today. Our names are _____ and I would like to talk to you about your experience in getting HIV/AIDS related services from the Primary Health Centre/ Nurse. The purpose of this interview is to gather your opinions on how to improve services available at local government hospitals. I want to reiterate that the information you provide will be kept confidential. We will use it only for this evaluation. We may include some quotes in the evaluation report but we will not mention your details anywhere in the report. The interview will take up to two hours.

1. How did you find out about the HIV related services at the PHC?
2. Have you ever accessed HIV-related services at the district hospital? What has been your experience in accessing HIV-related services at the PHC versus district hospital? (Probe- preference for one over the other? Why? time taken to travel now versus earlier? satisfaction with services at PHC via a vis district hospital?)
3. What has been your experience with the HIV services that you have accessed at the PHC? Why? (Probe- e.g. counseling and testing (e.g. what and how was the process of counseling? satisfaction with counseling and testing provided? Why? NP sensitive to your needs? counseling and testing in private? confidentiality issues?), referral for other services, ANC services (e.g. CT, communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, etc.)
4. Which HIV services at the PHC have been most beneficial ? Why? (Probe- e.g. counseling and testing (e.g. satisfaction with counseling and testing provided? Why? NP sensitive to your needs? counseling and testing in private? confidentiality issues?), referral for other services, ANC services (e.g. CT, communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, After taking services from PHC have you referred/told anyone to avail services, etc.)
5. Which HIV services at the PHC have been least beneficial? Why? (Probe- e.g. counseling and testing (e.g. satisfaction with counseling and testing provided? Why? NP sensitive to your needs? counseling and testing in private? confidentiality issues?), referral for other services, ANC services (e.g. CT, communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, etc.)
6. Why did you decide to have your delivery somewhere other than the PHCEP PHC? (Probe for reasons—distance, customs, stigma/discrimination, felt more confident f the care at the district hospital etc.)
7. Tell me about the services you received from the nurse practitioner in the community. (Probe- SHG meetings, school meetings, community risk assessments, home visits?)
8. If the nurse practitioner is not there, how will that affect your decision to avail HIV services at the PHC?
9. How do you think the HIV services at the PHC can be improved so that they would be more helpful for you?

## 8. IN-DEPTH INTERVIEW GUIDE – BENEFICIARY: PLHIV who is residing in the PHCEP PHC catchment area but accessed CT services at a higher public health facility between March 2010-May 2010

I want to thank you for taking the time to meet with us today. Our names are _____ and I would like to talk to you about your experience in getting HIV/AIDS related services from the Primary Health Centre/ Nurse. The purpose of this interview is to gather your opinions on how to improve services available at local government hospitals. I want to reiterate that the information you provide will be kept confidential. We will use

it only for this evaluation. We may include some quotes in the evaluation report but we will not mention your details anywhere in the report. The interview will take up to two hours.

1. Do you know about the HIV related services at the PHC? (Probe for the type of services available; How did s/he know of the services?)
2. Where did you get your HIV test done? (Probe for reasons of choosing the health facility; In case s/he knew of the CT service available at PHC, why s/he did not go there?)
3. Have you ever accessed HIV-related services at the district hospital? What has been your experience in accessing HIV-related services at the PHC versus district hospital? (Probe- preference for one over the other? Why? time taken to travel now versus earlier? satisfaction with services at PHC via a vis district hospital?)
4. What has been your experience with the HIV services that you have ever accessed at the PHC? Why? [Probe- Counseling service, TB and ART referral services, ANC services (e.g. CT, communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, After taking services from PHC have you referred/told anyone to avail services, etc.)]
5. In case you have availed HIV services at the PHC, which of them have been most beneficial ? Why? [Probe- e.g. counseling (e.g. what and how was the process of counseling? satisfaction with counseling provided? Why? NP sensitive to your needs? counseling in private? confidentiality issues?), referral for other services, ANC services (e.g. communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, etc.)]
6. In case you have availed HIV services at the PHC, which of them have been least beneficial? Why? [(Probe- e.g. counseling (e.g. satisfaction with counseling provided? Why? NP sensitive to your needs? counseling in private? confidentiality issues?), referral for other services, ANC services (e.g. communicating about the dos and don'ts of pregnancy, ready to answer your queries, advise on regular check-ups, assistance during labor and delivery, assistance post labor and delivery, etc.)]
7. Tell me about the services you received from the nurse practitioner in the community. (Probe- SHG meetings, school meetings, community risk assessments, home visits?)
8. If the nurse practitioner is not there, how will that affect your decision to avail HIV services at the PHC?
9. How do you think the HIV services at the PHC can be improved so that they would be more helpful for you?

## 9. IN-DEPTH INTERVIEW GUIDE –PHC STAFF NURSE

I want to thank you for taking the time to meet with us today. Our names are _____ and I would like to talk to you about your experience in getting HIV/AIDS related services from the Primary Health Centre/ Nurse. The purpose of this interview is to gather your opinions on how to improve services available at local government hospitals. I want to reiterate that the information you provide will be kept confidential. We will use it only for this evaluation. We may include some quotes in the evaluation report but we will not mention your details anywhere in the report. The interview will take up to two hours.

1. Can you describe the services you provide? (Probe: HIV related services, for beneficiaries, how much time the beneficiaries need to spend in a visit, say for HIV testing?)
2. What has been your experience in providing the services? (Probe: planning the service e.g. setting up the services, supplies, logistics, field travel support; what have been your good experiences, what you think did not work well, is there something you would want to be improved/strengthened)
3. What has been the contribution of the PHCEP in HIV/AIDS services? (Probe: coverage, quality, referral for other services, good practices, innovations, if any)

4. What have been your successes? (Probe: in delivering the planned HIV/AIDS services, in integrating the HIV/AIDS services with the other PHC services)
5. What will be the important lessons in implementing the PHCEP approach of delivering HIV/AIDS services? (Probe: added value if any of including PHCEP nurse; both for positive and negative lessons, ask to justify each lesson)
6. What will be your recommendations on providing HIV/AIDS services at PHC? (Probe: for continuation of HIV/AIDS services through PHC, the approach to be followed in service delivery, the management and supervisory support, supply and logistic support, staffing, monitoring system)

## 10. IN-DEPTH INTERVIEW GUIDE –PHC MEDICAL OFFICER

I want to thank you for taking the time to meet with us today. Our names are _____ and I would like to talk to you about your experience in getting HIV/AIDS related services from the Primary Health Centre/ Nurse. The purpose of this interview is to gather your opinions on how to improve services available at local government hospitals. I want to reiterate that the information you provide will be kept confidential. We will use it only for this evaluation. We may include some quotes in the evaluation report but we will not mention your details anywhere in the report. The interview will take up to two hours.

1. Can you describe the services you provide? (Probe: HIV related services, for beneficiaries, how much time the beneficiaries need to spend in a visit, say for HIV testing?)
2. What has been your experience in providing the services? (Probe: planning the service e.g. setting up the services, supplies, logistics, field travel support; what have been your good experiences, what you think did not work well, is there something you would want to be improved/strengthened)
3. What has been the contribution of the PHCEP in HIV/AIDS services? (Probe: coverage, quality, referral for other services, good practices, innovations, if any)
4. What have been your successes? (Probe: in delivering the planned HIV/AIDS services, in integrating the HIV/AIDS services with the other PHC services)
5. What will be the important lessons in implementing the PHCEP approach of delivering HIV/AIDS services? (Probe: added value if any of including PHCEP nurse; both for positive and negative lessons, ask to justify each lesson)
6. What will be your recommendations on providing HIV/AIDS services at PHC? (Probe: for continuation of HIV/AIDS services through PHC, the approach to be followed in service delivery, the management and supervisory support, supply and logistic support, staffing, monitoring system)

## 11. IN-DEPTH INTERVIEW GUIDE –KEY INFORMANTS (DAC, APSACS, DIRECTOR GENERAL—CHAI, LEPRA, CDC INDIA)

I want to thank you for taking the time to meet with us today. Our names are _____ and I would like to talk to you about your experience in getting HIV/AIDS related services from the Primary Health Centre/ Nurse. The purpose of this interview is to gather your opinions on how to improve services available at local government hospitals. I want to reiterate that the information you provide will be kept confidential. We will use it only for this evaluation. We may include some quotes in the evaluation report but we will not mention your details anywhere in the report. The interview will take up to two hours.

1. What difference has this project made, if any, in the provision of HIV-related services to rural populations in Andhra Pradesh? (Probe- consider the duration of the project- evolution since 2005 when no ICTCs existed and HIV services were not available at the PHC level.)
    a. Service provision (model of project, access to rural population, availability of service at PHC)

b. Implementation (establishing and scaling-up services at PHCs—availability of space, supply chain management, funding)
c. Quality of services (e.g. adherence to DAC guidelines, EQAS from SRL)
d. Reporting (timeliness of reporting, availability of data, data quality)
e. Training (only for CHAI staff and APSACS)
f. Partnership (advocacy, recruitment)

2. What have been the challenges in provision of HIV-related services to rural populations in Andhra Pradesh?
   a. Service provision (model of project, access to rural population, availability of service at PHC)
   b. Implementation (establishing and scaling-up services at PHCs—availability of space, supply chain management, funding)
   c. Quality of services (e.g. adherence to DAC guidelines, EQAS from SRL)
   d. Reporting (timeliness of reporting, availability of data, data quality)
   e. Training (only for CHAI staff and APSACS)
   f. Partnership (advocacy, recruitment)
3. What have been the lessons learned in provision of HIV-related services to rural populations in Andhra Pradesh?
   a. Service provision (model of project, access to rural population, availability of service at PHC)
   b. Implementation (establishing and scaling-up services at PHCs—availability of space, supply chain management, funding)
   c. Quality of services (e.g. adherence to DAC guidelines, EQAS from SRL)
   d. Reporting (timeliness of reporting, availability of data, data quality)
   e. Training (only for CHAI staff and APSACS)
   f. Partnership (advocacy, recruitment)
4. If the PHCEP project was to continue, what would be your recommendations to improve the HIV services at the PHC ? (Probe- i.e. if all elements of the model were to continue)
   a. Service provision (model of project, access to rural population, availability of service at PHC)
   b. Implementation (establishing and scaling-up services at PHCs—availability of space, supply chain management, funding)
   c. Quality of services (e.g. adherence to DAC guidelines, EQAS from SRL)
   d. Reporting (timeliness of reporting, availability of data, data quality)
   e. Training (only for CHAI staff and APSACS)
   f. Partnership (advocacy, recruitment)
5. What is the relevance, if any, of the PHCEP model from the point of view of future planning? Why?

# ANNEXURE 7: CONFIDENTIALITY AGREEMENT FORM

I, _____, associated with the evaluation of PHCEP, understand that, in the course of my association, I will come in contact with sensitive information about personal information of participants enrolled in the PHCEP evaluation. I understand that this information is confidential and pledge to protect the confidentiality of all enrolled subjects. I will protect the confidentiality of subjects by not discussing, disclosing or sharing any information with any individual, institution or organization not directly involved with the evaluation and not authorized to receive the information. I understand the potential harm that may come to the individuals/groups as a result of disclosure of information. I understand that willful disclosure of any information about this evaluation could result in administrative and disciplinary action against me.

I, the undersigned agree to abide by the above and follow highest ethical standards. Furthermore, I understand that violation of these standards is subject to appropriate disciplinary action.

Initialing the following statements I further agree that:

Initial Below

_____All information/data about the project including evaluation procedures and information of enrolled subjects will be kept confidential.

_____Any document to be disposed of that contains identifiers shall be processed as per the guidelines in data management policy.

_____All confidential files, including computer diskettes/data, will be kept in a secured (locked) file cabinet when not in use.

_____ Any information regarding the evaluation participants will not be disclosed to any person not directly involved with the evaluation.

Signature of team member: _____

Signature of Principal Investigator of the evaluation: _____

Date: _____

# ANNEXURE 8: CODES

| Resources: Human, Material and Financial | Services: Presence or Absence, Types, and Quality of Services | Project Cycle and Management: Stages, Oversight and Benchmarks | Stakeholders: Issues of coordination, partnerships and ownership |
|---|---|---|---|
| Absence of NP | Access to Services in facilities | Project Start-up and scale-up | Coordination |
| Capacity building | Area/ District hospital | Monitoring and Supervision | Partnership |
| Funding | Confidentiality | Reporting | Ownership |
| Infrastructure | Discrimination | Project transition | |
| Staffing | Fear | | |
| | HIV services | | |
| | Private health facilities | | |
| | Services-Counseling and Testing (CT) | | |
| | Services - Referral | | |
| | Services -– Outreach | | |
| | Services - PPTCT | | |
| Recommendations | Recommendations | Recommendations | Recommendations |

# ANNEXURE 9: FICTC DATA

**Annex 9a Table:** Percentage of individuals who know their HIV test results on the same day among those counseled and tested Guntur and Nizamabad FICTC sites, June 2009-June 2010

| FICTC sites | GUNTUR (1 site) | | NIZAMABAD (3 sites) | | TOTAL | |
|---|---|---|---|---|---|---|
| **Category** | **Number** | **Percent** | **Number** | **Percent** | **Number** | **Percent** |
| Pre-test date is the same as Post-test date | 7 | 100.0 | 498 | 68.3% | 505 | 68.6% |
| Post-test date is after the pre-test date | 0 | 0.0 | 7 | 1.0% | 7 | 1.0% |
| Test result not collected | 0 | 0.0 | 138 | 18.9% | 138 | 18.7% |
| Errors * | 0 | 0.0 | 86 | 11.8% | 86 | 11.7% |
| **TOTAL** | **7** | **100.0** | **729** | **100.0%** | **736** | **100.0** |

- Errors include (i) pre-test date missing, or (ii) pre-test recorded as having occurred on a later date than post-test
- **Source:** APSACS ICTC non-ANC register

**Annex 9b Table:** Number of HIV positive pregnant women diagnosed at Guntur and Nizamabad FI ICTC sites had institutional deliveries, June 2009-June 2010

| FICTC sites | Guntur (1 site) | Nizamabad (3 sites) | Total |
|---|---|---|---|
| Number of registered positive pregnant women | 0 | 3 | 3 |
| Number of institutional deliveries | 0 | 2 | 2 |

**Source:** APSACS positive ANC line list register

*…the supply of kits would stop at district level ...going there [district headquarter] and getting test kits, surgical stuff [delivery kits], test tubes, etc is a difficult task."* – *Service provider*

# NOTES

# NOTES

**FHI 360**
India Country Office
H-5, Green Park Extension,
Ground Floor, New Delhi - 110016
Tel: +91-11-40487777
Website: www.fhi360.org

CDC

SAATHII
Solidarity and Action Against The HIV Infection in India

fhi360
THE SCIENCE OF IMPROVING LIVES