

Micro-planning in Andhra Pradesh:

Ensuring Quality HIV Care for Individuals and Communities



Bhavani Sankar

Peer outreach worker developing a micro-plan in consultation with community members.

Peer outreach workers (PORWs) in coastal Andhra Pradesh, India, say that they've become more confident in their HIV outreach work as a result of training in micro-planning,¹ part of a range of skills they learned under the U.S. Agency for International Development's (USAID) Samastha Project. One worker who received the training recalls, "We used to go to the villages not sure as to how to approach clients and what to say to them." Now, she says, she feels confident that she can help vulnerable clients deal with a wide range of problems—including prevention of parent-to-child transmission, early identification of new infections, and timely registration for antiretroviral treatment (ART) at government-run clinics.

Community-based micro-planning was a critical element of the training that Samastha's PORWs received to prepare them for their work in community-based care and support. Another PORW explains, "Micro-planning helped us to understand the service delivery systems and how we can maximize [clients'] utilization of services."

Micro-planning is a low-cost, simple, yet effective approach for use in community-based interventions. Samastha's training in micro-planning provided PORWs with skills and tools to help them identify people living with HIV (PLHIV) and other vulnerable community members, prepare individualized action plans for all clients, and ensure that the clients obtain access to the services in their action plans. PORWs reported that as a result of their work, the majority of clients accepted, and utilized,

¹ Micro-planning is the use of community-based assessment and planning tools to help identify vulnerable community members and specific individualized action plans for each client to ensure that they obtain access to needed services.

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the necessary services. Over the course of the project, micro-planning enhanced the local response to HIV and increased the impact and sustainability of Samastha’s efforts (and those of the Indian Government) to provide comprehensive coverage for PLHIV. A villager widowed by HIV attests, “Over a period of time, knowledge at the community level about the available services and the benefits of accessing them has increased and now patients are utilizing them on their own.”

This case study describes the Samastha Project’s community-level work in Andhra Pradesh, specifically, the development, implementation, and results of community-based micro-planning for addressing the needs of PLHIV and other vulnerable individuals.² The study gives an overview of the Samastha Project, describes micro-planning and its implementation in Andhra Pradesh, outlines major results and the benefits and challenges encountered, and posits a way forward.

Before the micro-planning system had been initiated, the outreach, referral and client tracking used to be very complicated and confusing. Now, we are more organized and can make a better plan to reach out and follow up with clients. The PORWs are now able to document the work in the computerized monitoring information system (CMIS) formats as a result of their training.

—Samastha Program Coordinator

The Samastha Project: Overview

Samastha was a comprehensive project for HIV prevention, care, support, and treatment implemented from October 2006 through March 2012. The project supported the broad implementation of India’s HIV strategy from the community level through the district, state, and national levels and focused on two populous states with a high prevalence of HIV: Karnataka and Andhra Pradesh. Samastha was carried out through a cooperative agreement between USAID/India and the University of Manitoba with technical support from EngenderHealth and Population Services International. The Karnataka Health Promotion Trust (KHPT), a partnership between the University of Manitoba and the Karnataka State AIDS Prevention Society (KSAPS), was the lead implementing agency for Karnataka. LEPRASociety was Samastha’s main implementing organization in Andhra Pradesh.

The goal of the Samastha Project was to reduce transmission and mitigate the impact of HIV in selected districts in these two states, with a focus on vulnerable and affected populations in rural, previously underserved areas. The project worked in close collaboration with KSAPS and Andhra Pradesh State AIDS Control Society (APSACS).

Samastha in Andhra Pradesh: Samastha-Andhra Pradesh (Samastha-AP) was a community-based care, treatment, and support project that was implemented in 19 blocks (sub district administrative areas) of five coastal districts (see Figure 1) of Andhra Pradesh between February 2007 and September 2011. Local implementation was carried

² Other case studies available at www.aidstar-one.com provide details on a range of components of the Samastha Project.

out by four Community Care Centers (CCCs),³ the Telugu Network of Positive People (TNP+), and nine Drop-in Centers (DICs)⁴ with technical and managerial support provided by LEPROA Society in coordination with APSACS.

Figure 1. Map of Andhra Pradesh state showing Samastha's areas of operation



Graphic developed by Leproa Society, 2011.

The project's strategies were based on findings from a needs assessment (Samastha Project 2006) that identified a number of gaps in services that compromised the quality of care, left a large number of potential clients unaware of available services, and failed to conform to National AIDS Control Organization (NACO) guidelines and standards. To address these programmatic gaps, Samastha used a four-pronged approach, focusing on:

³ Community Care Centers, established under the guidelines of the National AIDS Control Organization (NACO), provide treatment for opportunistic infections and other short-term medical facilities for PLHIV. These are mostly established by nongovernmental and faith-based organizations that have sufficient infrastructure.

⁴ Drop-in Centers are established under NACO guidelines. They are generally attached to an ART center or a PLHIV network office, and implement support group meetings and awareness activities.

- Improving access to quality clinical care in facilities through a process of training, clinical mentorship, and supportive supervision
- Instituting a system of CCC self-assessment and monitoring to prevent infection and improve quality
- Implementing a computerized management information system (CMIS) that tracks individuals to support program planning and monitoring
- Consolidating community outreach services by using micro-planning and support groups.

Micro-planning Implementation

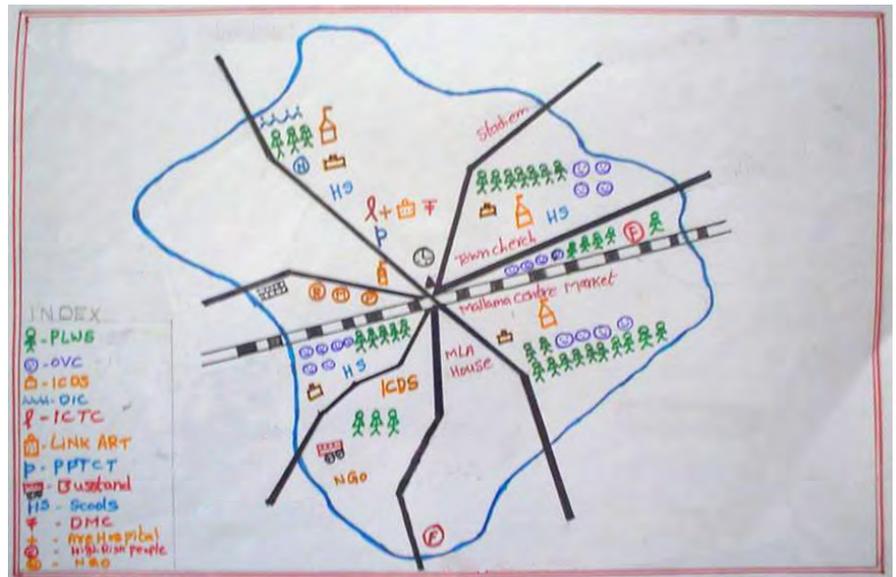
Micro-planning is a “bottom-up” tool for developing, implementing, and monitoring activities tailored to the needs of, and for the benefit of, local communities. Communities or village leaders wishing to improve local HIV services can use micro-planning to serve multiple purposes:

- Identifying vulnerable populations
- Assessing their specific needs
- Analyzing the availability and accessibility of services (and gaps in services) and the required frequency of interactions for target groups and individuals
- Prioritizing service delivery according to the available services
- Delivering key messages through existing services and institutions
- Tracking clients' use of services.

BOX 1. IMPORTANT OUTCOMES OF MICRO-PLANNING

- Increased number of new client registrations
- Enhanced ability to provide comprehensive care services to community
- Improved client understanding about the importance of testing spouse and children
- Improved ability to prioritize clients' needs
- Ensured individual tracking system and timely referrals
- Improved quality of life for clients because of timely service provisioning and increased utilization of available services
- Enhanced clinical service quality through regular visits and follow-up.

In addition, micro-planning feeds into the CMIS by providing information about new registrations, clients who are lost to follow-up (LFU), cluster of differentiation 4 (CD4) test results, ART registration and adherence, regular medical check-ups, tuberculosis (TB) testing and referral to treatment, HIV testing for partners and children, and other details.



Social map of an Andhra Pradesh target area. Town and street names have been erased to protect confidentiality.

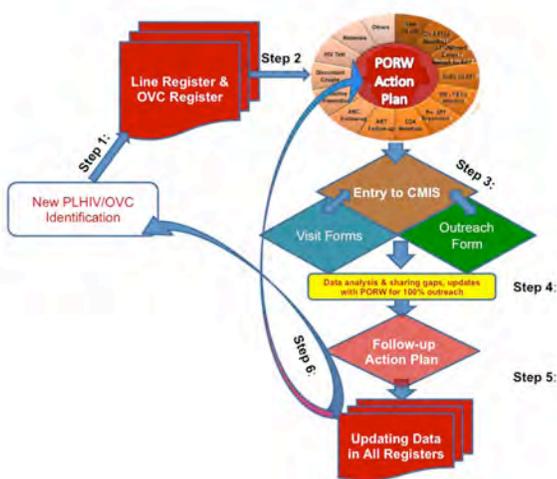
Micro-planning: Tools and Processes: Peer outreach workers—Samastha’s staff at the grass-roots level—are PLHIV chosen from the community to conduct outreach, referrals, and follow-up in the target areas. Peer outreach workers played a critical role in that they initiated and maintained contact with the project’s target populations, and also provided essential details about the local context—the needs and characteristics of the community in their coverage area. The PORWs used a range of tools to help them identify PLHIV and vulnerable individuals, develop action plans to address each client’s needs, and make sure that clients used the necessary services. This section describes the steps that PORWs used for micro-planning.

Step Zero: Social mapping

Micro-planning begins with social maps that describe the physical location of potential clients as well as the available resources within a specific village or community. Outreach workers begin by gathering full details about PLHIV and orphans and vulnerable children (OVC) on these social maps, also including landmarks and locally available services for general health care, HIV-specific care, and related services. Thus a typical map might list not only Integrated Counseling and Testing Centers and centers for ART, but also Primary Health Centers, Designated Microscopy Centers for TB, government centers that provide other services such as nutrition support, and nongovernment resources.

Bringing clients into treatment is a cyclical process (see Figure 2). Details about the steps depicted in Figure 2 appear below.

Figure 2. Steps of micro-planning



Graphic developed and provided by the LEPROA Society, 2011.

Step 1: Identifying and registering clients

Initially, PORWs identify PLHIV and OVC during outreach and record their information in the respective registers that list different types of clients, such as line registers (for PLHIV) and OVC registers.⁵ Once clients are registered with Samastha, they get regular support such as outreach, referrals, and follow-up from the PORW working in the village or community. The support includes providing counseling on HIV and linking clients to the appropriate services, such as testing, antenatal care, ART, and government schemes and benefits, such as widows’ pensions and housing support. PORWs also refer clients to DICs and CCCs, where counselors provide information and referral for appropriate HIV and related medical services.

Step 2: Setting priorities and developing plans

For each area and client they cover, PORWs develop an action plan using a priority wheel—a wheel sectioned into categories of clients (such as “on ART,” “not tested for HIV,” and “in ANC [antenatal care]”), the services provided for each category, and the number of clients in each category (see Figure 3). The priority wheel and action plan enable the PORW to list the number of clients to be provided with services under each category and prioritize the clients based on need. The priority wheel gives a visual depiction of services needed, which allows workers to make an action plan—called an advance tour plan—that is used to provide appropriate outreach over the next month.

⁵ Line registers and OVC registers are the master registers that are maintained at the project level. These registers capture clients’ socioeconomic details and keep track of service utilization by each registered client.

Figure 3. Elements included in the priority wheel



Inputs from CMIS

- New registrations
- Clients missed CD4 Testing in previous month
- Clients missed ART visit in previous month
- Clients missed HIV repeat testing in previous month
- Clients who missed visit to Community Care Centers for the last three months
- Clients who are due to services like CD4, HIV test, ART visit, etc., in the current month.

Inputs from line listing

- Location from the social map
- Address and contact details
- Past medical and social history from registration form, outreach of the previous month.

Step 3: Computerizing data

At the project level, information is gathered on a daily basis from a range of sources, including inpatient registrations, outpatient visit forms, and outreach forms. These data are entered into a web-based database, the CMIS. The CMIS provides a medical history of registered PLHIV and their family members, and facilitates individual tracking of clients' use of HIV testing, adherence to ART, and access to other services such as TB diagnosis and treatment services and social entitlements.

Step 4: Data analysis

An essential part of the Samastha Project is a monthly project-level review meeting, attended by all project collaborators, including PORWs. During this meeting, the monitoring and evaluation or data entry staff member analyzes the data from the CMIS and shares with the PORW essential details pertaining to each client such as CD4 count, appointment dates, schedule for collecting ART medicines, loss

to follow-up if applicable, and participation in support group meeting. PORWs use these data to update their priority wheels and, based on those updates, their action plans. This process is carried out by all PORWs for their respective coverage areas.

Step 5: Review and follow-up

The details collected after follow-up visits by the PORW are again updated in the PORW and CMIS registers. If new PLHIV are identified during follow-up visits, the process begins again with registration (Step 6).

Step 6: Updating the data

All the work done is fed in to relevant data forms / table in the computerized data management system. The data updated in all registers will provide achievements and gaps leading to planning for the next month.

Capacity Building for Micro-planning

To be successful as an approach, micro-planning required a series of capacity building activities for PORWs, data entry operators, and project coordinators on such topics as communicating effectively to different types of audiences, setting priorities for care, and the continuum of HIV care. Along with formal training, Samastha provided mentoring in the field as well as technical support refresher training throughout the project's duration.

Training and technical support covered the following issues and skills:

- Conducting micro-planning exercises using social maps, resource maps, registration forms, and other resources to understand the needs of PLHIV and OVC in each PORW's area
- Understanding local community resources and government-sponsored resources and guiding clients toward these as needed
- Using, maintaining, and updating various types and formats of client registers to keep abreast of clients' evolving needs and address (and resolve) loss to follow-up.

Technical support also gave PORWs a broad background in HIV services by covering community-based care, counseling for children and adults, ART adherence, infection prevention, formation and management of support groups, and other topics.

A total of 50 PORWs received the training. All of them had positive views of the training, saying that it greatly increased their interpersonal communication skills and their ability to provide appropriate

information for each client's needs. Over time, the PORWs were able to handle a larger client volume successfully—from 11 per PORW in 2006 to 179 in 2011 (Samastha Project 2011).

Importantly, their training and growing experience helped PORWs to establish relationships with government offices that provide social services and also with other organizations that provide nutrition, education, and medical support to PLHIV and OVC. The strong linkages between community workers and government, private, and donor organizations was one of Samastha's major innovations, and resulted in enhanced advocacy for these vulnerable populations. Donors responded positively, and were able to mobilize 30 million Indian Rupees (approximately U.S.\$625,000) to support provisions for nutrition, medicines, education, welfare, and social entitlements.

Samastha added a lot of value to the community. The trainings given were very good, however, this has to be scaled up and continue for longer periods of time.

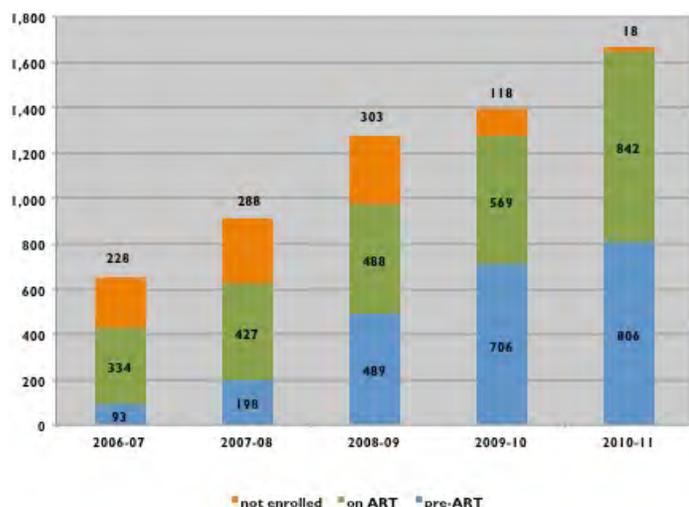
—Dr. Rajendra Prasad, Superintendent, Community Health Centre, Challapalli

Results

The implementation of micro-planning significantly enhanced the effectiveness of outreach and clients' use of services in the areas where Samastha worked. Registration of PLHIV increased from 610 in 2007 to 5,907 in 2011 (Samastha Project 2011). Utilization of ART services increased sharply, as

shown in Figure 4. The number of clients receiving ART or pre-ART services nearly quadrupled, while the number of eligible PLHIV who were not enrolled for ART services diminished from 228 to 18.

Figure 4: Access to ART services through the Samastha Project, Andhra Pradesh: October 2006–October 2011



Source: Samastha Project 2011

Loss to follow-up diminished significantly with the use of micro-planning. Program managers noted a reduction from 111 LFU cases to 12 over the course of three years using the micro-planning approach—with the result that patients were healthier. A medical officer from a participating ART center reported that in Samastha Project areas, the ART center staff observed “regular CD4 visits, ART follow-up, and improvement in the clients’ health.”

The micro-planning approach also enhanced documentation. Previously, documentation at all levels was mostly activity-based, with minimum details; with micro-planning, documentation became detailed and process-based, which facilitated planning throughout the project. The database management and analysis of indicators, which were initially a major challenge because the indicators are elaborate, over time proved to be a great help for further planning.

PORWs interviewed for this report noted the practicality and effectiveness of the tools used in micro-planning—the social mapping for familiarizing outreach workers with local resources, for example, and the various registration forms for helping to track the status not only of PLHIV but also of their family members.

Program coordinators cited other benefits ensuing from micro-planning:

- Systematizing planned activities for easy follow-up and monitoring
- Ensuring the quality and timeliness of services
- Increasing the ability of PORWs to serve a larger number of PLHIV
- Improving access to care for PLHIV and their families.

The benefits of the enhanced linkages between PORWs and the various entities involved in addressing HIV included:

- Over 1,000 OVC (1,211) received educational support
- A total of 685 OVC were linked to the Integrated Child Development Scheme, Government of Andhra Pradesh
- Women widowed by HIV were linked to pension schemes (483), housing loans (39), other loans for PLHIV (102), and household provisions (923).

Expanding micro-planning training:

Samastha took into account the need to ensure cohesiveness among PORWs, staff at service delivery points, and the data management team. To ensure good integration and understanding of all

project functions among all staff, Samastha extended training in micro-planning to field personnel who were working on other areas of HIV management.

The micro-planning approach was also expanded beyond the immediate project areas. The district-level AIDS nodal agencies from coastal Andhra Pradesh benefited from micro-planning and Samastha was asked to provide training on the approach in CCCs in states outside the implementation area. These CCCs gave very favorable reports on the quality of the training and later reported good results in reducing loss to follow-up cases in their operational areas. The training was adopted by a partner of the Clinton Foundation for their nurse mentoring program.

[The follow-up by PORWs] ensures that we practice healthy habits such as taking medicines on time and keeping hygiene. . . . We can also help the other clients in our area in maintaining the habits and accessing services.

—a PLHIV

What Worked Well

Micro-planning supported the goal of achieving universal HIV care by ensuring that vulnerable individuals and communities had access to, and received, appropriate care, support, and treatment that responded to their specific needs. The approach also yielded additional benefits, detailed below.

Increasing access to treatment:

Registration of PLHIV and OVC increased dramatically after the implementation of micro-planning, as did utilization of ART services.

Ensuring a full range of services: Micro-planning made it possible to ensure that PLHIV had access to services along the full continuum of care. Overtime, the spectrum of referrals and services widened, and it became possible to include other issues, such as general health and social welfare schemes. Thus, micro-planning created opportunities for clients to obtain wider access to many kinds of services.

Improving tracking: Micro-planning made it possible to track LFUs at an early stage and motivate them to adhere to ART treatment. This reduced workloads for providers. Micro-planning also made follow-up outreach more effective by helping to structure outreach work according to specific client needs.

Increasing the community's awareness and self-efficacy:

Micro-planning helped to add visibility and value to the care, support, and treatment programs in the coastal regions of Andhra Pradesh by supporting improvement in service quality and staff capacity. The approach also increased access to services by regularly identifying, registering, and tracking new clients. Over time, clients began to visit service delivery points and receive services on their own, showing that the community's knowledge about HIV services (and the acceptability of services) had increased.

Challenges

Clarifying the approach: Because micro-planning was introduced when Samastha was already underway, a major challenge was ensuring that all project partners (including, critically, the PORW themselves) understood the approach. Because the interrelationships among planning, referrals, and outreach are indirect and intangible, most of Samastha's stakeholders—including the

implementing organizations, government officials, and PORWs themselves—had difficulty understanding the link between micro-planning and effectiveness of outreach. Samastha reinforced understanding through periodic training and on-site mentoring.

Integrating micro-planning at all

project levels: Micro-planning proved to be a vital element in the Samastha Project—an aid in planning, implementing, and monitoring services, and in tracking data through a flow of various interconnections. At first, integrating the approach with other project components and ensuring a logical flow of data proved a major challenge for program coordinators. After several months, once staff members had experienced for themselves the cycle of using micro-planning, entering data, and using the data for ongoing planning, the process became much smoother.

Recommendations

Micro-planning as practiced during the Samastha project helped to expand the effectiveness and impact of community-based outreach and care for PLHIV while also improving the data available on vulnerable communities. The results of adapting the tools of micro-planning are likely to vary depending on how the approach is implemented—whether it entails only information-gathering, for example, or extends to more intensive monitoring and outreach that help to guide programmatic implementation.

- Agencies working at the local level in care, support, and treatment for HIV—including, in India, the Link Workers scheme, Prevention of Parent to Child Transmission (PPTCT), and APSACS—should adopt community-based micro-planning as part of their approach.
- Organizations that seek to replicate micro-planning as it was implemented through Samastha would need to integrate the process and outcomes within their own planning frameworks. Program developers (and all stakeholders) need to be clear from the outset about the micro-to-macro connections: how micro-planning will link with the project's larger-level planning processes.
- Program managers must clarify to staff from the beginning—before launching a micro-planning initiative—how data gathered at the community level will be integrated among multiple levels of a planned project, and how the approach can inform program planning and implementation.
- It is also vital to collect feedback at the community worker level about the training that they receive and any changes they recommend.
- It would be useful to conduct research, such as a comparative study between outcomes in intervention and non-intervention areas, to assess and substantiate the benefits of micro-planning—providing evidence that can be used to convince stakeholders to expand or replicate the approach in other areas or fields.
- Programs need to develop a method to obtain detailed documentation of the community-based micro-planning process and its effects on the quality of services. ■

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