

# Strengthening HIV/AIDS Programs in Two Indian States

## Samastha's Technical Assistance



Karnataka Health Promotion Trust

During a course conducted under the Samastha Project, people living with HIV, trained as expert patient-trainers, help HIV patients learn to manage their condition.

**A** newly qualified physician, Dr. Ramakrishnan (not his real name), the new medical officer of a community care center (CCC) in Gulbarga city in the state of Karnataka, India, attended the Samastha Project's basic training course on HIV prevention and care in June 2008. During the six-day training, he was found to be rather withdrawn. Several months later, when on-site mentoring for the trainees began at the CCC, the mentor, a senior physician from St. John's Academy of Health Sciences, Bangalore, felt that Dr. Ramakrishnan's development as a clinician was impeded by his lack of confidence. He would not attempt to carry out even simple clinical procedures, and his diagnostic and management skills were rudimentary at best. The mentor suggested sending Dr. Ramakrishnan to Snehadaan Learning Site, a comprehensive care and support center for people living with HIV.

Over the course of two weeks at the Learning Site, Dr. Ramakrishnan worked with a more experienced doctor and learned how to provide comprehensive care to sick patients. His confidence blossomed, and he became more proficient in diagnostic and therapeutic procedures. He returned to his CCC with new enthusiasm and confidence, and a greater willingness to learn and apply new knowledge to solve clinical problems. He began discussing clinical problems with his mentor on the phone, rather than requiring on-site visits. The CCC coordinator reported that the care provided to clients had improved greatly (Chatterjee and Washington 2011).

Mentoring and learning centers were part of a constellation of technical assistance (TA) activities undertaken as part of the Samastha Project, a six-year intervention implemented in two Indian states, funded by the

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U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development (USAID). In addition to outreach and service provision in the two states, Karnataka and Andhra Pradesh, the project carried out TA that included institutional and human capacity building, strengthened systems on an as-needed basis, and targeted a broad range of stakeholders at the district, state, and national levels. This case study focuses on Samastha's TA work and describes the rationale behind the TA strategy, the approaches used with specific collaborators and stakeholders, and recommendations for carrying out similar TA.

## Overview of the Samastha Project

The PEPFAR through USAID supported Samastha Project, implemented between October 2006 and March 2012, sought to integrate HIV prevention and care for high-risk and vulnerable populations (such as sex workers and orphans and vulnerable children) with community-based care, support, and treatment programs. Implemented in selected districts of two high-prevalence states, Karnataka and Andhra Pradesh, Samastha supported a comprehensive program of networked services for HIV/AIDS prevention, treatment, care, and support through linkages across services and strengthening of public and private sector involvement, as well as capacity building and systems strengthening at both state and national levels.

Samastha worked in close collaboration with Karnataka State AIDS Prevention Society (KSAPS), the Andhra Pradesh State AIDS Control Society, and the National AIDS Control Organisation (NACO). The lead implementing agency was the Karnataka Health Promotion Trust (KHPT), a partnership between the University of Manitoba and KSAPS that implements a number of state- and national-level projects in India. For field implementation, KHPT

worked with a consortium of nongovernmental organizations (NGOs) that included St. John's Medical College, The National Institute for Mental Health and Neurosciences (NIMHANS), and Snehadaan, a faith-based organization and a leader in Karnataka for the provision of high-quality HIV and AIDS care and support.

The Samastha Project implemented a district model for integrated HIV services using a three-pronged approach that included (1) village outreach involving link workers<sup>1</sup> in villages and peer educators (to reach sex workers in rural areas); (2) service provision through CCCs and integrated positive prevention and care (IPPC) centers (drop-in centers for, and run by, people living with HIV and their families); and (3) TA and capacity building to strengthen government service. The initiatives at the district level were intended to strengthen local implementation of national HIV programs, ensure better convergence<sup>2</sup> with the general health system and National Rural Health Mission,<sup>3</sup> and help build sustainable models of district-level HIV programming (Karnataka Health Promotion Trust [KHPT] 2011a).

Although this case study focuses on Samastha's TA program, case studies about other aspects of the Samastha project are available at: <http://www.aidstar-one.com/SamasthaTA>.

## Samastha's Technical Assistance Program

About one-quarter of Samastha's budget was devoted to TA with the aim of sustainably building local

<sup>1</sup> Link workers were chosen from among people proposed by the community and trained in the skills needed to ensure that those needing HIV testing or treatment were linked to the appropriate services and adhered to treatment regimes.

<sup>2</sup> The term "convergence" as used in this case study signifies coordinated implementation or delivery of distinct but related services.

<sup>3</sup> The National Rural Health Mission is a government program that seeks to improve health care infrastructure and delivery across rural India. The scheme includes a number of innovative mechanisms for health care delivery.

capacity to address HIV and provide appropriate care for people living with HIV and those affected by HIV. Samastha followed two broad strategies for providing TA: (1) human capacity development program to develop staff capacities and systems for service delivery in Karnataka and Andhra Pradesh, designed to complement the government's capacity-building program under the National AIDS Control Programme Phase-3 (NACP III); and (2) needs-based TA to strengthen programs, systems, institutions, and services throughout the range of HIV services.

## Capacity Development

Samastha's human capacity development strategy emphasized ongoing learning initiatives because didactic sessions alone have limited impact. A review of existing training programs identified several gaps, including limited interaction among providers in different categories (e.g., doctors, nurses, and counselors), one-off training sessions that failed to provide ongoing support, and lack of training for outreach, medical, and paraprofessional staff at lower levels. Samastha's approach was to follow up basic training with clinical mentorship and supportive supervision. Further, the Samastha strategy focused on training medical and paraprofessional staff at the district and subdistrict levels to complement the reach of the NACP III training program. Elements of the program included the following.

**Multitiered induction training and capacity development:** This model, intended to provide continuous learning, consisted of a foundation of basic training for a range of professionals, followed by clinical mentoring, hands-on experiential training at learning sites, training in advanced topics, and finally ongoing support and education through various continuing medical education programs. Training was provided to doctors, nurses, and counselors from centers across the state, including centers supported by Samastha and those funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria Round Six

(GFATM-6) and other funding sources. The Learning Sites established by Samastha served as centers for experiential learning for program implementers, but also as exposure visit sites for program managers and officers from State AIDS Control Societies (SACs), Technical Support Units (TSUs),<sup>4</sup> District AIDS Prevention and Control Units (DAPCUs), and donor agencies. All of the training programs operated by Samastha were subsequently integrated by KSAPS into its capacity development program and were also funded by KSAPS.

**Supportive supervision system for counselors:** Samastha funded, and NIMHANS implemented, a supportive supervision system that provided continuing on-site technical support to counselors. This system decentralized technical support for counselors to the regional (substate) level in Karnataka and helped to establish a district-level technical resource on HIV/AIDS and counseling. Samastha also supported two senior counselors from antiretroviral therapy (ART) centers in north Karnataka to travel to other ART centers in the state to provide on-site mentorship.

**Quality improvement:** Capacity development initiatives to improve quality within health facilities included whole-site training programs that trained staff throughout the site in infection prevention, stigma and discrimination in the health care setting, and the Client Oriented Provider Efficient (COPE) tool for quality improvement (Chatterjee and Washington 2011).

**Regional resource training center network<sup>5</sup>:** This network of medical colleges was established under the earlier India-Canada Collaborative HIV/AIDS Project implemented by

<sup>4</sup> The TSU provides technical support to the SACS.

<sup>5</sup> Regional resource training centers were a Karnataka network of 14 medical colleges with St. John's Medical College as the center for training of trainers. The 14 medical colleges were responsible for mapping, recruiting, and training all general private practitioners who saw more than five patients for STIs in a month and all primary health center doctors. They also trained nurses in the private and public sectors.

KHPT. Under Samastha, the network continued to help the government scale-up training on management of sexually transmitted infections (STIs) and basic HIV prevention and care services, while NIMHANS played a critical role in enhancing the skills of counselors in the government system.

To provide ongoing training and clinical mentorship for the CCCs and IPPCs, some of the regional resource training centers were converted into regional centers for continuous clinical mentorship focused on enhancing the practice and quality of HIV care.

**Training on rural HIV prevention:** Samastha designed and implemented several training activities to support implementation of rural prevention interventions and interventions for most-at-risk populations. This training, which covered rural outreach for link workers and communication skills for outreach staff, was aimed at equipping program implementers with the knowledge, attitudes, and skills to deliver quality programs and services. In addition, life skills education training sessions were conducted for orphans and vulnerable children (aged 9–15 years).

**Learning systems and knowledge translation:** In response to requests from SACS and NACO to provide technical assistance in capacity building, field-level mentoring, module development, and documentation, Samastha established its Strategic Initiative and Knowledge Translation Unit. The unit supported human capacity development initiatives in Karnataka and Andhra Pradesh and also provided capacity development assistance and needs-based TA to other states and the national government.

**Samastha Project learning sites:** In the context of HIV care, the concept of a learning site is unique in that it provides opportunities to engage in hands-on training, cross-disciplinary learning, and discussion of concepts and approaches to care. Within the Samastha Project there were four Learning Sites. Of these, three focused on care and

prevention, and the fourth was for training on counseling and supportive supervision:

1. Bagalkot Learning Site provided an example of a comprehensive district response model encompassing rural HIV prevention and care interventions (see Box 1). This site included three community-based organization demonstration projects for high-risk groups (female sex workers, men who have sex with men, and people living with HIV).
2. Pragati Learning Site in Bangalore demonstrated targeted interventions for urban female sex workers in a large city.
3. Snehadaan Learning Site was a comprehensive care and support center for people living with HIV, including children living with HIV.
4. The NIMHANS-supported Integrated Counselling and Testing Centre (ICTC) Learning Site at Belgaum Institute of Medical Sciences, Belgaum, was an initiative for training in counseling and supportive supervision.

### BOX 1. RURAL HIV PREVENTION

KHPT/Samastha developed the first rural HIV prevention model in the country in Bagalkot district of Karnataka. Subsequently, in 2008, NACO initiated rural HIV prevention activities in the country using the Bagalkot project as an example. NACO recognized the Bagalkot Learning Site as a national learning site for staff from states that were rolling out the link workers scheme. Samastha developed training modules and guidelines and made arrangements for exposure visits by staff from other regions.

## Needs-based Technical Assistance

The project provided needs-based TA to various agencies and stakeholders in the two project states Karnataka and Andhra Pradesh, in other states, and at the national level. A variety of stakeholders—including government agencies, autonomous institutions, nongovernmental and community-based organizations, and private sector entities—received the TA, which spanned the entire range of HIV programs and services and all levels of implementation from national through district and subdistrict levels. Samastha carried out needs-based TA by providing experts who fulfilled specific mandates within participating agencies and participated in technical working groups established by NACO and the SACS on various topics. The project provided TA on a wide range of topics, including developing systems and guidelines, carrying out surveys and evaluations, and building capacity at the state and national levels.

Under Samastha, KHPT used a team approach to TA, with different partner agencies playing the lead according to the situation at hand. Office and field staff from KHPT and other consortium partners, who represented a very wide range of expertise, provided the bulk of needs-based TA. Samastha engaged only a few external consultants, mainly for documentation.

KHPT's decentralized structure, as well as the approach of building teams with expertise across multiple disciplines (established during an earlier project), had many advantages compared to using external experts to provide TA. The approach facilitated continuous and sustained support to system strengthening processes from inception through implementation and monitoring—including course correction as needed. KHPT staff also served as an external repository of institutional memory, which gave them added advantage in their

role as TA providers. KHPT directors of program core areas contributed to all KHPT projects, including Samastha, which created synergy among all the projects. These factors gave Samastha the ability to adapt to local conditions and to try new approaches or adapt approaches used in other situations and projects.

In Karnataka, Samastha provided the bulk of its TA to KSAPS and DAPCUs, but significant assistance was also provided to the Department of Women and Child Development, the National Rural Health Mission, the Revised National Tuberculosis Control Programme, and Rajiv Gandhi University of Health Sciences, among others. In Andhra Pradesh, the TA was mainly provided to DAPCUs, but it was also extended to certain donor and program implementing agencies. Specific examples of TA include the following.

### **Karnataka State AIDS Prevention**

**Society:** The Samastha Project financially supported and technically backstopped certain key consultant positions at the state level. Two Samastha staff members were seconded to KSAPS on a full-time basis; of these, one provided consultancy support for ART services and the other for TB-HIV services. Samastha also placed and supported a consultant with KSAPS for integration of Prevention of Parent-to-Child Transmission (PPTCT) with the National Rural Health Mission, including mainstreaming PPTCT at the state level (see Box 2). These consultants did not play a mere advisory role, but were embedded within KSAPS and essentially led the implementation of tasks assigned to them, including planning, executing program rollout and related capacity building, monitoring, analyzing data, and reporting. Additional TA to KSAPS included:

- Leading the technical working group for HIV care that KSAPS convened to guide the implementation and scale-up of HIV care, treatment, and support in Karnataka, as well as related capacity building

**BOX 2. INTEGRATION IN KARNATAKA**

**Rural PPTCT Services**

During 2008–2009, the Government of Karnataka rolled out the PPTCT/National Rural Health Mission integration model across the state. Samastha provided TA to the initiative by developing guidelines, placing a consultant at KSAPS, and mentoring the consultant—thus contributing to a significant improvement in service provision. Among Karnataka’s estimated 1.2 million pregnant women who seek delivery services each year, the proportion who received HIV counseling and testing increased from 20.1 percent in 2008 to more than 67 percent in 2010—about three times the national average. Similarly, the proportion of HIV-positive pregnant women who delivered in hospitals and received single-dose nevirapine increased, from 40.3 percent in 2008 to 62.1 percent in 2010, to marginally exceed the national average of 59.3.

**Tuberculosis (TB)-HIV Collaborative Activities**

Samastha provided TA in Karnataka to strengthen the implementation of the government’s Revised National Framework for TB-HIV collaborative activities. KSAPS, supported by technical guidance and monitoring from the Samastha TB-HIV consultant located in KSAPS, made significant progress in integrating TB and HIV services. Coverage of HIV testing among an estimated annual population of 55,000 newly identified TB patients in Karnataka increased from 50 percent in 2008 to 82 percent in 2010, in contrast to the national average of 65 percent in 2010. Of these TB patients, 13 percent tested positive for HIV, in contrast to a national average of less than 5 percent. The proportion of clients referred from HIV counseling and testing for TB diagnoses increased from 6 percent in 2008 to 9 percent in 2010, also exceeding the national average of 7.4 percent in 2010 (Pillsbury et al. 2011).

- Participating in the technical groups for framing guidelines and strengthening drop-in centers and HIV care programs for people living with HIV
- Developing a logistics management information system (MIS) for ART in Karnataka
- Piloting first-ever training for pharmacists working in ART centers, in partnership with the program Strengthening Pharmaceutical Systems (implemented by Management Sciences for Health) and KSAPS
- Strengthening the MIS for KSAPS’ program components including the link workers scheme, ICTCs, CCCs, and ART
- Supporting participation in various surveys, assessments, and evaluations
- Implementing a program to sensitize a wide variety of government and nongovernment stakeholders to the HIV epidemic in Karnataka state.

**State-level agencies in Karnataka:**

Samastha provided TA to the National Rural Health Mission, State Institute of Health and Family Welfare<sup>6</sup>, and state National Rural Health Mission to strengthen provision of HIV services within existing government

<sup>6</sup> The State Institutes of Health and Family Welfare are state-level institutions with a mandate to help improve the total effectiveness of the health care delivery system by imparting knowledge and technical skills at different levels. Specifically, State Institutes of Health and Family Welfare are responsible for imparting training to trainers from selected institutions in accordance with approved training plans.

health settings and promote better convergence and mainstreaming of services.

### **Rajiv Gandhi University of Health**

**Sciences:** Samastha and Swami Vivekananda Youth Movement (SVYM) helped the university to establish the first ever university-recognized HIV fellowship course for doctors in India. In addition to the one-year, full-time course, the project helped to develop a six-month HIV care certificate course for nurses. The project also supported the university in integrating HIV care into the curricula of undergraduate medical, nursing, dental, pharmacy, and related paraprofessional studies using the World Health Organization (WHO) modules for Integrated Management of Neonatal and Childhood Illness-HIV and Integrated Management of Adolescent and Adult Illnesses (KHPT 2011b).

### **Department of Women and Child Development, Karnataka:**

The state offers various programs for children. However, orphans and vulnerable children, estimated at 33,000 (Washington 2012) need special treatment in order to not remain marginalized, and most did not receive support before 2009. Samastha carried out advocacy and developed a concept note<sup>7</sup> that led to an initial commitment of Rs 10 million by the Government of Karnataka to the state Department of Women and Child Development for orphaned children and women made vulnerable as a result of HIV (KHPT 2009).

During 2009 to 2010, Samastha helped to establish multisectoral partnerships and supported the government in developing a system for direct cash transfer to address special needs of orphans and vulnerable children. Funds were routed to eligible families through district- and subdistrict-level Department of Women and Child Development

officials. Samastha organized capacity-building activities for district-level government functionaries who implemented this program.

These initiatives resulted in the creation of the Karnataka State Orphans and Vulnerable Children Program. Of the 8,319 orphans and vulnerable children reached in 15 districts, 2,100 received support. The collaboration between Samastha and its partners resulted in new models for the care and support of this previously underserved group, including community-based foster care units, outreach interventions, local village committees supporting temporary residential homes, and linkages to existing government schemes for education and residential care. Further, Samastha contributed to the development of national guidelines for children affected by AIDS.

**District-level TA:** In Karnataka, KHPT regional managers (each responsible for two to four districts) gave various types of needs-based technical support to district HIV programs before the DAPCUs were set up in September 2008. Samastha contributed to the establishment of DAPCUs by providing TA to KSAPS for recruiting and ongoing training for district supervisors<sup>8</sup> and medical officers under the DAPCU, and afterward supported capacity building, as well as ongoing training and supportive supervision, for these supervisors. During the latter half of the project, Samastha's district-level TA—which was provided through technical specialists and regional managers—focused on strengthening DAPCUs' capacities to promote coordination among public, private, and community-based facilities and agencies involved in HIV services.

<sup>7</sup> A concept note is a preliminary description of the rationale and ideas behind a proposed project or scheme. An agency or individual may use a concept note to develop a project concept, to communicate it to potential stakeholders and donors, and, together with them, to further refine it.

<sup>8</sup> A district supervisor is provided in each high-prevalence district to support and supervise ICTC services in the district.

**Strengthening NGO capacity to provide technical assistance:** Working with Samastha developed the capacities of many NGO partners to provide TA on their own, because KHPT and other consortium partners played a supporting and capacitating role, rather than merely managing or overseeing the NGO partners. Now, KSAPS often draws upon Snehadaan and SVYM, among others, for training and other support. Other developments include:

- SVYM recently developed a course on palliative care. SVYM's Vivekananda Memorial Hospital, Saragur, is now a regional center for the Indian Association of Palliative Care offering a certificate course in essentials of palliative care for nurses and doctors.
- Snehadaan developed a special module to develop counseling skills specific to care settings. This complements the basic training given to all counselors using NACO's 12-day module.

## Technical Assistance Beyond the Samastha Project Area

In its initial stages, Samastha planned to provide TA for the national HIV program mainly by developing learning sites for rural and urban programs. Later on, in response to requests from NACO, the scope of TA was expanded, both at the national level and in other states. KHPT/Samastha staff helped write guidelines for a number of NACO initiatives and served as members of NACO's technical resource groups for targeted interventions, the link worker scheme, CCCs, ART, PPTCT, and TB-HIV. The project also developed training modules for various types of health workers and provided mentorship for implementation of interventions and hands-on experiential learning at Samastha learning sites for personnel from other states.

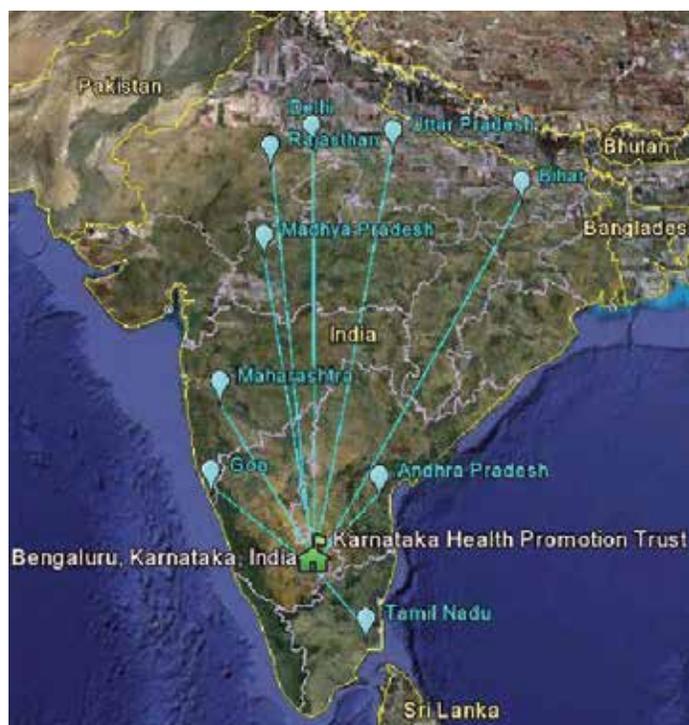
In non-Samastha states, KHPT/Samastha provided TA to state agencies, government staff, and other U.S. Government–supported projects by means of capacity building and participation in studies and evaluations. Instances of this TA include:

- Support to SACS of Tamil Nadu and Kerala for training peer educators in targeted intervention programs
- Capacity building for community leaders in Kerala to strengthen the effectiveness of community-based organizations
- Assistance for development of model targeted intervention learning sites in different regions in U.S. Government–supported states

TA to other institutions included the following:

- *WHO:* St. John's Medical College and Hospital, a Samastha partner, worked with WHO to pilot the adaptation of the Integrated Management of Adult and Adolescent Illnesses guidelines in India.
- *Indira Gandhi National Open University:* Samastha staff from KHPT and EngenderHealth were appointed as resource persons by NACO for writing certain sections of the curriculum for a distance learning HIV course and, subsequently, participating in the training of trainers program for this course.
- *Indian Council of Medical Research (ICMR):* The Samastha Project partnered with the ICMR to develop two research proposals on pediatric HIV. One of the proposals was implemented in Belgaum district as a "task force" study of the ICMR. The project also partnered with ICMR to conduct a study on preparing sites for prevention trials in India.

**Figure 1. Samastha’s Technical Assistance and Capacity Building in India.**



Graphic courtesy of KHPT

Figure 1 shows the wide reach of Samastha’s capacity building and TA beyond Karnataka and Andhra Pradesh.

## Evaluation of Samastha’s Technical Assistance

A final evaluation of the Samastha Project was carried out by an independent team during early 2011. The evaluators found that the project’s large investment in TA and capacity building had resulted in significant contributions to the response to HIV in Karnataka and Andhra Pradesh. The evaluators noted that where Samastha had worked, capacity had increased and the health system had been strengthened, top to bottom. The assessment noted a number of strengths in Samastha’s approach to training, including:

- Interactive, hands-on training rather than lectures
- Frequent reinforcement through mentoring and supportive supervision
- Effective monitoring and evaluation
- Strengthening of backward, forward, and lateral referral links<sup>9</sup>

The evaluators also commented on the benefits of Samastha’s learning sites. Doctors and nurses who attended training at Snehadaan emphasized how much they learned by seeing procedures with their own eyes and by then applying the new skills in a nonthreatening learning environment. Such sites proved very valuable for training illiterate populations, such as sex workers, who could observe their peers at work and be taught directly by people who fully comprehended the conditions they were facing (Pillsbury et al. 2011).

## What Worked Well

**Strong staff and partners:** The Samastha Project was implemented by a strong consortium whose members brought together a complementary blend of technical capabilities. This gave Samastha strong TA capacities from the outset. Key KHPT/ Samastha personnel also had extensive experience and complementary skills that helped ensure strong project leadership. Furthermore, all of Samastha’s staff members, in addition to their areas of specialization, had a working knowledge of all aspects of prevention and care.

<sup>9</sup> In the Samastha context, “backward referral” meant referral back to the person or place that originally referred a patient. “Forward referral” meant the usual type of referral. “Lateral referral” meant referral to co-located or other services at the same level. For example, a person living with HIV with suspected TB would be referred by a link worker to a Designated Microscopy Centre operating under the TB control program. If the person living with HIV was diagnosed with TB, the link worker would become the person’s DOTS provider. Conversely, a Designated Microscopy Centre would appropriately refer patients to an ART center for initiation of ART or change of regimen, as needed.

**Ability to experiment with different approaches:** Samastha's partners had experience in implementing a range of service and operational models, which increased the project's capacity to try new approaches. This diversity of experience allowed Samastha to experiment with alternative approaches and develop models to suit stakeholders working in diverse contexts.

**Strong ongoing relationships between consortium members and government agencies:** KHPT and other consortium members had established close and constructive relationships with government agencies, especially KSAPS, before the Samastha Project began. Thus, partners had a good understanding of the systems and procedures of their government collaborators. Partners used an approach of responsive, constructive, and empathetic engagement with government instead of positioning themselves as "experts" who were more technically qualified than other stakeholders. Also, KHPT shared ownership of project activities, recognizing that often it was the client government agency that identified a problem, participated in the problem-solving with KHPT, and bore sole responsibility for the implementation of any systems or solutions developed. These factors helped to improve the quality of TA.

The team that carried out the external evaluation of Samastha during the first quarter of 2011 noted that by placing key, full-time Samastha staff members inside KSAPS (for ART, HIV-TB, logistics management, and mainstreaming/integration with the National Rural Health Mission), KHPT had been able to achieve near-seamless coordination with KSAPS. The presence of these embedded staff allowed evidence from Samastha's field implementation to be fed directly into KSAPS' planning and decision making (Pillsbury et al. 2011).

**Decentralized setup:** KHPT regional- and district-level staff worked closely with district-level government stakeholders and therefore had intimate knowledge of their operations and systems. This enabled KHPT staff under Samastha to provide customized support for problem solving and systems strengthening as and when required. KHPT staff generally gave such support without having to refer to their head office; although, where needed, the head office provided backstopping. Their autonomy enabled KHPT staff to respond quickly to TA requests and to provide sustained support and follow-up.

**Flexible approach that maximized application of evolving experience:** Where possible, the project used an adaptive approach to TA, rather than resorting to packaged solutions. Starting in 2008, Samastha modified the project design to tailor the prevention model and interventions to local conditions, and changed the TA approach in response to the government's rapid scale-up of HIV services and service delivery infrastructure. The evolving expertise of project staff over time, cross-pollination with other KHPT projects, and the application of evidence from those projects to Samastha enhanced the project's capacity to respond and change at need.

**Samastha's TA complemented TA under other projects:** Other than USAID, the only key donor working in the area of HIV in Karnataka was the Gates Foundation, whose Avahan projects were also implemented by KHPT. Some of Samastha's TA complemented the TA efforts under Avahan. A prominent example is the TA provided by Avahan to strengthen the Karnataka TSU; this TA was mainly focused on strengthening the TSU to implement targeted interventions. Samastha provided TA to further strengthen and expand the TSU's capacities to manage care, support, and treatment activities and to support integration of HIV services with the general health services in the state.

## Challenges

Samastha faced several challenges, some of which affected its provision of TA. In some of these cases, the project was able to develop responses.

### **Meshing strong, diverse partners into a cohesive team was a major challenge:**

Samastha's partnership with strong organizations benefited the project—but meshing them into a cohesive team proved to be a major challenge, given that the organizations had widely different operating styles. For example, some partners practiced different models of care for people living with HIV: some preferred to play a lead role whereas others preferred a more supportive role as implementers.

To address these differences in style, Samastha established a practice of conducting quarterly meetings with all the capacity-building partners. This mechanism was effective in resolving problems with coordination. During each meeting, priorities were clearly laid down for the forthcoming quarter, and the role adjustments required of each institution in order to align with the priorities were openly discussed and collectively decided. For instance, if SVYM was to lead a training program on community home-based care, all other partners would contribute, either by identifying and mobilizing partners for training or by providing resource persons. This allowed consortium members to coordinate their responsibilities and to work together supportively, rather than competitively.

### **Frequent turnover of government and NGO staff:**

Staff turnover at all levels, both among government stakeholders and NGO partners, resulted in changes to the extent of about 20 to 30 percent of personnel over the course of Samastha. The frequent changes in leadership of the SACS in Karnataka and Andhra Pradesh required time and effort to re-establish working relationships between the project and the SACS, brief new SACS project directors about the project, and carry out advocacy where necessary.

### **Differing viewpoints on what issues required TA:**

Samastha project staff and government collaborators often had different views on when and whether TA was necessary. With regard to training, for example, the KSAPS focus was on going to scale, whereas Samastha was keen to imbue the scale-up with quality through various means, including clinical mentorship. It was not easy to convince government that ensuring training quality required an intensive and sustained process.

**Difficulty of measuring impact:** Because program achievements could be attributed to several factors and causes including the efforts of other agencies and projects, it was generally difficult to isolate and measure the impact, or even outcomes, of Samastha's TA. Samastha viewed this as a challenge because it sometimes made it difficult to justify the investment in TA.

### **Challenges specific to capacity development:**

Samastha faced certain challenges specific to its capacity development initiatives but was able to formulate responses to many of these.

**Challenge:** Designing and implementing capacity-building strategies for a large-scale comprehensive intervention such as Samastha.

**Response:** Samastha helped its NGO partners to establish district-level teams and equipped them to respond to a range of needs, including carrying out training of trainer programs as necessary. Subsequently, Samastha established district-level regional resource persons who served as faculty and facilitators for a number of state-driven initiatives. The KSAPS and the state Department of Women and Child Development also drew upon the expertise and experience of the regional resource persons for rollout of government-sponsored training.

**Challenge:** There was considerable turnover of field staff, which required repeated induction training for the new recruits.

**Response:** The project strengthened the district-level teams to meet this requirement. This was effective; the district teams were able to meet the recurring training needs with support from the project's regional managers without needing support from KHPT head office—all they had to do was to report on their activities to KHPT head office.

**Challenge:** Sometimes KHPT's capacity building plans and schedules conflicted with KSAPS' training priorities.

**Response:** Under its capacity building program, KSAPS had established specialized training committees around various themes. KHPT staff were members of these committees, so this forum was used to resolve conflicts in training priorities. Further, embedding KHPT consultants within the KSAPS training committees helped to ensure that they did not “reinvent the wheel” and that they drew lessons from experiences of success and failure. Conversely, because KSAPS, the TSU, and State Institutes of Health and Family Welfare were permanent invitees at all the quarterly coordination meetings, they kept KHPT and its partners informed about the government's training plans.

## Recommendations

### **Governments should use consultants from an independent external agency rather than directly engaging experts:**

Government-appointed consultants have to operate under fairly stringent administrative and logistical constraints. The lack of operational flexibility and autonomy tends to affect the quality and efficiency of the consultants' work. Also, government programs generally involve a significant amount of routine management and logistical activities, such as procuring goods and managing contracts, which allows government-appointed staff and consultants

little time to oversee the quality and technical details of programs. In the case of Samastha, KHPT was able to use its expertise to recruit highly qualified staff for assignment to KSAPS. These staff had already worked with government, so they were able to establish good working relationships with KSAPS and function like insiders. Yet, because they were engaged by KHPT, they could operate with optimal efficiency.

**Use TA providers who have hands-on experience:** TA providers may not necessarily have experience of implementing services themselves, but, in fact, hands-on experience is the best preparation for delivering good TA. A “white collar” approach—providing TA without soiling one's own hands—often results in solutions that are impractical and unsuited to local conditions. Samastha's capacity to provide TA was considerably strengthened by its own experience in service implementation, both in Samastha and other KHPT projects.

**Include research in the project design:** Provision for research should be incorporated into TA projects. The research could, for example, study the outcomes and impact of TA initiatives, which would help to justify investment in TA. Research could also help identify additional TA needs based on evidence, rather than on anecdotal inputs.

**Incorporate strategies for sustainability into capacity building:** Initiatives to scale-up HIV/AIDS training and replicate it in other high-prevalence settings should address the sustainability of the new knowledge acquired. Training alone is rarely enough to build lasting skills. A successful capacity development strategy requires a broader package of technical support that includes mentoring, hands-on learning, and ongoing support to enable trainees to put their new skills into practice. ■

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## RESOURCES

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KHPT has produced several publications and resources under the Samastha Project. Many of these can be found on the KHPT's website at: <http://www.khpt.org/Publication.html>.

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Sudhir Mehra. 2013. *Strengthening HIV/AIDS Programs in Two Indian States: Samastha's Technical Assistance*. Case Study Series. Arlington, VA. USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

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