Final Evaluation

of the

Concern Worldwide EU-funded Programme

Strengthening Local Responses to HIV and AIDS in Orissa, India

(Programme Period 1st January 2009 – 31st December 2013)

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The evaluator would like to thank Concern staff for their courteous assistance in carrying out this evaluation. In India, Concern staff and partners were endlessly helpful and provided every support. Having conducted this end of project evaluation for this project, the evaluator is in no doubt that the many successes of this project is due to the commitment, hard work, dedication and support of the Concern staff in Odisha and project partners; INP+, Ruchika, South Orissa Voluntary Action (Sova) and Utkal Sewak Samaj (USS).

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AAY	Antyodaya Anna Yojana
ANM	Auxiliary Nurse/Midwife
ART	Anti-Retroviral Therapy
ASHA/s	Accredited Social Health Activist/s
AWW/s	Anganwadi Worker/s
AVERT	AIDS Education and Research Trust
BCC	Behaviour Change Communication
CBO/s	Community Based Organisation/s
CCC	Community Care Centre
CDMOs	Chief District Medical Officer/s
Concern	Concern Worldwide, India
CRS	Catholic Relief Services
DAPCU	District AIDS Prevention and Control Unit
DLN	District Level Network of People Living With HIV
EoP	End of Project
EU	European Union
GIPA	Greater Involvement of People Living with HIV or AIDS
GOI	Government of India
HCP	Health Care Provider
HRG	High Risk Groups
HIV	Human Immunodeficiency Virus
IDA	Ideal Development Agency
IDU	Injecting Drug User/s
IEC	Information Education and Communication
INP+	Indian Network of People Living With HIV
ICTC	Integrated Counselling and Testing Centre
KRA/s	Key Result Area/s
LFA	Logical Framework Analysis
LFU	Lost to Follow Up
LTW	Local Transport Workers
MARPs	Most at Risk Populations
MBPY	Madhu Babu Pension Yojana
MIS	Management Information System/s
MSC	Most Significant Change
MSM	Men Who Have Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO/s	Non-Governmental Organisation/s
NREGA	National Rural Employment Guarantee Act
NSA	Non-State-Actors
OI	Opportunistic infections
OSACS	Odisha State AIDS Control Society
OVI	Objectively Verifiable Indicators
PEPFAR	Presidents Emergency Fund for AIDS Relief
PLA	Participatory Learning and Action
PLHIV	People Living With HIV
PPTCT	Prevention of Parent to Child Transmission
RLF	Revolving Loan Funds
ROM	Results Oriented Monitoring
RUCHIKA	Ruchika Social Service Organisation
SACS	State AIDS Control Society
SGSY	Swarnajayanti Gram Swarozgar Yojana

SOVA	South Orissa Voluntary Action
STI	Sexually Transmitted Infections
SW/s	Sex Worker/s
TG/s	Transgender Persons
TI/s	Targeted Intervention/s
UNDP	United Nations Development Programme
UNAIDS	Joint United Programme on HIV and AIDS
UNICEF	The United Nations Children's Fund
USS	Utkal Sewak Samaj

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1.0 Executive Summary

An evaluation of Concern's Programme *Strengthening Local Responses to HIV and AIDS* in Odisha, India was undertaken in October 2013. The Programme was funded by the EU from 1 January 2009 to 31 December 2013 and was implemented in partnership with 4 partner organisations.

In 2008, at the start of the programme, there were 2.47 million people living with HIV (PLHIV) in India and HIV seroprevalence was 0.36 percent of the adult population. Infection was (and is) concentrated among high risk groups that are predominantly male; however as transmission is primarily sexual and transmitted through heterosexual sex, women are hugely vulnerable and have a high level of infection (38 percent).

Odisha (formerly Orissa), with a lower than national average HIV seroprevalence rate of 0.23 percent in 2007, was considered HIV-vulnerable due to a large migrant population, large-scale development projects, low literacy, rapid urbanisation and industrialisation. Stigma and discrimination against people living with HIV (PLHIV), sex workers, sexual minorities and injecting drug users was intense; its prevalence within families, communities and healthcare facilities greatly inhibited HIV prevention, care and support service provision. This was exacerbated by extreme poverty, the lack of basic service infrastructure, undermining key populations and PLHIV access to essential health services. Both the State AIDS Control Society and partner NGOs had limited HIV capacity in 2008.

Concern, operational in India since 1999, and in Odisha (formerly Orissa) since 2002, had a programmatic focus on governance and livelihoods, HIV and disaster risk reduction and climate change in this state. Since 2004, Concern with national and international NGOs had been implementing HIV projects. This experience led to the development of the EU funded *Strengthening Local Responses to HIV and AIDS* Programme. The **overall objective** of the Programme was:

> *To respond effectively to the HIV and AIDS epidemic in Orissa; reducing risk and vulnerability to infection and ensuring that people infected and affected by HIV and AIDS have an improved quality of life by the end of 2013.*

The programme primarily focused on underserved and at-risk and vulnerable sub-populations such as local transport workers (LTWs), urban slum and rural-based adolescents (13-19 years) and youth (20-34) and PLHIV. Partner organisations effectively mobilised their respective target groups in order to promote HIV prevention, care and support in combination with other development activities; promoting behaviour change, STI treatment, HIV testing and Anti-Retroviral Therapy (ART) uptake and adherence and education regarding HIV re-infection prevention and condom use. Females were educated regarding the importance of HIV testing while pregnant and the added value of an institutional delivery. District level networks of PLHIV (DLNs) were strengthened and/or formed and provided a range of essential supports to their male and female members, including training regarding the importance of ART adherence, linking them to existing pension and livelihood schemes and undertaking advocacy to challenge stigma and discrimination.

The end of programme monitoring and end line data indicated that:

- The number of respondents who had used condoms with paid/paying heterosexual partners at last sex had increased by 20.5%.
- The number of respondents that have seen a condom demonstration increased by 58%.
- The number of respondents in the past one year that have received messages and support on HIV prevention and care had increased by 68%.

Stigma and discrimination against PLHIV and most at risk populations (MARPs) presents a major challenge to effective HIV prevention, care and treatment. At the outset of the programme, stigma and discrimination against PLHIV in Odisha was pervasive and widespread in the community, leading to rejection, isolation and despair. Baseline data – reported - that 9.5 percent of PLHIV respondents had been subjected to negative attitudes and discrimination by healthcare staff. Such negative attitudes can lead to PLHIV keeping their status a secret, with negative implications for them and their families.

A 2 tiered approach to addressing this was developed:

- Supporting the government health care system in developing an accepting and positive attitude towards PLHIV through the *Prathama Sopana* (First Step) targeting frontline health care workers (Class IV). Post training assessment found a considerable change in the attitudes and opinions of these workers, maintaining that "earlier we were scared, now we are not". As a result of *Prathama Sopana* they now understand that with universal precautions their chances of getting infected with HIV were practically zero. They also indicate that they now **like** working with pregnant HIV positive women, providing them with advice and support.
- Supporting the community by creating an enabling and supportive environment within the families of PLHIV and the communities in which they live. A broad-based media campaign, educational activities and events, community engagement and interventions were implemented.

Monitoring and end line data indicated that:

- 1,429 people living with HIV disclosed and discussed their status with family members.
- 1,592 people living with HIV disclosed and discussed their HIV status with health care providers.
- 19,125 unique individuals were reached through interpersonal communication.

Concern's targeted communities in Odisha are characterised by extreme poverty. The baseline survey of PLHIV showed decreased income post-infection with an inability to work due to increased morbidity and many returned migrants cut off from their previous sources of livelihood. The impact of reduced income is loss of morale, anxiety and worry, inability to pay for essentials such as nutrition, transport to and from healthcare facilities, medicines and family upkeep.

To address this need the programme included livelihood support:

- Linking beneficiaries to a broad range of existing government livelihood schemes through developing a knowledge base about available schemes and criteria and providing support to PLHIV to apply for them.
- Providing direct livelihood support through the provision of individual loans to PLHIV to fund income-generating activities (selling bangles and miscellaneous items, making leaf plates, making food items, doing electric wiring, tailoring, and selling foodstuffs); priority was given to the poorest PLHIV and female-headed households. One time grants were received by 73 beneficiaries and the remaining 508 received loans. The income generated ranged from 2,000 to 10,000 rupees per month. This enabled beneficiaries to feed themselves and their families, send their children to school and take care of their most basic needs.

Monitoring data covering the period January 2009 to September 2013 and baseline-endline data covering the period 2010 to 2013 indicated that:

- The number of PLHIV respondents that spontaneously reported four or more principles of positive living increased by 6%.

- The number of PLHIV respondents that expressed the benefit of reduced mental depression and despair via association with PLHIV network decreased by 3%.

PLHIV had improved access to and uptake of a range of health services and social security schemes. As a result of the project PLHIV were trained on the state government's social security schemes and procedures with 1,000 beneficiaries linked to social security schemes that included pension salaries, housing schemes and waged employment.

As a result of advocacy, joint monitoring visits (OSACS, Concern and partners), facilitated discussions with PLHIV, the provision of transport costs to the ART centres, and support to OSACS and district hospitals, over the lifetime of the project, in the State of Odisha, there was a large increase in ART uptake from 1,754 to 10,675 and in pre-registration from 4,390 to 20,307.

A critical success from this programme has been the establishment of an ART defaulter tracking system that succeeded in bringing people back to treatment, which has been adopted by Odisha State AIDS Control Society for replication throughout the State.

Concern has made a major contribution to developing partners' capacity to undertake extensive HIV and AIDS prevention care and support work and to liaise with government health and administrative services in order to provide health and other supports to mobilised populations. At the outset of the programme partner organisations had limited HIV capacity and required up-skilling in order to introduce HIV and AIDS prevention, care and support into their existing work and communities. A range of capacity building strategies were delivered, including 85 thematic and sector based training programmes, 10 exposure visits and on-site mentoring and support, enabling partners to design, manage, monitor and document this programme. Endline data indicate that the number of respondents that have received outreach services in the past year increased by 66 percent.

Many valuable lessons were learnt in the programme delivery: the value of a technically sound, collaborative approach to service provision for PLHIV; the benefits of networks, not only as a support for PLHIV, but as a means to advocate on their behalf; the contribution of a Positive Speakers Group in raising awareness; How on-going and sustained education and awareness raising can impact on stigma and discrimination, drawing specifically on the example of the *Prathama Sopana* training for frontline health workers. How income generation and livelihoods support provides considerable benefits to PLHIV; Gender inequalities are pervasive, and a considerable focus on women is required in order to address their heightened risk and vulnerability; and the risks attached to males as bread winners and being obliged to migrate or work in transport.

There were considerable changes between baseline and endline data; e.g., 2.8 percent of rural female youth had seen a condom demonstration at baseline stage, but had increased to 68 percent by endline. With regard to receiving messages and support on HIV prevention and care, 15.3 percent of urban male youth at baseline had, whereas this increased to 69 percent by endline. With regard to family and community discrimination, at baseline 14.9 of males and 34.7 percent of females reported being subject to negative attitudes and at endline, this had changed to 12 percent for males and 20 percent for females.

The project also contributed to OSACS capacity, including the following.

- Liaison and support between OSACS, Concern India and INP+ in undertaking Class IV health care worker stigma and discrimination training in district hospitals, medical colleges and hospitals throughout the state.
- A request to Concern India to conduct health care worker stigma and discrimination training for health care workers following a health care providers opinion poll in 8 district-level hospitals The development and institutionalisation of a state-level ART LFU tracking system.
- The strengthening of the referral mechanism between the ART Centres and the DLNs.

- The concrete tracking of the backlog of LFU ART defaulters in Cuttack ART Centre.
- The development and dissemination of Posters for Positive Living, Universal Precautions and HIV Prevention.

The programme delivered quality inputs in order to effectively achieve its objectives. With the completion of the programme and closure of the Concern office, there will undoubtedly be a gap in the support provided to Odisha State's HIV prevention, care and support services. The project has, however, built the capacity of the partner organisations; supporting them in developing equality and HIV mainstreaming strategies and work practice; enabling them to continue implementing technically sound HIV prevention, care and support programmes.

2.0 Introduction

2.1 HIV and AIDS in India and Odisha in 2008

India: India has a population of 1.2 billion, of whom approximately 50 percent are adults in the sexually active age group. At programme start-up up in 2008, India had an estimated 2.5 million people living with HIV (an adult seroprevalence of 0.36 percent of the adult population) and HIV infection had been reported in all states and union territories. Among those infected with HIV, 38 percent were female and 4 percent were children.[1] Sixty percent of the burden of HIV was in the 6 high prevalence states of Andhra Pradesh, Karnataka, Maharashtra, Mizoram, Nagaland, and Tamil Nadu. Preliminary 2008-09 sentinel surveillance results identified an increased trend in low and moderate prevalence states such as Odisha.[2]

In India, transmission is primarily sexual – 87.4 percent – with perinatal accounting for 4.7 per cent, infected needles and syringes 1.8 percent and unsafe blood and blood products, 1.7 percent. Prevalence among high risk groups continued to be high (6 to 8 times that of the general population).[3] HIV transmission was (and is) concentrated among higher risk groups that are predominantly male including truck drivers, migrants, and clients of sex workers (SWs), as well as men who have sex with men (MSM). The vast majority of infections occurred through heterosexual sex. Men who buy sex were the single most powerful driving force in India's epidemic. Migrants constitute a significantly higher-than-average client group of sex workers, ranging from a low of 16 percent to a high of 88 percent of unaccompanied out-migrants visiting sex workers.[4] In 2008-09, HIV prevalence among male migrants was estimated to be 2.35 percent.[5] Gender inequalities affect women's ability to protect themselves from HIV infection, for example, in India, an estimated 90 percent of females acquired HIV infection from their husbands.[6] Females' sexual lives are characterised by an earlier sexual debut than their male age mates, 10 percent of girls versus 2 percent of boys have their first sexual intercourse by age 15.[7]

HIV in Odisha at project start up: HIV seroprevalence in Odisha in 2007 was 0.23 percent, which was significantly below the national average. In 2008-9, this figure was revised to 0.73 percent and again in 2010-11 to 0.43 percent.[8] Another revision was made in 2012, and the current estimate for HIV in Odisha in 2008 is 0.46 percent. Other than to observe that the original estimate of 0.23 was low, it is difficult to say with accuracy how the epidemic is progressing in the state. However, Odisha was considered HIV-vulnerable because of such factors as a large migrant population, large-scale development projects such as mining industries, hydroelectric and irrigation projects, low literacy (especially among females) and rapid urbanisation and industrialisation. As well, HIV prevalence among high risk groups was significant, for example, STI patients; 1.5 percent, IDU; 7.3 percent, MSM; 7.2 percent and sex workers; 0.8 percent.[9] In 2008, based on the Odisha State AIDS Control Society (OSACS) data at that time, four districts in Odisha had generalised epidemics – more than 1 percent ante natal sentinel surveillance (ANC) prevalence (Category A), namely, Ganjam, Angul, Bhadrack and Bolangir and Koraput and Khurda had concentrated epidemics – more than 5 percent prevalence in High Risk Groups [HRGs] (Category B). According to available data, in 2007 Ganjam

[1] WHO (2007 6th July) *2.5 million people in India living with HIV, according to new estimates* (http://www.who.int/en/index/html).
[2] NACO, *UNGASS Country Progress Report, 2010, India* (2008 data).
[3] NACO, *UNGASS Country Progress Report 2008, India.*
[4] NACO, *UNGASS Country Progress Report*, op cit.
[5] NACO *Annual Report, 2011-12.*
[6] NACO, *UNGASS Country Progress Report,* op cit.
[7] NACO, *UNGASS Country Progress Report,* op cit.
[8] NACO, *HIV Sentinel Surveillance 2010-11: A Technical Brief.*
[9] OSACS, Sentinel Surveillance, 2007.

accounted for 40 percent of people living with HIV in Odisha and 32 percent of people with AIDS.[10] That earlier sexual debut puts young girls at risk of HIV infection is borne out by recent data from OSACS; in the 15-24 age group, females were 54 percent of those infected.[11]

At programme start-up, the evidence base regarding high risk groups was weak and they were - largely speaking excepting a few urban pockets - undefined and unreached with HIV prevention, care and support services. Odisha, a state characterised by substantial out and in-migration had large numbers of migrants affected by HIV. The National Aids Control Organisation (NACO) estimates found that migrants in Odisha represented a large portion of people living with HIV in 2007.[12] Migrant outreach and service provision was very limited.

In 2008, a total of 9,031 people living with HIV were identified by 129 Integrated Counselling and Testing Centres (ICTC) and 1,754 people living with HIV were accessing ART from two functioning ART centres. There were 5 District Level Networks (DLNs) of people living with HIV registered in Odisha State.[13]

At programme start-up, stigma and discrimination against people living with HIV, sex workers, sexual minorities and injecting drug users was intense. This stigma existed within families, communities and healthcare facilities and greatly inhibited HIV prevention, care and support service provision. Extreme poverty and lack of basic service infrastructure exacerbated the risk and vulnerabilities of key populations and people living with HIV and compromised their access to essential health services. Both the State AIDS Control Society and partner NGOs had limited HIV and AIDS capacity in 2008.

The project began in a context whereby the commitment of the Government of India (GoI) to halt and reverse the HIV epidemic in India was articulated in National AIDS Control Programme III (NACP III, 2007-2012[14]), through a four-pronged strategy that sought to:

- Prevent new infections in high risk groups (HRGs) and general populations through the saturation coverage of high risk groups with targeted interventions and scaled up interventions in the general population.
- Provide greater care, support and treatment to larger numbers of PLHA.
- Strengthen the infrastructure, systems and human resources for scaling-up prevention, care, support and treatment programmes at district, state and national levels.
- Strengthening the nationwide Strategic Information Management system.

The GoI's commitment to HIV prevention is reflected in the fact that of the estimated Rs. 11.585 crore needed for NACP III, the amount allocated to prevention is Rs. 7.78 crore. HRGs including sex workers, men who have sex with men and injecting drug users were intended to reach saturation coverage under NACP III and programmes for bridge populations – migrants and long-distance drivers were to be scaled up. General population areas of focus include women, youth and children, within which street children, adolescent sex workers, orphans, migrant children and youth are considered marginalized. In order to scale up the reach of HIV prevention, care and support services – particularly HIV counselling and testing and the prevention of parent to child transmission services, in 2012, the Planning Commission proposed that NACO should be merged with the National Rural Health Mission (NRHM) in order to build on their public health infrastructure and decentralized health provision and both the Global Fund and PEPFAR are supporting this convergence.

[10] UNICEF *HIV/AIDS Profile Orissa*, 2007.
[11] OSACS *Statistics at a Glance, Up to August 2013*.
[12] NACO, *HIV Sentinel Surveillance and HIV Estimates*, 2007.
[13] Data from Orissa State AIDS Control Society.
[14] *NACO, NACP III: To Halt and Reverse the HIV Epidemic in India. 2007.*

2.2 Concern Worldwide in India

Concern Worldwide has been working in India since 1999, providing support to local non-governmental organisations (NGOs) to implement relief, rehabilitation and development work. In 2002, Concern Worldwide established its country office in Bhubaneswar, Odisha, which was identified as Concern's priority state for India. Concern's programme focused on three core sectors; governance and livelihoods, HIV and disaster risk reduction and climate change.

2.3 Concern's HIV Programme in Odisha, India

In 2004, Concern piloted two HIV projects to address the HIV-related risks and vulnerabilities of adolescents and people living with HIV and AIDS. These projects were undertaken in partnership with Ruchika Social Service Organisation (Ruchika) and the Indian Network of People Living with HIV (INP+). Starting in 2006 Concern and Hivos developed a more comprehensive HIV intervention in Odisha in line with the global policy and strategy of the Alliance 2015.[15] The core objectives of this programme were minimising the vulnerabilities and impact of HIV on the people of Odisha, advocating for the elimination of discrimination against people living with HIV and promoting the rights of people affected by HIV. Five implementing partners were part of this collaboration; the Ideal Development Agency (IDA), INP+, Ruchika, South Orissa Voluntary Action (SOVA) and Utkal Sewak Samaj (USS). The Alliance 2015 HIV programme in Odisha focused on issues not currently being addressed with populations not being reached.

In 2008, in response to an in-country call for proposals, Concern sought additional support from the European Union (EU) to expand and further consolidate its HIV programme in Odisha. In 2009, the EU awarded a five year programme to Concern; 1 January 2009 to 31 December 2013.

[15] Alliance 2015 is a global partnership of seven European NGOs working in the field of development cooperation. The members are CESVI, Italy, Concern Worldwide, Ireland, Welthungerhilfe, Germany, Hivos, the Netherlands, IBIS, Denmark, People in Need from the Czech Republic and ACTED from France.

3.0 The European Union-supported HIV Programme in Odisha, *Strengthening Local Responses to HIV and* AIDS in *Orissa*.

3.1 The Concern Worldwide-EU Programme Framework.

In 2009, the European Union (EU) awarded a five-year programme to Concern India for the time period, 1 January 2009 to 31 December 2013. The programme - based in Odisha State (then Orissa) - sought to build on, strengthen and expand the HIV and AIDS work to date with key implementing partners, targeting populations out of reach of mainstream services, including; rural and tribal youth, slum and street adolescents, and college students. Also targeted were mobile populations such as auto taxi drivers, people with high risk behaviours within target communities and people living with HIV.

The original proposal included an explicit focus on "high risk and highly vulnerable groups" including sex workers (SWs), injecting drug users (IDU) and men who have sex with men (MSM) as well as a standalone objective "to prevent and control the spread of HIV and to reduce stigma and discrimination". By November 2009, the programme design was adjusted to capture the key lessons learnt from the implementation of the Alliance 2015 programme and a revised results framework was developed, focussing on one specific objective and 5 Key Results Areas (KRAs). In this revised framework, high risk groups would be reached through generalised service provision in the slums and villages where they were likely to be living.

The **overall objective** of this programme was:

> *To respond effectively to the HIV and AIDS epidemic in Orissa; reducing risk and vulnerability to infection and ensuring that people infected and affected by HIV and AIDS have an improved quality of life by the end of 2013.*

The **specific objective** of this programme was:

> *To prevent and control the spread of HIV and AIDS among populations at high risk (in 3 Districts) and among people living with HIV (District-level networks in 6 Districts) through community empowerment approaches.*

There were **5 KRAs** identified as follows[16]:

KRA 1: Communities have increased knowledge and capacity to take up HIV testing and prevention services in targeted districts.

KRA 2: Health care providers and community members have accepting and positive attitudes towards PLHIV and their families.

KRA 3: PLHIV and families live positively and with dignity through livelihood support

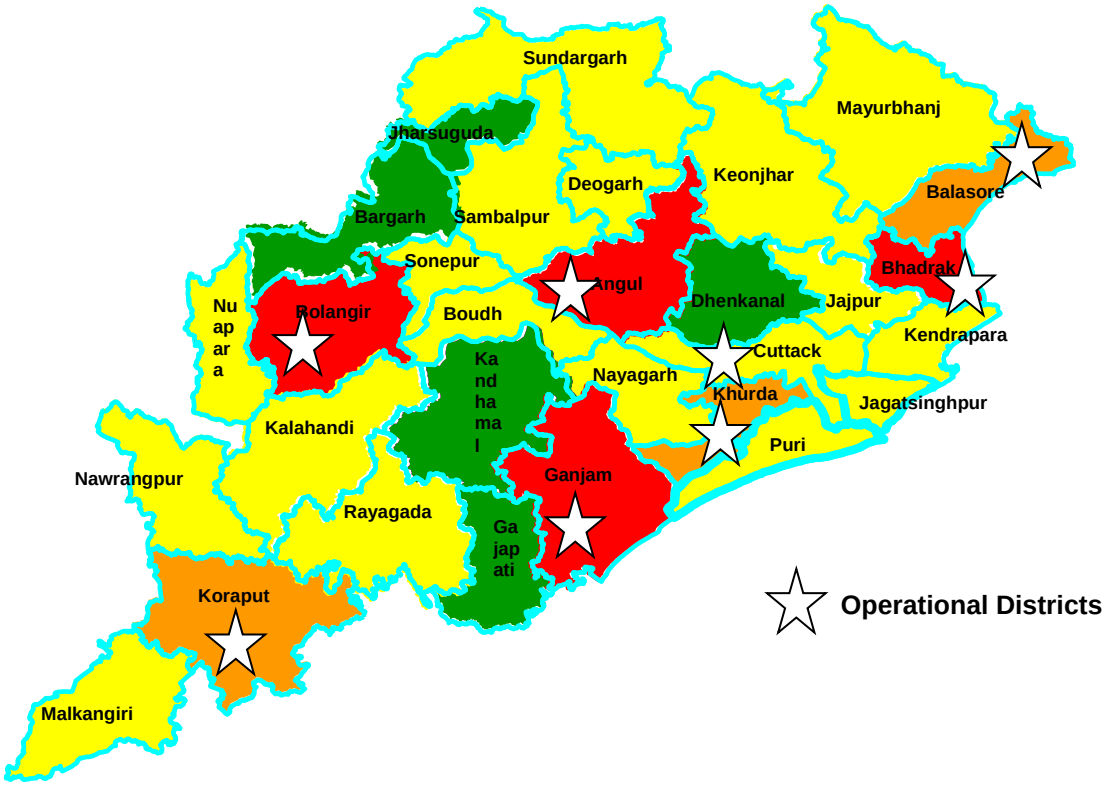
KRA 4: PL HIV are able to access and receive appropriate and affordable care and treatment (STI, ICTC, OI/TB, ART services) and social security.

KRA 5: Partners are able to design and implement effective and efficient HIV and AIDS programme interventions to reduce HIV infection among programme participants.

[16] This is based on an agreed revised project results framework in November 2009.

The Geographic areas of focus: In 2009, Concern and partners began implementing the programme in eight districts of Odisha; Angul, Balasore, Bhadrak, Bolangir, Cuttack, Ganjam, Khurda and Koraput. There were four active implementing partners; INP+, Ruchika, SOVA and USS.

Map of Operational Districts, Strengthening Local Responses to HIV and AIDS in Orissa, India



3.2 The Scope of the Programme:

Programme Partners	Operational Areas	Target participants	Intervention Sites
INP+	Ganjam, Khurda, Bolangir, Balasore and Angul Districts	People Living with HIV	DLNs in the five target districts: Ganjam, Khurda, Bolangir, Balasore and Angul Districts
Ruchika	Bhubaneswar City	Urban slum and street dwelling adolescents, youth and auto drivers	Slums in Bhubaneswar, Local Transport Worker Associations in Bhubaneswar
SOVA	Koraput District	Rural tribal adolescents and youth, rural women, auto and taxi drivers, and people living with HIV	Focused villages in Koraput District Support to DLN in Koraput District
USS	Cuttack City	Urban slum adolescents and youth	Slums in Cuttack City
	Cuttack and Bhadrak Districts	People living with HIV	Support to DLNs in Cuttack and Bhadrak Districts

4. 0 Scope and Methodology of the End of Programme Evaluation

4.1 Purpose of the End of Programme Evaluation

The purposes of this evaluation were as follows:

1. To evaluate whether the Specific Objective and KRAs were relevant in the context in which they were made, whether they are still valid in the current dynamic context.

2. To evaluate to what extent the Specific Objective and KRAs are effectively met and key lessons learnt.

3. To review to what extent the structure and processes in place are appropriate and help achieve desired results. Also, outline the roles of these structures in the current changing scenario.

4. To assess how the programme has developed, the overall quality and progress, identify successes and promising practices, horizontal and vertical linkages in the partner projects and document lessons.

5. To report the consolidated changes from the baseline to the endline and disaggregated by groups, sex.

6. To review the equality and HIV mainstreaming strategies being implemented by partners in their ongoing projects and in their other organisational programmes.

7. To review the collaborative efforts undertaken with the OSACS and the contribution of the programme in meeting the state indicators (as per National AIDS Control Programme [NACP] III) and EU NSA objectives on increasing access to services, strengthening capacities of community-based organisations among populations at high risk of HIV and infected and target interventions for populations out of reach of the mainstream services. Reference – Objectives of the Programme and Priority Issues under the Call for Proposals.

8. To reflect on the recommendations of the mid-term review and the Results Oriented Monitoring (ROM) visit and how well they have been incorporated into the present programme. For a copy of the complete terms of reference, see Annex 1.

4.2 Methodology

The methodology for this review was participatory and qualitative complemented and informed by baseline-endline data. The consultant facilitated meetings, reviews and discussions with partner staff, project beneficiaries, senior management and supporting organisations including the EU. The consultant was accompanied by the Concern India HIV and AIDS Programme Manager. The consultant had overall responsibility for the report.

As part of the evaluation process, a desk review of key online HIV portals such as ELDIS was carried out. The consultant also reviewed relevant documents from the UNAIDS, AVERT, NACO and Global Fund websites. In addition, the consultant carried out a review of key programme documents, including the original proposal, the revised logical framework, the annual work plans, the

monitoring framework and data, the narrative reports, the mid-term review, partner documentation, Learning Documents developed by the project and the project baseline and endline reports.
The consultant spent a full two weeks in Odisha. In-country, following a briefing by the Concern Country team, a two-day participatory partner workshop took place during which project staff – both management and field-level – reflected on key issues pertaining to the project, including the status of HIV in Odisha at project start up, the ways in which HIV and AIDS affected males and females differently, the drivers of HIV in Odisha at that point in time and the major issues and needs in the state at that time. The workshop participants from different organisations also mixed with their age and work colleagues and considered the extent to which programme objectives were achieved. In their organisational groups, participants also considered the ways in which their work had influenced State Policy and what key components could be sustained going forward.

This was followed by a four-day meeting with the SOVA and INP+ teams and their beneficiaries in one central location. Although a field trip had been planned to Koraput for an on-site visit to SOVA, this had to be cancelled at the last minute for security reasons (Maoist-government conflict). SOVA, and key beneficiary representatives instead travelled to Berhampur. SOVA presented their work and the consultant met and interacted with their male and female Peer Educators and Youth Club members.

INP+ also presented their work and a full-day was devoted to 8 DLN networks presenting the work of their networks. The consultant also visited the MKCG Medical College and Hospital, the ART Centre and the Ganjam DLN . Finally, the consultant had a chance to interact with ART Defaulters and people living with HIV livelihood beneficiaries.

Following these workshops, the consultant, accompanied by members of the Concern HIV team visited USS and Ruchika in Cuttack and Bhubaneswar and engaged with the organisations and key beneficiaries on the ground as well as relevant health care facilities, District Administration offices and key District-level Staff. In all instances, the evaluator facilitated interactive one-to-one or group discussions. Following these Field Visits and workshops, Concern India hosted a meeting with project partners and the evaluator debriefed on the key findings. For a copy of the evaluation itinerary, see Annex 2.

The 'changes' being reported are for a 36 month period only as Baseline was completed in mid 2010 and Endline in mid 2013. The 'Routine Monitoring Data' reported is from January 2009 to September 2013.

5.0 Findings

5.1 Were the Specific Objective and KRAs relevant in the context in which they were made, whether they are still valid in the current dynamic context?

Introduction: There is no doubt that both the Specific Objective of the project and the KRAs were all keenly relevant in the context in which they were made. Concern designed this project based on four years of HIV and AIDS programme experience in Odisha and had, therefore, an excellent understanding of the service and capacity gaps in meeting the needs of unreached and at-risk and vulnerable populations.[17]

Although a low prevalence state, in 2008, Odisha had an evident problem with HIV that was concentrated in population pockets such as SWs, MSM, IDU, migrants and mobile transport workers. To the extent that data was available, it was clear that SWs, MSM and IDU were among the sub-populations most at risk in the state. There was low to stagnant economic growth, and Odisha had one of the lowest levels of per capita income in the country and one of the highest levels of net out-migration. Extremes of poverty were compounded by a lack of basic service infrastructure, including health care for people living with HIV. Stigma against people living with HIV was intense and HIV and AIDS prevention care and support service provision and both government and NGO capacity to address the needs of populations at-risk, vulnerable, infected and affected was limited. There was a huge lack of awareness concerning HIV and AIDS among vulnerable populations in the state at that time. Thus, the geographic areas and vulnerable populations focused on by the project were in great need of HIV prevention, care and support services.

Having said that, the evaluator is of the opinion that HIV prevention would have been strengthened by maintaining a greater focus on HRGs and/or bridge populations in the geographic areas of focus. This would have lent additional support to the revised specific objective to "prevent and control the spread of HIV and AIDS among populations at high risk in three Districts". Given this overarching prevention objective, the evaluator would have expected the project re-design to include an analysis of which populations are most at risk in the three Districts of focus and the extent of their current coverage, particularly in the light of NACP III priority focus on HRGs and bridge populations. The choice of target groups, implementation partners and geographic areas of focus would then have been rationalised within such an analysis. There is no doubt that the project re-design supported NACP III's commitment to women, youth and children (including marginalized children) very well. This could have been complemented by a more comprehensive focus on auto transport workers, in-migrants or other bridge populations, all of which the existing implementing partners have demonstrated the capacity to undertake.

The Specific Objective: The Specific Objective's focus was on the prevention and control of HIV and was very relevant in Odisha.

> *To prevent and control the spread of HIV and AIDS among populations at high risk (in 3 Districts) and among people living with HIV (District-level networks in 6 Districts) through community empowerment approaches.*

[17] Starting in 2004, Concern Worldwide had piloted two HIV projects with slum-based and street-dwelling adolescents vulnerable to HIV and AIDS. This led to an expanded response in 2006, when – in partnership with HIVOS and five NGO partners – Concern undertook a more comprehensive HIV intervention strategy that focused on minimising the vulnerabilities of the people of Odisha, eliminating discrimination against people living with HIV and promoting the human rights of those affected by HIV.

In addition to MARPs such as SWs, MSM and IDU, at project start up, other population groups experienced the vulnerabilities (the factors than enhance risk) than put them at risk (the probability that an infection will occur) of HIV. These vulnerabilities included gender inequalities, slum dwelling, homelessness, extremes of poverty and other kinds of marginalisation such as being members of Tribal Communities. Within these sub-populations are degrees of high risk behaviour that were often hidden and hard to address. Such sub-populations were identified by Concern as being hard-to-reach and underserved, as they were not on the radar screen of the Indian government that had prioritised MARPs and bridge populations (mobile and migrant workers) for targeted interventions. The evidence-base regarding the HIV-related risks and vulnerabilities of these additional population groups was weak to non-existent.

Relevance of KRA 1: *Communities have increased knowledge and capacity to take up HIV testing and prevention services in targeted districts.*

In the original project design, the programme intended to explicitly target the following sub-populations: youth, mobile populations, high risk and vulnerable groups (SWs, IDU, MSM, pregnant women, PLHIV and slum communities).[18] However, by the end of the first programme year, the population denominators were revised to focus on Local Transport Workers, slum and rural-based youth and adolescents and people living with HIV and to address high risk behaviours such as having multiple sex partners, selling and buying sex, injecting drugs and sex between males *within* these population groups.

There is no doubt that KRA 1 was extremely relevant for the targeted communities in the districts of focus. At project start up, rural and slum adolescents and young people, people living with HIV and Local Transport Workers had very little knowledge about HIV and its prevention and care. Risk behaviour existed within all these populations and prevention service uptake was very low. This is borne out by the project baseline whereby only 17.3 percent of rural female youth and 16.0 percent of female adolescents knew that consistent condom use could prevent HIV transmission. Only 17.5 percent of rural male youth and 8.3 percent of male adolescents reported using condoms at last sex with a casual partner. Furthermore, rural populations were particularly vulnerable. For example, while 42.5 percent of urban female youth knew that consistent condom use could prevent HIV transmission, this contrasts with the 17.3 percent of rural female youth stated above.[19]

However, it is the opinion of the evaluator, that HIV prevention work in these vulnerable communities would have been strengthened by HIV-specific risk (the likelihood that an infection will occur) and vulnerability (the factors that enhance risk) analysis for each target sub-population within rural and urban areas of outreach. In other words, the context of HIV-specific risk and vulnerability for each target group would be analysed and described. Such a risk and vulnerability analysis would have provided a strong context-specific complement to the very useful baseline analysis which provided more generalised data across all target groups.

Relevance of KRA 2: *Health care providers and community members have accepting and positive attitudes towards people living with HIV and their families.*

> "People living with HIV were marginalised into oblivion by stigma and discrimination".
>
> *Standing Right Next to You.*

[18] Nowhere in the project document are the terms "high risk" and "vulnerable" defined.
[19] *Concern Worldwide Intervention on HIV/AIDS, Orissa India: Baseline Survey 2010.*

One of the major challenges to effective HIV prevention, care and treatment is stigma and discrimination against people living with HIV and MARPs. According to a 2009 UNDP study, the majority attitude towards people living with HIV – especially in low prevalence states – was a mixture of sympathy, disgust, sadness and fear of infection.[20]

At project design and start-up, stigma and discrimination against people living with HIV in Odisha was pervasive and widespread, both from health care workers and community members. This was confirmed by the baseline study that confirmed that 9.5 percent of people living with HIV respondents had been subjected to negative attitudes and discrimination by healthcare staff.[21] Stigma against people living with HIV is intensified if they are known to be from a MARPs sub-population. Such stigma in health care settings and within communities discourages disclosure and services uptake. Negative attitudes from health care workers generate anxiety and fear within people living with HIV and as a consequence, many keep their status a secret. This is to the detriment of people living with HIV and their families.
KRA 2, therefore, was completely relevant to the needs of target communities in Odisha and to supporting the achievement of the overall project objective and the specific objective.

Relevance of KRA 3: *People living with HIV and families live positively and with dignity through livelihood support.*

The lives of many people living with HIV from Concern's targeted communities in Odisha are characterised by sheer and absolute poverty. Concern's baseline survey of people living with HIV in eight districts in Odisha showed decreased income post-infection. So many people living with HIV were unable to work due to increased morbidity and so many returned migrants were cut off from their previous sources of livelihood. The impact of such reduced income is loss of morale, anxiety and worry, inability to pay for essentials such as nutrition, transport to and from healthcare facilities, medicines and family upkeep.

KRA 3, therefore, was completely relevant to the needs of target communities in Odisha and to supporting the achievement of both the overall project objective and the specific objective.

Relevance of KRA 4: *People living with HIV are able to access and receive appropriate and affordable care and treatment (STI, ICTC, OI/TB, ART services) and social security*.

ART has considerable benefit, both as treatment and in preventing HIV and TB.[22] However, at project start-up, there were only two functioning ART centres in the state. Consequently, distance, stigma, restrictive gender norms and poverty inhibited ART take-up with the resultant unnecessary morbidity and mortality and lost prevention opportunity. Health seeking behavior, including STI and other services uptake were very low among people living with HIV targeted populations and communities. Many people living with HIV were not accessing the social security benefits (pension schemes, housing schemes, insurance schemes, below poverty line schemes) to which they were entitled.

KRA 4, therefore, was completely relevant to the needs of target communities in Odisha and to supporting the achievement of both the overall project objective and the specific objective.

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[20] UNDP, *Study on Levels of HIV-related stigma in the General Population in 18 States in India* 2009.
[21] *Concern Worldwide Intervention on HIV/AIDS, Orissa India: Baseline Survey 2010*
[22] WHO, *Antiretroviral Treatment as Prevention of HIV and TB*. 2012.

Relevance of KRA 5: *Partners are able to design and implement effective and efficient HIV and AIDS programme interventions to reduce HIV infection among programme participants.*

Although some of the partners had a degree of experience in implementing HIV projects, with the exception of INP+, they were mainstream development and not specialist HIV and AIDS organisations. Therefore, they had limited HIV capacity and they needed considerable technical support in order to introduce HIV and AIDS prevention, care and support into their existing work and communities. However, given that they had identified substantial levels of HIV risk and vulnerabilities among their target communities, building their capacity to address HIV for the duration of this project and beyond was extremely relevant. In addition, there was low overall capacity among NGOs in the state to undertake Targeted Interventions TIs with MARPs and bridge populations.

5.2 To what extent the specific objective and KRAs were effectively met and key lessons learnt[23].

To What Extent the Specific Objective Was Effectively Met

Specific Objective: *To prevent and control the spread of HIV and AIDS among populations at high risk (in 3 Districts) and among people living with HIV (District-level networks in 6 Districts) through community empowerment approaches.*

Concern Worldwide and its four implementing partners, INP+, Ruchika, SOVA and USS have been extremely successful in achieving the targets set by the project's key objective and KRAs. The project adopted an effective geo-focused approach, whereby HIV prevention and support services were strengthened in the same geographic location where mobilised communities live, thus encouraging service uptake through closing the gap between needed services and their availability. The project also supported and strengthened referrals *to* and *within* contiguous health care facilities and satellite supports (e.g. from the ICTC to the STI department and ART Centre to the DLN network or the Community Care Centre). In addition, the project put a strong emphasis on helping target communities access various support schemes available through the Government of India (GoI). This was an extremely practical and strategic and cost-effective strategy. As a result, many hundreds of people living with HIV now have pensions, housing benefits and other supports.

Each project partner has been very successful in mobilising hard-to-reach and underserved target communities for HIV prevention, care and support in their geographical locations, that is slums and villages as units of implementation. In addition, local transport workers were reached as a target population and people living with HIV were reached and organised through their DLNs.

The information generated by the project's routine monitoring data provides an excellent complement to the project's baseline-endline data, e.g. the total number of STI referrals, the number of programme participants that attended STI-related training/s, or the number of pregnant women testing positive for HIV. This routine monitoring data provides a concrete measure of the sheer volume of work carried out and the overall success of the project.

The extent of project success can be gauged from the end of project (EoP) monitoring and endline data. For example, over the project duration, there were a total of 6,853 STI referrals, 98,202 people attending STI/HIV meetings/discussions, and 85 trainings provided for implementing partners.

[23] Please note that the question of "lessons learned" has been addressed under evaluation purpose number 4 below.

Among target communities, by the EoP, 98 percent had seen a condom demonstration, 4 percent of males living with HIV reported being subject to negative attitudes and discrimination compared to 9.5 at project start-up, and 10,675 individuals were on ART compared to 1,754 at project start up. For an overview of partner deliverables that contributed to these results, see Annex 3.

District-specific revised HIV surveillance data for the years 2008 and 2010 were as follows[24]:

District	2008	2010	District	2008	2010
Angul	0.75	1.26	Cuttack	1	1.5
Bolangir	1.5	≥ 0.5	Ganjam	1.25	1
Balasore	0.5	0.75	Khurda	0	1
Bhadrack	0	≥ 0.5	Koraput	0	0.5

In relation to the overall project design, KRA 1, the major prevention result area was overly crowded, addressing STI, OI, prevention of parent to child transmission PPTCT, community mobilisation and behaviour change, and could have benefited from the key elements having a stand-alone focus, not unlike KRAs 2, 3 and 4.

Within this overall context, it is the opinion of the evaluator the indicators related to the specific objective could have been stronger; from an emphasis on knowledge-based change indicators to a stronger emphasis on behaviour change indicators, related for example, to the delay of sexual debut or to partner reduction or health-seeking behaviour within a week of developing STI symptoms. At the specific objective level pertaining to the prevention and control of the spread of HIV among populations at high risk, the *% of respondents having seen a condom demonstration* is a weak indicator.

To what extent was KRA 1 effectively met:

KRA 1: *Communities have increased knowledge and capacity to take up HIV testing and prevention services in targeted districts?*

In every project area, the implementing partners have been successful in mobilising their target groups, building their knowledge and understanding of HIV and AIDS and increasing their uptake of HIV testing and prevention services. Working in urban slums and villages, project partners mobilised male and female adolescents (13-19), young males and females (20-34), mobile transport workers and people living with HIV.

The strategy of working through Peer Educators/Leaders proved very effective in organising and supporting male and female adolescents and young males and females in target sites. Through providing such practical inputs and supports as training and start-up seeds for organic gardening, jewellery making, basic hygiene, reproductive health, first aid etc the project was able to combine practical support with HIV and AIDS education and services promotion. Working through the associations of local transport workers, Concern partners have been extremely effective in educating auto rickshaw drivers regarding HIV-related risk and vulnerabilities and promoting STI and HIV testing and condom use. The DLN networks have been an extremely effective way to organise, support, validate and de-stigmatise people living with HIV. These networks have promoted HIV testing and ART uptake and adherence and education regarding HIV re-infection prevention and condom use.

[24] For more complete data, including estimates of people living with HIV, see Annex 6.

In all project sites, females were educated regarding the importance of HIV testing while pregnant and the added value of an institutional delivery. The project, through its work in villages and slums and through the DLNs, has referred many pregnant women to their local hospital for ICTC , PPTCT and institutional deliveries.

During visits to programmes sites and discussions with a variety of target population groups, it was evident that partner organisations had been very successful in mobilising them for HIV-related and other development activities. Community members were very relaxed with partner staff and willing and able to engage with the evaluator on a range of issues including HIV.

The **auto drivers association** visited in Bhubaneswar proudly showed how worn their Information Education and Communication (IEC) playing cards were, their snakes and ladders game, their condom dispenser. They were quite aware of their own risks and vulnerabilities; a full 40 percent of the group lived away from their families. They gave testimonies as to how they had reduced their own risk behaviour through increased condom use and one member showed us the condom he carried in his wallet for his own personal use. They spoke freely about their role as transporters of clients to sex workers – one group member had just taken "one man from Nepal" to visit a sex worker in a brothel- and how they advocated condom use in these instances. They also said that their engagement with the project partner had inspired them to undertake social work, for example, as an association; they brought 100 old people to see Lord Jagannath.

According to Ruchika staff, many of the local transport workers they work with have an average of 6-7 sexual partners per month. Given that at project baseline, only 46.5 percent used condoms in their last commercial sex encounter, this population group is at very high risk of HIV. On reflection, more blanket coverage of auto rickshaw drivers in every project site would have made a robust contribution to HIV prevention. The implementing partner, Ruchika, was clearly very comfortable with this target population, even if their primary mandate and focus is work with at risk and vulnerable children.

One **adolescent girls group** in Cuttack performed a role play about the ways in which they were vulnerable to being procured into sex work. They talked about the importance of their remaining in school. In discussing with them and their male counterparts about HIV, they were quite knowledgeable about transmission and how to prevent infection. When meeting **youth club** members – boys and girls - from Tribal Communities, they gave testimony about the ways in which the Youth Clubs were important for them, as before that they had nowhere to go. They talked about how their interaction with the partner and their role as Peer Educators/Leaders had increased their self-confidence and how they were proud to be contributing to the cleanliness of their villages through their weekly clean-up operation. Through their contributions of 5 or 10 rupees when they meet, they built up a fund that they used to support people in trouble. They tried to ensure that children who dropped out of school, returned. They were very knowledgeable about HIV. In addition to taking care of themselves, they also referred people in their villages who had STI symptoms. When asked about the age of sexual debut for young boys and girls, the boys immediately said "13-14 for boys". Initially, they said that it was 18 for girls. With a little further discussion, the group agreed that the age of sexual debut for girls was also 13-14. Girls from more than one project site expressed concern regarding the early age of marriage and how they wanted to increase the age at which they married.

Clearly, adolescent girls and boys in target slums and villages have HIV-related risks and vulnerabilities. Given that the early sexual debut of adolescent girls puts them at high risk of HIV transmission – for both biological and social reasons – in future work with adolescents in all sites, project partners could explain why young girls and so vulnerable and how the delay of their sexual debut could protect them from HIV. As well, early marriage to older partners also increases their risk

of HIV, so an overall strategy regarding increasing the age at which young girls enter into sexual relationships or get married would contribute to HIV risk reduction.

In all project sites, partners educated community members regarding the importance of HIV testing in pregnant women and also the advantages of the institutional delivery of babies and receiving the benefit of government schemes. In Cuttack, the evaluator met with a group of **HIV positive mothers**. They had gone for HIV testing through encouragement from USS. The husbands of 7 of the 8 women were also HIV positive and four of them were migrants. All eight women were members of the district DLN. Through USS and DLN efforts, they received livelihood support and were also linked to government services. USS conduct home visits and ensure that they and their husbands take their medicines regularly. One of the women, on testing HIV positive, was driven away from her home by her in-laws, who blamed her for infecting their son, who continued to stay at home. (A similar experience was shared by one DLN member who – on receiving her HIV diagnosis - was abandoned by her husband and beaten by her brother, demonstrating HIV related GBV.

The evaluator spent a full day interacting with eight **DLN networks**, as they each presented the structure of their networks, the results of their SWOT analysis and their concerns and aspirations. It was a remarkable day, with each network presenting the problems they had faced and how they were organising to address them. It was all the more remarkable, given that the majority of network members were from very poor and vulnerable communities, yet through their DLN, they were organising to help themselves to access services and support. The networks primarily talked about the intense stigma and discrimination they faced and how they became members of the Positive Speakers Group. Every network was undertaking anti-stigma advocacy. One example from Balasore concerned an orphan child. The family would not take her in and the local barber refused to shave her hair. After advocacy, she was taken in by the family, sent to school and the barber shaved her head. All the networks shared how they advocated with local authorities regarding availing their members of government pension and housing schemes. Sometimes, they met with the Collector, sometimes they met with key personnel in various government departments. In addition, they provided their members with livelihood support, subject to funds being available. Of course they also educated their members about HIV and AIDS and the importance of OI and ART treatment and adherence and where necessary, the DLNs undertook advocacy with health care institutions where people living with HIV were being denied operation facilities. Some provided legal support for their female members. What was clear that being organised entities, going public as people living with HIV and fighting for their rights had greatly improved the situation for people living with HIV in their Districts of operation.

What was interesting is that it was only through the DLN that issues pertaining to MSM, Sex Workers and Transgender people were raised (by two networks, Bolangir and Gangam). Although the issue of MARPs had been subsumed under geographic programme outreach, very little specific information regarding MARPs within target communities came through in project documentation or discussion or presentation. What this implies is that MARPs are indeed at elevated risk of HIV and a people living with HIV network will attract their membership. This does not mean that project partners don't know who are those most-at-risk in their programme areas, but that they continue to be addressed within the general programme strategy and framework. In one field visit, there was a combined meeting between two groups of young girls in a Bhubaneswar slum. One of these groups was known to the partner to be engaging in high risk behaviour. Because we met in a combined group, it was not possible to engage with on issues pertaining to high risk, except in the most general terms. Risk-tiering linked to more robust behaviour change indicators could have helped the partners to engage in a more focused way with the dynamics of transmission in the context of the lives of the young people at risk. The evaluator would have welcomed more evidence of robust condom uptake through project accounts of the numbers of condoms distributed or bought in project sites.

KRA 1 Routine Monitoring Data[25]		
• 6,854 STI referrals	12,232 attended HIV and AIDS training	• 474 women had an institutional delivery
• 98,202 people attending STI/HIV meetings	• 1,325 pregnant women were tested for HIV	• 3,439 people had a HIV test
• 28,053 attending condom demonstrations	• 46 pregnant women tested positive for HIV	• 3,338 participants know their HIV status

KRA 1 Baseline/Endline Results[26]		
Indicators	**Baseline**	**Endline**
% of respondents who had paid/paying heterosexual partners who used condoms at last sex with one of the said partners	22%	42.5%
% of respondents that have seen a condom demonstration	20%	78%
% of respondents in the past one year that have received messages and support on HIV prevention and care	21%	89%

To what extent was KRA 2 effectively met: *Health care providers and community members have accepting and positive attitudes towards people living with HIV and their families.*

At project start-up, a universal problem for people living with HIV was extremes of stigma within health care facilities and among community members. Stigma within health care facilities inhibited service uptake and the receipt of necessary treatment, care and support. Stigma within the community set-up resulted in painful rejection, isolation and despair. Without exception all the eight DLN presentations from all eight districts identified stigma and discrimination in health care settings and in the communities where they live as a problem they faced in their everyday lives. The principal strategies that the Concern programme used in order to achieve this KRA to address stigma and discrimination at the healthcare level was to work with the government health care system to create an accepting and positive attitude towards PLHIV among government health care providers. At the community level, all implementing partners undertook educational activities and events, and community engagement and interventions to reduce stigma against people living with HIV.

Health care providers: in collaboration with OSACS and INP+, the project undertook Class IV employee training in 18 government hospitals throughout the state. This training programme – *Prathama Sopana* (First Step) – covered the basic facts on HIV transmission and its prevention and stigma and discrimination against PLHIV in health care settings. Prior to 2009, Concern had undertaken sensitisation training with other cadres of health care workers; however Class IV staff had not been reached. Yet, Class IV employees were the frontline workers and the first point of contact for any patient. Among other duties, Class IV staff would be delegated to administer injections to patients, often with universal precautions. Under this project, Concern, INP+ and OSACS

[25] For the complete summary of project monitoring results, see annex 4.
[26] For the complete logical framework results, see Annex 5.

undertook 64 training courses, covering 2,542 staff. OSACS played a proactive role in ensuring the participation of Class IV staff in this *Prathama Sopana* training.
Four months after Class IV staff had undertaken the *Prathama Sopana* training, a participatory and rapid assessment was carried out to assess the impact on participant's behaviour. The assessment found that staff hesitancy to mix and engage with PLHIV had reduced. Training participants shared that they had been very affected by listening to the life stories told by the Positive Speakers. Knowledge about HIV transmission and the protective nature of universal precautions reassured Class IV staff that they would not be infected if they observed the mandatory use of gloves and destroyed used syringes. Participants also mentioned that now they would share the same bathroom as a PLHIV. In discussions with Class IV employees and nurses at the MKCK Medical College, Berhampur, the health staff stated that one of the effects of the training was that "earlier we were scared, now we are not" as they now understand that with universal precautions their chances of getting infected were practically zero. They also mentioned that they now like working with pregnant HIV positive women, providing them with advice and support. Participants greatly valued this in-service training, as up to then, they had only received waste management training. Ironically, for this anti-stigma training, Class IV employees in a number of instances were refused access to the college hospitals training halls, due to their status within the health institution. They, therefore, greatly appreciated it when their training took place in the medical college training hall.

Community Members: Concern partner NGOs and the DLN networks undertook a range of activities under this KRA to create an enabling and supportive environment within the families of people living with HIV and with the communities in which they live. Strategies included broad-based media coverage through radio and TV and through hosting interactive stalls at fairs and cultural festivals and through high profile World AIDS Day and Red Ribbon Express activities. These broad-based approaches were complemented by partners organisations and the DLNs undertaking more focussed approaches at the community level, e.g. family awareness programmes, PLHIV Positive Speakers training, community-based anti-stigma campaigns and Block-level awareness programmes. The DLN networks intervened in local communities when there were specific instances of discrimination occurred. People living with HIV and their allies are now engaging with key District-level stakeholders (the Collector, District Collector, the District AIDS Prevention and Control Unit (DAPCU), Chief District Medical Officer (CDMO) and Block-level entities). INP+ instituted a State-level convention of people living with HIV. This state level convention of people living with HIV in Odisha, the object of which is to promote a HIV stigma-free society, has now become an annual event, jointly hosted by OSACS and INP+.

KRA 2 Routine Monitoring Data

- 1,429 people living with HIV disclosed and discussed their status with family members
- 1,592 people living with HIV disclosed and discussed their HIV status with health care providers
- 19,125 unique individuals were reached through interpersonal communication

KRA 2 Baseline/Endline Results

Indicators	Baseline	Endline
% of people living with HIV respondents reported being subject to negative attitudes and discrimination by health care providers	9	6
% of people living with HIV respondents reported being subject to negative attitudes and discrimination by family and community members	24	16
% of non- people living with HIV respondents in the past one year that have received messages on people living with HIV for reducing stigma	16	91
% of non- people living with HIV respondents felt that they would be	32	27

ashamed if someone in their family got infected with HIV

When the stigma results are broken down by male-female a strong gender streak is evident in the levels of stigma experienced by females living with HIV and this was more impervious to change. For example, the male experience of health care worker stigma was 9.5 percent at baseline and 4 percent at endline in contrast to 8.5 percent of females at baseline and 8 percent at endline. At community level, male experiences of stigma were 14.9 percent at baseline and 12 percent at endline in contrast to 34.7 percent for females at baseline and 20 percent at endline.

There is evidently a need for a better analysis of the gender dimensions of stigma against females and males living with HIV and a real need to develop strategies to counter these.

To what extent was KRA 3 effectively met: *People living with HIV and families live positively and with dignity through livelihood support?*

Many people living with HIV are faced with a sudden loss of income and employment opportunity when they initially fall ill, and this situation results in a loss of morale and contributes to feelings of hopelessness. On a practical level, without income, the nutrition and health care of people living with HIV and their families is severely compromised. To address this real need, the project included a component of livelihood support. This component had two strategies for people living with HIV; to link them to existing government livelihood schemes and to provide direct livelihood support.

In order to help people living with HIV access existing central and state government livelihood schemes, all project partners liaised with relevant stakeholders at district administration levels. These stakeholders included the Chief District Medical Officer (CDMO), the DAPCU the Programme Manager of Women and Child Development, the District Welfare Officer, and the Manager of the National Bank for Agriculture and Rural Development. These stakeholders helped the DLNs to link up with such livelihood support schemes as National Rural Employment Guarantee Act (NREGA) and Swarnajayanti Gram Swarozgar Yojana (SGSY) or the Mission Shakti, managed by the District Welfare Officer. This strategy is very effective, as it is not project dependent, and simply facilitates the levering of existing supports through developing a knowledge base about available schemes and their criteria and providing support to people living with HIV to apply for them.

The second strategy under this KRA, the provision of direct livelihood support has also proved to be very effective. Livelihood support was organised through the provision of individual loans to a person living with HIV to fund an income-generating activity. In 2011, the DLNs took over the sole implementation of this activity and were provided with technical support in how to assess applicant business plans and implementation capacity. Priority was given to the poorest people living with HIV and female-headed households. The amount provided could not exceed 10,000 rupees. All the DLNs followed a careful assessment process; applicants had to be members of the DLN, have bank accounts and demonstrated family back-up for their businesses for times when they travelled for health care or were too ill to work. Applicants were reviewed on a 50 point scale; there were 10 questions, each worth 5 points. Over time, the DLNs have shifted from grant-based to loan-based support. The institution of revolving loan funds (RLFs) was to build in a measure of sustainability into their livelihood support and to maximise the number of beneficiaries. The DLNs were charging an interest rate of 1 percent. Given that India's inflation rate in September 2013 was 6.46 [27] percent, even in a 100 per cent repayment rate scenario, the fund would necessarily deplete over time. Of the beneficiaries who received livelihood support, 73 received one-time grants, and the balance of 508 beneficiaries received loans. The repayment rate by September 2013 was 93 percent.

[27] India Wholesale Price Index, September 2013.

During the field visit, the evaluator met a number of loan recipients, and it was evident that the small input of approximately €120 per beneficiary was extremely effective in supporting them to take care of their basic needs. Participants' source of income included selling bangles and miscellaneous items, making leaf plates, making food items, doing electric wiring, tailoring, and selling foodstuffs. The income earned ranged from 2,000 rupees per month to 10,000. Beneficiaries talked about how they were able to feed themselves and their families, send their children to school and take care of their most basic needs. INP+ shared that in their experience of implementing livelihood support through the DLNs, one key result was an increase in ART adherence and overall healthcare.

KRA 3 Routine Monitoring Data

- The number of people living with HIV network members that are linked to livelihood support : 232

The number of people living with HIV network members that are provided with livelihood support: 581

KRA 3 Baseline/Endline Results

Indicators	Baseline	Endline
% of people living with HIV respondents that spontaneously report four or more principles of positive living	7	13
% of people living with HIV respondents that expressed the benefit of reduced mental depression and despair via association with PLHIV network	94	91

With regard to the reduction in the percentage of PLHIV expressing reduced mental depression and despair from 94 to 91 percent due to their association with a PLHIV network, the following can be observed. While representing an overall reduction in the success of this outcome, it is relatively small and the overall percentage remains very high at 91 percent. However, as the networks expand and attract more members, they are under increasing pressure to provide services and support with the same level of resources. It has also been suggested that the DLN networks, in addition to the very useful advocacy, health, networking, livelihood and support services that they provide could also address the spiritual needs of their members in a more robust way. After all, HIV and AIDS are about life and death, and spirituality is an integral part of this equation.

To what extent was KRA 4 effectively met: *People living with HIV are able to access and receive appropriate and affordable care and treatment (STI, ICTC, OI/TB, ART services) and social security*.

There is no doubt that the successes achieved under this KRA have made a very valuable contribution to the improved welfare, morbidity and mortality of people living with HIV. Through the DLNs and NGO implementing partners, PLHIV had improved access to and uptake of a range of health services and social security schemes. Males and females in targeted communities were educated about STI signs and symptoms and referred to free STI treatment services provided through NACO. Community members were also encouraged to seek treatment for their OI. HIV testing and ART treatment and treatment adherence were promoted. ART patients who were lost to follow-up (LFU) were tracked and as many as possible were counselled and retrieved for consistent ART treatment.

In terms of social support, through the DLNs and implementing partners, people living with HIV were trained on the state government's social security schemes and procedures. Almost 1,000 were linked to social security schemes that included pension salaries, housing schemes and waged employment.

However, by far the most critical success under this KRA initiated by Concern and its partner INP+ was the very successful piloting and establishment of an **ART defaulter tracking system** that succeeded in bring people back to treatment. This system is being adopted by OSACS for replication throughout the State of Odisha.

Among the successes of this lost-to-follow-up (LFU) defaulter tracking initiative that was piloted in Ganjam District were the following:

- Creating an understanding of the **barriers PLHIV experience** in seeking ART treatment and maintaining treatment adherence. These include:

  - At the ICTC centre, the HIV positive patient is not properly assessed regarding their understanding of the importance of ART registration and treatment.
  - Poor coordination between various HIV-related services, for example, between the ICTC and ART centres, the DLN conducting LFU work with only their network members, and the Community Care Centres (CCC) limiting their remit to the clinical areas.
  - Stigma and discrimination by health care providers– while on the decline – continues to be experienced by people living with HIV.

- Developing an effective tracker system for LFU ART defaulters. This worked as follows:

  - As per OSACS directive, the ART monthly defaulter list is shared with Concern, INP+ and implementing partners.
  - A mix of male and female people living with and without HIV Trackers followed up this list with home visits in their geographic Blocks of operation.
  - Trackers then determine if the LFU person lives at home, has died, migrated, or given a false address.
  - With LFU in residence, Tracker/s probe the reasons for non-adherence and counsel the person regarding the negative health consequences of treatment default. A range of 3-7 home visits are conducted to bring the person back to treatment.
  - The LFU person signs a letter confirming the conversation with the Tracker/s. In the case of migration or death, a credible signature is obtained confirming the information pertaining to the LFU, for example, from a Sarpanch (head of Panchayat or local governing body) or Auxiliary Nurse/Midwife (ANM).
  - In monthly District-level ART meetings, home visits and letters are cross-checked with ART data and Trackers' monthly reports. A tally is made regarding the LFUs; dead, migrated, given wrong address, have gone back to treatment elsewhere, retrieved on ART, etc. This monthly report is then shared with OSACS, the DAPCU and other tracking NGOs.

- The DLN networks complement the above system with ART Adherence Meetings which they hold for their members. In these meetings, their members are educated regarding the importance of ART adherence and participation in these meetings has enhanced compliance to ART.

- The Social Security scheme access facilitated by the DLNs also enhanced ART access.

- Over time it was discovered that conducting follow up with ART patients who had only missed one or two ART centre monthly visits was easier and more effective than follow up with more long term defaulters.

- Over time it was also discovered that female defaulters need more intense follow up than males. This was because many of them are illiterate, many are widows and need to be accompanied to the ART Centre as it was culturally inappropriate for them to travel alone, or indeed without the permission of their husbands or family members.

One evident success under this KRA, is that OSACS adopted Concern and Partners' defaulter tracking system and OSACS, the DLNs, NGOs and Hospitals were in an agreed liaison regarding ART tracking. As well, various District Administrative Offices were in active collaboration and helping people living with HIV access a range of available supports.

The project contributed in no small part to increased ART uptake. Through advocacy, joint monitoring visits (OSACS, Concern and partners), facilitated discussions with people living with HIV and their mobilisation through the DLNs and the provision of transport costs to the ART centres, over the life time of the project, there was a large increase in ART uptake from 1,754 to 10,675 and in pre-registration from 4,390 to 20,307. These services were provided by 9 ART Centres, 17 Link Centres and 3 ART Plus Centres compared to 2 at project start up.

Having given due credit to these successes, the consultant found this to be a very crowded results area encompassing STI, ICTC, OI, TB, ART Services and Social Security schemes. It is inevitable, therefore, that some areas would have a stronger emphasis and a greater success than others. However, it was never fully explained why which strategy was chosen to strengthen and promote which service and how some services received considerable inputs and technical support and not others. During the field trip, it was evident that the STI and ICTC Centres visited could have benefited from technical support and strengthening (for example, under-use of the examination couch, lack of confidentiality). From the point of view of HIV prevention, the consultant would have welcomed a greater emphasis on improving the quality of STI service provision.

KRA 4 Routine Monitoring Data

- The number of ART defaulters tracked: 744
- Of these, more than 224 have been brought back to treatment
- The number of persons living with HIV network members who have been linked with social security schemes: 989

KRA 4 Baseline/Endline Results

Indicators	Baseline	Endline
% of people living with HIV that are availing of the Madhu Babu pension scheme	51	55
% of people living with HIV respondents that completed prescribed treatment for opportunistic infections over the past year.	46	45

The relative stability of the percentage of people living with HIV completing prescribed treatment for opportunistic infections reflects the fact highlighted above that certain aspects of this results area received more emphasis than others.

To what extent was KRA 5 effectively met: *Partners are able to design and implement effective and efficient HIV and AIDS programme interventions to reduce HIV infection among programme participants.*

Concern made major investments in strengthening partner organisations technical and managerial capacity to implement this project. Through a range of capacity building strategies, including formal training courses, exposure visits and on-site mentoring and support, Concern has made a substantial contribution to supporting partners to design, manage, monitor and document this programme. To gauge the degree of managerial and technical input, partners received 88 training courses and participated in 10 exposure visits. Project partners learnt a lot through their participation in the Baseline Survey, whereby they had to understand the target groups and indicators and measures of success on the one hand and on the other hand engage with their target communities on the whole

range of HIV-related areas covered in the results framework. In 2010, Concern India hosted the Concern Global HIV technical meetings where representatives from 9 countries participated, and an EU Delhi representative. Key stakeholders from Concerns partners participated in this technical meeting and this – in combination with all the other capacity development supports – contributed to strengthening the ability of the partners to implement the project and deliver results. Finally, in 2012, Concern staff and two partner representatives participated in the International HIV and AIDS Conference in Washington DC. In this conference, participants had the opportunity to present their work in two poster presentations and also to gain exposure to the huge body of knowledge presented at this conference.
To a large extent partners underwent a huge learning curve, simply by "doing". All the partners built their capacity through implementing and learning in an iterative fashion. In addition to the range of capacity development inputs mentioned above, Concern undertook very regular monitoring visits to project sites and provided context-specific advice and support.

Concern has also been very successful in establishing and maintaining good working relationships between its partners and OSACS at the state level, and DAPCU, partners and health authorities at the district levels and has coped quite well with staff and leadership turnover and transfer of government staff and competing demands of these government agencies.

There is no doubt that Concern has made a major contribution to developing partners capacity to undertake extensive HIV and AIDS prevention care and support work and to liaise with government health and administrative services in order to provide health and other supports to mobilised populations. This is evident both from the project results and also from the fact that some of the partners are now also an OSACS partner in the implementation of a migrant TI project (USS). INP+ has successfully strengthened DLNs in 5 Districts and Ruchika, SOVA and USS have been extremely successfully in incorporating HIV into the existing mandate and ongoing work of their NGOs.

Between January 2009 and September 2013, under KRA 5, the following concrete achievements were documented in routine monitoring date:

KRA 5 Routine Monitoring Data

- The number of exposure visits by partners: 10
- The number of thematic and sector-based trainings: 85

KRA 5 Baseline/Endline Results

Indicators	Baseline	Endline
% of respondents that have received outreach services in the past year	27	93

5.3 To what extent the structure and processes in place are appropriate and help achieve desired results. Outline the roles of these structures in the current changing scenario.

Concern has worked through partnership with NGOs, CBOs and GoI institutions with a geo-focused programmatic approach to achieve desired results. The core strategy that Concern employed was to work through INP+, Ruchika, SOVA and USS in targeted areas to mobilise at risk and vulnerable populations in defined geographic locations and to strengthen health services and social supports within those areas in order to maximise service take-up. At state and district levels, Concern and its partners have had a proactive engagement with OSACS and other relevant authorities to improve health care and social services for mobilised communities. Supporting all of this was a strong technical team from Concern, who facilitated regular project meetings and the provision of necessary capacity building support to the implementing partners.

With the closing of the project and the Concern office, the engine of support provided by the project and Concern staff and partners and facilitated by financial support will no doubt be a loss to Odisha State's HIV prevention, care and support services. However, there is no doubt that the project has built the capacity of the partners to implement technically sound HIV prevention, care and support projects. At least one partner, USS, has already accessed support from OSACS to implement a migrant project. It is hoped that the other key partners can also access support from OSACS to work with populations prioritised under such initiatives as the Link Workers Scheme, e.g. vulnerable groups such as women having casual partners, partners/spouses of high risk and vulnerable groups, women in women-headed households, out-of school youth, migrants, truckers and people living with HIV.[28] Otherwise, the partners will need to source funds from donors outside of the state-funding system.

Many project successes are at the system level, e.g. ART defaulter tracking, Class IV Health workers HIV training, DLN links to the ART centres and support for people living with HIV. However, it is also true to say that the high levels of government personnel turnover in OSACS and elsewhere is a challenge. And while Concern was able to be a steadying support to help withstand such turnover during the project duration, this will definitely be a loss to the state going forward.

5.4 How has the programme developed, what was its overall quality and progress, what were successes and promising practices, horizontal and vertical linkages in the partner projects and document lessons learned? What were the key challenges and constraints experienced by the project? To what extent are programme benefits sustainable? Outline priority recommendations.

How has the programme developed?

By the end of the first year of the project, the population denominators were revised to focus on local transport workers, slum and rural-based youth and adolescents and people living with HIV. With the exception of INP+, Concern's project partners – Ruchika, SOVA and USS – were mainstream development organisations and at that time did not have the experience, capability or corporate mandate to work exclusively with MARPs. The project decided to build the capacity of their partners to address HIV and most-at-risk behaviours within their existing geographic areas and/or populations.

The development of the project was influenced by its design structure which has a strong focus on care and support for people living with HIV and the strengthening of health care and services to support this. In terms of the project structure and the relationship between the Specific Objective and the KRAs, while the Specific Objective has a prevention and control focus, one of four programmatic KRAs focus on prevention and three address the care, support and anti-stigma needs of people living with HIV (KRAs 2-4). While these five KRAs definitely support the overall objective: *To respond effectively to the HIV and AIDS epidemic in Orissa; reducing risk and vulnerability to infection and ensuring that people infected and affected by HIV and AIDS have an improved quality of life by the end of 2013* perhaps the Specific Objective would have been better served with KRA 1 being separated to have a stand-alone focus on such strategies as STI referral, treatment and uptake, ICTC mobilisation and uptake, promoting behaviour change strategies, and PPTCT. This could have helped to strengthen the prevention component of the overall project. Another strategy to strengthen the prevention and control component of the project would have been to increase the funding envelope from existing budget allocations; 31 percent of total KRA allocations went to support KRA 1 and 48 percent to support KRAs 2-4.

[28] *NACO Annual Report*, 2011-12.

Odisha State TI coverage was nowhere near saturation point when the project was re-designed. Maybe the project could have brought on board additional partners with some expertise in working with MARPs sub-populations. This could have helped to build the MARPs evidence base and strengthen expertise in the state to prevent and control HIV in MARPs. This could also have contributed to a stronger capacity among the implementing partners as the basic principles of TIs are relevant for addressing HIV prevention and care among any target population or community and better positioned them to access TI and other funds from OSACS with the ending of the project and the closing of the Concern India office.

As the project developed, it became increasingly clear that the capacity of health care providers and institutions to provide quality, non-judgemental services to people living with HIV in Odisha State was limited. As many people living with HIV could not afford private health care, this necessitated a robust engagement of the project with the government health care system. Thus, initiatives to reduce stigma against people living with HIV in health care settings, including pregnant HIV positive women who wanted to deliver their babies institutionally were undertaken. The project also engaged robustly with the strengthening of ART services, including the development of an effective system of tracking defaulters that were LFU. Finally, the project focus on improving the lives of people living with HIV through improved livelihood and income support was a major achievement in project development.

As the project progressed, strategies for community organising ranged from the formation of peer-led youth clubs, adult men or women's groups, to peer-led adolescent groups and the active promotion of Community Based Organisations (CBOs). HIV and AIDS and reproductive health education, risk reduction strategies, and the promotion of HIV prevention and care education and service uptake were promoted as *one* part of the mobilised groups' activities; e.g. organic gardening, jewellery making, savings, hygiene promotion, livelihood promotion, village cleaning, health referrals, etc. This proved to be practical and effective.

What was the overall quality and progress of the project?

The project has provided quality inputs across the board; training, technical support, resource materials, IEC materials were all to a very high standard. The impact of these inputs was evident to the evaluator, everywhere, project stakeholders exhibited knowledge and confidence in discussing issues pertaining to HIV risks and vulnerabilities and what needs to be done to strengthen prevention care and support services in their districts or state. These stakeholders include implementing partner staff from ever level, DLNs, Youth Clubs, Peer Leaders, Women's Groups, Class IV Health Workers, ART staff and defaulters, HIV positive mothers etc.

However, the question of quality is most relevant in the context in which the project work has been carried out. For example, the training of health workers on HIV, stigma and discrimination or the development of an ART defaulter tracking system and its implementation and linking people living with HIV to a range of social service supports have all taken place in a context of limited resources. In this context, the coordination and technical support role played by Concern and its partners was critical and will be missed. In terms of the communities mobilised and organised into self-help groups and/or youth clubs or DLNs, in most cases these entities will continue to need encouragement and support as the project timeframe within which they were formed is relatively short. The DLNs have contributed greatly to the improvement of the self-stigma of its members, and self-organising for pensions, livelihood supports, ART and other health care. But to a large extent, the members come from poor and vulnerable communities and they will continue to need ongoing capacity building and support. Finally, the project's direct support to the RLFs designed to help people living with HIV have been quite well run, but the – legitimate - principle of soft loans

means that there will be an ongoing need to augment these funds even in a best case scenario of 100 percent loan repayments.

What were its successes and promising practices?

It is evident that Concern and its partners were very successful in mobilising their target communities and achieving the goals set by the project. Promising practices included the following:

- Combining community mobilisation, HIV education and referrals with practical inputs and support. Communities were mobilised, educated, organised and empowered. IEC materials were developed, Behaviour Change Communications (BCC) was carried out, condom demonstrations took place and STI, ICTC, PPTC and ART referrals were made. Combining these activities with practical support such as Organic Gardening, Jewellery Making Training, hygiene, village and slum cleaning operations and reproductive health training was a promising practice.
- ART defaulter tracking through home-visits carried out by a mix male and female people living with HIV and people not living with HIV.
- Supporting ART adherence through linking ART patients to their local DLN, who in turn promoted ART adherence through training and support meetings.
- Targeting Class IV Health care workers for HIV and anti-stigma education.
- Developing a Positive Speakers roster and engaging with stigma and discrimination from the point of view of the lived experiences of people living with HIV. Providing people living with HIV with education about and links to a whole range of existing government support schemes.
- Ensuring that Class IV health worker training, LFU defaulter tracking and the Annual State Conference of people living with HIV were sanctioned by OSACS and integrated into their systems.

What were the horizontal and vertical linkages?

Throughout the duration of the project, Concern has had an active and supportive collaboration with OSACS and the various services under it. This engagement with the main umbrella body in the state tasked with HIV prevention, care and support worked to promote coherence between the project and state-level indicators, the carrying out of state-wide HIV training for Class IV health care providers, strengthening referral mechanisms between the ART Centres and the DLNs and a strong mechanism for LFU tracking.

At the District level, having credible, organised and supportive entities (NGOs and DLNs) facilitated the accessing of better health care and social services support for mobilised communities in the geographic areas of focus. The implementing partners and DLNs were well-networked with the DAPCU. The partners' participation in the monthly coordination of the CDMO greatly facilitated information sharing, coordination and service strengthening. Importantly, all partners have been successful in leveraging existing state resources to support people living with HIV from livelihood and housing support schemes and pensions. This required an active collaboration between the NGOs, INP+ and the District Administrations. The referral system between the ART centres and the DLNs has greatly enhanced the health seeking behaviour of people living with HIV through improved OI treatment and ART compliance. To this end there was active collaboration between Concern, the ART Centres, the DLNs/NGOs and OSACS.

What were the lessons learned?

- **Collaboration between governmental and non-governmental stakeholders possible in order to improve services delivery**. With a technically sound, facilitative, organised and

credible state and district-level presence, such as that represented by the project and its partners, government service providers will collaborate in the betterment of services for people living with HIV, e.g. training for Class IV health care providers, ART defaulter tracking, or accessing pension and livelihood schemes. Such initiatives can influence government policy and practice and can be integrated into the government programme, ensuring their sustainability beyond the lifetime of the project.

- **The formation of District-level networks of people living with HIV is very effective in providing support to people living with HIV**. Such support includes validation, training, service referrals and linkages, and addressing community-level stigma. Simply having an organised presence of people living with HIV to represent their interests and to engage directly with service providers is very powerful as well as encouraging more broad-based HIV testing, disclosure and treatment. In addition, building a positive speakers forum proved very effective in training designed to address stigma and discrimination against people living with HIV as training participants heard real life stories from real people. People living with HIV who start to play public roles personalise and humanise HIV and challenge the ease with which people feel free to devalue them. The way in which the training of Class IV health care providers was carried out with collaboration between OSACS and INP+ represents the active implementation of the Greater Involvement of People Living with HIV (GIPA) principle as members of the Positive Speakers Group participated in all of these trainings.

- **In mainstream development organisations, it is possible to undertake the mobilisation of underserved and under-reached vulnerable communities for HIV prevention, care and support.** This is most effective when combined with other practical supports such as organic gardening, community libraries, youth club formation, etc.

- **Stigma and discrimination against people living with HIV is tenacious and widespread and requires sustained and tenacious and iterative awareness raising and training**. As part of their Learning Documentation Series 3, *Class IV Employee in the Health System: Lessons from HIV and AIDS Sensitisation Activity in Orissa, India*, Concern captured the lessons learned from this excellent initiative. Among the key recommendations in this document is that "capacity building and sensitisation of Class IV employees form a part of the total awareness programme for health care institutions and that OSACS allocate resources to replicate this process in uncovered districts and not limited to District headquarter hospitals". This recommendation still stands. To this, the evaluator would add that this *Prothama Sopana* training should be carried out as a matter of routine, as a minimum in all district hospitals for Class IV at least once every two years.

- **It is possible to improve PPTCT and ART services in such a way that fewer babies contract HIV and the mortality of people living with HIV is extended**. It is difficult to overemphasise the importance or contribution of this lesson learned.

- **The strategy of linking people living with HIV to existing livelihood support schemes is a very strong and commendable one and has a built-in sustainability**, given that the project acted as a facilitator and lever of funds as opposed to being the provider of funds. However, provision of soft loans to support income-generation initiatives of people living with HIV is also an excellent strategy given the extensive social benefits to loan participants. The most prominent social benefit was an improvement in people's quality of life in terms of participants being able to take care of their food, health and educational needs. The strategy of working through the DLNs was a good one, as they were well-placed to assess programme participants and to conduct home visits and business visits where necessary.

- **Gender inequalities greatly affect male and female risks and vulnerabilities in a number of ways**:
  Female risks and vulnerabilities are both biological and social.

- Added risk of HIV infection through adolescent girls' biological vulnerability to HIV infection and their sexual debut in adolescent years with older sexual partners.
- Added risk of HIV through early marriage to older and more sexually experienced spouses.
- Higher levels of illiteracy and lower levels of knowledge about HIV/STI transmission.
- The inability of wives to negotiate safer sex with their –sometimes risk-taking – husbands.
- Higher levels of stigma in health care, family and community settings when diagnosed with HIV.
- High levels of vulnerability to spousal and in-law abuse/abandonment when diagnosed with HIV.
- Barriers in access to ART and other services due to cultural norms regarding the need to have the husbands or family permission to travel, the need to be accompanied and also through lack of resources for travel and accommodation.

Male risks and vulnerabilities on the other hand, are more connected to them being considered the "head of the household" and being expected to earn income to support their families, as mobile transport workers or migrants.

What were the key challenges and constraints experienced by the project?

Among the challenges experienced by the project was the generally low capacity in Odisha State and limited HIV services provision in both governmental and non-governmental entities at project start-up. This is not uncommon in low HIV prevalence environments as support for populations at risk of HIV and PLHIV emerge and strengthen in response to increasing demand for a range of – heretofore – unavailable and unneeded services. From the point of view of Concern India, this meant that a huge effort was required to build the capacity of key stakeholders at State and District levels to provide HIV prevention and support services. This included Concern implementing partners who – with the exception of INP+, were general development organisations. Thus, the building of stakeholder capacity in order to expand HIV and AIDS services in Odisha State was a major and inevitable focus of the project. This takes time and realistically speaking, the project really needed a second phase in order to build on and optimise the capacities built within this project's timeframe. However, the net result is that by EOP across the project areas of focus, there are now NGOs and government services that are now capable of providing HIV prevention, care and support services.

Linked to the low capacity is the fact that the project was constrained by a weak evidence base at project start up. OSACS surveillance and epidemiological capacity was modest and there was insufficient mapping and assessing of HIV-related risks and vulnerabilities across the state. MARPs data was sparse and there was a limited understanding regarding the numbers and needs of males and females living with HIV. In such a context, it is very difficult to know what services are needed and for whom. Concern India, therefore, first had to establish a project baseline for target communities and this took time.

Another key challenge was the fact that there was a high turnover of OSACS staff, including the Project Director. This meant that the pace of implementation was slowed down as the project awaiting for key officials to be in place in order for important decisions to be jointly agreed regarding services development, implementation and roll-out. The reality was that OSACS was constrained by such high staff turnover and actually needed technical and capacity building support.

As already discussed, the project faced certain constraints as a result of the re-design at the end of year one. HIV prevention and care were unbalanced in the project re-design. Only 1 KRA out of 5 focused on HIV prevention compared to 3 KRAs focusing on care and support. The net result of this was that KR1 was overcrowded. As well, 31 percent of total KRA allocations went to support KRA 1 and 48 percent to support KRAs 2-4. In addition, the shift of primary focus from addressing

HIV risk among HRGs to HIV risk among marginalized rural and urban populations (e.g. slum dwellers and tribal communities) represented a design constraint as there continued to be a need to reach HRGs and bridge populations in the project areas of focus and therefore, HIV prevention results were not optimised.

To what extent are the programme benefits sustainable?

The geo-focused programme model adopted by the project has fostered the very best chance of the continuity of project benefits to target communities. In district and urban centres of concentration, the level of horizontal and vertical linkages fostered by the project has built a strong programme architecture, with backwards and forward linkages and referrals, and GOI and NGO committee structures that can continue beyond the life of the project. For example, the referral of ART patients to their local DLN network for on-going support or the partners' participation in the monthly CDMO meetings. Communities are now well versed in existing health and other available services and can continue to access these independent of any project.

The strategy of linking target communities and programme beneficiaries with existing pension and livelihood schemes has built-in sustainability as these schemes have government and other funding. In addition, the project shift from grant-based to loan based livelihood support funds by INP+ built in a measure of sustainability into such loan provision. However, there is no doubt that the existence of the DLNs and partner NGOs on the ground with offices and staff has been critical to the success of these referral and loan strategies. Their continued presence on the ground would be very important to the on-going linking of community members to existing schemes and benefits.

The adoption of the ART defaulter tracking system by OSACS is the best possible assurance of the sustainability of ART service provision in projects sites and beyond in Odisha. It will be very important going forward that OSACS provides sufficient funding for the Trackers who can continue to conduct follow-up with ART patients who have missed their monthly ART visits.

The mainstreaming of HIV and AIDS within project partners and the enhanced capacity of project partners and the DLN networks will continue to support HIV and AIDS programming in Odisha State. USS, for example, is now an OSACS partner and implementing a TI programme with migrants. All project partners now have the capacity to partner with OSACS in implementing HIV prevention and care projects. At the District Level, a viable presence now exists in 13 districts through the DLN networks.

The successful Class IV employee training that was implemented in partnership between OSACS, Concern and partners has built the capacity of key stakeholders to support such training. If OSACS adopts this training as part of their ongoing training commitments in the state, its sustainability will be more assured.

5.5 Report on the consolidated changes from the baseline to the endline and disaggregated by groups, sex.

Global changes from baseline to endline have been included in the body of this evaluation report. The changes in State and District level seroprevalence between 2008 and 2010 are relatively small. According to revised estimates, state level seroprevalence was 0.46 percent in 2008 and 0.43 percent in 2010. District level data is a mixture of small increases and decreases. For example, Ganjam District was 1.25 percent in 2008 and 1 percent in 2010 and Balasore was 0.5 percent in 2008 and 0.75 percent in 2010. At State level, the overall change was down, but it is too short a time period to determine if this is an overall trend. In 2008 HIV in HRGs was as follows, STI patients; 1.5 percent, IDU; 7.3 percent, MSM; 7.2 percent and sex workers; 0.8 percent. Published surveillance data for

2010-11 shows that HIV among HRGs was as follows, STI patients 1.6 percent, IDU, 7.16 percent, MSM; 3.79 percent and sex workers; 2.07 percent.[29] More data is needed to determine the overall trend in HIV in HRGs. As the overall trend is difficult to assess, it is therefore, at the level of the baseline-endline data for project target groups that an assessment can be made with regard to the performance of the project.

The percentage of females across all sites who had seen a condom demonstration at project baseline was very low; only 2.8 percent of rural and urban female youth and 3.1 percent of female adolescents. By the project endline this had changed to 68 percent of urban female youth, 99 percent of rural females and 81 percent of female adolescents. Males who had seen a condom demonstration at project baseline was also quite low; 3.1 per cent of urban male youth, 21.6 percent of rural male youth and 4.4 percent of male adolescents. By the project endline, this had changed to 65 percent of urban male youth, 98 percent of rural male youth and 62 percent of male adolescents. At baseline, 13.4 percent of local transport workers had seen a condom demonstration and this had increased to 62 percent at endline.

For respondents who had received messages and support on HIV prevention and care, at baseline the figures were low for both males and females; 30.2 percent of urban females, 8.1 percent of rural females and 14.7 percent of female adolescents reported receiving HIV prevention and care messages and support. By the project endline this had changed to 85 percent of urban female youth, 99 percent of rural female youth and 98 percent of female adolescents. Male respondents reported the following; 15.3 percent of urban male youth, 34.4 percent of rural male youth and 12.2 percent of male adolescents had received information and support. By the project endline, this had changed to 69 percent of urban male youth, 97 percent of rural male youth and 95 percent of male adolescents. On this indicator, local transport workers were 34.2 percent at baseline and 84 percent at endline.

With regard to stigma, the evaluator noted earlier that stigma against HIV positive females was more intense and persistent than stigma against males and the baseline-endline data confirms this. With regard to people living with HIV reporting being subject to negative attitudes and discrimination by health care providers, at baseline 9.5 per cent of male respondents reported discrimination and 8.5 percent of females. Endline data found that while only 4 percent of males reported experiences of discrimination, this figure was 8 percent for females. With regard to family and community discrimination, at baseline 14.9 of males and 34.7 percent of females reported being subject to negative attitudes and at endline, this had changed to 12 percent for males and 20 percent for females.

At project baseline, while fewer females had received positive messages to reduce stigma (a low of 0.8 to a high of 10.8 percent) by the project endline, both male and female target groups had very high coverage, ranging from a low of 82 percent (urban male youth) to a high of 98 percent (female adolescents).

With regard to people with HIV living positively and with dignity, a modest improvement was observed in respondents that could spontaneously report four or more principles of positive living; at baseline 6.0 percent of males and 8.5 percent of females and at project endline this had changed to 14 percent of males and 12 percent of females.

Concerning the extent to which the partners' were able to design and implement effective HIV and AIDS programme interventions, at project baseline, outreach to the various target populations ranged from 12.7 percent to 42.1 percent. By the project endline, this had changed to an 82 to 98 percent range, with five target groups reporting a more than 90 percent reach.

[29] NACO, *HIV Surveillance 2010-11, a Technical Brief*. 2011

5.6 Review the equality and HIV mainstreaming strategies being implemented by partners in their ongoing projects and in their other organisational programmes.

The HIV mainstreaming strategy adopted by the project was for one of the implementing partners to act as the mainstreaming "lead". Accordingly, USS developed and adopted a strong HIV mainstreaming model to support both the institutional and programmatic mainstreaming of HIV. At the institutional level, as a matter of routine, all USS staff undertakes HIV training, particularly with regard to stigma and discrimination. In addition, the USS governing board is sensitised with regard to HIV issue. USS also hired 13 people living with HIV (7 females and 6 males) to work on their programme and integrated them into the staff structure. When hired, USS personnel receive a letter of appointment that underscores that USS is a HIV stigma free work place, and this is also included in their work place policy. The USS leave policy has been adjusted to include the principle that people living with HIV are respected and have the right to work. Specific support includes special leave for illness and time off for regular CD4 tests and pension support. USS also has a sexual harassment policy to protect the interests of women and girls, and a humanitarian accountability policy within which HIV is integrated. USS has also taken steps to mainstream HIV in their other programme initiatives. Thus, all programmes address HIV through training and integration strategies and HIV is integrated into the training materials for all their initiatives. USS also undertakes training with other NGOs, CBOs and educational institutions. In addition, they provide IEC materials to external agencies as and when needed. One of the unintended outcomes for USS of their participation in this project was that they have become recognised for their HIV and AIDS expertise. In this regard, OSACS has partnered with them in undertaking a TI working with migrants.

With regard to the other partners, SOVA has hired HIV positive people and provided lot of support in strengthening the PLHIV network in Koraput. Simultaneously they have also trained all their organisational staff on HIV and AIDS, gender and sex and sexuality. They also ensure that HIV is included in the training of other project staff and they promote inter-linkages within their projects for better HIV-related outcomes. Ruchika has trained all their organisation staff on HIV and AIDS. Many of the organisational staff are provided with hands-on support to continue to integrate HIV and other practical initiatives with adolescent groups and women's groups. INP+ being a national network of people living with HIV, the focus has remained on ensuring appropriate support and services for both HIV positive and negative staff and the implementation of GIPA principles in all aspects of their internal and external work. Their training programmes include gender, sex sexuality, HIV and other empowering approaches.

5.7 Review the collaborative efforts undertaken with the Odisha State AIDS Control Society (OSACS) and the contribution of the programme in meeting the state indicators (as per NACP III) and EU NSA objectives.[30]

Collaboration between the project and OSACS contributed to the following achievements:

- Coherence between NACP III and OSACS state-level indicators, as reflected in the project results framework.
- Support for Concern and INP+ in undertaking Class IV health care worker training to address stigma and discrimination in district hospitals throughout the state.

[30] Increasing access to services, strengthening capacities of community-based organisations among populations at high risk of HIV and infected and target interventions for populations out of reach of the mainstream services. Reference – Objectives of the Programme and Priority Issues under the Call for Proposals.

- A request to Concern to conduct health care worker stigma and discrimination training for health care workers following a patient-based opinion poll in 8 district-level hospitals.
- The strengthening of the referral mechanism between the ART Centres and the DLNs.
- The development and institutionalisation of a state-level ART LFU tracking system.
- The concrete tracking of the backlog of LFU ART defaulters in Cuttack ART Centre.
- The development and dissemination of Posters for Positive Living and Prevention Messages.

The contribution of the programme in meeting state indicators and the EU NSA Objectives:

This programme has made an enormous contribution to meeting both the EU NSA objectives and the state indicators as per NACP III. First of all, there has been a huge increase in access to prevention, care and support services. To achieve this, the project mobilised populations that had been heretofore out of reach of mainstream services, organised them into peer-led community based organisations and built their capacity to organise organisational and self-help capacity. As well, district level networks of people living with HIV were either strengthened or established and they, in turn, undertook a range of advocacy and support services for their members. In order to ensure responsible service referrals, the project also undertook the strengthening of crucial HIV prevention, care and support services for mobilised populations in their geographic areas of concentration. This included the fostering of stigma free health care facilities, the strengthening of linkages between ICTC, PPTC, ART treatment and follow-up as well as links to DLN networks and existing livelihood and pension schemes.

The contribution of the project in meeting state indicators was very strong in the category, "Interventions for Vulnerable Populations" and can be gauged from the fact that the project succeeded in reaching hundreds of vulnerable women across all project sites and by August 2013, 68 percent of urban and 99 percent of rural females had seen a condom demonstration and a full 86 percent of urban and 99 percent of rural females had received HIV prevention care and support messaged. Concerning the many hundreds of youth mobilised by the project, 83 percent of male youth and 92 percent of female youth were reached with HIV prevention, care and support education and service referrals. A full 98,202 general community members received HIV prevention, care and support messages.

With regard to the package of services for PPTCT indicators, the project's contribution is also strong. The number of HIV positive pregnant women in Odisha on ART increased from 290 in 2008 to 1,472 by August 2013. Additionally, over the duration of the project, 1,325 pregnant women were tested for HIV and 473 HIV positive pregnant women had institutional deliveries.

Considering out-of-school youth, while the project data does not disaggregate between in and out of school youth, 95 percent of adolescent males and 98 percent of adolescent females were reached (many of these are out of school) with HIV prevention, care and support education.

Concerning media coverage, the project – at both state and district levels – has achieved widespread media coverage through television programmes, radio shows, print media and annual high profile World AIDS Day events.

The project also made a substantial contribution to the increased number of people living with HIV on ART services. By December 2008 in Odisha, through 2 ART centres, 4,390 people were pre-registered for ART and 1,754 were on ART. By August 2013, this had increased to 9 ART Centres and 21 Link Centres, through which 20,307 people were pre-ART and 10,675 were on ART. By August there were 14 DLN networks in Odisha State. Social security services for people living with

HIV increased across the board; 232 were linked to livelihood schemes, 451 were provided with direct livelihood support and 989 were linked with social security schemes.

5.8 To reflect on the recommendations of the mid-term review and the ROM visit and how well they have been incorporated into the present programme.

The recommendations of the mid-term review and the ROM visit are to a large extent incorporated into the programme. The community programme witnessed an expansion of the Go Organic programme to other sites and the self-organising of the mobilised communities was strengthened. During the field visit, the evaluator had the opportunity to witness this first hand when meeting a women's group in Cuttack who had developed organic gardens all over their slum and in Bhubaneswar, both the women and men's group visited were self-sustaining and viable. The women's group's activities were effectively independent, including their organic gardens and the men's group was just about to start their own gym in the slum where they lived. Both groups met on a regular basis and Ruchika's role was quite hands-off at this point in time. All eight DLNs were registered or in the process of registering.

The mid-term review recommendation to map and assess risks and vulnerabilities among the people they work with and to track changing trends in HIV risk practices and emerging pockets of risk was not so systematically attended to and so the work with the more at risk members of target populations took place at the informal levels. Certainly, risk tiering and a more intensified strategy for engaging with those males and females most at risk was not formally reported in project reports and documentation. The project data continued to address general population denominators (e.g. adolescent girls, young men) and the terms "more at risk" or "most at risk" were not applied. The recommendation to engage in such methodologies as *Community Conversation* was not adopted within project sites. In the opinion of the evaluator, the timeframe was too short post mid-term review to train and implement such a human resource intensive strategy. However, the evaluator concurs that a methodology such as *Community Conversation* or *Stepping Stones* would have been extremely effective in engaging with target communities across all project sites.

Concern, INP+ and partners engaged in a robust way with OSACS with regard to health-related stigma reduction and have recently undertaken advocacy with OSACS regarding the promotion of "stigma free" health facilities. As well, the project undertook a health care facility survey regarding stigma and discrimination and undertook general health worker anti-stigma training in eight districts. The "stigma free" health facility advocacy is ongoing and will continue to be taken up by INP+. With regard to recommendation that Concern and partners continued to advocate for livelihood and pension support for people living with HIV, linking people living with HIV with livelihood and pension support schemes is an integral part of the work of the DLNs. This will continue to be supported by INP+.

The mid-term reviews recommendation for an integrated strategy at the District-level was taken seriously by the project and strengthened post-review. This has been reported on earlier in the evaluation document. It is likely that the monthly DAPCU meetings will continue to be attended by project partners and the DLNs in the districts of concentration.

In response to the ROM monitoring report, the project was extremely successful in developing an ART defaulter tracking system as per the reports recommendation. The project was also extremely successful in integrating baseline data to appraise the achievement and trend of the objectively verifiable indicators OVIs in key reports. Finally, the project was also successful in selecting one operational district (Ganjam) in order to develop a model to strengthen coordination among key stakeholders. The recommended systematic quality improvement (SQI) approach was first developed with regard to ART defaulter tracking and then broadened to include other Districts in the state.

6.0 Priority Recommendations

1. **Project partners – Ruchika, SOVA and USS** should build on their enhanced capacities in geo-focused programming in HIV prevention and care and seek funding to continue and expand the work started under this project. Funding could be sought to support target populations that are a priority of NACO; vulnerable populations such as youth, female-headed households or people living with HIV, bridge populations such as mobile transport workers and migrants and MARPs (SWs, MSM, IDU). This funding can be sought from OSACS or other donors.
2. **Project partner – INP+** should make every effort to ensure continued support for their DLN network members in Odisha State. The rights of people living with HIV can best be protected by organised entities of people living with HIV being supported to advocate for their rights and necessary services. In order to sustain the benefits of the horizontal linkages between the DLNs and government services (ART coherence, livelihood and pension schemes) in Odisha at state level, the DLNs will need ongoing financial support. Fighting stigma and discrimination against people living with HIV is crucial and given the intractability of such stigma at health care and community levels it is very important that people living with HIV have organised capacity to address such stigma.
3. **INP+ should promote positive prevention.** Understandably, a major focus of the work of INP+ and the DLN networks has been on fighting stigma and discrimination, advocating for health care services for their members and facilitating livelihood support. Going forward, in addition to these care and support functions, INP+ should also focus more intensively on the promotion of HIV prevention among their members.
4. **OSACS should provide the necessary support to sustain ART defaulter tracking.** OSACS should ensure that there is a sufficient government investment in ART defaulter tracking and provide support for personnel to fulfil the tracker function. As well, OSACS should provide sufficient support to the DLN networks to enable their role in supporting ART compliance.
5. **OSACS should adopt Level IV Health Care Worker HIV Training.** OSACS should integrate Level IV Health Care Worker Training into its ongoing health care training programme. Given the turnover of health care personnel, the degree of stigma experienced by people living with HIV, the dearth of training provided to Level IV workers and the success of this training it is very important that it continue.
6. **The gender dimensions of HIV should be described, analysed and responded to.** There are evident gender-related risks and vulnerabilities that enhance both female and male risk and these are not being addressed. Among females, these result in the higher levels of infection in adolescent girls, the participation of females in survival sex, intense stigma against females living with HIV and additional financial and social difficulties in accessing services. Among males, the breadwinner role and the greater tolerance of risk behaviour (multiple sex partners, alcohol and drug abuse) puts them at additional risk. Such gender risks and vulnerabilities should be included in state policies, programmes and budgets.
7. **The EU should continue to support HIV prevention, care and support in Odisha State.** The excellent results achieved through this project need to be consolidated and expanded. For HIV and AIDS work, five years is a relatively short time frame. In many areas, the project is poised to be even more effective and the state does not yet have the capacity to facilitate all that is required. Stigma against people living with HIV continues to be intense, the gender dimensions of risk and vulnerability need to be addressed, work with migrants and mobile transport workers is not yet comprehensive and health care facilities and programmes continue to need support. Perhaps most importantly, the key role played by the DLN networks stands to

be one of the greatest losses to the state if they cannot continue. Many of them are now registered in their own right and they can be support through a range of mechanisms. Overall, the fact that Concern Worldwide is closing offices in Odisha does not mean that the work of the project cannot continue, as the project partners are still there and there are a number of credible international NGOs that could take over the Concern role.

7.0 Conclusion

This project has made a major contribution to HIV prevention, care and support in Odisha State. This is evidenced by the large numbers of institutions and communities mobilised and capacitated to improve HIV prevention, care and support. At project start-up, people living with HIV had minimal supports and struggled with intense stigma, limited services and increased impoverishment.

Through the project and the strengthening of the DLN networks, people living with HIV gained access to increased ART and PPTC services, were linked to pension and livelihood schemes and were participated actively in fighting stigma and discrimination across the state.

The project also contributed to building the capacity of NGOs and health care institutions to work together in the provision of HIV prevention, care and support services. Large numbers of heretofore vulnerable community members were mobilised, organised, educated and referred to health care services that in turn, were strengthened by the project.

The brunt of stigma and discrimination against people living with HIV was addressed at both community and health care levels. This is no small part contributed to the reduced morbidity and mortality of people living with HIV.

Sustainability was addressed through OSACS adopting the ART defaulter tracking strategy and system developed by the project, linking people living with HIV with existing livelihood and pension schemes, and the mainstreaming of HIV in partner NGOs.

The project also contributed to strengthening the evidence base in Odisha state through the baseline and endline data that measured HIV knowledge, risk behaviour and experiences of stigma among heretofore unmobilised communities.

Annex 1: Terms of Reference

Terms of Reference

Final Evaluation EU Programme "Strengthening local responses to HIV and AIDS in Orissa, India"

Organization

Concern Worldwide has been working in India since 1999, providing support to local organizations to implement relief, rehabilitation and development work. Concern Worldwide established its Liaison Office in India with an approval of the Reserve Bank of India in January 2002. The country office is in Bhubaneswar, Odisha, which is the priority state for Concern's long term development work in India. Concern's long term programme focused around three core sectors: Governance and Livelihoods, HIV and AIDS and Emergencies.

Programme Background

The estimated HIV prevalence in the general population in Odisha is low and has remained stable over time.[31] However, as in other parts of India, HIV prevalence among key populations[32]—sex workers, men who have sex with men (MSM), transgender people, and people who inject drugs—is believed to be much higher. As much of the key populations in the state remain hidden, the exact extent of HIV epidemic among them is still largely undefined, and other than in some pockets in larger cities, they are largely unreached by HIV and other services. Odisha is a major source of migrant labour, with large numbers of men, and women, migrating seasonally to other parts of India. In addition to key populations, this migrant population also is believed to be at an increased risk of HIV, and the National AIDS Control Organisation (NACO) estimates that they represent a large proportion of people living with HIV (PLHIV) in the state.[33]

Extreme poverty, inequity, and lack of basic service infrastructures in many parts of the state exacerbate the vulnerability of key populations and PLHIV and compromise their access to essential health services, including HIV prevention, treatment, and care services. Inadequate manpower in some Integrated Counselling and Testing Centres (ICTCs) for HIV, lack of adequate Anti Retroviral Therapy (ART) facilities and withdrawal of care and support centres remain major challenges in the HIV response in Odisha.

Concern was awarded support from the EU under its Call for proposals - India - Non-State Actors and Local Authorities in Development - Action in Partner Countries. The Concern proposal had its main focus on one of the priority sectors – health.

The overarching objective of the (Brussels-based) EU Civil Society programme is poverty reduction in the context of sustainable development, including the pursuit of the Millennium Development Goals (MDG) and other internationally agreed targets.

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[31] The sentinel surveillance data shows over the last three years HIV prevalence in Odisha has remained stable at 0.22%. Orissa State AIDS Control Society, May 2013.

[32] UNAIDS defines key populations as people who are most likely to be exposed to HIV or to transmit it, and whose engagement is critical to a successful HIV response. That is, they are 'key' both to the HIV epidemic dynamics in a specific context and to the response. UNAIDS Terminology Guidelines 2011

[33] Technical Brief, HIV Sentinel Surveillance and HIV Estimates 2007, National AIDS Control Organisation (NACO).

It is an "actor-oriented" programme aimed at strengthening the capacity of civil society organisations and local authorities as a pre-condition for a more equitable, open and democratic society through support to their "own initiatives".
The programme therefore supports actions aimed at promoting an inclusive and empowered society in partner countries and its specific objectives are:

- benefit populations out of reach of mainstream services and resources and excluded from policy making processes;
- strengthen the capacity of civil society organisations and local authorities in partner countries, with a view to facilitating their participation in defining sustainable development strategies and in implementing actions aiming at poverty reduction ;
- facilitate interaction between State and Non-State Actors in different contexts and support an increased role for local authorities in decentralisation processes.

The general objective of the India NSA health component is to:

(i) increase access to and use of prevention of mother-to-child HIV transmission services;
(ii) contribute to strengthening capacities of community-based organisations (CBOs) among populations at high risk of HIV infection, and
(iii) target interventions in the health sector for population out of reach of the mainstream services. [for HIV and AIDS interventions, this is to be achieved within the framework of the National AIDS Control Programme (NACPIII).

Performance Indicators of the supported programme are to be selected from the existing NACPIII Indicators3.

Concern Worldwide commenced a five year HIV and AIDS programme from 2009 with the support of EU funding. The programme based in Odisha state has worked to strengthen local responses to the HIV and AIDS pandemic which has been achieved through working with the implementing partners (local organisations) with strong roots in the communities they work with. The target groups include; Youth – rural and tribal youth, college students and young professionals and slum and street adolescents; Mobile populations such as mini truck and long distance taxi drivers, auto/taxi drivers and coolies; High risk and Highly vulnerable groups – sex workers, IDUs, MSMs, women, slum communities and People Living with HIV.

Programme goal, result areas and outreach: The overall objective of this programme is to respond effectively to HIV and AIDS epidemic in Orissa; reducing risk and vulnerability to infection and ensuring that people infected and affected by HIV and AIDS have an improved quality of life by end of 2013.

The *key result areas (KRAs)* identified for the programme are:

- KRA 1 – Communities have increased knowledge and capacity to take up HIV testing and prevention services in the targeted districts.
- KRA 2 – Health care providers and community members have accepting and positive attitude towards PLHIV and their families.
- KRA 3 – PLHIV and their families have improved livelihood security and live positively and with dignity.
- KRA 4 – PLHIV are able to access and receive appropriate and affordable care and treatment (sexually transmitted infections, opportunistic infections, tuberculosis, anti-retroviral therapy and integrated testing and counselling services) and social security schemes.
- KRA 5 – Partners are able to design and implement effective and efficient HIV and AIDS programme interventions to reduce HIV infections among the programme participants.

Concern started implementing the EU supported programme in 2009 in eight districts of Odishin partnership with the four local implementing organisations As outlined in the table below:

Partners	Operational area	Programme participants
INP+	Ganjam, Khurda, Bolangir, Balasore & Angul districts	PLHIV
Ruchika	Bhubaneswar city	Urban slum and street dwelling adolescents, youth, and auto drivers
SOVA	Koraput district	Rural tribal adolescents and youth, rural women, auto and taxi drivers, and PLHIV
USS	Cuttack city	Urban slum adolescents and youth
	Cuttack & Bhadrak districts	PLHIV

Programme participants	Operational definition
Local Transport Workers (LTW)	Men, aged 18 and above, who drive autos, taxis, or small trucks, or plies paddle rickshaws in Bhubaneswar, and selected urban areas of Koraput district.
Youth	Women and men, aged between 20 and 34 years, living in selected urban slums areas of Cuttack and Bhubaneswar or in selected rural areas of Koraput district.
Adolescent	Girls and boys, aged between 13 and 19 years, living in selected urban slums areas of Cuttack and Bhubaneswar or in selected rural areas of Koraput district.
People Living with HIV (PLHIV)	Women and men, aged 18 and above, who know their HIV positive status and are members of district level networks (DLNs) of PLHIV. Some DLNs include self-identified key populations living with HIV, such as MSM and people who use drugs.

Intervention sites
Extensive programme activities focussed in
18 LTW associations in Bhubaneswar and Koraput 34 slums in Bhubaneswar and Cuttack 52 focussed villages in Koraput district 8 DLNs of PLHIVs in eight districts
Some programme activities implemented in
15 additional slums in Bhubaneswar and 187 villages in four blocks of Koraput

The programme outreaches annually to a total of 49,047 people including 10,413 adolescents, 2,618 local transport workers, 22,453 youth, 1,896 PLHIV and 11,667 external stakeholders and slum communities.

Working with local implementing partners, the programme seeks to achieve the above KRAs by focusing activities and efforts on the following strategies:

- Promoting accessible and culturally appropriate programmes that address the multiple needs of young people both rural and urban youth and adolescents.
- Implementing prevention programmes with a holistic approach that promote safer behaviours as well as builds life skills e.g. safer sex negotiation, personal hygiene, provide service linkages with existing providers on income generation, small savings, health and other developmental issues.
- Support initiatives like sensitizing health care providers, ART LFU tracking, organizing state level PLHIV meet towards improved coordination and networking, specifically building greater collaboration with the government agency.

- Linking those who are infected as well as those affected with the virus to appropriate service providers including health care providers, nutritional support agencies, vocational training institutions, legal service sector and others.
- Providing direct livelihood support to PLHIV and their families and supporting them in establishing linkages with other agencies and institutions.
- Condom Promotion remains a key strategy in the prevention of the spread of the virus. Efforts are made to link the programme participants to sources of subsidized or free condoms.
- Support direct lobby and advocacy initiatives which aim towards improved access to treatment and services. Supporting PLHIV both to organise and mobilize into a formalized network for greater advocacy potential as well as mutual care and support. Efforts have been made to develop these networks into independent bodies that have the capacity to manage themselves to lobby and advocate for issues that they identify as well as to raise funds if appropriate.

<u>In 2009, the key initiatives undertaken were:</u>

- Review done by an external consultant of the programme activities implemented from October 2006 to September 2009 (prior to EU funding) – to capture the key lessons learnt and to make necessary adjustments in the programme.
- Strategic visioning exercise to develop a clear roadmap for partners.
- Learning documentation of the Peer Education approach to capture the effectiveness and efficacy of the approach.
- Revision of the Logical Framework for the programme, which was also approved by the European Union.
- Initiation of extensive baseline study of the programme to capture the evidence.

<u>In 2010, the key initiatives undertaken were:</u>

- ROM (result orienting monitoring) visit. This visit is undertaken by an external person on behalf of European Union.
- Completion of extensive baseline study of the programme and adjustments agreed within projects and the programme
- Finalising Monitoring and Evaluation framework for Programme and for individual partner projects
- Developing Social Behaviour Change Framework for Programme with focus on individual population groups
- Developing communication materials to support behaviour change
- Redesigning partner projects for three years (2011 – 2013)

<u>In 2011, the key initiatives undertaken were:</u>

- Implementation of the revised logframe, which has streamlined monitoring and evaluation processes and strengthening the partner level MIS with specific information on the key indicators in the log frame.
- Up scaling of livelihood support to 194 PLHIV members through district level networks.
- Piloting the tracking mechanism to retrieve ART defaulters, a collaborative initiative with the State Agency
- Opinion Poll of health care providers conducted.
- Initiation of qualitative study to understand the barriers in adhering to ART.
- Social behaviour change communication strategy implemented. Communication materials developed in line with the strategy.

- Health care providers sensitized in three district headquarter hospitals, the sensitization programme designed in line with the strategy.
- Initiated mid-term review of the programme

In 2012, the key initiatives undertaken were:

- HIV programme mid-term review was concluded and findings disseminated among partners.
- Up-scaling of flagship initiatives i.e. ART defaulter tracking in ART centres in all operational districts and SCB Medical College and Hospital in Cuttack.
- Up-scaling of livelihood support for PLHIV and strengthening their capacities in revolving the support fund.
- Innovative ways of dealing with the media was undertaken as a strategy by engaging with major television serials and reality shows of a leading television channel (Otv) in Odisha.
- Behaviour Change Communication activities conducted with a focus on adolescents. World AIDS Day events organised with a focus on adolescents and PLHIV.
- Continued collaboration with State Agency, OSACS and rolling out health care providers' sensitization in 11 blocks of Ganjam and Koraput districts.
- Annual review of progress of activities and log frame indicators carried out.

In 2013, the key initiatives undertaken were:

- Endline study of the HIV programme is being undertaken
- Sensitizing health care providers in six district head quarter hospitals and two medical college and hospitals conducted
- Opinion poll of health care providers conducted
- Initiation of handing over of tracking ART LFU initiative
- Documenting key lessons of the programme

The five year EU supported programme will come to an end in December 2013. The present exercise will be an end-term evaluation of the HIV programme being facilitated by an external consultant.

Purpose

The purposes of this Evaluation are as follows:

1. To evaluate whether the Specific objective and KRAs were relevant in the context in which they were made, whether they are still valid in the current dynamic context.
2. To evaluate to what extent the specific objective and KRAs are effectively met and key lessons learnt
3. To review to what extent the structure and processes in place are appropriate and help achieve desired results. Also outline the roles of these structures in current changing scenario.
4. To assess how the programme has developed, the overall quality and progress, identify successes and promising practices, horizontal and vertical linkages in the partner projects and document lessons.
5. To report the consolidated changes from the baseline to the endline, and disaggregated by groups, sex.
6. To review the equality and HIV mainstreaming strategies being implemented by partners in their ongoing projects and in their other organisational programmes.
7. To review the collaborative efforts undertaken with the State Agency (OSACS) and the contribution of the programme in meeting the state indicators (as per NACP III) and EU NSA objectives on increasing access to service, strengthening capacities of community based organizations amongst populations at high risk of HIV and infected and target interventions

for populations out of reach of the mainstream services. Reference – Objectives of the Programme and Priority Issues under the Call for Proposals

8. To reflect on the recommendations of the mid-term review and the ROM visit and how well they have been incorporated into the present programme.

Scope

The evaluation will look at the relevance, efficiency, effectiveness, impact (preliminary and potential) and of the programme. The consultant will conduct the review in the context of following points based on Development Assistance Committee (DAC) Criteria for Evaluating Development Assistance:

- Are activities and outputs of the programme consistent with the overall objective and the attainment of the key result areas and the intended impacts, as well as the EU NSA objectives (see Annex 1 – Guidelines for Grant applicants, attached) If not, why and what are the challenges and obstacles?
- What real difference has the intervention made to the target groups and final beneficiaries?
- What were the major factors that influenced the behaviour change processes?
- Has the Programme influenced the implementation of state policy and programme in any way? Review the pilots and initiatives undertaken.
- Has the programme supported in achieving NACP III indicators for the state? If not, why and what are the reasons
- Has the programme enhanced partners' capacity in implementing health and HIV programmes?
- What were the key implementation challenges, and how the programme has overcome?
- Has the programme documented and shared key lessons with key stakeholders and actors?

Methodology

The review is aimed to be a participatory process, with the consultant acting as the facilitator. The consultant will facilitate meetings and discussions with partner staff, senior management and supporting organisations including Orissa State AIDS Control Society (OSACS), European Union, Hivos and Concern US. The exact methodology will be worked out by the consultant in consultation with Concern. Feedback from European Union will be taken into account by Concern prior to finalizing the Terms of Reference (ToR). The tools will be developed once information about the programme is made available. The tools will be discussed with Concern and finalised.

Desk Review: The desk review will be used as an important tool to assemble evidence of programme activities and outputs, as well as to determine if necessary documentation is being maintained by implementing partner organisations. These would include programme documents, study reports, learning documents, frameworks being used and individual project documents. Important programme documents includes Proposal, Monitoring and Evaluation Framework, Social behaviour Change framework, Learning documents, Presentations and papers, Annual Programme Reports, Mid Term Review report, Baseline report, dipstick survey and Endline survey reports.

Documenting promising practices and the impacts of the programme: One of the proposed tools is Most Significant Change (MSC) is a form of participatory monitoring and evaluation based on recording stories amongst all kind of stakeholders. Unlike conventional approaches to monitoring and evaluation, the MSC approach does not employ quantitative indicators. Essentially, the process involves the collection of significant change stories emanating from the field level, and the systematic selection of the most significant of these stories by panels of designated partner staff. Necessary steps to be taken are:

- Collect stories of change

- Review the stories and select most significant
- Document reasons for choice

A debriefing meeting will be conducted with local partners and senior management.

Output:
Final report, the format for the report will be finalised by the consultant in consultation with Concern. The full review report would be a maximum of 25 pages. The proposed format:
1. Executive Summary (maximum 3 pages)
2. Introduction
3. Scope and methodology
4. Findings

5. Lessons learnt
6. Recommendations – exploring next phase of programme priorities and opportunities for partners
7. Annexes

Timeframe
Overall the consultancy will be 18 days including travel, 1 day for travel, 1 day for planning/induction, 2 days in Odisha meeting with Concern & partners, 8 days field visits (including travel), and 1 day for debrief/presentation in country. Write up Report time is 5 days inclusive.

Lines of communication/ management
The contract will be managed by the Programme Manager (HIV), Concern India. The consultancy agreement to be signed with HQ with inputs from the Regional desk and Global HIV Advisor taken at each stage.

Qualifications
Due to multiple tasks, preference would be given to individual consultant having extensive experience in conducting end term evaluations and qualitative studies, and should have specific knowledge of country context, key indicators listed, and on HIV and AIDS and behavior change processes. Familiarity with the local language and previous experience of conducting evaluations in Eastern India would be an advantage. The consultant should have sound English writing skills and demonstrated ability to write high-quality evaluation reports (examples should be provided). The consultant must have fair knowledge on assessing quantitative data and surveys.

Annex 2 – In-country Evaluation Meetings

Date	Time	Venue	Meeting	In Attendance
25-09-2013	9.30-11.00	Concern Office, Odisha	Introduction to Concern India	Ben Tricks, Concern India Country Director
	11.00-5.00		Introduction to *Strengthening Local Responses to HIV and AIDS in Orissa, India* Project and Evaluation Programme Review	S. Gomathi, HIV and AIDS Project Manager
26-09-2013	11.00-5.00	Hotel La Franklin, Odisha	Evaluation Partner's Workshop	7 Representatives from Senior Management, Programme and Field Staff from each Project's Implementation Partners; INP+, Ruchika, SOVA and USS
27-09-2013	9.00-5.00		Evaluation Partner's Workshop	Do
28-09-2013	10.30-1.00	St. Vincent's, Gopalpur	Programme Overview with SOVA Senior Staff	Sanjit Pattanayak, Secretary Balaji Panigrahi, Programme Manager Tapaswini Jena, Sunil Kumar, Bhupen Bihari, Purnima Das – Community Organisers
	2.00-5.00		SOVA Adolescent Youth Club Members	9 Youth; 4 males and 5 females
	5.00-6.30		SOVA Peer Leaders	12 Peer Leaders, 6 males and 6 females
29-09-2013	9.00-6.00	St. Vincent's, Gopalpur	8 DLN Networks present their project-supported achievements and challenges	Angul: 7 Board Members Balasore: 9 Board Members Bhadrak: 7 Board Members Bolangir: 7 Board Members Cuttack: 7 Board Members Ganjam: 7 Board Members Khurda: 7 Board Members Koraput: 9 Board Members
30-09-2013	9.00-11.30	St. Vincent's, Gopalpur	INP+ Programme Overview with Senior INP+ Personnel	K.K. Abraham, General Secretary Dilip Chhotray, Consultant S Santosh Kumar, Advocacy Officer Rakesh Mohapatra, Senior Staff Kanmani Chandran, Programme Manager Rakesh Mohapatra, Network Support Officer
30-09-2013	12.00-1.30	MKCG Medical College	College relationship with project, including Class IV HIV training	Dr. B. N. Sahu, Hospital Manager Prof. R.N. Mangual, Superintendent-in-Charge Ratnamali Dei, Matron Steward and Assistant Steward Nursing Staff; 6 INP+ staff
	2.00-2.25	Berhampur Hotel	Telephone discussion with EU Representative	Mr. Laurent Danois
	3.30-4.30	Berhampur ART Centre	Review ART Service, Defaulter Tracking and relationship with project	Dr. Ganeshwar Sethi, Medical Officer Dr. M.V. Ramachandra Rao, Snr. Medical Officer Counsellors: 2 Staff Nurse: 2 Laboratory, Data Management and Community Care Staff INP+ Staff

Date	Time	Venue	Meeting	In Attendance
	4.30-5.30	DLN Network, Ganjam	Review DLN's work on the ground	A Dilip Kumar Rao, Secretary Nihambar Patna, President INP+ staff
01-10-2013	9.30-11.30	St. Vincent's, Gopalpur	ART Defaulters	10 male PLHIV 6 female PLHIV INP+ staff
	11.30-1.30		PLHIV Livelihood Beneficiaries	9 male PLHIV 3 female PLHIV INP+ staff
	2.30-4.00		Debriefing INP+	K.K. Abraham, General Secretary Kanmani Chandran, Programme Manager Dilip Chhotray, Consultant S Santosh Kumar, Advocacy Officer Rakesh Mohapatra, Network Support Officer
02-10-2013	Consolidation Day			Evaluator
03-10-2013	9.30-10.30	USS Office, Cuttack	Meeting with USS Senior Project Team	Amiya Bhusan Biswal, Secretary Dr. Reeta Sahoo, Programme Manager
	10.30-12.30	SCB Medical College and Hospital, Cuttack	Meeting with ICTC Counsellor	Anjali Das
	2.00-3.00		ART Centre	Three Counsellors; Tanusmita, Sushmita, Nivedita
	3.30-5.30	Purighat Baurisahi Slum	Discussion with Adolescent Boys and Girls and Youth	12 Adolescent Girls 10 Adolescent Boys 8 Female Youth 7 Male Youth
04-10-2013	9.20-11.00	Matamatha Mallasahi Slum, Cuttack	Discussion with Peer Leaders, Female Youth	Peer Leader Group, 20 members Female Youth Group, 16 members
	11.00-12.00	Cuttack Municipal Corporation	Meeting re. Project's relationship with local authorities	Ashok Kumar Mishra, ADSWO Sundip Das, Regional Coordinator, UNICEF
	12.30-1.30	USS Office	PLHIV Mothers	8 HIV Positive Mothers
	2.30-4.00		Debriefing Meeting, USS Key Staff	Amiya Bhusan Biswal Dr. Reeta Sahoo Rashmita Behera, Project Coordinator Rakesh D Podha, Project Manager Malaya Kumar Saransho, Administration in Charge Pramod K Ojha, Project Manager Narayan Malleck, District Resource Person
05-10-2013	Consolidation Day			Evaluator, Interacted with Dr. Amitava Das, State Epidemiologist, OSACS for data on state surveillance
06-10-2013	9.30-10.30	Ruchika Office	Partner Overview of Project Work	Dr. Narayan Rao, Secretary Benudhar Senapati, Programme Manager Keshab Chandra Senapati, Project Coordinator Santoshi Manjari Singh, Documentation Officer A. Sina Prasad Rao, Mobile Health Educator Rabi Narayan Tripathy, Mobile Health Educator
	11.00-12.30	Vani Vihar	Mahananta Auto Association's Project Involvement	20+ members in group discussion
	2.30-5.30	Ganganagar Slum	Meetings with Adolescent Girls, Female Youth and	Female Youth: 15 Adolescent Girls: 19 Male Sports Club Members: 17

Date	Time	Venue	Meeting	In Attendance
			Male Sports Club members	
07-10-2013*	9.30-11.00	Shakti Vihar Slum	Meeting with Shakti Vihar Women's Group	20 members attending
	11.30-1.00	Capital Hospital, Odisha	STI Centre	Dr. M Srichandan, MD, Dermatology Sarmistha Patnaik, STI Counsellor
08-10-2013	Debrief Preparation			Evaluator
09-10-2013	9.30-11.00	Hotel Marrion	Evaluation Debrief	Representatives from Senior Management, Programme and Field Staff from each Project's Implementation Partners; INP+, Ruchika, SOVA and USS
09-10-2013	Consultant Departs			

Annex 3 – Summary of Partner Deliverables

INP +
INP+ is a national, secular non-profit CBO established in 1997. INP+ has 24 state level networks and 258 district-level networks. INP+ has focused activities with the 5 DLNs of Angul, Balasore, Bolangir, Khurda and Ganjam Districts and also provides training and advocacy support to 9 other DLNs in Odisha. Over the project duration, INP+ has effected 633 STI referrals, 9859 people attending HIV meetings, 1572 attending condom demonstrations and 1,301 undergoing HIV training and 280 women undergoing institutional delivery. Impressively, through INP+ support, 1,474 people were able to disclose their HIV status to family members and 1,792 were able to disclose their status to their health care providers. A total of 624 people living with HIV were linked to two sustainable income and livelihood security funds; National Rural Employment Guarantee Act (NREGA) and Swarnajayanti Gram Swarozgar Yojana (SGSY). INP+ was involved in tracking 592 ART defaulters (primarily from Ganjam District) and linked 716 people to social security schemes.

RUCHIKA
RUCHIKA works in Bhubaneswar, Khurda District. Bhubaneswar is the state capital. The population of Bhubaneswar is 837,737 of whom 400,000 (approximately) live in 398 slums in the city. Under this project, Ruchika works with 1,333 adolescents aged 13-19 in 13 slums in the city, 754 auto taxi drivers and a large number of youths. Over the duration of the project, Ruchika has reached 3847 slum dwellers with IPC, formed 23 CBOs (Balika Mandals), held 19 meetings in 2013 with 575 auto drivers, referred 252 for STI testing, 396 for HIV testing, held 36 meetings with 1680 parents. Ruchika has distributed 48,885 free condoms and also promoted condom purchase. Through the development of organic gardens, 172 women have benefited and 30 female adolescents have gained through livelihood training. Jewellery training was provided to 13 CBOs and 14 libraries have been established are running successfully.

SOVA
SOVA works in Koraput District where 75 percent of families live below the poverty line, 50 percent of the population are tribal and the literacy rate is 47.2 percent for males and 24.2 percent for females. There are high levels of in and out migration, alcoholism and a national highway that runs through the district. Among their key achievements are the establishment of 1000 Peer Leaders, an increase of HIV testing by 53 percent in the project area, and 68 percent of pregnant women have delivered at health institutions, and 80 percent of HIV positive mothers have delivered at PPTCT service centres and their babies are HIV negative. The Koraput DLN has been strengthened, there are 20 positive speakers and 60 percent of members are accessing ART services with 100 per cent adherence.

USS
USS works in Cuttack and Bhadrak Districts. USS works in 24 slums of Cuttack City reaching 861 adolescent boys, 714 adolescent girls, 1493 male youth and 1251 female youth, and 81 females and 144 males living with HIV. They have established organic gardens with 126 males and females, established 287 peer educators, referred 753 people for STI treatment, promoted condoms among 4139 participants, referred 221 for HIV testing and 312 for institutional delivery. Many participants have engaged with project IEC materials and more than 60,000 have attended festival events with a HIV and AIDS focus. USS has also campaigned against HIV-related stigma and sensitized 101 Health Care Providers (HCPs). USS has also supported ART defaulter tracking (45 people), provided livelihood support for 62 people and linked 99 people to the Madhu Babu Pension Yojana (MBPY) and 55 to the (AAY).

Annex 4: Cumulative Project Monitoring Data

	Indicators for routine Monitoring of the programme	2009	2010	2011	2012	09-2013	Total
KRA 1: Communities have increased knowledge and capacities to take up HIV testing and prevention services in the targeted districts							
1	Number of referrals for STI treatment (referrals defined as initiation of treatment, follow up and completion of treatment) by peer educators, CBOs and partner staff.	2344	836	1139	1309	1225	6853
2	Number of people attending STI/HIV meetings/discussions	16524	13965	11905	26215	29593	98202
3	Number of people attending condom demonstrations	8115	518	5866	7731	5823	28053
4	Number of programme participants (including CBO members) that attend HIV related trainings	1806	2133	2548	4562	1275	12324
5	Number of pregnant women tested	45	58	378	743	101	1325
6	Number of pregnant women tested positive	2	13	21	10		46
7	Number pregnant positive women that did institutional delivery	13	24	137	260	39	473
8	Number of targeted participants that go to have an HIV test	409	477	698	1028	827	3439
9	Number of targeted participants that know their status	409	477	659	1004	789	3338
KRA 2: Health care providers and community members accepting and having positive attitudes towards PLHIV and their family							
10	Number of PLHIV who have been able to disclose their HIV status and discuss with family members	397	172	339	347	174	1429
11	Number of PLHIV who have been able to disclose their HIV status and discuss with healthcare providers	475	256	390	361	110	1592
12	Number of unique individuals reached through interpersonal communication	1514	2409	5086	4262	5854	19125
KRA 3: PLHIV and Families having livelihood security, living positively and dignity							
13	Number of PLHIV network members that are linked to livelihood schemes (NREGA, SGSY)	32	95	50	53	2	232
14	Number of PLHIV network members that are provided livelihood support	26	23	194	208		451
KRA 4 : PLHIV accessing and receiving appropriate and affordable care and treatment (STI, ICTC, OI, TB, ART services) and social security schemes							
15	Number of ART defaulters (absence for 3 consecutive months or more)	4	47	326	247	120	744
16	Number of PLHIV who have been linked with social security schemes	162	244	261	265	57	989
KRA 5: Partners are able to design and implement effective and efficient HIV and AIDS programme interventions to reduce HIV infections to reduce HIV infections among the programme participants.							
17	Number of exposure visits by partners	0	2	3	5		10
18	Number of thematic/sector based partner trainings	11	30	32	11	1	85

Annex 5: LFA Baseline-Endline Data

INTERVENTION LOGIC	INDICATOR	BASELINE	ENDLINE
Overall Objective: To respond effectively to the HIV and AIDS epidemic in Odisha; reducing risk and vulnerability to infection and ensuring that people infected and affected by HIV and AIDS have an improved quality of life by the end of 2013.	✓ Reduction in HIV prevalence (Data is the mean of positivity rate, of ANC sites of all districts in the state)	0.46 (2008)	0.43 (2010)
	✓ Reduction in stigma and discrimination towards PLHIV		
	✓ PLHIV have increased access to treatment	On ART till Dec 2008 – 1,754 Pre ART till Dec 2008 – 4,390 HIV positive pregnant women till Dec 2008 - 290	On ART till Aug 2013 – 10,675 Pre ART till Aug 2013 – 20,307 HIV positive pregnant women till Aug 2013 – 1,472
	✓ PLHIV have increased access to social security schemes	Scheme initiated	18,200 outreached under this scheme
Specific Objective: To prevent and control the spread of HIV and AIDS among populations at high risk (in 3 districts) and among people living with HIV (District-level networks in 6 Districts) through community empowerment approaches.	✓ % of all respondents who, in response to prompted questions say that a person can reduce their risk of contracting HIV by using condoms or having sex only with one faithful, uninfected partner	22	Not available
	✓ % of all respondents who, in response to prompted questions say that a person can reduce their risk of contracting HIV by using condoms	43.4	86.6
	✓ % of respondents who had paid/paying heterosexual partners used condoms at last sex with one of the said partners	22	42.5
	✓ % of respondents that have seen a condom demonstration	20.4	78
Key Result 1			
Communities have increased knowledge and capacity to take	✓ % of respondents who had paid/paying heterosexual partners who used condoms at last-sex with one of the	22	42.5

INTERVENTION LOGIC	INDICATOR	BASELINE	ENDLINE
up HIV testing and prevention services in targeted districts	said partners		
	✓ % of respondents that have seen a condom demonstration	20	78
	✓ % of respondents in the past one year that have received messages and support on HIV prevention and care	21	89
Key Result 2			
Health care providers and community members have accepting and positive attitudes towards people living with HIV and their families	✓ % of people living with HIV respondents reported being subject to negative attitudes and discrimination by health care providers	9	6
	✓ % of PLHIV respondents reported being sub subject to negative attitudes and discrimination by family and community members	24	16
	✓ % of non-PLHIV respondents in the past one year that have received positive messages on PLHIV for reducing social stigma	16	91
	✓ % of all non-PLIV living with HIV respondents that felt they would be ashamed if someone in their family got infected with HIV	32	27
Key Result 3			
People living with HIV and families live positively and with dignity through livelihood support	✓ % of people living with HIV respondents that spontaneously report four or more principles of positive living	7	13
	✓ % of people living with HIV respondents that expressed the benefit of reduced mental depression and despair via association with PLHIV networks	94	91
Key Result 4			

INTERVENTION LOGIC	INDICATOR	BASELINE	ENDLINE
People living with HIV are able to access and receive appropriate and affordable care and treatment (STI, ICTC, OI/TB, ART services) and social security	✓ % of people living with HIV that are availing of Madhu Babu pension scheme	51	55
	✓ % of people living with HIV that completed prescribed treatment for opportunistic infections over the past year	46	45
Key Result 5			
Partners are able to design and implement effective and efficient HIV and AIDS programme interventions to reduce HIV infection among the programme participants	✓ % of respondents that have received outreach services in the past year	27	93

Annex 6: People living With HIV in the State and District Seroprevalance Data (from 2002/2003)

People living with HIV diagnosed through ICTC, September 2013			ANC Surveillance Data		
District	**Number**	**% of those identified**	**District**	**2008**	**2010**
Angul	989	3.3	Angul	0.75	1.26
Bolangir	686	2.3	Bolangir	1.5	≥ 0.5
Balasore	911	3.1	Balasore	0.5	0.75
Bhadrak	588	2	Bhadrak	0.0	≥ 0.5
Cuttack	3,834	12.9	Cuttack	1	1.5
Ganjam	10,973	37	Ganjam	1.25	1
Khurda	1,339	4.5	Khurda	0	1
Koraput	1,661	5.6	Koraput	0	0.50
State Total: 29,643			**State Mean**	**0.46**	**0.43**