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END OF PROJECT EVALUATION OF THE GLOBAL HIV/AIDS INITIATIVE NIGERIA

[FINAL REPORT JANUARY 2011]

January 2011

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END OF PROJECT EVALUATION OF THE GLOBAL HIV/AIDS INITIATIVE NIGERIA (GHAIN) PROJECT

Final report January 2011

DISCLAIMER

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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The GHAIN End of Project Evaluation Team
January 2011

A Note on Terminology

The GHAIN project funding year is from July to June; similarly its work plan year is from July to June and its performance targets are set for July to June each year. GHAIN reports to PEPFAR semiannually.

Where ever “COP” appears in the narrative of this report, it refers to the PEPFAR Country Operating Plan for the year specified (from October to September).

However, FHI/GHAIN uses different terminology. Some of the figures in this report were produced by GHAIN staff for the End of Project Evaluation. In GHAIN produced figures, “FY” or financial year refers to the COP year (from October to September). In GHAIN produced charts, “COP” refers to GHAIN’s work plan year – from July to June.

Comparisons of GHAIN performance against target are only meaningful for GHAIN work plan years as GHAIN does not have targets for PEPFAR COP years.

ABBREVIATIONS AND ACRONYMS

A/B	Abstinence/Be Faithful
AFASS	Acceptable, Feasible, Affordable, Sustainable, Safe
AHNI	Achieving Health Nigeria Initiative
AIDS	Acquired Immune Deficiency Syndrome
AMAC	Abuja Municipal Area Council [FCT equivalent of an LGA]
APR	Annual Progress Report
ART	Antiretroviral Therapy
ARV	Antiretroviral/s (drugs)
BCC	Behavior Change Communication
CBO	Community-based Organization
CEDPA	Centre for Development and Population Activities
CiSHAN	Civil Society Network on HIV & AIDS in Nigeria
CTRR	Counseled, Tested and Received Result
CDC	Centers for Disease Control and Prevention
CHEW	Community Health Extension Worker
COP	Country Operational Plan
CoP	Chief of Party
CP	Community Pharmacist
CSO	Civil Society Organization
CSS	Community Systems Strengthening
CSW	Commercial Sex Worker
DBS	Dried Blood Spot [for EID]
DCoP	Deputy Chief of Party
DFID	Department for International Development (UK)
DHIS	District Health Information System
DHS	Demographic and Health Survey
DQA	Data Quality Analysis
EID	Early Infant Diagnosis
EOP	End of Project
EOP/E	End of Project Evaluation
FBO	Faith-based Organization
FCT	Federal Capital Territory
FHI	Family Health International
FMOH	Federal Ministry of Health
FP	Family Planning
FSW	Female Sex Worker
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GHAIN	Global HIV/AIDS Initiative Nigeria
GHI	The Global Health Initiative
GIPA	Greater Involvement of People Living with HIV & AIDS
GLRA	German Leprosy and Tuberculosis Relief Association
HAST	HIV/AIDS, STI and TB (GHAIN LGA-level component)
HBC	Home-based Care
HCT	HIV Counseling and Testing

HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HU-PACE	Howard University Pharmacists and Continuing Education Center
IA	Implementing Agency
IBBSS	Integrated Biological and Behavioral Surveillance Study [most recent study: 2009]
IDU	Injecting Drug Use/User
IEC	Information, Education, and Communication
IMAI	Integrated Management of Adolescent and Adult Illness
IMCI	Integrated Management of Childhood Illness
IMPACT	Implementing AIDS Prevention and Control Project
IP	Implementing Partner
IPAC	Infection Prevention and Control
IR	Intermediate Result
KII	Key Informant Interview
LACA	Local [Government Area] Action Committee on AIDS
LAMIS	Lafiya Management Information System [developed by GHAIN]
LGA	Local Government Area
LTFU	Lost To Follow Up (pre-ART clients and those who have initiated ART)
MARP	Most At Risk Population/s
MCH	Maternal and Child Health
MDG	Millennium Development Goal/s
MDR-TB	Multi-Drug Resistant TB
M&E	Monitoring and Evaluation
MIPA	Meaningful Involvement of People Living with HIV & AIDS
MIS	Management Information System/s
MOU	Memorandum of Understanding
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
MTE	The GHAIN 2008 evaluation
NACA	National Agency for the Control of AIDS
NARHS	National AIDS and Reproductive Health Survey
NASCP	National AIDS & STI Control Programme
NEPWHAN	Network of People Living with HIV/AIDS in Nigeria
NGI	Next Generation Indicator/s (PEPFAR)
NGO	Non-governmental Organization
NNRIMS	Nigeria National Response Information Management System
NPHCDA	National Primary Health Care Development Agency
NSF	National Strategic Framework [for HIV & AIDS] 2010-2015 (NSF II)
NSHDP	National Strategic Health Development Plan 2010-2015 (FMOH)
NTBLCP	National TB and Leprosy Control Programme
OGAC	Office of the Global AIDS Coordinator
OI	Opportunistic Infection
OP	Other Prevention
OVC	Orphans and Vulnerable Children
PEPFAR	The President's Emergency Plan for AIDS Relief
PHC	Primary Health Care

PLHIV	People Living with HIV & AIDS
PMI	The President's Malaria Initiative
PMM	[GHAIN] Patient Management Monitoring
PMP	Performance Monitoring Plan [GHAIN]
QA/QI	Quality Assurance/Quality Improvement
RH	Reproductive Health
REA	Request For Applications
SACA	State AIDS Control Agency/State Action Committee on AIDS
SAPR	Semi-annual Progress Report
SASCP	State AIDS and STI Control Programme
SAVI	State Accountability and Voice Initiative [DFID-funded program in Nigeria]
SBBC	Strategic Behavior Change Communication
SCMS	Supply Chain Management Systems
SFH	Society for Family Health (Nigeria)
SIDHAS	Strengthening Integrated Delivery of HIV/AIDS Services [proposed new USAID Nigeria program]
SO	Strategic Objective
SOP	Standard Operating Procedure
SoW	Scope of Work
SPARC	State Partnership for Accountability, Responsiveness and Capability [DFID-funded program in Nigeria]
SQA	Service Quality Assessment
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session [on HIV & AIDS - 2001]
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

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EXECUTIVE SUMMARY

The *Global HIV/AIDS Initiative Nigeria* (GHAIN) end of project evaluation was undertaken between September and December, 2010, with in-country work in September and October, report writing in November and finalization in December. Three international consultants led the evaluation team. Other evaluation team members included experts in HIV/AIDS treatment, care and support and prevention and also in health and community system strengthening, gender and social development. Four members of staff from USAID/Nigeria participated in the evaluation: the Senior Laboratory and VCT Manager, the Treatment Program Manager, the MCH Program Manager and the Monitoring and Evaluation Manager. A CDC Monitoring and Evaluation Specialist joined the team as other commitments permitted. The Head of Strategic Planning from the Federal Ministry of Health AIDS Division participated throughout, while two National Agency for the Control of AIDS (NACA) representatives joined the team for the field visits.

This Executive Summary is structured as follows:

1. An overview of the methodology
2. Findings: whether GHAIN has achieved its three Strategic Objectives (Intermediate Results)
3. Discussion of the GHAIN end of project evaluation objectives and questions, as set out in the Scope of Work
4. An overview of changes to GHAIN since the project evaluation in May 2008
5. Recommendations: to the end of GHAIN and for the proposed follow-on SIDHAS program. (Note: This sub-section was deleted due to the procurement sensitive nature of its content.)

1. METHODOLOGY

The following data collection methodologies were used:

1. Document review: GHAIN, FHI, USAID, PEPFAR, GFATM and other relevant national and international literature
2. Key informant interviews were applied in fourteen states (including the Federal Capital Territory)
3. Field visits to GHAIN implementing agencies, with team completion of eight clinical service delivery area checklists, moderation of focus group discussions and participant observation
4. Completion of self-assessment questionnaires by the four GHAIN partners (FHI, GLRA, HU-PACE and Axios Foundation).

The evaluation team split into two field groups, one visiting southern states, the other northern. The evaluation team and USAID/Nigeria jointly decided selection of sites, with close attention to achieving as representative a sample as possible. Analysis of all findings was also a joint team effort, as was the writing of this report. The methodology allowed triangulation of findings from a range of sources. As agreed with USAID/Nigeria, the scope of the evaluation was to be a *programmatic* evaluation, not an *impact* evaluation, assessing value added at outcome level rather than researching the higher-level impact of the activity.

2. FINDINGS

The end of project evaluation findings answering to all three intermediate results,

as well as detailed discussion of the GHAIN prevention, treatment and care and support interventions are to be found in sections 4 and 5 of this report (see also 3.1). **The end of project evaluation finds that GHAIN has achieved the three intermediate results and has supported work towards achievement of the goal.**

3. EVALUATION OBJECTIVES AND QUESTIONS

Objective 1: To determine whether the GHAIN project continued to achieve its goal and strategic objectives (intermediate results) following the May 2008 evaluation.

Question 1a

In assessing the extent to which these IRs have been achieved, the evaluation team will analyze the extent to which GHAIN has met its PEPFAR targets that are set each year during the COP planning process and reported to OGAC on a semi-annual basis.

Discussion of key GHAIN PEPFAR cumulative targets and achievements are to be found in sections 4 and 5. **The end of project evaluation finds that since COP05 to date GHAIN has largely met or exceeded its COP targets.**

Question 1b

In assessing the extent to which the GHAIN project contributed towards furthering the goal of USAID Nigeria SO14 through a review and analysis of the available data pertaining to the relevant program areas.

The GHAIN project can be said to have contributed greatly to USAID/Nigeria's SO14 by reducing the disease burden of both HIV and TB through its prevention and treatment programming. **The scale of the GHAIN activity means that it is probably the largest contributor to achievement of USAID Nigeria Strategic Objective 14.**

Question 1c

In assessing the extent to which the GHAIN project contributed towards the seven principles of the Global Health Initiative's approach

GHAIN has achieved considerable progress in a number of the seven principles, perhaps most notably principles 2 (*increase impact through strategic coordination and integration*) and 3 (*strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement*); it has been most weak with regard to principles 1 (*implement a woman and girl-centered approach*) and 5 (*build sustainability through health system strengthening*).

Question 1d

In assessing the extent to which the GHAIN project contributed to the overall PEPFAR Nigeria program.

Analysis of GHAIN's contributions to PEPFAR Nigeria Annual Program Results 09 (APR09) and Semi-Annual Progress Results 10 (SAPR10) indicates **GHAIN's contribution is considerable in many program areas**. Table 8 (on pp 114-115) presents the results for indicators that are common or comparable in APR09 and SAPR10. GHAIN contributed a third of the PEPFAR APR09 results for (i) HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission; (ii) service outlets providing ART; and (iii) adults and children with advanced HIV infection newly enrolled on ART. GHAIN contributed slightly more than a third of these PEPFAR results in SAPR10. GHAIN also contributed nearly 25% of the results in SAPR10 for individuals provided with HIV-related palliative care (including TB/HIV).

Objective 2: Determine to what extent the capacity building efforts by the

GHAIN project contributed to the implementing agencies' overall performance in and sustainability of the delivery of comprehensive HIV/AIDS prevention, care and treatment [and/or] TB [and/or] malaria in pregnancy [and/or] RH-HIV integration programs.

Question 2a: To what extent have activities been transferred to the government or local partners?

This remains a challenge: parallel GHAIN systems persist from PEPFAR 1 when the emphasis was on delivering numbers of persons on treatment. Transfer of activities, skills to manage and sustain those activities, ownership and stewardship has been variable.

Question 2b: With respect to treatment services, the evaluation team will assess the organizational capacity of selected sites to deliver effective care and to deliver care with less USG support and more GON support.

Although GHAIN-supported sites are currently delivering adequate to good quality services, GHAIN's structure and processes have largely bypassed GON systems for training, coaching and mentoring staff. This compromises future organizational capacity.

Question 2c: The evaluation team will assess the benefits and program outcomes of the collaborative and multiple-pot funding (PEPFAR, Child Survival and Population Funds) using the GHAIN project as a single mechanism

Overall, the addition of relatively modest multiple-pot funds to the GHAIN grant has been highly effective in leveraging the PEPFAR-funded GHAIN infrastructure to deliver far greater results in a number of technical areas than the same level of funding could achieve if given to a smaller organization without the extensive infrastructure that GHAIN has built.

**Objective 3: Collaboration and synergies between GHAIN and GFATM funding
Determine to what extent the collaboration and synergies between PEPFAR and GFATM funding contributed to the overall program and health system impact.**

Question 3a: What are the challenges and benefits of close collaboration with GFATM, and should this be encouraged among USAID IPs?

FHI/GHAIN's collaboration with NACA as a sub-recipient on Nigeria's Round 5 HIV/AIDS grant has brought benefits to the GON and to GHAIN, with the outcome of extending the availability of ART and other HIV/AIDS services to more health facilities, benefiting more PLHIV than NACA could have reached with the FMOH as sole sub-recipient, or GHAIN could have reached with only its PEPFAR funding. Decisions should be made on a case-by-case basis regarding USAID implementing partners adopting the same approaches. Challenges of collaboration and discussion points for future approaches are to be found in 5.1.

Question 3b: What are the effectiveness and efficiencies of the collaboration with GFATM?

GHAIN has been able to deliver more results than expected with its Global Fund sub-grant because its programming/management base has been funded and established with its USAID/PEPFAR funding.

Question 3c: What is the impact of the collaboration and synergies between PEPFAR and GFATM under the GHAIN program on the overall health systems in Nigeria?

GHAIN has influenced development of GON standard operating procedures, training curricula and materials. GHAIN activities have included training individuals rather than building the capacity of the system and, for example, the MIS reporting system is still

dependent on GHAIN involvement and or funding. Thus GHAIN has had limited impact on health systems as its activities have not strengthened health systems and are not sustainably owned by the GON. However, it must be stressed that GHAIN was not set up as a capacity building project and, during PEPFAR 1, effort was focused on rapid scale up of numbers of PLHIV on ART and not on building GON capacity to sustain delivery of the services.

Objective 4: Determine lessons learned that will assist USAID, Government of Nigeria and other implementing partners with future comprehensive HIV/AIDS, TB and reproductive health-HIV integration programs in Nigeria and elsewhere.

Question 4a: What are the benefits of implementing large-scale integrated programs such as the GHAIN project, which [covers] the whole country?

Large-scale projects such as GHAIN reduce the number of contracts/cooperative agreements USAID has to manage. They can also reduce the number of external partners that the GON, in particularly NACA at all levels and the ministry of health at all levels, has to deal with. Government agencies and ministries at state level are under-resourced and of limited capacity reducing their ability to lead and coordinate many external partners effectively. As a result of the scale-up of its activities and range, there are now serious GHAIN management and oversight weaknesses not noted in the 2008 evaluation, indicating that the project is now spread too thinly. The 8% rule under PEPFAR 1 limited GHAIN's ability to implement large-scale comprehensive HIV/AIDS programs; under PEPFAR 2 it will be important to discourage repetition of the current GHAIN situation, where the project is spread too thinly and has exceeded its management/oversight capacity.

Question 4b: Should the project continue to offer a wide range of integrated prevention, care and treatment services or focus on treatment only?

The range of services in a new project should continue to cover integrated prevention, care and treatment. This is in line with international best practice that seeks to provide a continuum of support, where opportunities for normalization of HIV and AIDS in the context of people's daily lives and their communities are facilitated as much as possible.

Question 4c: Should the project continue to offer treatment services nationwide or focus on providing services in particular regions or zones? Is the oversight provided by FHI HQ, FHI Nigeria Country Office and the Zonal Offices sufficient? Are the current staffing levels and management design adequate? Has there been any difference to date, from the evaluation of May 2008?

Planning for future interventions should very seriously consider a number of zonal or regional projects and not necessarily continue with further application of the nationwide GHAIN model. Oversight at country and zonal office level is sub-optimal in certain key management and institutional areas. GHAIN management design and structure do not always most effectively manage the current national spread of project activities. Since mid-2008, GHAIN has been retrofitted to address the increased focus on HSS, prevention, OVC and other community engagement that has resulted from the introduction of the Global Health Initiative and the implementation of the PEPFAR Next Generation Indicators.

4. CHANGES TO GHAIN SINCE MAY 2008

There have been four key changes in GHAIN management and implementation since mid-2008. These are:

1. A shift to overt focus on Health Systems' Strengthening (HSS), described as a 'transition' by GHAIN

2. Full introduction and expansion of the HAST model
3. Changes in procurement and supply chain management and the role of Axios
4. The inclusion of quality in USAID *Intermediate Results*.

All four changes have had significant implications and outcomes. There is discussion of these throughout the report and its appendices.

5. RECOMMENDATIONS

Section 6 in the body of the report provides discussion of each of the recommendation areas.

5.1 To the end of the GHAIN project

- As a priority, GHAIN should address end-of-project issues and activities with *all* implementing partners.
- GHAIN should expand its project exit strategy discussions with national and state-level partners.
- GHAIN should further develop hand-over plans, activities and documentation procedures to be provided to the follow-on program.
- Community-based organization (CBOs) should receive training in and support for proposal writing, sustainability planning and independent advocacy to health policy makers.
- GHAIN should not expand its HAST and OVC activities any further.

5.2 Recommendations from the GHAIN end of project evaluation outbrief to USAID/Nigeria for the follow-on program

Recommendations here were provided to USAID/Nigeria on October 29, 2010, before the international consultants had sight of the SIDHAS RFA.

- The follow-on activity should include consortium partner/s with internationally recognized expertise in designing and implementing:
 - Chronic care management activities¹
 - Prevention activities
 - Community-based activities
 - Health systems strengthening, including community systems strengthening
- The follow-on program should include closer attention to health systems strengthening, so as to enable GON to manage and sustain activities
- Parallel systems of service delivery, records, data management, human resource management, etc. should be avoided
- There should be a standalone program to work with MARP
- Consideration should be given to separate regional program management structures
- Serious consideration should be given by USAID to providing FHI with a grant for overheads to enable it to continue its GFATM engagement.

5.3 Recommendations for the GHAIN follow-on project: SIDHAS

(Note: This sub-section was deleted due to the procurement sensitive nature of its content.)

¹ Chronic care management (CCM) represents a key aspect of moving from an acute emergency response focused on treatment and supply-side service delivery, to chronic and palliative care where demand-side/community engagement becomes key. CCM forms an important plank of the Global Health Initiative approach and is increasingly addressed in multilateral and bilateral HIV initiatives.

I. INTRODUCTION²

1.1 GHAIN: AN OVERVIEW

Family Health International (FHI) and its partners Axios Foundation, Howard University Pharmaceutical care And Continuing Education Center (HU-PACE), and the German Leprosy and Tuberculosis Relief Association (GLRA) implement the seven-year *Global HIV/AIDS Initiative Nigeria* (GHAIN) project. The initial five-year GHAIN Cooperative Agreement became effective on June 24, 2004. GHAIN has now entered its final year of operation. It is one of the largest President's Emergency Plan for AIDS Relief (PEPFAR) comprehensive HIV and AIDS treatment projects in the world. A major GHAIN achievement is that it pioneered provision of antiretroviral treatment (ART) services at secondary health facilities in Nigeria, thus greatly increasing access to treatment. Currently, GHAIN supports provision of ART to a third of all Nigerians on treatment. The fact that it is now possible to envisage a move to primary health care (PHC) facilities is to be acknowledged as a further and significant GHAIN achievement.

GHAIN received a two-year cost extension on June 24, 2009 from USAID; the project will now close on June 23, 2011. Under PEPFAR the United States Government (USG) will provide FHI with an additional \$144.3 million during the extension period. Total funding for GHAIN from USG over the seven-year lifetime of the project will be \$418,453,640. As of August 26, 2010 \$280,232,118 had been disbursed. GHAIN receives a funding mix from the USG, through PEPFAR, TB and Population streams (see FHI 2009 for detailed information). FHI/GHAIN has been highly successful in leveraging resources from additional funding streams, most notably the Global Fund to fight AIDS, TB and Malaria (GFATM) Round 5 grant, on which it is a sub-recipient, and private sector organizations such as the NiDAR project supported by Shell. As noted by PEPFAR Nigeria "GHAIN has been able to harness synergies and achieve more, contributing significantly to the increased access to the life saving antiretroviral therapy in Nigeria." (PEPFAR Nigeria 2010b).

The four GHAIN consortium partners provide specific inputs to the project:

- FHI: overall management and technical oversight
- Axios: management of health commodities and logistics
- HU-PACE: pharmacy services
- GLRA: technical assistance for TB/HIV collaboration

See Appendix B for a timeline overview of the four GHAIN partners' activities since project inception in 2004. The timeline separates activities before and after the May 2008 evaluation, for ease of reference and in light of the project changes experienced since that time.

GHAIN has experienced significant shifts in activity focus and remit during its lifetime

² This end-of-project evaluation report represents the second detailed assessment of GHAIN activities during its implementation. The first evaluation was undertaken in May 2008; the original intention was that it should lead to an end of project report. Due to the awarding of the cost extension the report might be considered a mid-term evaluation. However, the report was not made available to GHAIN project management until mid-2010 and thus there was no scope for GHAIN management to act on recommendations. This report considers activities throughout the life of the project, while paying particular attention to changes made and work undertaken subsequent to the 2008 evaluation (see also section 1.2). Readers of this report are referred to USAID 2008 (the 2008 evaluation report) for a closely detailed account of project work prior to May 2008.

to date, in large part shaped by the different priorities of the first and second five-year PEPFAR strategies and the Global Health Initiative. Changes have also come about as a result of the changing Nigerian epidemiological profile and developing national, international and project understanding of people's and groups' needs. GHAIN began its implementation as an emergency treatment program whose primary objective was to get large numbers of people with advanced HIV disease onto antiretroviral therapy. It is now increasingly focused on supporting health systems strengthening and providing expanded inputs to palliative care and wider chronic care components and community engagement, while maintaining its core treatment provision.

The original consortium underwent fundamental partnership changes at inception and in the first two years of existence. The University of Maryland, with its mandate to support laboratory strengthening, withdrew almost immediately from GHAIN after the intervention of the Office of the Global AIDS Coordinator (OGAC). In 2006 the PEPFAR Nigeria budget allocation was changed to cap the proportion of its budget that any one implementing partner might receive, in line with OGAC directives. FHI, as GHAIN prime, had its budget reduced to accommodate the move towards achieving the 8% ceiling on its PEPFAR funding. At that time FHI had to make strategic decisions about how to accommodate the reduced budget while still being held accountable for PEPFAR targets. The FHI decision was to shed program areas and focus on rapidly scaling up access to treatment. This was one of the main reasons why The Futures Group, the Centre for Development and Population Activities (CEDPA) and the American Red Cross/Nigerian Red Cross – original GHAIN consortium partners – left the project (see FHI 2009).

In response to the budget changes, one major change to GHAIN activities in 2006 was a reduction of community-focused services, with greater emphasis being placed on facility-based care. The project has latterly sought to redress the balance between community and facility, between demand and supply-side prioritization, e.g. through its HAST work (see 4.3. Community and PHC-based support interventions (HAST LGAs) for discussion of the initiative and also Appendices G (HAST) and H (where Community Systems' Strengthening is considered)).

The National Agency for the Control of AIDS (NACA) - formerly the National Action Committee on AIDS - was established to lead the multisectoral response, mobilize national and international resources and coordinate HIV/AIDS activities throughout Nigeria. GHAIN senior staff members have liaised closely with NACA since project inception in 2004, identifying priority sites for establishing comprehensive services and sharing information. GHAIN has shared technical information such as site assessments, standard operating procedures and guidelines, and supported the development of national reporting systems.

The close liaison extended into collaboration in 2007 when Nigeria was awarded a Global Fund Round 5 HIV/AIDS grant with NACA as principal recipient and FHI/GHAIN as one of the sub-recipients. FHI/GHAIN is also a sub-recipient to the Society for Family Health (SFH), another Round 5 HIV/AIDS grant primary recipient. FHI/GHAIN³ is currently a sub-recipient in the consolidated Round 9 HIV/AIDS grant (as yet unsigned), that includes and rolls up the Round 5 and Round 8 (Health systems strengthening component). NACA's performance on the Round 5 grant has shown a remarkable improvement over its two Round 1 grants that were both given a

³ The Nigeria GFATM Round 9 grant application R9_CCM_NGA_HT_PF_s1-2_4Aug09_en available at www.theglobalfund.org/grantdocuments/9NGAT_1899_0_full.pdf refers to "FHI/GHAIN" being subrecipient in the Round 5 grant and proposal for Round 9.

'no go' in Phase 1. The Round 5 grant is currently in Phase 2 and its latest performance rating is B1.⁴

Between 2006 and 2008 GHAIN instituted a major scale-up of its activities, from the original six states to all thirty-six states and the Federal Capital Territory. The original six state offices became zonal office, with their number increased to eleven in order to provide nationwide coverage. It is the opinion of GHAIN that synergies with GFATM enabled straightforward entrance into states and that without GFATM support the project would have been able to provide services in a maximum of fifteen states, rather than nationwide.

GHAIN has been able most efficiently to leverage GFATM funding inputs: these represent 6% of total funding (outwith that from USG) since GHAIN became a sub-recipient, yet in effect the value and leverage impacts of GFATM monies represent 17% of the total results (specific to number of individuals on ART) over the life of the project to date. GHAIN funding from NACA/GFATM between July 2010 and June 2011 will be \$3,750,903.

1.2 CHANGES TO GHAIN SINCE MID-2008

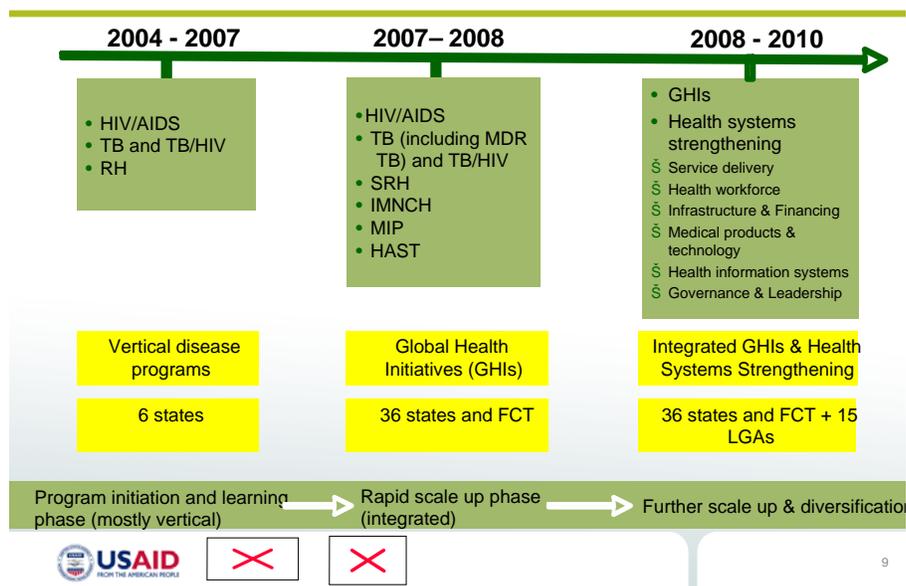
There is consideration here of major changes in GHAIN since mid-2008, i.e. since the 2008 evaluation was undertaken. Please note that section 4, *Evaluation Findings*, includes brief discussion of specific changes experienced over time for each GHAIN technical area. Where relevant, discussion of each technical area includes text entitled *Introduction and background*, which covers changes both since GHAIN inception and where appropriate also since mid-2008 and considers implications for GHAIN implementation.

There has been a major paradigm shift between the first and second PEPFAR strategies and since the launch of the USG *Global Health Initiative* (GHI), all of which have had to be accommodated by GHAIN partners, management and its implementing agencies. Figure 1 illustrates the changes over the lifetime of the project, with attention to those instituted since 2008.

This end of project evaluation has found that while the project has invested major resources in seeking to respond to the greater GHI and PEPFAR focus on prevention, health system strengthening, gender and other new priorities, efficacy of processes and strength of outcomes and impacts have varied. As matters stand it will not be possible in the short time until the end of the project adequately to measure GHAIN process, outcomes and impacts through application of the NGI criteria.

⁴ GFATM 2010e. NGA-506-G07-H Grant Performance Report:
http://www.theglobalfund.org/grantdocuments/5NGAH_1180_515_gpr.pdf Accessed 11/20/2010.

Figure 1: GHAIN Program Development



(Figure provided by GHAIN to the end of project evaluation team in September 2010)

Attention will be given here to four key changes in GHAIN management and implementation since mid-2008. These are:

1. A shift to overt focus on Health Systems Strengthening (HSS)
2. Full introduction and expansion of the HAST model
3. Changes in procurement and supply chain management and the role of Axios
4. The inclusion of quality in USAID *Intermediate Results*

1. A shift to overt focus on health systems strengthening (HSS)

Although not in the original RFA and project design, GHAIN has developed an explicit focus on HSS as part of its activity portfolio over the last two years in response to new PEPFAR requirements. This focus, described as a ‘transition’, was the frame within which senior GHAIN staff presented its activities and achievements to end of project evaluators on September 24, 2010, and was reiterated during key informant interviews held with GHAIN technical directors. It is also described as such in a number of GHAIN documents (see e.g. GHAIN 2010h). However, as GHAIN receives no funding for HSS (as is shown in Table 1 in section 1.3), GHAIN can only view its existing activities through the lens of the WHO/GFATM HSS framework and cannot transform itself into a HSS project. **GHAIN’s performance must be measured against its original purpose and agreed targets.**

GHAIN management (and particularly FHI as the prime) defines the project as *de facto* addressing five of the six HSS components (as identified by WHO and GFATM) throughout the life of the project, with increased, programmed focus since 2007/8. The six WHO ‘HSS Building Blocks’ described as applied by GHAIN are:

- Block 1. Service delivery
- Block 2. Health workforce
- Block 3. Health infrastructure and financing
- Block 4. Medical products and technology
- Block 5. Health Information Systems
- Block 6. Governance and leadership

In 2008 GHAIN created a new country office department, *Health Policy and Systems Strengthening* (one of whose responsibilities is management of HAST). GHAIN states that the new HSS component addressed since 2008 is financial management, with support to implementing agencies' capacities for effective financing, budget planning and costing services. In this regard refer also to Figure 1 above.

“FHI [has] begun looking beyond service availability to systems strengthening and sustainability. Using the WHO six building blocks of health systems strengthening, during the past two years, FHI has put more resources into building the capacity of public and private sector organizations so as to engender their technical and institutional abilities sustainably to provide quality services, improve their infrastructure, make health commodities available and support the development and implementation of enabling policies and standards.” (FHI 2010a).

The GHAIN strategy on HSS is encapsulated as:

- Partnership with public and private sector and civil society
- In-house capacity building and skills transfer to government
- HSS based on the WHO framework/building blocks
- HSS initiatives at all levels with especial focus on LGA PHC systems
- Integration of multiple funding sources; leveraging

Since mid-2008, GHAIN has in effect been retrofitted to address the increased focus on HSS, prevention and community engagement that has resulted from the implementation of the GHI and the PEPFAR Next Generation Indicators. This end of project evaluation report considers that these components have not been optimally integrated into project management, activities or M&E (see sections 4.3. Community and PHC-based support interventions (HAST LGAs), 4.6. Health Systems Strengthening, 5.1 (Q4) and Appendix H (CSS) for further discussion). As GHAIN was established under PEPFAR 1, the lack of optimal integration of HSS should not detract from GHAIN's remarkable achievements in other areas of project implementation.

Another activity described during the EOP evaluation as a key HSS initiative is that FHI has instituted and registered a new organization with the Corporate Affairs Commission in Nigeria. This organization is named *Achieving Health in Nigeria Initiative* (AHNi). “AHNi will be responsible for implementing comprehensive HIV prevention and care and treatment services, including community-based interventions, in the FCT and Lagos. FHI/Nigeria GHAIN will actively support the organizational development of this new entity in a phased approach, allowing a gradual decrease in involvement as AHNi develops internal program and financial management systems and capacity.” (GHAIN 2009b; p27)

2. Full introduction and expansion of the HAST model

See section 4.3. Community and PHC-based support interventions (HAST LGAs) for full discussion of HAST implementation to date.

HAST is the GHAIN acronym for *HIV/AIDS, Sexual and Reproductive Health and TB services at Local Government Area (LGA) level*. GHAIN is supporting secretariats, primary health care (PHC) and M&E departments in fifteen LGAs to implement decentralized services to PHC facilities and communities. A GHAIN community health officer sits at the LGA PHC office and supports M&E and other activities. A central plank of the HAST model is the active involvement of community-based organizations (CBOs) and community members, as peer educators and community volunteers. GHAIN began its

HAST work in March 2008, in two LGAs: Nassarawa in Kano state and Yakurr in Cross River. Six of the fifteen LGAs began their actual HAST work as recently as early or mid-2010; engagement with the other nine began in 2008. The number of sites activated in a particular year is negotiated annually with USAID/ Nigeria and is not the sole prerogative of GHAIN. The intention is to expand HAST activities before the end of the project: “In year seven, GHAIN will continue to integrate other services such as community TB care, malaria, and early infant diagnosis (EID) with HIV/AIDS in target LGAs so as to increase access to services, while decongesting saturated secondary and tertiary health facilities.” (GHAIN 2010a; p3).

The GON, the GHI and GFATM all currently prioritize the need to bring services closer to the people in their own communities and through primary health care (PHC) service delivery. The chief rationale for the HAST model and its focus on LGA-level interventions is a realization that most HIV and AIDS services are located at secondary and tertiary health facilities, yet these are increasingly overwhelmed with clients, are often managed as vertical interventions and are not always responsive to demand-side needs. This is the case with many of the GHAIN-supported comprehensive antiretroviral therapy (ART) sites. If scale-up of HIV, STI/SRH and TB (and linked) services is to be achieved (the ‘one-stop-shop’ approach), then decentralization to PHC level is essential, in order to bring services closer to clients. PHC facilities represent more than 70% of all Nigerian public health facilities.

There are clear opportunities to develop health service delivery synergies by integrating decentralized services - and many challenges, too, as will be discussed in 4.3. Community and PHC-based support interventions (HAST LGAs).

3. Changes in procurement and supply chain management and the role of Axios

A major shift since the 2008 evaluation has been the introduction of the pooled procurement system whereby NACA through the Global Fund Round 5 grant buys all first line ARV drugs and cotrimoxazole tablets with the Central Medical Stores, supported by JSI Inc, undertaking central logistics and supply, and the Clinton HIV/AIDS Initiative donating second line ARV drugs and pediatric ARV drugs. This has minimized Axios’ role in the procurement of HIV drugs and commodities. Axios’ GHAIN effort has been shifted to supporting the forecasting process and the redistribution of drugs between health facilities to manage shortages. Axios is also a subcontractor to NACA and the GF grant for the distribution of drugs.

Other changes since mid-2008 as defined by Axios include:

- Transition of GHAIN logistics services into GON procurement/Central Medical Stores logistics and supply management without interruption in service
- Successful integration of logistics MIS into the DHIS (the data management system used by GHAIN and the Federal Ministry of Health)
- Establishment of nine GHAIN zonal stores/depots, all located within State Central Medical Stores, with the objective of bringing HIV commodities closer to health facilities, thereby reducing delivery lead times
- Decentralization of distribution to the GHAIN zonal stores/depot locations and integration of deliveries, i.e. the ‘one trip’ concept per site for delivery of all supplies
- Development of training curriculum and standard operating procedures for commodities logistics; training of 517 health facility staff members on inventory management and logistics data reporting. (See Axios 2010)

Please see section 4.4. Pharmacy services (including Community Pharmacists) for further discussion of the implications, impacts and outcomes of such changes.

4. The Inclusion of quality in USAID Intermediate Results

The USAID Nigeria *Strategic Objective 14* is: *reduced impact of HIV/AIDS and TB in selected areas*. This has remained the same throughout the lifetime of GHAIN, while its Intermediate Results (IR) have altered over time since 2004 and in the past two years (see 3.1 and 5.2 for discussion of current IRs).

The 2003 *Request for Applications* (RFA) included three IRs that addressed demand creation, access and creation of an enabling environment (USAID Nigeria 2003). When the GHAIN two-year project cost extension was agreed in 2009, the three then current Intermediate Results (IRs 14.1, 14.2 and 14.3) stated:

IR 14.1: Increased demand for HIV/AIDS and TB services and interventions, especially among selected target groups (MARF)

IR 14.2: Increased access to quality HIV/AIDS and TB services and interventions in selected states

IR 14.3: Strengthened public/private and community enabling environments (FHI 2009).

The Intermediate Results, as set out in the GHAIN end of project evaluation *Scope of Work* (SoW) are:

IR1: “increased use of quality HIV/AIDS and TB prevention services and interventions”

IR2: “increased use of quality HIV/AIDS and TB care and support services and interventions”

IR3: “increased use of quality HIV/AIDS and TB treatment services and interventions”

PEPFAR indicators prior to the introduction of the Next Generation Indicators [NGI] in mid-2009 focused primarily on achievement of numerical targets. PEPFAR 2009a discusses the precise definition and scope of the new emphasis on quality in the NGI.

“PEPFAR [NGI] seek to strengthen country programs with the inclusion of ‘coverage’ and ‘quality’ measurements. Monitoring and ensuring coverage of quality HIV services is a major focus for this next phase of PEPFAR programming... In the past, PEPFAR indicators described program outputs with little attention to coverage and quality. Coverage indicators include measures of *program* coverage and *population* coverage.” (PEPFAR 2009a: pp 6-7).

The introduction of the Next Generation Indicators requires a comprehensive shift away from achievement of primarily numerical targets (as required in PEPFAR 1) to far closer and more detailed attention to measurement of quality, frequently through engagement with far smaller groups than previously (e.g. when addressing prevention). It is relevant also to mention that the GHAIN Monitoring and Evaluation (M&E) system was set up to report to PEPFAR 1. GHAIN M&E systems have not primarily been geared to address quality issues, although there has been increasing programmatic attention as from mid-2010. However, there is too short a time left in the lifetime of GHAIN adequately to measure, monitor and evaluate quality criteria as set out in USG guidance and requirements and in the current USAID Nigeria SO14 Intermediate Results.

The implications of the recent increased USG attention to quality are discussed at many points in this report, most closely in sections 4 and 5.

1.3 OVERVIEW OF GHAIN ACTIVITIES IN YEAR 7

To provide a brief overview of GHAIN activities until the end of project on June 30, 2011: PEPFAR funding for GHAIN has been set at \$52,844,762; details of funding for intervention areas and the number of implementing agency sites are given in Table 1 here below. Table 2 sets out GHAIN technical areas.

'Implementing agency site' covers the following 234 entities nationwide (information provided by GHAIN on 09/22/2010):

- 187 health facilities (the great majority of which are public sector, while a number are faith-based). 170 are secondary facilities, 8 are tertiary (Federal Medical Centers and Teaching Hospitals) and 9 Primary Health Care facilities
- 30 community-based organizations (CBOs), of which 15 are working on Local Government Area (LGA) HAST interventions (see section 4.3.5 for further discussion), 12 are working on Other Prevention, 2 on Early Infant Diagnosis and 1 on PMTCT
- 15 HAST LGAs
- 2 'policy institutions', one of which is the Lagos SACA.

All 234 entities have a sub-agreement with GHAIN.

Table 1: PEPFAR GHAIN funding and number of sites								
Prevention								
Intervention	PMTCT	A&B	C&OP	Blood Safety	Injection Safety	Drug Use	Male Circ	HCT
Funding	\$5,378,846	\$446,011	\$2,005,795	\$60,000	\$175,000			\$177,350
Implementing Agency Site	185	9	13	30	68			147
Care								
Intervention	Adult Care & Support	Ped C & S	OVC	TB/HIV				
Funding	\$7,529,300	\$1,000,000	\$2,273,906	\$1,950,000				
Implementing Agency Site	124	124	69	186				
Treatment								
Intervention	ARV Drugs	Adult Trt	Ped Trt	Lab				
Funding	\$3,423,284	\$17,738,775	\$1,626,350	\$6,600,200				
Implementing Agency Site	124	124	124	118				
Other								
Intervention	Strategic Information	HSS						
Funding	\$2,459,945							
Implementing Agency Site	185							

Source: PEPFAR Nigeria 2010b. PEPFAR Nigeria inter-agency portfolio review.

The following technical areas are receiving support from GHAIN in Year 7.

Table 2: GHAIN technical areas			
Prevention	Care	Treatment	Health Systems' Strengthening
Abstinence/Be Faithful PMTCT Counseling and Testing for HIV (HCT) (Condoms and other sexual prevention (OP) Blood safety Injection safety	Orphans and other vulnerable children Pediatric care and support Adult care and support TB/HIV integration Community-based TB Care RH/HIV integration	Antiretroviral treatment (ART) services ART drugs Laboratory services	6 building blocks [as per WHO/GFATM definitions]

2. BACKGROUND

2.1 THE HIV EPIDEMIC IN NIGERIA

Table 3 Nigeria: HIV & AIDS status at a glance 2009	
National Median HIV prevalence (ANC)	4.6%
Estimated number of people living with HIV & AIDS	2.98 million
Annual HIV positive births	56,681
Cumulative AIDS deaths	2.99 million: male 1.38 million; female 1.61 million
Annual AIDS Deaths	192,000: male 86,178; female 105,822
Number requiring Antiretroviral Therapy	857,455: adults 754,375; children 103,080
New HIV infections	336,379: males 149,095; females 187,284
Total number of AIDS orphans	2,175,760
Source: FMOH (2008) <i>ANC 2008 Report</i> HIV estimates and projection	

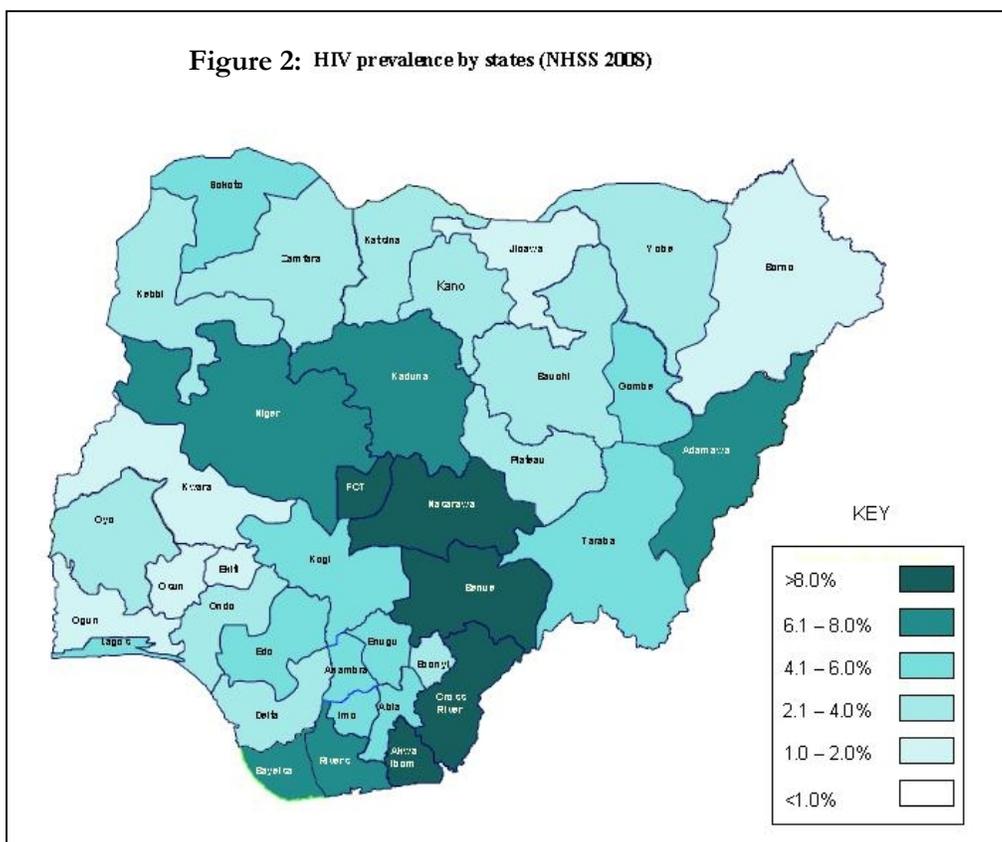
UNAIDS states that Nigeria has the second highest number of people living with HIV in the world; people infected represent about 9% of the global HIV burden (UNAIDS 2009a). This does mean that over 95% of the general population is negative.

The NACA UNGASS report for 2008 and 2009 indicates that HIV prevalence in the general population is 3.6%, based on NARHS 2007 data (NACA 2010); as shown in the table above, 2008 data calculate a higher prevalence rate among women attending antenatal care (ANC) (FMOH 2008: ANC data 1991-2008). There is a higher rate of infection among women in the general population than among men: 4% and 3.2%. Young people aged between 20 and 29 have the highest prevalence rate, at 4.9%. The UNGASS report further demonstrates the socio-cultural variations for all such epidemiological data: HIV prevalence is higher in the general population among those with tertiary education than among those with no education (4.0% vs. 2.7%). Prevalence is higher among single people than among those married.

The National HIV Sentinel Survey (NHSS) 2008 revealed a national HIV prevalence of 4.6%. The prevalence varied by state ranging from 1% to 10.6%. The prevalence was generally higher in urban than rural areas except in 9 states and the FCT. See Figure 2 below.

Drivers of the epidemic continue to be entrenched from both the health systems and societal perspectives. They include: chronic and intractable poverty; lack of equitable access and entitlements to health care; lack of adequate provision of appropriate HIV, opportunistic infection (OI), sexually transmitted infection (STI), sexual and reproductive health (SRH) and maternal and child health (MCH) care at all levels of the public health system; often insurmountable opportunity costs for such access; lack of female empowerment and opportunity to negotiate not only safe sex but also personal autonomy; and widespread male perceptions of entitlement to multiple and often concurrent sexual partners irrespective of personal marital status. Other factors are: low risk and vulnerability perceptions; far too low correct knowledge of modes of HIV transmission and prevention activities; unsafe sexual practices; socio-cultural barriers to effective attention to issues of sexual behaviors; societal and legislative barriers to comprehensive focus on a number of most at risk populations (MARF: e.g. men who have sex with men (MSM) and injecting drug users (IDU)); and seemingly deep-rooted and very high levels of stigma and discrimination.

Figure 2: HIV prevalence by states (NHSS 2008)



A number of key action points are highlighted in recent documents (those listed in this section and also the 2008 DHS and GON & USG 2010):

- The need to institute and follow through on genuinely gender-aware and gender-appropriate interventions, with all sectors of the community. Both the UNGASS report and the *Epidemiological profile of HIV infection in Nigeria* (PEPFAR Nigeria 2010a) and indeed the new National Strategic Framework 2010-2015 (the NSF II: NACA 2009a) emphasize the disproportionately female nature of the epidemic. Thus the epidemiological data indicate 'high prevalence among widowed/divorced/separated women'; as seen in table 3, more women are infected with HIV and more women die of AIDS
- The need for yet more systematically focused work on prevention and other interventions for MARP (e.g. sex workers (male as well as female) and their clients, migrant populations, MSM and IDU and truckers and other transport workers). New data indicate that 40% of new infections are attributable to IDU, female sex workers (FSW), MSM and their partners (these groups are estimated to constitute about 3.5% of adult population; UNAIDS 2009b indicates that upwards of 20% of all new infections occur among FSW and their clients)
- The need to address modes of transmission in the context of individuals' and groups' perceptions of risk and vulnerability
- The importance of effectively addressing and supporting young people with prevention messages

- The importance of providing prevention for positives interventions
- The absolute need to address the situation of orphans and other vulnerable children.

In the general population, 40% of new infections occur among persons perceived (or perceiving themselves) as practicing ‘low risk sex’, including married partners (PEPFAR Nigeria 2010a). It should be noted in this context that the data do not define what is meant by ‘low risk sex’, so the range of perceptions is not known. It may be that some people characterize such sexual acts as including e.g. non-condom use with particular partners, anal/oral/homosexual acts and/or sexual acts with very young and physically immature partners, while others would place such activities in high risk sex. There are also the gender and other variables to consider.

The UNAIDS *Modes of Transmission* study (UNAIDS 2009b) recommends a number of key prevention interventions, among which are in-depth studies and targeted activities with MARP, strategic behavior change work with both MARP and the general population to address risk and vulnerability perceptions, promotion of condom use as normative sexual practice and enabling far greater access to HIV counseling and testing (HCT), including to couple counseling.

2.2 CURRENT APPROACHES TO HIV BY THE GON AND USG⁵

This part of the report sketches a number of approaches, all of which have been developed and/or implemented since the GHAIN evaluation in May 2008. Most detailed discussion of the implications of the current approaches for GHAIN programming will be found in section 5 of this report.

The NSF II and other Government of Nigeria instruments

The *National Strategic Framework 2010-2015* (NSF II; NACA 2009a and the replacement for the first NSF 2005-2009) represents a key federal government policy framework for action on HIV in Nigeria. Its development has taken note of other key national and international policies, plans and goals, such as the Nigeria FMOH *National Strategic Health Development Plan 2010-2015* (NSHDP), the *National Policy on HIV & AIDS*, the *National Economic Empowerment and Development Strategy*, as well as seeking most effective means of achieving UNGASS and MDG targets.

The six thematic areas as set out in the NSF II are:

1. Behavior Change and Prevention of New HIV infections
2. Treatment of HIV/AIDS and Related Health Conditions
3. Care and Support for People Infected and Affected by HIV/AIDS and Orphans and Vulnerable Children (OVC)
4. Institutional Arrangements, Infrastructure Requirements, and Human and Financial Resource Issues
5. Policy, Advocacy, Legal Issues, and Human Rights.
6. Monitoring and Evaluation, Research, and Knowledge Management

It is noteworthy that the NSF II is more informed than was its predecessor by a social development agenda that seeks to address both supply and demand-side aspects of the epidemic. This represents a more nuanced perspective relative to the first NSF (2005-2009) and is indicative of Nigerian and global developments regarding how best to

⁵ Issues discussed in 2.2 have been much informed by team debate and by KII with NACA, SACA, NASCP, SASCP and NPHCDA respondents, as well as by information from USAID and GHAIN.

support prevention as a priority while attending to the whole continuum of support to HIV, from prevention through care, support and treatment. For instance, the NSF II is more detailed in its attention to gender aspects of the epidemic and the need to address social development issues if prevention initiatives are to be successful. The NSF II additionally considers treatment scale-up in the context of a detailed package of biomedical interventions and care and support aspects. There is welcome attention to policy issues, such as attention to ensuring the rights of people living with HIV and AIDS (PLHIV). Consideration is given to institutional strengthening (i.e. under the broad rubric of health systems strengthening) and to M&E and research.

The GON and USG Partnership Framework

The GON and United States Government (USG) *Partnership Framework* signed in August 2010 (GON & USG 2010), sets out the expected contributions of both parties to the policy and programmatic agenda, as defined in the NSF II and the NSHDP. Central to the *Partnership Framework* is facilitation of the implementation of the goals, strategies and objectives of the NSF II and the NSHDP, as well as a reiteration of joint commitment to the ‘Three Ones’. Focus is on optimal coherence of PEPFAR [GHI] and GON objectives and on overall harmonization and alignment of USG (and by extension, other development partners) support to Nigerian action on HIV and AIDS. Top-level goals (2010-2015) of the *Framework* are: a re-focus on prevention; assuring that at least 50% of PLWHA have access to quality care and support services; increasing access to ART from 32% to 80%; increasing GON financing of the national HIV and AIDS response at all levels from current 7% to 50%; and ensuring that at least 80% of all HIV and AIDS programs have ‘adequate numbers of appropriately skilled and gender-responsive professional and community health workers.’ (p6)

The Global Health Initiative

Through the Global Health Initiative (GHI), introduced by the Obama administration, the United States will invest \$63 billion over six years (from 2009) to help partner countries improve health outcomes through strengthened health systems - with a particular focus on bolstering the health of women, newborns and children by combating infectious diseases and providing quality health services. The seven principles underlying the Global Health Initiative are to:

1. Implement a woman and girl-centered approach
2. Increase impact through strategic coordination and integration
3. Strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement
4. Encourage country ownership and invest in country-led plans
5. Build sustainability through health systems strengthening
6. Improve metrics, monitoring and evaluation
7. Promote research and innovation

Achieving major improvements in health outcomes is the paramount objective of the GHI. To that end, GHI will support action on HIV and AIDS through PEPFAR, which will: (1) support the prevention of more than 12 million new HIV infections; (2) provide direct support for more than 4 million people on treatment; and (3) support care for more than 12 million people, including 5 million orphans and vulnerable children (see USG 2009a & b).

PEPFAR

In order to coordinate with the objectives of the GHI, PEPFAR released a five-year strategy that outlined its contributions to the initiative, with focus on the program transitioning from an emergency response to a sustainable, country-owned effort

(PEPFAR 2009b).

PEPFAR’s new five-year strategy goals are to:

1. Transition from an emergency response to promotion of sustainable country programs.
2. Strengthen partner government capacity to lead the response to this epidemic and other health demands.
3. Expand prevention, care, and treatment in both concentrated and generalized epidemics.
4. Integrate and coordinate HIV and AIDS programs with broader global health and development programs to maximize impact on health systems.
5. Invest in innovation and operations research to evaluate impact, improve service delivery and maximize outcomes.

Prevention is at the core of the new strategy, as are more gender-sensitive approaches, treatment and health systems strengthening. In relation to the latter, the strategy states:

“PEPFAR has had a positive impact on the capacity of country health systems to address the WHO’s six building blocks of health systems functions. However, the program to date has not placed a deliberate focus on the strategic strengthening of health systems. In its next phase, PEPFAR is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. PEPFAR now emphasizes the incorporation of health system strengthening goals into its prevention, care and treatment portfolios. Doing so will help to reduce the burden of HIV/AIDS on the overall health system.” (PEPFAR 2009b: p8).

PEPFAR Next Generation Indicators

These were published in June 2009.

Table 4: PEPFAR Next Generation Indicators	
PEPFAR Legislative Goals	Monitoring Indicators
Treatment	
Treatment for at least 3 million people	Percent of adults and children with advanced HIV infection receiving antiretroviral therapy
Prevention	
12 million new infections averted	No routine monitoring indicator – Goal is measured through modeling at HQ
80% coverage of testing and counseling among pregnant women	Percent of pregnant women with known HIV status (includes women who were tested for HIV and received their results)
80% coverage of ARV prophylaxis for HIV-positive pregnant women	Percent of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission
Care	
Care for 12 million people, including 5 million orphans and vulnerable children	Number of eligible adults and children provided with a minimum of one care service (disaggregated by age)
Human Resources for Health – Work Force	
Professional training for 140,000 new health care workers	Number of new health care workers who graduated from a pre-service training institution
Source: PEPFAR 2009a	

The following quote encapsulates the changes introduced as part of the GHI specific to the Next Generation Indicators.

“PEPFAR Next Generation Indicators – Directional Shifts

The [NGI] reflect PEPFAR's strategy to increase country ownership of HIV/AIDS efforts and ensure that host countries are at the center of decision-making, leadership, and management of their HIV/AIDS programs...PEPFAR [NGI] seek to strengthen country programs with the inclusion of 'coverage' and 'quality' measurements. Monitoring and ensuring coverage of quality HIV services is a major focus for this next phase of PEPFAR programming... In the past, PEPFAR indicators described program outputs with little attention to coverage and quality. Coverage indicators include measures of *program* coverage and *population* coverage." (PEPFAR 2009a: pp 6-7).

See also discussion on definitions of quality in section 1.2 above.

3. EVALUATION APPROACH AND METHODS

3.1 THE EVALUATION SOW, OBJECTIVES AND QUESTIONS

Limitations and changes to the Scope of Work

The original intention for the evaluation was that four international consultants were to participate in the end of project evaluation; this proved not to be possible, with the withdrawal of the fourth consultant a few days prior to start of the assignment, due to family considerations. This had repercussions in terms of the expansion of the three remaining international consultants' roles and responsibilities, during both the in-country assignment and report writing. Despite this limitation, the evaluation team managed to undertake visits to a representative sample of GHAIN-supported sites and implementing agencies and was able to meet a sufficient number of project beneficiaries/target population representatives to ensure sufficient depth and breadth in assessment. Therefore, the evaluation findings are deemed to be generalizable and applicable to the project as a whole.

Consideration had also been given to the inclusion of a health economist in the evaluation team. When this did not occur, discussions were held with USAID Nigeria (specifically the HIV/TB Team Leader and the Strategic Information Advisor) so as to modify the Scope of Work (SoW). The changes made were as follows:

- Objective 2c: the evaluation team assessed benefits and program outcomes (not cost benefits)
- Objective 3b: the evaluation team considered benefits (not cost benefits and efficiencies)
- Objective 4a: the evaluation team considered benefits (not cost benefits and effectiveness).

It was agreed that the evaluation team did not include expertise to undertake any type of economic analysis. Furthermore, it was agreed between USAID Nigeria and the evaluation team that the team would not seek to explore GHAIN financial management aspects in any depth, as it lacked the expertise to do so effectively.

In addition, **the scope of the evaluation was clarified as a *programmatic* evaluation (not an impact evaluation)**, assessing value added at outcome level rather than researching the higher-level impact of the activity.

There was also consideration of the precise definition of 'quality' as set out in the SOW, most notably in Objective 1 for the three SO14 Intermediate Results. In the context of discussion of quality throughout this report it should be noted that PEPFAR indicators prior to the Next Generation Indicators focused primarily on achievement of numerical targets. As a result, the GHAIN M&E systems have not primarily been geared to address quality issues, although there has been increasing programmatic attention due to the publication of the NGI in mid-2009. PEPFAR 2009a discusses the precise definition and scope of the new emphasis on quality in the NGI. This report discusses the implications of such a shift in terms of GHAIN implementation (e.g. in sections 2.2, 4.2. Abstinence and Be Faithful interventions, 4.2. Condoms and Other Prevention Interventions, 4.3. Community and PHC-based support interventions (HAST LGAs), and 4.6. Strategic Information/Monitoring and Evaluation, as well as above in 1.2).

The end of project evaluation team has applied current criteria, as set out in the PEPFAR NGI definitions.

“PEPFAR Next Generation Indicators seek to strengthen country programs with the inclusion of ‘quality’ measurements. Monitoring and ensuring quality is a major interest for this phase of PEPFAR programming...PEPFAR is employing the...[definition of quality] offered by the Institute of Medicine, using three fundamental dimensions:

- **Structure:** the settings in which health care takes place and the instrumentalities of which it is the product
- **Process:** whether what is known as ‘good’ medical care has been applied
- **Outcome:** in terms of recovery, restoration of function and of survival.” (PEPFAR 2009a: pp8-9).

It should be noted that the above definitions apply primarily to supply-side (service delivery) aspects of quality. The EOP evaluation team sought throughout to address demand-side (client, community and beneficiary) aspects of quality of service and care.

Discussion was held between USAID/Nigeria and the team during the early stages of in-country work regarding the degree to which focus should be given to the entire life of the project and how much to activities subsequent to the evaluation of May 2008. The SoW indicates that the main thrust of the evaluation should be on post mid-2008 GHAIN work. However, the eventual agreement between USAID Nigeria and the evaluation team was that while particular attention would be given to activities after May 2008, this report should document the entirety of the project. Therefore, all sections of the report discuss activities since GHAIN inception in 2004, while detailed consideration of activities prior to the 2008 evaluation is to be found in the 2008 report. See also Appendix B for the GHAIN timeline: this encompasses activities undertaken during the entire life of the project.

Scope of Work End of Project Evaluation questions

See section 5.2 of this report for detailed discussion of findings arising out of the Scope of Work evaluation questions. The SoW sets out four objectives (please see Appendix A for the full text). The (amended) objectives and questions are included in this section for reference purposes.

Objective 1: Achievement of the GHAIN goal and strategic objectives

Determine whether the GHAIN project continued to achieve its goal and strategic objectives (intermediate results) following the May 2008 evaluation. The GHAIN Goal is: *reduced impact of HIV/AIDS and TB in selected areas.*

IR1 is: ‘increased use of quality HIV/AIDS and TB prevention services and interventions’.

IR2 is: ‘increased use of quality HIV/AIDS and TB care and support services and interventions’.

IR3 is: ‘increased use of quality HIV/AIDS and TB treatment services and interventions’.

Question 1a

In assessing the extent to which these IRs have been achieved, the evaluation team will analyze the extent to which GHAIN has met its PEPFAR targets that are set each year during the COP planning process and reported to OGAC on a semi-annual basis.

Question 1b

In assessing the extent to which the GHAIN project contributed towards furthering the goal of USAID Nigeria SO14 through a review and analysis of the available data pertaining to the relevant program areas.

Question 1c

In assessing the extent to which the GHAIN project contributed towards the six principles of the Global Health Initiative's approach.⁶

Question 1d

In assessing the extent to which the GHAIN project contributed to the overall PEPFAR Nigeria program.

Objective 2: GHAIN capacity building efforts

Determine to what extent the capacity building efforts by the GHAIN project contributed to the implementing agencies' overall performance in and sustainability of the delivery of comprehensive HIV/AIDS prevention, care and treatment [and/or] TB [and/or] malaria in pregnancy [and/or] RH-HIV integration programs.

Question 2a

To what extent have activities been transferred to the government or local partners?

Question 2b

With respect to treatment services, the evaluation team will assess the organizational capacity of selected sites to deliver effective care and to deliver care with less USG support and more GoN support. The team will identify elements or areas that need technical assistance as well as areas that can serve as resources for expansion or scale-up in other sites.

Question 2c

The evaluation team will assess the benefits and program outcomes of the collaborative and multiple-pot funding (PEPFAR, Child Survival and Population Funds) using the GHAIN project as a single mechanism.

Objective 3: Collaboration and synergies between GHAIN and GFATM funding

Determine to what extent the collaboration and synergies between PEPFAR and GFATM funding contributed to the overall program and health systems impact.

Question 3a

What are the challenges and benefits of close collaboration with GFATM, and should this be encouraged among USAID IPs?

Question 3b

What are the benefits of the collaboration with GFATM?

Question 3c

What is the impact of the collaboration and synergies between PEPFAR and GFATM under the GHAIN program on the overall health systems in Nigeria?

⁶ Please note that the 2009 documents *Implementation of the GHI: consultation document* and *Fact Sheet: The U.S. Government's Global Health Initiative* both list seven principles. This report addresses those seven; this was agreed with USAID Nigeria.

Objective 4: Lessons Learned

Determine lessons learned that will assist USAID, Government of Nigeria and other implementing partners with future comprehensive HIV/AIDS, TB and reproductive health – HIV integration programs in Nigeria and elsewhere.

Question 4a

What are the benefits of implementing large-scale integrated programs such as the GHAIN project, which [covers] the whole country? PEPFAR country programs are prohibited from allocating more than 8% of total funding levels to one partner, since funding levels for the GHAIN project exceeded the 8% threshold, USAID Nigeria requested and was granted a waiver to fund FHI. The evaluation team will examine the relevance of the 8% threshold for PEPFAR activities in terms of the cost of managing larger projects versus costs of managing multiple smaller projects.

Question 4b

Should the project continue to offer a wide range of integrated prevention, care and treatment services or focus on treatment only?

Question 4c

Should the project continue to offer treatment services nationwide or focus on providing services in particular regions or zones? Is the oversight provided by FHI HQ, FHI Nigeria Country Office and the Zonal Offices sufficient? Are the current staffing levels and management design adequate? Has there been any difference to date, from the evaluation of May 2008?

3.2 THE EVALUATION TEAM

Three international consultants were contracted by FHI for the GHAIN EOP evaluation (see section 3.1 for limitations): Dr. Ruth Hope, Lucy Shillingi and Janet Gruber von Kerenshazy (team leader). The consultants have reported throughout directly to USAID Nigeria, specifically to the HIV/TB Team Leader and the Strategic Information Advisor, and not to FHI.

The entire evaluation team comprised eleven people. In addition to the international consultants, four USAID Nigeria staff members participated throughout the evaluation: McPaul Okoye, Dr. Joseph Monehin, Akinyemi Atobatele and Dr. Emeka Okechukwu; McPaul Okoye was also interviewed as a key informant. A national counterpart from NASCP (Dr. Sampson Ezikeanyi) participated for the entirety of the evaluation. Two NACA staff members (Hafatu Aboki and Musa Doba) were involved in the fieldwork as members of the northern team. A CDC staff member, Dr. Ahmad Aliyu, was able to join the team for part of the tools' development, the first day of northern teamwork and during the outbrief; he was additionally a member of the CDC KII group.

3.3 EVALUATION APPROACH

The evaluation was conducted with the intention of achieving broad and representative involvement of as many GHAIN stakeholders as possible. Of primary importance was engagement with Nigerian public health sector actors. To this end, key informant interviews (KII) were undertaken with Nigerian public sector counterparts at federal, state and LGA levels: representatives of NASCP, NACA and the NPHCDA were met, as were SACA and SASCP staff members in Sokoto, Taraba, Lagos, Anambra, Edo and Cross River states and the FCT. Meetings were held with LGA staff members in a number of HAST LGAs. Health workers in twenty-two secondary and two tertiary health facilities were also interviewed, either by KII or while completing health facility

clinical service delivery checklists, as were health workers in four primary health care facilities.

GHAIN staff members at country and several zonal offices were interviewed through the use of KIIs. The four GHAIN partners (FHI, Axios, HUCE-PACE and GLRA) responded to self-assessment questionnaires; these were sent out through GHAIN country office channels but received back from all partners directly to the Team Leader. (See Axios 2010, FHI 2010a, HUCE-PACE 2010 and GLRA 2010.)

3.4 EVALUATION METHODOLOGY

Four methods of data collection, triangulation and verification were employed during the evaluation. These were:

1. Review of GHAIN, USAID Nigeria, PEPFAR, GHI, USG, GFATM and other relevant documentation, including peer-reviewed papers, international best practice reports and other Nigeria and Africa-specific HIV literature;
2. Key informant interviews and focus group discussions with a wide range of GHAIN staff members, stakeholders and beneficiaries;
3. Health facility checklists for eight service delivery areas and three crosscutting components (referrals, health system strengthening and medical waste management);
4. Self-assessment questionnaires for the four GHAIN partners.

The GHAIN EOP evaluation was a **subjective, qualitative** review of program implementation whose approach and tools were designed so as to achieve maximum triangulation of findings within the limitations of the assignment. **It was not a research study**; while both the northern and southern field teams obtained as much in-depth information as was achievable in the time available, it was neither possible nor appropriate to explore subjects in great detail. **This report does not represent a quantitative evaluation.** While certain sections of the report, e.g. on adult and pediatric ART, discuss number reached in considerable detail, other sections, e.g. on Condoms and Other Protection and on HAST, focus more on qualitative aspects. The evaluation team accepted the veracity of GHAIN data, as these have been subject to verification exercises by USAID and PEPFAR Nigeria.

The three international consultants initiated the site selection process for the northern and southern field teams; they developed key criteria (e.g. for health facilities (sites) a range of rural, peri-urban and urban sites, hard to reach facilities, mature and more recent GHAIN-supported sites, PMTCT facilities and a number of sites where the FP/RH integration component has been implemented). In addition the consultants requested that site selection reflect geo-political considerations, e.g. visits to all 6 Zones and a balanced weighting between North and South. Another selection criterion was that a sample of the fifteen HAST LGAs should be visited.

USAID Nigeria staff members undertook finalization of site selection.

A total of fourteen states, twenty-eight health facilities and a representative sample of HAST LGAs were visited.

3.5 EVALUATION TOOLS

A selection of evaluation tools is included in Appendix E. All are available from the evaluation team leader. The evaluation tools were developed in a participatory manner, with initial work undertaken by the three international consultants, with subsequent

inputs from other team members and the USAID Nigeria Strategic Information Advisor.

A total of eight clinical service delivery checklists were developed. These were applied in all the twenty-two secondary and two tertiary health facilities visited by the southern and northern evaluation field teams:

- HCT Services
- PMTCT Services
- ART Services (adult and pediatric)
- Palliative Care (TB/HIV)
- Palliative Care (basic health care and support – adult and pediatric)
- M&E Systems
- Laboratory Services
- Pharmacy Services

In addition, the checklists included three crosscutting sections: on referrals and linkages, medical waste management and health systems strengthening.

Seven key informant interview (KII) guides were developed, six of which were used during fieldwork and Abuja interviews. It was not possible to hold a meeting with NEPWHAN; therefore, that KII was not applied. The other KIIs were used by the southern and northern field teams and in Abuja where appropriate. The KII guides were:

- NACA/NASCP and SACA/SASCP; F/SMOH; NPHCDA staff members
- Health facility managers/management team
- LGA PHC and other staff members
- USAID and CDC staff members
- GHAIN country office staff members
- GHAIN zonal office staff members
- NEPWHAN

A focus group discussion guide was also developed. It included questions to be addressed to members of health facility support groups assisted by GHAIN programming, CBO members, community volunteers, peer educators, community pharmacists and other community beneficiaries of GHAIN programming (e.g. caregivers of orphans and other vulnerable children).

The evaluation tools were intended as guides rather than prescriptive sets of questions. Because the team comprised highly experienced and competent experts in a number of fields, the approach agreed by the team members was that the tools would be used as a basis for more searching, qualitative questions, based on individuals' expertise and professional experience and also on participant observation and individual circumstances pertaining at sites and with respondents.

Each of the two teams held daily evening meetings where checklist, KII and Focus Group findings were discussed and collated for subsequent use in preparation of the outbrief and this report.

3.6 EVALUATION SCHEDULE

See also Appendix D for a detailed, daily itinerary.

The evaluation process began with a teleconference call facilitated by FHI Arlington in mid-September, in which USAID/Nigeria, senior GHAIN country office staff members and the three international consultants participated.

The international consultants spent the first full week in country (September 20 to 26) in briefing meetings with USAID/Nigeria and GHAIN country office staff members, participation in a one-day GHAIN project presentation, review of documentation, discussion of site selection and initial preparation of fieldwork tools. The second week (a four-day week because of the celebration of the 50th anniversary of independence on October 1) saw GHAIN and USAID KIIs being conducted and finalization of field tools and methodology. Fieldwork began in the third week, with the team splitting into northern and southern teams, the former beginning its site visits in the FCT and the latter traveling to Lagos.

The northern team spent the next almost three weeks (until October 22) visiting health facilities and HAST LGAs located in the FCT and in Niger, Kaduna, Sokoto, Kebbi, Adamawa and Taraba states. The southern team worked in Lagos, Ogun, Osun, Edo, Anambra, Enugu and Cross River states, returning to Abuja on October 23.

The final week in-country for the international consultants was spent on conducting a KII with NACA, visiting the FCT HAST location (at AMAC - the Abuja Municipal Area Council – the equivalent of an LGA) and on preparing the outbrief; this was delivered at USAID on the morning of October 29, with a presentation also being given to GHAIN later on the same day.

The draft report was submitted on November 29, 2010 and a debrief meeting cum teleconference held with USAID/Washington staff members on December 3, 2010. A rapporteur took notes of comments and questions and these have subsequently been reviewed and where necessary addressed by the international consultants.

In addition, the international consultants received detailed comments on the draft report from USAID/Nigeria and GHAIN, and discussion points from FHI, during December 2010, for all of which they are grateful. All USAID/Nigeria comments, queries and requests for clarification have been addressed in full in this final report. Factual errors identified by FHI and/or GHAIN have been corrected. Other points identified by FHI and/or GHAIN have been addressed where considered necessary and/or appropriate by the international consultants, bearing in mind evaluation findings and the entire independent evaluation process and its integrity as such.

This document represents the final version of the report.

4. EVALUATION FINDINGS

The following structure is used in this section of the report. Where relevant, sub-sections on evaluation findings (each addresses an individual intervention area, the first being PMTCT at 4.2.Prevention of mother-to-child transmission) are prefaced by an overview of the current situation in Nigeria, USG requirements and any changes in GHAIN programming since the 2008 evaluation (entitled *Introduction and background*). Each GHAIN intervention area is then discussed in terms of project *achievements*. *Challenges* are also considered; the EOP evaluation team has defined these as issues that are not within the immediate remit of the project (e.g. Nigerian socio-cultural barriers to OP), but which nonetheless have either had or may have an impact on its implementation. In order to provide the most detailed discussion of GHAIN interventions as considered against the national and international environment, challenges are discussed after GHAIN-specific achievements and before attention to GHAIN-specific *gaps*. The rationale for this is that this sequence allows the most comprehensive consideration of gaps and lessons. *Lessons learned* by the project over its lifetime specific to each intervention area are described; lessons learned as defined by the evaluation team are also included. This final section includes consideration of innovations and standardizations introduced by and/or supported by GHAIN—which should be acknowledged as achievements in their own right.

The reader is also referred to a number of appendices that provide more detailed discussion of topics such as prevention, RH/FP integration, HAST and gender and social development and community systems strengthening.

4.1 INTRODUCTION AND OVERVIEW OF THE EVALUATION FINDINGS

The evaluation findings blend the qualitative data obtained from site visits, supplemented by data derived from key informant interviews and focal group discussions, with quantitative data from GHAIN reports.

The end of project evaluation was hampered, particularly in the south, by ongoing doctors' strikes and at one site in Edo the evaluation was disrupted by wildcat demonstrations involving many other staff cadres as well as the doctors. Additionally, also especially in the south, there was an unfortunate tendency for GHAIN staff to have gone beyond supporting facilities to present "their best face" to the evaluation team. Staff at some SACAs, SASCPs, hospitals, and LGAs had been primed with briefing notes and provision of wall charts that they claimed they had generated. Most SACA and SASCP staff quickly abandoned prepared notes and engaged in frank discussion with the evaluation team. The evaluation teams (north and south) were rapidly able to demonstrate that many of the staff members who claimed to have produced charts had no access to functioning printers, and none of the staff members understood what the charts showed. This was particularly regrettable as most staff members who could not interpret their charts were able to discuss, for example, the causes of variations in service utilization when asked. Thus they had the right knowledge but were simply not used to interpreting information presented in charts.

Clinical services

GHAIN pioneered provision of comprehensive HIV/AIDS treatment services at secondary level in Nigeria. GHAIN established the practicality of delivering comprehensive services in secondary hospitals and then scaled up quite remarkably. At the time of the 2008 evaluation there were 133 GHAIN-supported sites, of which 90

provided ART services; in 2010 GHAIN is supporting the delivery of services in 170 secondary hospitals, of which 124 provide ART services. The great majority of the secondary facilities are government hospitals, while a small number are faith-based hospitals. GHAIN also supports eight tertiary hospitals (Federal Medical Centers and teaching hospitals). GHAIN is supporting service delivery in all 36 states and the Federal Capital Territory.

The evaluation team was broadly impressed with the majority of the clinical services visited; most facilities were providing adequate or good quality services, often with inadequate staffing levels in congested clinics. Many had at least 1 or 2 people living with HIV working as volunteers supporting the service delivery – assisting with follow up of persons who failed to attend an appointment, providing peer support to clients and or guiding new clients from one service delivery point to another. With very few exceptions, service delivery staff members were professional and caring, and all spoke warmly of the support they receive from GHAIN staff.

Prevention

GHAIN has supported a wide range of systems, prevention and community-based activities throughout the lifetime of the project, with significant developments since the evaluation in 2008 (see 1.2 for an overview). PMTCT site expansion has gone from 25 in 2004, to 145 in March 2008, and a total of 185 service outlets provide a minimum package of PMTCT services according to national or international standards (as of June 2010). 739,291 pregnant women have been provided with PMTCT services, including counseling and testing (with results received) cumulatively from inception to June 2010.

GHAIN has more than met its prevention targets between COP05 and end of COP09 in terms of PMTCT, A/B and C/OP. A/B and OP activities are experiencing refocus, in line with the PEPFAR Next Generation Indicators. This does present challenges in terms of technical capacity, both within GHAIN and also its implementing agencies.

GHAIN continues to be a leader in the provision of HCT; it is estimated to provide this service to upwards of 50% of the total number of Nigerians counseled and tested.

Care and Support

GHAIN has significantly supported TB/HIV palliative care, with expansion of sites providing TB-HIV services to 106 in March 2008, and to 187 by June 2010. 285,662 PLHIV have been screened for TB from inception cumulatively to June 2010, with a target in the year to June 2010 of 20,000 and achievement of 93,208. A total of 57,455 individuals have received HCT and their results in TB settings cumulatively from inception to June 2010, with a target in the year to June 2010 of 5,830 and an achievement of 33,384. Other palliative care has received considerable attention, while community-based focus requires strengthening.

Support to orphans and other vulnerable children represents an area of weakness for GHAIN. While much action has taken place since GHAIN inception on support to PLHIV, the core concept of facility-based support groups is unsustainable. The HAST LGA model requires considerable review; the evaluation indicated substantial limitations.

RH/HIV Integration Project

From 2007 onwards, GHAIN has introduced and institutionalized RH/HIV integration in 131 of its supported HIV/AIDS services facilities. Achievements include: FP clinic utilization is reported to have increased in centers where RH/HIV integration is instituted, both in terms of attendance and number of new users; major stakeholders - facility managers, program managers, service providers, government officials, GHAIN

staff, and community providers - are generally aware of, understand the issues, and appreciate the benefits of RH/HIV integration.

Strategic Information/Monitoring and Evaluation

GHAIN has developed and internally instituted many data collection systems of high quality and robustness. The biggest challenge is to support genuine, sustainable downstream capacity, utilization and ownership.

Health Systems Strengthening

As reported by GHAIN to the end of project evaluation team, this has been a major GHAIN focus since mid-2008 and much has been undertaken. A number of factors, including short time span and insufficient in-house technical expertise, mean that the institutionalization and ownership of HSS components by all GHAIN public sector and civil society implementing agencies is only in its early stages.

4.2 HIV/AIDS AND TB PREVENTION SERVICES AND INTERVENTIONS

Prevention of mother-to-child transmission

Introduction and background

The 2008 evaluation noted that GHAIN espouses four strategies in its approach to prevention of mother-to-child transmission of HIV (PMTCT):

- Primary prevention of HIV infection in women of reproductive age and their partners
- Prevention of unintended pregnancies among HIV infected women
- Prevention of HIV transmission from infected women to their infants
- Provision of treatment, care and support to women infected with HIV, their infants and families

Since 2008, PEPFAR information⁷, and WHO guidance on use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants⁸ and on HIV and infant feeding⁹ have been updated. Inevitably, FMOH PMTCT guidelines lag behind. GHAIN has collaborated with UNICEF to strengthen and extend PMTCT service delivery, with GHAIN providing drugs and UNICEF taking the lead on developing the curriculum and training health staff.

PMTCT services have been successfully integrated into ANC and midwifery services at GHAIN-supported sites, although the PMTCT registers duplicate rather than replace the existing ANC registers. While group pre-test “counseling” — in truth this is information sharing — continues to be the norm at GHAIN-supported PMTCT sites, there appears to be increasing recognition that providing group post-test “counseling” for pregnant women who are non-reactive on rapid testing, while ensuring women who are reactive on testing receive individual post-test counseling is both stigmatizing and undesirable. This is an improvement in PMTCT service delivery quality since 2008. Additionally, a significant number of PMTCT staff members in ANC recognize the need to involve male partners in PMTCT—a further improvement since 2008—and the

⁷ Prevention of Mother-to-Child Transmission (Updated January 2009)

<http://www.pepfar.gov/press/79674.htm> downloaded November 2, 2010

⁸ WHO 2009b. Rapid advice: Use of antiretroviral drugs for treating pregnant women and preventing HIV Infection in infants.

⁹ WHO 2009c. HIV and infant feeding revised principles and recommendations. Rapid advice November 2009.

evaluation team did see some men attending ANC with their pregnant partners at some sites in the South; this was reported for the North too.

In recognition that the majority of pregnant women do not deliver in health facilities in Nigeria, many GHAIN-supported PMTCT sites have started providing pregnant women who test positive at ANC booking with a single dose of nevirapine for the woman to take home and use when she goes into labor. Despite GHAIN reporting that “To ensure quality service delivery, GHAIN PMTCT teams conducted PMTCT clinical audits to ensure that all HIV positive pregnant women undergo clinical and immunological staging and are provided with the appropriate intervention as and when due” (GHAIN 2010f), many of the PMTCT sites visited in the evaluation are unable to ensure positive pregnant women attend the ART clinic for clinical assessment and CD4 count because ANC booking clinics are not on the same day as the ART clinic. Few if any positive pregnant women have blood taken for CD4 from the ANC clinic so that the result is available when they arrive at the ART clinic. Some ANC clinics refer positive pregnant women to pharmacy to collect supplies of single dose nevirapine for the women to take in labor and cannot be sure that the women collect their dose.

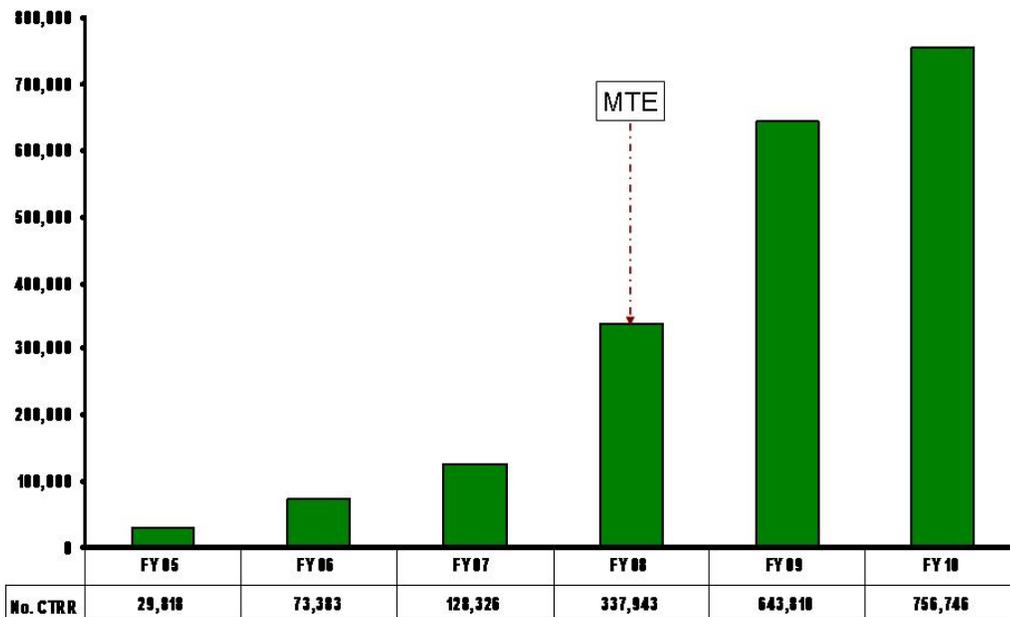
In contrast, some women who are doing well on ART become pregnant and continue on ARVs—possibly with modification of their regimen—in pregnancy.

Achievements

- PMTCT site expansion from 25 in 2004, to 145 in March 2008, and a total of 185 service outlets providing minimum package of PMTCT services according to national or international standards by June 2010
- 739,291 pregnant women provided with PMTCT services, including counseling and testing (with results received) cumulatively from inception to June 2010
- From July 05, GHAIN has more than met its targets for women, counseled and tested who receive their results, with a target for the year to June 2010 of 120,000 and achievement 139,958
- 31,563 pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting, cumulatively from inception to June 2010, with a target for the year to June 2010 of 4,000 and GHAIN achievement 9,855
- 3,126 individuals trained in PMTCT according to national or international standards from inception to June 2010 with target for the year to June 2010 of 325 and achievement of 753
- Continued rapid expansion of service delivery sites during FY08 and FY09, along with introduction of routine, opt out, HCT in ANC settings ensured that there was a corresponding rapid increase in the number of pregnant women who were counseled, tested for HIV and received their results. As GHAIN-supported site expansion ended, the rate increase was not so great in FY10. See Figure 3 below.
- Similarly, GHAIN reported an increase in numbers of positive pregnant women who received ARV prophylaxis in FY09 and FY10 although the percentage of tested mothers who are positive is low, varying between 5.84% in FY06 to 3.3 in FY10, and thus the numbers receiving prophylaxis are small 9844 in FY09 and 9237 in FY10 when 76% and 77% of positive mothers received prophylaxis. [However, there is no way of knowing how many positive women who received doses of nevirapine to take home actually used them when they went into labor. See Figure 4 below.]

Figure 3:

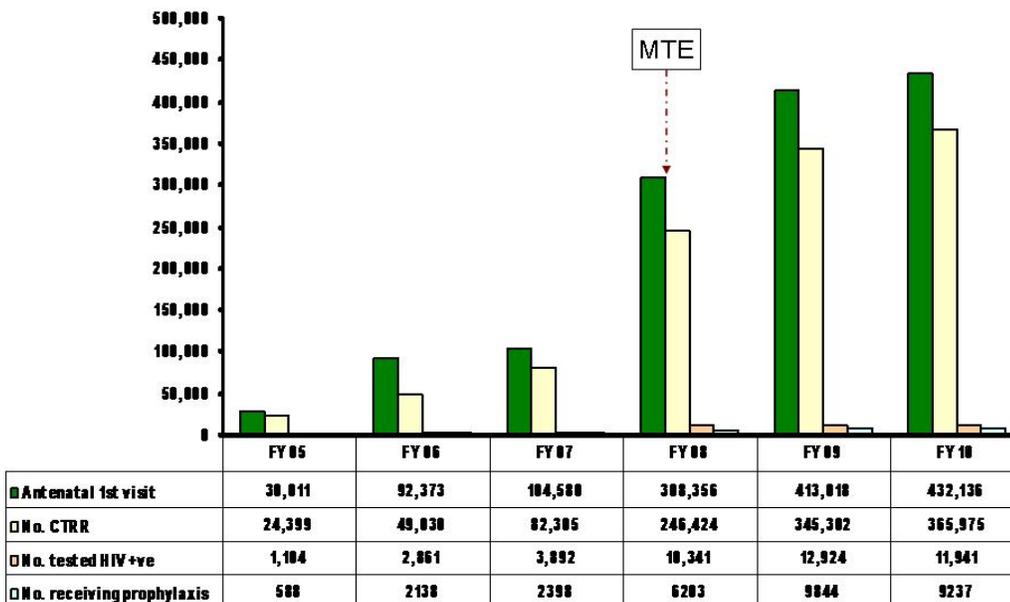
No. of pregnant women counseled, tested for HIV and received their results – cumulative



MTE = 2008 evaluation

Figure 4

No. of HIV+ pregnant women who received ARVs to reduce risk of MTCT by FY



CTRR = counseled, tested & received results; MTE = 2008 evaluation

- Another marked improvement since 2008 is in PMTCT staff knowledge of the importance of exclusive breast-feeding in resource-poor settings where it is not possible to provide AFASS¹⁰ conditions. Many PMTCT staff can now discuss the importance of exclusive breastfeeding for 6 months with continued breast-feeding during the introduction of complementary feeding throughout the infant's first year (and beyond), and report that they counsel mothers about this.

Challenges

- Many of the challenges noted in the 2008 evaluation report persist, including:
- Gender inequality
- High percentage of unplanned pregnancies
- Overall only 56% of pregnant Nigerian women attend ANC with wide regional differences, and only 24% are delivered by a skilled birth attendant (and there are inconsistencies in definition of what constitutes a skilled attendant)¹¹
- Religious and cultural barriers to facility delivery
- Denial, stigma and fear of discrimination or desertion are persistent barriers to uptake of PMTCT services
- Low partner notification and testing—*although awareness of the need for partner involvement has increased since 2008*
- The vast majority of labor and delivery wards in the GHAIN-supported sites visited during the end of project evaluation remain overcrowded and lacking in basic infrastructure. Women labor alone in unfriendly environments, without the support of female relatives and friends, or male partners, on beds without wedges or pillows and with rubber sheets. In delivery, the environment for most women deteriorates with overcrowding, lack of privacy and pain relief, and with the women delivering in stirrups in lithotomy position¹². Labor wards visited are chronically understaffed and only a minority of staff members has had PMTCT training.¹³

Gaps

- Follow up of women who test positive in pregnancy is often poor; many are not seen in the ART clinic for clinical assessment and CD4 testing for eligibility for ART. Tracking of referrals and tracing of those who do not attend from PMTCT to ART is far less common than tracking of referrals from HCT or TB/DOHS to ART. Very few positive pregnant women are offered combination regimens of ARVs for PMTCT that are both more effective in reducing transmission and less likely to cause resistance than use of nevirapine only.
- A significant gap (40% in FY08, 24% in FY09 and 23% in FY10) remains between the number of pregnant women who test positive and those who receive ARV prophylaxis. Further, the loss of clients from PMTCT services was reported by service delivery and GHAIN zonal staff to continue with HIV-exposed infants not receiving ARV prophylaxis and not having PCR testing for early infant diagnosis of HIV infection.

¹⁰ Definition of AFASS in relation to replacement feeding: **A**cceptable, **F**easible, **A**ffordable, **S**ustainable, **S**afe

¹¹ NPC & ICF Macro 2009 (*NDHS 2008*).

¹² Lithotomy not only compromises the physiology of delivery, but it is very unpleasant for the mother, who in many Nigerian cultures would customarily deliver in a squatting posture at home

¹³ One notable exception to this situation is at Isoro General Hospital, Lagos that has a brand new "model" mother and child health unit with excellent delivery facilities.

- The biggest gap is in addressing the demand side for PMTCT services. While effort has been made to make counseling and testing routine for all pregnant women attending booking ANC, corresponding effort has not been made into addressing barriers to pregnant women attending ANC, using PMTCT services and delivery services and ensuring their HIV-exposed infants receive ARV prophylaxis. While many, but not all, GHAIN-supported PMTCT sites have links to laboratories that do early infant diagnosis [EID] of HIV infection, there is no concerted effort at community level to ensure exposed infants receive prophylaxis and have dried blood spots taken for EID.

Lessons learned

- It has been possible to move from “opt in” HCT to routine, “opt out”, HCT in ANC settings. However, this does not seem to have significantly increased the proportion of positive mothers and HIV-exposed infants receiving ARV prophylaxis
- Without attention to demand side, there has not been significant improvement in proportions of positive mothers and HIV-exposed infants receiving ARV prophylaxis
- Collaboration with UNICEF, with regard to HIV and infant feeding, has significantly improved the knowledge of PMTCT staff and increased the numbers of PMTCT staff in resource poor settings reporting that they are supporting mothers exclusively to breast feed their infants for the first 6 months of life and continue breast feeding after the introduction of complementary feeding where conditions are not AFASS.

Abstinence and be faithful interventions

See Appendix F for more detailed discussion of this topic.

Introduction and background

Attention to “abstinence and be faithful” (A/B) has been a key component of GON, USG and GHAIN activities throughout the lifetime of the project. The changes in emphasis and approach over time, and most notably since the introduction of the USG *Global Health Initiative* and the PEPFAR *Next Generation Indicators* are well known. There have been significant programmatic implications for GHAIN inherent in such shifts, e.g. away from achievement of large numerical targets and sometimes undifferentiated and unrealistic assumptions about efficacy of A/B prevention messages to specific target groups.¹⁴ GHAIN began implementing such shifts only from July 2010.

The new approach to A/B prevention does not appear to have been fully instituted within GHAIN. While previously the A/B targets were number-driven, the focus now within GHAIN is for implementing agencies’ peer educators to work with small ‘cohorts’ (up to fifteen members per cohort and up to three cohorts per peer educator) and to achieve a minimum of three meetings per cohort. This necessitates not only a major alteration in approach; it also requires what may be substantial changes in individual implementing agencies’ and peer educators’ skills sets and capacities. GHAIN staff members do not directly work on A/B (or indeed on C and OP); this is undertaken by implementing agencies.

COP10 funding for GHAIN A/B activities is \$446,011; the number of GHAIN

¹⁴The end of project evaluation consultants did not have sight of a GHAIN final year A/B activity overview, by contrast to those reviewed for earlier years, e.g. GHAIN 2009c.

implementing agency sites listed as working on A and B is nine (PEPFAR 2010b).

Achievements

GHAIN has applied many A/B prevention strategies over the life of the project. These include advocacy, capacity building of to date close on 4,500 peer educators and other volunteers, mass and mid media and community outreach. A wide range of information, education and communication (IEC) and strategic behavior change communication (SBBC) methodologies and materials have been used across several media and communication platforms (e.g. mass media (radio and television); mid media (e.g. posters); latterly interpersonal communication through peer educator-moderated cohort focus group discussions). These efforts are to be fully acknowledged.

Indicator	Final year target (July 2010-June 2011)	Cumulative achievements (July 1 – Aug 31, 2010)	Cumulative targets to be reached by June 30, 2011	Cumulative achievements to date (Sept 2004 –August 2010)
Prevention (Abstinence and Be Faithful)				
# of targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	25,000	12,230 (Male = 6,134 and Female =6,096)	972,894	2,932,507 (Male = 1,825,663 and Female = 1,106,844)
Source: GHAIN 2010d				

The numbers listed above do not encompass the entire numerical achievement of GHAIN A/B targets. The indicator used is from PEPFAR NGI. Data provided by GHAIN (covering a period when PEPFAR 1 indicators (i.e. pre-GHI) were applied) indicate that the cumulative target for Sept 04 to June 10 specific to A/B was 4,456,395 individuals. The cumulative achievement was in fact 13,506,753 people (GHAIN 2010c).

Peer educators volunteering to work with GHAIN-supported implementing agencies are said to have been retrained as from mid-2010 to apply the *Minimum Prevention Package*, which is the new overall prevention approach now being applied by GHAIN and its implementing agencies. The *Prevention Intervention Tracking Tool* has been developed by USAID to facilitate collection of *Minimum Prevention Package* data by peer educators.

Peer educators work on A/B communication with MARP as well as with members of the general population (e.g. young people in and out of school). Cohorts are being developed within each MARP for work that will address A/B and C and OP.

Challenges

1. There is a need to address modes of transmission through prevention activities (A/B and OP), in the context of individuals' and groups' perceptions of (lack of) risk and vulnerability. This will have to be addressed by all partners working on HIV in Nigeria.
2. There is an imperative need to address gender aspects of HIV prevention and to

support women and girls, as well as men and boys, to engage with sustainable *and* gender-sensitive prevention activities.

3. All work on prevention that introduces new approaches, with concomitant demands on implementing agencies, peer educators and other volunteers, has to be matched by expertise and appropriate planning, management and support to implementation. This applies at national and other levels, not merely within projects.

Gaps

Key issues

Implementing agencies and peer educators working on A/B are not being sufficiently supported to institute and then implement what are significant and far-reaching changes in approach, practice and reporting. It is inappropriate to require CBOs, peer educators and other volunteers to make such changes without the most comprehensive and expert technical inputs from GHAIN. These have not been forthcoming.

The gender implications hidden in bald statistics (see e.g. those above) represent another essential aspect of A/B (and indeed C and OP) prevention interventions, and an area where GHAIN does not have sufficient technical expertise to achieve effective, targeted communication.

The relevance does need to be questioned of provision of A/B communication to people who may engage in transactional or commercial sex work or who may be resistant to behavior change to such an extent that the inputs may not be answered by any impacts. MARP members may also become opposed to OP messaging if they are presented with inappropriate A/B interventions.

Insufficient GHAIN technical capacity on prevention (A/B and also OP): field discussions and (minimal) observation during the EOP evaluation indicate that a comprehensive shift to close, longitudinal and cohort prevention focus has not yet been effectively introduced and implemented by GHAIN, whether within its own workforce or with its community-based implementing agencies and volunteers.¹⁵

The view of the end of project evaluation team is that there is inadequate internal GHAIN technical expertise on prevention at country office level. This appears to have resulted in a degree of imprecision in planning and implementation, with repercussions at zonal and lower levels, both for GHAIN staff members and implementing agencies and volunteers.

The evaluation findings further indicate that GHAIN does not have specialist expertise to develop prevention messages and materials. Moreover, the project does not have the expertise to work on SBCC materials' development. As a result, generic FHI prevention materials (found in e.g. Ethiopia and Tanzania) are being used, sometimes with minimal adaptation, which is inadequate. GHAIN staff working on prevention made mention that SBCC and IEC materials will not change, despite re-orientation of prevention focus; this too is an inadequate response. This is the case equally for C/OP, and will not be repeated there.¹⁶

¹⁵ It is acknowledged that GHAIN is responding to USG priorities and imperatives and as such may on occasion have relatively limited room for maneuver. Despite this, the discussion of gaps remains pertinent, both for the remainder of the GHAIN project and for future interventions.

¹⁶ The evaluation team had only brief opportunity to review SBCC materials applied by GHAIN in order to support prevention activities. It was not possible to assess the full range of media, e.g. mass media materials (television, radio) were not evaluated.

Incomplete coverage

There is no funding in the GHAIN North East zone for A/B work. Out-of-school youth represent another vulnerable group that has received limited attention from GHAIN.

The Minimum Prevention Package and the Prevention Intervention Tracking Tool

No peer educator working on either A/B or C and OP mentioned actual application of either.

Lessons learned

1. Insufficient technical assistance and management leadership are being provided by GHAIN to institute and embed internally and at implementing agency level what are in fact major changes in prevention focus. Such changes require dedicated expertise and longitudinal planning, monitoring and evaluation, as well as far more participation by target group/cohort members at all stages of prevention activity planning, implementation and M&E. All such factors need to be considered in the follow-on program to GHAIN.
2. Careful consideration has to be given by both USG and projects to how best to address and accommodate major shifts in programmatic focus, as has occurred for GHAIN with prevention activities. This attention should include consideration of comparative advantage and value added, as well as realistic assessment of existing technical capacity within a project and the best use of additional such expertise.
3. Overall prevention messaging must optimize effective communication; e.g. provision of A/B SBBC to FSW may not represent highest priority or most acceptable support.
4. Numbers reached in all prevention activities must be balanced against the quality of separate and cumulative interventions and their actual value in terms of promoting and sustaining A/B behaviors; this is now more of a priority within GHAIN. However, it is not possible to assess quality of prevention activity inputs from the demand-side, as no such monitoring and evaluation has been undertaken by GHAIN, as could have been attempted e.g. through peer panels linked to peer educator work or by participatory M&E interventions. This too indicates a certain lack of technical expertise.
5. Dedicated expertise on creation of targeted SBCC methods, tools and materials is essential.
6. Adequate gender expertise on prevention is also essential.
7. Adequate support to peer educators is imperative if they are to deliver prevention effectively; this is especially the case if significant shifts in focus occur.

Condoms and other prevention interventions

See Appendix F for more detailed discussion of this topic; there is also additional information in that document on work with MSM.

Introduction and background

The need to provide prevention services to particular groups of people vulnerable to HIV infection (MARP) has been a consistent theme throughout the lifetime to date of PEPFAR and thus also GHAIN. Attention to condoms and other prevention (C/OP) has seen significant changes in international, GON and USG approaches during the past few years (as discussed in section 2.2). The most profound change internationally

as supported by USG is movement away from focus on (very) large numbers of people being reached with prevention messages (often a combination of A, B and C/OP), inevitably all too often in a superficial manner without effective monitoring of quality or follow-up regarding efficacy of communication. Numbers are no longer to stand as proxy for quality of engagement.

A key alteration in the overall GHI and PEPFAR approach is the toolkit of other prevention activities, which includes expanded strategic behavior change communication (SBBC) approaches and a focus on more longitudinal, qualitative, intensive interventions (including condom provision) with cohorts of MARP. In addition, there is now far more explicit attention to gender aspects of prevention. Impacts and outcomes are no longer to be measured primarily through prioritization of numbers reached through any one encounter (e.g. community mobilization). Moreover, there is now more overt support to prevention for positives, an area previously somewhat neglected. Next Generation Indicators reflect this more nuanced and disaggregated approach. GHAIN has been required to accommodate such changes, albeit with a limited timescale. Therefore, there is minimal information available as to efficacy or otherwise of the new approaches.

The 2008 evaluation report indicates that by March 2008 GHAIN had significantly exceeded its C/OP targets, both for July 07–June08 and for the life of the project to that date. While the cumulative C/OP target between Sept 04 and June 08 was 174,250 [aggregate figure], the numbers reached [unspecified as to through which activities other than ‘community outreach’] numbered 658,229. In July 07-June 08 the target number to be reached during the entire year was 146,250; by the end of March 2008 people reached numbered 235,001.¹⁷

There is evidence of considerable work to accommodate changes in terms of OP emphasis and approach, especially since the introduction of the GHI in 2009, and so far to a much lesser extent also the PEPFAR NGI.

The funding available to GHAIN for C/OP interventions under the cooperative agreement for its final year is \$2,005,795 (aggregate amount). Condoms used in GHAIN are PEPFAR funded, procurements are coordinated by USAID (SCMS) while Society for Family Health (SFH) distributes to all implementing partners. Condoms are distributed from GHAIN zonal level to health facilities, for provision in e.g. HCT, RH/FP, PMTCT, pharmacy and other service delivery points; HAST LGAs also receive condoms, through umbrella CBOs (including at least one Catholic CBO, the AMAC CACA in the FCT), as do other OP implementing agencies (see FHI 2010b, published in July 2010).

Achievements¹⁸

The number of implementing agencies engaged in OP activities is stated as thirteen (GHAIN 2010a). In COP09 aggregate OP funding was \$2,295,000, targeted condom

¹⁷ Please note that numbers given for GHAIN OP targets and achievements do not always tally. A partial explanation is probably changing indicator definitions and possibly also more precise definitions of MARP.

¹⁸ It also proved challenging during the end of project evaluation to gauge actual GHAIN OP achievements and especially to ascertain the quality of such interventions. This was in no small part due to mixed messages from GHAIN staff members. In addition, there was inadequate opportunity to meet representatives of most at risk populations, other than two far too brief encounters with FSW, in the FCT and in Onitsha, Anambra state. It was also not possible to have detailed discussion with peer educators on the specific subject of OP (despite 1,676 having been trained to date by GHAIN, as seen in Table 6).

outlets numbered eighty-eight and the number of implementing agencies engaged in OP was twenty-five. In COP09 the total number of people designated as MARP (e.g. female sex workers, truckers, men who sex with men, occupational migrant workers) who were to receive information on prevention through GHAIN-supported activities apparently numbered 69,545, of whom 31,295 were men and 28,250 women (GHAIN 2009e). However, see the table below, where such precise numbers are not allocated.¹⁹

Table 6: Overview of GHAIN OP achievements over life of the project to date			
Indicators	Year 6 (July 2009 - June 2010): targets	Year 6 (July 2009 – June 2010): achievements	Cumulative achievements from inception to June 30th 2010
1. Number of individuals trained to provide HIV/AIDS prevention Programs that are not focused on abstinence and/or be faithful	165	202	1,676
2. Number of targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	N/A	49,137 (M=26,612; F=22,525)	330,896 (M=191,242; F=139,654)
3. Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards	N/A	59,768 (M=31,034; F=28,734)	625,942 (M=368,435; F=257,507)
Source: GHAIN 2010f (Quarterly Report April-June 2010)			

It is undoubtedly the case that GHAIN has invested considerable effort in condom and OP interventions during the life of the project and this is to be fully acknowledged. A great deal of work has focused throughout the life of the project to date on provision of OP IEC and SBCC materials in English and local languages, across various media and through various channels (e.g. to be used by peer educators).

Since the evaluation in May 2008 GHAIN has sought to deepen its OP activities. It works with implementing agencies to address the OP needs of vulnerable people belonging to MARP, e.g. female sex workers, uniformed services, migrant populations, okada drivers and other transport workers and older orphans and vulnerable children.

One area of much expanded focus is work with men who have sex with men (MSM). GHAIN now works with two implementing agencies: one CBO in Lagos, the other in the FCT (Alliance Rights Nigeria). It was not possible to obtain much information as to GHAIN-supported MSM interventions, their quality or their frequency, despite considerable attempts by evaluation team members (see Appendix F for a somewhat more detailed discussion).

¹⁹ A few points should be considered when reviewing this table. The three indicators are PEPFAR Next Generation Indicators. Therefore, there is inevitably a degree of aggregation/retrofitting involved in the cumulative account given above. The indicators are insufficiently disaggregated, not only by sex, but also by MARP groups, type of intervention, follow-up, etc.

Community pharmacists (see section 4.4. Pharmacy services (including community pharmacists) for detailed discussion) provide condoms and also FP/RH counseling: information from GHAIN in September 2010 is that overall, condom provision to [aggregate] clients represents 19% of community pharmacists' (CP) activities, while counseling takes up 41%.

GHAIN provides MARP peer educators with condoms secured and supplied through the Society for Family Health and other USG implementing partners. In its final year GHAIN will supply upwards of 20 million male and female condoms to members of MARP. Condoms are also provided by GHAIN to all comprehensive ART sites, in support of dual protection (HIV prevention and FP). While the GHAIN final year target for [unspecified] condom outlets is 88, the cumulative total achieved as of August 31, 2010 was 280 (GHAIN 2010d).

Challenges

There is an imperative need for more systematically focused, coordinated (GON, development and civil society partners) and participatory work on prevention and other interventions for MARP, based on epidemiological data (see 2.1 above). This will need to address the often profound societal barriers to engagement with members of such groups, and the stigma and discrimination meted out to individuals and groups.

Gender-sensitive and gender-appropriate approaches specific to OP need to be addressed as a priority; there appears to be only limited attention to this important aspect of prevention, both within GHAIN and more widely in the national environment.

Support to young people living positively is not a focus of attention in Nigerian national instruments; this needs to be addressed as a priority, given both the epidemiological imperatives and also for ethical reasons.

Engagement with MSM is an especially challenging environment in which to work. GON legal instruments criminalize homosexual acts and it is difficult to gain trusted access to MSM, whose sexual behaviors may make them vulnerable to HIV infection and to transmission of the virus. Such issues will nonetheless need to be addressed, not least in view of recent epidemiological data.

Prevention for positives represents an under-served area; this will need to be rectified.

Gaps

Gender perspectives

No information was made available by GHAIN regarding any actual work undertaken by the project on addressing gender issues in the context of working with MARP.

Insufficient GHAIN technical capacity on OP

Please refer to the discussion under A/B, as issues are virtually identical. The major difference with regard to OP is that engaging with MARP represents on occasion even more of a challenge than other prevention work and as such should be supported by the most technically able and appropriately capacitated expertise. This is not forthcoming from GHAIN.

Lack of internal GHAIN clarity on changes in OP approach

There appears also to be lack of clarity internally within GHAIN about just how OP is to be addressed in the final year of the project. Some staff members working on

prevention, at country and zonal office levels (on occasion senior level), described continued prioritization of numbers reached.

Incomplete coverage

Evidence from the end of project evaluation indicates that not all GHAIN zones are working on OP. Thus the North East Zone (Adamawa and Taraba states) implements nothing in this intervention area (clear reasons were not forthcoming); the North West Zone (Sokoto, Kebbi and Zamfara states) is not currently undertaking any such activities. The latter zone has previously worked with FSW, but once its numerical targets had been reached, its activities ceased.

“MARP are not a priority in this zone; other zones have sub-agreements with CBOs that work directly with various MARP groups. There has been no discussion within GHAIN as to looking at the PEPFAR Next Generation Indicators to ascertain their degree of focus on MARP.” (NW zonal staff member)

Inappropriate partnerships

At least one Catholic implementing agency (the Catholic Action Committee on AIDS in AMAC in the FCT, which is the AMAC HAST umbrella CBO) is the umbrella CBO for activities including work on OP for MARP. This may neither be appropriate nor likely to be optimally effective. In Ajeromi HAST LGA, Lagos, the umbrella CBO was initially a Catholic institution (Community Health Project, Amumkoko). It has had to cease that role, as it could not fulfill the umbrella CBO capacity-building responsibilities and was unwilling to monitor other CBO activities.

Prevention for Positives

Prevention for young people who are positive is minimal in GHAIN according to end of project evaluation findings. It is neither a specific intervention area nor appears to have been addressed in terms of training, provision of SBCC materials, etc.

Support groups in the south (and to a far lesser extent in the north) do discuss prevention for positives and many understand about avoiding re-infection (super-infection) when both partners are positive. Several members described the challenges and moral dilemmas inherent in home-based care, where self-evident need for greater attention to prevention for positives is unmatched by any effective support. Adherence counselors in both northern and southern facilities report that they frequently discuss prevention at each client interaction and distribute condoms to clients who want them. The evaluation team checked that adherence counselors who claimed distribution actually had condom supplies.

When discussing with HCT counselors regarding post-test counseling for positive clients, mention was made of the very important counseling on condom use, condom demonstrations using penile models and provision of condoms on the spot. However, a number of counselors stated that they would welcome far more attention to prevention for positives' focus. Distribution of condoms and counseling on prevention for positives was much weaker in PMTCT settings than in HCT or ART settings in southern sites (and sometimes also in northern sites).

Lessons Learned

1. Adequate technical expertise on prevention and specifically OP is essential in any HIV project from its inception; as this is a difficult intervention area, optimizing comparative advantage and working closely with all other partners engaged in OP should be a priority.

2. Evaluation findings are that GHAIN has not made optimal use of international best practice in terms of engaging with members of MARP, among whom are to be found people often extremely vulnerable to infection and frequently very difficult of access.
3. There is too little time left in the life of GHAIN for effective rapport building and development of trust with MARP members in light of the new approaches (as against earlier big number approaches under PEPFAR 1, where communication with individuals and groups was inevitably more superficial and short-term). It is inappropriate for the project to initiate and/or expand such activities with less than one year remaining. This is a general lesson learned, e.g. also for HAST, for HSS and CSS. It is noted that external (i.e. primarily funding agency) priorities do on occasion require projects such as GHAIN to institute new intervention areas. Perhaps closer attention should be given to realistic expectations of useful and sustainable inputs vis-à-vis time available.
4. Proper and technically expert attention to prevention for young people should be strengthened and integrated into any future project.
5. The same is true for gender perspectives on prevention, with all internal and external gender mainstreaming training focusing on practical (and long-term, monitored, evaluated and reported) application of gender-sensitive approaches throughout the life of the project.
6. Prevention for positives does not appear to have been addressed as a priority by GHAIN in terms of actual implementation of activities, despite close discussion in the GHAIN final year OP overview document (GHAIN 2010e). This situation should be rectified in future projects.
7. Partnerships between programs/projects and implementing agencies need to be realistic in terms of genuine suitability and comparative advantage. Inclusion of Catholic FBOs as C/OP implementing agencies does not represent best practice.
8. The brief encounters possible during the EOP evaluation with community pharmacists indicate that there may be scope for further linking of CPs into condom and OP activities (see also 4.4. Pharmacy services (including Community Pharmacists)).

Blood and injection safety

Introduction and background

The 2008 evaluation noted that GHAIN first received funding for injection safety in COP07. Activities expanded injection safety practice and compliance with universal precautions to all GHAIN comprehensive sites, and this has continued as GHAIN has scaled up the number of comprehensive sites.

Achievements

- Injection safety and management of medical waste are important components of GHAIN's laboratory training, and included in GHAIN's HCT training curriculum
- As of August 31, 2010:
 - GHAIN reported 68 sites to be carrying out injection safety activities, against a Year 7 target of 60
 - 30 service outlets are carrying out blood safety activities – meeting GHAIN's Year 7 target
 - **35,190 blood units screened** for 4TTIs (HBV, HIV, HCV, Syphilis) cumulatively from program initiation; 31,668 were emergency on site collections, and 3,522 collected from NBTS
 - **16,586 blood units screened** for 4TTIs (HBV, HIV, HCV, Syphilis) against the Year 7 target of the 12,480; 14,766 were emergency on site collections, and 1,820 collected from NBTS

There have been notable improvements in sharps' disposal at sites visited during the end of project evaluation vis-à-vis 2008 experiences. Some sites have acquired/refurbished incinerators, and in Lagos State the Ministry of Health has contracted out collection and disposal of medical waste.

Gaps

None observed during the end of evaluation field visits.

Lessons learned

1. GHAIN support to blood and injection safety and overall medical waste disposal has led to visible improvements in service delivery, with e.g. the majority of HCT service points visited demonstrating close adherence to safe disposal procedures. Such efficacy is said to stand in often stark contrast to neighboring, non-GHAIN supported, health facilities.

HIV counseling and testing

Introduction and background

GHAIN built on the foundation of the FHI/IMPACT project experience of expanding access to HIV counseling and testing (HCT) services, establishing many standalone "Heart to Heart" HCT sites and undertaking mobile HCT at markets, soccer games and other busy and popular locations. As awareness has increased and stigma decreased (to an extent), GHAIN has moved away from supporting standalone and mobile HCT as entry points to ART services. Instead GHAIN has focused on increasing the service delivery points within ART sites that i. offer HCT or ii. refer clients to Heart to Heart sites within the facility for HCT.

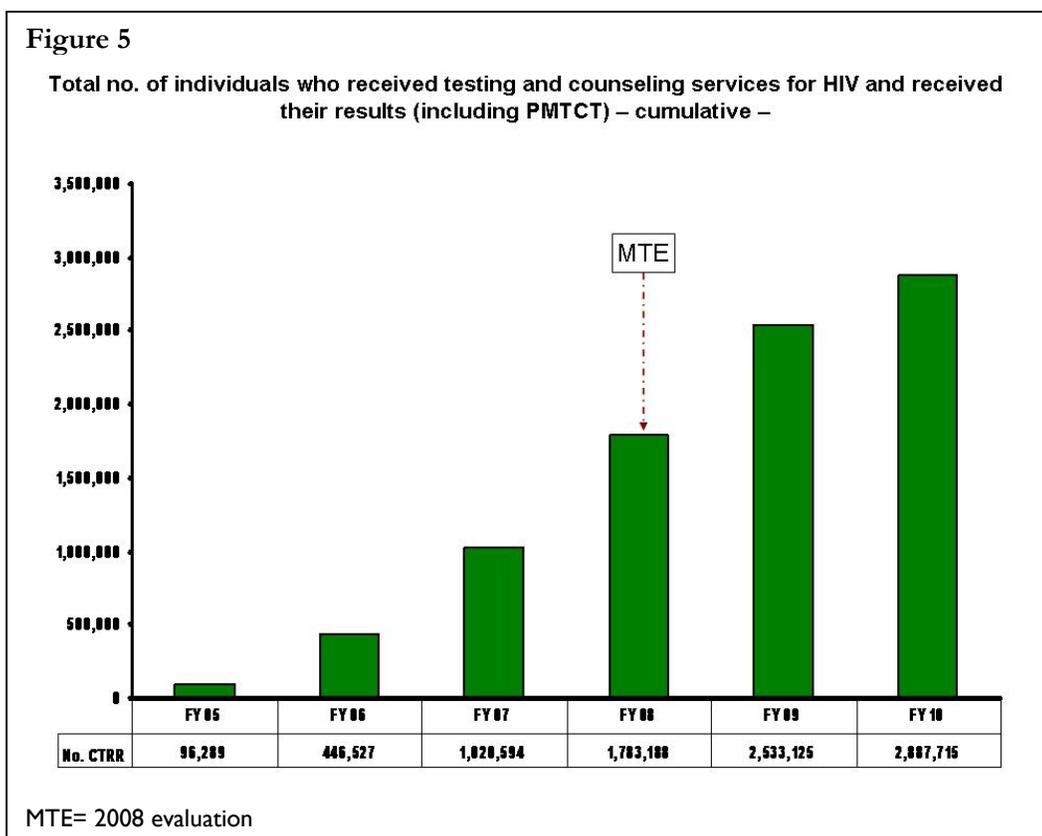
GHAIN strategizes to provide quality HCT services, through capacity development, mentorship and support. The 2008 evaluation found that GHAIN focuses on seven key strategies in its scale-up approach towards provision of HCT services:

1. Create demand for HCT services
2. Multi-point testing
3. Target MARP and youth
4. Develop strong linkages between service points
5. Use of lay counselors/volunteers
6. Quality assurance and improvement
7. Monitoring and evaluation of services

This focus continues, albeit with limited efficacy in terms of targeting MARP and youth; there are also monitoring and evaluation challenges.

Achievements

- GHAIN continues to be a leader in the provision of HCT; it is estimated to provide this service to upwards of 50% of the total number of people counseled and tested in Nigeria
- Such activity has resulted in a significant and sustained increase in the number of people (including pregnant women) who have been counseled, tested for HIV and received their results (CTRR) over the life of the project to date. See Figure 5 below.

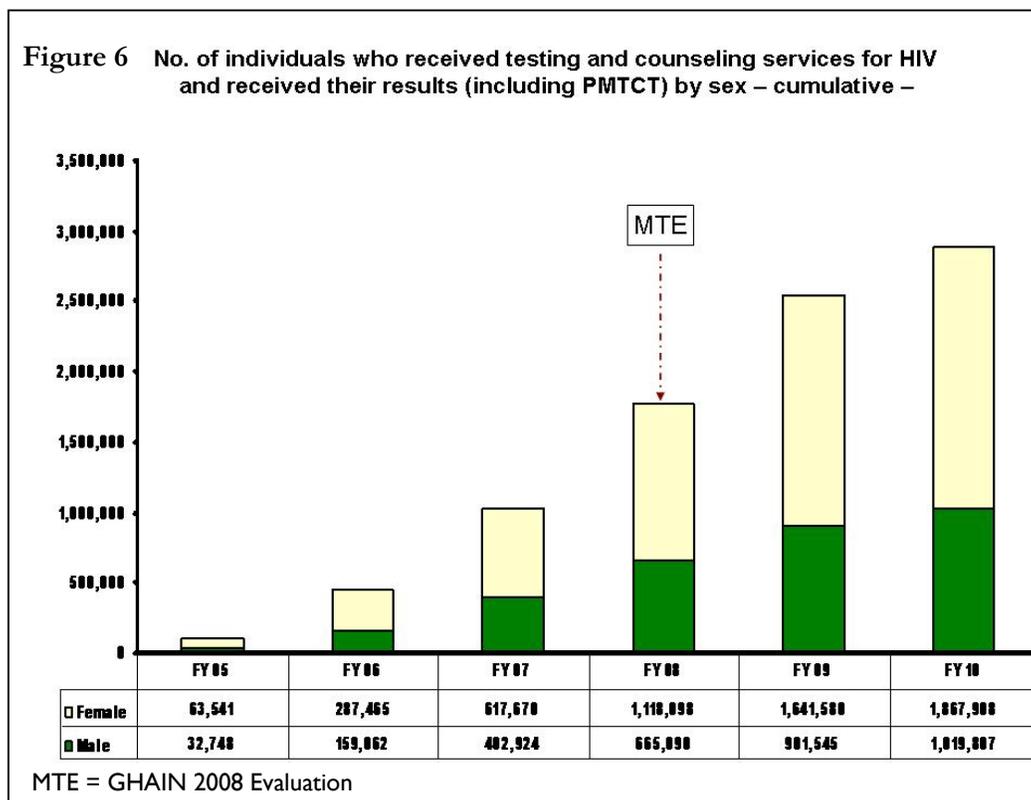


- The 2008 evaluation found that the number of HCT service outlet was 195; all remain operational, while a number are now managed under the GFATM grant and not reported to PEPFAR. Currently 147 HCT service outlets are operational with GHAIN support and PEPFAR funding.
- The total number of people who have been tested for HIV and have received their results has increased from 96,289 in COP05 to 2,887,715 in COP10.
- GHAIN has continued its collaboration with the Nigerian Nursing and Midwifery Council and supports 4 nursing schools that provide in-service CT training. These are:
 - Nursing school Gwagwalada
 - Nursing school Lagos Island
 - Nursing school Kano
 - Nursing school Calabar
- 2376 Health care workers have been trained on HCT through in-service institutional support.
- The majority of HCT service outlets supported by GHAIN visited by the end of evaluation field teams are staffed by caring, committed and well-trained HCT counselors.
- There is consistent use of approved national HCT guidelines and standard operating procedures; algorithms for serial and opt-out testing are also widely available and applied.
- Overall, the evaluation team observed generally strong commitment to confidentiality and privacy at the majority of GHAIN-supported health facilities, both north and south, with a few exceptions.
- A number of hospitals undertake community outreach (e.g. Sokoto Specialist

Hospital), where hospital staff members provide mobile HCT services

- An effective referral system is operated in many facilities, either through the triage nurse or volunteers from the PLHIV support group who escort clients
- An external referral system is also in place, through the use of a national directory providing information on where to go for HCT services (its development facilitated by GHAIN). This referral system is also used by community volunteers and peer educators reaching MARP

It is also observed that by the end of COP10 cumulatively more women (1,867,908) had accessed HCT services than men (1,019,807) since inception, as reflected in Figure 6 below.



Challenges

- Couple counseling is encouraged and uptake slowly increasing, but many socio-cultural barriers persist, e.g. husbands refuse, women fear divorce if they test positive.
- There is a lack of disaggregated data on couple registration and HCT in the HMIS registers.
- Counselors have to fill in four or more registers after each HCT session. This affects the quality of both counseling and data collected.
- The male/female counselor ratio is 1:3. This can cause problems for clients, e.g. for northern women who need to see a female counselor.
- The high client load and lack of adequate space in most facilities undermine quality of counseling
- Staff attrition – trained counselors are transferred to other facilities (not supported by GHAIN). This is an MOH human resource requirement, where health workers do not serve more than 2 years at any one workplace. This leaves a gap in service

delivery, as newcomers in many cases are not trained.

- Frequent strikes by health workers in many health facilities affect routine service delivery.
- The GON failed routinely and systematically to supply rapid test kits after GHAIN handed over. This caused gaps in HCT services in some facilities, most recently in mid-2010. Several northern health facilities visited by the evaluation team had experienced stock out of rapid test kits in May and/or June 2010, with zero HCT sessions being provided (e.g. at Kotangora General Hospital).
- Some health facilities still maintain that HCT must be done in the laboratory, rather than by dedicated counselors, trained in rapid testing procedures, who are supervised by the laboratory for service quality. This frequently leads to fatigue among clients due to lengthy waits for results.

Gaps

There appears to have been inadequate focus in training and subsequently in integrated supportive supervision on provision of counseling to ‘challenging’ clients. Thus several HCT counselors interviewed mentioned that they had received insufficient training in couple counseling and issues related to discordant couples. Counseling of couples is not covered in SOPs. This can result in unprofessional handling of couple counseling, e.g. where one client tests positive, the counselor tells that person to return with their partner, but under the guise of being a new client. Some counselors demonstrate a lack of confidence in handling young people/adolescents who test HIV positive. All negative clients are told to return for HCT after three months, irrespective of individuals’ risk profiles; this is not international best practice.

Another gap, again brought up by counselors, e.g. at Maitama District Hospital, and also observed by the evaluation team, is that counselors have not been adequately trained on gender issues, specifically in terms of actual pre and post-test approaches. There are gaps in provision of HCT to orphans and vulnerable children. There appears to be insufficient knowledge of the age at which children must be asked for their consent.

HCT counselors’ own attitudes can militate against effective service delivery. The end of project evaluation team found inappropriate attitudes and behavior among HCT counselors in one GHAIN-supported Catholic facility, where use of condoms is viewed as indicative of promiscuity, and condoms are neither talked about nor distributed. This indicates a lack of optimal selection and monitoring by GHAIN of trained HCT counselors. This example exemplifies another gap found at several GHAIN-supported facilities: a lack of close supervision of HCT and the quality of counselors’ service delivery. Several counselors themselves stressed that they would like to have more focused, supportive supervision to ensure they kept to the highest quality of service delivery.

There is observed occasional lack of confidentiality in terms of HCT forms being reported on monthly and collated at the PMM/HIV M&E Unit, often by data entry clerks whose salaries are paid by GHAIN and whose observed attitudes and professional practice did not always demonstrate proper attention to confidentiality.

Another gap and opportunity missed appears to be that while HCT counselors report monthly to the HIV PMM Unit, there is little dissemination and iteration. Therefore, most counselors interviewed during the end of project evaluation were unable to discuss any issues related to trend and/or gender analysis, to evaluate data and to consider how they might adapt their own service delivery to address findings.

Exit forms are all in English; counselors translate for clients who do not read English. This can result in biased responses as well as potential loss of confidentiality and conflict of interest. There is an occasional lack of IEC materials in local languages for clients.

HCT at other service delivery points (e.g. ANC and TB/DOts) sometimes does not adhere to SOPs and serious departures from testing SOPs were found by the evaluation team at one site.

Another gap relates to support to HCT counselors themselves; there is much international evidence of the importance of providing counselors with opportunities to discuss with other professionals, to have counseling themselves, to set up regular meetings: all to reduce the possibility of burn-out and attrition.

Lessons learned

1. In some health facilities HCT focal persons and site coordinator are closely engaged with the support groups, thus there is a degree of genuine absorption of the members into hospital activity and real development of a proper relationship between the supply and demand-side. In order for this behavior to become sustained it needs to be institutionalized.
2. Opportunities for further and more focused support to young people living with HIV needs to be explored, as do those for other 'challenging' clients.
3. Constant vigilance is essential regarding maintenance of absolute confidentiality.

4.3 HIV/AIDS AND TB CARE AND SUPPORT SERVICES AND INTERVENTIONS

Palliative care: tuberculosis and HIV

Introduction and background

In Nigeria, it is estimated that 27% of TB patients are HIV positive. The 2008 GHAIN evaluation noted that the German Leprosy Relief Association (GLRA) takes the lead on TB-HIV in the states in the south of Nigeria and FHI takes the lead in other states where GLRA does not have a presence. GHAIN TB-HIV strategies include:

- Support to joint TB-HIV planning and implementation at state and national level
- Support to the establishment of an effective monitoring and evaluation system
- Intensify TB case finding among people living with HIV
- Ensure TB infection control in supported facilities
- Increase access to HIV counseling and testing for TB patients
- Introduce cotrimoxazole prophylactic therapy for TB HIV patients

Since 2008, the knowledge base regarding TB/HIV co-infection has continued to expand and provides further imperative to implementation of WHO guidance on concurrent treatment of TB/HIV co-infection²⁰. Whereas in 2008, TB/DOts staff were not referring positive clients for ART during the initial intensive phase of TB treatment – out of concerns for adverse rifampicin efavirenz reactions and immune reconstitution inflammatory syndrome – TB/DOts staff are now more likely to refer to ART and to leave it to the ART doctor to use an alternative ARV regimen without efavirenz if concurrent treatment is clinically indicated by a low CD4 count. However, not all ART doctors recognize that despite the risk of paradoxical worsening of the condition of patients with active TB after initiation of ART, overall mortality is reduced

²⁰ http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.330.pdf

in co-infected patients with CD4<100 concurrently treated with ART.

Achievements

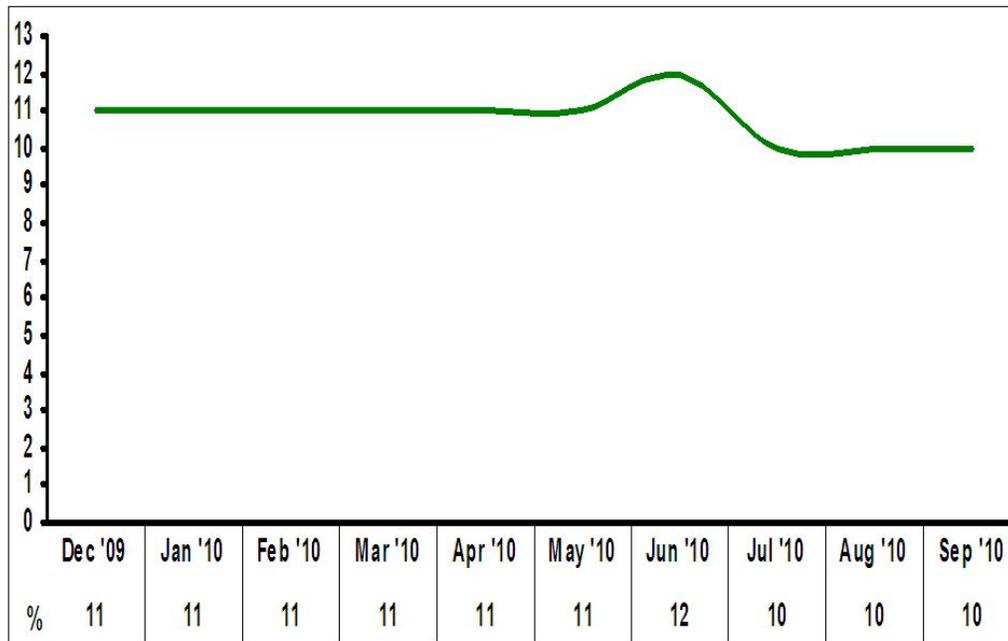
- Expansion of sites providing TB-HIV services to 106 in March 2008, and to 187 by June 2010
- 285,662 PLHIV screened for TB from inception cumulatively to June 2010 with a Year 6 target of 20,000 and achievement of 93,208
- 57,455 individuals receiving HCT and receiving their results in TB settings cumulatively from inception to June 2010 with a Year 6 target of 5830 and achievement of 33,384
- 25,564 (m=11,951; f=13,613) individuals provided with TB prophylaxis and or treatment from inception cumulatively to June 2010 with a Year 6 target of 4,741 and achievement of 10,185 m=4,794; f=5,391)
- 3,359 individuals were trained in TB/HIV according to national or international standards from inception cumulatively to June 2010, with a Year 6 target of 300 and achievement of 574
- GHAIN supported the National Tuberculosis and Leprosy Control Programme Strategic Plan 2006-2010, by introducing community-based TB services and increased community participation in TB care in HAST LGAs, and by strengthening diagnosis and treatment services

GHAIN has successfully integrated HIV awareness and screening into existing TB/DOts services at secondary and referral hospitals and supported strong referral linkages between ART and TB/DOts as well as between TB/DOts and ART. This has been facilitated by strong TB/DOts systems and provisions, as a result of historical vertical management and support through the National TB and Leprosy Control Programme. As with PMTCT, the TB/HIV registers largely duplicate rather than replace existing TB/DOts registers although it would be very difficult to introduce new integrated TB/DOts/HIV registers and tools when the existing ones have strong “ownership” by the national program and staff.

Many TB/DOts sites have successfully introduced routine, opt-out, HCT for TB/DOts clients either by referral to a Heart to Heart service within the facility, or by offering HIV counseling within the TB/DOts clinic. Many TB/DOts clinics also offer rapid HIV testing within the clinic, although a minority refers clients to the laboratory for the HIV test. Many of the sites evaluated have achieved 100% HCT for their DOts clients, with an overall GHAIN tested rate of 92% in Year 6 (July 09 - June 10).

Figure 7

Percent of HIV positive patients in HIV care/treatment (pre-ART or ART) who started TB treatment



All ART staff reported that they clinically screen clients for TB at each visit including questioning clients on presence of chronic cough (>3 weeks), weight loss and night sweats. Referrals of clients to TB/DO TS from ART (for clients on ART and pre-ART) are generally tracked through duplicate referral forms, by the referral coordinator. Many ART clinics have PLHIV volunteers who go with patients referred to TB/DO TS. Since December 2009, GHAIN has tracked the percent of HIV positive patients in HIV care/treatment (pre-ART or ART) who started TB treatment. See Figure 7 above. The numerator used is the number of PLHIV (ART and non-ART) started on TB treatment, while the denominator is number of HIV positive individuals enrolled (pre-ART). The limitation, however, is that the numerator is not exclusively a sub-set of the denominator, as some HIV positive clients starting TB treatment may have been referred from outside. Nonetheless, 10-11 percent of HIV infected clients are treated for TB at GHAIN-supported sites, decreasing the TB burden of people living with HIV. Rates for TB clients testing positive for HIV at sites visited by the evaluation team were somewhat lower than the 17% national estimate of TB clients who are co-infected with HIV.

Challenges

1. At the time of the 2008 evaluation there was nationwide stock out of anti-TB drugs – beyond GHAIN manageable interest as all TB drugs were supplied through the National Tuberculosis and Leprosy Control Programme. This had been resolved by the time of the EOP evaluation and there were very few reports of TB drug stock outs, although supplies of cotrimoxazole remained insecure at a number of sites.
2. The major challenges to TB/HIV services are trained staff shortages and physically limited space for services. In at least one facility where HIV testing of TB/DO TS patients is carried out in the laboratory, the TB/DO TS staff report that they would prefer to do rapid HIV tests themselves. This is because TB positive patients who

receive HIV positive test results from laboratory staff sometimes abscond and do not return for their TB treatment.

Gaps

Although there is greater willingness to refer TB infected patients for ART assessment during the intensive phase of TB treatment than there was in 2008, and the concurrent treatment of TB/HIV co-infected patients is allowed when indicated by the patient's clinical and immunological condition, there is still reluctance to give concurrent treatment. This is likely to be the most important gap; a further gap is in ensuring that all HIV positive TB clients receive cotrimoxazole prophylaxis – particularly at sites that do not have secure supplies of cotrimoxazole. At sites that do not have cotrimoxazole in stock, clients are told to buy from private pharmacies.

Lessons learned

A number of lessons learned were noted in 2008 that are worthy, with some amendment, of inclusion in the end of project evaluation:

1. A good policy environment and Government commitment are essential for successful program implementation
2. Close collaboration between the national TB program and the national AIDS program ensures effective coordination of TB/HIV activities
3. Harmonizing TB and HIV recording and reporting systems is necessary for efficiency in TB/HIV services monitoring and evaluation to avoid duplication
4. Routine monitoring of TB drug logistics management by GHAIN to 2008 proved to be very useful in alerting NTBLCP on imminent drug stock out leading to corrective measures being put in place
5. It is also worth noting that good TB/HIV service integration has been achieved because the existing TB/DO'TS service was a robust, well-managed program.

Palliative care: other services

Introduction and background

The 2008 evaluation noted that GHAIN's basic health care and support activities "aimed at extending and improving the quality of life of people living with HIV and people affected by AIDS from diagnosis as HIV positive to end of life care, by providing clinical, psychological, spiritual, social, and prevention services. GHAIN provides comprehensive facility-based, non-ART basic care and support, including support for clinical management of opportunistic infections (OIs); basic nursing care; assessment of signs and symptoms; prevention, management and treatment of OIs non-ART laboratory support; treatment adherence counseling; and technical assistance to facility-based support groups." (USAID 2008)

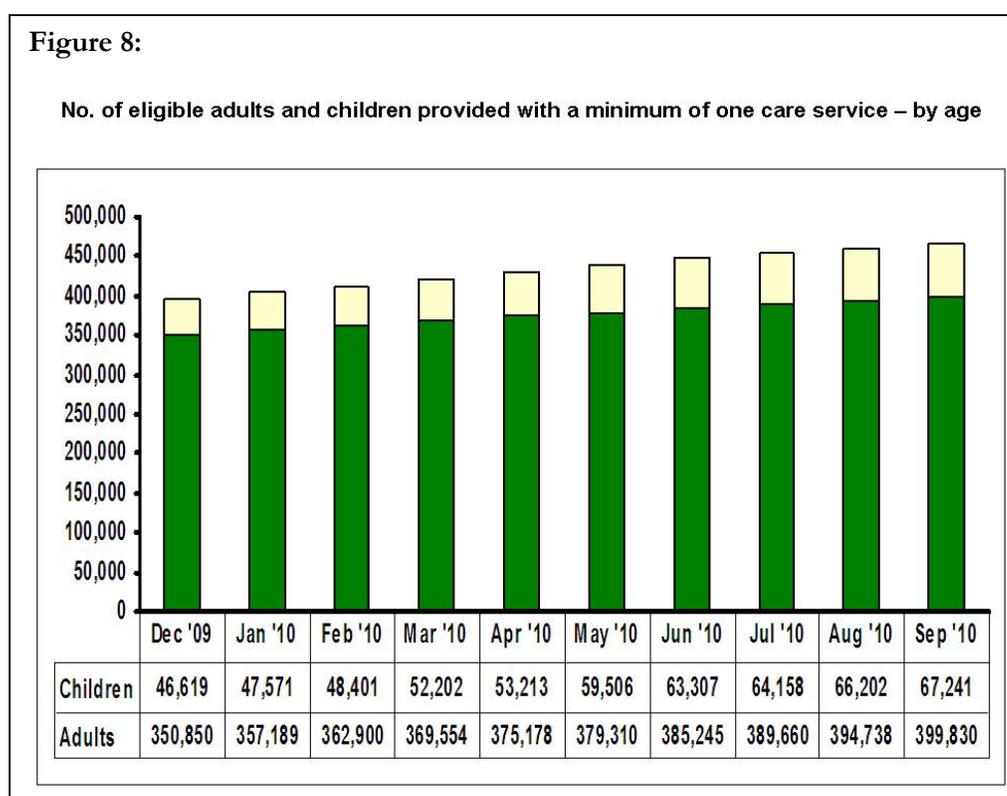
Although GHAIN funding support for palliative care: basic health care and support was drastically reduced in 2006 in response to required budget cuts towards FHI receiving a maximum of 8% of the PEPFAR Nigeria budget, GHAIN continued to offer basic health care and support at facility level, and in the community through coordination with CEDPA and sub-contracts to community-based implementing agencies that provide a minimum package of services. In 2008 GHAIN linked clients in all its zones with CEDPA for community-based care and support although CEDPA worked in 14 states and GHAIN then operated in 32 states. The CEDPA program has now ended, although CEDPA community care and support volunteers were reported by Edo SACA to be still active.

At the facilities visited during the end of project evaluation, nutritional support is

limited to advice; a few sites have Plumpy Nut for therapeutic use in malnourished children, and some support groups are making and selling soya fortified flour [known colloquially as “Tom Brown”]. A few support groups reported that they receive rice and or beans and distribute them to attendees at monthly meetings. Other support groups use their funding from GHAIN to provide refreshments at their monthly meeting.

Achievements

- 448,552 eligible adults and children (a=385,245; c=63,307) provided with a minimum of one care service from inception cumulatively to June 2010. (See Figure 8 below for achievements from December 2009 to September 2010.)
- 430,137 HIV positive adults and children (a=385,245; c=44,892) provided with a minimum of one clinical services from inception cumulatively to June 2010
- 118,269 HIV positive persons commenced²¹ on Cotrimoxazole prophylaxis
- 80,057 eligible clients, including 40,610 pregnant women, have received food and or other nutrition services cumulatively from inception to June 2010
- 3,763 individuals have been trained in palliative care according to national or international standards from inception cumulatively to June 2010 with a Year 6 target of 500 and achievement of 1,541
- From July 05, GHAIN has trained more than twice its target numbers of persons to provide palliative care.



Challenges

The principle challenges for GHAIN provision of palliative care were the 2006 reduction in GHAIN funding, leading to the loss of the GHAIN consortium partner with the most wide-ranging palliative care expertise, and the dropping of most of GHAIN’s community care and support activity (see USAID 2008—the 2008 evaluation

²¹ Although the PEPFAR indicator is number of positive persons receiving cotrimoxazole prophylaxis.

report—for detailed discussion). The funding restrictions severely limited GHAIN's ability to provide a comprehensive continuum of care, including community-based palliative care, defined by PEPFAR 1.

Facility-based support groups are inherently unsustainable, and can contribute to dependency, stigmatization and self-stigmatization of members while not fostering PLHIV as resource persons and agents for change in their communities. Mobilizing and strengthening effective community-based responses to HIV requires involvement of PLHIV and community-based partners/activities.

Further challenges included lack of therapeutic food supplements for adults and inadequate supplies for children, recurrent stock outs of cotrimoxazole and other OI drugs. Many PLHIV are the poorest of the poor, having lost their employment and used up family/household resources before they receive their diagnosis of HIV infection. Attending secondary and referral hospitals for frequent follow up appointments further drains depleted resources and can be a barrier to adherence to treatment.

Gaps

Health facility provisions for PLHIV remain structured round acute service delivery. There is little evidence of a move to a chronic care model with strong links to PHC and the community. Involvement of PLHIV in coordinating and tracking long-term care and support is underdeveloped. Some facilities have volunteers – receiving GHAIN allowances – who are *not* PLHIV. Such volunteers have access to confidential information such as individuals' HIV status and do not have a stake in maintaining confidentiality or providing quality services, and are drawing on resources that might be more equitably used by PLHIV.

Many GHAIN support groups still operate in isolation without links to NEPWHAN or other local associations of PLHIV. Significant Global Fund provisions for PLHIV support groups are available through NEPWHAN including office furniture, computers, printers and photocopiers. Some of those support groups that are affiliated with local chapters of NEPWHAN are using the equipment received to generate income for their activities.

Lessons Learned

GHAIN translated its experience into technical support to the GoN to develop:

- The National Palliative Care Guidelines and Standard Operating Procedures
- The National Palliative Care Strategic Framework.

Orphans and other vulnerable children

This part of the report should be read in concert with 1.2, 4.3. Community and PHC-based support interventions (HAST LGAs), 4.6. Strategic information/monitoring and evaluation and Appendices G and H.

Introduction and background

National Nigerian policy increasingly focuses on the need to deliver HIV services at PHC and community levels (e.g. the NSHDP 2010-2015). The 2nd NSF II principle states: “Multi-sectoral approach that is community-based and forges broad partnerships, dialogue, consultations, coordination and synergies at all levels.” (NACA 2009; p2). Objective 4 of the NSF II component on *Care and Support of People Living with and Affected by HIV/AIDS* is: “To support effective referral and linkages within and between relevant health care facilities and community-based care services - improved by 80% by

2015” (ibid. p20). These approaches are intrinsically relevant to the provision of support to orphans and vulnerable children.

The projection is that Nigeria will have 3.4 million AIDS orphans and children made vulnerable by AIDS by 2015. Although only 25% of orphans in Nigeria are orphaned by AIDS, the effects of AIDS have exacerbated the situation and increased children’s vulnerability. As a major global strategy towards improving health outcomes, the Global Health Initiative aims at providing direct support for more than 12 million people worldwide, including 5 million orphans and vulnerable children.

In COP06, based on OGAC requirements for GHAIN to move towards a cap of 8% of the PEPFAR Nigeria budget, USAID made intense efforts to transition orphans’ and vulnerable children’s (OVC) interventions from GHAIN to other implementing partners, and to bring new implementing partners into the OVC portfolio. This move was necessitated as a result of GHAIN budget changes (in response to OGAC requirements for GHAIN). Congress required in 2008 that all PEPFAR programs dedicate 10% of budget to OVC activities; in GHAIN terms over the lifetime of the project, some \$45 million. This decision has had an influence on the decision to focus on OVC activities in the HAST LGAs.

GHAIN continues to support facility-based services for OVC. GHAIN has continued to use dried blood spots and DNA PCR assay for strengthening early infant diagnosis of HIV infection through trained health facility staff and is now expanding its early infant diagnosis activities. Children who are identified as HIV positive by PCR assay are enrolled in facility-based care and support.

During the 2008 evaluation of GHAIN it was found that the project had scaled up nutritional support by supplying Plumpy Nut (ready to use therapeutic food) donated by the Clinton Foundation HIV/AIDS Initiative for severely malnourished children on ART. GHAIN and health facility staff had received training to ensure proper distribution. Other facility based OVC activities included distribution of Water Guard. These activities continue and have been expanded considerably, through the implementation of HAST (see 4.3.Community and PHC-based support interventions (HAST LGAs)).

Achievements

- Community identification and enrollment of OVC in HAST LGA communities is undertaken by community volunteers using an OVC selection tool developed by Ministry of Women Affairs and other stakeholders with support from GHAIN.
- After enrollment, an individual child’s information is (theoretically) entered (and their subsequent progress monitored) by using the *KidMap* M&E software system, developed by GHAIN. *KidMAP* is lodged at HAST umbrella CBO offices. Children whose guardians/parent consent for them to be tested for HIV are referred for HCT and data are subsequently recorded by *KidMap*. The intention is to provide integrated prevention, support and treatment services.
- GHAIN-supported HAST CBOs have begun to implement components of the *Minimum Service Package*.
- During Year 6 (July 2009-June 2010) 13,225 OVC were enrolled through CBOs, exceeding the target of 12,000.
- Caregivers have been selected and supported.

Challenges

1. CBOs with *KidMap* electronic software face the challenge of fluctuating electricity.
2. Links between the Federal and state Ministries of Women's Affairs and LGA Social Welfare departments are weak, which has serious implications in terms of effective implementation of the *OVC National Action Plan*.
3. There sometimes appears to be limited harmonization of OVC programs at state level, with projects often working in isolation.

Gaps

- The process of orphans' and vulnerable children's enrolment began in May 2010 in some HAST LGAs; this is entirely inappropriate, as support will be short-lived given the few months left until the end of the project. The very process itself is flawed. The OVC intervention is on balance a mechanistic, portmanteau program, supported by GHAIN staff members whose technical expertise is not ideal (despite evidence of individuals' commitment to supporting OVC).
- There appears to be public and all too speedy identification of OVC, which in itself may lead to increased stigmatization and potentially also gender bias (more boys than girls appear to have been registered)
- There are gaps in the selection and enrollment process of OVC, with many CBO members and volunteers appearing unaware of the nationally approved selection criteria and international standards
- Some enrolled OVC seem to be well cared for while others appear to be above the ceiling age of 18 years
- No attention to hidden children (e.g. domestic servants and foster children).
- Child labor is not used as a criterion for selection/support
- In some areas there appear to be inadequate data on type of OVC, e.g. if a child is a single or a double orphan, if s/he is living in a child or female-headed household
- There appears to be insufficient attention given to children's rights (inadequate adherence to the provisions of the Convention on the Rights of the Child, to which Nigeria is a signatory)
- The end of project evaluation field teams found indications of inadequate and at times inappropriate application of both the Child Status Index (e.g. insufficient safeguards of children's autonomy) and the Minimum Service Package (e.g. seeming across the board prioritization of deworming as the sole/chief health intervention)
- Most of the CBOs have not received any training in vulnerability, gender and do not have proper understanding of how to apply the Child Status Index – thus they do not appreciate useful is its application, if done by people unaware of its efficacy
- Few OVC know their HIV status (not one of approximately 2,000 registered in Wamakko LGA in Sokoto state while in one HAST LGA visited in Enugu State only 2 children knew their HIV status and both were on ART)
- Referrals to non-medical services (e.g. social welfare and legal) are often weak and in certain cases non-existent
- In addition, the support each orphan or vulnerable child receives is apparently not individually recorded, with obvious implications
- Some caregivers are entirely inappropriate: they have no relationship to the OVC; there is no supervision of type and quality of care given
- There is a seeming absence of links between GHAIN-supported HAST OVC interventions and GHAIN-supported support groups; it is not known how many OVC enrolled and registered are children of members of facility-based support groups and how exactly such children link into services offered through implementation of the *Minimum Service Package*. No child of a support group

member was described as having received any such assistance

- Confidentiality and respect of OVC (records and individuals) is not universally recognized. In some cases LGA and CBO M&E officers are demonstrably under-trained to work with OVC
- In some HAST LGAs, the social welfare department is sidelined and does not play any role in OVC activities. Social Welfare Department staff members have not been trained on *KidMap* or on supervision. Those interviewed did not know how to use the software for future planning for OVC interventions.

Lessons learnt

1. OVC interventions are complex and multi-faceted interventions that necessitate longer term support, so that children once enrolled can be assured of consistency of support. Short-term interventions (as implemented by GHAIN) are inappropriate.
2. OVC interventions require technical expertise on social development, social protection and inclusion, rights-based approaches and community system strengthening, as well as obvious core expertise in implementation of effective OVC activities where children are at the center.
3. Gender expertise is also required when working with OVC.

Support to People Living with HIV

Introduction and background

The Nigeria National Strategic Framework II (2010 – 2015) on HIV & AIDS specifies *Care and Support for People infected with and affected by HIV/AIDS* as a core thematic area. One of the NSF II top-level goals is: *assuring that at least 50% of PLHIV have access to quality care and support services*. This is in line with PEPFAR Next Generation Indicators: the NGI state that globally an objective is to care for 12 million people, including 5 million orphans and vulnerable children [who are to be] provided with a minimum of one care service.

The NSF II further considers treatment scale-up in the context of a detailed package of biomedical interventions and care and support aspects, with brief discussion of MIPA/GIPA issues. It would be helpful were such attention to include demand-side perspectives. There is also welcome attention in the NSF II to policy development, such as through attention to ensuring the rights of PLHIV.

There have been significant changes over the life of GHAIN to date with regard to capacity to provide an effective continuum of support to people living with HIV & AIDS (PLHIV).

As already discussed in 1.2, in 2006 the PEPFAR Nigeria budget allocation was changed to cap the proportion of its budget that any one GHAIN project partner might receive, in line with OGAC directives. FHI, as GHAIN prime, had its budget reduced to accommodate the move towards achieving an 8% ceiling for any one partner. At that time FHI had to make strategic decisions about how to accommodate the reduced budget while still being held accountable for PEPFAR targets. The FHI decision was to shed program areas and focus on rapidly scaling up access to treatment. This was one of the main reasons why the Centre for Development and Population Activities (CEDPA) left the project in 2008 (see FHI 2009).

In response to the budget caps, one major alteration to GHAIN activities in 2006 was a reduction of community-based services such as home-based care and focused OVC interventions, with greater emphasis being placed on facility-based care. Shedding

community services and partners was the only feasible action for GHAIN when faced with a reduced budget and a PEPFAR/COP system that required the prioritization of facility-based treatment services.

The development and continued expansion of facility-based support groups for PLHIV and the inclusion of members of those groups into facility HIV service delivery represent key aspects of GHAIN work to continue its support to PLHIV. In addition, the project has latterly sought to redress the balance between community and facility, between demand and supply-side prioritization, e.g. through its HAST work (see 4.3. Community and PHC-based support interventions (HAST LGAs) for discussion of the initiative and also Appendices G (HAST) and H (that includes discussion of Community Systems' Strengthening)).

Achievements

- During focus group discussions support group members often stated their gratitude to GHAIN and the support they receive from facilities: one frequent remark was that positive women had been helped to have negative babies; another was that members are alive and in reasonable or good health
- Over the lifetime of the project and with GHAIN support a total of 114,802 PLHIV have been enrolled on ART
- 430,137 HIV positive adults and children (adults = 385,245; children = 44,892) have been provided with a minimum of one clinical service between COP04 and end of COP09
- 448,552 eligible adults and children (adults = 385,245; children = 63,307) have been provided with a minimum of one care service from inception cumulatively to June 2010
- 118,269 PLHIV have received prophylactic treatment such as cotrimoxazole
- 80,057 eligible clients, including 40,610 pregnant women, have received food and/or other nutritional services cumulatively from inception to June 2010
- GHAIN has provided support group members with prevention kits, containing e.g. insecticide impregnated mosquito nets, Water Guard and buckets; it appears that such provision is usually a one-off, without top up
- The end of project evaluation field teams noted the following positive points in terms of Support group management and activities, all of which have been initially facilitated by GHAIN:
 - The majority of the support groups visited have relatively functional leadership structures; in the south women are in the majority of leadership positions, while the reverse is true in the north (as exemplified at the FMC Birnin Kebbi focus group, where approximately 90% of support group members present were female and almost all committee members male)
 - Many support group members evinced a remarkable degree of voluntarism: one key activity is membership of the facility tracking team (usually coordinated by either the referral coordinator or less commonly the triage nurse), which seeks to trace clients lost to follow up (LTFU) and to encourage them to return for ART; another is to become a trained adherence counselor and/or a clinic health advisor. Other roles include pharmacy support, work in the HIV PMM Unit as M&E clerks and overall initial and continuing support to people newly identified as HIV positive. A few support group members have been trained as HCT counselors, e.g. at Calabar General Hospital. All such roles were developed as part of the GHAIN package of support to facilities. In addition, and an indication of a degree of increased independence of some support groups, members openly living with HIV provide HIV talks at secondary

- schools (e.g. in Benin City) or provide information to community leaders
- Support groups receive on average 20,000 Naira per month through GHAIN financial allocations to its facility implementing agencies; 50% is often used to support tracking team activities and the remainder to provide nutritional and other assistance to members
- The monthly support group meetings have over time become valuable opportunities for mutual assistance as well as for information, health talks, consideration of optimal provision of support to members, distribution of food items, etc
- The national PLHIV network NEPWHAN has provided income-generating training to some support groups; it has also on occasion provided start-up funds to enable members to undertake advocacy; it has also facilitated registration of a number of support groups as CBOs, the essential first step in terms of being eligible for grants and other support.

Challenges

1. Due in large part to the success of getting large numbers of people on to ART and to the changing nature of the HIV epidemic in Nigeria, there is a need to move into chronic care management. This requires dedicated expertise in social development and health/HIV, where adequate attention is given to community-focused support to PLHIV, including *community*-based support groups. This is a very real challenge in resource-constrained environments such as Nigeria, but one that will need to be addressed by the successor project to GHAIN.
2. Any HIV project that is fundamentally focused on provision of health services is always faced with the challenge of the enormous range of needs expressed by PLHIV: for nutrition, for employment opportunities, for education, etc. No one project can provide for more than a fraction of such needs; lessons learned from GHAIN indicate that support to capacity development and networking represent two potentially fruitful intervention areas.
3. Weaknesses and inefficiencies in the Nigerian public health sector have significant impacts on delivery of services to PLHIV. Health worker strikes represent another major challenge, obviously outwith the remit of GHAIN or any other project, but nonetheless most disruptive of service delivery and consistent support.
4. An inefficiency that is partially being addressed is inflexibility in refill appointments for stable ART clients: there is increasing realization that e.g. people in the military cannot always keep monthly or two-monthly appointments.
5. A major challenge is the lack of understanding of socio-cultural and gender aspects of support to PLHIV; a one-size-fits-all approach is untenable. Issues such as permission to attend hospital, opportunity costs, degree of personal autonomy with regard to health-seeking behavior: all are informed by gender issues, yet minimal attention has been given to such matters by supply-side providers at any level. Another factor is that a number of female PLHIV may require particular support to leave high-risk occupations such as sex work.
6. The public sector needs to work in closer concert with the private sector, to encourage action on stigma reduction and cessation of blatantly discriminatory practice, e.g. dismissal of staff members found/rumored to be HIV positive. Open employment/ retention in both the public and private sector of PLHIV would be a major step towards potential normalization of HIV.
7. Some female support group members expressed need for financial empowerment so that they are able to meet their financial needs instead of engaging in risky behaviors such commercial sex and passing on the infection to others.
8. Current supply chain and logistics management systems are not always able to ensure reliable supply of drugs. In some GHAIN-supported facilities PLHIV are given two or

four weeks' supply when they should only attend at three monthly intervals for refills. This uncertainty not only has potentially deleterious health impacts, it also increases individuals' opportunity costs.

Gaps

A key gap is GHAIN lack of attention to international best practice on greater/ meaningful involvement of people living with HIV and AIDS (GIPA and MIPA). It might be argued that creation of, and assistance to, facility-based support groups constitutes a central plank of such focus. However, evidence from the end of project evaluation is that such support groups do not represent best practice in the longer term regarding sustainability, however focused their activities might be. Support group location at a health facility separates PLHIV from the community, which is intrinsically stigmatizing and ultimately unsustainable, because so project-driven and defined.

Another GIPA/MIPA gap is that there is no reported engagement of PLHIV in GHAIN programmatic design, monitoring and evaluation and/or documentation. One area where such inclusion might be fruitful would be on development of messages for prevention for positives and subsequent M&E of implementation; another would be in terms of seeking to bridge the pre-ART gap (as described in 4.2. Abstinence and be faithful interventions).

GHAIN's approach to working with support groups has disempowered many, who have become too dependent on GHAIN's financial support.

Children, adolescents and young adults are not fully integrated into support groups (itself indicative of a lack of GHAIN expertise on facilitating participation of such groups). Male membership of support groups is usually in a minority; while this is due to a myriad of influences, many beyond the remit of GHAIN, here too there appears to have been sub-optimal planning and attention. Lack of male membership also has repercussions in terms of actual male motivation and involvement, especially where community-based activities are concerned.

There has been insufficient attention to promotion of positive living and prevention for positives (see also 4.2. Condoms and other prevention interventions, and Appendix F).

Health workers continue on occasion to display considerable stigma and discrimination towards support group members; while the end of project evaluation team found such attitudes and behavior to be rare, it is important that it be addressed and far more rigorously sanctioned – advocacy on such issues from GHAIN would have been relevant.

Lessons learned

1. A key issue is: how sustainable can a facility-based support group be? The entire thrust of PLHIV support is nowadays to root it within the community, to seek every opportunity to 'normalize HIV'. The very existence of facility-based support groups, however (and undoubtedly) well intentioned, demonstrates not only the lack of community/social development/social protection expertise within GHAIN. There is a possibility of increased stigma and discrimination of PLHIV when GHAIN support ceases – the support group members are identified with the facility, not with the communities in which they live (in the context of being PLHIV).
2. It is always challenging to find and sustain the most appropriate and equitable balance between enabling PLHIV to be active partners in HIV prevention, care, support and treatment and ensuring any such inputs are genuinely voluntary and properly supported.

Evidence from GHAIN indicates that this balance has not yet been achieved.

3. It is essential to ensure that only PLHIV are members of support groups; there was occasional evidence during field visits of negative people assuming roles that are inappropriate if the ultimate goal is to normalize HIV and to maintain the highest standards of privacy, confidentiality and probity.
4. There is limited evidence of a degree of support group independence and movement towards longer term post-GHAIN sustainability, e.g. a few have started rotating credit funds (tontines) and a few have access to funds from better off members to assist others to start businesses.
5. While building partnerships with national networks such as NEPHWAN have not been a universal feature of GHAIN assistance to PLHIV, the fact that some support groups have become CBOs represents a positive move for the future.
6. Linked to the above, any future PLHIV support initiative must institute the building of such connections as standard from the outset.
7. GHAIN has not applied international best practice in terms of M/GIPA principles: the meaningful/greater involvement of people living with HIV & AIDS. This requires true and equitable partnership and inclusion of PLHIV in policy, planning, state-level meetings, etc as well as proper engagement at community level.

Community and PHC-based support interventions (HAST LGAs)

This section should be read in conjunction with Appendix G, which sets out in more detail the discussion on HAST implementation. It should also be read while bearing in mind sections 1.2, 4.3. Orphans and other vulnerable children; 4.6. Health systems strengthening; as well as Appendix H (that considers community systems strengthening). See the map at the end of this section for further details as to geographical spread of GHAIN HAST activities. Appendix G contains a map that shows geographical spread of HAST LGAs and a chart that sets out in detail the dates of GHAIN engagement with LGAs to set up HAST.

HAST stands for *HIV/AIDS, SRH and TB services at Local Government Area level*. The original name included *STI* (sexually transmitted infections) rather than SRH (sexual and reproductive health).

Introduction and background

The primary rationale for focus on LGA-level interventions is a realization that most HIV and AIDS services are located at secondary and tertiary health facilities, yet these are increasingly overwhelmed with clients, are often managed as vertical interventions and are not always responsive to demand-side needs. This is the case with many of the GHAIN-supported comprehensive ART sites. If scale-up of HIV, SRH and TB (and linked) services is to be achieved (the 'one-stop-shop' approach), then decentralization to PHC level is essential, in order to bring services closer to clients. PHC facilities represent more than 70% of all Nigerian public health facilities. There are clear opportunities to develop health service delivery synergies by integrating decentralized services - and many challenges, too, as will be discussed. A central plank of the HAST model is the active involvement of community-based organizations (CBOs) and community members, as peer educators and community volunteers.

National Nigerian policy increasingly focuses on the need to deliver all such services at PHC and community levels (e.g. the NSHDP 2010-2015). The 2nd NSF II principle states: "Multi-sectoral approach that is community-based and forges broad partnerships, dialogue, consultations, coordination and synergies at all levels." (NACA 2009; p2). Objective 4 of the NSF II component on *Care and Support of People Living with and Affected by HIV/AIDS* is: "To support effective referral and linkages within and between

relevant health care facilities and community-based care services - improved by 80% by 2015” (ibid. p20).

The Global Health Initiative addresses ‘coordination, collaboration and integration – at all levels’; its Operational Plan describes the imperative need to “Innovate for results: Identify, implement, and rigorously evaluate new approaches that reward efficiency, effectiveness, and sustainability. Focus particular attention on promising approaches to service integration and delivery, community-based approaches...”. (USG 2009a; p8). The GHI intention is that PHC service delivery should be genuinely integrated and address clients’ needs.

GFATM is similarly attentive to the requirement to bring services closer to communities: “In Round 9 [in Nigeria] the gap in access and coverage of HIV services to rural communities will be bridged by further decentralizing HIV/AIDS prevention, care and support services to the PHC and community levels...” (GFATM 2009; p2).

GHAIN presents the HAST model as offering: integrated HAST services; LGA systems strengthening; community systems strengthening; and linkage of community services to facility-based services. It is perceived by GHAIN as a crosscutting activity and one that supports health systems strengthening.

“[HAST] is an integrated approach, coordinated by the local government health authority and links community based activities to health facilities through a network of referrals between implementing agencies...under the lead of an umbrella NGO which is contracted by and reports to the LGA administration.” (Ibrahim, M., Cartier, S. A., Gana, C., Adegoke, F., Abdallah, A., Chabikuli, O. & Hamelmann, C. (not dated: 2009/10); p4).

GHAIN is implementing a number of exit/sustainability actions targeted at HAST. According to information received by the end of project evaluation team, these include: “creation of decision-making structures within LGA secretariats, support to HAST committees (chaired by the LGA PHC coordinator), assistance with budget development that includes HAST-related activities, support/inclusion of the LGA M&E officer in data collection and efforts to strengthen CBOs to be able to compete for unlinked funding.” (GHAIN communication October 2010.)

Implementation of HAST is a major undertaking for GHAIN, as well as a significant change of direction towards community engagement and community system strengthening. These factors should be borne in mind when reading the remainder of this section.

Achievements

The HAST model has been the entry point for something that has to be done in the Nigerian context: moving towards integrated primary health care antiretroviral therapy service delivery. The intention has been to move away from what have been in the past vertical delivery systems towards a more integrated and responsive approach that is reflective of resource-poor setting constraints. GHAIN has begun a process through the HAST model for decentralization of HIV/STI (now expanded to SRH)/TB services to PHC facilities and the community (working with community volunteers, peer educators and community pharmacists). The HAST model seeks to strengthen mechanisms for eventual referrals to the secondary health facility located in each LGA.

As such, the GHAIN experiences of HAST work to date should serve as lesson

learning, with achievements, challenges and gaps all rigorously scrutinized and put to best use in future planning for optimal PHC and community service delivery.

GHAIN has committed very considerable time and effort to developing and supporting the implementation of the HAST model; these activities have been predominantly theorized and led from the country office, while management has been largely from GHAIN zonal office level (NB: the fifteen HAST LGAs are situated in nine states and the FCT. Not all zonal offices are engaged with HAST, e.g. the North East zone). LGAs, umbrella and partner CBOs and community members volunteering to work with HAST have also invested very substantial time, effort and energy into supporting activities. Many people have done so in a spirit of admirable voluntarism.

The HAST model is multi-faceted and comprehensive in its components, all of which are being supported by GHAIN. It is important to bear in mind that the full range of support and activities are not being implemented in all fifteen HAST LGAs; this is especially the case for those whose sub-agreements have recently been finalized.

GHAIN describes the range of inputs at LGA level as covering a number of core areas, including (see Appendix G for details):

Health systems strengthening (through working with LGAs, CBOs and volunteers)
community systems strengthening (through working with CBOs, community volunteers and community gatekeepers)
Support to orphans and vulnerable children, including KidMAP

To date (October, 2010), 213 peer educators are supporting services in 93 facilities and 351 community volunteers have been trained and supported to work in nine HAST LGAs. 1308 TB patients received treatment support from community volunteers between June 2008-Dec 2009.

One achievement perceived by LGA staff members is that implementation of the HAST model in itself necessitates more engagement with community members as active partners.

Challenges

1. Lack of guaranteed support from state level to HAST LGAs. LGA annual plans may not be funded or if monies are allocated these may not be disbursed. Such issues must gravely compromise post-GHAIN sustainability.
2. Some linkages have been developed between SACAs and HAST LGAs, but these are not systematized. SASCPs appear out of the loop almost entirely.
3. Lack of engagement in HAST of key public sector stakeholders, e.g. state Ministries of Local Government. Despite the links with the Federal Ministry of Women's Affairs and Social Development, this is absent at state and LGA levels.
4. Overall inadequate or non-existent training of health workers and local government officers on community engagement, community systems, accountability to community members, gender and health, support to orphans and vulnerable children, child protection, social protection writ large, social exclusion, and other social development foci essential when seeking to build and then sustain community (health) system strengthening.
5. Only a few PHC facilities can be refurbished and otherwise supported through HAST; this has resulted in community members 'abandoning' unsupported PHCs and seeking to gain access to 'HAST PHCs'. This can result in considerable and increased opportunity costs and also reduced access for some members of the community, e.g.

women in the north.

6. Sometimes grossly inadequate human resources for health, which results in seriously compromised delivery of any PHC services – and may also result in over-emphasis on HAST service delivery, to the expense of other conditions and diseases.

Gaps

Limitations of the HAST model

- One significant limitation of the HAST model is that it is not fully in line with WHO's Integrated Management of Adolescent and Adult Illness, nor its Integrated Management of Childhood Illness. There is a risk that the HAST emphasis will distract from delivery of critical primary health care services — such as those concerned with child health and safe motherhood. Neither WHO approach advocates focusing on three infectious diseases. Currently HAST places unsustainable burdens on under-capacitated health workers and community volunteers as well as on CBOs.
 - Its implementation to date has not adequately strengthened overall health systems at LGA level and may in fact have introduced ultimately unsustainable and vertical/silo HIV, STI and TB service delivery elements.
 - There are also ethical issues to be addressed, e.g. support to orphans and vulnerable children; its orphans' and vulnerable children's services are inadequate.
 - Neither umbrella nor any implementing CBOs has received appropriate and tailored HSS/CSS training in order to support effective delivery of HAST services.

The Global Health Initiative seeks to support integrated PHC service delivery; as currently implemented HAST diverts attention from such a broad-based approach to PHC service delivery.

As currently implemented, the HAST model does not adequately address strengthening of primary health care, it prejudices delivery of safe motherhood and child health services and its OVC services are woefully inadequate. HAST is *de facto* positioned in competition with overall primary health care service delivery.

In some HAST LGAs visited there was evidence of increased uptake of services; while this is encouraging, it needs to be viewed in the context of insufficient information on whether such uptake was supported at the expense of other PHC service components and also on the quality of service provided.

Insufficient ownership of HAST by LGAs

A key example of top-down and too close management by GHAIN is that the end of project evaluation team discovered evidence of pre-prepared data in several LGA M&E departments. In other words, charts had been developed by GHAIN zonal offices and given to LGA M&E officers to present as their own work; this became obvious when individual M&E officers were unable to provide analysis and interpretation. Moreover, evidence was found that on occasion LGA and/or umbrella CBO M&E officers are unable to use DHIS and KidMAP.

Insufficient support to umbrella and other CBOs

Neither umbrella nor implementing CBOs have received appropriate Health/Community Systems' Strengthening in order to support effective delivery of HAST services. In addition, training on management of confidential data and action to reduce stigma and discrimination appear to have been absent. No social development focus was apparent.

Inappropriate volunteer selection and insufficient training

Selection and training of volunteers appears to have been flawed. For instance, most community volunteers are at the least middle-aged while some are elderly – and the majority is male. While individuals' commitment and voluntarism should not be questioned, their capacity to gain access to, and then engage with, the opposite sex and other age groups, especially the young, does need to be considered. Peer educators in Wamakko HAST LGA in Sokoto state and Kachia HAST LGA in Kaduna state were embarrassed and confused when asked about provision of OP SBCC to MARP.

Inadequate links to the public sector

State ministries of local government have not been adequately integrated into the HAST model, yet these are key actors in management of human resources for health. LGA Social Welfare Departments have been entirely sidelined in the HAST process, yet these are key community-public sector interfaces (see also the comment regarding the Federal Ministry of Women's Affairs and Social Development).

Inadequate and inappropriate OVC processes

The process of OVC enrollment began in May 2010 in some HAST LGAs; this is entirely inappropriate, as support will be short-lived given the few months left until the end of GHAIN. The very process itself is flawed (see 4.3.Orphans and other vulnerable children and Appendix G for more detailed discussion).

Inappropriate selection of caregivers

Evidence of this was found primarily in Wamakko LGA, during a field visit to Gumbi community. A number of the caregivers interviewed appeared to have been selected due more to their closeness to community leaders rather than either their appropriateness or a pre-existing relationship to the child in question. Discussion as the roles and responsibilities of caregivers elicited occasionally inadequate responses.

Lessons learned

1. The main lesson is that activation of HAST is very different from activating a district hospital for ART. It is important to bring all stakeholders on board early, governmental (LGA secretariat) and non-governmental (CBO, community gate keepers/leaders, etc) and keep them engaged too. All this takes time but is essential for ownership and sustainability.
2. Proper, preliminary and participatory mapping of stakeholders, capacities, existing activities, health needs, socio-cultural barriers to health-seeking behavior, etc is essential in order to provide a firm foundation for HAST-type action.
3. Learning from other interventions and international best practice is crucial, yet this appears to have been missed for HAST. FHI itself has experience from the DFID Nigeria funded *Supporting the National [HIV & AIDS] Response*, where its partner Action Aid Nigeria (an organization with international renown in social development, community systems and gender) supported community system strengthening.
4. It is of absolutely critical importance that all community-focused interventions be supported by adequate technical expertise in CSS, social development, gender, OVCs, social protection, rights, and other fundamental social development approaches. A primarily biomedical approach will not work, however well intentioned it might be.
5. Child and wider social protection expertise should be an intrinsic and non-negotiable component of all community-based interventions.
6. The rights of the child and of adults should be thoroughly integrated into all components of any community intervention; this is not the case with HAST.

4.4. HIV/AIDS AND TB TREATMENT SERVICES AND INTERVENTIONS

General overview of GHAIN support to HIV/AIDS treatment services through ART

Introduction and background

AIDS treatment was a PEPFAR I key priority to improve the duration and quality of the lives of those living with HIV. Getting ever increasing numbers of adult and child PLHIV on to ART was the imperative that was the main driver of HIV/AIDS program development, approaches and implementation. As noted in the 2008 evaluation **GHAIN pioneered provision of ART services at secondary health facilities in Nigeria**, thus greatly expanding access to treatment. However, to deliver the required treatment targets, GHAIN expanded to high volume sites throughout Nigeria, rather than penetrating deeper into states, where health facilities had lower client loads.

At the time of the 2008 evaluation, GHAIN supported **90 ART sites**, exceeding its target for July 06 – June 07 and doubling its target for July 07- June 08. This was possible through collaboration with NACA, and being a sub-recipient of the Global Fund Round 5 grant. Further rapid expansion occurred throughout July 08 – June 09 and from July 09. **By June 2010, GHAIN was supporting 124 service outlets providing ART** services according to national or international standards.

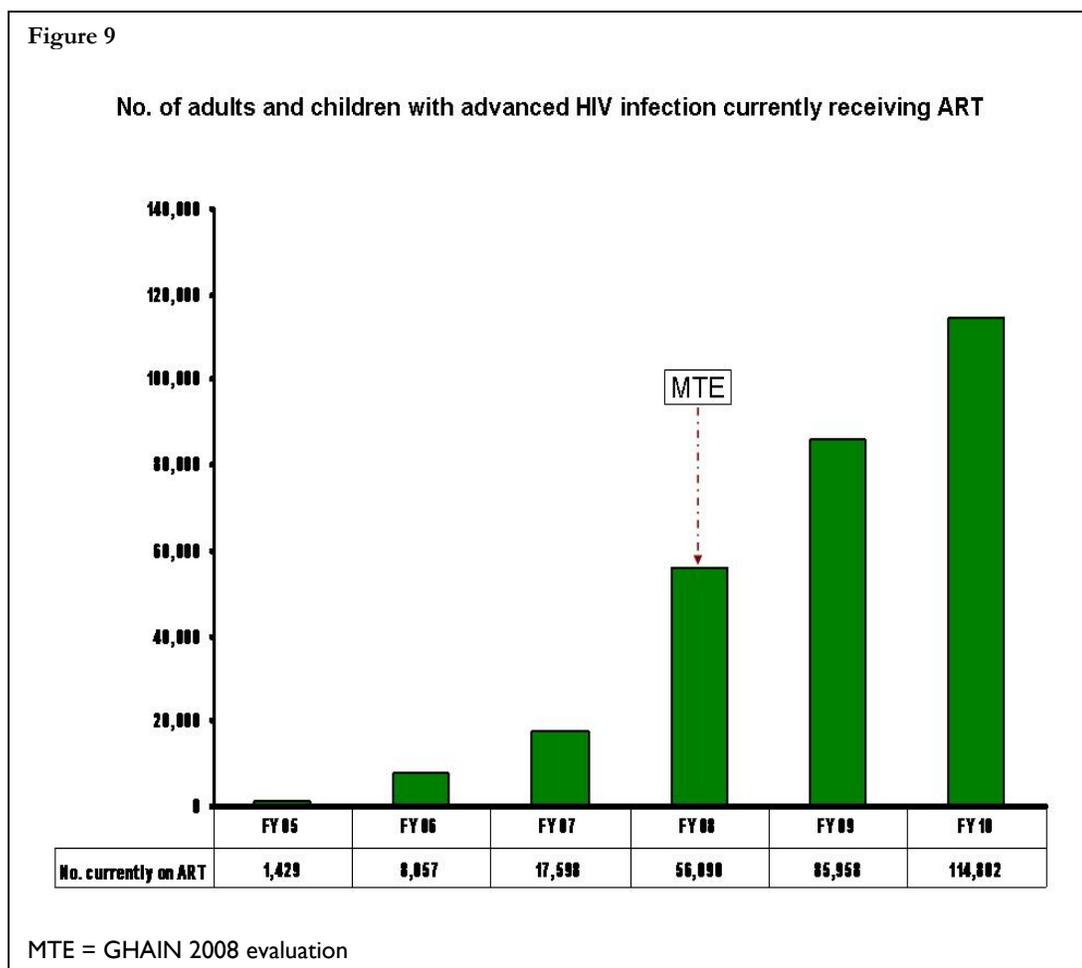
Since July 05, new ART clients have risen sharply each subsequent year, and **GHAIN has exceeded targets** in the years since July 05. [ARV drugs were not available at GHAIN-supported sites in before July 05.] By June 2010, 137,666²² (m=49,928; f=87,738) individuals had been newly initiated on ART, including 40,148 (m=14,023; f=26,125) from July09 – June 2010 when GHAIN had a target of 5,500 newly initiated on ART

Achievements

- **Remarkable, rapid and wide geographic scale up** of HIV/AIDS treatment services at secondary level facilities
- Overall, **all the sites visited** in the end of project evaluation were judged by the evaluation team to be **providing adequate or good ART services**
- From July 05 to June 10 greatly exceeded targets for new patients on ART
- Introduced **treatment support by lay volunteers** including facility-based peer support groups for people living with HIV, and home visits to persons missing clinic appointments
- Consistently **exceeded its targets for training health workers**: 3,967 health workers have been trained to deliver ART services according to national or international standards as of June 2010, including 886 in the year July 09 to June 10 which had a target of 255
- Introduced **site assessment tools** (used with FMOH) and processes for preparing health facilities for comprehensive AIDS services
- Developed:
 - Adherence support training and a related training manual
 - **Standard operating procedures** for the provision of antiretroviral treatment in GHAIN-supported sites

²² According to the *GHAIN Quarterly report April – June 2010*

- **Standard Operating Procedures** for evaluating and reporting adverse drug reactions in ART clinical settings.



Challenges

1. GHAIN HIV/AIDS treatment services are provided at only a small number of secondary and referral hospitals in most states, necessitating long and expensive travel for clients for clinic appointments and to facility-based support group meetings. (There are in addition ART services provided in each state at sites not supported by GHAIN).
2. HIV/AIDS treatment services are delivered through acute service delivery models, as the infrastructure for chronic service delivery is not developed.
3. Attrition of trained staff continues to be a major challenge to ART service provision, with staff lost to higher paid donor and NGO projects, the private sector, retirement and regular 2-yearly transfers of GON staff by States. GHAIN zonal offices are advocating for retention of trained staff or transfer of trained staff to other GHAIN sites to reduce the loss of trained staff.

Gaps

Some GHAIN zonal offices do not hold databases of persons they have trained and, because of GHAIN staff attrition, are struggling to construct databases from records of trainings they do hold and surveying facilities for trained staff. Until the GHAIN zonal records are complete, GHAIN is unable to provide state health services commissions the data they need to ensure retention of trained staff in positions where they will continue to make use of their GHAIN training.

HIV/AIDS treatment services are frequently co-located in hospital premises rather than integrated into hospital services (to an extent this is a legacy of the PEPFAR 1 emergency response). ART services are often delivered in separate clinics – even in separate accommodation from hospital outpatient departments – on specific days. Similarly ART laboratories are often separate from the main hospital laboratories and only function on ART clinic days. Thus patients referred from other hospital outpatient departments (for example ANC or FP, and TB/DOTS) are frequently not seen on the day of referral but have to return for ART assessment. There are many important reasons for sites having separate pharmacies and laboratories, e.g. space constraints and, in some cases, to alleviate potential problems because HIV/AIDS drugs and laboratory tests are provided free of charge, whereas other drugs and laboratory tests are fee-for-service. While some clients report that they prefer attending ART clinics away from the hospital outpatient department, integration of services is best practice — as segregation fosters stigmatization, including self-stigmatization.

Provision of services from separate premises encourages the view that the hospital staffs are providing “GHAIN” services or, less commonly, “PEPFAR services”, reducing local ownership, increasing the scope for demands for financial reward for doing work that is not standard hospital work, and risking stigmatization of patients attending the segregated services.

Although the current ART care card is adapted from WHO for longitudinal patient follow up and monitoring, the current paper-based medical/clinical records are not well suited to long-term care and treatment because of the great bulk that occurs over time with chronic care. However, electronic systems — at the LAMIS sites visited — are not maintained by the clinical and pharmacy staff; it is clinicians who should enter data into LAMIS, for reasons such as data accuracy and patient confidentiality. GHAIN-paid data entry clerks add data to the electronic record retrospectively, in the medical records department. Such retrospective data entry, with non-clinical and non-pharmacy staff extracting information from hand written paper-based records, is fraught with opportunities for error.

Clinical staff members at some LAMIS sites tried to demonstrate the use of the electronic system, but were easily derailed by simple questions or requests to examine other records than the one they had on the screen when the evaluators arrived. Electronic medical records systems can only be useful if there is ownership by the clinicians that provide the clinical care who see the benefit of the electronic system over a paper-based system for patient care management. This has not yet happened at LAMIS sites, where the electronic remains a parallel system that State ministries of health may well be unable to sustain after GHAIN ends.

Lessons learned

1. GHAIN has developed a **patient monitoring management (PMM) system** that has now been adopted by the GON
2. GHAIN experience significantly contributed to the development of the FMOH clinical guidelines.

Adult antiretroviral therapy

Introduction and background

Although ART has been available in Nigeria since 2002, it was only available at a few tertiary health facilities and provision had not met GON targets of 10,000 adults and

5,000 children on treatment. GHAIN's initial strategy for getting enough people onto ART to meet its PEPFAR targets involved mass media campaigns and community awareness raising linked to rapidly scaled up provision of HCT. GHAIN built on the foundation of the FHI/IMPACT project experience expanding access to HCT, establishing many stand alone "Heart to Heart" HCT sites and undertaking mobile HCT at markets, soccer games and other venues that would attract many clients. As awareness has increased, and stigma decreased, GHAIN has moved away from supporting stand alone and mobile HCT as entry points to ART services. Instead, GHAIN focused on increasing the service delivery points within ART sites that i. offered HCT or ii. referred clients to Heart to Heart services within the facility for HCT. Alongside the strategy of increasing availability of HCT within facilities providing ART services, GHAIN - facilitated by its collaboration on the Global Fund Round 5 grant from 2007 - rapidly expanded the number of secondary facilities providing ART throughout Nigeria.

Achievements

- GHAIN has successfully and significantly expanded access to comprehensive HIV care and treatment services in Nigeria
- GHAIN consistently exceeds the targets for "number of individuals ever received ART" and "number of individuals currently receiving ART"
- GHAIN has established coordinated HIV care treatment services in the supported facilities, with systematic client flow through most service delivery areas
- Established PLHIV support groups in many facilities. These have the potential through members volunteering to improve service delivery and strengthen the relationship between service providers and beneficiaries/clients. This will be especially valuable once the concept is fully developed and support group members are included in hospital management meetings
- Provision of ART-related job aids and other IEC materials
- Development of an electronic medical records system (LAMIS) for patient care monitoring, with its introduction in selected facilities
- Introduction of adherence support and counseling – in some facilities involving PLHIV providing peer support and counseling – in the ART clinic and ARV dispensary, thereby potentially providing adherence counseling at every contact.

Challenges

1. Many secondary facilities are increasingly congested as patient load increases; many service providers work in cramped and overcrowded conditions that compromise privacy and confidentiality

2. Human resources for health constraints:

- Clients at many facilities experience very long waiting times when picking up refills (e.g. at Suleja General Hospital where the conscientious yet severely overworked dispensary staff describe clients sleeping at the facility overnight and then waiting until late afternoon on the following day for drugs)
- On occasion poorly motivated facility staff members: in some GHAIN-supported facilities service providers are overworked without any concomitant increase in salary, while believing that staff members at other such sites receive increased emoluments
- Occasional health worker strike actions

Gaps

- Difficulties in follow up of pre-ART patients (positive patients enrolled into care

but not yet eligible for ART)

- The tracking system in place focuses on patients on ART because the list of patients who have missed appointments is almost always generated from the ARV dispensary/pharmacy appointments diary
- Duplicate referral forms are in use at many facilities, but patients who do not attend referral appointments are not actively/routinely followed up
- Insufficient focus on prevention for positives, especially at northern ART sites.

Lessons learned

GHAIN experience developing training materials/curricula and standard operating procedures for secondary facilities represents an important resource for the FMOH.

Pediatric antiretroviral therapy

Achievements

- As of end March 2008: **2,219** children ever received ART and 1,836 currently receiving ART.
- GHAIN developed standard **operating procedures** for antiretroviral therapy for pediatric patients that have been adopted by the FMOH
- Most ART clinics have pediatric dosing charts/dosing wheels available
- Through partnership with the Clinton Foundation HIV/AIDS Initiative, GHAIN introduced Plumpy Nut therapeutic nutritional supplement into the pediatric ART package, which also includes insecticide treated bed nets and Waterguard
- Since 2008, more PMTCT services have started following up HIV-exposed infants with EID, to get HIV infected infants onto ART
- Some GHAIN facilities have introduced **family ART services** so that children and their mothers/parents can receive treatment at the same time. (An important innovation for minimizing the costs and disruption to families through attending for long term follow up, and thus increasing the number of children receiving ART and remaining on treatment)

Challenges

Some stock outs of pediatric ARVs and formulations.

Gaps

The 2008 evaluation noted that

- Pediatric ART services had in some ways lost sight of the child – providing services that are essentially adult ART services for small people.
- The initial registration form was the same as for adult ART with nowhere to record children’s developmental milestones, immunizations, and growth
- Growth monitoring was not used as growth monitoring charts were (wrongly) associated with primary health care level clinics
- Lack of recognition of the importance of growth monitoring in long term pediatric care reflects clinical training and hospital services that are essentially geared to acute pediatric care rather than long term chronic HIV care.
- Family ART clinics and pediatric ART clinics were not “child friendly” and did not offer toys, colorful posters, age appropriate materials.

The 2008 situation largely persists although the National Pediatric Initial Clinical Evaluation form provides for the documentation of relevant information for the

management and monitoring of children.²³

The end of project evaluation found that many facilities provide pediatric ART – sometimes with pediatricians delivering the pediatric ART services – concurrently and co-located with adult ART services so that mothers/parents and children can be seen together. However, other GHAIN-supported facilities (for example at St Charles Borromeo Hospital, Onitsha and Yola Specialist Hospital) provide pediatric ART separately from adult ART. At CH Benin, the pediatric ART clinic has been transferred to new premises across a busy main road from the hospital, while pediatric clinical records are co-located with the adult ART clinical records in the main hospital. Thus a parent has to pick up the child’s clinical records at the main hospital, cross the road with the child to obtain pediatric ART services, and then return to the main hospital with the child to queue up again and receive adult ART services.

Although staff delivering pediatric or family ART services may well be kind, child-focused and demonstrate caring attitudes and behaviors, the facilities evaluated are still not “child friendly”. Larger facilities with high client loads on ART clinic days necessitate parents with children to queue to obtain their clinical records, queue for the out patient consultations including any adherence counseling or peer support, queue at the laboratory for drawing blood for ART monitoring tests and queue again at the pharmacy to obtain their ARVs and OI drugs.

Lessons learned

1. There is considerable need to provide genuinely child-friendly pediatric ART services.
2. Pediatric and adult ART clinics should be more effectively integrated, ideally as a one-stop-shop, where parents’ and children’s needs are simultaneously addressed.
3. Far more focus is required on integration of OVC services (e.g. as provided under HAST) and pediatric ART and palliative care services.

Pharmacy services (including community pharmacists)

Introduction and background

GHAIN, through its consortium partner Howard University PACE Center, has supported the implementation of good pharmacy practice through training and support supervision, with implementation of standard operating procedures and tools. Prior to the 2008 evaluation, GHAIN trained a cadre of community pharmacists [private sector pharmacists who work primarily through their own pharmacy shops] some of whom work as volunteers in government health facilities that have critical shortage of pharmacists—several sites visited do not have a trained pharmacist and entirely rely on this volunteer cadre and youth corpsers. In Cross River State the same five trained community pharmacists work at both GH Hospital Calabar and General Hospital Ugep. However, more than 80% of GHAIN-trained community pharmacists have ceased to volunteer and are not reporting on HIV activities in their private pharmacies.

Initially, after assessment and determining eligibility for ART, clients receive adherence counseling and a one or two-week prescription for ARVs. They are seen at follow up and at the pharmacy to ensure they are taking the medication correctly and managing any side effects appropriately. The pharmacies keep a diary of when clients are expected to return for refills, and generate lists of persons who missed appointments for follow

²³ It is relevant to point out that GHAIN first received the 2008 evaluation report in mid-2010 and was, therefore, unable to have earlier sight of its recommendations. Nonetheless, it could also be argued that such gaps could reasonably be expected to have been noted and even acted upon to some degree in those two years.

up. Pharmacists are supposed to provide adherence counseling at every contact, but at least one heavily congested site are unable to do so. Once clients are stable on ART, their prescription is extended to one or two months' supply. However, at sites that have experience shortages of ARVs, clients may have a two-month follow up appointment in the ART clinic but only receive two or one week supply of drugs at a time, necessitating further visits between ART appointments. In many of the sites, when possible, flexible refill appointments are made for patients with special needs – such as patients who plan to travel, or those who reside in towns and villages far away from the hospital—in line with the standard best practice of tailoring pharmaceutical services to the clients' needs.

Achievements

- Main drug stores and dispensing units visited were observed to be hygienic, with good temperature control and monitoring, stock cards were used as a rule, and the pharmacies able to maintain the standard minimum and maximum stock levels
- Pharmacies visited have IEC materials prominently displayed although only few had IEC materials in local languages
- Client registers are standardized across sites and national data collection tools are used for data collection, which are mostly paper based, even when GHAIN has supplied a computer and printer
- At many sites, members of the support group play key roles in client adherence support; they also play the critical role of tracing patients who fail to show up for their appointments (defaulters)
- There was clear evidence that pharmacists involved in ART patient care had been provided with good pharmaceutical care training

Challenges

- Congested dispensing facilities in many of the sites visited: dispensaries are often packed with cartons of drugs, there is rarely a space for the pharmacy staff to sit and patients have to wait for hours under the sun or in cramped waiting areas.
- Staff shortages —sometimes critical, with no employed hospital pharmacists only volunteers and corpsers.
- Trained staff attrition exacerbated by GON human resource policies that move staff every two years; GHAIN has increasingly relied on step-down training
- Shortfalls in ARV supply (currently offset by GHAIN interventions)
- Stockouts of pediatric formulations, OI rugs and TB drugs.

Gaps

The major gap is that pharmacy services for ART clients are provided as a parallel structure to the hospital system; in part this is a legacy of PEPFAR 1 processes. However, there has also not been sufficient attention to health system strengthening has not occurred; this does not augur well for sustainability. In a few of the sites, for example General Hospital Kotangora, the ART drug store has been integrated into the main drug store of the hospital, but the management systems differ. In Specialist Hospital Yola, the sharp contrast between the ART drug store and the main hospital drug store is really depressing, especially in light of the knowledge that each of these stores is managed by the same individuals.

Most of the pharmacists complained of work overload. Patient data recording is mostly paper based despite the provision of computer systems for all the sites – most of the facilities reported they have one problem or another with their computers and have not been able to use them for data management since the inception of the program. Only one pharmacy visited uses an electronic system to manage its patients' data and generate

reports.

A long client waiting time was observed in most sites; in some cases clients may have to return the next day to pick up their drugs. This is often because there are not enough ART clinic days. In FMC Jalingo, where there is only one ART clinic a week, the site staff raised the need to increase the number of clinic days to at least two days a week. As yet this has not been addressed by the hospital management.

At Central Hospital Benin, pharmacists dispense ARVs and OI drugs from one table piled high with drug containers, two clients at a time. At the time of the evaluation visit, the two pharmacists (one of whom was new—working there for only one month—and untrained in pharmacy requirements for supporting ART) were working with a long line waiting at 5.30 pm. They were clearly not counseling clients and if clients raised any issue about their drugs, the client was not given a prescription refill but referred back to the following day's ART clinic. Similarly, at General Hospital Suleja clients do not have privacy during consultation with the pharmacists.

Lessons learned

1. Engaging volunteers, mostly community pharmacists and some youth corpsers, to support pharmacy service delivery by alleviating the impact of inadequate number of deployed pharmacy staff has been successful. Many of these volunteers reported that they are motivated volunteering in the GHAIN program to initiate HIV/AIDS focused activities in their own pharmacies. The involvement of PLHIV in pharmacy service delivery has also been successful.
2. The GHAIN-initiated community pharmacy program has also had some success despite high attrition rates. The trained and active community pharmacists provide a set of services including HCT using rapid HIV tests and referral of positive clients; provision of TB-DOTS, and referrals of persons with symptoms of sexually transmitted infections based on defined service delivery standards, extending the availability of these services further into the community. The community pharmacists have a professional organization and an active group in Lagos—met in Ajerome HAST LGA—are planning to write grant requests through the professional organization to pharmaceutical companies to extend their work and continue after GHAIN support finishes.
3. In a few of the sites, the main pharmacy dispensaries have adopted the concept of patient counseling as a standard practice and have discontinued the old practice of window dispensing of drugs.

Procurement, logistics, commodities and laboratory supplies

Introduction and background

Prior to Nigeria receiving the Global Fund Round 5 grant, GHAIN consortium partner Axios Foundation undertook all the drug and commodity procurement and supply for GHAIN-supported sites. At the time of the 2008 evaluation, there had been no stockouts of ARVs or other drugs procured by Axios at GHAIN-supported sites. Since the shift to Central Medical Stores supported by JSI procuring and supplying ARVs and cotrimoxazole, GHAIN (through Axios) has supported drug, reagents and other commodities logistics management for all the GHAIN-supported sites. To ensure efficient commodities' distribution, the program continues to use GHAIN zonal stores that it established within the State Medical Stores in States where GHAIN has a zonal office that serves states within each of the zones.

Achievements

- Most sites have had consistent ARV supplied in the last 6-12 months

- GHAIN has also achieved consistent supply of pediatric ARV formulations, but some sites have had shortfalls
- Many sites have maintained minimum and maximum stock levels [1:3, or 2:4] for ARVs in the last 12 months
- All the sites have been supported to implement good drugs and commodities logistics management practice, including infrastructural support for the creation of drug stores, with very good temperature control and monitoring
- Site staff, pharmacists and laboratory scientists are trained on logistics management as a component of their specialized trainings by the program
- GHAIN has developed and uses a standard checklist for baseline commodities' logistics needs assessment prior to site activation.

The evaluation site visits showed that large ARV drug cartons are stored on pallets, stores are hygienic and tidy and stock cards are used consistently; commodities' utilization are monitored using appropriate tools and the principle of *First Expiry First Out* is practiced. Good controls are also in place to ensure safety of the commodities.

Challenges

1. The transition from Axios procurement and supply to GON procurement and Central Medical stores supply was challenging. Axios used drugs that were in its pipeline to avoid stockouts at GHAIN-supported sites during the transition.
2. Since the transition from Axios to Central Medical Stores, the most critical challenge observed by the evaluators is frequent stock out of major opportunistic infection (OI) drugs and HIV rapid test kits at all the sites due to the weaknesses of the government system through Central Medical Stores.
3. There have also been occasions when GHAIN-supported sites were running perilously low on ARVs. GHAIN has been alert to this through their work assisting pharmacies to forecast their needs and send requisitions to Central Medical Stores. GHAIN has managed to avert stockouts by redistributing some supplies from sites with larger stocks to sites that were running low.
4. In the north of Nigeria, the evaluators identified an erratic and unpredictable supply of TB drugs to sites through the national TB program that resulted in most sites reporting they are unable to maintain minimum and maximum stock levels for TB drugs.
5. The evaluators also observed significant drugs and commodities stock outs of drugs for OI treatment and prophylaxis, for example cotrimoxazole, and rapid HIV test kits. As a results HIV testing was halted for a period of time in some facilities, and patients in need of OI drugs could not get these.
6. As a result of the changes in the supply role of Central Medical Stores and Axios, the commodities' "pull system" established by GHAIN has essentially been reversed to a "push system". In Sokoto state, SACA and SASCP staff reported that on several occasions sites did not get rapid HIV test kits from the Central Medical Stores because they lacked funds for the team to travel to Lagos and pick up their supplies.²⁴
7. Acute infrastructural challenges are hampering appropriate drug storage and management in several of the sites. In General Hospital Minna, the dispensing unit is grossly inadequate for dispensing, also doubles as the main drug store for ARVs and related commodities. While in Federal Medical Centre Kebbi, every conceivable space is

²⁴ To manage this situation, many states have procured their own test kits to supplement GON supplies or are planning to do so.

used for drug storage due to its space constraints.

8. Several sites have stockpiles of expired drugs waiting to be returned to Central Medical Stores for appropriate disposal. This causes storage problems for facility pharmacies: some sites visited had expired ARVs on shelves and hospital drugs store on the floor; in General Hospital Kachia, the stock pile now occupies an entire store room.

Gaps

In the treatment sites evaluated, in the drug stores supported by GHAIN where drugs are collocated with hospital drugs, they are stored separately—not only on separate shelves but also using different bin cards and often different styles of storage. The ARVs are more likely to be well managed than the hospital's other drugs; the standard logistics management practices implemented in the supported stores are not replicated in the main stores. This indicates that facility drug management system strengthening has not occurred and is a barrier to program sustainability.

GHAIN training site staff to implement good commodities logistics management was specific for HIV/AIDS treatment related drugs, apparently without a proactive focus or encouragement to replicate these standard practices in the other hospital commodities logistics management.

GHAIN has trained laboratory staff working in the “GHAIN” or “PEPFAR” laboratories to monitor reagents and consumable consumption and to prepare appropriate consumption data for use by GHAIN to quantify and forecast future requirements, rather than training laboratory staff actively to manage the lab reagents and consumables logistics.

Lessons learned

1. It is important to strengthen systems rather than establish parallel systems. While GHAIN's original drug quantification, procurement and logistics system delivered secure supplies to GHAIN-supported sites, it did not strengthen the GON system. Since GON took over using its Global Fund Round 5 grant, supplies have no longer been secure.
2. Similarly GHAIN training on support to pharmacy management of drugs has not extended to improved practices within hospital drugs stores and pharmacies.

Laboratory services

Introduction and background

GHAIN has supported the infrastructural upgrading of the hospital laboratories at health facilities it supports, to enable them to provide the laboratory services necessary for diagnosis and monitoring treatment for HIV/AIDS, TB and other opportunistic infections. Infrastructure upgrades include: structural renovation and repairs to the laboratory building; provision of basic amenities where needed, such as water, stand-by generator and power inverters, to ensure reliable water and power supply; and the provision of all the necessary equipment (including state-of-art automated systems) for efficient lab service delivery to PLHIV. In many laboratories, GHAIN has supported improvements in lab work and patients'-flow, and improvements in laboratory safety by creating separate sample collection and patients' waiting areas (this was one of the gaps observed in the 2008 evaluation).

Achievements

- GHAIN has exceeded its PEPFAR targets for the number of laboratories with the capacity to perform HIV and CD4 tests and/or lymphocyte tests from July 06 to

June 10; see Figure 10 below

- 118 laboratories in secondary and tertiary facilities supported to provide diagnosis and treatment monitoring
- GHAIN has enabled the establishment of two molecular laboratories
- For early infant diagnosis (EID), and
- TB culture and drug resistant testing respectively
- GHAIN has exceeded its PEPFAR targets for training laboratory staff from July 06 to June 10; see Figure 11 below

In all the sites visited by the end of project evaluation team, GHAIN has supported the training and retraining of lab scientists and other lab staff in good lab practice, lab safety procedures, lab quality assurance, lab commodities logistics management, and general lab procedures and equipment operations.

Lab Service Package and Quality

Baseline lab tests for HIV positive clients include: clinical chemistry tests (SGOT, SGPT, serum creatinine, potassium, and blood glucose), hematology (full blood count), CD4 count, and hepatitis B surface antigen test. Some labs visited in the South also provide pregnancy tests. Lab staff members indicate that they receive “adequate” or “frequent” supervisory visits by GHAIN Zonal Staff –sometimes as often as weekly.

GHAIN has provided generic standard operating procedures to ensure service quality for use at all the sites; many laboratories displayed bench references and job aids on the workbenches. All the labs visited are enrolled into one or two external proficiency programs (the South African NEQAS and the Medical Laboratory Science Councils’ PT program), mainly for CD4 count and HIV serology. These enrollments form part of GHAIN’s quality assurance strategy, and review of the proficiency testing results indicates a generally “good” performance by the labs.

GHAIN supported the development of a specimen referral system within its laboratory networks and this ensures uninterrupted service delivery even during equipment breakdown and long downtimes. Thus in General Hospital Minna samples for baseline CD4 count were logged to Suleja General Hospital when the Cyflow equipment was non-functional.

Figure 10

Number of laboratories with the capacity to perform HIV and CD4 tests and/or lymphocyte tests

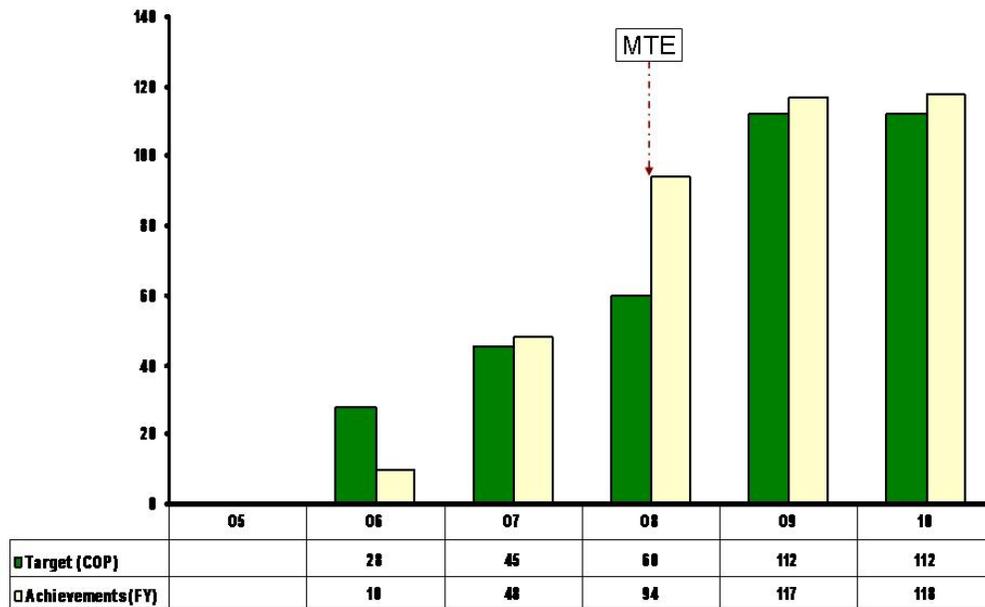
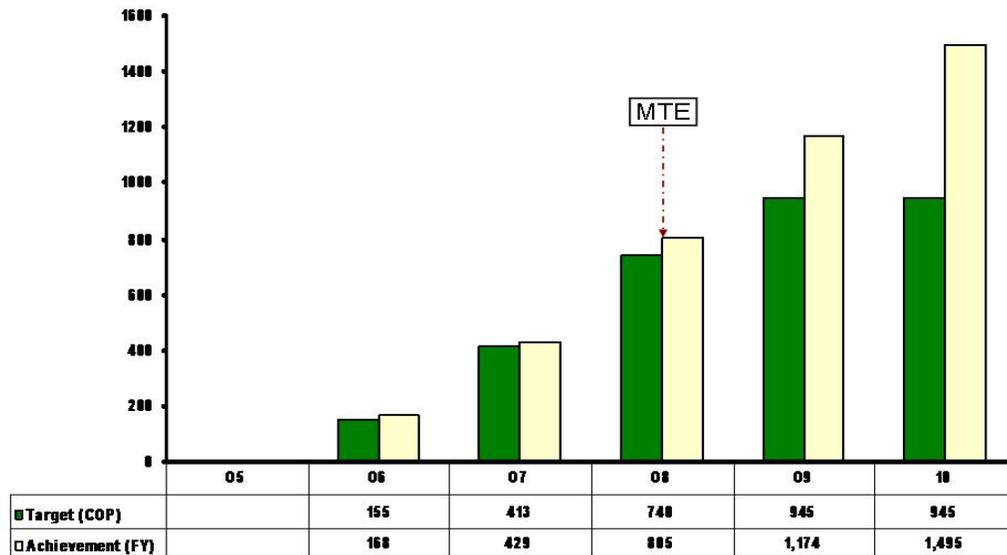


Figure 11

No. of lab site staff trained – cumulative –



MTE = GHAIN 2008 evaluation

Documents and Records

All the sites evaluated had in place standard lab registers for patient data and results documentation, and maintained good records (mainly paper-based). Some labs have

desktop computers provided by GHAIN and some of the labs are linked to the GHAIN LAMIS and HMIS, although laboratory staff members are not entering client data into the electronic systems.

Safety

Laboratory staff indicate that post exposure prophylaxis is provided by the hospitals. Basic safety equipment was seen, including fire extinguishers, and access to the Lab by non-lab personnel was generally restricted, while there were examples of bad practice (e.g. GH Ugep). Appropriate access restriction signs were clearly visible in most of labs. The evaluation noted that GHAIN has significantly upgraded TB laboratories at Dr Lawrence Henshaw Memorial Hospital Calabar, Federal Medical Center Jalingo, General Hospital Suleja and Specialist Hospital Yola, thus enhancing TB infection control for the laboratory staff and patients, in addition to supporting improved diagnosis and case detection (not assessed in this evaluation.)

GHAIN has provided laboratory waste management training for most laboratory staff in collaboration with the JSI/MMIS program funded by USAID. In Sir Yahaya Memorial Hospital Kebbi, a model low cost hospital incinerator was observed. This was made possible through the support of Médecins Sans Frontières after the Ebola outbreak in 2009.

Challenges

1. Site staff attrition was a major complaint in most of the sites visited. In St Mary's Hospital Gwagwalada, it was observed that all the trained lab staff have left the facility except for one lab technician, who was said to be on leave at the time of the evaluation.
2. Coupled with this is the work overload suffered by staff "dedicated" to the "GHAIN Lab". This does not exempt them from attending to their routine lab tasks. Several site staff complained of work overload and the need for what they called "motivation" or "compensation" by GHAIN.
3. Further analysis indicates that the work overload is occasioned by the parallel lab structure established by GHAIN. In FMC Jalingo for example, there were a total of 50 lab staff members, 28 of whom were professional medical laboratory scientists. But only 3-5 of these staff members are dedicated to the ART Lab. If the ART Lab were integrated into the mainstream lab, the workload imposed upon these 5 lab staff would have been better managed. (It is important to emphasize that the majority of the lab staff are dedicated to their work despite the workload complaints.)
4. Some laboratories evaluated have insufficient number of medical laboratory scientists. A shifting of key laboratory management responsibilities to lower cadres of lab staff results, with negative impacts on the overall lab quality service delivery. In General Hospital Kachia, only two of the ten lab staff members are medical lab scientists, in General Hospital Kotangora, three of twenty-two. By stark contrast, fifteen of thirty-three lab staff members at Maitama District Hospital Abuja are lab scientists. This inappropriate skills mix varies from sites to site in a given region, between Federal and State facilities, and between the north and the south.
5. The other palpable challenge evident in many of the sites was the lack of lab space (physical space), dilapidated infrastructures, and unavailability of basic amenities such as water, and electricity, This has had considerable cost implications for GHAIN: in order to implement quality laboratory service delivery it has had to provide virtually all the essential amenities and engage in significant infrastructural upgrades before service delivery could begin.
6. Most of the sites visited reported scarcity of HIV Test kits from the Government supply, for the last 2 to 3 months. As a result of GHAIN and Global Fund grant collaboration, test kit supply to many of the sites became the responsibility of GON

(through Central Medical Stores). Lab staff attributed the scarcity and unreliability of test kits to weaknesses in GON procurement and distribution systems.

7. There is no apparent monitoring and supervision of quality of service delivery provided by State Ministries of Health.

Gaps

While GHAIN is commended for the laboratory infrastructural upgrades it has supported at all the facilities, GHAIN has not maintained consistent standards in the infrastructural support and work-flow/patient flow improvements provided to the facilities. There is also variation in support: e.g. distinct and adequate specimen collection/phlebotomy units were noted at St Mary's Hospital Gwagwalada, yet e.g. General Hospital Suleja does not have these. The lab at General Hospital Kachia has no water supply; General Hospital Suleja has no lavatories, either for patients or laboratory staff.

Although all the labs evaluated have been provided with computers, lab data remain mostly paper based. None of the Labs visited used the GHAIN-provided computers for routine patients' data management.

Internal quality control processes were noted to be "poor" in most of the facilities assessed. A few labs (e.g. at FMC Jalingo) have taken the initiative to test and re-test "control samples" and document the results. However, GHAIN has not introduced and institutionalized an internal quality control strategy. In St Mary's Hospital Gwagwalada, staff members expressed their lack of confidence in the clinical chemistry results generated, due to the inbuilt equipment quality validation check has been out of range for the last 4 months. In many of the labs visited, lab staff members were unable to interpret the Proficiency Testing results they have – stating that these have not been explained to them well enough by GHAIN staff.

GHAIN support for TB and TB/HIV laboratories was found to be inconsistent. Thus the Sir Yahaya Memorial Hospital TB Lab Unit is in a poor state and poses a health risk to staff and patients. Assessment of the blood transfusion safety program at Sir Yahaya indicates that units of blood for transfusion are screened using only HIV Rapid Test Kits (and in many cases only one test kit is used, due to scarcity).

In several sites visited laboratory quality oversight for HIV testing by nursing staff and by lay counselors was completely lacking. At Agbani District Hospital the nurse providing HCT in the TB DOTS clinic was recording only one reactive test result and not using confirmatory tests. For more than two months, that nurse had used only the confirmatory test for testing all TB DOTS clients. The lab is not involved in HCT services at Yola Specialist Hospital or in the majority of HCT sites evaluated in the south. GHAIN supplies test kits for rapid HIV testing directly to TB DOTS nurse, PMTCT nurses and lay counselors, not passing them through the laboratory. GHAIN provides no significant support provided to PHCs involved in HAST; such support would enable PHCs to provide basic laboratory services essential to the HAST integrated program concept.

It was difficult to ascertain the package of services provided to pre-ART patients in the labs, as there were no clear data. While a few of the labs visited provided CD4 count, clinical chemistry and hematology tests as baseline and treatment monitoring tests for ART patients, most of the labs provide only CD4 counts for ART patients as the routine monitoring test (based on clinicians' requests). This is not consistent with best practice standard for ART monitoring.

GHAIN does not provide viral load assays for clients on treatment when clinically indicated either directly or through sample referrals to other USG partners that support this assay. GHAIN is currently planning to address this gap through the expansion of services capacity at the PCR lab in Jalingo to include viral load assays.

Facility level laboratory staff have had no inputs into development of the generic standard operating procedures. In the south GHAIN had only recently commenced training to implement and adapt the generic tool to suit specific local procedures and processes, while in the north, GHAIN had not provided training.

GHAIN is not supporting lab staff to imbibe basic laboratory management concepts, including development of budgeting, planning, forecasting and quantification, team building skills and to apply this in the “GHAIN” labs (and also in the main hospital labs). Most of the labs visited do not have a clear organogram, and few labs hold regular lab staff meetings with documented minutes; many laboratories do not have laboratory quality and safety policy manuals. None of the labs provides any input into the specifications for lab equipment and reagents that GHAIN procures for them.

A *major* gap is the parallel laboratory structure that GHAIN has set up in all the supported sites. On one side of this parallel structure is the “PEPFAR Lab” (or GHAIN Lab) and on the other side is the main hospital laboratory. The labs differ greatly in terms of infrastructure, equipment, quality processes and procedures. This structure does not lend itself to systems strengthening and program sustainability. The site staff members who work in the PEPFAR Labs are “stigmatized” by their professional colleagues as they feel they are unduly favored.

Lessons Learned

GHAIN has developed and uses a comprehensive standard checklist for its baseline/needs assessment prior to laboratory activation in supported sites. The consistent use of this tool to assess available human resources and infrastructural capacity vis-à-vis the required minimum standard is useful in ensuring that sites are supported to meet the minimum defined standards. It is, however, apparent that this standard checklist has not been consistently applied.

The program has recently initiated the training of site level/MOH biomedical engineers, in conjunction with the equipment manufacturers/vendors, to provide on-site equipment repairs and routine maintenance on demand. While this will ensure reduced equipment down-times, it is also a strategy that is focused on system strengthening, as the trained biomedical engineers will not only be available to support equipment for ART services but the entire facility.

An outstanding innovation with many opportunities for lesson learning and institutionalization of best practice is the support for the establishment of a high-tech molecular laboratory for the early diagnosis of HIV infection in HIV-exposed infants (early infant diagnosis), in FMC Jalingo. In addition to supporting the capacity building of site staff to implement quality laboratory systems management, and fully transitioning laboratory management responsibilities of this high-tech lab, GHAIN has supported the development of a unique specimen and result shipment collaboration between the benefiting two states (Adamawa and Taraba states) – based on the GON EID scale-up plan. The arrangement includes joint funding of specimen transport and results retrieval. The state branches of the National Union of Road Transport Workers plays a key role. This joint alliance and collaboration has seen an improvement in the

turn-around –time of test results to less than two weeks.

Medical laboratory scientist working in the PCR lab



4. Recent laboratory quality management systems assessment of the PCR lab in Jalingo scored it at 95%, (an excellent rating) and the ongoing local and international proficiency testing program has shown a sustained quality improvement in the lab with a current performance of 100%.

5. GHAIN has trained SMOH quality supervisors to enable them provide quality service delivery monitoring to facilities within their domain. However, and as noted above, there is no indication that these trained SMOH staff provide the required supervisory visits.

4.5 RH/HIV INTEGRATION PROJECT

GHAIN has been instrumental in initiating and supporting integration of reproductive health/family planning (RH/FP) services, to begin with through a pilot in 2007 and currently in 131 sites.

Introduction and background

The overall goal of RH/HIV integration is to reduce the disease burden of HIV/AIDS and to increase the reproductive health of clinical service users. The objectives include awareness raising and commitment for integrated family planning (FP) and HIV services among key stakeholders.

To achieve this, GHAIN does the following:

1. Provides technical assistance to FP and HIV stakeholders interested in developing integrated FP and HIV services:
 1. integrated HCT and FP services
 2. strengthened FP component of PMTCT, and
 3. addressing the FP needs of HIV positive clients (including those on ART).
2. Monitors and evaluates the integrated points of service in GHAIN-supported facilities for quality, integrated FP and HIV prevention, care, and treatment.
3. Institutes sustainable quality improvement activities.

Achievements

From 2007 onwards, GHAIN has introduced and institutionalized RH/HIV integration

in 131 of its supported HIV/AIDS services facilities; this may continue after the GHAIN project ends.

Documented referrals from HCT, PMTCT and ART to FP and conversely documented referral of FP clients to HCT [with a small number of sites offering HCT in the FP clinic] resulting in improved RH service provision and better meeting of HIV/AIDS service users' FP needs

Tools were developed and utilized for documenting and reporting RH/HIV integration FP clinic utilization is said to have increased in centers where RH/HIV integration is instituted, both in terms of attendance and number of new users.

Major stakeholders - facility managers, program managers, service providers, government officials, GHAIN staff, and community providers - are generally aware of, understand the issues, and appreciate the benefits of RH/HIV integration.

Challenges

1. Catholic facilities only provide information on natural FP, if they provide FP counseling at all (one such facility is a GHAIN-supported site working on RH/HIV, out of the total of 131). Some providers in Catholic facilities (for example at St Charles Borromeo Hospital) say that “when a client has the need for FP, we tell them they can go to the [government] hospital”. Although this *might* happen as staff in Catholic facilities are not themselves all Catholic, staff in Catholic facilities have not received GHAIN RH/HIV integration training and it seems that staff members, not the client, make the decision as to whether a client needs FP.

Gaps

An important gap is in the SOPs and guidelines for HCT and PMTCT, where FP counseling and referral is only mentioned in relation to positive clients. Most HCT and PMTCT clients are HIV negative and it is a missed opportunity not to provide these persons with FP counseling and referral if needed. For optimum care, best practice dictates that all HCT clients should receive FP counseling and referral if needed. It was noted that some HCT staff say that they do provide FP counseling for all clients irrespective of HIV status — some of the HCT providers are FP nurses.

There is huge disparity in the number of clients documented as having been referred from HCT to FP clinics with the number of clients who actually received FP services. There might also be issues regarding data quality at some of the integration centers. Few PMTCT services counsel and refer clients (positive or negative) for FP and many do not provide guidance on safer sex.

HIV service providers seem to view FP as a way to reduce pregnancy in positive clients rather than a way to achieve optimum reproductive health for all clients seen in HCT or ANC clinics.

Lessons learned

1. It is essential that RH/FP integration becomes institutionalized at all relevant service delivery points.
2. HCT is frequently the entry point for FP service delivery; there is need for considerable strengthening of capacity and quality of service.
3. Both positive and negative clients require effective FP services.

4.6 CROSSCUTTING INTERVENTIONS

Strategic information/monitoring and evaluation

Introduction and background

GHAIN has reported against PEPFAR 1 quantitative indicators for the majority of its project implementation. Since October 2009 it has been using the Next Generation Indicators and reported against these for the first time for the Semi-annual Progress Report (SAPR) in May 2010. SAPR covered the 6-month period of October 1, 2009 to March 30, 2010. GHAIN continues to measure performance towards the PEPFAR and USAID/Nigeria HIV/TB unit indicators as contained in its *Performance Monitoring Plan*, which is the foundation of GHAIN's Monitoring and Evaluation (M&E) system.

GHAIN also contributes data to measurement of work towards achievement of USAID SO14 and *Intermediate Results* 14.1, 14.2 and 14.3.

As already discussed elsewhere in this report, GHAIN has introduced or significantly expanded a number of new project components in the past two years (since the 2008 evaluation), most notably health system strengthening and virtually all of its HAST activities. These are not measured against PEPFAR indicators.

Also as previously discussed in this report, the change to Next Generation Indicators, with their more qualitative and disaggregated approach to what remain quantitative indicators, has necessitated considerable alteration in approach and activity focus at implementing partner level. One such example is the shift in prevention from achievement of large numbers reached to intensive focus on small cohorts. Such factors need to be considered when GHAIN strategic information systems are addressed in this section: all systems ultimately depend on the capacity of the people collecting data, the quality of those data and the iterative processes. Thus, while systems may be exemplary in their design, the degree and type of their application downstream is of critical importance.

GHAIN continues to have pivotal involvement in national strategic information interventions, building on its earlier and notable support (see USAID 2008 – the 2008 evaluation report). One such input has been to the 2009 *Integrated Behavioral and Biological Sentinel Survey* (IBBSS). The 2009 IBBSS is being used to inform programming for MARP, especially MSM and IDU. A further and important element of support is that during the life of the project GHAIN in partnership with the FMOH has developed standard operating procedures on a range of HIV clinical treatment areas, on HCT, on PMTCT and on monitoring and evaluation. GHAIN has facilitated the adoption of the District Health Information System (DHIS), which is stated by the project to 'have become the backbone of the Nigeria national HMIS', with the FMOH applying it as a national system. GHAIN continues to build the capacity of public sector partners to apply DHIS; these include NACA, NASCP and the National Malaria Control Programme. The DHIS is used at certain health facilities and in HAST LGAs. GHAIN has developed a Logistics Management Information System, to support GON logistics management.

GHAIN has developed the *Lafiya Management Information System* (LAMIS) as from early 2008 as an electronic medical record system for PLHIV accessing care and treatment. The *Quality Assurance/Quality Improvement* system (QA/QI) has been developed by FHI as GHAIN prime as a project system to manage focus on quality. QA has been established to identify 'issues of deviation' from standards previously established by GHAIN and other partners, while QI focuses on addressing quality and performance

issues through systems changes. Both include a measurement component. QA informs QI: monitoring of performance and standards informs systems review and eventual changes. QI is used at GHAIN health facility implementing partners through the introduction of the LAMIS electronic database, to support longitudinal patient monitoring and management. This is sited at the HIV PMM Unit, i.e. not in the hospital General Medical Records Unit, and sometimes also at the HIV Lab. A *Quality Improvement Project* team is established, as is MLEG: the *LAMIS Multi-Center Evaluation Group*. At the core of the QI process is the improvement of “quality of clinical outcomes and public health interventions using evidence-based practices” (GHAIN 2010g).

USAID conducts regular data quality assessments (DQA) of all its partners, including GHAIN. Findings and recommendations from these DQA are used to improve monitoring processes and the accuracy of data reported. The GON has begun implementing joint DQAs of HIV sites, including GHAIN-supported sites, in collaboration with USG PEPFAR.

Achievements

- GHAIN has been an invaluable partner to the GON in development of management information systems and support to surveys
- FHI as prime on GHAIN has invested considerable human resources over the life of the project to achieve the high quality of its data
- Development and management of GHAIN project activities is supported by an impressive internal strategic information/M&E system. Collection, analysis and dissemination of strategic information is a central plank of GHAIN institutional capacity, with the M&E departments at country and zonal office levels maintaining a closely managed and effective system of data collection and analysis; GHAIN zonal office collate data and these are mainly analyzed at country level
- GHAIN worked with the Federal Ministry of Women’s Affairs in 2009-2010 to develop *KidMAP*, which is an electronic database to capture data for orphans and other vulnerable children
- GHAIN continues to participate in harmonizing national indicators, developing national tools and participating in DQA exercises at state level
- GHAIN supports state-level monthly M&E meetings; in some states the funding for such meetings has been taken over by state government

Challenges

1. Staff attrition at government facilities affects strategic information (SI): trained staff members are all too often redeployed and an untrained replacement sent. This compromises regularity of data collection and management, institutional memory and sustainability.
2. Despite all the many laudable GHAIN inputs to development of systems, the DHIS is not universally implemented at health facilities, in part due to weak state systems and inadequate resources; in these instances M&E/MIS systems remain paper-based.

Gaps

The evaluation team found there has been development of parallel SI/M&E systems at health facilities that are supported by GHAIN: the HIV PMM unit is frequently not integrated with hospital general medical records. This separation is exacerbated by the fact that PMM unit data entry clerks have their salaries paid by GHAIN (out of the monthly allocation to the facility) and answer to the project, i.e. not to the hospital management.

At sites visited during the end of project evaluation, it was found that the Head of Medical Records is not usually invited to participate in the facility-based monthly M&E meeting. This adds to the silo effect and also raises questions about the post-GHAIN sustainability of the PMM unit and the system of strategic information management introduced by GHAIN.

The end of project evaluation team found that data entry clerks in particular do not always sufficiently observe privacy and confidentiality; there are on occasion significant lapses and also inadequate understanding of the reasons why these are unacceptable. This lack of confidentiality was additionally observed at a HAST LGA umbrella CBO that was using *KidMAP*: these practices should not be permitted to set root. Their existence suggests a weakness in capacity and in supervision.

In most visited sites where LAMIS is available (relatively few as yet), it is either not functional or non-GHAIN staff members have not been trained in its use. *KidMAP* has similarly limited distribution and qualified application.

Discussion during the end of project evaluation with a wide range of respondents indicates that GHAIN has not yet developed a fully iterative M&E system. This has resulted in what is perceived to be inadequate feedback and proper debate, where those providing raw data from health facilities, from other implementing agencies, from HAST umbrella and partner CBOs and from support group members and volunteers do not engage closely in analysis-level debate. In many cases they have no opportunity to participate and do not receive feedback. This is despite the undoubted innovation of the monthly M&E meetings (with a limited membership, in large part for practical reasons, but without an effective system of further downstream iteration).

Information received during the evaluation is that SOPs have been developed by GHAIN without the participation of those who deliver the services; they are not owned by counselors, ART clinicians, etc. This has resulted in SOPs often either used in a mechanistic fashion, or barely used at all, rather than being applied and adapted to suit individual circumstances.

Lessons learned

1. GHAIN indicates the importance of developing an SI/M&E system that works both upstream and as far downstream as it is required to go. The project has developed and internally institutionalized a SI system that is robust and of high quality. While the system entirely supports GHAIN reporting requirements, there are issues to address in terms of enabling public sector and civil society partners to have increased ownership and stewardship of strategic information. (See 4.1 and 4.6. Health systems strengthening for consideration of zonal offices preparing charts to which facility and CBO representatives were unable to speak.) The challenge otherwise is that once GHAIN closes, its complex and demanding SI/M&E systems will not be adequately maintained, with resulting weaknesses in capacity to apply evidence-based planning. While questions of sustained budget allocations at state and LGA levels are not within GHAIN's remit, transfer of systems is now under PEPFAR 2.
2. It is essential that all partners (in the current context GHAIN implementing agencies) are properly involved in analysis and iteration. Otherwise there is increased likelihood of lack of use of analyzed data for evidence-based planning at state and LGA levels, where data on location-specific trends in health-seeking behavior, uptake of services, etc, can be effectively used. Given the socio-cultural and epidemiological variables seen in HIV in Nigeria, such partnership on strategic information management is important.

3. There are inadequate iteration/feedback processes to state, facility & LGA levels – this may well result in limited opportunities to use data for decision-making and evidence-based planning.

4. While it is acknowledged that GHAIN has to report to PEPFAR indicators and USAID reporting requirements, future projects' strategic information systems should ideally include focus on qualitative data, on social and gender analysis and the use of such data in evidence-based planning. Currently (and understandably to a considerable extent, given the project history) there is overwhelming focus on supply-side data generation; opportunities for inclusion of demand-side perspectives need to be systematically developed and applied. Just one example of the demand-side gap is the lack of follow-up on the 'pre-ART' loss of enrolled clients.

Health systems strengthening

This part of the report should be read in concert with 5.1 (GHAIN End of Project Evaluation SoW Objectives), specifically objective 2, as that also addresses health systems strengthening issues. See additionally Appendix H, which in part considers community systems strengthening, which is increasingly recognized as an essential and demand-side component of service delivery, and thus closely linked to health systems strengthening with its supply-side focus.

Introduction and background

Health systems strengthening (HSS) has become increasingly central to issues of program and project management, partnerships and sustainability. This paradigm shift has occurred largely in the past three years, and has been led by GFATM and WHO, in partnership with multi- and bilateral donors such as USAID.

There are six core 'HSS constraints' as identified by the WHO framework, applied by GFATM and now increasingly addressed by GHAIN. These constraints are:

1. Limited availability of competent and effective health workers;
2. Poor health information systems;
3. Weak procurement and supply chain management systems for drugs and health products;
4. Ineffective health financing systems;
5. Limited planning, policy-making, management and governance capacity;
6. Inadequate service delivery capacity.

The WHO framework is a useful tool for describing country and lower-level/ decentralized HSS support needs. It forms the basis of the GFATM Round 10 Proposal Form.

“One of the primary bottlenecks to achieving the health Millennium Development Goal (MDG) targets [is] weak and fragmented health systems, which are unable to deliver the volume and quality of needed services. Strong and effective health systems are increasingly considered a prerequisite to effective implementation of disease control interventions.” (GFATM 2010d; p1. See also Atun *et al* 2009, Atun, Lazarus *et al* 2010).

Through the Global Health Initiative the US government is pursuing a comprehensive whole-of-government approach to global health. The Initiative promotes a new business model to deliver its dual objectives of achieving significant health improvements and creating an effective, efficient and country-led platform for the sustainable delivery of essential health care and public health programs. HSS is the fifth of the seven GHI core principles.

“PEPFAR has had a positive impact on the capacity of country health systems to address the WHO’s six building blocks of health systems functions. However, the program to date has not placed a deliberate focus on the strategic strengthening of health systems. In its next phase, PEPFAR is working to enhance the ability of governments to manage their epidemics, respond to broader health needs impacting affected communities, and address new and emerging health concerns. PEPFAR now emphasizes the incorporation of health systems strengthening goals into its prevention, care and treatment portfolios.” (PEPFAR 2009b; p8).

Nigerian HIV instruments also pay increasing attention to HSS aspects of programming. Thus the goal of the NSF II component on *Institutional Architecture and Resourcing* is: “...to strengthen structures and systems for the coordination of a sustainable and gender-sensitive multi-sectoral HIV/AIDS response in Nigeria.” (NACA 2009; p29).

GHAIN action on HSS

It is only in the past two years that the GHAIN program has had explicit focus on HSS as part of its activity portfolio. GHAIN’s performance cannot be measured against the WHO/GFATM HSS framework (see above), because this focus was not in the original RFA and is not measured against either previous or current PEPFAR indicators. GHAIN receives no funding for HSS, as is shown in Table 1 in section 1.2.

The following information from USAID should also be borne in mind:

“GHAIN was designed under phase one of the Emergency Plan (PEPFAR 1). Thus, the project was designed to immediately address some of Nigeria’s most urgent HIV/AIDS needs. Projects designed under PEPFAR 1 did not aim to address HSS and GHI principles.

Other PEPFAR implementing partners in Nigeria (e.g. Abt Associates and MEASURE Evaluation) have been provided with HSS funding to strengthen specific aspects of the health system. While GHAIN did not receive HSS funding, the project is still attempting to implement activities to *contribute* to HSS. From USAID Nigeria’s perspective, most PEPFAR implementing partners do not have the capacity to address each of the six HSS building blocks. Hence, the reason why USAID uses various implementing partners to do work in various areas.” (Communication from USAID December 2010)

While considering the above, it is nonetheless the case that GHAIN management (i.e. FHI as the prime) describes the project as *de facto* addressing five of the six HSS components throughout the life of the project, with increased, programmed focus since 2007/8 and presented it as such to the end of evaluation team, e.g. during a day-long presentation on 9/24/2010. In 2009 GHAIN created a new country office department, *Health Policy and Systems Strengthening*. GHAIN states that the new HSS component addressed since 2008 is financial management, with support to implementing agencies’ capacities for effective financing, budget planning and costing services.

“FHI [has] begun looking beyond service availability to systems strengthening and sustainability. Using the WHO six building blocks of health systems strengthening, during the past two years, FHI has put more resources into building the capacity of public and private sector organizations so as to engender their technical and institutional abilities to sustainably provide quality services, improve their infrastructure, make health commodities available and support the development and implementation

of enabling policies and standards.” (FHI 2010).

Another activity described during the end of project evaluation as a key HSS initiative is that FHI (NB) has instituted and registered a new organization with the Corporate Affairs Commission in Nigeria. This organization is named *Achieving Health in Nigeria Initiative* (AHNi). “AHNi will be responsible for implementing comprehensive HIV prevention and care and treatment services, including community-based interventions, in the FCT and Lagos. FHI/Nigeria GHAIN will actively support the organizational development of this new entity in a phased approach, allowing a gradual decrease in involvement as AHNi develops internal program and financial management systems and capacity.” (GHAIN 2009b; p27)

The GHAIN strategy on HSS is encapsulated as:

1. Partnership with public and private sector and civil society
2. In-house capacity building and skills transfer to government
3. HSS based on the WHO framework/building blocks
4. HSS initiatives at all levels with especial focus on LGA PHC systems
5. Integration of multiple funding sources; leveraging

Achievements

Because HSS is an over-arching component and one that should be integral to any service delivery program, this section of the report will prioritize key issues; readers are referred to specific sections where individual topics are discussed in depth (1.2, 5.1, 4.6.Strategic information/monitoring and evaluation, 6.2, etc).

National level

FHI/GHAIN (NB: identified as such in GFATM documentation; see e.g. GFATM 2009) is a sub-recipient to NACA in GFATM Round 5, which has been rolled with Round 8 into Round 9. “PR and SRs: NACA is the PR. The SRs are Institute of Human Virology of Nigeria (IHVN), Family Health International/Global HIV/AIDS Initiative Nigeria (FHI/GHAIN), FMOH (HIV/AIDS Division), APIN and HYGEIA.” (*ibid*; p16). GHAIN is unique in that it is the only project or program globally that has a role as a sub-recipient. See also section 5.2 for consideration of the end of project evaluation SoW objective 3, *Collaboration and synergies between GHAIN and GFATM funding*.

GHAIN has provided inputs to the development of the NHSDP and to the NSF II. GHAIN has additionally provided support to the development of the Nigeria National Response Information Management System (NNRIMS) and DHIS strategic information systems. Furthermore, GHAIN has been a key partner to the FMOH in development of standard operating procedures (SOP). GHAIN is a member of a number of technical working groups, such as HIV & AIDS, TB, Malaria, and Procurement and Supply Management (no information was forthcoming on whether there is a national or indeed state-level TWG on HSS).

State and LGA level

GHAIN has supported the introduction of strategic information structures at state level, primarily through the monthly M&E meetings; a number of states have taken on responsibility for funding of the meetings (e.g. Sokoto SACA until its budget restraints precluded further allocations). GHAIN is also active in supporting a number of state-level HIV & AIDS, TB and Orphans’ and Vulnerable Children’s TWGs and task teams. The HAST model represents GHAIN support to HSS at LGA level; as such it is in line with efforts to decentralize health service delivery to PHC level (PHC sites represent more than 70% of all Nigerian public health facilities). Such focus is also coherent with

national policy. See 4.3. Community and PHC-based support interventions (HAST LGAs) for further, close discussion of HAST achievements, challenges and gaps.

GHAIN has provided support on financial management at LGA level, where such capacity is generally weak and where planned decentralization is putting/will put increased demands on LGA Secretariats and departments. GHAIN has provided technical assistance to develop annual LGA work plans and budget line allocations for health inputs.

Secondary health facilities

Training of health workers represents perhaps the most long-term and consistent HSS input by GHAIN at this level. More recently GHAIN has additionally supported infrastructural refurbishment of a large number of implementing agency sites (health facilities); equipment has been provided, e.g. for laboratories. Commodities have been sourced and procured (see 4.4. Procurement, logistics, commodities and laboratory supplies for consideration of achievements, gaps and challenges).

Quality assurance and quality improvement (QA/QI) measures represent a significant area of inputs from GHAIN (but see also 4.6. Strategic information/monitoring and evaluation). GHAIN's M&E system has an inbuilt service quality assessment (SQA) mechanism that seeks to strengthen QA/QI. The SQA looks at three areas: structure standards (broadly HSS inputs); process standards (broadly supply-side interventions); and outcome standards (broadly service delivery and demand-side achievements). The evaluation team found that quality assurance was especially strong in laboratory services and that medical waste management had been significantly improved since the 2008 project evaluation.

Financial management support has been provided by GHAIN; each secondary health facility has a support staff member paid by GHAIN whose assignment is to manage the budget allocations from GHAIN, to retire funds and to report to GHAIN.

Service delivery

As already discussed above in earlier parts of section 4, GHAIN has indubitably achieved praiseworthy service delivery in the areas of prevention and treatment. This discussion will not repeat arguments regarding numbers reached vis-à-vis quality of intervention. A couple of statistics can serve just to reiterate the breadth of GHAIN achievements (cumulative statistics, from September 2004 to June 2010):

- Number of individuals [aggregate, including MARP] reached with HIV prevention messages: 3,877,115
- Number of laboratory tests performed: 3,516,177

GHAIN has also been instrumental in initiating and supporting integration of RH/FP services, to begin with through a pilot in 2007 and currently in 131 sites. See 4.4 for detailed discussion.

Many GHAIN-supported secondary health facilities now offer integrated HCT at a number of service delivery points, e.g. PMTCT and TB DOTS. Client-centered intra- and inter-facility referral systems have been developed and instituted successfully at the great majority of GHAIN-supported secondary health facilities (and tertiary). A new post of referral coordinator has been created to manage such systems; the evaluation team found considerable and consistent support for this post at health facilities, with recognition of improved service delivery seen as its primary added value.

An ART client-tracking system has been introduced at all GHAIN-supported secondary and tertiary health facilities, with attention to lost to follow up (LTFU). Support group members and referral coordinators play pivotal roles in maintenance of this system, which commonly involves considerable physical effort through visits to lost/defaulting clients as well as communication by telephone.

Training

As of June 2010, GHAIN had trained more than 41,000 health workers in a wide range of technical areas. GHAIN has developed a curriculum for integrated training of PHC workers (including community health extension workers: CHEWs) on HIV and AIDS, TB, SRH, malaria and apparently also integrated management of maternal and childhood illnesses. The National Primary Health Care Development Agency (NPHCDA) is adapting the curriculum for wider use. Counseling and testing training has been developed by GHAIN and adopted for use in four nursing schools.

Infrastructure and equipment

During the life of the project GHAIN has supported the refurbishment of more than 400 health facilities, through provision of power and water supplies, structural repair and development, computers, furniture and laboratory equipment. GHAIN has also supported the implementation of the *Planned Preventive Maintenance* system, leveraging on the now closed DFID-funded PATHS 1 experiences in Enugu state.

Procurement

GHAIN now subscribes to pooled procurement of ART and other HIV service commodities coordinated by USG/PEPFAR and actively supports the FMOH in developing strategies and efficient operations of a Nigerian supply chain management system for health commodities.

Challenges

A virtual absence in the public sector of proper management systems for human resources for health (HRH). Such a system would develop robust and accountable systems for training, retention, deployment, remuneration, etc, where e.g. health workers trained by GHAIN to provide services designated by the GON as critical to health service provision are guaranteed retention at a health facility for a previously agreed length of time. Development and sustaining of such HRH systems are outwith the remit of GHAIN.

At many GHAIN-supported primary and secondary health facilities, health workers continue to deliver their primary assignments; i.e. GHAIN activities frequently represent additional tasks.

Reference was made at a number of facilities to health workers seeking not to take up positions at 'GHAIN hospitals' (described as such by interviewees), due to a perception that staff members work much harder for no extra remuneration.

State-level development and sustaining of infrastructural and equipment maintenance systems remains limited, as do budget allocations and disbursements.

Gaps

Insufficient GHAIN capacity and planning

Please note the discussion in the *Introduction and background*.

GHAIN has indisputably been instrumental and indispensable in the Nigerian context

in terms of service delivery, provision of training, of support to knowledge management, etc and all such services must be acknowledged and credited. However, the situation is that any future program must have dedicated HSS expertise (demand as well as supply-side, and with community system strengthening capacity too). Any such expertise must integrate HSS as an over-arching and crosscutting component within project management. GHAIN does not have genuinely adequate technical expertise to plan, implement and manage a full and coherent HSS program. There has been considerable retrofitting by GHAIN management to present its current HSS inputs as always having been integral to the project. GHAIN appears not to have been sufficiently guided by either internal HSS/CSS expertise (e.g. FHI experiences derived from the SNR program) or national and international best practice.

Insufficient advocacy focus

This falls under the broad rubric of governance and accountability; these represent core planning and management aspects of HSS. GHAIN does not appear to have undertaken any strategic situation analysis of key public sector actors/gatekeepers prior to beginning its engagement at national, state and LGA levels. Perhaps as a result, insufficient attention has been paid to the HSS influences and powers vested in e.g. the Ministry of Local Government (which manages HRH) and State Hospital Management Boards. Policy makers such as members of State House of Assembly Health Committees (which decide on health budgets and which can, therefore, ring fence HIV budget lines, albeit without guaranteed disbursements) do not appear to have received any advocacy from GHAIN. The NPHCDA relationship with GHAIN was stated by several interviewees to be limited, yet it too is an important national and state actor.

Supply-side focus

GHAIN has focused overwhelmingly on supply-side HSS. While the majority of its inputs have been entirely necessary, the absence of a coherent strategy to engage with and systematize demand-side perspectives raises questions of sustainability as well as of stewardship and partnership: who are to be the ultimate beneficiaries of all the GHAIN HSS inputs and which measures are in place to ensure demand-side voice is heard and health workers and other supply-side actors are held to account? One such gap is the virtual absence of any demand-side inputs into assessment of quality of care: it is inadequate and inappropriate to leave such assessments to health workers, to the supply-side. As previously mentioned, please refer to Appendix H.

State level

SASCPs (and indeed NASCP) appear to have been virtually sidelined relative to SACA, in terms of participation in GHAIN technical training and mentoring of health workers (minimal mention was made during field visits of any SASCP involvement in e.g. DQA and integrated supportive supervision (ISS) activities). While SACAs have received training and other support from GHAIN, most visited during the evaluation have not been empowered to lead on state-level ISS, mentoring and SI/M&E management. SASCPs have been bypassed in terms of participation in technical training and mentoring of facility staff members (except in both contexts for M&E).²⁵

LGA level

As already described in section 4.3. Community and PHC-based support interventions (HAST LGAs) (and see also 6.2): the HAST model as currently implemented is challenging. Its implementation to date has not adequately strengthened overall health systems at LGA level and may in fact have contributed to ultimately unsustainable and

²⁵ Lessons could perhaps be learned from the two DFID Nigeria programs SAVI (State Accountability and Voice Initiative) and SPARC (State Partnership for Accountability, Responsiveness and Capability), both of which have provided support to state HSS advocacy.

vertical/silo HIV, STI and TB service delivery elements. HAST in its current form prejudices delivery of safe motherhood and IMCI services. HAST is not (yet) an *integrated LGA services' model*. There are also ethical issues to be addressed, e.g. support to OVC; its OVC services are inadequate (see also section 4.3. Orphans and other vulnerable children). Neither umbrella nor any implementing CBO has received appropriate and tailored HSS/CSS training in order to support effective delivery of HAST services.

The current situation is that many PHC facilities are so under-staffed that HSS as currently applied by GHAIN becomes well-nigh superfluous. In addition, PHC health workers have inadequate job aids, no SOPs and minimal IEC materials to support them in service delivery.

LGA Social Welfare Departments and LACAs have not benefitted in terms of HSS provision, such as training. While elements such as peer educator training and HMIS rollout to LGAs have been introduced, GHAIN has at times provided insufficient support and ineffective supervision (there is on occasion a feeling of list ticking). Thus community volunteers cannot describe HAST approaches and activities; MIS software is installed on computers that are non-functioning; etc.

One quite frequent finding from the field was that M&E officers at LGA (and indeed at many secondary health facilities) were unable to disaggregate and analyze service delivery charts (e.g. on ART uptake, or LTFU) that were displayed in LGA offices and PMM units and claimed as in-house data generation. The conclusion reached by the evaluation team is that these charts were in fact generated at GHAIN zonal office level. This leads to a number of points, including a perception that M&E officers have in fact been inadequately trained, both in data collection and analysis; such gaps in training are likely to result in an absence of use of data for evidence-based planning. In addition, such practice suggests top-down management by GHAIN, as well as potentially insufficient probity in knowledge management and indeed overall management.

Secondary health facilities

The main gap is that little evidence was gleaned during the evaluation of a systematic HSS intervention approach being applied by GHAIN.

There is minimal facility ownership of M&E data; the HIV PMM unit remains largely separate from general medical records in many facilities. Parallel and unsustainable data management systems have been introduced, e.g. TB/HIV (note here the relevance of the PEPFAR legacy). No evidence was found of financial management training and there has been no transfer of ownership from GHAIN to facilities on financial management, due in large part to the presence of the GHAIN support staff members tasked with such oversight. Laboratories are not doing their own forecasting and requisitioning.

Health workers at GHAIN-supported secondary health facilities have seldom had any input into development or adaptation of SOPs; the evaluation team found that this has frequently resulted in a visible lack of ownership or engagement, of concern because SOPs represent key service delivery and quality assurance documents.

Opportunities for linking health and community systems strengthening, e.g. to address the significant service delivery gap on lack of attention to retention of enrolled pre-ART clients, have not yet been optimally considered by GHAIN. Linked to this issue is the concern that the creation of facility-based support groups is neither sustainable nor

inherently challenging of stigma and discrimination and adverse societal normative behavior. This approach appears to place often very considerable demands on vulnerable people (e.g. tracking LTFU), without adequate returns from GHAIN and its facility and CBO implementing agencies. International best practice now requires genuine balancing within M/GIPA engagement, where people living positively become partners.

Lessons learned

1. Any service delivery project that includes HSS components requires dedicated, specific and integrated expertise, on both supply and demand-side aspects of HSS.
2. Inclusion of HSS should be from the inception of a project, focus on an incremental, longitudinal approach that cumulatively builds an integrated health system strengthening platform and crucially plan from the outset on exit, i.e. on tangible HSS legacy.
3. While the GHAIN exit strategy (GHAIN n/d) sets out ambitious criteria and targets, its objectives appear largely to be unattainable due to a number of factors. Among these are the parallel systems present in GHAIN-supported facilities, the lack of a longitudinal plan to ensure legacy, e.g. where training is institutionalized, rather than remains dependent on the retention of those individuals trained, and the lack of genuine transfer of ownership and stewardship, e.g. as demonstrated by GHAIN control of financial management.
4. GHAIN has not introduced effective performance-related management, which ideally goes hand in hand with HSS. Such performance-related management should integrate elements of supply and demand-side quality assurance; (Note: Part of this sub-section was deleted due to the procurement sensitive nature of its content.).

5. DISCUSSION OF SoW OBJECTIVES AND QUESTIONS

5.1 THE GHAIN END OF PROJECT EVALUATION OBJECTIVES AND QUESTIONS

The Scope of Work sets out four objectives and a number of detailed questions (please see Appendix 1 for the full text of the SoW).

There is detailed discussion in sections 1.2, 4 and here of the many ways in which GHAIN has over the past two and a half years (since the 2008 evaluation) sought to varying degrees and with varying success to be responsive to the changes in perspectives, priorities and *modi operandi* of the new GON and USG HIV instruments as well as to new focus on issues such as health system strengthening.

The end of project evaluation has found that while the project has invested considerable effort in seeking to respond to the greater focus on prevention, health systems strengthening, gender and other new priorities, efficacy of processes and strength of outcomes and impacts have varied.

Objective 1: Achievement of the GHAIN goal and strategic objectives

Please also see section 1.2.

The evaluation is to “determine whether the GHAIN project continued to achieve its goal and strategic objectives (intermediate results) following the May 2008 evaluation”. The GHAIN Goal is: *reduced impact of HIV/AIDS and TB in selected areas.*

- IR1 is: increased use of quality HIV/AIDS and TB prevention services and interventions.
- IR2 is: increased use of quality HIV/AIDS and TB care and support services and interventions.
- IR3 is: increased use of quality HIV/AIDS and TB treatment services and interventions.

Question 1a

In assessing the extent to which these IRs have been achieved, the evaluation team will analyze the extent to which GHAIN has met its PEPFAR targets that are set each year during the COP planning process and reported to OGAC on a semi-annual basis.

Table 7 below summarizes GHAIN’s cumulative targets and cumulative achievements for key indicators for the first 6 years (September 04 to June 10). The table demonstrates **GHAIN more than exceeded its targets for its first 6 years**. Also, in Year 6, GHAIN exceeded its targets for all the indicators in Table 7.

Table 7: Summary of GHAIN Achievements Sept 2004 – June 2010 against key PEPFAR indicators

Service Area	Cumulative Targets	Cumulative Achievements
No. of individuals reached with community outreach HIV/AIDS prevention promoting A/B	947,894	2,920,277 M=1,819,529; F=1,100,748
No. of pregnant women who received HIV counseling and testing and their test result	347,000	739, 291
No. of pregnant women receiving ARV prophylaxis	15,100	31,563
No. of individuals, excluding pregnant women, who have received and their test results	1,218,538	2,085,104 M=995,101; F=1,090,003
No. of individuals who have ever received ART	81,000	137,666
No. of individuals receiving ART at the end of reporting period	69,635	107,854 M=37,706; F=70,148; Children<15 6,526
No. of OVC served	41,772	63,307 (M=32,107; F=31,200)
No. of PLHIV screened for TB among HCT clients	107,939	285,662
No. of HIV-infected clients attending HIV Care & Treatment services that are receiving treatment for TB disease	23,709	25,564 M=11,951; F=13,613
No. of clients (HCT, PMTCT & ART) accessing FP/RH counseling or services at FP clinics	12,375	48,312 M=6,655; F=41,657
No. of laboratory tests performed	2,000,520	3,516,177 including 1,663,909 HIV tests and 1,842,818 CD4 counts

Question 1b

In assessing the extent to which the GHAIN project contributed towards furthering the goal of USAID Nigeria SO14 through a review and analysis of the available data pertaining to the relevant program areas.

The GHAIN project has probably contributed greatly to USAID/Nigeria's SO14 - *Reduced impact of HIV/AIDS and TB in selected areas* - by reducing the disease burden of both HIV and TB through its prevention and treatment programming. The scale of the GHAIN activity means that it is probably the largest contributor to USAID/Nigeria's SO14.

Reduction of the disease burden is important for reducing new TB and HIV infections; it is also important for getting infected persons back to good health and productive life. The evaluation team met scores of PLHIV at GHAIN-supported treatment sites who eagerly give testimony to the wonderful impact of ART, and some to the impact of PMTCT, on their lives. Thus GHAIN's programming is likely to have had significant impact on HIV/AIDS and TB at population level, and also at household and individual level.

Important interventions are

- Prevention with MARP – GHAIN reached 625,942 (M=368,435; F=257,507) with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards in Year 6
- Blood and injection safety:
 - 35,190 blood units screened for 4TTIs (HBV, HIV, HCV, Syphilis) cumulatively from program initiation to end August 2010; 31,668 were emergency on site collections, and 3,522 collected from the National Blood Transfusion Service
 - 16,586 blood units screened for 4TTIs (HBV, HIV, HCV, Syphilis) to end August 2010 against the Year 7 target of the 12,480; 14,766 were emergency on site collections, and 1,820 collected from the National Blood Transfusion Service
- Getting PLHIV onto treatment:
 - from COP05, new ART clients have risen sharply each subsequent year, and GHAIN has exceeded targets. By the end of COP10, 147,805 (m=53,029; f=93,776) individuals had been newly initiated on ART
- Screening PLHIV for TB and TB patients for HIV, and use of TB prophylactic treatment:
 - 285,662 PLHIV screened for TB from inception cumulatively to end Year 6
 - 57,455 individuals receiving HCT and receiving their results in TB settings cumulatively from inception to end Year 6
 - 25,564 (m=11,951; f=13,613) individuals provided with TB prophylaxis and or treatment from inception cumulatively to end Year 6

During Year 6 (July 09 – June 10), GHAIN-supported sites averaged a 92% rate for TB clients receiving HCT; most of the sites visited in the EOP evaluation had achieved virtually 100% rate for TB clients receiving HCT. Overall December 2009 to October 2010, nearly 11% of PLHIV at GHAIN-supported sites were co-infected with TB.

Question 1c

In assessing the extent to which the GHAIN project contributed towards the six principles of the Global Health Initiative's approach²⁶

The seven principles underpinning the Global Health Initiative were first promulgated in mid 2009, late in the life of GHAIN. As a result, explicit focus on the principles, all of which are crosscutting, is lacking in terms of specific programmatic planning and implementation. Nonetheless, there is ample evidence to show that GHAIN has achieved considerable progress in a number of the seven principles.

The seven Global Health Initiative principles are to:

1. Implement a woman and girl-centered approach
2. Increase impact through strategic coordination and integration
3. Strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement
4. Encourage country ownership and invest in country-led plans
5. Build sustainability through health systems strengthening
6. Improve metrics, monitoring and evaluation
7. Promote research and innovation

Principle 1: Implement a woman and girl-centered approach

This is perhaps the principle where GHAIN has achieved least. One major factor is that inadequate technical expertise exists within GHAIN on gender, either at country or zonal level, to have addressed this principle effectively. Where such expertise does exist, e.g. in the North East zone, there is inadequate programmatic scope for the use of such skills. Therefore, although the Year 6 gender overview document (GHAIN 2009e) goes into considerable detail as to a comprehensive, mainstreamed, coherent, consistent and crosscutting approach to gender, actual evidence of such focus was thin on the ground during the end of project evaluation. This is equally true of demand and supply-side activities, e.g. in HAST LGAs and in secondary health facilities.

An absence of gender mainstreaming within GHAIN appears to have resulted to an extent in somewhat mechanistic and superficial interpretations, which may have had repercussions in terms of quality of interventions. There is incomplete disaggregation of many data sets, beyond sex, while further analysis may have revealed information on e.g. opportunity costs, gender-based barriers to health-seeking behaviors, etc. This incomplete focus is evidenced in e.g. FHI 2009 (the Application for Project Extension) and in Year 7 GHAIN documentation.²⁷ There is also a virtual absence of attention to gender in the *GHAIN Year 7 Performance Monitoring Plan* (GHAIN 2010b), beyond one reference to 'gender equality'.

Despite the GHI focus on a woman and girl-centered approach, an effective, engendered response to HIV requires inclusion of male perspectives, while acknowledging the "pressing need to address the persistent gender inequalities and human rights violations that put women and girls at a greater risk of, and more vulnerable to, HIV and that threaten the gains that have been made in preventing HIV transmission and in increasing access to antiretroviral therapy." (UNAIDS 2010). This has been lacking within GHAIN.

²⁶ Please note that the 2009 documents *Implementation of the GHI: consultation document* and *Fact Sheet: The U.S.G. Global Health Initiative* both list seven principles. This report addresses those seven; this was agreed with USAID Nigeria

²⁷ It should be noted that such lack of attention is not limited to GHAIN activities and documentation; see e.g. NACA 2009b (the DQA report).

Principle 2: Increase impact through strategic coordination and integration

The GHI states with regard to its second principle: “Coordinating and integrating the delivery of health interventions is essential for improving health outcomes. Under the GHI “integration” has both downstream benefits at the point of contact as well as upstream benefits in the structure of U.S. government assistance.” (USG 2009a; p6).

GHAIN pioneered provision of comprehensive AIDS treatment services at secondary level in Nigeria. GHAIN established the practicality of delivering comprehensive services in secondary hospitals and then scaled up quite remarkably. In 2010 GHAIN is supporting the delivery of services in 170 secondary hospitals, of which 124 provide ART services. The great majority of the secondary facilities are government hospitals, while a small number are faith-based hospitals. GHAIN also supports eight tertiary hospitals (Federal Medical Centers and teaching hospitals. GHAIN is supporting service delivery in all 36 states and the Federal Capital Territory.

GHAIN has sought over its more than six years of operation to implement coherent and coordinated supply-side service delivery, most notably through development of services available at comprehensive sites and the inclusion of the RH/FP integration project, TB/HIV integration and malaria in pregnancy. The intention is to provide a ‘downstream’ package of entry points to service delivery, e.g. through HCT, PMTCT, ANC, etc. and to enable clients to have straightforward access to whichever services required.

All such laudable activity has had influence on upstream planning and on the shape of USAID/Nigeria development assistance.

Principle 3: Strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement

The most notable example of GHAIN inputs to strengthening and leveraging multilateral organizations is the close relationship with the Global Fund. Nigeria was awarded a Global Fund Round 5 HIV/AIDS grant with NACA as principal recipient and FHI/GHAIN as one of the sub-recipients. GHAIN represents the only project worldwide to have attained such a role on a GFATM grant. FHI/GHAIN is also a sub-recipient to the Society for Family Health (SFH), another Round 5 HIV/AIDS grant primary recipient. FHI/GHAIN is currently a sub-recipient in the consolidated Round 9 HIV/AIDS grant (as yet unsigned), which includes and rolls up the Round 5 and Round 8 (Health Systems strengthening component).

GHAIN has supported action towards achievement of Millennium Development Goal 6, specifically its targets 6a (*Have halted by 2015 and begun to reverse the spread of HIV/AIDS*) and 6b (*Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it*).

GHAIN engagement with the private sector is limited; the end of project evaluation did not find evidence of public/private health partnership at programmatic management level. FHI has a contract to manage the Shell Nigeria NiDAR program. Private sector community pharmacists are involved in GHAIN service delivery, both as volunteers at facility pharmacies and through their own businesses.

Principle 4: Encourage country ownership and invest in country-led plans

GHAIN has been a significant actor in terms of encouragement of national ownership. GHAIN senior staff has liaised closely with NACA since project inception in 2004, identifying priority sites for establishing comprehensive services and sharing

information. GHAIN has shared technical information such as site assessments, standard operating procedures and guidelines, and supported the development of national reporting systems. GHAIN has supported the development of the *National Strategic Framework II (2010-2015)*, the NHSDP and other national HIV plans.

Principle 5: Build sustainability through health systems strengthening

Since mid-2008, GHAIN has in effect been retrofitted to address the increased focus on health systems strengthening, prevention and community engagement that has resulted from the introduction of the Global Health Initiative and the PEPFAR Next Generation Indicators. GHAIN receives no funding for health systems strengthening. This end of project evaluation report considers that these components have not been optimally integrated into project management, activities or M&E (see e.g. sections 4.3. Community and PHC-based support interventions (HAST LGAs), 4.6. Health systems strengthening, and Appendix H (community systems strengthening) for further discussion).

Another activity described during the end of project evaluation as a key health systems strengthening initiative is that FHI (NB) has instituted and registered a new organization with the Corporate Affairs Commission in Nigeria. This organization is named *Achieving Health in Nigeria Initiative* (AHNi).

Principle 6: Improve metrics, monitoring and evaluation

During the life of the project GHAIN in partnership with the FMOH has developed standard operating procedures on a range of HIV clinical treatment areas, on HCT, on PMTCT and on monitoring and evaluation. GHAIN has facilitated the adoption of the District Health Information System (DHIS), which is stated by the project to 'have become the backbone of the Nigeria national HMIS', with the FMOH applying it as a national system. GHAIN continues to build the capacity of public sector partners to apply DHIS; these include NACA, NASCP and the National Malaria Control Programme. It has supported many other strategic information activities

However, and despite such investments, GHAIN indicates the importance of developing an SI/M&E system that works both upstream and as far downstream as is required to go. There is no doubt that the project has developed and internally institutionalized a strategic information system that is robust and of high quality, yet while the system entirely answers to GHAIN reporting requirements, there are issues to address in terms of developing iterative processes and enabling public sector and civil society partners to have increased ownership and stewardship of strategic information.

Principle 7: Promote research and innovation

GHAIN (on occasion specifically FHI) has promoted internal and external research and innovation throughout its implementation. For instance, GHAIN has supported the 2007 and 2009 *Integrated Biological and Behavioral Surveillance Studies*, implemented by the FMOH HIV/AIDS Division with FHI technical assistance; similar support was given to the 2007 *National HIV/AIDS and Reproductive Health* (NARHS) study, which has been only recently released.

Internally generated research has also been undertaken and GHAIN staff members have presented papers at national, regional and international conferences. Recent papers published in peer-reviewed journals include one on '*Integrating Reproductive Health and HIV indicators into the Nigerian health system: building an evidence base for action*' and another on '*The use of routine monitoring and evaluation systems to assess a referral model of family planning and HIV service integration in Nigeria*' (Chukwujekwu *et al* 2010 and Nzapfurundi O.

Chabikuli *et al* 2009).

Question 1d

In assessing the extent to which the GHAIN project contributed to the overall PEPFAR Nigeria program.

Analysis of GHAIN's contributions to PEPFAR Nigeria Annual Program Results 09 (APR09) and Semi-Annual Program Results 10 (SAPR10) indicates **GHAIN's contribution is considerable** in many program areas. Table 8 below presents the results for indicators that are common or comparable in APR09 and SAPR10.

GHAIN contributed a third of the PEPFAR APR09 results for (i) HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission; (ii) service outlets providing ART; and (iii) adults and children with advanced HIV infection newly enrolled on ART. **GHAIN contributed slightly more than a third of these PEPFAR results in SAPR10.** GHAIN also contributed nearly 25% of the results in SAPR10 for individuals provided with HIV-related palliative care (including TB/HIV).

PEPFAR Nigeria received \$1,539 million from FY 2004 to FY 2009²⁸, and the FY10 approved funding for PEPFAR Nigeria was \$459m — a total \$1,998m for FY2004 through FY2010. By comparison, GHAIN's funding for its first 6 years was \$346m²⁹, or a little over 17% of the PEPFAR Nigeria budget. Thus GHAIN's delivery of 33% of the PEPFAR treatment and other results is truly remarkable.

²⁸ <http://www.pepfar.gov/countries/nigeria/index.htm>

²⁹ <http://www.pepfar.gov/about/2010/africa/150622.htm>

TABLE 8

GHAIN Contribution to PEPFAR/Nigeria Results for APR09 and SAPR10

Indicator Ref.#	APR09 Table 3.3	Total	GHAIN APR09	GHAIN % of APR09 total	Total SAPR10	GHAIN SAPR10	GHAIN % of SAPR10 total	NGI Indicator Ref#	SAPR 10 Table 3.3
1.1	# service outlets providing the minimum package of PMTCT services according to national and international standards	651	183	28.11	657	185	28.16	NP1.1D	Number of service outlets providing the minimum package of PMTCT services according to national and international standards
1.2	# pregnant women who received HIV counselling and testing for PMTCT and received their test results	747,564	299,280	40.03	328,701	58,142	17.69	NP1.2D	Number of pregnant women who received HIV counselling and testing for PMTCT and received their test results
1.3	# pregnant women provided with antiretroviral prophylaxis in a PMTCT setting	23,351	8,330	35.67					
NI1.3	# pregnant women provided with antiretroviral prophylaxis in a PMTCT setting (incl. those on treatment for their disease)	34,037	11,400	33.49	22,763	7,894	34.55	P1.2D	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission (includes 670 on ARV treatment)
1.4	# health workers trained in the provision of PMTCT services according to national and international standards	3,230	897	27.77	832	27	3.25	NP1.5D	Number of health workers trained in the provision of PMTCT services according to national and international standards
2.2	# Individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful	43,184	220	0.51	377,039	48,074	12.75	PS.2D	Number of individuals reached with individual/small group interventions primarily focused on abstinence and/or being faithful.
5.1	# targeted condom service outlets	1,309	234	17.88	1,080	280	25.93	NPS.5D	Number of targeted condoms service outlets
3.1	# service outlets carrying out blood safety activities	234	30	12.82	185	30	16.22	NPS.7D	Number service outlets carrying out blood safety activities
NI3(a)	# units of blood collected and screened for all the four TTI (HBV, HCV, HIV, Syphilis)	219,375	1,675	0.76	55,968	6,847	12.23	NPS.8D	Number of units of blood collected and screened for all the four TTI (HBV, HCV, HIV, Syphilis)
3.2	# individuals trained in blood safety	1,292	72	5.57	834	25	3.00	NPS.9D	Number of individuals trained in blood safety
NI4(a)	# service outlets provided with training in injection safety	1,294	68	5.26	380	68	17.89	NPS.11	Number of service outlets provided with training in injection safety
4.1	# individuals trained in medical injection safety	13,051	903	6.92	10,706	82	0.77	NPS.11	Number of individuals trained in medical injection safety
6.1	# of service outlets providing HIV-related palliative care (including TB/HIV)	953	243	25.50	641	123	19.19	NC2.6D	Number of service outlets providing HIV-related palliative care (including TB/HIV)
6.2	# of individuals provided with HIV-related palliative care (including TB/HIV)	1,043,134	124,099	11.90	477,178	117,897	24.71		Number of HIV-positive adults and children receiving a minimum of one clinical service
	Male	381,426	42,012	11.01	165,390	40,678	24.60	C2.1 D	males
	Female	661,708	82,087	12.41	204,265	65,301	31.97		females
NI6(a)	# of HIV+ individuals NOT on ART provided with palliative care (including TB/HIV)	162,259	30,412	18.74	162,273	17,308	10.67		Number of HIV-positive adults and children <u>NOT on ART</u> receiving a minimum of one clinical service
	Male	54,257	8,812	16.24	55,085	5,390	9.78	NC2.7D	males
	Female	108,002	21,600	20.00	204,265	65,301	31.97		females
6.3	# of individuals trained to provide HIV palliative care (including TB/HIV)	7,617	1,588	20.85	2,672	1,103	41.28	NC2.9D	Number of individuals trained to provide HIV minimum care services (including TB/HIV)
7.1	# service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting (subset of Ind. 6.1)	657	180	27.40	716	187	26.12	NC2.4D	Number service outlets providing treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting
7.2	# HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (a subset of indicator number 6.2)	33,324	9,851	29.56	12,320	3,580	29.06		TB/HIV: (numerator) Number of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment.
7.3	# individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed) [subset of 6.3]	2,137	693	32.43	893	283	31.69	NC2.7D	Number individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed)
NI7(a)	# individuals who received counseling and testing for HIV and received their test results at a USG supported TB service outlet (including suspects).	223,068	95,610	42.86	73,532	17,608	23.95	NC2.6D	Number of individuals who received counseling and testing for HIV and received their test results at a USG supported TB service outlet (including suspects)

Table 8 continued

9.1	# service outlets providing counseling and testing according to national and international standards	1,137	267	23.48	1,031	148	14.35	NP11.1D	Number of sites providing Testing and Counseling according to national and international standards
9.2	# individuals who received counseling and testing for HIV and received their test results (including TB).	1,548,634	481,823	31.11	987,366	179,755	18.21	P11.1D	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results (including PMTCT, EID, HCT, TB/HIV)
11.1	# service outlets providing ART	354	118	33.33	337	123	36.50	NT.4D	Number of service outlets providing ART
11.2	# individuals NEWLY initiating ART during the reporting period (TOTAL)	121,842	41,305	33.90	59,296	20,819	35.11	T1.1D	Number of adults and children with advanced HIV infection newly enrolled on ART
	Male	42,631	14,722	34.53	20,612	7,326	35.54		Male
	Female	79,211	26,583	33.56	38,684	13,493	34.88		Female
11.2(a)	Children (0-14)	7,215	2,097	29.06	3,487	1,100	31.55		
	Male	3,805	1,136	29.86	1,809	551	30.46		
	Female	3,410	961	28.18	1,678	549	32.72		
11.2(b)	Adults 15+	114,627	39,208	34.20	211,137	69,794	33.06		
	Male	38,826	13,586	34.99	18,803	6,775	36.03		
	Female	75,801	25,622	33.80	192,334	63,019	32.77		
11.2(c)	Pregnant female (all ages- a subset of all females)	5,577	1,502	26.93	2,411	674	27.96		Pregnant women
11.4	# individuals receiving ART at the end of the reporting period (TOTAL)	286,449	85,742	29.93	306,945	101,700	33.13	T1.2D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]
	Male	100,940	30,356	30.07	106,545	35,724	33.53		Male
	Female	185,509	55,386	29.86	200,400	65,976	32.92		Female
11.4(a)	Children (0-14)	16,680	5,122	30.71	16,992	6,170	36.31		Children (<15)
	Male	8,704	2,689	30.89	8,926	3,213	36.00		Male
	Female	7,976	2,433	30.50	8,066	2,957	36.66		Female
11.4(b)	Adults 15+	269,769	80,620	29.88	289,953	95,530	32.95		Adults 15+
	Male	92,236	27,667	30.00	97,619	32,511	33.30		Male
	Female	177,533	52,953	29.83	192,334	63,019	32.77		Female
11.4(c)	Pregnant female (all ages- a subset of all females)	10,686	3,070	28.73	10,932	3,810	34.85	Pregnant women	
11.5	# Health workers trained to deliver ART services, according to national and/or intrnl stds	3,123	510	16.33	2,453	578	23.56	NT1.6D	Number of health workers trained to deliver ART services, according to national and/or intrnl stds
11.6	malnutrition receiving food and nutritional supplementation during the reporting period	4,272	0	0.00					
12.1	# Laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	319	117	36.68	356	117	32.87	H1.1D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests
12.2	# individuals trained in the provision of laboratory-related activities	1,343	310	23.08	1,201	125	10.41	N1.3D	Number of individuals trained in the provision of laboratory-related services

Objective 2: GHAIN capacity building efforts

Determine to what extent the capacity building efforts by the GHAIN project contributed to the implementing agencies' overall performance in and sustainability of the delivery of comprehensive HIV/AIDS prevention, care and treatment [and/or] TB [and/or] malaria in pregnancy [and/or] RH-HIV integration programs.

See also section 4.6. Health systems strengthening.

The World Health Organization (WHO) classifies health systems strengthening into six functions (building blocks) of the wider health system: stewardship and governance, service delivery, demand generation, monitoring and evaluation, planning, and financing. HSS has variously been used to describe the ability of a health system to respond to specific diseases, the ability of health workers to deliver services and improve their perceived role in a community, and the extent to which specific interventions coordinate with existing health system activities. Current PEPFAR HSS discussion chiefly addresses components focusing on improved donor coordination and service delivery.

GHAIN was designed under phase 1 of PEPFAR; therefore, it was not established as an HSS project but rather to address as a matter of urgency Nigerian HIV/AIDS needs. Projects designed under PEPFAR 1 did not aim to address HSS and GHI principles.³⁰ PEPFAR 1 approaches and objectives rather pre-disposed towards development of parallel systems and structures; it is relevant to consider such factors while reading this section.

GHAIN has notably supported the achievement of current level and quality of service delivery at its supported sites. However, and bearing in mind the project history and shifts in focus, GHAIN has contributed relatively little to **post-project sustainability of service delivery** at its sites. The most sustainable aspects are related to training curricula (e.g. for malaria in pregnancy) and influencing the development of GON standard operating procedures that can continue to be used by the GON.

The ideal objective is that GHAIN activities should strengthen the overall health system and should avoid any negative impacts upon its overall functioning. The end of project evaluation visits revealed isolated/stand alone services in some facilities. Some services are co-located with wider hospital services while others are not.

Thus “GHAIN laboratories” are frequently separate from main hospital laboratories. In some instances at the sites visited it is apparent that the “GHAIN laboratory” has an adverse impact on the main hospital services. At Central Hospital Uromi in Edo state, the GHAIN laboratory takes up so much hospital laboratory space that large amounts of SMOH-supplied equipment and analyzers are still unused in their boxes, stored against a wall, because there is no space to deploy additional equipment. In this hospital GHAIN-provided equipment is used only for “GHAIN” ART clients. This has created an imbalance in service delivery and is also a waste of scarce human resources when “GHAIN laboratory” staff do not undertake main laboratory work.

³⁰ However, in the interests of balance it must be noted again that GHAIN was described by several of its country and FCT zonal office senior staff members as now being very much an HSS project and was indeed presented to the end of project evaluation team through the prism of the 6 WHO blocks. This approach was borne in mind by the end of project evaluation team when making its assessments.

An opportunity missed is that GHAIN has supported some facilities' M&E activities without supporting their financial management. Developing the financial management capacity of facilities in line with service delivery points will facilitate allocative efficiency and potentially reduce costs. In most health facilities visited (north and south), a "GHAIN accountant" (paid for by GHAIN) pays volunteers and staff allowances, as well as other budget items such as fuel for generators that GHAIN supports. This person reports back to GHAIN, bypassing the facility main accounts' department and systems. This is likely to result in minimal legacy/sustainability once GHAIN closes. Some health facilities have no logistics management system in place at all. They entirely rely on Axios for forecasting needs and requesting re-supply.

With specific reference to the GHAIN malaria in pregnancy intervention: this was a pilot initiative that lasted one year and was implemented in two states. Total funding was \$200,000, yet the systems strengthening outcomes include the malaria in pregnancy curriculum, representing an influential and lasting return on modest funding and scope.

Question 2a: To what extent have activities been transferred to the government or local partners?

An efficient health system requires having enough health workers, appropriately distributed. Institutional and human capacity development are both key ingredients of health service delivery. Trained local providers most efficiently address new public health challenges. While institutional development takes many years, capacity development and retention of effective leaders and creation of management plans are crucial. Project partners should own their programs and data, and be accountable for their results.

Such approaches were witnessed not across the board in GHAIN-supported sites visited by the end of evaluation team. Frequent mention was made of the "GHAIN lab", "GHAIN clinic", and "GHAIN pharmacy". Although GHAIN has conducted much training for different cadres of healthcare providers at all levels, this has not necessarily translated into skills development and ownership. For instance, pharmacists receive good pharmacy management training. Yet while trained pharmacists maintain excellent ARV stores, they do not extend those good practices to their wider hospital pharmacies. GHAIN trainings are often held centrally in Abuja and appear not to be speaking to the optimal integration of services and local ownership.

Innovations such as the LAMIS electronic clinical medical records systems are not contemporaneously maintained and used by health care workers and pharmacy staff. Instead data are retrospectively entered and updated by GHAIN-hired data entry clerks in the PMM unit. Even the much appreciated implementation of HMIS is highly dependent on persons receiving travel and other allowances from GHAIN—allowances that most SACAs have neither costed nor included in their 2011 budget. It can be argued that many of GHAIN's capacity development activities are not systems strengthening and may not facilitate post-project handover of activities to government and local partners.

Furthermore, GHAIN's current strategy for addressing redeployment/other attrition of GHAIN-trained staff is to encourage step-down training by those facility staff members who have received GHAIN training. GHAIN has not provided training of trainers skills for clinical service staff. Thus GHAIN-trained clinical services staff members have not been capacitated to provide step down training.

There is no GON strategy in place for creating a critical mass or pool of highly trained

trainers of trainers to continue step down training in the future. For an effective HSS approach, the health system should have institutional memory in order to replicate and carry out continuous medical education and or on the job mentoring and coaching of clinical staff, including newly deployed staff. (In mitigation, it should be remembered that the GON human resources in health system are inefficient, bureaucratic and under-resourced and GHAIN's set up under PEPFAR 1 to deliver rapidly increasing numbers of clients on ART was not well-placed to influence the GON human resources system.)

Question 2b: With respect to treatment services, the evaluation team will assess the organizational capacity of selected sites to deliver effective care and to deliver care with less USG support and more GON support. The team will identify elements or areas that need technical assistance as well as areas that can serve as resources for expansion or scale-up in other sites.

GHAIN's structure and processes have largely bypassed (or been bypassed by) GON systems for training, coaching and mentoring staff. Few if any SASCPs have had their capacity built to train, coach and mentor health care workers — most are not involved in GHAIN supportive supervision site visits. Moreover, most SASCPs are under-resourced with inadequate staff and little access to transportation for site visits. MOH staff are not routinely brought in by GHAIN as trainers for local staff in HIV/AIDS treatment related areas; with the exception of M&E training, many have not received training from GHAIN and have not received training of trainers training from GHAIN.

This results in GHAIN training being vested in current staff in a GON system that experiences high attrition and implements a policy of rotating health workers every two years. The impact of GHAIN training inputs over the past seven years has been compromised as trained staff have left the service or been moved to other facilities that do not provide AIDS treatment services. Existing service quality will only be maintained while GHAIN-trained staff members are still providing the services. Although GHAIN has heavily influenced the development of MOH training curricula, standard operating procedures and other job aids, the sustainable benefit of this may well reduce as the numbers of GHAIN-trained staff diminish or are spread thinly across many facilities. Innovations such as LAMIS (which has huge potential benefit for AIDS treatment clients) are not truly functional as they are not maintained and used by the clinical staff whose practice could benefit and whose client care could improve through the use of electronic medical records. There is additionally a possibility that LAMIS will not continue once GHAIN closes.

Overall, it is essential that future USAID AIDS-treatment activities work through and build capacity in government structures if there is to be health systems strengthening and sustainability of activities.

Question 2c: The evaluation team will assess the benefits and program outcomes of the collaborative and multiple-pot funding (PEPFAR, Child Survival and Population Funds) using the GHAIN project as a single mechanism

Overall, the addition of relatively modest multiple-pot funds to the GHAIN grant has been highly effective in leveraging the PEPFAR-funded GHAIN infrastructure to deliver far greater results than the same level of funding could achieve if given to a smaller organization without the extensive infrastructure that GHAIN has built. Some of the benefits may extend beyond the life of the GHAIN project when they have included the development of training curricula and job aids that the GON can continue to use.

Objective 3: Collaboration and synergies between GHAIN and GFATM funding
Determine to what extent the collaboration and synergies between PEPFAR and GFATM funding contributed to the overall program and health system impact.

The Global Fund Round 5 sub grant is only 7% of FHI/GHAIN's budget but it enabled GHAIN to deliver 17% more results than its targets with its USAID/PEPFAR funding alone. The actual results that can be attributed to the Global Fund grant are not clear cut as GHAIN was delivering above its PEPFAR targets before it commenced collaborating on the Global Fund grant. The process for setting GHAIN targets under PEPFAR involved annual negotiations with the Mission based on overall PEPFAR/Nigeria targets, country-level calculations of the cost of delivering the results, and a certain amount of "horse trading" on the targets and the funding GHAIN would receive. That this process was not exact is evident from the repeated exceeding of targets throughout the life of the GHAIN project. However, GHAIN was certainly able to expand to more sites and to deliver ART and other services to more PLHA than were agreed with USAID/Nigeria in the later COP years. Thus the collaboration resulted in more beneficiaries in more states than GHAIN would have reached with only its PEPFAR funding.

GHAIN has also supported the introduction and functioning of the HMIS and reporting to NACA and ultimately the Global Fund, that is required for the Global Fund grant. While the HMIS and reporting is still heavily GHAIN dependent—that is system capacity has not yet been sustainably built—there is potential for sustainability with stronger GON commitment. GHAIN has also contributed its experience in site assessments, standard operating procedure development, curriculum design and training to the Federal Ministry of Health, heavily influencing the development of ministry of health standard operating procedures and training manuals.

Question 3a: What are the challenges and benefits of close collaboration with GFATM, and should this be encouraged among USAID IPs?

FHI/GHAIN's collaboration with NACA as a sub recipient on Nigeria's Round 5 HIV/AIDS grant has brought benefits to the GON and to GHAIN, with the outcome of extending the availability of ART and other HIV/AIDS services to more health facilities, benefiting more PLHIV than NACA could have reached with the FMOH as sole sub-recipient, or GHAIN could have reached with only its PEPFAR funding. Further, FHI/GHAIN's role enabled NACA to turn round from being a Global Fund Round 1 AIDS grant principal recipient that had its grant cancelled for poor performance to being a Round 5 grant principal recipient of a high performing AIDS grant that has moved onto implementation phase 2, and is to be rolled into Nigeria's Round 9 grant.

The challenges of collaborating with NACA on implementation of the Global Fund Round 5 grant have been:

1. The need to make a transition from Axios procurement and supply chain management of ARVs, other drugs, and consumables, to Central Medical Stores procurement and supply chain management in 2008
2. The ongoing need to manage weaknesses in GON procurement and supply chain management through re-distribution from sites with enough to sites about to have stockouts
3. The continuing need to support sites to forecast and quantify their drug requirement

and submit to Central Medical Stores because the system has reverted to being a “push” system—with Central Medical Stores not supporting sites in forecasting and quantification—rather than a “pull” system, and is frequently under- or over-supplying health facility pharmacies.

Additionally, there have been reporting difficulties as sites receive Global Fund grant support [for drugs and test kits] and PEPFAR funding for almost everything else.

Under PEPFAR definition of attribution, all the results from the sites have had some support from PEPFAR and so are attributable to USAID/PEPFAR. However, they are also attributable to the Global Fund grant and are reported to NACA for this. Double counting occurs if PEPFAR attributed results are added to NACA attributed results for inclusion in the “one national reporting system”. This situation is understood and acknowledged by PEPFAR and NACA.

While it is not currently a challenge, there is the potential challenge to the continuation of FHI/GHAIN support to the Global Fund grants after its PEPFAR funding ends.

NACA and the Global Fund grant are not paying FHI/GHAIN overheads for the services it is providing in support of the Global Fund Round 5 grant. The Round 5 grant does not end in June 2011, when GHAIN ends. Thus, unless FHI wins the follow on USAID/PEPFAR activity to GHAIN, it will be unable to continue in its sub-recipient role to the Global Fund Round 9 grant.

FHI/GHAIN collaboration as a sub-recipient³¹ to NACA on implementation of a Global Fund grant is essentially undertaking tasks that GON, through the Federal Ministry of Health, is unable to undertake (undertaking contracted out activities). FHI/GHAIN’s role in the implementation of the Round 5 grant is not building GON capacity but it is establishing the precedent for GON/Federal Ministry of Health contracting out activities to organizations that have a comparative advantage over the GON/FMOH. While it is expedient for NACA to contract out activities implementing the Global Fund grant to ensure good performance of the grant, it is important that this does not undermine FMOH core business (and FHI/GHAIN does not seem to be undermining core business). There might be larger benefits from the FMOH contracting out drug and consumables procurement and supply chain management, which it performs poorly, despite JSI/SCMS technical assistance. However, FHI/GHAIN is not involved in Global Fund grant procurement and supply chain management activities.

Thus whether other USAID IPs should be encouraged to collaborate on the implementation of Global Fund grants needs to be determined on a case-by-case basis:

- (1) Ideally the IP collaboration should be building GON/FMOH capacity
- (2) The collaboration should not undermine FMOH core business – policy, standard setting, oversight of health service delivery at federal level; planning, human resource management and delivery of clinical services at state and local government levels in Nigeria
- (3) Collaboration would be best limited to undertaking contracted out services that are not FMOH core business
- (4) There should be agreement from the get go on how Global Fund activities will continue after the end of USAID/PEPFAR funding to the IP when Global Fund grant implementation extends past a USAID/PEPFAR contract/cooperative agreement with

³¹ The Nigeria GFATM Round 9 grant application *R9_CCM_NGA_HT_PF_s1-2_4.Aug09_en* available at www.theglobalfund.org/grantdocuments/9NGAT_1899_0_full.pdf refers to “FHI/GHAIN” being subrecipient in the Round 5 grant and proposal for Round 9

the IP.

Question 3b: What are the effectiveness and efficiencies of the collaboration with GFATM?

GHAIN has been able to deliver far more results than expected with its Global Fund sub grant because its programming/management base has been funded and established with its USAID/PEPFAR funding. None of the Global fund sub grant has been spent on setting up new offices or systems; Global Fund grant activities are undertaken as marginal costs on the much larger USAID/PEPFAR funded project set up.

Question 3c: What is the impact of the collaboration and synergies between PEPFAR and GFATM under the GHAIN program on the overall health systems in Nigeria?

As discussed above, and as further evidenced in section 5 of this end of project evaluation report, GHAIN has influenced development of GON standard operating procedures, training curricula and materials. GHAIN activities have included training individuals rather than building the capacity of the system and, for example, the MIS reporting system is still dependent on GHAIN involvement and or funding. Thus GHAIN has had limited impact on health systems as its activities have not strengthened health systems and are not *sustainably* owned by the GON. However, it must be stressed that GHAIN was not set up as a capacity building project and, during PEPFAR 1, effort was focused on rapid scale up of numbers of PLHIV on ART—often with support from parallel systems in drug procurement and supply, and laboratory services—and not on building GON capacity to sustain delivery of the services.

Objective 4: Determine lessons learned that will assist USAID, Government of Nigeria and other implementing partners with future comprehensive HIV/AIDS, TB and reproductive health-HIV integration programs in Nigeria and elsewhere.

Question 4a: What are the benefits of implementing large-scale integrated programs such as the GHAIN project, which [covers] the whole country?

PEPFAR country programs have been prohibited from allocating more than 8% of total funding levels to one partner, since funding levels for the GHAIN project exceeded the 8% threshold, USAID Nigeria requested and was granted a waiver to fund FHI. The evaluation team will examine the relevance if the 8% cap for PEPFAR activities in terms of the cost of managing larger projects versus costs of managing multiple smaller projects. (See section 3.1 for discussion of agreed changes made to the SoW.)

Large-scale projects such as GHAIN reduce the number of contracts/cooperative agreements USAID has to manage. They can also reduce the number of external partners that the GON, in particularly NACA at all levels and the ministry of health at all levels, has to deal with. Government agencies and ministries at state level are under resourced and of limited capacity reducing their ability to lead and coordinate many external partners effectively.

At the time of the 2008 evaluation, GHAIN management was proving successful in implementing its rapidly scaled up program. Although GHAIN management made the assertion in 2008 that the project had institutional capacity and appropriate structure—with decentralization to zonal offices—to enable rapid scale up, and could continue to expand rapidly geographically, it is now obvious that there are serious management and oversight weaknesses, indicating that GHAIN is spread too thinly.

GHAIN has employed a Compliance Manager and has also installed state of the art video conferencing technology to enable communication with and between zonal offices. The Compliance Manager may ensure financial probity but cannot guarantee program technical soundness or the veracity of monthly M&E reports. Very many GHAIN zonal office staff complained that they never see their directors from Abuja. Some specifically complained that communication with Abuja is unidirectional – Abuja issues instructions that zonal offices have to implement; Abuja does not listen to feedback or respond to programmatic requests. For example, some zonal offices would like to undertake new more innovative prevention activities with MARP and have proposed this to Abuja but received no response. A number of zonal office staff have concerns about commencing HAST field activities in Year 7. While zonal offices began identification of IPs in Year 5 and Year 6, there was then a hiatus until late Year 6 before the go-ahead was received from Abuja to commence field activities.

One clear example of inadequate technical oversight from Abuja, with GHAIN directors relying too heavily on reports from zonal offices, is in relation to LAMIS. GHAIN country-level directors clearly believe that LAMIS is an excellent system and is being used in patient management. While the evaluation team wholeheartedly acknowledges the great potential for LAMIS to improve client management, it is currently not being managed or used by clinical and pharmacy staff at the LAMIS sites visited. LAMIS records are updated retrospectively by data clerks who extract client data from the paper-based medical records that clinicians use at the site. Clinicians who had a LAMIS file open in the PC on their desktop when the evaluation team arrived were unable to provide detailed responses to questions and were unable to open a new record for the next client in line.

The USG 8% rule led to GHAIN making strategic decisions to drop programmatic areas, and hence partners, in 2006. GHAIN decisions were likely the best decision to allow GHAIN [and USAID] to deliver PEPFAR 1 results. It also freed up consortium partners—for example CEDPA—to manage a PEPFAR project as CEDPA itself was then subject to the 8% rule, not CEDPA in partnership with FHI subject to FHI's 8% cap.

If the decisions had been made under PEPFAR 2 with its systems strengthening and sustainability requirements, GHAIN may very well have made strategically different decisions. To deliver health systems strengthening and build GON capacity for sustainable delivery of HIV/AIDS services, a greater depth of presence is required at state level. Further, the mode of entry into states would have to be through the state ministry of health to build their capacity from the get go to plan, manage and oversee HIV/AIDS services throughout the state. However, to deliver PEPFAR treatment targets, GHAIN had to pick up high volume sites in many states rather than penetrate more deeply into sites.

In sum, the 8% rule under PEPFAR 1 limited GHAIN's ability to implement large-scale comprehensive HIV/AIDS programs. While it freed consortium partners such as CEDPA to receive funding for its own programs, it reduced the coordination between GHAIN and CEDPA's program, and, as the 2008 evaluation found, led to rivalry between GHAIN staff and CEDPA staff. Nonetheless, the 8% rule under PEPFAR 2 will be important to discourage repetition of the current GHAIN situation: it is the considered opinion of the majority of the end of project evaluation team that the project is spread too thinly and it has exceeded its management/oversight capacity.

Question 4b: Should the project continue to offer a wide range of integrated prevention, care and treatment services or focus on treatment only?

This question is taken to refer to post-GHAIN projects, given the short amount of time remaining until the end of GHAIN.

The GHAIN country and zonal office technical resources remain primarily treatment-oriented, an enormous undertaking in itself and one where GHAIN has indisputably achieved a great deal. The main issue here is that if a nationwide project as capacitated as GHAIN (a frequent comment is that GHAIN employs more medical doctors than the FMOH) cannot always adequately address components that are not primarily biomedical in focus, serious consideration should be given to the optimal composition, scope and mandate of future projects.

The view of the EOP evaluation team is that the range of services in a new project should continue to cover integrated prevention, care and treatment. This is in line with international best practice that seeks to provide a continuum of support, where opportunities for normalization of HIV and AIDS in the context of people's daily lives and their communities are facilitated as much as possible. Patients receiving treatment will at some stage require prevention for positives, they will also be eligible for palliative care and they may well wish to link into PLHIV support activities. Furthermore, a narrow focus on treatment of HIV is likely to have greater impacts on any moves to integrate such services into the wider health service delivery environment. This is especially the case at LGA and PHC level, where the experiences to date of HAST implementation indicate that there are all too many pitfalls of verticalization and prioritization, to the detriment of other diseases.

Chronic care management represents the increasingly preferred option for effective support to PLHIV and their families (in a very wide literature, see Epping-Jordan, Pruitt, Bengoa & Wagner 2004, Stuart (FHI) 2008, USAID 2009 and Vaz 2006 (the latter specific to care of children with HIV)). The chronic care management model is consistent with the approaches set out in the Global Health Initiative and the new PEPFAR Five-Year Strategy (USG 2009a and PEPFAR 2009b).

A standard definition of chronic care is that it encompasses acute and palliative care (for both infectious and chronic diseases and conditions) and that it is a 'larger model that includes the domains of comprehensive and palliative care.' (FHI 2005). Key principles of the chronic care management model include proper and informed partnership between patient and health care provider, prevention (ongoing, i.e. including prevention for positives) is integrated, chronic care is delivered at PHC level by both health workers and community members working in partnership.

GHAIN AIDS treatment services are delivered through acute service delivery models, as the infrastructure for chronic service delivery is not developed. Change to chronic care service delivery requires extensive development of PHC service delivery and community based services, with stronger inter-facility referral mechanisms and patient management monitoring. Development of the required chronic care systems must engender local (rather than project) ownership of the systems and processes from the outset, so that the chronic care service providers have a major stake in ensuring the systems work.

With these points in mind, it is the structure and geographical scope of any one such new project that should be addressed (see discussion of question 4c immediately below).

Question 4c: Should the project continue to offer treatment services nationwide or focus on providing services in particular regions or zones? Is the oversight provided by FHI HQ, FHI Nigeria Country Office and the Zonal Offices sufficient? Are the current staffing levels and management design adequate? Has there been any difference to date, from the evaluation of May 2008?

This section is written with full acknowledgement of the major and challenging work undertaken by GHAIN in its implementation and management of a complex range of interventions. Those interventions have had significant and positive impacts on the lives of many Nigerians. The GHAIN intention has been to support its public sector and civil society partners in delivery of services and assistance. While inevitably discussion here will focus on challenges, gaps and rationale for changes in direction, it is appropriate to bear in mind all the achievements of GHAIN, as primarily discussed in section 4 of this report.

Nationwide vs. regional/zonal services

See also section 4.6. Health systems strengthening and the discussion in this section of objectives 2a and 2b.

The first question is interpreted here to refer to post-GHAIN programming. GHAIN itself has little more than seven months to run at the time of writing this report; it would, therefore, obviously be invidious to recommend that treatment be scaled back at this juncture, given the ethical and human rights considerations.

The considered view of the evaluation team is that planning for future projects should very seriously consider a number of zonal/regional projects and not necessarily continue with business as usual with further application of the nationwide GHAIN model (see also 6.2).

(Note: Part of this sub-section was deleted due to the procurement sensitive nature of its content.)

Please refer to discussion of the following GHAIN components/programmatic gaps for further corroboration of this finding (4.3.Orphans and other vulnerable children, 4.3.Support to people living with HIV, 4.3.Community and PHC-based support interventions (HAST LGAs), 4.6.Strategic information/monitoring and evaluation, 4.6.Health systems strengthening and Appendix H (Gender and Community Systems Strengthening)).

Management oversight

Points discussed here are also relevant regarding adequacy of staffing levels and management design. A number of issues of concern emerged during the end of project evaluation specific to management oversight (see also 4.1).

GHAIN zonal offices report upwards, to the country office, yet there does not always appear to be a well-defined and managed system of iteration downstream, i.e. a number of KIIs with zonal staff members indicate that these offices do not always receive adequate feedback from Abuja to enable responsive (zone-specific) planning and management. Zonal offices appear not always to be able effectively to put forward requests for programming that GHAIN staff members at that level consider appropriate. There was also mention at zonal office level of insufficient inputs to financial management – not so much the actual accounting and retirement, more perceived limited opportunity to negotiate for changes within monthly budgets and to specific budget lines dependent on circumstance. One reference was made to a resultant

lack of flexibility: changing priorities is difficult, e.g. if a zonal office wished to dedicate more resources to support to PLHIV or to focus on addressing LTFU.

It seems that on occasion insufficient attention is given to the need to provide a continuum of interventions. One example is that the GHAIN North East Zone (Adamawa and Taraba states) does not undertake any prevention activities (A/B or OP), despite strong opinions voiced by GHAIN staff members during fieldwork that such work is necessary. It was not possible to ascertain whether the absence of prevention work in this zone is due to financial constraints or is more a result of a top-down, somewhat distant country office management approach, or indeed a combination of both factors. It is also possible that the overall GHAIN technical weakness regarding the new GHI and PEPFAR approaches to A/B and OP interventions that have applied since 2009 is another factor.

A further finding is that the country office is on occasion too remote from zonal activities. This is exemplified by the GHAIN end of project evaluation finding that while the country office systems of training and support to Integrated Supportive Supervision may be exemplary in theory, there appears to be insufficient attention to follow through at any level of GHAIN management. Thus a great deal of step-down training is undertaken, where health facility staff members trained by GHAIN are either obliged or requested to train other personnel, apparently without systematic supervision as to quality.

Another indication of the disconnect between country and zonal offices in terms of oversight is the evaluation finding that a number of zonal offices visited during fieldwork worked in concert to pre-prepare responses to KIIs. Thus a number of KIIs with zonal staff members and also facility management team members, SACA and SASCP staff members and CBO representatives were of little use, because respondents had been coached. This behavior mirrors that observed during the evaluation in May 2008. Discussion was held at that time as to the inappropriateness and unethical nature of such collusion and a request made before the end of project evaluation that it not happen again. It is the opinion of the evaluation team that this collusion was not led from the country office and that senior management was unaware. (See also 4.1.)

The end of project evaluation has found that GHAIN management oversight of implementing agencies at zonal level can on occasion be weak and sometimes mechanistic, the latter exemplified by the closed loop of M&E structures that does not support health facilities and CBOs to develop appropriate collection of strategic information and evidence-based planning capacity (see also 4.6.Strategic information/monitoring and evaluation). CBOs (both umbrella CBOs and their CBO partners) have often not received adequate training in the development of effective approaches and methods for engagement with communities. The relative lack of GHAIN staff members with deep-rooted experience in community system strengthening is a factor. As is discussed in 4.3.Community and PHC-based support interventions (HAST LGAs), this lack of technical expertise has had repercussions for the appropriateness and efficacy of HAST activities, e.g. work with orphans and vulnerable children (and in this context, see also 4.3.Orphans and other vulnerable children). Another issue is the fact that almost all GHAIN-linked support groups are facility-based; as discussed elsewhere in this report (4.3.Support to people living with HIV) this is an inherently unsustainable approach and one that has considerable potential for entrenching stigma.

Staffing levels and management design

It is the considered opinion of the evaluation team that GHAIN does not have a management design or structure that effectively manages the current national spread of project activities. This is despite its very considerable staffing levels. It has to be borne in mind that for most of its project life GHAIN has been overwhelmingly and successfully a treatment-focused intervention and this has inevitably shaped management design and structures as well as human resource management. GHAIN staffing is still weighted towards biomedical, treatment priorities; in addition, a number of senior staff members at country office who work on other components (e.g. prevention) are also medical doctors. This does not appear always to represent the best use of expertise and individuals' comparative advantage.

There are particular technical gaps at all GHAIN levels in areas focused on prevention, care, support, health and community system strengthening, social development and gender. GHAIN has not undertaken internal or external gender and HIV mainstreaming training and institutional structures have not been shaped to address such matters. It should, however, be noted that individually excellent staff members work on such areas (e.g. on prevention and BCC in the North Western zonal office and on prevention in the FCT zonal office). The point here is that internal GHAIN institutional and management structures have not been adequately reshaped to deal with the new Global Health Initiative and PEPFAR realities (due acknowledgement is given here to the complexity and demands of such a task). GHAIN has instituted the country office *Health Policy and Systems' Strengthening* department in order to address HSS; the evaluation team was told that the FCT and Lagos zonal office also have such a department.

The evaluation team was told that GHAIN does not have an HIV workplace policy.

Management design specific to internal GHAIN partnerships

Views on this vary to an extent among the four GHAIN partners: FHI, Axios, HU-PACE and GLRA. There is obvious acknowledgement from all partners of the role and remit of FHI as GHAIN prime, and the specific responsibilities these bring.³²

GLRA and HU-PACE broadly describe the management design and internal relationships with FHI, GHAIN country and GHAIN zonal offices as close, effective and well managed, while noting inevitable occasional bottlenecks and differences of opinion and approach. Each organization feels that its comparative advantage is appropriately integrated into GHAIN management. Mention is also made of the project being able to become greater than the sum of its parts, due to appropriate synergies.

Less successful aspects of the management design and implementation are from the GLRA perspective a feeling of unequal acknowledgement of the contribution of all partners in attaining achievements and inadequate involvement of GLRA in planning. HU-PACE notes "Least successful aspects of partnership include the selective sharing of relevant information for programming, reduced attribution for items of contributions and the dictatorial style of the previous administration. One example is the formation of AHNi and the demand that partners cede staff to the newly formed entity without prior consultations." (HU-PACE 2010)

³² Each of the GHAIN partners completed a self-assessment questionnaire as part of the end of project evaluation. Information here is taken from those responses as well as from KII with members of staff. The completed questionnaires are available upon request from the evaluation team leader.

Axios describes positive elements of the internal partnership arrangements and similarly points out synergies, effective use of skills, etc. There is discussion also of FHI having previously assumed too dominant a role, not being sufficiently proactive in responding to partners' requirements and there being minimal opportunity for partners other than FHI having close contact with USAID. There is also a feeling that Axios has not always been kept adequately informed about the entirety of project activities, about M&E findings and other key management functions. The Axios view is that since the change of FHI leadership in the GHAIN program, GHAIN consortium partner relationships have improved and are now functioning more harmoniously

Axios is the consortium partner whose remit has changed most significantly due to e.g. the new system of pooled procurement through SCMS.

Specific changes since 2008

See 1.2 for detailed discussion.

Since mid-2008, GHAIN has in effect been retrofitted to address the increased focus on HSS, prevention, OVC and other community engagement that has resulted from the introduction of the Global Health Initiative and the implementation of the PEPFAR Next Generation Indicators (see 1.2 and throughout section 4). These components have not been optimally integrated into project management, activities or M&E.

6. RECOMMENDATIONS

6.1 TO THE END OF THE GHAIN PROJECT

- As a priority, GHAIN should address end-of-project issues and activities with *all* implementing partners.
- GHAIN should expand its project exit strategy discussions with national and state-level partners.
- GHAIN should develop hand-over plans, activities and documentation procedures to be provided to the follow-on program.
- CBOs should receive training in and support for proposal writing, sustainability planning and independent advocacy to health policy makers.
- GHAIN should not expand its HAST and OVC activities any further.

6.2 FOR THE FOLLOW-ON PROGRAM

Recommendations from the GHAIN end of project evaluation outbrief

These recommendations were written before the evaluation team had sight of the SIDHAS RFA. They were presented to USAID/Nigeria on October 29, 2010.

- The follow-on activity should include consortium partner/s with internationally recognized expertise in designing and implementing:
 - Chronic care management activities
 - Prevention activities
 - Community-based activities
 - Health systems strengthening, including community systems strengthening
- The follow-on program should include closer attention to HSS, so as to enable GON to manage and sustain activities
- Parallel systems of service delivery, records, data management, human resource management, etc. should be avoided
- There should be a standalone program to work with MARP
- Consideration should be given to separate regional program management structures
- Serious consideration should be given by USAID to providing FHI with a grant for overheads to enable it to continue its GFATM engagement.

Recommendations for SIDHAS

The recommendations listed here are based on the three end of project evaluation international consultants' comments, sent to USAID Nigeria in November 2010.

(Note: This sub-section was deleted due to the procurement sensitive nature of its content.)

7. LESSONS LEARNED

The GHAIN end of evaluation SoW suggests that this section of the report cover presentation of information that could be useful to those designing or implementing broadly similar programs elsewhere. As such, the reader is referred to section 6.2 immediately above: SIDHAS recommendations are based on core GHAIN lessons learned as defined by the end of evaluation team.

In addition a number of both positive and negative key lessons learned are listed here.

1. PREVENTION SERVICES AND INTERVENTIONS

PMTCT

1. It has been possible to move from “opt in” HCT to routine, “opt out”, HCT in ANC settings. However, this does not seem to have significantly increased the proportion of positive mothers and HIV-exposed infants receiving ARV prophylaxis.
2. Without attention to demand side, there has not been significant improvement in proportions of positive mothers and HIV-exposed infants receiving ARV prophylaxis.
3. Collaboration with UNICEF with regard to HIV and infant feeding has significantly improved the knowledge of PMTCT staff and led to reported increases in mothers making informed choices.

Prevention (A/B and C/OP)

1. GHAIN is currently providing insufficient technical assistance and management leadership to institute and embed internally and at implementing agency level what are in fact major changes in prevention focus (both A/B and C/OP). Such changes require dedicated expertise and longitudinal planning, monitoring and evaluation, as well as far more participation by potential beneficiaries/cohort members at all stages of prevention activity planning, implementation and M&E. All such factors should be considered in the follow-on program to GHAIN.
2. End of project evaluation findings are that GHAIN has not made optimal use of international best practice in terms of engaging with most at risk persons, among whom are to be found people often extremely vulnerable to infection and frequently very difficult of access.
3. Adequate support to peer educators is imperative if they are to deliver prevention effectively; this is especially the case if significant shifts in focus occur.

HCT

1. In some health facilities, HCT focal persons and site coordinator are closely engaged with the support groups, thus there is a degree of genuine absorption of the members into hospital activity and real development of a proper relationship between the supply and demand-side. In order for this behavior to become sustained it needs to be institutionalized.
2. Opportunities for further and more focused support to young people living with HIV are needed.

2. CARE AND SUPPORT SERVICES AND INTERVENTIONS

Palliative care: TB and HIV

1. Close collaboration between the national TB program and the national AIDS program ensures effective coordination of TB/HIV activities.
2. Harmonizing TB and HIV recording and reporting systems is necessary for efficiency in TB/HIV services monitoring and evaluation to avoid duplication.

Palliative care: other services

1. GHAIN translated its experience into technical support to the GoN to develop:
 - The National Palliative Care Guidelines and Standard Operating Procedures
 - The National Palliative Care Strategic Framework.

Orphans and other vulnerable children

1. OVC interventions are complex and multi-faceted interventions that necessitate longer-term support, so that children once enrolled can be assured of consistency of support. Short-term interventions (as implemented by GHAIN) are inappropriate.
2. OVC interventions require technical expertise on social development, social protection and inclusion, rights-based approaches and community systems strengthening, as well as obvious core expertise in implementation of effective OVC activities where children are at the center.
3. Gender expertise is also required when working with OVC.

Support to people living with HIV and AIDS

1. A key issue is: how sustainable can a facility-based support group be? The entire thrust of PLHIV support is nowadays to root it within the community, to seek every opportunity to ‘normalize HIV’. The very existence of facility-based support groups, however well intentioned, demonstrates not only the lack of community/social development/social protection expertise within GHAIN; it also indicates insufficient attention to longer-term ramifications. One such is the possibility of increased stigma and discrimination of PLHIV when GHAIN support ceases – the support group members are identified with the facility, not with the communities in which they live (in the context of being PLHIV).
2. GHAIN has not applied international best practice in terms of M/GIPA principles: the meaningful/greater involvement of people living with HIV & AIDS. This requires true and equitable partnership and inclusion of PLHIV in policy, planning, state-level meetings, etc as well as proper engagement at community level.

Community and PHC-based support interventions (HAST LGAs)

1. The main lesson is that activation of HAST is very different from activating a district hospital for ART. It is important to bring all stakeholders on board early, governmental (LGA secretariat) and non-governmental (CBO, community gate keepers/leaders, etc) and keep them engaged too. All this takes time but is essential for ownership and sustainability.
2. It is of absolutely critical importance that all community-focused interventions be supported by adequate technical expertise in CSS, social development, gender, OVC, social protection, rights, and other fundamental social development approaches. A primarily biomedical approach will not work, however well intentioned it might be.

3. TREATMENT SERVICES AND INTERVENTIONS

Adult ART

1. GHAIN experience developing training materials/curricula and standard operating procedures for secondary facilities represents an important resource for the FMOH.

Pediatric ART

1. There is considerable need to provide genuinely child-friendly pediatric ART services.
2. Pediatric and adult ART clinics should be more effectively integrated, ideally as a one-stop-shop, where parents’ and children’s needs are simultaneously addressed.
3. Far more focus is required on integration of OVC services (e.g. as provided under HAST) and pediatric ART and palliative care services.

Pharmacy services (including community pharmacists)

1. Engaging volunteers, mostly community pharmacists and some youth corpers, to support pharmacy service delivery by alleviating the impact of inadequate number of deployed pharmacy staff has been successful. Many of these volunteers reported that they are motivated volunteering in the GHAIN program to initiate HIV/AIDS focused activities in their own pharmacies. The involvement of PLHIV in pharmacy service delivery has also been successful.
2. The GHAIN-initiated community pharmacy program has also had some success despite high attrition rates.

Procurement, logistics, commodities and laboratory supplies

1. It is important to strengthen systems rather than establish parallel systems. While GHAIN's original drug quantification, procurement and logistics system delivered secure supplies to GHAIN-supported sites, it did not strengthen the GON system. Since GON took over using its Global Fund Round 5 grant, supplies have no longer been secure.

Laboratory services

1. GHAIN has developed and uses a comprehensive standard checklist for its baseline/needs assessment prior to laboratory activation in supported sites. The consistent use of this tool to assess available human resources and infrastructural capacity vis-à-vis the required minimum standard is useful in ensuring that sites are supported to meet the minimum defined standards. It is, however, apparent that this standard checklist has not been consistently applied.
2. An outstanding innovation with many opportunities for lesson learning and institutionalization of best practice is the support for the establishment of a high-tech molecular laboratory for the early diagnosis of HIV infection in HIV-exposed infants (early infant diagnosis), in FMC Jalingo.

APPENDICES

- APPENDIX A: SoW of the GHAIN End of Project Evaluation
- APPENDIX B: GHAIN consortium partners' timelines (2004 to date)
- APPENDIX C: Persons Contacted
- APPENDIX D: GHAIN End of Project Evaluation Itinerary
- APPENDIX E: Representative Sample of GHAIN EOP Evaluation Field Tools
- APPENDIX F: Detailed Discussion of GHAIN Prevention Activities (A/B and C/OP and MSM)
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APPENDIX A. SCOPE OF WORK (DRAFT VERSION JULY 30, 2010)

SCOPE OF WORK: END OF PROJECT EVALUATION OF THE GLOBAL HIV/AIDS INITIATIVE NIGERIA (GHAIN) PROJECT

BACKGROUND

Global HIV/AIDS Initiative Nigeria (GHAIN) is a PEPFAR-funded project designed to support the Federal Government of Nigeria's (FGoN) response to the expanding HIV epidemic in the country. Initially 5-year later extended to 7-year project focused on providing support to ensure that the relevant health infrastructure was functional, and to improve skills in prevention, care and support, and treatment of HIV and AIDS. GHAIN's efforts focused on ensuring that providers can safely and effectively deliver Counseling and Testing (CT), Prevention of Mother to Child Transmission (PMTCT), Antiretroviral Therapy (ART) - including quality laboratory diagnosis/monitoring, PMTCT-plus programs - and treatment of other opportunistic infections (OIs), as well as ensuring that ongoing prevention and care and support efforts are effectively carried out as articulated in the Nigerian National HIV/AIDS Strategic Plan. The project also ensured the implementation of tuberculosis and reproductive health – HIV integration services in focus sites.

The Program Management Team (PMT) of the GHAIN consortium is comprised of the following four partners, and program activities are structured to maximize the expertise and strengths of each of the partner organizations. The current GHAIN PMT partners, all of which were included in the original consortium, are the following:

Family Health International (FHI) provides GHAIN's general management and technical leadership in HIV counseling and testing, prevention of mother-to-child transmission, clinical services, and palliative care including TB, home-based care, care of orphans and vulnerable children, and community education. FHI has been actively implementing HIV/AIDS projects in Nigeria since 1988.

The Axios Foundation procures antiretrovirals and other drugs and manages commodities (including lab reagents) for GHAIN.

The German Leprosy and TB Relief Agency (GLRA) expands and strengthens the quality of Nigeria's tuberculosis services, and the integration with HIV/AIDS services.

Howard University, as well as through its Pharmacists & Continuing Education (PACE) Center, strengthens the ability of pharmacists and pharmacy systems to be a part of clinical services and to provide information on and treatment referrals for HIV/AIDS, sexually transmitted infections, tuberculosis, and other OIs.

Due to USG programmatic shifts and funding priorities, the Futures Group, CEDPA and American Red Cross/ Nigerian Red Cross were withdrawn from the original consortium at various points in the implementation of the project.

As with all other PEPFAR initiatives, the goal of the GHAIN project is to reduce the impact of HIV/AIDS in selected areas. Thus, the project contributes towards achieving Agreement Objective (AO) - reduced impact of HIV/AIDS in selected states, through:

IR 14.1: Increased use of quality HIV/AIDS and TB prevention services and interventions

IR 14.2: Increased use of quality HIV/AIDS and TB care and support services and interventions

IR 14.3: Increased use of quality HIV/AIDS and TB treatment services and interventions

One of the major focuses of the GHAIN project has been to strengthen the capacity of collaborating partners to enable them to undertake their relevant activities as well as to strengthen their competencies in programming, financial management, and monitoring and evaluation (M&E). This includes building capacity of local organizations to the extent that they can become viable prime recipients of USG funds. Although not originally envisaged in the project application, the GHAIN project has developed a significant collaboration with the Global Fund (GFATM) by becoming a GF sub-recipient, and has leveraged GF and PEPFAR resources to build Nigerian capacity and systems in HIV/AIDS prevention, care and treatment.

The project was aimed to deliver the following range of quality HIV/AIDS prevention, care and treatment services:

HIV Prevention Services

Prevention of mother-to-child HIV transmission, including counseling and testing for pregnant women, ARV prophylaxis for HIV-infected pregnant women and newborns, counseling and support for maternal nutrition, and safe infant feeding practices;

Abstinence/Be faithful activities that include training to promote abstinence, a delay in the onset of sexual activity, fidelity, partner-reduction messages, and related social and community norms;

Other activities aimed at preventing HIV transmission, including the purchase and promotion of condoms and STI management in non-palliative care settings; and

Blood Safety and Safe Injection activities to reduce the nosocomial transmission of blood-borne pathogens, including HIV.

Care and Support

Palliative Care (Basic Health Care and Support) - all clinic- and home/community-based activities for HIV-infected adults and children and their families aimed at optimizing the quality of life throughout the continuum of illness by means of symptom diagnosis and relief; psychological and spiritual support; clinical monitoring, related laboratory services and management of opportunistic infections (excluding TB) and other HIV/AIDS-related complications (including pharmaceuticals); culturally appropriate end-of-life care, clinic- and home/community-based care and support; social and material support such as nutrition support, legal aid and housing by leveraging support from other organizations and training and support of caregivers; health care services for orphans and vulnerable children (OVC), including HIV/TB services when delivered outside a program for OVC affected by HIV/AIDS;

Palliative Care (TB/HIV) – includes examinations, clinical monitoring, related laboratory services, treatment and prevention of tuberculosis in HIV basic health care settings (including pharmaceuticals); screening and referral for HIV testing; and clinical care related to TB clinical settings;

Orphans and Vulnerable Children - activities aimed at improving the lives of orphans and other vulnerable children and families affected by HIV/AIDS with an emphasis on strengthening communities; support for community-based responses to help children and adolescents meet their own needs; a supportive social policy environment; training for caregivers; increased access to education, economic support, targeted food and nutritional support and institutional responses; and palliative care, including basic health care support and TB/HIV prevention, management and treatment, as well as related laboratory services and pharmaceuticals; and

Counseling and Testing – activities in which both HIV counseling and testing are provided for those who seek to know their HIV status (as in traditional voluntary counseling and testing (VCT) or as indicated in other contexts (e.g., STI clinics).

Treatment

HIV/AIDS treatment/ARV drugs – includes distribution/supply chain/logistics, pharmaceutical management and cost of ARV drugs; and

HIV/AIDS treatment/ARV services – including infrastructure, training of clinicians and other providers, examinations, clinical monitoring, related laboratory services and community-adherence activities.

Strategic Information

Development of improved tools and models for collecting, analyzing and disseminating HIV/AIDS behavioral and biological surveillance and program monitoring data; supporting the national government institutions establish and/or strengthen health information management systems; targeted program evaluations (including operations research); developing and disseminating best practices to improve program efficiency and effectiveness; planning/evaluating national prevention, care and treatment efforts; analysis and quality assurance of data; testing implementation models; and the assessment and improvement of FHI/GHAIN as an organization.

Other services

The GHAIN project also implemented capacity building interventions for the prevention of malaria in pregnancy, establishment of multi-drug resistance TB bio-safety level 3 laboratory, and community based TB care and RH-HIV integration services. The GHAIN project also initiated the LGA-based integrated care model (HAST) and the family-centered model of care for HIV/AIDS in a number of sites.

Recently, the GHAIN project also piloted CVD and cervical cancer screening programs.

Since inception of the GHAIN project, there were various contractual changes from the original design. Among the many changes that have occurred, several were at the request of the USG. The reasons varied, but included resource constraints, changes in USG programming objectives, variations in the roles of the participating agencies and organizations, and the appearance of new parties.

During the 4th year of the GHAIN project, prior to the official determination of the 2-year extension, the

GHAIN project was evaluated by USAID Nigeria in May 2008. The objectives of the evaluation were to:

1. Determine whether the GHAIN project has achieved its goal and strategic objectives (intermediate results)
2. Assess the implications of guidance issued by the Office of the Global AIDS Coordinator (OGAC) on the GHAIN project's ability to achieve its objectives
3. Provide recommendations for continuing activities

The evaluation found that the GHAIN project had achieved its three strategic objectives (intermediate results) and its goal – working with the Government of Nigeria (GoN) and other local partners, to reduce the impact of HIV/AIDS and TB in selected areas.

EVALUATION OBJECTIVES

The Automated Directive System (ADS) 203.3.6.1 requires that an evaluation be conducted when there is a distinct and clear management need to address an issue. This request sets forth guidelines for an external assessment of the Global HIV/AIDS Initiative in Nigeria (GHAIN) project implemented by Family Health International (FHI) under USAID Cooperative Agreement 620-A-00-04-00122-00. The GHAIN project is a seven-year, \$418,453,640 agreement that began in September 2004 and will terminate in June 2011.

The objectives of this evaluation are four-fold:

1. Determine whether the GHAIN project continued to achieve its goal and strategic objectives (intermediate results), following the May 2008 evaluation:

Goal: Reduced impact of HIV/AIDS and TB in selected areas

IR1. Increased use of quality HIV/AIDS and TB prevention services and interventions

IR2. Increased use of quality HIV/AIDS and TB care and support services and interventions

IR3. Increased use of quality HIV/AIDS and TB treatment services and interventions

- a. In assessing the extent to which these IRs have been achieved, the evaluation team will analyze the extent to which GHAIN has met its PEPFAR targets that are set each year during the Country Operational Plan (COP) planning process and reported to OGAC on a semi-annual basis.
 - b. In assessing the extent to which the GHAIN project contributed towards furthering the goal of USAID Nigeria SO14 through a review and analysis of the available data pertaining to the relevant program areas.
 - c. In assessing the extent to which the GHAIN project contributed towards the six principles of the Global Health Initiatives' approach.
 - d. In assessing the extent to which the GHAIN project contributed to the overall PEPFAR Nigeria's program.
2. Determine to what extent the capacity building efforts by the GHAIN project contributed to the implementing agencies' overall performance in and sustainability of the delivery of comprehensive HIV/AIDS prevention, care and treatment [and/or] TB [and/or] malaria in pregnancy [and/or] RH-HIV integration programs;
 - a. To what extent have activities been transferred to the government or local partners?
 - b. With respect to treatment services, the evaluation team will assess the organizational capacity of selected sites to deliver effective care and to deliver care with less USG support and more GoN support. The team will identify elements or areas that need technical assistance as well as areas that can serve as resources for expansion or scale-up in other sites.
 - c. The evaluation team will assess the cost-benefits and program outcomes of the collaborative and multiple-pot funding (PEPFAR, Child Survival and Population Funds) using the GHAIN project as a single mechanism.
 3. Determine to what extent the collaboration and synergies between PEPFAR and GFATM funding contributed to the overall program and health systems impact;
 - a. What are the challenges and benefits of close collaboration with GFATM, and should this be encouraged among USAID IPs?
 - b. What are the cost effectiveness and efficiencies of the collaboration with GFATM?
 - c. What is the impact of the collaboration and synergies between PEPFAR and GFATM under the GHAIN program on the overall health systems in Nigeria?

4. Determine lessons learned that will assist USAID, Government of Nigeria and other implementing partners with future comprehensive HIV/AIDS, TB and reproductive health – HIV integration programs in Nigeria and elsewhere.
 - a. What are the cost-benefits and effectiveness of implementing large-scale integrated programs such as the GHAIN project, which covered the whole country? PEPFAR country programs are prohibited from allocating more than 8% of total funding levels to one partner. Since funding levels for the GHAIN project exceeded the 8% threshold, USAID/Nigeria requested and was granted a waiver to fund FHI. The evaluation team will examine the relevance of the 8% threshold for PEPFAR activities in terms of the cost of managing larger project versus costs of managing multiple smaller projects.
 - b. Should the project continue to offer a wide range of integrated prevention, care and treatment services or focus on treatment only?
 - c. Should the project continue to offer treatment services nationwide or focus on providing services in particular regions or zones? Is the oversight provided by FHI HQ, FHI Nigeria Country Office, and the Zonal Offices sufficient? Are the current staffing levels and management design adequate? Has there been any difference to date, from the evaluation of May 2008?

The final list of evaluation questions will be agreed upon between USAID Nigeria, FHI, and consultants at the time when the team of consultants is fully on board.

PERFORMANCE PERIOD OF THE EVALUATION TEAM

The evaluation will begin on or before September 6, 2010 and will require 54 days of effort: 7 days for preparation and document reviews; 22 days of field work; and 25 days for data analysis, debriefs with USAID and other stakeholders and report writing. In addition to the time to be spent in the GHAIN Country Office and the 11 Zonal Offices, it is proposed that evaluation team members will spend time with a sample of GHAIN implementing agencies in each GHAIN Zonal Office, where appropriate. A draft report will be submitted to USAID Nigeria prior to the departure of the evaluation team leader, and the final report will be submitted to USAID no later than December 1, 2011.

EXISTING INFORMATION SOURCES

The following information, documents and materials are available and relevant to the evaluation exercise:

- GoN: National frameworks, policies and implementation guidelines from the National Agency for the Control of AIDS (NACA) and Federal Ministry of Health.
- USAID:
 - Original Request for Proposal,
 - Emergency Plan documentation,
 - USAID program and financial reporting requirements,
 - The Role of Evaluation in USAID
- Other
- GHAIN:
 - Contract and other amendments,
 - Annual, semi-annual and quarterly reports
 - Tools, guidelines, training materials, SBC materials, etc.
 - Internal assessments and reviews
 - Implementing agencies' sub-agreements
- Other

EVALUATION METHODOLOGY

The evaluation team will be required to propose a clear methodology to answer all the evaluation questions. With regard to data quality, the evaluation team is expected to be familiar with USAID data quality standards for objectivity, validity, reliability, precision, utility and integrity and be able to apply them in the final report, by identifying such data limitations as may exist with respect to these standards (ADS 78.3.4.2 – <http://www.usaid.gov/policy/ads/500/578.pdf>) and ADS 203.3.5.1 – <http://www.usaid.gov/policy/ads/200/203.pdf>).

DELIVERABLES OF THE EVALUATION TEAM

1. Draft outline of the report (an illustrative outline is presented in Section XI) for review by USAID Nigeria and FHI.

2. Draft report that addresses the evaluation objectives and specific questions outlined in Section II: Evaluation Objectives. The report will present a clear and concise summary of the evaluation team's findings, conclusions and recommendations.
3. Debriefing presentation made to USAID Nigeria before the conclusion of the in-country evaluation work. The presentation will include findings, conclusions and recommendations for future programming.
4. Debriefing presentation made to USAID Nigeria and USG inter-agency group/partners, GHAIN and other key stakeholders before the conclusion of the in-country evaluation work. The presentation will include findings, conclusions and recommendations.
5. Final report that addresses the evaluation objectives and specific questions outlined in Section II: Evaluation Objectives as well as the comments received from USAID Nigeria and GHAIN after presentation of the draft report. The final report will present a clear and concise summary of its findings, conclusions and recommendations.

EVALUATION TEAM COMPOSITION AND LEVEL OF EFFORT

The evaluation team shall consist of a Team Leader and six-to-seven Team Members.

1. **Team Leader:** The Team Leader will provide leadership for the team, finalize the evaluation methodology design to be shared with USAID Nigeria for their feedback and comments, coordinate activities, arrange periodic team meetings, consolidate individual input from team members and coordinate the process of assembling the final findings and recommendations into a high quality document. S/he will be responsible for writing the final report and leading the preparation and presentation of key findings and recommendations to USAID Nigeria, GHAIN, and other stakeholders, as appropriate. S/he will also lead in providing recommendation for future directions (LOE 54 days).

Skills/Experience: The team leader will be a senior person having more than 10 years experience working in the field of HIV/AIDS prevention, care and treatment programs and services. S/he should have a post graduate degree in medicine, public health or a related discipline. S/he should have an excellent understanding of evaluation methodology, as well as a good understanding of project administration, financing and management skills, including USAID program management. S/he should have excellent writing and communication skills. S/he should have past experience of leading a team for health project evaluations or related assignments.

2. **Team Members:** The additional five-to-six team members will assist in the design of evaluation instruments and will be responsible for reviewing the progress in accomplishing the evaluation's planned results and outcomes per their assigned roles and responsibilities. The team members will be responsible for drafting portions of the evaluation report and debriefing. (3 Team Members = LOE 54 days; 2 USAID Team Members = LOE 22 days; 1-2 GoN staff members = LOE 22 days).

Skills/Experience: The team members will have a mixture of the following expertise, qualifications, and experiences:

Individual(s) with an in-depth understanding of HIV/AIDS prevention, care and treatment programs and services in a public health context in an international setting.

Individual(s) with program monitoring and evaluation experiences.

Individual(s) with an in-depth understanding of USAID and PEPFAR procedures and reporting frameworks.

FHI will propose a pool of external evaluation consultants from which USAID Nigeria will choose up to three. Alternatively, FHI may propose three teams or organizations from which USAID Nigeria will select. This evaluation team will be complemented by an additional two members that USAID Nigeria will select from HQ technical resources and in-country individuals who are familiar with the GHAIN Project and the Nigerian HIV/AIDS epidemic.

LOGISTICAL SUPPORT

USAID Nigeria will provide overall direction to the evaluation team, identify key documents and assist in facilitating a work plan. USAID Nigeria will assist in arranging and/or participate in meetings with key stakeholders prior to the initiation of fieldwork. The evaluation team is responsible for arranging other meetings as identified during the course of this evaluation and advising USAID Nigeria prior to each of those meetings. The evaluation team is responsible for arranging vehicle rental and drivers as needed for the external team's site visits around Abuja and throughout Nigeria. USAID Nigeria will provide for the internal team's transport, support, and accommodation as required. USAID Nigeria staff will be available

to the evaluation team for consultations regarding resources and technical issues throughout the evaluation process.

DISSEMINATION

A one-day workshop involving national stakeholders will be held in Abuja to disseminate the findings and the recommendations of the evaluation. State-level dissemination workshops will be held through the monthly State M&E Meetings.

FUNDING

This evaluation will be funded by FHI through the GHAIN Cooperative Agreement, with the exception of the two-to-three in-country evaluation team members (i.e., USAID Nigeria staff), who will be fully funded by USAID Nigeria Mission.

CONTACT INFORMATION

Carl Hawkins, HIV/TB Team Leader (chawkins@usaid.gov), and Trevor Rittmiller, HIV/TB Deputy Team Leader (trittmillertdy@usaid.gov) at USAID/Abuja, as well as Lungi Okoko, SI Advisor (lokoko@usaid.gov), are the points of contact for this assignment at USAID Nigeria. Robert Chiegil, Director of Program Management (RChiegil@ghain.org) and Chiho Suzuki, Director of M&E (CSuzuki@ghain.org) for the GHAIN Project, are the FHI in-country points of contact.

ILLUSTRATIVE REPORT OUTLINE

Cover page (Title of the study, the date of the study, recipient's name, name(s) of the evaluation team.

Preface or Acknowledgements (Optional)

List of Acronyms

Lists of Charts, Tables or Figures [Only required in long reports that use these extensively]

Executive Summary [Stand-Alone, 1-3 pages summary of report. This section may not contain any material not found in the main part of the report]

Main Part of the Report

Introduction/ Background and Purpose: [overview of the final evaluation. Covers the purpose and intended audiences for the final evaluation and the key questions as identified in the SOW]

Study Approach and Method: [Brief summary. Additional information, including instruments should be presented in an Annex].

Findings: [This section, organized in whatever way the team wishes, must present the basic answers to the key evaluation questions, i.e., the empirical facts and other types of evidence the study team collected including the assumptions].

Conclusions: [This section should present the team's interpretations or judgments about its findings.

Recommendations: [This section should make it clear what actions should be taken as a result of the study]

Lessons Learned: [In this section, the team should present any information that would be useful to people who are designing/managing similar or related new or on-going programs in Uganda or elsewhere. Other lessons the team derives from the study should also be presented here.]

Annexes: [These may include supplementary information on the evaluation itself; further description of the data collection/analysis methods used; data collection instruments; summaries of interviews; statistical tables; and other relevant documents.]

APPENDIX B. GHAIN PARTNERS' TIMELINES (BEFORE AND AFTER THE EVALUATION IN MAY 2008)

This appendix includes as section 1 the timelines developed by the four GHAIN partners (FHI, HU PACE, GLRA and Axios) for the 2008 evaluation undertaken in May 2008. These timelines have been copied in their entirety from the that evaluation report.

Section 2 includes the four timelines for activities since June 2008. These were also prepared by each of the four project partners. The GHAIN EOP evaluation team has not edited them.

1. GHAIN PARTNERS' TIMELINES FROM PROJECT INCEPTION UNTIL MAY 2008

	2004	2005	2006	2007	2008
USAID	<p>June 24, GHAIN award signed with partners FHI, UMD, CEDPA, Axios, Howard University, Futures Group, American Red Cross, and GLRA</p> <p>June 29, O/GAC directed that UMD be awarded as a prime partner instead through a CDC mechanism</p> <p>August 5, FHI, UMD signed memo: lab</p>	<p>COP05, O/GAC: no single partner could receive more than 15% of the total budget</p>	<p>April 1, UMD, FHI “divorce” FHI picks up lab</p> <p>COP 06 guidance 10% cap: \$4M reprogrammed from GHAIN A&B, OVC and CEDPA, Futures Group and the American Red Cross removed from the consortium</p>	<p>COP07 limit: 8%. GHAIN waiver approved for 11% of the budget. Reductions in Palliative Care. GHAIN cedes non-facility based PC to CEDPA, to provide home- and community-based care</p>	<p>COP08 limit 8% GHAIN waiver was approved for 9% of the budget</p>

activities provided

under CDC

	2004	2005	2006	2007	2008
FHI	<p>Mobilization of GHAIN consortium partners and start-up stakeholders' workshops</p> <p>Team formed at FHI/HQ</p> <p>Rapid community and facility assessments conducted in six states</p> <p>Implementation plans developed; execution of initial sets of sub agreements with local health facilities and NGOs/CBOs</p> <p>Chief of Party and key leadership at country office hired</p> <p>University of Maryland (UMD) separated from GHAIN consortium</p>	<p>First three comprehensive ART sites opened in secondary health facilities with linkages to community services</p> <p>RH/HIV integration services initiated with uniformed services</p> <p>April, FHI/Nigeria becomes "decentralized" to allow for rapid program scale-up and contextually-appropriate responses</p> <p>Edo office established as sixth state office</p>	<p>Discontinued funding for OVC, AB prevention and community/home-based care</p> <p>49 out of 149 implementing agencies closed out program activities</p> <p>Futures Group, CEDPA and ARC separated from the GHAIN consortium</p> <p>Six mobile counseling and testing teams established</p> <p>Rapid increase in the number of staff at country and state offices</p> <p>Negotiation with Global Fund and Shell to leverage program resources to scale-up comprehensive HIV services</p> <p>President Obasanjo publicly tested for HIV by GHAIN and launched Heart-to-Heart</p>	<p>Funds leveraged from GFATM, Packard and Shell to allow for rapid expansion and integration</p> <p>Scale-up to 242 implementing agencies in 31 state</p> <p>Counseling and testing services established in over 150 primary health care facilities</p> <p>HAST approach piloted in 2 local government areas</p> <p>RH integration expands beyond uniform services</p>	<p>Modification to GHAIN scope of work and increase in financial ceiling approved by USAID</p> <p>Development of early infant diagnosis laboratory and TB culture lab</p> <p>GHAIN and BBC World Service Trust develop TV spot aired on Africa's Cup to promote HIV prevention</p> <p>By March 2008, 90 ART sites; 197 CT sites; 145 PMTCT sites; 67 TB/HIV</p> <p>May 2008: External Review</p>

PMTCT and counseling and testing services are available through GHAIN

First state offices established - Lagos, Anambra, Kano, and FCT
 Site identification and assessment for new ART sites
 PMTCT and CT services started in Edo state

State office staff hired in five states

GHAIN program officially launched by Nigerian President Obasanjo on December 1, 2004

End of 2005, 118 implementing agencies engaged in comprehensive services (TB, HIV prevention, care and treatment)

campaign on World AIDS Day

University of Maryland discontinued lab technical assistance to GHAIN

GHAIN discontinued counseling and testing TA to all USG Nigeria partners

10 comprehensive ART sites implemented in six states

Community-TB care implemented in 3 states

DHIS adopted by national program as their M&E platform for data collection

State offices converted to zonal offices: three additional zonal offices opened

Counseling and testing provided to 1,000,000th person in Nigeria

	2004	2005	2006	2007	2008
HUCE-PACE	Feb- Invitation to join consortium. Aug Project Year 1: Pre-obligation	Jan –HUCE/PACE Component launch; Orientation for HUCE/PACE team; training on	Jan– Restoration of Year 1 funding; Next round of Community Pharmacy/Pharmacists Assessment	Jan Engagement of Deputy Project Director Feb- Skills	Jan- Restructuring of country office staff; hiring of Senior M&E Pharmacist Manager and

authorization	HIV/AIDS for Hospital Pharmacists,	Feb- start of subcontract with NIPRD, Development of Training Modules for CP Training	Enhancement Workshops continue in 6 states	Accounts Officer
Sept-Start-up Funds, Partners Meeting, work plan preparation, Pharmacy Officer hired	Feb Supplementary Proposal to USAID/OGAC for restoration of funds for year 2	Apr- Proj Yr 3 begins: (Apr 06 - Mar 07)	Mar- Didactic Training for Hospital Pharmacists in new sites; Resignation, Disengagement of Data Manager –	Feb- Apr – Next round of Onsite Best Practice Training in new sites
Oct-Dec Assessments of Health Facilities in States	Jan to Feb-Official Engagement of State Coordinators for HUCE/PACE and set-up of State Offices	Jun -Aug Field Externships of Pharmacy Students (Howard, UNC)	Apr - Project Year 4 begins: (Apr 07 – mar 08), Disengagement of Staff	Mar-Centralized Training of Pharmacy Support Staff, work plan approved, budget in progress
Oct-Nov Cooperative Agreement; 1 st Tranche	Mar- State Coordinators Team Meeting; Draft of Pharmacy Best Practices reviewed for field testing	Sept –skill certification training on HIV/AIDS, STI, OI for CPs,	Apr-Jun– Onsite training on Best Practices for Pharmacists in new sites	Apr- Proj Yr 5 begins: 15 months (Apr 08 - June 09)
Nov- GHAIN Project launch– HQ TA to field	Apr-May - Initiating training & development & use of HUCE/PACE database system	Nov - M&E Pharmacists Technical review Meeting, Yr 3 funding received, PD Chairs National Conference of Pharmaceutical Society of Nigeria; Skills Enhancement Workshops in 6 focal states	Jun – PMTCT Training for CP to supervise PMTCT sites	
Dec- USAID Compliance Training; establishment of Bank Accounts, initiating structure of HUCE/PACE team, training curriculum. Notice of Reduction in Award	May - Hospital		Jul - Recruitment of Pharmacy Specialists	

Pharmacy
Consultant
Hired; ARV services
activation in
facilities; Advocacy
Visits in states

(PS) and (M&E)
Pharmacists;

Sept-Training for
pharmacy staff in
NiDAR sites,

May -Jun - Physical
Upgrade of
Pharmacies,
installation of Best
Practices

Oct- Proj Yr 4 signed
approving work plan
& budget;
partnership extended
through LOP

Jun- Sept Onsite
training on
Pharmacy Best
Practices in 6 focal
states

Jun - Aug - Project
Yr 2 begins: 8
months (Aug 05 -
Mar 31 06) –
stipulates
partnership
continues through
April, 2009

Aug– Sept –
Community

Pharmacy/Pharmacists Assessment

Oct– Publication of Pharmacy Best Practices Manual

Dec –finalize NIPRD subcontract

	2004	2005	2006	2007
GLRA	Oct GLRA/GHAIN AGREEMENT agreement signed	Apr Orientation Workshop for officers carrying out TB/HIV activities May Induction Workshops in CRS & Lagos State; Workshop with PLWHA Group; TB-HIV Awareness Workshop. MoU between the Lagos State Ministry of Health and the German Leprosy and TB Relief Association was signed; comprehensive 5-day	Jan A Strategic Planning Meeting to map out GLRA activities for the year; Implementation of TB/HIV activities in Anambra State Feb stakeholders' meeting involved in TB/HIV Feb Technical Review Meeting Lagos State and Edo States; Hand-Over of Project Motor-bikes	Oct GLRA/GHAIN amended agreement was signed

Laboratory Workshop was held	Feb Assessment of General Hospital Calabar (GHC) for possible
Nov -Development of SOP for GHAIN TB/HIV activities by GLRA Medical Advisors	Introduction of TB Microscopy Medical Services;
Nov TB/HIV Integration within GHAIN; meeting of the GHAIN Medical Services Department, M&E and GLRA was convened to address TB/HIV integration within GHAIN.	Retreat on Universal Access HIV/AIDS Care in CRS; Meeting with Stakeholders (CRS) GLRA represented in GHAIN Office, Abuja by a GLRA Medical Consultant; TB in Lagos Slums planning meeting
Dec-TB/TB-HIV Management Workshop for doctors and GHWs in General Hospital Calabar (GHC); TB/TB-HIV Refresher Workshops conducted in 5 health facilities; GLRAs budget and work plan was approved by GHAIN	Mar TB/HIV Workshops for 62 General Health Workers (GHW) involved in the GHAIN project; TB/HIV Workshops
	May-Jun TB/HIV

Training Workshop
in

Jun- The CRS
Assessment for
Universal Access,
TB in Lagos Slums
meeting,

Oct and Dec
Induction
workshops on
TB/HIV joint
activities

Nov Counseling &
Testing Training for
DOTS Providers;
discussions with the
program coordinator
for tuberculosis

	2004	2005	2006	2007	2008
AXIOS	Nov/Dec Prepared forecasts for COP04 and COP05 and got approvals with FHI & UMD and USAID Obtained NAFDAC	Jan-Mar Conducted Orientation/Sensitization for Pharmacist Workshop Jointly with other GHAIN Partners; participated in the			

<p>waiver & tax exemptions to facilitate procurement.</p>	<p>general assessment of facilities in Abuja; Engaged CHAN–Pharm as the warehousing and distribution vendor.</p>
<p>Start up stocks that match enrollment plan successfully negotiated with suppliers, and timely delivered by end of Dec.2004.</p>	<p>Apr-Jun Developed and installed Logistics Management System at the facilities; Conducted 6 training workshops conducted in (one per state) for 105 staff from 14 hospitals in core functions of ARV and other drugs logistics management</p> <p>July-Sept Commenced orders for generic ARVs drugs following approvals of the COP 05 forecast; Minor renovations were carried out at the Abuja Central Medical Store</p> <p>Oct-Dec Arranged with GSK the training of 22 clinicians</p>

on the hypersensitivity of
Abacavir;
Co-facilitated training
session on Logistics
Management
Information Systems for
the FMOH.
Made presentation on
‘Scaling up access to
ARVs requires efficient
drug delivery systems
and supply management:
A case study from
Nigeria’

2. GHAIN PARTNERS' TIMELINES FROM JUNE 2008 TO SEPTEMBER/OCTOBER 2010

1. FHI Timeline: activities undertaken since June 2008	
Timeline	Milestone
2008	
	Osun and Borno Zonal Offices established
2009	
	Health Policy and Systems' Management department fully operational to anchor HSS related implementation
	AHNI established and managing GHAIN project implementation in two zones – Lagos and the FCT
	Early Infant Diagnosis laboratory in Jalingo, Taraba State fully operational
2010	
	HAST project established in 9 new LGAs increasing the number of LGAs supported under HAST program to 15
	MDR TB laboratory situated at Lawrence Henshaw Memorial Hospital, Calabar established and operationalized
	Additional 9 ART sites activated [originally PMTCT sites] and providing HIV/AIDS comprehensive care and support services
2010-2011	
	Activities for COP 09 implemented according to USAID approval, targets achieved. COP 10 obligated activities currently being implemented until June 2011

2. AXIOS Timeline: activities undertaken since June 2008	
Timeline	Milestone
July to Sept. 2008	a) Transition of Logistics to GON/NACA -participated in NACA LMIS training. Operationalized the Anambra Program b) Integration of Logistics Mgt. Information System in to the District Health Information System commenced.
Oct- Dec, 2008	a) Transition continued with on site training of HF staff on CRIDDAR – GON reporting system
Feb.2009	Destruction of expiries by GON at NAFDAC dump site.
April 2009	Pooled procurement of all first line ARV drugs & CTX.
May 2009	Strategized with FHI on the following; Mgt of new expiries Mgt of supplies from diff. sources Monitoring of commodities with high months of stock.
June 2009	Supplies of ARV drugs extended to 8FMC GHAIN project extension for 2years approved – contract signed.
Aug.2009	- Adequate quantities of tenofovir and truvada were pushed out to encourage usage by new patients.
Nov.2009	- Short dated reagents received from NACA
Feb- Mar.2010	USG initiated disposal of expired ARVs through AIDSTAR -One
June -2010	-Destruction of expiries at Boskel, PH - Expansion/Improvement of warehouses commenced to meet program growth
July –Sep 2010	Refresher training on LMIS reporting using the National System conducted, 214 pharmacists & Lab scientists trained Change to mSupply inventory mgt system commenced.

3. HU-PACE Timeline: activities undertaken since June 2008	
2008	Milestone
June	Retirement of the pioneer Project Director and appointment of HUCE Director as Interim Project Director
July	ARV Dispensing and Documentation training for Pharmacy Technicians and pharmacy support staff
July - September	Pharmaceutical Care in HIV/AIDS, Pharmacy Best Practices and HAST trainings for the new and some old sites
July - September	Service activation and start-up monitoring and mentoring
July - September	New sites' assessments, physical upgrades, and pre-activation orientations
August	Acceptance of the evaluation of clients' satisfaction with HIV palliative care services provided by HU-PACE trained community pharmacists for presentation at the 2008 AIDS Conference in Mexico in August 2008
September	Best practices and lessons learnt from the HU-PACE/GHAIN Pharmacist Volunteer Scheme (HPVS) was accepted for presentation at the November 2008 ICASA conference in Senegal
September	Recruitment of 11 new members of staff (Pharmacy Specialists (PS) and Monitoring and Evaluation (M&E) Pharmacists)
October	Engagement of Senior M&E Pharmacy Manager for Operational Research and Pharmacovigilance at the Country Office
October	Constitution of the GHAIN Pharmacovigilance multidisciplinary team led by HU PACE
October	Advocacy to National Agency for Food and Drug Administration and Control (NAFDAC) and other key stakeholders on the implementation of ART Clinical Pharmacovigilance in GHAIN supported sites
October - December	October to December - New sites assessments, physical upgrades, pre-activation orientations, trainings and service activation
October - December	October to December - Pharmaceutical Care in HIV/AIDS, Pharmacy Best Practices and HAST trainings for the new and some old sites Development of Active Pharmacovigilance of ARVs concepts, standard operating procedures, training curriculum, job aids and tools
October - December	ARV Dispensing and Documentation training for Pharmacy Technicians and other pharmacy support staff.
November	Training of Community Pharmacists volunteers to provide pharmaceutical care services at the community level in support of the integrated HAST model

November	Interim Project Director visited the Country Office for discussions on the project with GHAIN senior management and meetings with stakeholders
November	Training of project staff on Drug Logistics Management Information System
November	Presentation on the roles of Community Pharmacists in public health Programs at the Annual National Conference of the Association of Community Pharmacists of Nigeria
December	Deputy Project Director represented GHAIN and made a presentation on “ <i>Influence of a Global Public Health Program, PEPFAR, on Hospital Pharmacy Advancement in Nigeria</i> ” at the Annual Clinical Meeting of the American Society of Health System Pharmacists (ASHP) in Orlando, Florida
2009	
January - March	Medication adherence counseling and SOP trainings for PMTCT facility staff
January - March	New sites’ assessments, physical upgrades, pre-activation orientations, trainings and service activation
January - March	Pharmaceutical Care in HIV/AIDS, Pharmacy Best Practices and HAST trainings for the new and some old sites
January - March	HU PACE conducted pre-service training, and clinical rotation supervision for intern pharmacists from National Assembly Clinic
January - March	ARV Dispensing and Documentation training for Pharmacy Technicians and pharmacy support staff.
April	Development and production of the first training manual on ART Clinical Pharmacovigilance for healthcare professionals in Nigeria (done in collaboration with National Agency for Food and Drug Administration and Control (NAFDAC) and National Drug Safety Committee)
May	Training of trainers on ART Clinical Pharmacovigilance for healthcare professionals
	Start-up of the pilot implementation of a active pharmacovigilance of ARVs using electronic medical record system (LAMIS) as database support in Maitama District Hospital
June	Initiation of the scale up of active ART Clinical Pharmacovigilance in the 2 nd Comprehensive ART sites (FMC Owo) and sensitization of facility staff on active surveillance of adverse effects of ARVs.
July	Technical Report on Clinical pharmacovigilance of Antiretroviral therapy at Maitama District Hospital, Abuja was produced
July	Medication Adherence Counseling and SOP training for staff of the PMTCT –standalone sites
July - August	Organized and conducted certification for volunteer Pharmacists based on the length of time served to acknowledge the selfless services provided at GHAIN supported sites.
August	HU PACE cedes its staff in FCT and Lagos zonal offices to FHI/AHNI
July - September	Development of Pharmacy/Commodity/EDP module of integrated HSS/HAST training curriculum/tools

July - September	Staff from Hygeia supported sites trained on the use of the pharmacy documentation and reporting tools whose development were pioneered by HU PACE
July - September	Sensitization of Patent and Proprietary Medicines Vendor License holders in HAST LGAs
October	Facility pharmacists feedback and peer review meetings
October	Retirement of HUCE Director and Interim Project Director of HU PACE – GHAIN
October	Transfer of HU PACE from Continuing Education to Provost Office under the leadership of Dr Alvin Thornton, Provost and Chief Academic Officer, as new Interim Project Director of HU-PACE
October - December	Review of training curricula and modules for Pharmaceutical Care in HIV/AIDS and Pharmacy Best Practices
October - December	Akwa-Ibom state government engaged HU PACE trained community pharmacists to support facility pharmacists
2010	
January	Pharmacy Technicians from supported sites retrained on ARV Dispensing and documentation
January - March	Pharmaceutical Care in HIV/AIDS retraining for pharmacists using revised modules, general quality audit in all sites
February	Training of Staff of Federal Medical Center, Owo on ART Clinical Pharmacovigilance in preparation for the implementation of active surveillance of adverse effects of ARVs
February - March	HU PACE conducted pre-service training, and clinical rotation supervision for intern pharmacists from National Assembly Clinic
March	Interim Project Director and HU Senior Advisor to the President for Academic and Strategic Initiatives and the Project Coordinator visited Nigeria for meetings with GHAIN management and key stakeholders
March	Staff disengagements, recruitment and transfers
March	Commenced quarterly feedback and peer review meetings of facility and community pharmacists with State Directors of Pharmaceutical Services
March	Site assessment of selected PHCs in preparation for take off of PMTCT services
March	Retraining of Trainers for PBP, Pharmacy Best Practices re-trainings for sites using revised curricula commences
April - June	More facility staff trained on PMTCT Adherence Counseling
April - June	Pharmacy Best Practice retraining for old sites using reviewed curriculum
April – May	HU-PACE conducted pre-service training and clinical rotation supervision for another batch of intern pharmacists from

	National Assembly clinic
May	Participated in the review of the curriculum for the mandatory continuing professional development for pharmacists in Nigeria with Pharmacists' Council of Nigeria
June	Formal request from top management of GHAIN for HU PACE to handle drug inventory control at the facility level in all supported sites
June	Participated in the development of harmonized national training curriculum of pharmacovigilance by NAFDAC and key stakeholders
August	Acceptance of the results of the evaluations on the health-related quality of life and medication adherence of HIV-infected patients receiving antiretroviral therapy in GHAIN supported site for presentation at the ISPOR 13th Annual European Congress in Prague, Czech Republic in November
August	Pharmaceutical Care in HIV training for state Directors of Pharmaceutical Services (DPS).
August	Training of trainers on pharmacy best practices for all DPS and consultants
August	Retraining of facility staff on Pharmacy Best Practices using revised curriculum
October	Training of Staff of four more facilities on ART Clinical Pharmacovigilance in preparation for the implementation of active surveillance of adverse effects of ARVs

4. German Leprosy Relief Association Timeline: activities undertaken since June 2008	
Timeline	Milestone
Throughout	Quarterly review meetings of GHAIN Zonal TB/HIV focal persons
2008	Amendment of GLRA GHAIN agreement
July 2008 onwards	Supervision and onsite mentoring for staff of GHAIN supported facilities in 15 southern states
2 - 3 July 2009	NTBLCP Planning cell meeting
July 2009	Development of draft concept paper for Infection Prevention and Control (IPAC)
4 - 6 August 2009	3-day review of the HSS/HAST training curriculum
10 - 20 August 2009	Integrated HAST training of HCW and Community volunteers
August 2009	Development of training modules for Infection Prevention and Control trainings
9 - 11 September 2009	Sensitization and training of zonal managers and focal persons on IPAC
September 2009	Development of draft IPAC assessment tools
23 - 25 September 2009	Training of medical officers from supported facilities on the management of smear negative tuberculosis
23 - 28 November 2009	Training of selected medical officers on management of Multi Drug Resistant Tuberculosis (MDR TB)

APPENDIX C. PERSONS CONTACTED

Please note that during the end of project evaluation field trips to northern and southern states names of individuals were not always recorded, while their job description or role (e.g. community volunteer or Support Group member) was. This has resulted in a large number of people being identified solely by their designation and not by their name.

1. MEETINGS IN ABUJA

USG Nigeria

Carl Hawkins, USAID HIV/TB: HIV/TB Team Leader
Trevor Rittmiller, USAID HIV/TB: Deputy Team Leader
Lungi Okoko, USAID/HIV: SI Advisor
McPaul Okoye, USAID/HIV (member of the EOP Evaluation team)
Emeka Okechukwu, USAID/HIV (member of the EOP Evaluation team)
Joseph Monehin, USAID/HIV (member of the EOP Evaluation team)
Akin Atobatele, USAID/HIV (member of the EOP Evaluation team)
Pamela Gado, USAID/HIV
Otse Ogorry, USAID/HIV-TB
Abiye Kalaiwo, USAID/HIV-TB: Sexual Transmission Program Mgr
Kalada Green, USAID/HIV/TB
Olubunmi Dili-Ejinaka , USAID/HIV
Onyih Egbogu, USAID/HIV
Gbemi Kehinde, USAID/HIV
Hamzat Shuaibu, USAID
Doreen Magaji, USAID (Treatment)
Dr. Temitayo Odushote , USAID TB Advisor (KI)
Philomena Irene , USAID (OVC)
Sharon Epstein, HPN Team Leader
John Quinley, HPN Senior Health Advisor
Kayode Morenikeji, RH Program Manager
Dolapo T. Ogundchin, Program Manager, PMTCT
Abu Ugbede, Pharmaceutical Commodities' Logistic Manager
Jerry Gwamna, CDC: Prevention Lead
Aina Anthonia, CDC: Program Specialist HCT/Prevention
Muhammad Mukhtar, CDC SI Program Manager
Kate Anteyi, CDC: Care
Dr Tony Okwuosa, CDC: Treatment
Dr Ahmad Aliyu, CDC: M&E (contributor to EOP Evaluation team)

GHAIN Country Office staff members

Dr Otto Nzapfurufundi Chabikuli, Country Director and GHAIN Chief of Party
Robert Chiegil, Deputy Chief of Party Management
Dr Lilian Anomnachi, Director Communication and Knowledge Management
Nkata Chuku, Director HP & SM
Cartier Simon, AD Medical Services (community)
Mohammed Liman, AD Malaria TB/HIV, CVD
Bolatito Aiyenigba, AD, Research and PHE (M &E)
Oluyinka Ajayi, AD Program Management
Ben Igbinsosa, Director IT & Admin
Simpson Tumwikirize, Ag Director Programs
Richard Msowoya, AD, HP & SM
Dramane Coulibaly, Compliance Manager
Bill O'Callaghan, AD Finance
Samson Chesseret, AD, Procurement /Contracts and Grants
Paul Iyaji, Pharmacy Specialist/Data Manager
Muhammad Alfa Isah, SPM
Agu Kenneth, Snr Project Manager Pharmacy
Ngozi Ezema, Ag AD Program Management
Gloria Onyeabor, AD Programs Management
Chiho Suzuki, Dir M & E
Ignatius Mogaba, AD M & E
Oluwasanmi Adedokun, SMEO Health Informatics
Henry Ayuk, Snr AD HPS M
Dr Henry Mbah, Director Lab
Tim Lockhart, Director Shared Services
Humphrey Musuluma, AD Lab
Abidemi Fasanmi, AD Health Promotion, (Comm. & KM)
Solomon Odafe, AD Medical Services, Care and Treatment
Dr Mohammed Ibrahim, Director Medical Services
Shehu Salihu, AD Tech Document and Knowledge Mgt
Gbolagade Falade, Snr Waste Management Officer
Michael Odo, AD Medical Services
Amina Abba Gana, Snr Database Officer
Frankline Echeruo, GIS Officer
Dr Eric Lugada, Country Director, Axios Foundation
Lubega Joseph, Technical Director, Axios Foundation
Gbenga Peters, Director, SCM/Operations, Axios Foundation
Dr. Dorothy Oqua, Deputy Project Director Howard University
(HU-PACE)
Ikechukwu Ezekpazu, TB/HIV Advisor, GLRA

National AIDS & STI Control Programme

Dr Wapada Balami: National Co-ordinator
Dr Evelyn Ngige: Head of Prevention (incl. PMTCT)
Dr Chisma Mulazue: FP & TB/HIV Collaboration

National Agency for the Control of AIDS

Dr Kayode Ogungbemi: Director, Strategic Management/GFATM (KI)
Dr Akudo Ikpeazu: Director, Programs (KI)
Dr Louis Edema, M&E Focal Person

National Primary Health Care Development Agency

Dr Nnenna Ihebuzor: Director, Community Health Services

2. NORTHERN FIELD TRIP: PEOPLE MET

St Mary's Catholic Hospital, Gwagwalada, FCT

Reverend Sister Bibiana Madugba: Hospital Administrator
Donatus Kolbe Amuzue: Site Co-ordinator
Reverend Sister Janet Ayim: Matron
St Christiana Ekechukwu: Adherence Counsellor
Jacob Tachio: Referral Co-ordinator and Records' Officer
ART Co-ordinator
Lab staff
PMTCT Coordinator
Pharmacy staff
Members of SMCH Support Group

Maitama District Hospital, FCT

ART Co-ordinator
Medical Records' Officer
Mr Ola Aruwajoye: Referral Co-ordinator/HCT Counsellor
Elizabeth Achumia: HCT Counsellor and nurse
TB/HIV Focal Person
Members of Support Group

FACA

Dr Kasimu Tanko Zachari: FACA Project Manager

GHAIN FCT zonal office/AHNI

Solomon Pai: GHAIN FCT Zonal Officer
Yahaya Ibrahim: FCT Program Officer
Nana-Ann Dutse: SBC Officer
David Adewole: Senior Health Policy & Systems Advisor

Suleja General Hospital, Niger State

Dr Hussaini Yabagi: Head, Hospital Services (and previously Site Co-ordinator)
Olufemi Lucas: HOD, Laboratory
Halima Ahmed Aboki: HOD, Nursing
Buhari Mohammed: HOD, Medical Records/M&E
Abubaka JD Abuchi: HOD, Stores
Abdullahi Yakubi: Hospital Secretary
Nsemam Umoh: HCT Counsellor
Mrs Sarah Audu: Focal Person, HCT
Members of SGH Global Support Group

Kotangora General Hospital, Niger State

Dr Fatima Gimba: Site Co-ordinator
Dr Musa: HHS
Nasiru Bala: DOTS Focal Person
Pharmacist Musa Abdul: HOD, Pharmacy
Al Haji Jibrin Aini: M&E Focal Person
Usman N Mohammed: SAO
Yusuf Ubanisoma: Triage Nurse
Helen Gamba: Referral FP [?]
Aisha Gono: PMTCT
Ahmed M Ladan: Lab
Halima Yahada: HCT Focal person
Buhari Mohammed: GHAIN Facility Consultant [financial management]
Abdullahi Baran: Hospital Secretary

Hassana T Zalci: RH/HIV/FP
Dr Adebayo: Asst HHS & ART Focal Person
Asabe Chioma: HCT Counsellor
Members of the Support Group

Minna General Hospital, Niger State

Dr Edison Okorie: Site Co-ordinator
Dr Ndeji Yusuf: Acting Medical Director
Chief Nursing Officer Ndagi A. Dzukogi: HCT Focal Person
Helen Cebawaza: HCT Counselor and registered nurse/midwife
Pharmacist Muhammed Muhid: Focal Pharmacist ART
Pharmacist Hamza: HOD, Pharmacy
Umar Umar: Referral Co-ordinator
A. A. Gomdea: M&E
And others
Members of the Support Group

GHAIN North Central zonal office

Dr Usman MD Gwarzo: GHAIN Zonal Manager

Kachia General Hospital, Kaduna State

Dr Ibrahim Sule: Project Manager (site co-coordinator)
Rahila D Kware: Program Officer and Referral Co-coordinator
Regina AL Kwagau: Matron i/c
Victor John: Facility support staff (GHAIN seconded, for financial management)
Daniel Zakaria: PMM Officer
Christopher Joseph: Data Entry Clerk
And others
Members of the Support Group

Kachia LGA PHC Department

Deborah J. Mukaddas: Director, PHC & HAST Program Manager
Peter A Yusuf: Supervisory Councilor, Health
Phoebe Saibu: APHCC & Essential Drugs' Officer
Veronica T Bagobiri: APHCC Medical
John Peter: Assistant, M&E
Angel A Sheyin: APHC Disease Control Officer

Kachia HAST LGA

Traditional leaders
Members of FOMWAN (Kachia HAST LGA umbrella CBO)
Members of the four partner CBOs: Orphans' and Mothers' Society; Widows; Zunnita Foundation; and Humanitarian Assistance for Women and Children
Peer Educators
Community Volunteers

Sir Yahaya Memorial Hospital, Kebbi State

Dr Jaffar Augie Muhammed: Medical Director
Jaffar Umar: Referral Coordinator
Dr Bunza: Project Officer
Amina Mohammed Muroro: HCT Counselor
Zayyanu Umar Dansola: GHAIN support staff seconded to SYMH
Gero Abdulahi: HIV R/M&E Focal Person
And others
Members of the Support Group

Federal Medical Center Birnin Kebbi, Kebbi State

Khalidu Abubakar: Head Counselor and Referral Focal Person
Dogara Yohana: Counselor
Dr. Aisha Nana Adamu: Acting Head of Clinical Services and Obstetrician/ Gynecologist
Abbas B. Muhammed: Head of Administration
And others
Members of the Support Group

Sokoto Specialist Hospita, Sokoto State

Dr Namadina Ibrahim Muhammed: CMD and Project Manager
A. Abubakar: Director, Admin
Aliyu A. Umaru: DDNS
Dr Nuhu Maishanu: Head of Clinical Services
Amin Muhammed: Project Officer
Abubakar S. Fada: Referral coordinator
Elias Aliyu: Project Finance Officer
Hajia Zainab Galadina: Financial Director
Al-Haji Tukur Sanyinna: DD, Pharmaceutical Services
And others
Members of the Support Group

GHAIN North West Zonal Office

Dr Labaran: Zonal Project Manager
Aminu Sarki: Senior Zonal Program Officer
Taije Babarnusa: Program Officer
Umar Abubakar: Community Health Officer
Muhammed Suleiman: SBCC Officer
Dr Hamza: Senior Medical Services' Advisor
Dr Boniface: Clinical Officer
Surajadeen Abdulrahman: Senior M&E Officer
Tanko Mohammed Langaya: Zonal HCT Officer
And others

Sokoto SACA and SASCP

Haliru Yusufu: State HIV & AIDS Coordinator (SASCP)
Mainasua Bello: M&E Officer (SASCP)
Nasiru Yahaya Isa: PM SOSACA
Suleiman Abdulahai: SACA M&E Officer

Wamakko LGA PHC Department

Abubakar Kaura: Director, PHC Wamakko
Mallam Muhammed Usman: Deputy Director PHC & M&E Officer

Wamakko HAST partner CBO: Lokobi Awareness and Mobilization Association (LAMA)

Lahi Jekeda: Project Coordinator
Lawal Zagi: Project Officer
Buda Muhammed: M&E
Garba Muhammed: Accountant
Peer Educators
Nafisa Tukur; Adama Muhammed; Jamila Almu; Faruk Abubakar; Gazali Jibrim; Maryam Muazu

LAMA Community Volunteers (Gumbi)

Aduki Buba (female, TBA); Bello Adamu; Isa Magadji; Ibrahim Mohammed

Gumbi OVC caregivers

Abubakar Galadima (Gidan Rimi, Gumbi), Hauwa Mohammed, Mohamaed Garban Dede, Yargande Nomau, Abubakar Gado, Hafsatou Umaru, Mohammed Abubakar, Ige Umaru, Aminu Shehu

Save the Child Initiative (Wamakko HAST umbrella CBO)

Abdulganju A Abubakar: CEO/Project Manager
Sheftina Mustafa: Project Accountant
Paulinus Onabe: Senior Program Officer
Yunusa Usman: Logistics' Officer
Bilyaminu Yakubu: Data Entry Officer (HAST)
Ofumne Onyinye: Project Officer
Muhammed Garba: Secretary/Project Officer (HAST)
Onjia Ebere: Human Resources' Officer
Rabiu Bello Gandi: M&E Officer (HAST)
Kauna Support Group members

Community Pharmacist, Sokoto

FMC Jalingo, Taraba State

Dr Idris Balasa: Medical Director
Dr Aisha S Adamu: ART Site Co-ordinator
Auzurta Ayuba: Facility Support Officer (GHAIN seconded)
Adamu Umar: Referral Focal Person
Dr Arinze Egboga: Head, Clinical Services
And others
Members of the Support Group

Taraba SACA and SASCP

Chief Dr Duwe: Permanent Secretary/State Coordinator, SACA
Dr Madaki M Micah: MOH AIDS Program Coordinator, SASCP

Yola Specialist Hospital, Adamawa State

Dr AP Amdzaranda: Acting Medical Director
Dr Laori Celime: ART Coordinator
Sunday H Chama: Director of Administration
Solomon Paive: ADMLS [?]
Sadiq Nasiru
Adamu Gidado: Referral Focal Person
And others

Farah N James: Coordinator, Spring of Hope Support Group
Members of the Spring of Hope community and the YSH Support Group

GHAIN North East zonal office

Julius Chinedu: Zonal Manager
Elizabeth Akor: Senior Program Officer
Ahmed Bolla: HCT/PMTCT Officer
Lan Terhembra: Senior Medical Services' Advisor
Monday L Danung: Senior Logistics' Officer
O. Guahadia: Axios Officer
Bennett Urama: Program Officer, Drugs' Logistics
Chidi Agbaraji: Senior M&E Officer
And others

3. SOUTHERN FIELD TRIP: PEOPLE MET

Ajeromi-Ifelodun Local Government Area [HAST LGA]

The participant sign-in sheet has disappeared but the meeting was well attended by LGA elected officers and staff, and the LGA Health Committee [volunteer committee]

Amukoko Partners for Health

Dr Bosun Babajide, Chairman/Project Director
Elder Odewale Michael, Accounting Officer
Data clerks
Peer Educators
Community Volunteers

Association of Community Pharmacists of Nigeria

Pharm. Jerome Nwokoro, National Treasurer
Pharm. Felix Anieh, Chairman ACPN, Lagos State
Pharm. Gbolagade Lyiola, Publicity Secretary
Community Pharmacist /ACPN members
Two patent medicine dealers [not ACPN members]

Community Health Project Ajeromi

Staff and volunteers

Community Health Project Amukoko/St Thomas PHC clinic

Sr Grace Akpan, Monitoring and Evaluation Officer
Mr Adrian Imhankobe, Accounts Officer
Mrs Alaigbogun Mary, Community Health Worker DOTS
Mrs Agnes Nwaka, Community Health Worker DOTS
Miss Ese Okorobiebi, Project Officer/HCT [Community Health Worker]
Miss Oluwadar Adenike, [Community Health Worker] HCT
Mrs Ibeh Chimwe Mary, [Community Health Worker] PMTCT

General Hospital Ajeromi

Dr S Babatunde O Oluseye, Medical Director
Clinical and support staff (not physicians as on strike) in

- HCT
- ART clinic
- PMTCT
- TB-DOTS
- Main Hospital laboratory
- ART laboratory
- TB laboratory
- Medical records
- Pharmacy

Better Life Support group members

General Hospital Isoro

Dr A Kunle Ogunlana, Chief Consultant Surgeon, Medical Director In-charge
Dr Akpan Auram-Essien, ART coordinator [came in for evaluation although on strike]
Clinical and support staff in

- ART clinic
- PMTCT
- TB-DOTS
- ART laboratory
- Medical records

- Pharmacy
- Total Care support group members

GHAIN Lagos Zonal Office

Dr. Susan Kanu, AHNi/GHAIN Zonal Manager
 Uju Edebeatu, Senior Program Officer
 Baruwa Sikiru, Senior &E Officer
 Amaka Dennis, Senior Finance and Admin Officer
 Olufunmilay Ojo. Senior Lab Officer
 Dr Ansle Audu, Senior edical Services Adviser

Lagos State Government

Adejumobi AA, HIV Monitoring and Evaluation Officer
 Dr. Oduwale Abiodun, Programme Officer for HIV, LMOH/LSASCP
 Mrs. Oshinowo-Bashorun O.O. PMTCT Focal Person, LMOH/LSASCP
 Michael Essien, Project Officer LSACA
 Dr Olusegun Ogboye, Head Project Office, Project Manager LSACA
 Dr Dayo Lajide Senior Project Officer, LSACA

Life Link CBO, Ikeja

Dr Dora Oforbrukweta - Project Director
 Ese Akpojotor - Program Officer
 Dr Regina Akpan and Maureen Chukwuemeka - M&E staff

Mainland Hospital, Lagos

Dr Olufemi O Onanuga, Medical Director
 Clinical and support staff (not physicians as on strike) in

- ART clinic
- TB-HIV
- ART laboratory
- Medical records

Mainland Hospital Support group members

State Hospital Ota, Ogun State

Dr. B.F. Banuso, Chief Medical Director
 Mrs G O Ayoinde, Chief Nursing Officer
 Clinical and support staff (not physicians as on strike) in

- HCT
- ART clinic
- PMTCT
- TB-DOTS
- ART laboratory
- TB laboratory
- Medical records
- Pharmacy

Hope is Vital support group members

State Hospital Asubiaro, Osogbo, Osun State

Clinical and support staff (not physicians as on strike) in

- HCT
- ART clinic
- PMTCT
- TB-DOTS
- ART laboratory

- TB laboratory
 - Medical records
 - Pharmacy
- Support Group members

Abudu, Orhionmwon LGA [HAST LGA], Edo State

Dr Daniel Aromeh Odekina, PHC Coordinator
 Odiase Otasdwie Juliana, PHNO, Ute-Oheze PHC
 Community Volunteers , Ute-Oheze PHC

Central Hospital, Benin City

Dr Oriakhi M O, Medical Director
 Clinical and support staff (not physicians as on strike) in

- HCT
- ART clinic
- Pediatric ART clinic
- PMTCT
- TB-DOTS
- ART laboratory
- Medical records/Patient Management Monitoring
- ART Dispensary

Central Hospital support group members

Central Hospital Uromi

Dr Lawani O L Site Coordinator
 Mrs S A Obedeomosen Adherence Counselor
 Clinical and support staff (not physicians as on strike) in

- HCT
- ART clinic
- PMTCT
- TB-DOTS
- Main Hospital Laboratory
- ART laboratory
- Medical records/ Patient Management Monitoring
- Pharmacy

God is Able support group members

Edo State Government

Mrs Nogi Igbinoba, Project Manager Edo SACA
 Mrs. Agbadua. Edo SMOH/SASCP
 Dr. Irowa, Edo SMOH/SASCP

General Hospital Abudu

Dr G I Ordia, Zonal Medical Director/Site Coordinator
 Clinical and support staff (not physicians as on strike) in

- HCT
- General Medical outpatients [not an ART clinic day]
- Hospital laboratory ART laboratory integrated
- Medical records/ Patient Management Monitoring
- Pharmacy

Abudu Support Group members

GHAIN Edo Zonal Office

Dr Irene Osaigbovo

Ekwelem Chuku[...]meka, Senior Monitoring and Evaluation Officer
Michael Baeg, Senior Lab Officer
Babatunde Odusolu, Senior Medical Services Adviser
Ajumobi Kayode, Senior Program Officer
Adamus Aigamhe, Senior Finance and Admin Officer

Girls' Power Initiative

Grace Osakakue, Coordinator, PM HAST
Elizabeth Okoojion, Program Officer
Ushiagwu Oliver, GPI, M&E Officer-ABUDU HAST

Planned Parenthood Federation of Nigeria

Dame D O Ekator, Project Executor
Mrs Blessing Ideheen, Project Manager
Nimem Frandcid, Project Accountant
Okonofua Oluireime, M & E Officer
Asemota Henry, Project Assistant

Anambra State Government

Mr Louis Anyason, Acting PM/Executive Director, Anambra SACA
State AIDS Program Coordinator Anambra SMOH/SASCP

GHAIN Anambra Zonal Office

Dr Hilary (Bishop) Ezeh, Anambra Zonal Manager
GHAIN Zonal Staff

National Union of Road Transport Workers, Awka

Officers, project staff and field staff

Saint Charles Borromeo Hospital, Onitsha

Reverend Father Daniel Onuora, Program Manager
Doctors, other clinicians and support staff in

- HCT
- ART clinic
- Pediatric ART clinic
- PMTCT
- TB-DOTS
- Hospital laboratory-ART Laboratory integrated
- Medical records/Patient Management Monitoring
- Pharmacy

God's Care support group members

Society of Women and AIDS in Africa Nigeria Chapter/Anambra Branch

Project staff

Field worker & Peer Educators army barracks brothel, Onitsha

Agbani District Hospital [HAST LGA], Enugu State

Dr Alphons Chunah Eze, Medical Director in Charge
Project Manager and clinical staff in

- HCT
- ART clinic
- Palliative care
- PMTCT
- TB-DOTS

- ART Laboratory
- Medical records/Patient Management Monitoring
- Pharmacy

Nkanu West LGA [HAST LGA]

Hon Barr Ekene Okenwa, LGA Chairman
 LGA elected members
 Dr Chineze Joy Okorowo, Medical Officer
 Nnamani Deuben PHCC
 Ezeugnu Aaron, Assistant PHCC
 Ugwu Patience, M&E officer
 Victoria Ekwedigwe, Social Welfare Officer

Ozalla PHC Clinic [HAST LGA]

Mrs Ani Stella, Principal CHO/ Officer in Charge Ozalla PHC
 Aminwoye Patience, Chief Community Health Technical Assistant

Society of Women and AIDS in Africa Nigeria Chapter/Ozalla Branch

Ezekunie Apollonia, Project Coordinator
 Onyegiri Charity, M&E Officer
 Edeh Modecaih Sunday, Project Supervisor
 Chief Nwonye Emmanuel, WHDC Chairman
 Community Volunteers

Spring of Life

Edeh Nkemdelia, Program Officer
 Chiadi Felix, M&E
 Mrs Agbo Lilian, Coordinator
 Chief Richard I K Nnaji, WDC Chairman
 Community Volunteers

Voice of Children

Rev Sr. Gertrude Ukanwoko, Program Coordinator

Dr Lawrence Henshaw Memorial Hospital, Calabar

Dr Nkereuwem E E. Chief Medical Director
 Mrs Henrietta Wowo, Chief Bursing Officer
 Clinical and support staff in

- HCT
- ART clinic
- Palliative care
- Specialist TB-Laboratory
- Medical records/Patient Management Monitoring
- Pharmacy

General Hospital, Calabar

Medical Director
 Clinical and support staff in

- HCT
- PMTCT
- ART clinic
- Palliative care
- TB-DOTS
- Laboratory

- Medical records/Patient Management Monitoring
 - Pharmacy
- Shelter of Hope support group members

General Hospital Ugep [HAST LGA referral hospital]

Medical Director

Clinical and support staff in

- HCT
- PMTCT
- ART clinic
- Palliative care
- TB-DOTS
- Laboratory
- Medical records/Patient Management Monitoring
- Youth Corper and 3 volunteer Community pharmacists

Health Foundation Support Group members

Cross River State Government

Mrs Loveth Chuckwuran, M&E Officer, SAPC

Mrs Virginia Inah, Head, SAPC

Philomina Omang, HCT Officer, SAPC

Regina A Odey, PMTCT Officer, SAPC

Grace Kekong, HBC/Gender Officer, SAPC

Mary E Amah, HCT Officer, SAPC

Lydia I Ogbeche, Pediatric ART Officer, SAPC

Roseary E Olcan, HBC/Gender Officer, SAPC

Bekpauke G Iwheye-Adie, PO/Pharmacist, SAPC

Project Manager/Policy Director, SACA

M & E Specialist, SACA

Director General

Director of Pharmacy

GHAIN Cross River Zonal Office

Hubert Obule Ogar, GHAIN Zonal Office

GHAIN senior Zonal Staff

Yakurr HAST LGA

Ikwo Okpebri, PHCC

Uduo Bassey, M&E Officer

LGA/PHC staff

Good Shepherd Initiative CBO, Yakurr

Elder Mrs Nkoyo Oka, Program Director

Omini Oini Onew, M&E Officer

Okoi Michael, Field Supervisor

Aki Catherine Omini, Accountant

Etom Okoi Etimita, Project coordinator

Agnes Okoi, Supervisor Group Coordinator

Initiative for People's Good Health CBO, Yakurr

Grace Ibor, Executive Director/ Program Manager

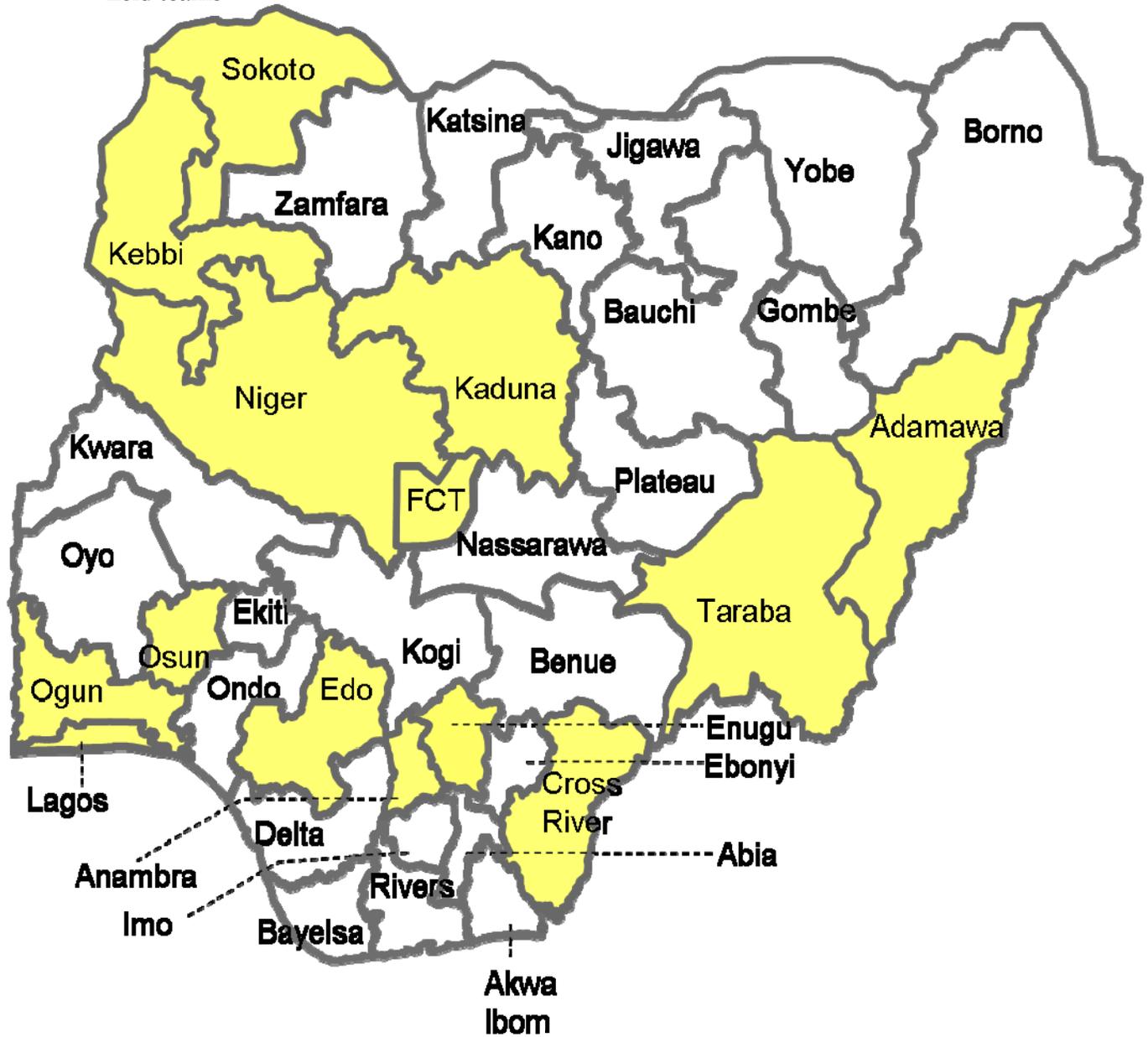
Nnake EtimIta, M&E Officer

Emmanuel Ibor, Project Officer

Other staff & volunteers

APPENDIX D: GHAIN END OF PROJECT EVALUATION ITINERARY

Figure 1: states visited by the northern and southern end of project evaluation field teams



DETAILED ITINERARY

1. Joint Abuja itinerary (1) – for the entirety of the GHAIN end of project evaluation team

Date & time	Activity	Organization/person responsible
Saturday 09/18/2010	International consultants arrive in Abuja	
Sunday 09/19/2010	International team leader arrival in Abuja and International team preliminary planning meeting	International consultants
Monday 09/20/2010	International consultants review documentation	
Tuesday 09/21/2010		
10.00-11.00	In-briefing with USAID Nigeria	USAID
11.00-12.30	Preliminary team meeting. Agenda covers: individuals' skill sets; site selection	USAID
13.30-15.00 & 16.00-18.00	International consultants continue document review	International consultants
15.00-16.00	Preliminary meeting with GHAIN COP & DCOP	GHAIN
Wednesday 09/22/2010		
09.00-18.00	International consultants continue document review; preliminary tools' development; draft site selection criteria	International consultants
Thursday 09/23/2010		
09.00-13.00	First full team meeting. Agenda covers: Abuja meetings; tools development; site selection	EOP/E consultant team
14.00-19.00	Further tools' development and other preparation	International consultants
Friday 09/24/2010		
09.15-18.00	GHAIN presentations	GHAIN
Saturday 09/25/2010		
09.00-18.00	Finalization of draft tools; report structure; consideration of team roles and responsibilities	International consultants
Sunday 09/26/2010	Free day	

Date & time	Activity	Organization/person responsible
Monday 09/27/2010		
08.45-09.30	Meeting to finalize site selection and to discuss SOW	USAID
10.00-11.30	Further tools' preparation	International consultants
11.30-13.00	KII with GHAIN COP & D/COP	International consultants
14.00-15.30	KII with GHAIN COP & D/COP (cont'd)	International consultants
15.30-18.00	Field site selection discussion	GHAIN EOP/E team
Tuesday 09/28/2010		
10.00-12.00	KII w. GHAIN COP & DCOP (cont'd)	International consultants
12.30-20.00	Tools' development (6+2 draft checklists)	International consultants
Wednesday 09/29 2010		
08.30-09.00	Meeting with GHAIN COP	International consultants
09.00-10.00	Meeting with GHAIN M&E Director and Associate Director	International consultants
10.00-10.30	Video conference w. GHAIN Zonal Offices	International consultants & GHAIN staff
10.30-11.15	Meeting w. GHAIN HP & SD	International consultants
12.00-12.45	Meeting w. GHAIN Director, Communications & Knowledge Management & Associate Director, Health Promotion	International consultants
14.30-18.00	Field reporting & report writing discussion. Agenda covers: discussion of field site visit tools, field schedule, team roles	GHAIN EOP/E team

Thursday 09/30/2010		
11.30-13.00	Meeting w. HIV-TB Team	USAID
13.00-14.00	Meeting with Carl Hawkins	USAID
14.00-15.00	Meeting w. HPN Team	USAID
16.00-17.00	Meeting w. Axios staff	International consultants
All public sector offices closed from noon		
Friday 10/01/2010 National public holiday		
International consultants further develop tools, review progress to date		
Saturday 10/02/2010		
International consultants finalize site visit checklists, daily summary sheets & discuss field issues		
Sunday 10/03/2010 Free day		

2. Field Itinerary For Team A (Northern Team)

Date & time	Activity	Organization/person responsible
Monday 10/04/2010		
08.30-13.30	Final preparations for field	Northern GHAIN EOP/E evaluation team
14.00-15.00	Meeting	CDC
15.30-16.30	Meeting	NASCP
Tuesday 10/05/2010		
1 st day of site visits		
10.00-13.30	Site visit to St Mary's Catholic Hospital, Gwagwalada, FCT	GHAIN FCT zonal office & implementing agencies
14.30-17.00	Site visit to Maitama District Hospital, Abuja	GHAIN FCT zonal office & implementing agencies
18.00-19.00	Preparation of Day 1 summary report	Northern GHAIN EOP/E evaluation team
Wednesday 10/06/2010		
11.00-16.45	Site visit to Suleja GH, Niger State	GHAIN FCT zonal office & implementing agencies
19.00-20.30	Preparation of Day 2 summary report	Northern GHAIN EOP/E evaluation team
Thursday 10/07/2010		
08.00-16.00	Site visit to Kotangora GH, Niger State	GHAIN FCT zonal office & implementing agencies

19.00-21.00	Preparation of Day 3 summary report	Northern GHAIN EOP/E evaluation team
Friday 10/08/2010		
08.30-13.00	Site visit to Minna GH	GHAIN FCT zonal office & implementing agencies
13.00-15.30	Travel to Abuja	
16.00-17.00	Preparation of Day 4 summary report	Northern GHAIN EOP/E evaluation team
Saturday 10/09/2010	Document review and completion of week 1 summary reports	Janet Gruber
Sunday 10/10/2010		Northern GHAIN EOP/E evaluation team
13.00-15.00	Travel to Kaduna	
18.00-20.00	Team discussion	
Monday 10/11/2010		
08.00-13.30	Site visit to Kachia GH	GHAIN NC zonal office & implementing agencies
13.30-16.30	Sit visit to Kachia LGA HAST	
19.00-21.00	Preparation of Day 5 summary report	Northern GHAIN EOP evaluation team
Tuesday 10/12/2010	Travel day: Kaduna to Abuja and Abuja to Sokoto	Northern GHAIN EOP evaluation team
16.30-18.30	First meeting with GHAIN NW zonal office	GHAIN NW zonal office
19.30-20.30	Preparation of Day 6 summary report	Northern GHAIN EOP evaluation team
Wednesday 10/13/2010		
08.00-16.00	Site visit to Sir Yahaya Memorial Hospital, Birnin Kebbi	GHAIN NW zonal office & implementing agencies
19.00-20.30	Preparation of Day 7 summary report	Northern GHAIN EOP evaluation team
Thursday 10/14/2010		
08.00-14.00	Site visit to FMC, Birnin Kebbi	GHAIN NW zonal office & implementing agencies
17.00-18.30	Preparation of Day 8 summary report	Northern GHAIN EOP evaluation team
Friday 10/15/2010		
09.00-13.30	Site visit to Sokoto Specialist Hospital	GHAIN NW zonal office & implementing agencies
18.00-19.30	Preparation of Day 9 summary report	Northern GHAIN EOP evaluation team
Saturday 10/16/2010		
09.00-15.30	Field visit to Wamakko HAST LGA	GHAIN NW zonal office & implementing agencies

19.00-21.00	Preparation of Day 10 summary report	Northern GHAIN EOP evaluation team
Sunday 10/17/2010	Free day	
17.00-19.00	Discussion with GHAIN NW zonal staff members on HAST, OVC & HCT issues	McPaul Okoye and Janet Gruber
Monday 10/18/2010		
09.00-10.00	Meeting with Sokoto SACA and SASCP	GHAIN NW zonal office & implementing agencies
11.00-14.00	Travel Sokoto-Abuja	
16.00-17.00	Meeting at USAID (Doreen Magaji)	Janet Gruber
18.00-19.30	Preparation of Day 11 summary report	Janet Gruber
Tuesday 10/19/2010		
08.00-11.30	Field notes' review	Janet Gruber
12.00-13.30	GHAIN presentation at USAID (PMTCT)	GHAIN & USAID
14.30-18.00	Travel to Yola	Northern GHAIN EOP evaluation team
Wednesday 10/20/2010		
07.00-13.00	Site visit to FMC, Jalingo	GHAIN NE zonal office & implementing agencies
14.00-15.00	Meeting with Taraba SACA and SASCP	
18.30-21.00	Preparation of Days 12 and 13 summary report	Northern GHAIN EOP evaluation team
Thursday 10/21/ 2010		
09.00-13.00	Site visit to Yola Specialist Hospital	GHAIN NE zonal office & implementing agencies
13.00-14.00	Meeting with Support Groups	
18.00-19.30	Preparation of Day 14 summary report	Northern GHAIN EOP evaluation team
Friday 10/22/2010		
08.00-11.30	Travel Yola-Abuja	Northern GHAIN EOP evaluation team
13.00-16.00	Meeting at GHAIN FCT zonal office	GHAIN FCT zonal office
16.30-17.30	Preparation of Day 14 summary report	Janet Gruber
Saturday 10/23/2010		
All day	Review of field notes and summary reports	Janet Gruber
Sunday 10/24/2010	Free day	

3. Field Itinerary For Team B (Southern Team)

Date & time	Activity	Organization/person responsible
Sunday 10/03/2010	Rest day	
Monday 10/04/2010 Morning	Preparation for field visits	Team
Monday 10/04/2010 Afternoon	Fly to Lagos	GHAIN/Abuja GHAIN/Lagos Team
Tuesday 10/05/2010 Morning	KIIs Lagos SACA and SASCP	Team
Tuesday 10/05/2010 Afternoon	KII Lagos Zonal Manager & Senior Zonal staff	Team
Wednesday 10/06/2010 Morning	Visit GH Ajeromi KII, Checklists, FGD	Team
Wednesday 10/06/2010 Afternoon	Visit Mainland Hospital KII Checklists, FGD	Team
Thursday 10/07/2010 Morning	Drive to Osun visit SH Asubiaro KII Checklists, FGD	Team
Thursday 10/07/2010 Afternoon	Drive back to Lagos	Team
Friday 10/08/2010 Morning	Drive to Ogun Visit SH Ota KII Checklists, FGD	Team
Friday 10/08/2010 Afternoon	Drive back to Lagos Visit GH Isoro KII Checklists, FGD	Team
Saturday 10/09/2010 Morning	Visit Ajeromi HAST Community Health Project & St Thomas's PHC clinic Amukoko; Amukoko Partners for Health; Assoc. of Community Pharmacists of Nigeria Ajeromi LGA FGDs KII	Team
Saturday 10/09/2010 Afternoon	Community Health Project Ajeromi (A/B) Life Link Ikeja (OP) FGDs	Team
Sunday 10/10/2010	Fly to Benin City Rest day	GHAIN/Lagos GHAIN/Edo Team
Monday 10/11/2010 Morning	Visit GHAIN Edo Zonal Off KII Zonal Manager and Senior Zonal Staff	Team
Monday 10/11/2010 Afternoon	Visit Edo SACA & SASCP KII	Team
Tuesday 10/12/2010 Morning	Visit CH Uromi KII Checklists, FGD	Team

Tuesday 10/12/2010 Afternoon	Visit CH Benin City KII Checklists, FGD	Team
Wednesday 10/13/2010 Morning	Visit GH Abudo KII Checklists, FGD	Team
Wednesday 10/13/2010 Afternoon	Visit Girls Power Initiative (A/B) Planned Parenthood Federation of Nigeria (OP) FGD	Team
Thursday 10/14/2010 All day	Drive to Anambra via Kogi Benue and Enugu states	GHAIN/Edo Team
Friday 10/15/2010 Morning	Visit Anambra SACA and SASCP KIIs Visit SCBH, Onitsha KII Checklists, FGD	Team
Friday 10/15/2010 Afternoon	Visit GHAIN Anambra Zonal Office KII Zonal Manager and Senior staff	Team
Saturday 10/16/2010 Morning	Visit National Union of Road transport workers, Awka Army Barracks Brothel, Onitsha FGDs	Team
Saturday 10/16/2010 Afternoon	Drive to Enugu	GHAIN/Anambra Team
Sunday 10/17/2010	Rest day	Team
Monday 10/18/2010 Morning	Visit Agbani HAST LGA Voice of Children Spring of Life Support Group SWAAN FGDs	Team
Monday 10/18/2010 Afternoon	Visit Agbani DH KII Checklists, FGD	Team
Tuesday 10/19/2010	Drive to Calabar	GHAIN/Anambra Team
Wednesday 10/20/2010 Morning	Visit Cross River SACA & SASCP KIIs Visit GHAIN/Cross River Zonal Office KII Zonal Manager and Senior staff	Team
Wednesday 10/20/2010 Afternoon	Visit DrLHMH KII Checklists, FGD	Team
Thursday 10/21/ 2010 Morning	Visit GH Calabar KII Checklists, FGD	Team

Thursday 12/21/2010 Afternoon	Writing up notes in hotel	Team
Friday 10/22/2010 Morning	Visit GH Ugep KII Checklists, FGD	Team
Friday 10/22/2010 Afternoon	Visit Yakurr HAST LGA FGD Visit Initiative for Peoples Good Health (OVC, SB) Good Sheppard Initiative (OVC, AB) FGDs	Team
Saturday 10/23/2010 Morning	Fly back to Abuja	GHAIN/Cross River GHAIN/Abuja Team

4. Joint Abuja Itinerary (2)

Date & time	Activity	Organization/person responsible
Monday 10/25/2010		
09.30-10.30	KII with FACA	GHAIN FCT zonal office & implementing agencies Ruth Hope, Lucy Shillingi & Janet Gruber
09.30-10.30	KII with FASCP	
11.00-13.30	Meetings with AMAC CBOs	
14.30-19.00	Preparation of field notes	
Tuesday 10/26/2010		
08.30-10.30	Preparation of field notes	Ruth Hope, Lucy Shillingi & Janet Gruber
11.00-13.00	KII at NACA	NACA
13.30-19.00	Continued preparation of field notes	Ruth Hope, Lucy Shillingi & Janet Gruber
Wednesday 10/27/2010		Throughout: Ruth Hope, Lucy Shillingi & Janet Gruber
08.00-20.00	Preparation of outbrief	
Thursday 10/28/2010		Throughout: Ruth Hope, Lucy Shillingi & Janet Gruber
08.30-19.30	Preparation of outbrief	
Friday 10/29/ 2010		
10.00-13.00	Outbrief at USAID	USAID
14.00-15.00	Outbrief at GHAIN	GHAIN
Saturday 10/30 and Sunday 10/31/ 2010	International consultants depart Nigeria	

APPENDIX E. REPRESENTATIVE SAMPLE OF GHAIN END OF PROJECT EVALUATION FIELD TOOLS

A complete set of all field tools is available from the End of Project Evaluation (EOP/E) Team Leader

1. KEY INFORMANT INTERVIEW: GHAIN/ABUJA STAFF QUESTION LIST

For all Qs probe on achievements, challenges, gaps, lessons learned

Q.1 How has GHAIN achieved its objectives of increased use of quality HIV/AIDS and TB prevention, care and support, and treatment services and interventions? What are the particular successes of which you are most proud? What have been the challenges? How were they managed?

Q.2 What have been the major changes required in the program? What measures, activities and (potentially) different approaches have been introduced to address those changes?

Q.3 How has GHAIN worked towards achieving its goal of reduced impact of HIV/AIDS and TB? What are the achievements? What have been the challenges? What are the lessons learned? What will be GHAIN's legacy? What are the plans for the future?

Q.4 How has GHAIN been involved in health system strengthening in the National Programme and at state level? [Probe on the 6 GFATM/WHO principles. HRH planning & systems; HMIS strengthening; procurement & commodities; health financing; planning/policy/management/ governance capacity]. *Also skills transfer? Development of guidelines, training manual/ tools etc? Do you think GHAIN has had influence on policy development?* What sort of impact do you think all such HSS has had on service delivery? How is it being tracked and recorded?

Q.5 How have GHAIN's contributions been institutionalized at national, state and LGA levels? How sustainable are they post-EOP? [Have the job descriptions of MoH staff been changed to include roles and responsibilities that were previously GHAIN staffs' roles and responsibilities? Are there increased budgets for incorporating GHAIN processes/management]?

Q.6 How has GHAIN worked towards increasing health facility capacity to deliver integrated quality HIV & TB services? Is the process still happening? [What is happening with TB services and with FP/RH integration? Is this co-location of services or does one health worker offer integrated services? What is happening with malaria in pregnancy interventions?]

Q.7 Now that long-term survival has been made possible, how has GHAIN supported the transition of services from acute to chronic care in response to the needs of positive clients who need long-term monitoring and treatment? How has this impacted on medical records and HMIS? What systems have been put in place for ensuring follow up? And client retention?

Q.8 How have people living with HIV been involved to ensure the organization of services to best meets their needs? How are clients involved in oversight of services? Are lessons emerging from the HAST LGA model with regard to client participation?

Q.9 If GHAIN finishes tomorrow, what will be the challenges to continued provision of quality services?

What areas will continue to function well?

What areas can serve as resources for scale up/replication elsewhere?

What areas will continue to require external technical assistance?

Are there any gaps that haven't as yet been addressed with GHAIN support?

Q. 10 What are the benefits of the collaborative and multiple pot funding (PEPFAR, USAID child survival and pop funds) channeled through GHAIN as a single mechanism? What has been the impact on the program outcomes?

Q. 11 What are the challenges and benefits/synergies of the GHAIN close collaboration with the GFATM? What has been the impact on the program outcomes? And on the overall health system in Nigeria? How has GHAIN collaboration with the GFATM facilitated achievement of increased results above those expected by GHAIN and the GFATM programs together?

Q.12 What are the economies of scale and synergies or added value of implementing large-scale integrated programs such as GHAIN Project that cover the whole country? What are the challenges? How might the challenges be managed and mitigated in the future?

Q.13 Should the project continue to offer a wide range of integrated prevention care and treatment services or focus on treatment only? For either - why? What are the challenges of programming comprehensive, integrated services?

Q.14 Should the project continue to offer treatment services nationwide or focus on providing services in particular regions or zones? What are the challenges of project programming with a national spread? How are these managed? How is sufficient oversight achieved with the sometimes frequent changes of GHAIN field staff and MoH staff?

2. KEY INFORMANT INTERVIEW: NACA, NMOH, NASCP, SACA, SMOH

For all questions, probe on achievements, challenges, gaps, lessons learned, best practice

Q. 1 How has GHAIN influenced the use of HIV/AIDS and TB prevention, care and support, and treatment services and interventions in Nigeria/[name of state]?

Q. 2 How has GHAIN impacted HIV/AIDS and TB in the areas it is working in? What will be GHAIN's legacy?

Q. 3 [National level only] How has GHAIN been involved in health system strengthening in the National Programme? [Probe on the 6 GFATM/ WHO principles. Human Resources for Health planning & systems; HMIS strengthening; procurement & commodities; health financing; planning/policy/

management/governance capacity]. Also skills transfer? Development of guidelines, training manual/tools etc? Do you think GHAIN has had influence on policy development? What sort of impact do you think all such health system strengthening has had on service delivery? How is it being tracked and recorded?

Q. 4 How have GHAIN's contributions been institutionalized? How sustainable are they post-EOP? [Have the job descriptions of MoH etc. staff been changed to include roles and responsibilities that were previously GHAIN staffs' roles and responsibilities? Has any government staff worked alongside GHAIN staff? Are there increased budgets for incorporating GHAIN processes/management]?

Q. 5 [State level only] What health systems strengthening activities has GHAIN undertaken? To what extent have activities and their ownership been transferred to the government at state and LGA level and/or local partners? Has your ministry worked with other ministries to deliver services supported by GHAIN? Have there been changes to state-LGA budgeting/working practices under GHAIN?

Q. 6 How has GHAIN worked towards increasing health facility capacity to deliver integrated quality HIV & TB services? Is the process still happening? [What is happening with TB services and with FP/RH integration? Is this co-location of services or does one health worker offer integrated services? What is happening with malaria in pregnancy interventions?]

Q. 7 How have people living with HIV been involved to ensure the organization of services to best meets their needs? How are clients involved in oversight of services?

Q. 8 [State level only] Experiences of HAST LGAs? What sort of engagement has your ministry had with HAST LGAs?

Q.9 What do you know about the GHAIN FP-HIV Integration service delivery model? What is the prospect of this approach being adopted in all facilities providing HIV services in Nigeria?

Q.10 If GHAIN finishes tomorrow, what will be the challenges to continued provision of quality services?

What areas will continue to function well?

What areas can serve as resources for scale up/replication elsewhere?

What areas will continue to require external technical assistance?

Are there any gaps that haven't as yet been addressed with GHAIN support?

Q. 11 What are the challenges and benefits/synergies of the GHAIN close collaboration with the GFATM? What has been the impact on the program outcomes? And on the overall health system in Nigeria/your state?

How has GHAIN collaboration with the GFATM facilitated achievement of increased results above those expected by GHAIN and the GFATM programs together?

Q.12 Should the project continue to offer a wide range of integrated prevention care and treatment services or focus on treatment only? Why? Should the project continue to offer treatment services nationwide or focus on providing services in particular regions or zones?

3. KEY INFORMANT INTERVIEW: HEALTH FACILITY MANAGERS

Q1. How has GHAIN influenced the use of HIV/AIDS and TB prevention, care and support, and treatment services and interventions in your [health facility]?

Q2. How have GHAIN's contributions been institutionalized? [Have the job descriptions of State MoH or facility staff been changed to include roles and responsibilities that were previously GHAIN staffs' roles and responsibilities? Are there increased budgets for incorporating GHAIN processes/management]?

Q3. What health systems strengthening activities has GHAIN undertaken in your [health facility]? How has GHAIN worked towards increasing your health facility capacity to deliver integrated quality HIV & TB services? Is the process still happening?

Q4. What is happening with TB services and with FP/RH integration? Is this co-location of services or does one health worker offer integrated services? What is the difference in service delivery approach since you commenced HIV-FP Integrated services in this facility? What effect has the integration of service had on providers and clients at both HIV VCT Centre and FP clinics?
What specific interventions are undertaken in this facility to prevent malaria in pregnancy? Which other stakeholders are involved?

Q5. [Secondary and tertiary health facilities] Please describe the role and responsibilities of the Referral Co-ordinator. Has this position enhanced service delivery; if yes, how? Has this position strengthened integration of service delivery; if yes, please describe in detail. Are any of the Referral Co-ordinators people living openly with HIV?

Q6. Now that long-term survival has been made possible, how has GHAIN supported the transition of services from acute to chronic care in response to the needs of positive clients who need long-term monitoring and treatment? How has this impacted medical records and HMIS? What systems have been put in place for ensuring follow up? And client retention?

Q7. How have people living with HIV been involved to ensure the organization of services to best meets their needs? How are clients involved in oversight of services? Are other members of the community involved in any way with the management/oversight of your health facility?

Q8. [For health facilities within a HAST LGA] Have you had any involvement with any HAST activities? Have you noticed any changes in client type, numbers, and reasons for seeking services?

Q9. If GHAIN finishes tomorrow, what will be the challenges to continued provision of quality services?

What areas will continue to function well?

What areas can serve as resources for scale up/replication elsewhere?

What areas will continue to require external technical assistance?

Are there any gaps that haven't as yet been addressed with GHAIN support?

4. BENEFICIARY FOCAL GROUP DISCUSSION GUIDE

Discussion questions for people living with HIV support groups, CBO members, community volunteers, community pharmacies and other community beneficiaries of GHAIN programming, e.g. orphans.

Q1. All: How have you benefited from the GHAIN program/the [IA] program?

Q2. All: What has GHAIN/[IA] done to help you that will continue after the end of the GHAIN program? Do you envisage any challenges? How can they be overcome?

Q3. All: How are clients/beneficiaries involved in oversight of health and welfare services? Have there been any challenges? How have they been addressed?

Q4. For CBOs: are you undertaking new activities as a result of GHAIN? What are these? What sort of support are you getting? How will you manage to keep activities going once GHAIN closes?

[Probe on any differences between HAST and non-HAST CBOs]

Q5. For Community Volunteers: are you undertaking new activities as a result of GHAIN? What are these? What sort of support are you getting? How will you manage to keep activities going once GHAIN closes? Have any volunteer colleagues dropped out?

Q6. For community pharmacists: are you undertaking new activities as a result of GHAIN? What are these? Are you seeing more/new clients? What sort of support are you getting? How will you manage to keep activities going once GHAIN closes?

For people living with HIV

Q7. How has stigma affected you? How has this changed as a result of the GHAIN/[IA] program? [Probe on any differences male/ female, young/old, educated/not educated, etc.]

Q8. How have people living with HIV been involved to ensure the organization of health and welfare services best meets their needs? Have there been any challenges? How have they been addressed?

Q9. What more could be done to empower people living with HIV or affected by HIV (orphans and other vulnerable children, families) to improve the quality of their lives *without* increasing their dependency on others? How could this be done?

5. CLINICAL SERVICE DELIVERY CHECKLISTS



SUMMARY	
Names of team members	Dates of field visit:
Brief summary of findings	
Key recommendations	
 Please attach a list of places visited and persons met (one consolidated list).	

ANALYSIS AND INTERPRETATION OF FINDINGS

Each evening, after completing the field visit, use the following template to collate the findings. Be sure to look from a gender perspective and to address stigma.

ONE template should be completed by each Team

1. Facility [Name]:				
1. HCT	2. PMTCT	3. ART	4. Palliative Care - TB	5. Palliative Care -Other
6. M&E	7. Labs	8. Pharmacy	9. Referrals	10. Medical Waste
11. HSS				
Achievements:				
Gaps				
Challenges				
Lessons Learned				
Innovations & Standardizations				
Recommendations for future programming				

1. HCT Services Assessment	M	F
# of individuals receiving CT and their test results during the last 6 months		
# of couples receiving CT and their results during the last 6 months		
# of trained counselors available each day in HCT Center		
# of private counseling rooms available in HCT Center		
Score 1-4 unless otherwise stated below	Score 1-4	
1. HCT available daily (Mon-Fri) [1 = no service; 2 = 1-2/week; 3 = 3-4/week; 4 = 5/week]		
2. Easy to follow, client-friendly, client flows [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
3. Waiting area with seats, protected from sun and adverse weather [1 = clients wait outside; 2 = inadequate space; 3 = too few seats; 4 = good waiting facilities]		
4. Client privacy and confidentiality observed throughout [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
5. Couple counseling encouraged [1 = poor; 2 = adequate; 3 = good; 4 = exceptional] please provide notes overleaf		
6. Rapid testing with same day results [1= no; 2= testing in lab; 3= testing in clinic in batches; 4= testing individuals without delay]		
7. Partner notification <i>note any unethical actions overleaf</i> [1 = staff notify partner of test results; 2 = staff notify partner that client has tested (but not divulging result) asking them to come for CT; 3 = staff provide client with invitation to partner to come in for couple CT; 4 = staff keep complete confidentiality]		
8. Client registers in place & used, confidentiality observed, kept securely [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
9. Pretest counseling [includes limitations of test & window period] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
10. Posttest counseling [includes partner disclosure for all clients/ information on ART for positive clients/ advice on safer sex for all clients / questions related to clinical staging for positive clients and screening for TB] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
11. Condoms available in counseling room for distribution to clients & use demonstrated [penile models available] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
12. Positive clients referred to ART clinic and to TB clinic if symptoms suggestive of TB [1 = CT staff do not mention follow up; 2 = CT staff tell clients to go for follow up with no guidance on when and how to register; 3 = CT staff tell clients how to find registration for follow up; 4 = CT staff go with client & help them register in follow up clinic]		
13. Stockouts of condoms in last 6 months [record number of days of stockouts]		
14. IEC materials in local language(s) [on HIV/AIDS/safer sex/positive living] available in counseling room & used [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
15. Client waiting time for pretest counseling [1= called back another day; 2= >1 hour; 3 <1 hour; 4= minimum waiting]		
16. SOPs readily available and used [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
17. Overall assessment [1 = poor; 2 = adequate; 3 = good; 4 = exceptional] Record observations on back of sheet		

2. PMTCT Services Assessment OPD, labor, delivery and postnatal	Number
# of pregnant women who received CT and their test result during the last months	
# of pregnant women who received ARVs in the last 6 months	
# of HIV exposed infants who received ARVs in the last 6 months	
# of staff providing PMTCT services trained in PMTCT	
Score 1-4 unless otherwise stated below	Score 1-4
1. Easy to follow, client-friendly, client flows [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
2. ANC Waiting area with seats, protected from sun and adverse weather [1 = clients wait outside; 2 = inadequate space; 3 = too few seats; 4 = good waiting facilities]	
3. Client privacy and confidentiality observed throughout [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
4. Private counseling room for posttest counseling positive mothers [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
5. Rapid testing with same day results [1= no; 2= testing in lab; 3= testing in ANC in batches; 4= testing individuals without delay]	
6. ANC Client registers in place & used, confidentiality observed, kept securely [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
7. All staff providing PMTCT are trained [1= none trained; 2= some trained; 3= > half trained; 4= All trained]	
8. Pretest counseling [includes information on window period/ ART/ PMTCT] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
9. Posttest counseling [includes partner disclosure for all pregnant women/ information on ART for positive clients/ safer sex] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
10. IEC materials in local language(s) [on HIV/AIDS/PMTCT/Positive living/safer sex/malaria in pregnancy] available and used [penile models and condoms for distribution available] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
11. Partner disclosure & male involvement in PMTCT encouraged [record how encouraged on back of sheef] [1= poor; 2 = adequate; 3 = good; 4 = exceptional]	
12. Exclusive infant feeding counseling in OPD [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
13. Nevirapine stocks in ANC and postnatal wards [PNW] [1= out of stock throughout last 6 months; 2= Out of stock for >1 <6 months; 3=out of stock for less than 1 month; 4= in stock throughout last 6 months contemporary records]	ANC: PNW:
14. Intermittent preventative treatment of malaria drugs—sulphadoxinepyrimethamine (SP)—available used [1= out of stock throughout last 6 months; 2= Out of stock for >1 <6 months; 3=out of stock for less than 1 month; 4= in stock throughout last 6 months contemporary records]	
15. Referrals for positive mothers [ART/TB/Palliative Care etc] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
16. Client waiting time [1= called back another day; 2= >1 hour; 3 <1 hour; 4= minimum waiting]	
17. SOPs and job aids readily available in ANC and used [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
18. Individual patient records/dockets [record of individual patient management] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	

2. PMTCT Services Assessment OPD, Labor, Delivery and Postnatal	Number
Score 1-4 unless otherwise stated below	Score 1-4
Labor, Delivery and Postnatal areas	
19. Medical records organization including availability in labor ward [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
20. Client privacy and confidentiality observed throughout labor, delivery and post natal wards [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
21. Private counseling room for posttest counseling positive mothers in labor and post natal wards [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
22. Rapid testing with same day results available in labor and postnatal wards [1 = no; 2 = testing in lab; 3 = testing in clinic in batches; 4 = testing individuals without delay]	
23. Exclusive infant feeding counseling with support post delivery [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
24. Safe delivery practices protecting health staff from contaminated fluids [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
25. SOPs and job aids readily available and used in labor delivery and postnatal wards [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
26. Early infant diagnosis testing and linkages [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
27. Cotrimoxazole prophylactic treatment for HIV exposed infants used [1= out of stock throughout last 6 months; 2= Out of stock for >1 <6 months; 3=out of stock for less than 1 month; 4= in stock & used throughout last 6 months contemporary records]	
28. Family planning counseling, provisions, referrals [penile models available] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
29. Defaulter tracking [missed appointments and lost to follow up] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
30. Overall assessment [1 = poor; 2 = adequate; 3 = good; 4 = exceptional] <i>Record observations below</i>	

Further observations (continue on back of sheet if necessary):

3. ART Services — ADULTS and CHILDREN	M	F
# of HIV+ clients enrolled into care and support during the last 6 months		
# of ART eligible clients identified in the last 6 months		
# of individuals put on ART in the last 6 months		
# of children age under 15 put on ART in the last 6 months		
# of staff trained in adult and pediatric ART		
# of staff trained in adherence counseling		
Score 1-4 unless otherwise stated below	Score 1-4	
1. Easy to follow, client-friendly, client flows [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
2. Waiting area with seats, protected from sun and adverse weather [1 = clients wait outside; 2 = inadequate space; 3 = too few seats; 4 = good waiting facilities]		
3. Client privacy and confidentiality observed throughout [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
4. Family ART service availability [1= No; 2= Waiting list; 3= mother & children only; 4=Full family ART service]		
5. All staff providing adult and pediatric ART are trained in AIDS treatment [1= none trained; 2= some trained; 3= > half trained; 4= All trained]		
6. For clinics treating children: pediatric dosing charts readily available [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
7. For clinics treating children: child friendly environment [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
8. Adherence counseling [1 = none ; 2 = prior to commencing ART only; 3 = adherence counselor is available for client referrals; 4 = staff providing ART services provide adherence counseling at every contact]		
9. Availability of ARVs [1= 1 or more ARV out of stock throughout last 6 months; 2= 1 or more ARV out of stock for >1 <6 months; 3=out of stock for less than 1 month; 4= in stock throughout last 6 months contemporary records]		
10. ART clients screening for TB; referrals for TB [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
11. Referrals [to support group/ TB/RH/FP/ social welfare(incl. OVC services)] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
12. Client waiting time [1= called back another day; 2= >1 hour; 3 <1 hour; 4= minimum waiting]		
13. Length of time between clinic appointments for stable clients [1= 1 month; 2= 2 months; 3= 4 months; 4= 6 months]		
14. People living openly with HIV volunteering in clinic [1 = none; 2 = positive persons working in clinic but not opening living with HIV; 3 = people openly living with HIV volunteering; 4 = people living openly with HIV receiving pay/honoraria for work in clinic]		
15. IEC materials in local language(s) [on HIV/AIDS/safer sex/nutrition/positive living] available & used [penile models and condoms for distribution available] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		

3. ART Services — ADULTS and CHILDREN	
Score 1-4 unless otherwise stated below	Score 1-4
16. SOPs and job aids readily available and used [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
17. Individual patient records/dockets record of individual patient care and treatment [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
18. Medical records organization [1= poor; 2= adequate; 3= good; 4= exceptional]	
19. Client registers in place & used, confidentiality observed, kept securely [1= poor; 2= adequate; 3= good; 4= exceptional]	
20. Defaulter tracking [missed appointments and lost to follow up] [1= poor; 2= adequate; 3= good; 4= exceptional]	
21. Overall assessment [1 = poor; 2 = adequate; 3 = good; 4 = exceptional] <i>Record observations below</i>	

Further observations (continue on back of sheet if necessary):

4. Palliative Care—TB and HIV [TB Setting]	M	F
# of TB clients in TB setting receiving HCT during the last 6 months		
# of TB clients in TB setting referred for HIV/AIDS care & treatment in the last 6 months		
# of new adult TB clients in TB setting in the last 6 months		
# of new children aged under 15 years treated in TB setting in last 6 months		
# of staff in TB setting who have had TB/HIV training		
Score 1-4 unless otherwise stated below	Score 1-4	
1. Easy to follow, client-friendly, client flows [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
2. Waiting area with seats, protected from sun and adverse weather [1 = clients wait outside; 2 = inadequate space; 3 = too few seats; 4 = good waiting facilities]		
3. Client privacy and confidentiality observed throughout [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
4. TB control procedures in place [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
5. All staff providing TB care are trained in TB/HIV [1= none trained; 2= some trained; 3= > half trained; 4= All trained]		
6. Availability of TB drugs [1= 1 or more TB drug out of stock throughout last 6 months; 2= 1 or more TB drug out of stock for >1 <6 months; 3=out of stock for less than 1 month; 4= in stock throughout last 6 months contemporary records]		
7. Client waiting time [1= called back another day; 2= >1 hour; 3 <1 hour; 4= minimum waiting]		
8. Chest X ray availability when required clinically [1 = no ; 2 = from private sector; 3 = in facility but often out of order; 4 = available]		
9. How long to receive back sputum test results [1 = >4 weeks; 2 = 2-4 weeks; 3 = next clinic/1 week; 4 = next day]		
10. IEC materials in local language(s) [on adherence/TB-HIV coinfection etc] available in clinic & used [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
11. SOPs and job aids readily available and used [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
12. Treatment for TB and HIV coinfection [1 = TB treatment not available; 2 = ART after completion of TB therapy; 3 = ART after intense phase of TB treatment; 4 = concurrent treatment as per WHO guidance]		
13. Individual patient records/dockets [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
14. Medical records organization record of individual patient care and treatment [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
15. Client registers in place & used, confidentiality observed, kept securely [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
16. Overall assessment [1 = poor; 2 = adequate; 3 = good; 4 = exceptional] <i>Record observations overleaf</i>		
LXI		

5. Palliative Care—Basic health care and support ADULTS and CHILDREN	M	F
# of adults >15 years receiving HIV palliative care in the last 6 months		
# of children age under 15 receiving HIV palliative care in the last 6 months		
# Staff trained in palliative care		
# Staff trained in RH/FP/HIV integration		
Score 1-4 unless otherwise stated below	Score 1-4	
1. Easy to follow, client-friendly, client flows [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
2. Waiting area with seats, protected from sun and adverse weather [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
3. Client privacy and confidentiality observed throughout [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
4. OI treatment drugs' (cotrimoxazole & fluconazole) availability [1 = 1 or more OI drug out of stock throughout last 6 months; 2 = 1 or more OI drug out of stock for >1 <6 months; 3 = out of stock for less than 1 month; 4 = in stock throughout last 6 months contemporary records]		
5. Counseling and support for positive living including dual protection [penile models & condoms for distribution available] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
6. Client waiting time [1= called back another day; 2= >1 hour; 3 <1 hour; 4= minimum waiting]		
7. Length of time between clinic appointments for stable clients [1= 1 month; 2= 2 months; 3= 4 months; 4= 6 months]		
8. Referrals & links [RH/FP/TB/social welfare services etc] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
9. SOPs and job aids readily available and used [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
10. Use of OI prophylactic treatment [cotrimoxazole, fluconazole etc] [1= not used or rarely; 2= not all clients get OI prophylaxis as per WHO guidelines; 3= when in stock used as per WHO guidelines; 4= always used as per WHO guidelines]		
11. Nutritional support [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
12. Availability of condoms for safer sex [1= out of stock throughout last 6 months; 2= out of stock for >1 <6 months; 3= out of stock for <1 month; 4= in stock and given to clients throughout last 6 months]		
13. IEC materials in local language(s) [on positive living/safer sex, nutrition etc] available in clinic & used [penile models available] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
14. Individual patient records/dockets record of individual patient care & treatment [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
15. Medical records organization [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
16. Client registers in place & used, confidentiality observed, kept securely [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
17. Overall assessment [1 = poor; 2 = adequate; 3 = good; 4 = exceptional] <i>Record observations overleaf</i>		

6. M&E system assessment	M	F
# designated staff responsible for reviewing aggregated numbers prior to submission to next level [eg State, regional offices, central M&E unit]		
# staff trained on data management processes, tools, and MN&E		
Score 1-4 unless otherwise stated below	Score 1-4	
1. Avoidance of double counting within and across service delivery points [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
2. Identification and recording of persons who “drop out”, are “lost to follow- up”, or die. [1 = no identification; 2 = identification and recording of single category of lost to follow up; 3 = recording of missed appointments and lost to follow up; 4 = recording of missed appointments, drop outs/lost to follow up, and deaths]		
3. Tools used for data collection and recording [1. = registers and forms missing (using handwritten registers/forms); 2 = most registers and forms are in sue but at least one missing in last 6 months; 3 = GHAIN own registers and forms in use; 4 = National registers and forms in use]		
4. Consistency of completing standard forms [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
5. Quality controls for data entry from paper-based tools to computer [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
6. Clear instructions on how to complete the data collection and reporting tools available and used [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
7. Responsibility for recording delivery of services on tools 1 = not regularly completed; 2 generally completed by whoever has time; 3 = always completed and trained person checks; 4 = always completed by trained person		
8. Integration of HIV/AIDS Unit’s reports into facility record system 1 = completely separate records systems; 2 = intention to integrate but not happened yet; 3 process of integrating records ahs begun but not complete; 4 = fully integrated systems		
9. Maintenance of confidentiality for personal data [1 = patient files/dockets freely available for all staff to access; 2 = outside of records/dockets identify HIV positive clients; 3 = medical records secure but patient personal information identifiable in electronic submission to next level; 4 = patient personal data maintained according to national/international confidentiality guidelines]		
10. Support supervision and mentoring of staff in M&E & data entry [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
11. Use of data for decision–making within the health facility [1 = data not used; 2 = occasionally data reviewed in facility; 3 = data regularly reviewed in health facility; 4 = data reviewed by facility management and management decisions based on analysis of the data]		

7. Laboratory services assessment				
# of CD4 count performed in the last 6 months				
# of Lab staff trained by FHI/GHAIN in the last 2 years				
# of the trained lab staff currently working in the lab				
Total number of Lab staff:				
Lab Scientists	Lab Technicians	Lab Assistants	Lab Attendants	
Dedicated Driver:	Dedicated Cleaner:	Others:		
1= poor; 2 = adequate; 3 = good; 4 = exceptional				Score 1-4
A - Laboratory Infrastructure and Capacity building				
Has IP supported any infrastructural changes in the lab, including renovations, water and electricity supply, and lab benches				
Has IP supported work-flow improvement in the Lab (indicate changes made); has this improved Lab services; are specimen collection areas separate from lab processing area, is there a separate space for TB smear microscopy				
Has IP provided Lab equipment and reagents for: HIV testing, CD4 Count, Hematology, Clinical Chemistry, Malaria Microscopy, Pregnancy testing, Urinalysis, TB microscopy, others (list)				
Is there an organogram of the Lab management structure, does the lab team have a specific time of meeting, are minutes of the meeting kept. Is the Lab part of the Facility Project Management Team				
Has there been IP supported training on the following areas:				
Good Lab Practice: Lab safety: Lab Quality Assurance: SOP development: Hematology: Clinical Chemistry: CD4 Count: TB Microscopy: Malaria Microscopy: Lab Logistics management: Others:				
Has there been a supervisory visit by the IP in the last 6 months and in the last 12 months, is feedback provided to the site at the end of each visit, is a standard checklist used during the visit, how are issues raised followed up				
B- Documents and Records				
Are patients data and results archived and retrieved according to Lab procedures				
Is a Lab safety and quality manual developed and updated, and accessible to lab staff				
is there a controlled access to Lab data (un-accessible by unauthorized personnel)				
C- Quality of Service				
Are Standard Operating Procedures (SOPs) available, for all Lab processes; list available SOPs, have they been updated, are they easily accessible and used by all lab staff				
Indicate days and hours the Lab is open for service to program and patients clients				

7. Laboratory services assessment	
Are all the equipment on the bench functional and calibrated, is equipment service log maintained for all equipment,	
how often has lab services been interrupted/suspended due to equipment brake-down in the last 6/12 months, How long did it take to resolve (average time)	
is there a designated Lab quality supervisor and how often does s/he monitor internal quality processes.	
Does the lab maintain routine quality control chart/log, how often are these reviewed, are the outcomes of the reviewed discussed with the Lab staff, how are corrective actions taken	
Is the lab enrolled in any External Proficiency Testing Program; list the tests with a PT program (review PT performance in the last cycle)	
Are quality issues brought up for discussion in the Lab staff/management meetings	
How are patients complaints handled	
D- Lab management	
is there a system for forecasting lab reagents and commodities needs	
is there a routine budgeting projection process for the lab	
is the lab management involved in making recommendation for lab equipment specifications and procurements	
which labs and services are referred to this lab, which tests and to which labs does this facility refer services to	

8. Pharmacy Services – at OPD and facility level	M	F
# of clients receiving ARVs in last 6 months		
# of children <15 years receiving ARVs in last 6 months		
# of clients receiving TB drugs in last 6 months		
# of clients receiving OI prophylaxis in last 6 months		
# of pharmacy staff trained in HIV/AIDS/ARV issues in facility		
# of professional pharmacists in facility		
# of pharmacy assistants/dispensers in facility		
Unless stated otherwise: 1= poor; 2 = adequate; 3 = good; 4 = exceptional	Score 1-4	
1. Main drug storage of ARVs hygiene security/temperature control & monitoring/etc 1= poor; 2 = adequate; 3 = good; 4 = exceptional		
2. Main drug store stock control & management 1= poor; 2 = adequate; 3 = good; 4 = exceptional		
3. Main drug store minimum and maximum ARV stock levels 1= stockouts, or excess stock >1 month; 2 = less than 1(2) month stock or more than 3(4) months >1 week each side of delivery; 3 = less than 1(2) month stock or more than 3(4) <1 week each side of delivery; 4 = always within 1/3 months or 2/4 months		
4. Main drug store minimum and maximum OI drug stock levels 1= stockouts, or excess stock >1 month; 2 = less than 1(2) month stock or more than 3(4) months >1 week each side of delivery; 3 = less than 1(2) month stock or more than 3(4) <1 week each side of delivery; 4 = always within 1/3 months or 2/4 months		
5. Main drug store minimum and maximum TB drug stock levels 1= stockouts, or excess stock >1 month; 2 = less than 1(2) month stock or more than 3(4) months >1 week each side of delivery; 3 = less than 1(2) month stock or more than 3(4) <1 week each side of delivery; 4 = always within 1/3 months or 2/4 months		
6. Main drug store stockouts of ARVs in the last 6 months [1= 1 or more ARV out of stock throughout last 6 months; 2= 1 or more ARV out of stock for >1 <6 months; 3=out of stock for less than 1 month; 4= in stock throughout last 6 months contemporary records]		
7. Main drug store stockouts of OI drugs [Cotrimoxazole & fluconazole] in the last 6 months [1= 1 or more OI drug out of stock throughout last 6 months; 2= 1 or more OI drug out of stock for >1 <6 months; 3=out of stock for less than 1 month; 4= in stock throughout last 6 months contemporary records]		
8. Main drug store stockouts of TB drugs in the last 6 months [1= 1 or more TB drug out of stock throughout last 6 months; 2= 1 or more TB drug out of stock for >1 <6 months; 3=out of stock for less than 1 month; 4= in stock throughout last 6 months contemporary records]		
9. Dispensing pharmacy dispensing hours 1= open less than clinic hours; 2 = open clinic hours clinic days only; 3 = open clinic hours Mon-Fri; 4 = open throughout facility opening hours		
10. Drug storage and security in dispensing pharmacy 1= poor; 2 = adequate; 3 = good; 4 = exceptional		
11. Availability of pediatric formulations 1= none available in last 6 months; 2 = 1 or more pediatric formulations available in last 6 months but long periods out of stock; 3= 1 or more pediatric formulation usually in stock but have been stockouts of <1month in last 6 months; 4 = >1		

pediatric formulation in stock throughout last 6 month period.	
12. Client registers in place & used, confidentiality observed, kept securely 1= poor; 2 = adequate; 3 = good; 4 = exceptional	
13. IEC materials in local language(s) & pictorial [on how to store drugs at home, when to take drugs, adherence, side effects and management etc] available in dispensing pharmacy & used 1= poor; 2 = adequate; 3 = good; 4 = exceptional	
14. Client waiting time [1= called back another day; 2= >1 hour; 3 <1 hour; 4= minimum waiting]	
15. Frequency of return to top up their prescriptions 1 = weekly between clinic appointments; 2= 2weekly between clinic appointments; 3= monthly between clinic appointments; 4= on day of clinic follow up only	
16. Availability of condoms for distribution to positive clients in <u>dispensing pharmacy</u> 1= not available; 2= sometimes available but out of stock for long periods; 3= condoms generally available; 4= condoms always available for distribution	
17. Overall assessment [1 = poor; 2 = adequate; 3 = good; 4 = exceptional] Record observations overleaf	

9. Referrals and Linkages:	Overall score 1-4: 3
<p>Achievements:</p> <p>Gaps</p> <p>Challenges</p> <p>Lessons Learned</p> <p>Innovations & Standardizations</p> <p>Recommendations for future programming</p>	
10. Medical waste management:	Overall score 1-4:
<p>Achievements</p> <p>Gaps</p> <p>Challenges</p> <p>Lessons Learned</p> <p>Innovations & Standardizations</p> <p>Recommendations for future programming</p>	
11. Health Systems Strengthening:	Overall score 1-4:
<p>Achievements:</p> <p>Gaps</p> <p>Challenges</p> <p>Lessons Learned</p> <p>Innovations & Standardizations</p> <p>Recommendations for future programming</p>	

APPENDIX F: DETAILED DISCUSSION OF GHAIN PREVENTION ACTIVITIES (A/B AND C/OP)

This Appendix sets out in greater detail discussion on prevention than is possible in the body of the report (as such in part it repeats text and footnotes found in the report, so as to be coherent and to be a standalone document if required). It is written in the spirit of providing comprehensive focus on prevention, so as to be supportive of GHAIN activities until the end of the project and also the development and implementation of future projects.

I. ABSTINENCE AND BE FAITHFUL

Introduction and background

Attention to abstinence and be faithful (A/B) has been a key component of GON, USG and GHAIN activities throughout the lifetime of the project. The changes in emphasis and approach over time, and most notably since the introduction of the USG *Global Health Initiative* and the PEPFAR *Next Generation Indicators* (NGI) are well known. There have been significant programmatic implications for GHAIN inherent in such shifts, e.g. away from achievement of large numerical targets and sometimes undifferentiated and unrealistic assumptions about efficacy of A/B prevention messages to specific target groups.³³ GHAIN began implementing such shifts only in its work plan from July 2010.

The NGI *Essential/Reported Indicator* P8.2.D represents the key PEPFAR A/B indicator (PEPFAR 2009a). There is discussion in the same document of comprehensive prevention programs and interventions operating at multiple levels; the “ABC paradigm” includes attention to abstinence, delay of sexual debut, mutual fidelity and partner reduction, with intended focus on young never married men and women aged 15-24 and men and women aged 15-49 who have had more than one sexual partner in the past 12 months.

The new approach to A/B prevention does not appear to have been fully instituted within GHAIN. While previously the A & B targets were number-driven, the focus now within GHAIN is for implementing agencies’ peer educators to work with small ‘cohorts’ (up to fifteen members per cohort and up to three cohorts per peer educator) and to achieve a minimum of three meetings per cohort. This necessitates not only a major alteration in approach; it also requires what may be substantial changes in individual implementing agencies’ and peer educators’ skills sets and capacities. GHAIN staff members do not directly work on A/B (or indeed on C and OP); this is undertaken by implementing agencies.

The GON NSF II sets out the following objectives linked to A/B prevention activities: “Behavior Change and Prevention of New Infections’ Objectives... [Objective] 10. At least 80 % of all Nigerians have comprehensive knowledge on HIV and AIDS by the year 2015. [Objective] 11. At least 80% of young people 15-24 years adopting appropriate HIV and AIDS related behavior...[Objective] 13. At least 80% of registered organizations engaging in HIV communication interventions comply with national standard/guidelines by 2015.” (NACA 2009a; p4).

³³ The EOP/E consultants did not have sight of a GHAIN Year 7 A/B activity overview, by contrast to those reviewed for earlier years, e.g. GHAIN 2009c.

All such focus is essential, given recent Nigerian data. These indicate that young people aged between 20-29 have the highest nationwide HIV prevalence, at 4.9%. The age of sexual debut is approximately 16 years for girls and approximately 17 years for boys, while approximately 43% of girls and young women have ever had sex and approximately 2% of young women (20-24) and 18% of young men (20-29) have the highest national levels of multiple sexual partnerships (PEPFAR 2010a).

Year 7 funding for GHAIN A & B activities is \$446,011; the number of GHAIN implementing agency sites listed as working on A & B is nine (PEPFAR 2010b).

GHAIN achievements

GHAIN has applied a wide range of A/B prevention strategies over the life of the project. These include advocacy, capacity building of to date close on 4,500 peer educators and other volunteers, mass and mid media and community outreach. A wide range of information, education and communication (IEC) and strategic behavior change communication (SBCC) methodologies and materials have been used across several media and communication platforms (e.g. mass media (radio and television); mid media (e.g. posters); latterly interpersonal communication through peer educator-moderated cohort focus group discussions). These efforts are to be fully acknowledged.

Table A: Overview of GHAIN A/B achievements over life of the project to date				
Indicator	Year 7 (July 2010- June 2011)	Cumulative Yr 7 achievements July 1 – Aug 31, 2010	Cumulative targets to be reached by June 30, 2011	Cumulative achievements to date (Sept 2004 –August 2010)
Prevention (Abstinence and Be Faithful)				
# of targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	25,000	12,230 (Male = 6,134 and Female =6,096)	972,894	2,932,507 (Male = 1,825,663 and Female = 1,106,844)
Source: GHAIN 2010d				

The numbers listed above do not encompass the entire numerical achievement of GHAIN A/B targets. The indicator used is from PEPFAR NGI, which has only been applied by GHAIN since July 2010 (so there has been a degree of GHAIN retrofitting to fit numbers to the new indicator). Data provided by GHAIN (covering a period when PEPFAR 1 indicators (i.e. pre-GHI) were applied) indicate that the cumulative target for Sept 04 to June 10 specific to A/B was 4,456,395 individuals; the cumulative achievement was in fact 13,506,753 people (GHAIN 2010c).

Peer educators volunteering to work with GHAIN-supported implementing agencies are said to have been retrained as from mid-2010 to apply the *Minimum Prevention Package*, which is the new overall prevention approach now being applied by GHAIN and its implementing agencies. The *Prevention Intervention Tracking Tool* has been developed by USAID to facilitate collection of MPP data by peer educators.

Peer educators work on A/B communication with MARP as well as with members of the general population (e.g. young people in and out of school). Cohorts are being developed within each MARP for work that will address A/B and C and OP.

Challenges

1. There is a need to address modes of transmission through prevention activities (A/B and OP), in the context of individuals' and groups' perceptions of (lack of) risk and vulnerability. This will have to be addressed by all partners working on HIV in Nigeria.
2. There is an imperative need to address gender aspects of HIV prevention and to support women and girls, as well as men and boys, to engage with sustainable *and* gender-sensitive prevention activities.
3. All work on prevention that introduces new approaches, with concomitant demands on implementing agencies, peer educators and other volunteers, has to be matched by expertise and appropriate planning, management and support to implementation. This applies at national and other levels, not merely within projects.

Gaps

Key issues

Implementing agencies and peer educators working on A/B are not being sufficiently supported to institute and then implement what are significant and far-reaching changes in approach, practice and reporting. The intention is now to focus on the cohort approach, a very much more labor-intensive and individually demanding activity than previous large-scale outreach activities where numerical target achievement rather than in-depth engagement was the priority. It is inappropriate to require CBOs, peer educators and other volunteers to make such changes without the most comprehensive and expert technical inputs from GHAIN. These have not been forthcoming.

The gender implications hidden in bald statistics (see e.g. those above) represent another essential aspect of A/B (and indeed C and OP) prevention interventions, and an area where GHAIN does not have sufficient technical expertise to achieve effective, targeted communication. For instance, GHAIN has not addressed other than most superficially issues such as negotiation of safe sex, gender-based and sexual violence, early marriage, coercion of young female OVC, and young sex workers. This is the case for both A/B and C/OP (and despite general discussion of gender aspects in e.g. GHAIN 2009c).

The relevance does need to be questioned of provision of A/B communication to people who may engage in transactional or commercial sex work or who may be resistant to behavior change to such an extent that the inputs may not be answered by any impacts. Most at risk persons may also become opposed to OP messaging if they are presented with inappropriate A/B interventions. Such apparent lack of clarity and prioritization is perhaps an indication of GHAIN lack of technical expertise on overall prevention.

Insufficient GHAIN technical capacity on prevention (A/B and also OP)

Field discussions and (minimal) observation during the end of project evaluation indicate that a comprehensive shift to close, longitudinal and cohort prevention focus has not yet been effectively introduced and implemented by GHAIN, whether within its own workforce or with its community-based implementing agencies and volunteers. It is inherently unsustainable to introduce such changes in approach and interventions so late in the lifetime of a project without genuinely sufficient project internal capacity to support implementing agency partners to deliver quality activities.³⁴

The view of the end of project evaluation team is that there is inadequate internal GHAIN technical expertise on prevention at country office level. This appears to have resulted in a degree of imprecision in planning and implementation, with repercussions at zonal and lower levels, both for GHAIN staff members and implementing agencies and volunteers. While this lack has been partially mitigated by greater technical expertise in some zonal offices, clear technical leadership and clarity of overall programmatic planning on overall prevention is nevertheless considered by the evaluation team to be sub-optimal.

The evaluation findings further indicate that GHAIN does not have specialist expertise to develop prevention messages and materials. Moreover, the project does not have the expertise to work on SBCC materials' development. As a result, generic FHI prevention materials (found in e.g. Ethiopia and Tanzania) are being used, sometimes with minimal adaptation, which is inadequate. Mention was made by GHAIN staff working on prevention that SBCC and IEC materials will not change, despite re-orientation of prevention focus; this too is an inadequate response.

Incomplete coverage

There is no funding in the GHAIN North East zone for A/B work. Out-of-school youth represent another vulnerable group that has received limited attention from GHAIN.

The Minimum Prevention Package and the Prevention Intervention Tracking Tool:

No peer educator working on either A/B or C and OP mentioned actual application of either.

Lessons learned

1. Insufficient technical assistance and management leadership are being provided by GHAIN to institute and embed internally and at implementing agency level what are in fact major changes in prevention focus. Such changes require dedicated expertise and longitudinal planning, monitoring and evaluation, as well as far more participation by target group/cohort members at all stages of prevention activity planning, implementation and M&E. All such factors need to be considered in the follow-on program to GHAIN.
2. Careful consideration has to be given by both USG and projects to how best to address and accommodate major shifts in programmatic focus, as has occurred for GHAIN with prevention activities. This attention should include consideration of

³⁴ It is acknowledged that GHAIN is responding to USG priorities and imperatives and as such may on occasion have relatively limited room for maneuver. Despite this, the discussion of gaps remains pertinent, both for the remainder of the GHAIN project and for future interventions.

- comparative advantage and value added, as well as realistic assessment of existing technical capacity within a project and the best use of additional such expertise.
3. Overall prevention messaging must optimize effective communication; e.g. provision of A/B SBBC to FSW may not represent highest priority or most acceptable support.
 4. Numbers reached in all prevention activities must be balanced against the quality of separate and cumulative interventions and their actual value in terms of promoting and sustaining A/B behaviors; this is now more of a priority within GHAIN. However, it is not possible to assess quality of prevention activity inputs from the demand-side, as no such monitoring and evaluation has been undertaken by GHAIN, as could have been attempted e.g. through peer panels linked to peer educator work or by participatory M&E interventions. This too indicates a certain lack of technical expertise.
 5. Dedicated expertise on creation of targeted SBCC methods, tools and materials is essential.
 6. Adequate gender expertise on prevention is also essential.
 7. Adequate support to peer educators is imperative if they are to deliver prevention effectively; this is especially the case if significant shifts in focus occur.

II. CONDOMS AND OTHER PREVENTION INTERVENTIONS

Introduction and background

The need to provide prevention services to particular groups of people vulnerable to HIV infection (most at risk populations: MARP) has been a consistent theme throughout the lifetime to date of PEPFAR and thus also GHAIN. Attention to condoms and other prevention (OP) has seen significant changes in international, GON and USG approaches during the past few years. The most profound change internationally as supported by USG is movement away from focus on (very) large numbers of people being reached with prevention messages (often a combination of A, B and C/OP), inevitably all too often in a superficial manner without effective monitoring of quality or follow-up regarding efficacy of communication. Numbers are no longer to stand as proxy for quality of engagement.

A key alteration in the overall GHI and PEPFAR approach is the toolkit of other prevention activities, which includes expanded strategic behavior change communication (SBBC) approaches and a focus on more longitudinal, qualitative, intensive interventions (including condom provision) with cohorts of MARP. In addition, there is now far more explicit attention to gender aspects of prevention. Impacts and outcomes are no longer to be measured primarily through prioritization of numbers reached through any one encounter (e.g. community mobilization). Moreover, there is now more explicit support to prevention for positives, an area previously somewhat neglected. Next Generation Indicators reflect this more nuanced and disaggregated approach. GHAIN has been required to accommodate such changes. The project began using the PEPFAR NGI in July 2010, as the GHAIN final year started. Therefore, there is minimal information available as to efficacy or otherwise of the new approaches.

The major shift in approach can be gauged through comparison of GHAIN 2007 OP literature and figures given in the June 2008 GHAIN evaluation report with discussion in the most recently available GHAIN OP documentation.

“GHAIN will provide condom and other prevention services to 130,000 most at risk populations (MARP)...while training 123 people and increasing coverage of each implementing agency... Targets for this activity will include road transport workers,

commercial sex workers (CSW), discordant couples, PLWHIV, mobile populations, truck drivers, medical personnel (public and private health care workers), clients/partners of CSW, and out of school youths.” (GHAIN 2007).

The 2008 evaluation report indicates that by March 2008 GHAIN had significantly exceeded its C/OP targets, both for COP07 and for the life of the project to that date. While the cumulative C/OP target between September 2004 and June 2008 was 174,250 [aggregate figure], the numbers reached [unspecified as to through which activities other than ‘community outreach’] numbered 658,229. In the year beginning July 07 the number to be reached during the entire year was 146,250; by the end of March 2008 people reached numbered 235,001.³⁵

“This year, GHAIN will implement other prevention activities targeting 9,000 individuals from MARP groups, including transport workers, female sex workers (FSW,) men having sex with men (MSM), and discordant couples... In [Year 7], GHAIN will continue supporting the two informal networks of MSM in Lagos and the FCT...During the [] year, GHAIN will strengthen the capacities of 25 IAs and their staff to train peer educators among MARP for enhanced skills, effective information dissemination, and behavior change... prevention for positives will be an important focus of sexual prevention programs in [Year 7]...” (GHAIN 2010a; pp11-12).

Information on C/OP activities was gathered from the GHAIN country offices and from the field (KIIs with GHAIN zonal staff members, umbrella and other CBO representatives and HAST LGA representatives and additionally from very brief communication with a few FSW). There is evidence of considerable work to accommodate changes in terms of OP emphasis and approach, especially since the introduction of the GHI in 2009, and so far to a much lesser extent also the PEPFAR NGI.

“ ‘From 2008 we began to switch from simple demand creation towards a wider, more integrated prevention approach. From the middle of 2008 we have re-focused on SBCC and more targeted MARP prevention work.’

‘Implementing agencies take IEC to the community, while in HAST LGAs GHAIN no longer funds individual implementing agencies, but seeks a more coherent approach, working with peer educators trained in A/B and OP and also (to an extent) Positive Living. GHAIN is using the Society for Family Health *Peer Education Plus* materials for work with MARP, which have been adopted by NACA. All these peer educators have been given inception training on the Minimum Prevention Package – but only very recently and not yet fully.’”

(KII with GHAIN zonal office prevention, SBCC and HAST staff members)

The funding available to GHAIN for C/OP interventions under the cooperative agreement for Year 7 is \$2,005,795 (aggregate amount).

Condoms used in GHAIN are PEPFAR funded, procurements are coordinated by USAID (SCMS) while Society for Family Health (SFH) distributes to all implementing partners. Condoms are distributed from GHAIN zonal level to health facilities, for provision in e.g. HCT, RH/FP, PMTCT, Pharmacy and other service delivery points;

³⁵ Please note that numbers given for GHAIN OP targets and achievements do not always tally. A partial explanation is probably changing indicator definitions and possibly also more precise definitions of MARPs.

HAST LGAs also receive condoms, through umbrella CBOs (including at least one Catholic CBO, the AMAC CACA in the FCT), as do other OP implementing agencies (see FHI 2010b, published in July 2010).

Achievements ³⁶

The number of implementing agencies engaged in OP activities is stated as thirteen (GHAIN 2010a). In Year 6 aggregate OP funding was \$2,295,000, targeted condom outlets numbered eighty-eight and the number of implementing agencies engaged in OP was twenty-five. In Year 6 the total number of people designated as MARP (e.g. female sex workers, truckers, men who sex with men, occupational migrant workers)

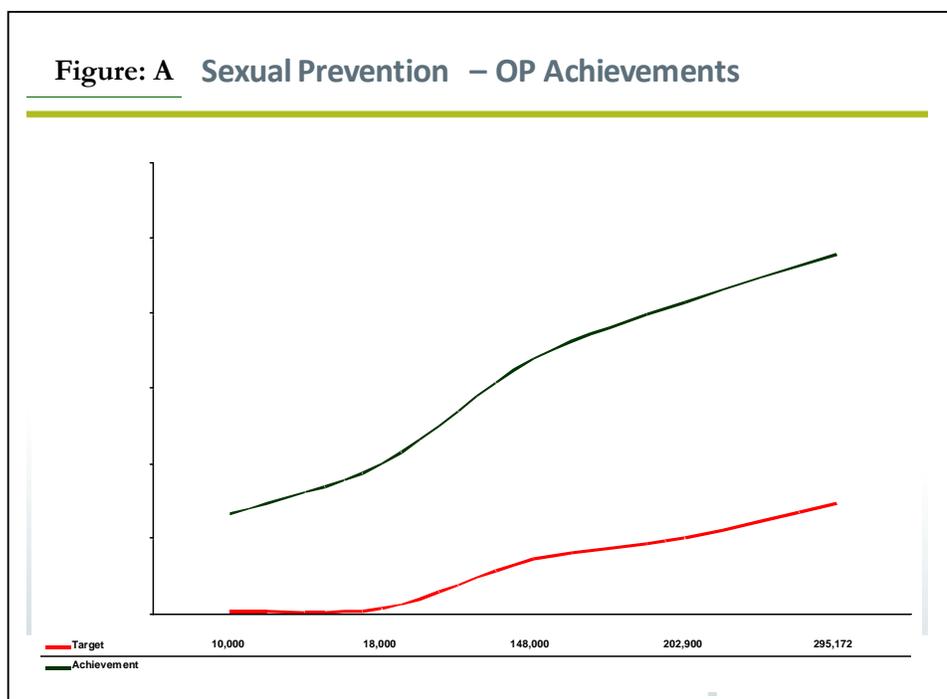
Table B: Overview of GHAIN OP achievements over life of the project to date			
Indicators	Year 6: targets	Year 6: achievements	Cumulative achievements from inception to June 30th 2010
1. Number of individuals trained to provide HIV/AIDS prevention programs that are not focused on abstinence and/or be faithful	165	202	1,676
2. Number of targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	N/A	49,137 (M=26,612 F=22,525)	330,896 (M=191,242; F=139,654)
3. Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards	N/A	59,768 (M=31,034 ; F=28,734)	625,942 (M=368,435; F=257,507)
Source: GHAIN 2010f (Quarterly Report April-June 2010)			

who were to receive information on prevention through GHAIN-supported activities apparently numbered 69,545, of whom 31,295 were men and 28,250 women (GHAIN

³⁶ It also proved challenging during the EOP evaluation to gauge actual GHAIN OP achievements and especially to ascertain the *quality* of such interventions. This was in no small part due to mixed messages from GHAIN staff members. In addition, there was inadequate opportunity to meet representatives of MARP groups, other than two far too brief encounters with FSWs, in the FCT and in Onitsha, Anambra state. It was also not possible to have detailed discussion with Peer Educators on the specific subject of OP (despite 1,676 having been trained to date by GHAIN, as seen in Table 1).

2009e). However, see the table below, where such precise numbers are not allocated. ³⁷

Figure A below shows incremental OP targets and achievements from Sept 2004 to June 2010 (for all MARP). (Data provided by GHAIN in October, 2010.)



It is undoubtedly the case that GHAIN has invested considerable effort in condom and OP interventions during the life of the project and this is to be fully acknowledged. A great deal of work has focused throughout the life of the project to date on provision of OP IEC and SBCC materials in English and local languages, across various media and through various channels (e.g. to be used by peer educators).

Since the evaluation in May 2008 GHAIN has sought to deepen its OP activities. It works with implementing agencies to address the OP needs of vulnerable people belonging to MARP, e.g. female sex workers, uniformed services, migrant populations, okada drivers and other transport workers and older orphans and vulnerable children.

One area of much expanded focus is work with men who have sex with men (MSM). GHAIN now works with two implementing agencies: one CBO in Lagos, the other in the FCT (Alliance Rights Nigeria). It was not possible to obtain detailed information as to GHAIN-supported MSM interventions, their quality or their frequency.

As noted in 4.2. Abstinence and be faithful interventions, MARP peer educators volunteering to work with GHAIN-supported implementing agencies have been

³⁷ A few points should be considered when reviewing this table. The three indicators are PEPFAR Next Generation Indicators, i.e. they were not applied by GHAIN prior to July 2010, despite their insertion in GHAIN documents for the year July 2009-June 2010. Therefore, there is inevitably a degree of aggregation/retrofitting involved in the cumulative account given above. The indicators are insufficiently disaggregated, not only by sex, but also by MARP groups, type of intervention, follow-up, etc.

retrained in the past few months to apply the *Minimum Prevention Package*. The *Prevention Intervention Tracking Tool* has been developed to facilitate collection of MPP data by peer educators. It should be noted that no peer educator working on either A/B or C and OP mentioned actual application of the *Prevention Intervention Tracking Tool*.

Community pharmacists—see section 4.4. Pharmacy services (including community pharmacists) for detailed discussion—provide condoms and also FP/RH counseling: information from GHAIN in September 2010 is that overall, condom provision to [aggregate] clients represents 19% of community pharmacist (CP) activities, while counseling takes up 41%.

GHAIN provides MARP peer educators with condoms secured and supplied through the Society for Family Health and other USG implementing partners. In its final year [Year 7] GHAIN will supply upwards of 20 million male and female condoms to members of MARP. Condoms are also provided by GHAIN to all comprehensive ART sites, in support of dual protection (HIV prevention and FP). While the Year 7 target for [unspecified] condom outlets is 88, the cumulative total achieved as of August 31st 2010 is 280 (GHAIN 2010d).

Challenges

1. There is an imperative need for more systematically focused, coordinated (GON, development and civil society partners) and participatory work on prevention and other interventions for MARP, based on epidemiological data (see 2.1 above). This will need to address the often profound societal barriers to engagement with members of such groups, and the stigma and discrimination meted out to individuals and groups.
2. Gender-sensitive and gender-appropriate approaches specific to OP need to be addressed as a priority; there appears to be only limited attention to this important aspect of prevention, both within GHAIN and more widely in the national environment.
3. Support to young people living positively is not a focus of attention in Nigerian national instruments; this needs to be addressed as a priority, given both the epidemiological imperatives and also for ethical reasons.
4. Engagement with MSM is an especially challenging environment in which to work. GON legal instruments criminalize homosexual acts and it is difficult to gain trusted access to MSM, whose sexual behaviors may make them vulnerable to HIV infection and to transmission of the virus. Such issues will nonetheless need to be addressed, not least in view of recent epidemiological data.
5. Prevention for positives represents an under-served area; this will need to be rectified.

Gaps

Key issues

The evaluation findings indicate that GHAIN does not have specialist expertise to develop messages and materials (whether mass or mid media or for use by peer educators in small group discussions) to engage with MARP. Moreover, the project does not have the expertise to work with MARP members on strategic behavior Change Communication (SBCC) development in a participatory fashion. As a result, generic FHI materials (found in e.g. Ethiopia and Kenya) are being used, which is inadequate. ³⁸

³⁸ The evaluation team had only brief opportunity to review SBCC materials applied by GHAIN in order

No information was made available by GHAIN regarding any actual work undertaken by the project on addressing gender issues in the context of working with MARP.

As with A/B, so too with OP: implementing agencies and peer educators working on OP are not being sufficiently supported to institute and then implement what are significant and far-reaching changes in approach, practice and reporting. It is inappropriate to require CBOs, peer educators and other volunteers to change to the MARP cohort approach without the most comprehensive and expert technical inputs from GHAIN. These have not been forthcoming.

The *Prevention Intervention Tracking Tool* appears to be insufficiently understood, especially at the actual engagement level (peer educators working with most at risk persons).

GHAIN staff members entrusted the evaluation team with honest discussion of gaps specific to condoms and OP. The quote below encapsulates these points.

“We are not yet adequately monitoring quality of OP interventions; we are still too much in the big numbers’ mindset. We need also to do much more on checking the quality of implementing agencies’ and peer educators’ activities; they’ve been trained, sometimes to a to a good standard, but we have to follow up more on what they actually do. It is also a lot to demand of community-based organizations and volunteers that they seek out and work so closely with MARP, when they themselves may feel inhibited and nervous and face often very entrenched resistance from community members.

We need much better and more targeted materials as well as better provision of condoms.”

(KII with GHAIN zonal office prevention, SBCC and HAST staff members)

Insufficient GHAIN technical capacity on OP

Please refer to the discussion under A/B, as issues are virtually identical. The major difference with regard to OP is that engaging with MARP represents on occasion even more of a challenge than other prevention work and as such should be supported by the most technically able and appropriately capacitated expertise. This is not forthcoming from GHAIN. In addition, such changes require dedicated expertise and longitudinal planning, monitoring and evaluation, as well as far more participation by representatives of target groups (MARP) at all stages of OP planning, implementation and M&E.

Lack of internal GHAIN clarity on changes in OP approach

There appears also to be lack of clarity internally within GHAIN about just how OP is to be addressed in the final year of the project. Some staff members working on prevention, at country and zonal office levels (on occasion senior level), described continued prioritization of numbers reached. Information from a number of staff members is that during Year 7 GHAIN is to work towards the same numerical targets for indicator 3 as in Year 6, approximately 60,000 individuals categorized as belonging to MARP. This is to be achieved by implementing agencies and retrained peer educators. However, as quoted above, the GHAIN Year-7 work plan (as well as the GHAIN Performance Monitoring Plan 2010-2011) indicates that 9,000 members of

to support prevention activities. It was not possible to assess the full range of media, e.g. mass media materials (television, radio) were not evaluated.

MARP groups are to be reached with OP activities, while 60,000 ‘target population’ individuals are to be reached with OP communications. This lack of clarity suggests insufficient management focus as well as less than precise planning, M&E and performance monitoring.

Incomplete coverage

Evidence from the EOP evaluation indicates that not all GHAIN zones are working on OP. Thus the North East Zone (Adamawa and Taraba states) implements nothing in this intervention area (clear reasons were not forthcoming); the North West Zone (Sokoto, Kebbi and Zamfara states) is not currently undertaking any such activities. The latter zone has previously worked with FSW, but once its numerical targets had been reached, its activities ceased.

“MARP are not a priority in this zone; other zones have sub-agreements with CBOs that work directly with various MARP. There has been no discussion within GHAIN as to looking at the PEPFAR Next Generation Indicators to ascertain their degree of focus on MARP.”

(NW zonal staff member)

Inappropriate partnerships

At least one Catholic implementing agency (the Catholic Action Committee on AIDS in AMAC in the FCT, which is the AMAC HAST umbrella CBO, is leading on condom and OP activities for GHAIN. This is neither appropriate nor likely to be optimally effective; the choice of such partners suggests a lack of forethought and planning on both sides. In Ajeromi HAST LGA, Lagos, the umbrella CBO was initially a Catholic institution (Community Health Project Amumkoko). It has had to cease that role, as it could not fulfill the umbrella CBO capacity-building responsibilities and was unwilling to monitor other CBO activities.

Prevention for Positives

Prevention for young people who are positive is absent in GHAIN according to end of project evaluation findings. It is neither a specific intervention area nor appears to have been addressed in terms of training, provision of SBCC materials, etc. It was noticeable during FGDs with support group members that very few were adolescents or aged under thirty; mention was made in a number of groups, e.g. at Sir Yahaya Memorial Hospital in Birnin Kebbi, that support to young people is essential yet is being ignored by all relevant parties, including GHAIN.

Support groups in the south (and to a far lesser extent in the north) do discuss prevention for positives and many understand about avoiding reinfection (superinfection) when both partners are positive. Several members described the challenges and moral dilemmas inherent in home-based care, where self-evident need for greater attention to prevention for positives is unmatched by any effective support. Adherence counselors in both northern and southern facilities report that they frequently discuss prevention at each client interaction and distribute condoms to clients who want them. The evaluation team checked that adherence counselors who claimed distribution actually had condom supplies.

When discussing with HCT counselors regarding post-test counseling for positive clients, mention was made of the very important counseling on condom use, condom demonstrations using penile models and provision of condoms on the spot. However, a

number of counselors stated that they would welcome far more attention to prevention for positives' focus. Distribution of condoms and counseling on prevention for positives was much weaker in PMTCT settings than in HCT or ART settings in southern sites (and sometimes also in northern sites).

No mention was made during the end of project evaluation of GHAIN applying the NGI indicator on prevention for positives. This states: "Prevention Sub Area 7: Prevention for Positives. P7.1.D PEPFAR Output Routine Program 1. *Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV interventions.*" (PEPFAR 2009a; p25). Moreover, there seems to be no attention to the NSF II objective: "At least 80% of people living with HIV/AIDS (PLWHA) have access to Positive Health, Dignity and Prevention (PHDP) interventions [by] 2015." (NACA 2009; p5).

Lessons Learned

1. Adequate technical expertise on prevention and specifically OP is essential in any HIV project from its inception; as this is a difficult intervention area, optimizing comparative advantage and working closely with all other partners engaged in OP should be a priority.
2. EOP evaluation findings are that GHAIN has not made optimal use of international best practice in terms of engaging with most at risk persons, among whom are to be found people often extremely vulnerable to infection and frequently very difficult of access.
3. There is too little time left in the life of GHAIN for effective rapport building and development of trust with most at risk persons. It is inappropriate for the project to initiate and/or expand such activities with less than one year remaining. This is a general lesson learned, e.g. also for HAST, for HSS and CSS. It is noted that external (i.e. primarily funding agency) priorities do on occasion require projects such as GHAIN to institute new intervention areas. Perhaps closer attention should be given to realistic expectations of useful and sustainable inputs vis-à-vis time available.
4. Proper and technically expert attention to prevention for young people should be strengthened and integrated into any future project.
5. The same is true for gender perspectives on prevention, with all internal and external gender mainstreaming training focusing on practical (and long-term, monitored, evaluated and reported) application of gender-sensitive approaches throughout the life of the project.
6. Prevention for positives does not appear to have been addressed as a priority by GHAIN in terms of actual implementation of activities, despite close discussion in the GHAIN Year 7 OP overview document (GHAIN 2010e). This situation will need to be rectified in future projects.
7. Partnerships between programs/projects and implementing agencies need to be realistic in terms of genuine suitability and comparative advantage. Inclusion of FBOs as C/OP implementing agencies does not represent best practice.
8. The brief encounters possible during the EOP evaluation with community pharmacists indicate that there may be scope for further linking of community pharmacists into C/OP activities (see also 4.4. Pharmacy services (including community pharmacists)).

III. FOCUS ON MEN WHO HAVE SEX WITH MEN

Introduction and background

During Year 6, GHAIN extended its prevention work to men who have sex with men (MSM). In Year 7, GHAIN will continue supporting the two informal networks of MSM in Lagos and the FCT, to conduct peer education training and stimulate demand and uptake of a range of HIV prevention services including testing and counseling.

The training will aim at equipping participants with appropriate knowledge and skills to influence positively the behavior of their peers towards taking precautionary measures to prevent HIV infection during sex and promote skills for protecting their female partners (those who have them). Furthermore, GHAIN will use different communication channels including components of the mass media, interpersonal communication and IEC materials to reach these often hard-to-reach populations with HIV/AIDS awareness including information on signs and symptoms of HIV/AIDS, prevention methods, treatment and care opportunities, prevention and treatment of sexually transmitted infections, prevention with positives, and decision making skills.

In addition to behavior change messages, GHAIN will provide MARP peer educators with condoms supply to their peers to motivate and encourage behavior change for safer sex practices. Working with the Society for Family Health (SFH) and other USG implementing partners (IPs), GHAIN will secure and supply an estimated 20 million male and female condoms to all target MARP. Additionally, the project will continue to avail condoms in all its supported comprehensive care centers and making them accessible for both family planning and HIV prevention, thus making the sites able to provide dual protection services to their clients.

Implementing agencies (apparently not including health facilities) will be supported to promote further the correct and consistent use of condoms, especially for casual and other high-risk sex such as commercial sex and sex among same sex partners. The activities supported will seek to strengthen the capacities of implementing agencies and their staff to train peer educators among MARP for effective information dissemination, and for them to become effective strategic behavior change communication agents.

Challenges

- Hostile social and political environment - thus stigma towards MSM (and CSW) still high
- High attrition of trained peer educators especially MSM (and CSW) peer educators

Gaps

- GHAIN has not made best use of international best practice in terms of engaging with most vulnerable people, such as MSM
- Lack of appropriate BCC/IEC materials among peer educators to use to reach MARP such as MSM
- GHAIN does not have specialist expertise to develop messages and materials in effective partnership with the most vulnerable, e.g. MSM
- Lack of clear link and follow up of MARP by peer educators to STI/HCT/ART services.

APPENDIX G: COMMUNITY AND PHC-BASED SUPPORT INTERVENTIONS (HAST LGAS)

This Appendix should be read while bearing in mind sections 1.2, 4.6. Health systems strengthening and Appendix H (that discusses, *inter alia*, community system strengthening) and very much also 4.3. Orphans and other vulnerable children. See the map and chart at the end of this section for further details as to geographical spread of GHAIN HAST activities and dates of engagement.

HAST stands for *HIV/AIDS, SRH and TB services at Local Government Area level*. The original name included STI rather than SRH.

Introduction And Background

The primary rationale for focus on LGA-level interventions is a realization that most HIV and AIDS services are located at secondary and tertiary health facilities, yet these are increasingly overwhelmed with clients, are often managed as vertical interventions and are not always responsive to demand-side needs. This is the case with many of the GHAIN-supported comprehensive ART sites. If scale-up of HIV, SRH and TB (and linked) services is to be achieved (the ‘one-stop-shop’ approach), then decentralization to PHC level is essential, in order to bring services closer to clients. PHC facilities represent more than 70% of all Nigerian public health facilities. There are clear opportunities to develop health service delivery synergies by integrating decentralized services - and many challenges, too, as will be discussed. A central plank of the HAST model is the active involvement of community-based organizations (CBOs) and community members, as peer educators and community volunteers.

National Nigerian policy increasingly focuses on the need to deliver all such services at PHC and community levels (e.g. the NSHDP 2010-2015). The 2nd NSF II principle states: “Multi-sectoral approach that is community-based and forges broad partnerships, dialogue, consultations, coordination and synergies at all levels.” (NACA 2009; p2). Objective 4 of the NSF II component on *Care and Support of People Living with and Affected by HIV/AIDS* is: “To support effective referral and linkages within and between relevant health care facilities and community-based care services - improved by 80% by 2015” (ibid. p20).

The GHI addresses ‘coordination, collaboration and integration – at all levels’; its Operational Plan describes the imperative need to “Innovate for results: Identify, implement, and rigorously evaluate new approaches that reward efficiency, effectiveness, and sustainability. Focus particular attention on promising approaches to service integration and delivery, community-based approaches...”. (USG 2009a; p8). The GHI intention is that PHC service delivery should be genuinely integrated and address clients’ needs.

GFATM is similarly attentive to the requirement to bring services closer to communities: “In round 9 [in Nigeria] the gap in access and coverage of HIV services to rural communities will be bridged by further decentralizing HIV/AIDS prevention, care and support services to the PHC and community levels...” (GFATM 2009; p2).

The GHAIN process of engaging with an LGA to set up a HAST is stated broadly to apply the following steps (information provided by GHAIN; all details were not followed up during the end of project evaluation field visits to HAST LGAs, due to time pressures):

1. 'Pre sub-agreement/pre-contract' activities' phase: GHAIN often undertakes considerable sensitization, assessments, CBO selection, formation of HAST committees and discussion of program interventions to be covered by the sub-agreement, before those are actually signed. Sub-agreements are signed with the LGA health authority. This covers e.g. the remit of the Health Management Committee, facility refurbishment, training and provision of commodities. Time is often spent after signing on preparation of LGAs and CBOs, before funds are released for core activities. Sensitization can include development of trust, 'participatory planning with stakeholders' and initiation of partnerships. This phase is not funded through the sub-agreement mechanism. As can be seen from Table 1 below, field activities began in quite a few of the fifteen HAST LGAs before any sub-agreement was signed (while in Wudil LGA the opposite has been true).

2. Post sub-agreement activities phase: during this time, activities contributing to systems strengthening, such as trainings, staff recruitment for the implementing agency (i.e. the umbrella CBO), continued collaborative planning and establishment of linkages and networks, precede actual funding for the implementing agency.

GHAIN presents the HAST model as offering: integrated HAST services; LGA system strengthening; community system strengthening; and linkage of community services to facility-based services. It is perceived by GHAIN as a crosscutting activity and one that supports HSS.

“[HAST] is an integrated approach, coordinated by the local government health authority and links community based activities to health facilities through a network of referrals between implementing agencies...under the lead of an umbrella NGO which is contracted by and reports to the LGA administration.” (Ibrahim, M., Cartier, S. A., Gana, C., Adegoke, F., Abdallah, A., Chabikuli, O. & Hamelmann, C. (not dated: 2009/10); p4).

GHAIN is implementing a number of exit/sustainability actions targeted at HAST. According to information received by the end of project evaluation team, these include: “creation of decision-making structures within LGA secretariats, support to HAST committees (chaired by the LGA PHC coordinator), assistance with budget development that includes HAST-related activities, support/inclusion of the LGA M&E officer in data collection and efforts to strengthen CBOs to be able to compete for unlinked funding.” (GHAIN communication October 2010.)

Implementation of HAST is a major undertaking for GHAIN, as well as a significant change of direction towards community engagement and CSS. These factors should be borne in mind when reading the remainder of this section.

Achievements

The HAST model has been the GHAIN entry point vehicle for something that has to be done in the Nigerian context: moving towards integrated PHC ART service delivery. The intention has been to move away from what have been in the past vertical delivery systems towards a more integrated and responsive approach that is reflective of resource-poor setting constraints. GHAIN has begun a process through the HAST model for decentralization of HIV/STI (now expanded to SRH)/TB services to PHC facilities and the community (working with community volunteers, peer educators and

community pharmacists). The HAST model is intended to strengthen mechanisms for eventual referrals to the secondary health facility located in each LGA.

As such, the GHAIN experiences of HAST work to date should serve as lesson learning for all USAID/Nigeria implementing partners working on community/demand-side approaches to HIV and other health interventions, with achievements, challenges and gaps all rigorously scrutinized and put to best use in future planning for optimal PHC and community service delivery.

GHAIN has committed considerable time and effort to developing and supporting the implementation of the HAST model; these activities have been predominantly theorized and led from the country office, while management has been largely from GHAIN zonal office level (NB: the fifteen HAST LGAs are situated in nine states and the FCT. Not all zonal offices are engaged with HAST, e.g. the North East zone). LGAs, umbrella and partner CBOs and community members volunteering to work with HAST have also invested very substantial time, effort and energy into supporting activities. Many people have done so in a spirit of admirable voluntarism.

The HAST model is multi-faceted and comprehensive in its components, all of which are being supported by GHAIN. It is important to bear in mind that the full range of support and activities are not being implemented in all fifteen HAST LGAs; this is especially the case for those whose sub-agreements have recently been finalized.

GHAIN describes the range of inputs at LGA level (it was again not possible to check all such process during end of project evaluation field visits):

Health systems strengthening

- Support to the HAST LGA Secretariat, PHC Department and M&E department:
- Training of health workers and support for regular supervision of service delivery, managers and M&E staff members
- Provision of equipment (e.g. computers), data management software (e.g. DHIS), support to LGA M&E meetings
- Some financial management training (see the draft GHAIN *HAST Operations' Manual* (not dated) for the range of supported intended/provided)
- Financial support to the LGA PHC Department (upwards of Naira 100,000 per month)
- Refurbishment of PHC facilities (e.g. in Kachia LGA in Kaduna state 9 of the total 56 PHC clinics have been refurbished by GHAIN through HAST)
- Leadership and stewardship: strengthening of the LGA Health Management Committee, whose membership is expanded to include CBOs, traditional and religious leaders and others engaged in the HAST process

Community systems strengthening

- Mapping of CBOs in the LGA
- Support to Ward Development Committees
- Work with community gatekeepers – traditional and religious leaders
- Selection of an umbrella CBO and signing of sub-agreement
- Selection of 4 further CBOs to work with the umbrella CBO (each CBO works in at least 1 Ward)

- Support to umbrella CBO (and to an extent also the 4 partners): management and technical capacity strengthened
- Support to CBO enrollment, training and management of peer educators and community volunteers (CVs) to provide community services (core messages include information on HCT and ART being free)
- Peer educators trained on A & B, seek to work with young people. Some have just been trained on the *Minimum Prevention Package*
- CVs do home visits, provide IEC, refer people to the PHC and report back to their CBO
- PLHIV are encouraged to participate as peer educators and CVs

Support to orphans and vulnerable children

- Support to strengthening community services for orphans and vulnerable children (OVC)
- Use of the Child Status Index
- OVC identification and registration by CBOs
- Inclusion of OVC on the GHAIN-developed KidMAP data management system (held at umbrella CBOs)
- Selection of OVC caregivers
- Provision of elements of the OVC Minimum Service Package (that covers health, education, shelter, protection/security, etc)

KidMAP

This is an electronic database developed by FHI for the HAST OVC program; it presently includes data on 18,300 OVC (as of August 2010)

Its intention is to support effective coordination and monitoring of the OVC program. KidMAP has been provisionally endorsed by the Federal Ministry of Women's Affairs and Social Development as a national database for OVC programs. (See also GHAIN 2010c).

To date (October, 2010), 213 peer educators are supporting services in 93 facilities and 351 CVs have been trained and supported to work in nine HAST LGAs. 1308 TB patients received treatment support from CVs between June 2008-Dec 2009. One achievement perceived by LGA staff members is that implementation of the HAST model in itself necessitates more engagement with community members as active partners.

Challenges

1. Lack of guaranteed support from state level to HAST LGAs. LGA annual plans may not be funded or if monies are allocated these may not be disbursed. Such issues must gravely compromise post-GHAIN sustainability.
2. Some linkages have been developed between SACAs and HAST LGAs, but these are not systematized. SASCPs appear out of the loop almost entirely.
3. Only a few PHC facilities can be refurbished and otherwise supported through HAST; this has resulted in community members 'abandoning' unsupported PHCs and seeking to gain access to 'HAST PHCs'. This can result in considerable and increased opportunity costs and also reduced access for some members of the community, e.g. women in the north.
4. Sometimes grossly inadequate human resources for health, which results in seriously compromised delivery of any PHC services – and may also result in over-emphasis on

HAST service delivery, to the expense of other conditions and diseases.

5. Lack of engagement in HAST of key public sector stakeholders, e.g. state Ministries of Local Government. Despite the links with the Federal Ministry of Women's Affairs and Social Development, this is absent at state and LGA levels.

6. Overall inadequate or non-existent training of health workers and local government officers on community engagement, community systems, accountability to community members, gender and health, support to orphans and vulnerable children, child protection, social protection writ large, social exclusion, and other social development foci essential when seeking to build and then sustain community (health) system strengthening.

Gaps

Limitations of the HAST model

- One significant limitation of the HAST model is that it is not fully in line with WHO's Integrated Management of Adolescent and Adult Illness, nor its Integrated Management of Childhood Illness. There is a risk that the HAST emphasis will distract from delivery of critical primary health care services — such as those concerned with child health and safe motherhood. Neither WHO approach advocates focusing on three infectious diseases. Currently HAST places unsustainable burdens on under-capacitated health workers and community volunteers as well as on CBOs.
 - Its implementation to date has not adequately strengthened overall health systems at LGA level and may in fact have introduced ultimately unsustainable and vertical/silo HIV, STI and TB service delivery elements.
 - There are also ethical issues to be addressed, e.g. support to orphans and vulnerable children; HAST OVC services are inadequate.
 - Neither umbrella nor any implementing CBOs has received appropriate and tailored HSS/CSS training in order to support effective delivery of HAST services.

The Global Health Initiative seeks to support integrated PHC service delivery; as currently implemented HAST diverts attention from such a broad-based approach to PHC service delivery.

As currently implemented, the HAST model does not adequately address strengthening of primary health care, it prejudices delivery of safe motherhood and child health services and its OVC services are notably inadequate. HAST is *de facto* positioned in competition with overall primary health care service delivery.

In some HAST LGAs visited there was evidence of increased uptake of services; while this is encouraging, it needs to be viewed in the context of insufficient information on whether such uptake was supported at the expense of other PHC service components and also on the quality of service provided.

In one HAST PHC facility visited one CHEW was delivering all PHC services (with the addition of HAST) with two orderlies. This represents inadequate human resources even to deliver services answering to the three HAST infectious disease areas, let alone wider PHC. While there would be similar challenges in delivering IMCI and IMAI, at least these would not separate out other important components of PHC to the extent seen in HAST contexts, where primary focus was given to addressing HIV, STIs (more

than SRH) and TB. This has resulted to an extent in a wider verticalization, away from a single disease silo (in itself not ideal) to one covering three diseases.

Insufficient ownership of HAST by LGAs

A key example of top-down and too close management by GHAIN is that the end of project evaluation team discovered evidence of pre-prepared data in several LGA M&E departments. In other words, charts had been developed by GHAIN zonal offices and given to LGA M&E officers to present as their own work; this became obvious when individual M&E officers were unable to provide analysis and interpretation. Moreover, evidence was found that on occasion LGA and/or umbrella CBO M&E officers are unable to use DHIS and KidMAP.

Insufficient support to umbrella and other CBOs

Neither umbrella nor implementing CBOs have received appropriate Health/Community Systems' Strengthening in order to support effective delivery of HAST services. In addition, training on management of confidential data and action to reduce stigma and discrimination appear to have been absent. No social development focus was apparent.

Inappropriate volunteer selection and insufficient training

Selection and training of volunteers appears to have been flawed. For instance, most community volunteers are at the least middle-aged while some are elderly – and the majority is male. While individuals' commitment and voluntarism should not be questioned, their capacity to gain access to, and then engage with, the opposite sex and other age groups, especially the young, does need to be considered. Peer educators in Wamakko HAST LGA in Sokoto state and Kachia HAST LGA in Kaduna state were embarrassed and confused when asked about provision of OP behavior change communication to MARP.

Inadequate links to the public sector

State Ministries of Local Government have not been adequately integrated into the HAST model, yet these are key actors in management of human resources for health. LGA Social Welfare Units have been sidelined in the HAST process, yet these are key community-public sector interfaces (see also the comment regarding the Federal Ministry of Women's Affairs and Social Development).

Inadequate and inappropriate OVC processes

The process of orphans' and vulnerable children's enrollment began in May 2010 in some HAST LGAs; this is entirely inappropriate, as support will be short-lived given the few months left until EOP. The very process itself is flawed; to cite just a few examples:

- There appears to be public and all too speedy identification of OVC, which in itself may lead to increased stigmatization and potentially also gender bias (more boys than girls appear to have been registered)
- There seem to be inadequate data on type of OVC, e.g. if a child is a single or a double orphan, if s/he is living in a child or female-headed household
- Some caregivers are entirely inappropriate: they have no relationship to the OVC, there is no supervision of type and quality of care given
- Few OVC know their HIV status (not one of approximately 2,000 registered in Wamakko LGA in Sokoto state), and

- there appears to be insufficient attention given to children’s rights (inadequate adherence to the provisions of the Convention on the Rights of the Child, to which Nigeria is a signatory)
- Inadequate and at times inappropriate application of both the Child Status Index (e.g. insufficient safeguards of children’s autonomy) and the Minimum Service Package (e.g. seeming across the board prioritization of deworming as the sole/chief health intervention, perhaps without due attention to individuals’ needs)
- Seeming absence of links between GHAIN-supported HAST OVC interventions and GHAIN-supported support groups; no child of a support group member was described as having received any such assistance.

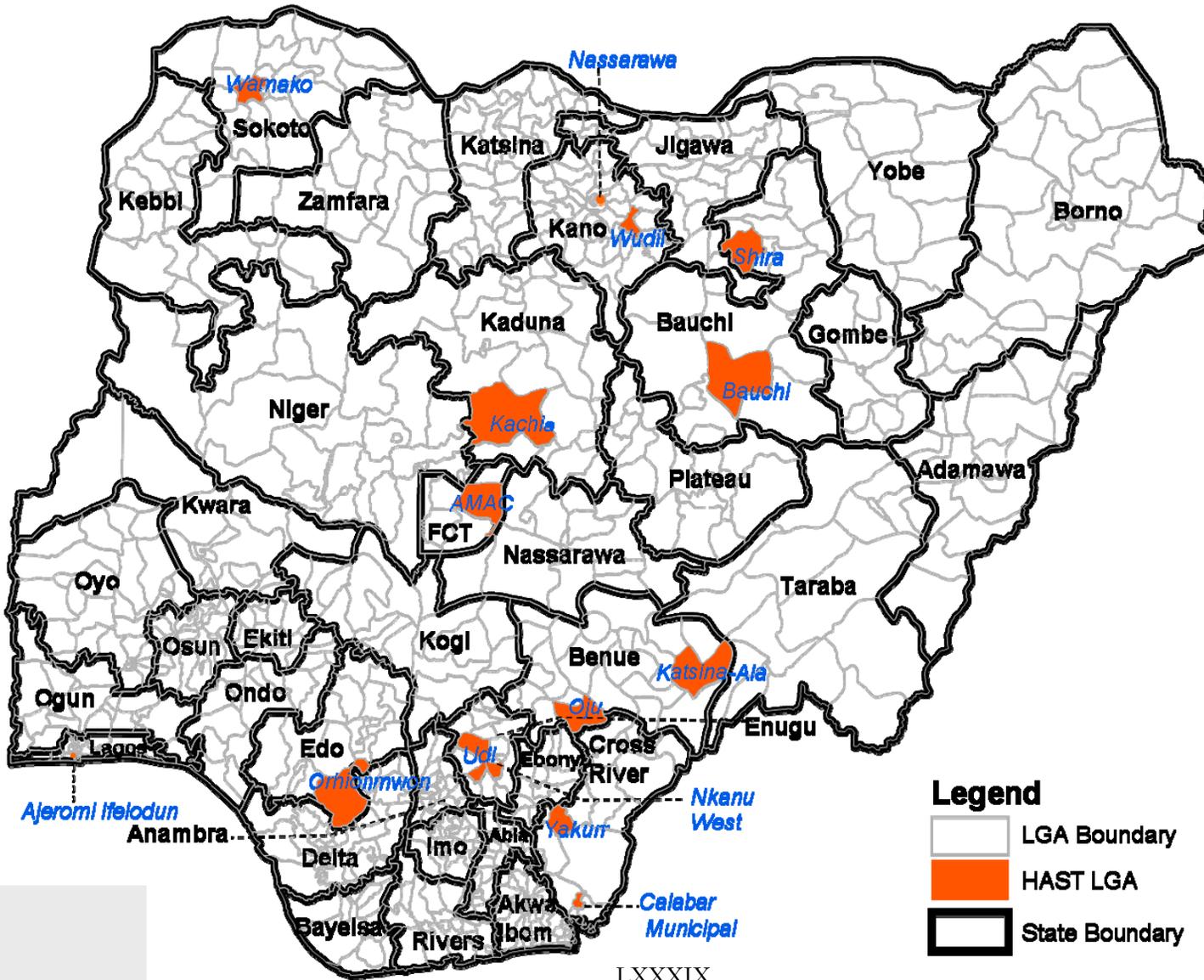
Inappropriate selection of caregivers

Evidence of this was found primarily in Wamakko LGA, during a field visit to Gumbi community. A number of the caregivers interviewed appeared to have been selected due more to their closeness to community leaders rather than either their appropriateness or a pre-existing relationship to the child in question. Discussion as the roles and responsibilities of caregivers elicited occasionally inadequate responses.

Lessons learned

1. The main lesson is that activation of HAST (*de facto* a health district intervention, with several facilities and communities) is very different from activating a district hospital for ART. It is important to bring all stakeholders on board early, governmental (LGA secretariat) and non-governmental (CBO, community gate keepers/leaders, etc) and keep them engaged too. All this takes time but is essential for ownership and sustainability.
2. Proper, preliminary and participatory mapping of stakeholders, capacities, existing activities, health needs, socio-cultural barriers to health-seeking behavior, etc is essential in order to provide a firm foundation for HAST-type action.
3. Learning from other interventions and international best practice is crucial. FHI itself has experience from the DFID Nigeria funded *Supporting the National [HIV & AIDS] Response*, where its partner Action Aid Nigeria (an organization with international renown in social development, community systems and gender) supported community systems strengthening.
4. It is of absolutely critical importance that all community-focused interventions be supported by adequate technical expertise in CSS, social development, gender, OVC, social protection, rights, and other fundamental social development approaches. A primarily biomedical approach will not work, however well intentioned it might be.
5. Child and wider social protection expertise should be an intrinsic and non-negotiable component of all community-based interventions.
6. The rights of the child and of adults should be thoroughly integrated into all components of any community intervention; this is not the case with HAST.

FIGURE 1: MAP OF GHAIN-SUPPORTED HAST LGAs



Legend

-  LGA Boundary
-  HAST LGA
-  State Boundary

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Table 1 HAST LGAs: process of GHAIN inputs (data provided by GHAIN October 2010)					
State	LGA	Date sub-agreement executed	Date field activities started	Project Title	Umbrella CBO
Kano	Nassarawa	March 3, 2008	Feb 15, 2008	Nasarawa LGA Council PHC HAST Project	Society for Women and AIDS in Africa (SWAAN) Kano
Cross River	Yakurr	March 11, 2008	Feb 15, 2008	Yakurr LGA/PHC HAST Project	Initiative for People's Good Health Kano
Kano	Wudil	April 12, 2008	March 1, 2010	Wudil LGA Council PHC HAST Project	Development in Action
Sokoto	Wamakko	June 13, 2008	July 1, 2008	Wamakko LGA Council PHC HAST Project	Save the Child Initiative Sokoto
Enugu	Udi	June 26, 2008	July 1, 2008	Udi LGA Council PHC HAST Project	National Union of Road Transport Workers Awka
Edo	Orhiomwon	July 4, 2008	July 1, 2008	Orhiomwon LGA Council PHC HAST Project	Girls' Power initiative, Edo
Bauchi	Bauchi	July 14, 2008	June 15, 2008	Bauchi LGA Council PHC HAST Project	Forward in Action for Education, Poverty and Nutrition
Kaduna	Kachia	Sept 9, 2008	Sept 10, 2008	Kachia LGA Council PHC HAST Project	Federation of Muslim Women Associations of Nigeria (FOMWAN), Kaduna
Lagos	Ajeromi/Ifelodun	Oct 20, 2008	Sept 1, 2008	Ajeromi-Ifelodun LGA Council PHC HAST Project	Amukoko Community Partners' Organization
Enugu	Nkanu West	March 22, 2010	March 1, 2010	Nkanu West LGA Council PHC HAST Project	Voice of Children International
Cross	Calabar	April 13,	March 1, 2010	Calabar Municipal LGA Council	Positive Development Foundation. Cross River

River	Municipal	2010		PHC HAST Project	
FCT	AMAC	April 20, 2010	August 1, 2008	Abuja Municipal Area Council PHC HAST Project	Catholic Action Committee on AIDS (CACA)
Benue	Oju	April 26, 2010	March 2, 2010	Oju LGA Council PHC HAST Project	Association for Promoting Quality Education in Igedeland, Oju LGA
Benue	Katsina Ala	April 29, 2010	March 1, 2010	Katsina Ala LGA Council PHC HAST Project	St. Gerald's Parish Action Committee on HIV/AIDS (PACA), Katsina Ala LGA
Bauchi	Shira	May 12, 2010	March 1, 2010	Shira LGA Council PHC HAST Project	Shira Yana Fahimta, Shira

APPENDIX H: GENDER AND SOCIAL DEVELOPMENT and COMMUNITY SYSTEMS' STRENGTHENING: POTENTIAL LESSONS FOR GHAIN AND FUTURE PROJECTS

This Appendix considers three topics: gender and social development and community systems strengthening. These are outwith the objectives of the evaluation and not in receipt of any funding under the GHAIN cooperative agreement. Nonetheless, each is of relevance, both for the remainder of the GHAIN project and especially for development and implementation of SIDHAS and for other USG-supported programs in Nigeria. Each topic has considerable implications in terms of attention to demand-side, client-focused definitions of quality and also to sustainable health system strengthening.

I. GENDER AND SOCIAL DEVELOPMENT

Introduction and background

The NSF II is more informed than was its predecessor by a social development agenda that seeks to address both supply and demand-side aspects of the epidemic. This is indicative of Nigerian and global developments regarding how best to support prevention as a priority while attending to the whole continuum of support to HIV, from prevention through care, support and treatment. The NSF II is more specifically detailed too in its attention to gender aspects of the epidemic and the need to address social development issues if gender-sensitive prevention initiatives are to be successful.

The first of the seven principles at the core of the Global Health Initiative states: "Implement a woman- and girl-centered approach". This gender-aware approach represents a significant shift in terms of explicit focus on such matters (there appears to be less consideration of male aspects of gender). The current PEPFAR five-year strategy and the PEPFAR Next Generation Indicators (PEPFAR 2009a & b) similarly indicate more explicit and more coherent attention to issues of gender and socio-cultural attitudes and behaviors than was often previously required for PEPFAR-supported programs. These issues are considered in the strategy and the NGI in the context of impacts on fundamental aspects of rights to health such as health-seeking behaviors and access to information, services, treatment and care.

"As a component of the Global Health Initiative, PEPFAR is working to implement women-centered care, and to ensure that its services are gender-equitable. Its programs address the particular vulnerabilities faced by women and girls, especially those who are impacted by gender-based violence..." (PEPFAR 2009b; p16).

The PEPFAR NGI Prevention sub-area 12 solely addresses gender; the Health Systems' Strengthening sub-area 6 (HSS Governance) includes gender as one of the Essential/Reported PEPFAR Indicators; the Prevention (General Population: AB interventions) describes the need to consider and address 'social and gender norms'. Appendix 4 (Monitoring Policy Reform) includes gender as one policy area and goes into considerable detail regarding both female and male gender issues, gender-based violence, etc, all through the prism of supporting more equal access to prevention, care, support and treatment, irrespective not only of gender but also of ethnicity, religion, age, social status and any other defining characteristics that might inhibit such access.

There is now an abundance of published and grey literature that demonstrates the barriers to health and HIV care that are all too frequently imposed by gender norms and socio-cultural attitudes and behaviors. Much work has been done to support greater

gender equity in HIV programs ³⁹. However, despite more than two decades' focus on gender and societal norms in the context of HIV, many deep-rooted and seemingly intractable barriers remain in Nigeria.

GHAIN and gender and social development

There is inadequate technical expertise within GHAIN on these two key crosscutting areas. One overall EOP evaluation finding is that there is insufficient gender and social development expertise within GHAIN, whether at country or zonal level; where such expertise does exist, e.g. in the North East zone, it appears that there is inadequate programmatic scope for the use of such skills. Therefore, although the COP09 gender overview document (GHAIN 2009e) goes into considerable detail as to a comprehensive, mainstreamed, coherent, consistent and crosscutting approach to gender, actual evidence of such focus was thin on the ground during the EOP evaluation. This was equally true of demand and supply-side activities, e.g. in HAST LGAs and in secondary health facilities.

Close questioning at GHAIN country and zonal office levels did not reveal any advisor or program officer specifically tasked with gender responsibility. None provided information on any dedicated gender training for GHAIN staff members or any coherent programmatic attention or inputs. There has been no internal or external gender mainstreaming undertaken by GHAIN. These are oversights that should have been addressed from the outset of the program in 2004, notwithstanding the initial focus on emergency treatment. It is impossible to calculate whether closer attention to gender and social development would have had impacts on GHAIN outcomes.

Questions on gender and socio-cultural perspectives (the latter commonly defined under the rubric of social development) were included in KIIs held with country and zonal office staff members responsible for prevention, SBBC, HAST, other community and OVC activities. Few of these KIIs elicited adequate responses in terms of awareness of the importance of gender and social development issues in the context of HIV.

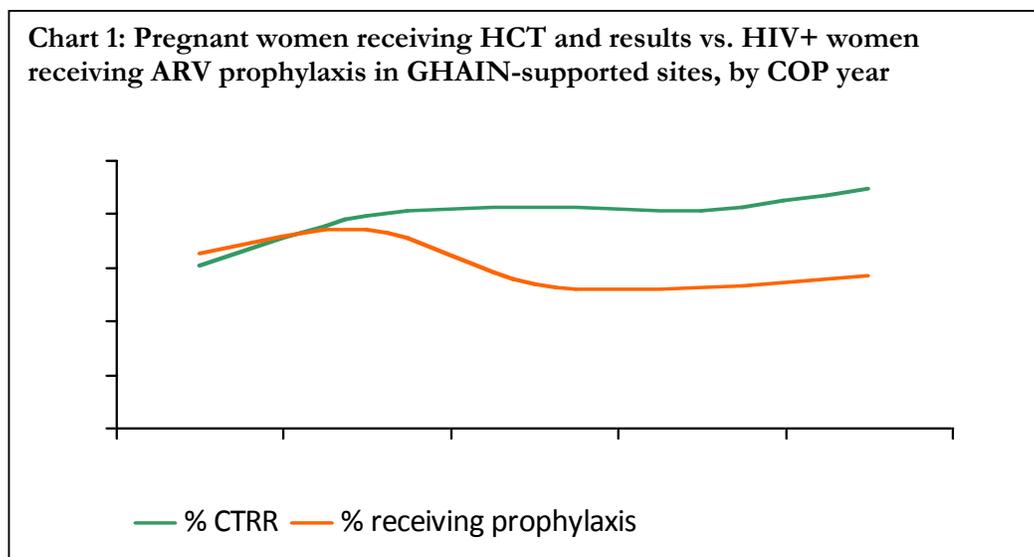
One example may suffice to indicate the potential limitations on inputs and effectiveness when gender and social development technical expertise are not integrated into interventions.⁴⁰ This is the work undertaken by GHAIN to examine the impact of HCT on PMTCT in sixty GHAIN-supported sites before and after quality assurance/quality improvement (QA/QI) interventions. GHAIN has estimated that MTCT events averted that are attributable to QA/QI are between 55 (4.6%) and 106 (9%) - as an aggregate of clients at all sixty facilities.

The 'root-cause analysis' undertaken by GHAIN addresses four perceived root causes of potential reasons for the 'service gap' in terms of number of pregnant women testing positive and receiving results, vis-à-vis those on ART. These four root causes are: policy, providers; resources; and patients. While all four are entirely relevant as influences on whether or not women receive prophylaxis and the 'patient level causes' note issues such as cost and domestic violence and further mention poor adherence and low levels of facility deliveries, there is overall an absence of a gender and social development lens specific to planned programmatic inputs. Thus the next step is described as cost-effectiveness analysis of the QA/QI effect. It might be argued that

³⁹ Including two WHO publications to which the evaluation team leader was a contributor (WHO 2003 & 2009). See also GFATM 2010c.

⁴⁰ This discussion is based on information in Chabikuli 2010 and debate at the presentation at USAID Nigeria on 10/19/2010. Chart 1 is from that presentation (Chabikuli 2010).

while such a study is relevant, there is need also for further inputs specific to addressing why some women may have low levels of adherence and why facility deliveries remain stubbornly low, especially in some parts of Nigeria such as the rural North. The 2008 DHS states that 8% of women in the North West zone deliver in any type of health facility (NPC & ICF Macro 2009).



An absence of gender mainstreaming and social development focus within GHAIN appears to have resulted to an extent in somewhat mechanistic and superficial interpretations, which may have had repercussions in terms of quality of interventions. There is incomplete disaggregation of many data sets, beyond sex, while further analysis may have revealed information on e.g. opportunity costs, gender-based barriers to health-seeking behaviors, etc. This incomplete focus is evidenced in e.g. FHI 2009 (the Application for Project Extension) and in Year 7 GHAIN documentation.⁴¹ There is also a virtual absence of attention to gender in the *GHAIN Performance Monitoring Plan: 1st October 2010 – 30th June 2011* (GHAIN 2010b), beyond one reference to ‘gender equality’; there is no mention of social development.

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II. COMMUNITY SYSTEMS STRENGTHENING

See also section 4.6. Health systems strengthening, as health and community systems should at all times be viewed as equal parts of a continuum addressing achievement of optimal support to potential and existing health and HIV beneficiaries. In addition, see section 4.3. Community and PHC-based support interventions (HAST LGAs) and Appendix G on HAST, which is the GHAIN component addressing community and

⁴¹ It should be noted that such lack of attention is not limited to GHAIN activities and documentation; see e.g. NACA 2009b (the DQA report).

⁴² It should be noted that such lack of attention is not limited to GHAIN activities and documentation; see e.g. NACA 2009b (the DQA report).

PHC-level interventions.

Introduction and background

GFATM has emerged as having particular current focus on the need for community systems strengthening (CSS), specifically to establish integrated demand-side interventions to improve access and also as an entry point for leveraging multi-faceted approaches to support the goal of more equitable health service delivery.

‘CSS is a way to improve access to and utilization of formal health services but it is also, crucially, aimed at increased community engagement (meaningful and effective involvement as actors as well as recipients) in health and social care, advocacy, health promotion and health literacy, health monitoring, home-based and community based care and wider responses to ensure an enabling and supportive environment for such interventions. This includes direct responses by community actors and also their engagement in responses of other actors such as public health systems, local and national governments, private companies and health providers, and cross-sectoral actors such as education and social protection and welfare systems.’ (GFATM 2010b: p1).

There is currently debate on the need for the WHO six Health Systems Strengthening (HSS) ‘blocks’ (as applied by GHAIN since mid/late 2008) to become ‘6+1’, with the addition of CSS and its integration into a scheduled and funded system strengthening program. There is also increasing realization that further HSS focus on training of health workers will be required, to facilitate shifts in attitudes and behaviors towards community members being accepted as partners in health. Notwithstanding this current prioritization of CSS, there has been long-standing understanding in the international development community that HSS cannot be achieved in isolation from the socio-cultural context in which services are provided and that community actors and social capital require strategic, planned, time-lined support to enable effective partnerships to be developed.

A wealth of international and Nigeria-specific best practice evidence exists regarding action to strengthen communities’ engagement in provision of health services. One such is the now closed DFID Nigeria-funded program *Strengthening the National Response* (to HIV & AIDS, elements of which have been continued in the current DFID-funded program *Expanding the National Response*). FHI was the lead partner in SNR, yet read-across from its community work to GHAIN appears to have been minimal at best. Action Aid International Nigeria led on community engagement in SNR through applying its civil society/community *Partnership and Development Assessment Framework* (PADEF) approach; SNR set up the ‘Community Drivers of Change’ process, which was inclusive of young people and women. Prevention was taken to the community level and a degree of genuine ownership transferred.

GHAIN and CSS

The GHAIN program has had no explicit focus on CSS, it seems primarily because this has not been required as part of programmatic planning. There is insufficient technical expertise in-house on civil society engagement and community support, gender and social development, or indeed on medical anthropology, all of which approaches address CSS. The initial thrust of GHAIN as an emergency treatment program whose primary objective was to build numbers of people receiving ART also militated against close attention to more nuanced issues of community engagement. However, any program or project engaging at community level should nowadays have knowledge of, and expertise in, community system strengthening.

GHAIN has not paid sufficient consistent attention to issues of community

engagement or gender and societal norms, all of which are likely to have considerable influences on health-seeking behaviors. In addition, pre-NGI PEPFAR indicators required insufficient disaggregation, not only in terms of sex, but for other potentially significant criteria such as age, religion, place of residence, level of education, marital status, etc.

Close questioning at GHAIN country and zonal office levels did not reveal any advisor or program officer genuinely knowledgeable about CSS, let alone specifically tasked with CSS responsibility. The HAST intervention addresses CSS in a piecemeal fashion if at all. Working with community-based organizations, even offering program-specific training, does not constitute coherent CSS focus.

Findings from the GHAIN evaluation indicate the challenges inherent in working towards achievement of an effective, sustainable integration of health and community system strengthening interventions at primary health care level. See 4.3. Community and PHC-based support interventions (HAST LGAs) for the discussion on the GHAIN HAST intervention, which exemplifies the difficulties. It is reiterated here that any future project with similar magnitude, reach, capacity and potential access to that of GHAIN should not be designed and implemented without effective social development, gender and CSS expertise, whether in-house or as part of a coherent TA call-down contract.

APPENDIX I: PRESENTATION TO USAID/WASHINGTON (12/03/2010)

(Note: This Appendix was deleted due to the procurement sensitive nature of its content.)

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