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LEADERSHIP, MANAGEMENT, AND SUSTAINABILITY—PREVENTION, ORGANIZATIONAL SYSTEMS AIDS CARE AND TREATMENT (PROACT) PROJECT

MID-TERM PERFORMANCE EVALUATION

FINAL REPORT

October, 2012

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DISCLAIMER

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LIST OF ACRONYMS

ANC	Antenatal Care
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
CBO	Community-Based Organization
CEO	Chief Executive Officer
CSO	Civil Society Organization
DOTS	Directly Observed Therapy, Short-Course
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
GI	Group Interview
GON	Government of Nigeria
HCT	HIV Counseling and Testing
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IP	Implementing Partner
IPT	Intermittent Prophylactic Therapy
KII	Key Informant Interview
LACA	Local Agency for Control of AIDS
LGA	Local Government Area
LMS-ACT	Leadership, Management, and Sustainability AIDS Care & Treatment Project
LMS	Leadership, Management, and Sustainability Program of MSH
MARPs	Most-at-Risk Populations
M&E	Monitoring and Evaluation
MEMS II	Monitoring and Evaluation Management Services
MOH	Ministry of Health
MSH	Management Sciences for Health
NACA	National Agency for Control of AIDS
NASCP	National AIDS and STI Control Program (of the Ministry of Health)
NGO	Non-Governmental Organization

OVC	Orphans and Vulnerable Children
PE	Peer Educators
PEP	Post-Exposure Prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PITC	Provider-initiated Testing and Counseling
PLWH	People Living With HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
ProACT	Prevention Organizational AIDS Care Treatment
SACA	State Agency for Control of AIDS
Step-down training	Onsite Skills Transfer and Training
SMOH	State Ministry of Health
TA	Technical Assistance
TB	Tuberculosis
ToT	Training of Trainers
USAID	United States Agency for International Development
USG	United States Government

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EXECUTIVE SUMMARY

Nigeria's colonial inheritance since independence from a federal system, comprising a loose affiliation of states that vary according to provincial allegiances, makes it particularly difficult to formulate a single, national healthcare policy. State and local government capacity varies widely, as does the capacity of each state (and distinct regions within states) to manage resources and administer social services efficiently. Accordingly, this report documents the disparity between those regions that are unusually well prepared to meet the complex healthcare needs of populations facing dissimilar degrees of human immunodeficiency virus (HIV) risk and those that are, as yet, unprepared.

The risk of HIV moving into the general population changes greatly from region to region due to the country's diversity of cultural practices. Some regions merit an immediate, strong campaign to promote HIV prevention among high-risk populations; others require advance preparation before such a campaign can be effective. For these reasons the differing HIV risk profiles among the population as a whole requires a nuanced, rather than uniform, national policy. Even though Nigeria still has an average HIV prevalence below 5%, the sheer size of its population gives the country the second-highest number of new HIV infections per year in the world. This makes for an urgent need for a nuanced, effective national policy. Fortunately, Nigeria's abundant resources and growing public support to use them to address the country's health crisis promise to offset many of the challenges documented in this report. Also important, there is growing awareness—both domestic and foreign—that the country's ability to take its place as one of the continent's most successful nations hinges on its ability to address its healthcare challenge.

This is a report of the midterm evaluation of the Leadership, Management, and Sustainability—Prevention, Organizational Systems AIDS Care and Treatment project (ProACT) managed by a US-based contractor, Management Sciences for Health (MSH) in Nigeria, with logistical support provided by its partner, the Axios Foundation.

The ProACT project is a 5-year USAID/Nigeria-funded project that started in the fall of 2009. This \$60 million dollar project, funded by US President's Emergency Plan for AIDS Relief (PEPFAR) is operating in six states in Nigeria. It is a follow-on to a PEPFAR Nigeria-funded project called Leadership, Management, and Sustainability AIDS Care and Treatment Program (LMS-ACT) which started in 2007. It received funding to expand and deepen the LMS-ACT's approach from the 17 original sites to a total of 21, all in the same six states: Kogi, Niger, Adamawa, Taraba, Kebbi, and Kwara. The follow-on project, ProACT, is the subject of this midterm evaluation. ProACT brings more of a focus on sustainable systems-building at the facility and community level, intensive integration, and other sustainability strategies. Also, there is an added component of prevention with high-risk target populations.

The project strategy is a move away from a vertical HIV response and is meant to

- Address the underlying weakness of the healthcare system;
- Ensure that HIV services are more sustainable;
- Ensure a realistic management of the comorbidity of tuberculosis (TB) and HIV; and
- Move HIV from being stigmatized as a fatal disease, but viewed as a chronic illness that is better managed within an integrated healthcare system.

PROJECT FINDINGS

The findings are organized around a group of topics generated by a list of questions in the body of the evaluation scope of work. The questions are organized around the following topic areas:

1. Integration of HIV and TB Services into Routine Public Healthcare Services
2. Project Management and Progress Toward Meeting Objectives
3. Sustainability
4. Capacity-Building
5. Challenges and Lessons Learned

1. INTEGRATION OF HIV AND TB SERVICES INTO ROUTINE PUBLIC HEALTHCARE SERVICES

The majority of the health facilities visited by the evaluation team in both Taraba and Kogi show signs of functional integration of primary to secondary care service integration. This includes records, waiting rooms, healthcare workers, laboratory services, and pharmacy.

Merging facility records proved the most challenging and essential task of integration. Confirmed in the two evaluation sites and by the final report, it was an early success.

Signs of successful integration of care services

- In interviews with people living with HIV (PLWH) as well as staff, the simple fact that all patients, whether HIV+ or not, have the same paperwork contributed to a decrease in stigma.
- Actual structural integration of services has been rapid and well received, and patients report that they feel less stigma and directly relate this to integration into the general patient population.

- An increase in counseling and testing services has continued to exceed the anticipated numbers per year.
- There has been a definite increase in HIV-related services, but there is no clear data to suggest an increase in other healthcare services.
- A marked increase in community mapping and referrals has been an unexpected side benefit of integration.
- Integration appears to be a highly successful strategy for increasing patient satisfaction and use of HIV services

Recommendations About Integration

- The integration of routine healthcare services with HIV care and treatment, as modeled in the ProACT project, deserves support, scale-up and adaption in other states. Essential to the model is early attention to good data collection; intensive targeted training, capacity-building at every opportunity, and attention to mentoring.
- Community health worker and volunteer attrition needs urgent attention. Many of the successes of integration depend on community members being at the center of key care activities

2. PROJECT MANAGEMENT AND PROGRESS TOWARD MEETING OBJECTIVES

Overall, MSH demonstrates exemplary capacity-building through clinical training and mentoring at local government facilities. Under ProACT, the project contributes a great deal to the success of current PEPFAR strategies by creating the opportunities for PLWH to get quality care and treatment for the first time.

The ProACT project team demonstrates successful progress toward integration of vertical programs in some states and sites, and is less successful in others. An example of an unquestionable success due to MSH staff as well as Kogi facility staff is the work in the state of Kogi.

The quality of the treatment and care is solid except for TB and Prevention of Mother-to-Child Transmission (PMTCT). Many of the challenges of meeting targets in these service areas are beyond the control of MSH. A detailed discussion of TB and PMTCT services is in the body of the report.

After a period of success and overachievement on many indicators, ProACT performance became more uneven over the last nine months. This is most evident in the new prevention work among Most-at-Risk Populations (MARPs) and PMTCT. However, ProACT will meet or exceed many of the other key PEPFAR targets, including testing and counseling, treatment, and care.

Attrition of MSH senior staff as well as staff at facilities MSH works with in the field sites has had a significant impact on productivity over the last 6 to 9 months, and actions to resolve this issue where it is under MSH control, by rehiring and recruiting replacement staff, should to be taken as quickly as possible. This is a critical issue that was identified late in the evaluation. It is discussed further on page 3 in the body of the text.

The MSH partnerships with key counterparts in national and state governments; implementing partners (IPs), including MSH's subcontractor/partner, Axios, and particularly counterparts in the local governments, have been solid and responsive.

Recommendations for Program Quality and Management

- Improve quality of TB care in PLWH. Integrated TB and HIV needs intensive ongoing quality assurance (QA) as well as continue remedial training.
- Improve work with MARPs. Explore narrowing MARP activities to the ones in marginally successful areas, and then launch an intense best-practices intervention.
- Involve more PLWH in key senior positions, especially among MARPs.
- Improve gender awareness throughout project cycle. Develop meaningful gender-related indicators that measure impact.
- Staff attrition requires attention. The evaluators recommend an immediate mediation session. All efforts should be made to involve MSH at central office and state staff levels and explore inclusion of staff from headquarters. Selective USAID participation is encouraged.

Recommendations for Prevention of Mother-to-Child Transmission

The problems MSH faces with PMTCT of HIV and MARP prevention work are common in many areas of Africa and especially Nigeria. The following recommendations are specific to MSH. Information and recommendations relevant to general improvement of PMTCT nationwide as well as throughout MSH are in the body of the text on page 3.

- MSH recently completed an operations research project on the subject of PMTCT, and the findings should be disseminated widely.
- Follow up on a planned study to examine issues that keep women from returning after a single ANC visit would be useful and highly recommended.
- Look closely at issues of the attrition of volunteers who identify pregnant women in the community. Look at ways to encourage volunteers to return.
- Explore all options to enlist traditional birth attendants as allies in identifying women at risk for HIV and to encourage testing and interaction with care facilities.

- Provide follow-up home visits to all women who come for antenatal care (ANC).
- Assess or readdress prior evaluations of the gender responsiveness of the ProACT project's clinical care program.

3. SUSTAINABILITY

The ProACT phase of the project made sustainability strategies more explicit.

Many IPs and community organizations underwent institutional development and training aimed at future sustainability.

The extensive skills building training is a key sustainability strategy.

Sustaining the quality of data continues to be a high priority, and appropriately so. Data quality is improving throughout all project sites despite increasing degrees of political instability in some project areas.

Sustainability efforts at the grass roots level are more recent and perhaps more difficult to quantify. The following strategies/activities suggest progress toward sustainability:

- CBOs have been trained in service provision and institutional strengthening,
- CBOs are registered and are receiving funds from a variety of donor sources.
- Work with PLWH groups is particularly strong, and evidence of their ability and willingness to continue to sustain serves as promising.

The likelihood of sustaining local government, state, and State Agency for Control of AIDS (SACA) activities supported under this project rests with the will and leadership of local and central government. The engagement of leadership varies widely over the project areas and is strongest in those areas suffering less political strife. Because of Nigeria's potential wealth and high literacy levels, it could be a model for sustainable development that not only manages growth, but also creates institutions and health systems that place meeting the basic needs of the most vulnerable outside the forces of the market.

Recommendations for Sustainability

- A designated implementing partner should continue quarterly mentoring on data quality.
- Explore the possibility of adding permanent low-level data clerks to work at sites on a permanent basis as a reasonable, albeit less sustainable strategy, to ensure data quality.

- Continued training and follow-up skills assessment of clinicians at local government health facilities and primary sites will be essential to retaining a cadre of healthcare workers able to practice integrated care and train new health personnel.
- MSH may need to devise other forms of motivation (aside from formal training) to encourage, motivate, and reward health facility staff for their contributions to the implementation process.
- Look at possibilities for increasing the number of trained local government area (LGA) staff, since findings suggest that they were more likely to stay on the job for the long haul than staff from other LGAs or states who may contemplate moving to their LGA or state of origin.
- Form an advocacy committee with representatives at all levels of the implementation.
- Key successes of step-down trainings at all points of implementation enabled “task-shifting” and decentralization of services. It is associated with increased access to services by the target population.

4. CAPACITY-BUILDING

- Stakeholders at all levels of implementation received trainings, and the trainings enhanced their performance on the job.
- CBOs and health facilities staff report the lowest proportion of staff trained by the project. This is a positive consideration for sustainability as they are more likely to remain at their posts.
- Linkages between trainings and job performance differ across levels of project implementation. The SACA/State Ministry of Health (SMOH) level appears to be the weakest level of service delivery but it is also the level where it is most difficult to measure the impact of training on performance. Opportunities for mentoring are limited as well
- Strengthen onsite skills transfer and trainings (step-down trainings), one of the strongest tools for capacity-building strategy in the project setting.

Recommendations for Capacity-Building

- Consider doing a capacity needs assessment, and factor the results into the design of a comprehensive re-training schedule for all staff of the project.
- Consider giving preferential training to the health facility personnel in the main thematic areas (formal or informal) in the interest of systems strengthening and sustainability of the project in the long run.

- Include SACA staff in all relevant training, followed by the strategic inclusion of interested staff in train-the-trainers programs for greater buy-in.
- Improved indicators to measure the quality of managerial capacity building is needed.
- Examples of government-owned comprehensive health facilities should be scaled-up in the next phase of the ProACT project to further broaden its systems strengthening and sustainability objectives.
- More step-down trainings should be encouraged at the health facilities and CBO levels to augment upcoming training shortfalls.

5. CHALLENGES AND LESSONS LEARNED

Challenges and lessons learned are covered under each heading for ease of reading and brevity.

I. INTRODUCTION

The progress of Nigeria toward equitable and rational development has been slow despite the fact that it is rich in natural resources and is the largest oil exporting country in Africa. Governance and leadership issues have plagued Nigeria since colonial times and have steadily increased, threatening the stability of the nation. At independence from colonial rule, Nigeria represented geographically, economically, and culturally diverse regions with little historical rationale for national unity. Good governance continues to be a major issue as Nigeria struggles to overcome a long history of sectarian politics and institutionalized corruption. A federal governmental system has variable levels of influence on widely heterogeneous states, making effective decentralized governance a critical necessity. The capacity of each state to effectively manage resources and administer social services varies widely by state and within each state.

Against this background, building an effective response to the epidemic presents tremendous challenges. Although Nigeria still has an average prevalence of HIV below 5%, the large size of the population means that Nigeria has the second highest number of new infections per year, and is second only to South Africa in the total numbers of PLWH.¹ HIV in Nigeria, similar to other African countries, is largely driven by heterosexual transmission (95%). Distinctive to Nigeria is a continued transmission through blood transfusions and the fact that women are proportionately affected at a much higher rate than men at 60% and 40%, respectively. This is particularly troublesome when paired with a very low rate of enrollment (5%) of pregnant women in PMTCT programs, resulting in a preventable and unacceptable burden of HIV in infants and children. Prevalence varies greatly by region and whether or not someone is engaged in activities associated

¹ WHO. "Progress Report 2011: Global HIV/AIDS Response." http://www.who.int/hiv/pub/progress_report2011/en/index.html

with high risk of contracting HIV. These activities are consistent with those identified in Eastern and sub-Saharan Africa: transactional sex; men having sex with men; high level of migration; and being young, poor, and out of school, particularly in the case of girls. Gender-related violence and social inequity also contribute greatly to increased risk for contracting HIV and disrupt prevention approaches that do not address these issues.

Nigeria has seen one of the largest investments in an HIV response on behalf of the international community. PEPFAR and the Global Fund have been by far the greatest contributors to the response, with the Nigerian government itself contributing approximately 5% of the total funds. During the early years of PEPFAR, I saw a focus on health facility, and then community-based approaches to getting PLWH in need of treatment on antiretroviral therapy (ART). There was too little focus on or success with two other important pillars of an effective HIV response: scaling up evidence-based effective prevention strategies among high-risk populations and building upon the developing capacity of government actors to take leadership of the response to HIV. Another result of the heavy emphasis on treatment and documentation of treatment was the generation of a vertical program that strained an already weak public health system and structures.

BACKGROUND

The Leadership, Management and Sustainability AIDS Care and Treatment Project (LMS-ACT) started in 2007 and was funded under PEPFAR. MSH, and its partner, Axios, was awarded a contract to implement the project.

The LMS-ACT project was designed to address the Nigeria government's capacity building and to extend HIV services to six states previously under-represented by donor support. The project established roots in six states, and comprehensive services related to HIV and acquired immune deficiency syndrome (AIDS) were delivered at 17 sites. The LMS-ACT project gained the support of influential community leaders and PLWH and AIDS and used this support to increase services and encourage increased local responsibility for local initiatives. The project has been particularly successful in developing leadership and management skills through health workers' technical training programs, resulting in improved performance of health providers, adding extensive HIV/AIDS management training to all health worker curriculum in order to reach thousands of clients with a rapid scale-up of increasingly more integrated HIV care and treatment services, including primary and secondary care services.

Because of the success of the LMS-ACT approach and its high-caliber staff, in 2009 PEPFAR provided \$60 million for a 5- year follow-on project, ProACT, to deepen and expand the LMS-ACT project's approach from the 17 original sites to a total of 21 sites, all in the same six states: Kogi, Niger, Adamawa, Taraba, Kebbi, and Kwara. The ProACT project, which is a part of a broad-based health initiative out of USAID's Global Bureau of Health, is the subject of this midterm evaluation. However, because the work under review is a second phase of a previously existing program, it will be difficult and unwise not to review the groundwork of the preceding LMS-ACT project.

ProACT continues to support integrated HIV/AIDS and TB services in the six project states, while placing a stronger emphasis on building government and civil society organization (CSO) capacity (organizational systems development) to strengthen health and HIV/AIDS systems for delivery of integrated health, HIV/AIDS, and TB services. With attention to gender-based approaches through small grants programs for local CSOs, the new project supports strengthening community organizational systems for the management of HIV/AIDS as a chronic illness, and for overall improvements in community health. This focus on local capacity building and health system strengthening is intended to move the project toward greater sustainability. As part of systems strengthening, the project assists the National AIDS Program in their support to the state's AIDS programs focusing on improving coordinated strategic planning skills across federal and state levels.

The goal of the previous LMS project and the ProACT project is to build the capacity of Nigeria's public, private, and community sectors for sustainable HIV/AIDS and TB prevention, control, care, and treatment, integrated within the health system. Therefore, the projects contribute towards achieving the assistance objective—reduced impact of HIV/AIDS in selected states, through the following intermediate results (IRs):

- IR 1: Increased demand for HIV/AIDS and TB services and interventions, especially among target groups;
- IR 2: Increased access to quality HIV/AIDS and TB services, practices, and products in selected states; and
- IR 3: Strengthened public, private, and community-enabling environments.

To meet USAID/Nigeria's three objectives for this project—maintaining the availability of quality comprehensive services, increasing accessibility to services, and strengthening systems—MSH and Axios proposed nine broad activities:

- Supporting comprehensive care and treatment sites in six states;
- Increasing the capacity of local governments to decentralize HIV/AIDS services to primary health facilities;
- Using fixed-cost small grants to develop the capacity of CSOs to deliver community-based services, linked with health facilities;
- Developing the capacity of state, local, and health facility teams to lead and manage HIV/AIDS programs;
- Establishing systems for QA of health and HIV/AIDS services;
- Expanding prevention programs for targeted populations;
- Strengthening the capacity of state and local governments to carry out strategic and operational planning and budgeting;
- Improving operational planning and budgeting; and
- Advocating for resources to sustain their programs.

As this report will demonstrate, the ProACT project has made great strides toward sustainable systems strengthening, particularly in activities aimed at integrating HIV within the public health facilities. The results of integration have been profound for PLWH, who report the stigma associated with HIV has decreased, along with the impact of recovered health after extreme illness from HIV-related diseases, as life-transforming. The morale of health facilities staff rose, and the quality of care of services for PLWH are markedly improved, as reported in interviews with beneficiaries and clinical staff. Entire cadres of health personnel have been trained in relevant HIV tasks, and organic task-shifting has increased opportunities for testing, adherence counseling, and treatment in general. But the quality of integrated TB/HIV care is still lagging. QA systems have been introduced, and the hope is that with time, it may be institutionalized throughout all the facilities, although such changes in medical habits and practice take vigilance, and it is unclear how well embedded such efforts will be by the end of the project.

As the evaluation report will also demonstrate, a few key issues will significantly impact the outcome of the work, ranging from the difficulties of working in geographically diverse states in a country with a loose federalist structure; widely varying capacities of SACA; differences in the capacities of local government hospitals and capacities of the various ministries of health; average low prevalence of HIV in the targeted states; willingness to take on full integration of health services from once-vertical systems; inherent difficulties of doing intense prevention work among poorly defined or threatened risk groups; as well as the challenge of doing PMTCT in areas where births are seldom attended at facilities and prenatal care is not well established as a norm. Additional challenges are measuring the results of training, since capacity-building programs focus on both clinical and leadership skills-building, and the lack of time and money making follow-on training and refresher management courses difficult to carry out.

RATIONALE OF THE EVALUATION

This independent midterm routine evaluation includes a detailed assessment of the project's organization, management, performance, and its overall implementation and sustainability. The report makes recommendations on areas of improvements, changes, and/or modifications. It will also document lessons learned. The overall purpose of the midterm evaluation is to determine how effective the ProACT project implementation has been and, specifically, to:

- Determine the extent to which the capacity building efforts by the ProACT project has contributed to the overall performance and sustainability of the delivery of comprehensive HIV/AIDS prevention, care, and treatment, and TB services.
- Determine how successful the project's management systems and procedures have been in facilitating the achievement of expected outcomes and the overall project goal.
- Document lessons learned that will assist the project, PEPFAR Nigeria, and the government of Nigeria (GON) in the continuous improvement of its projects and future comprehensive HIV/AIDS, TB programs in Nigeria.

The audience for this midterm report is USAID and project implementers, in the interest of improving the effectiveness of the interventions. The secondary users are other implementation partners, such as the health and HIV-related host country institutions, on how best to share their work and improve ProACT implementation.

EVALUATION QUESTIONS

In addition to the five main questions below, other questions were added in an appendix regarding the scope of work. Some are duplicative, and in the interest of clarity and brevity, we have tried to group the extra questions under likely main questions, but still be clear whenever possible about what question is being answered in the main text. In a few instances the extra questions were really requests for recommendations or conclusions and, again, will be labeled as such.

1. To what extent has the MSH/ProACT project and its partners supported the integration of HIV/AIDS and TB services into the healthcare service delivery system in the targeted states and facilities? What are the demonstrable effects of the integration efforts in reducing stigmatization, increasing uptake of HIV and non-HIV services, and improving the quality of care provided to patients seeking medical attention? Are there lessons that can be learned to strengthen integration?
2. Are the project's management systems and procedures facilitating the achievement of expected outcomes and overall project goal? Additionally, is the project likely to meet its set objectives and targets by the end of the life of the project?
3. What strategies and approaches have MSH/ProACT and its partners adopted and implemented to facilitate the sustainability of the supported activities and programs beyond the project's funding period? How do facilities, communities and government structures promote institutional, financial and programmatic sustainability and ownership of the HIV response in their respective health facilities and states? What support would they require from MSH/ProACT to ensure a seamless transition by the end of the project?
4. How has MSH/ProACT capacity building support improved the competence of service providers in providing quality services to patients? How has the capacity-building support to governments (SACA and SMOH) strengthened their coordination and leadership capacity in leading the HIV response in their respective states? What is the extent of the beneficiaries' (patients, organizations, SMOH, Federal Ministry of Health [FMOH], etc.) satisfaction with the project's interventions so far, and are there areas of modifications or changes necessary for the project to achieve its set objectives by the end of the life of the project?
5. What are the project's major challenges, lessons learned and innovative approaches that MSH/ProACT and its partners have implemented that could be adopted and scaled up in the PEPFAR program?

II. METHODOLOGY

The evaluation employed both quantitative and qualitative methods in the data collection process. The quantitative method was used largely to collate and aggregate secondary data on performance indicator targets and achievements between August 2009 and September 2012. The qualitative methods were used mainly to elicit information from stakeholders who were policy makers, implementers, or direct beneficiaries of the project at the time of the evaluation.

SAMPLING DESIGN

This evaluation employed multi-stage sampling design at three levels: the state, health facility/community, and beneficiary. Purposive sampling was conducted at the three levels using selected key criteria that ensured theoretical representation of the information obtained.

*Table 1: Intervention States by Key Health Parameters Considered for Selection**

State	No. of health facilities	Current no. of adults & children on ARV treatment	No. of sites with comprehensive services	HIV prevalence (%)	Selected States
Kogi	21	1960	7	5.8	✓
Adamawa	10	2186	6	3.8	
Kwara	6	663	3	2.2	
Niger	23	2508	6	4.0	
Taraba	9	3356	5	5.8	✓
Kebbi	5	904	3	1.0	

*Nigeria Monitoring and Evaluation Management Services (NMEMS), District Health Information System (DHIS) database.

Five parameters were considered in state selection: number of healthcare facilities; current number of adults and children on antiretroviral drugs (ARVs); number of healthcare facilities with comprehensive health services; HIV prevalence; and length of time ProACT has worked in the state. Kogi was purposively selected because it is one of the previously established intervention states with a comparatively high number of healthcare facilities offering comprehensive services, a high number of adults and children on ARV treatment, and high HIV prevalence. Taraba was selected because it is a fairly new intervention state with similarly high key health parameters as Kogi. Abuja, the country's federal capital, was included to obtain information from the National Agency for Control of AIDS (NACA) staff representing policy makers, ProACT project headquarters staff, and representatives of USAID, the funding agency.

In total, six healthcare facilities were purposively selected from the two states, three per state, including a specialist hospital located in an urban community, and two hospitals in semi-urban/rural

localities. In addition, four CBOs were also purposively selected, two per state, to provide information on the HIV prevention component of the project. The last level of the multi-stage sampling involved the random selection of beneficiaries at the selected healthcare facilities, and CBOs invited to participate in the evaluation.

Three teams simultaneously collected information from Kogi, Taraba, and Abuja. Key qualitative techniques used in data collection included focus group discussions (FGDs), key informant interviews (KIIs), and group interviews (GIs). In total, 17 FGDs (Kogi 8 and Taraba 9), 36 KIIs (Kogi 17, Taraba 11, and Abuja 8), and 13 GIs (Kogi 4, Taraba 7, and Abuja 2) were conducted. Variation in the number of FGDs, KIIs, and GIs across the two states was due to the convergence of GIs and KIIs by the evaluation teams in their respective states when group participants were unavailable to provide information at the same time.

The evaluation teams collected information from different categories of stakeholders, including PLWH who were patients at the selected healthcare facilities and their support group executive members; community leaders who were mostly traditional rulers; CBOs' staff, including their chief executive officers (CEOs); M&E and accounts staff; and peer educators (PEs) engaged in grassroots outreach at the community level. Also, information was obtained from Orphans and Vulnerable Children (OVCs) and their caregivers; healthcare facility staff, including doctors, nurses/midwives, pharmacists, laboratory technicians, and M&E staff.

LIMITATIONS

The following limitations are acknowledged, but there are no substantive reasons to suggest that they have significantly affected the results of this evaluation.

- A more robust methodology would have included more states, more healthcare facilities, more CBOs, and interviews with more beneficiaries, but this was not possible due to budget constraints. Ensuring that the states, facilities, and CBOs selected were theoretically representative of the project's objectives, thus providing insights on key evaluation questions useful for future program implementation, attenuated possible effects due to this constraint.
- The short time allocated for this evaluation, especially for fieldwork, may have affected the amount and quality of data collected. However, efforts were made to ensure that the evaluation teams interviewed key respondents who had institutional memory and were, in general, knowledgeable about the issues and questions addressed. In addition, the short time allocated for the evaluation did not provide adequate time for writing this report, leaving team members assigned to work on it with no option but to use personal unpaid time.
- Another possible limitation to this evaluation is the memory lapse of respondents as a result of retrospective questioning on issues dating back in time. For this project, a two-year window of recall was not a difficult hurdle that impeded the collection of

information. Also, since the respondents were continuously engaged in the project, it was not difficult to reflect on events of the past, and connect them to the present.

- It is important to note that gender issues were not deliberately included in the evaluation design, since this was not a major question to be addressed in the evaluation. However, attempts were made to ensure that the evaluation team reflected gender balance, and there were no deliberate skewing of respondents' selections during the evaluation. Also, major criteria for selecting respondents included their knowledge, involvement, and experiences in the project.
- Also, there may be differences in the skills and techniques of team members brought on board, but these were harmonized during the planning meetings, and team members were paired as much as possible during data collection to ensure that omissions and gaps in information were reduced to the minimum level possible.

III. QUESTION I:

TO WHAT EXTENT HAS MSH/PROACT AND ITS PARTNERS SUPPORTED THE INTEGRATION OF HIV/AIDS AND TB SERVICES INTO THE HEALTHCARE SERVICE DELIVERY SYSTEM IN THE TARGETED STATES AND FACILITIES?

SUB-RELATED QUESTIONS

What are the demonstrable effects of the integration efforts in reducing stigmatization, increasing uptake of HIV and non-HIV services, and improving the quality of care provided to patients seeking medical attention? Are there lessons that can be learned to strengthen integration?

To what extent have ProACT activities being implemented been integrated into the healthcare system delivery in the targeted areas?

PROGRESS TOWARD INTEGRATION

Under ProACT, despite the early delay and disruption of services, the integration activities and scale-up of new sites went at a fair pace and were not far behind original estimates for implementation. In fact, Kogi started three new integrated care sites funded solely through state budgets and staffed entirely with local government employees after mentoring and support from the ProACT project staff. This is particularly important, as Kogi is one of the two target states with the greatest need due to their relatively high HIV prevalence.

According to MSH project staff, one of the first and the most important tasks of integration is merging facility records. Reporting even standard indicators to PEPFAR is challenging. For a period, MSH asked for more data than PEPFAR, causing some friction. Resolution via a mediation session

with USAID ensured more clarity and harmony across the basic data requirements. MSH, in an effort to augment the flagging data collection process, hired and trained a cadre of data clerks. This allowed them to bridge the gap between the facility and the program's need for integrated information/data. See the section on sustainability for a further discussion. In summary, working relationships between monitoring and evaluation (M&E) teams from MSH, their IPs, and USAID appears to be very collegial; the data collection systems are a work-in-progress.

The quality of PEPFAR related data collected by MSH on 3 key indicators: HIV counseling and testing (HCT), PMTCT, and ART in 9 sites from 5 states supported by the ProACT project, and was reviewed in an exercise by MEMS II in June 2011. The review revealed typical problems with the quality of data contributing to the PEPFAR indicators, including:

- Transcription error of data submitted by the state and head office;
- Non-captured data from some sections in the facility;
- Over-reporting of achievement;
- Lost to follow-up was not properly captured in the calculation of current numbers on treatment;
- No written guidelines on how to fill registers and M&E forms;
- Lack of training for some of the data clerks;
- Little or no integration between M&E and record unit;
- No written guidelines on how to collect and analyze data; and
- No backup for data collected.

MSH responded and made corrections after the MEMS II review mentioned above. Some of the difficulties relate to an inability to get timely data and carry out routine quality control exercises in states where health workers are on extended work stoppages. Other issues go beyond state control and are national issues beyond the project's influence.

MSH did rigorous training and reformed systems as evidenced in work plans, training reports, and post-training interviews with health workers. An interview with a government hospital worker described learning key skills without undue pressure. This approach to training encourages questions and allows trainees to think through problems themselves and find solutions appropriate for each setting.

In the longest running project areas, MSH takes data reporting to the next level: that of extracting information from data in order to troubleshoot problems and improve upon performance or project design. For example Uche Ikenyei, Associate Director of Monitoring and Evaluation for the ProACT project, pointed out that the M&E officers in two of the target states, Niger and Kogi, no

longer rely on MSH for support and are able to report data to the state monthly. MSH still reviews that data for QA on a quarterly basis. According to Mr. Ikenyei, the data appears reliable and comes into the office in a timely fashion. Mr. Ikenyei reports that these states are able to conduct data analysis for management's use. Also, MSH currently supports the government in Kogi to develop an integrated database for the state that will have data from all facilities in the state. This will simplify data analysis and reporting from the state to the national level.

The healthcare facilities visited by the evaluation team in both Taraba and Kogi show the following signs of functional integration from primary through secondary care service (a few exceptions are described in a later paragraph):

- Patient consultations are integrated, and all patients share the same waiting room.
- PLWH have multiple points of access to any shared health unit, such as family planning services, prenatal services laboratory, and pharmacy.
- In primary healthcare units, HIV testing and counseling services is available at any and all points of consultation.
- All patients, regardless of HIV status, are admitted to the same inpatient ward, except in the case of highly infectious disease.
- PLWH no longer have identifying color case files.
- Records are kept in one place, and patient records are confidential and can only be identified by a coded ID.
- All physicians and many other healthcare providers are trained in HIV care, so any PLWH can be managed by any available clinician.

In Ibi General Hospital in Taraba, services are physically integrated, and all levels of health workers trained in HIV. Facility staff said there are no longer "HIV specialists," other than at tertiary sites or in situations where there is drug resistance or a need for a consultation with a more experienced HIV clinician.

There is knowledge about and a positive response to integration in all staff interviews. Interviews included HCW from primary care clinics all the way up to specialty hospitals. The perception of clinic and public health staff at multiple levels is that MSH/ProACT staff supports and, at times, leads the rollout of integration. A part of the integration process includes training on quality of care and attention to improved patient care experience.

A few exceptions to integrated services were noted, such as in Dekinna General Hospital in Kogi, where records for PLWH are housed separately from other patients' records. HIV M&E staff were also in separate locations at the same facility. This was explained as a temporary condition related to renovation of the facility by the state government.

IMPACT OF INTEGRATION ON STIGMA

Integration of HIV services into general primary care services resulted in a definitive reduction in reported incidences of stigma, both by patients as well as facility staff in interviews. In the focus groups, the majority of respondents across both states report a decrease in discrimination by the facility staff. This is accompanied by increased satisfaction with services received and a marked increase in HCT uptake in many sites. HIV testing at project sites has steadily risen and far exceeded targets by as much as 173% in 2011 and the first half of 2012. This increase cannot be attributed solely to service integration. PLWH in focus group interviews state that increased inclusion and decreased discrimination in target facilities improve patient satisfaction with the quality of care. There was no baseline data on levels of stigma experienced by PLWH before integration of services, but retrospective questions were posed, asking clients to compare levels of stigma experienced now versus before the intervention. The overwhelming trend was toward decreased stigma corresponding to the degree of integration of services.

Stigma reduction at the facility does not immediately translate into a similar reduction at the community level. Stigma persists, and findings from the focus groups with PLWH suggest a great deal of work remains to be done in the target communities to reduce discrimination. In an example of a community strategy aimed at mainstreaming all vulnerable children, MSH works at the community level through IPs to stop identifying children as vulnerable due to HIV. Instead, CBOs target all vulnerable children regardless of cause. This is a recognized best practice in community-based OVC programming.

PATIENT SATISFACTION WITH INTEGRATION

Interviews with senior staff at the ProACT project's supported health facilities report increased patient satisfaction for PLWH as a result of decreased waiting time, preservation of confidentiality, as well as a more accepting staff in general. In discussions with PLWH on ART, the fact that they no longer looked sick also contributed to their sense of acceptance and level of comfort in seeking healthcare services.

Interviews with PLWH receiving care at integrated facilities confirmed a high degree of satisfaction with recent changes related to service integration. Because integration was accompanied by workshops designed to raise awareness of issues about the quality of care, the perceived improvement in quality of services cannot be entirely attributed to physical integration. The responses of PLWH do suggest that simply sitting with the general patient population had a profound impact on the level of stigma they experienced.

Other indications of improved patient satisfaction reported by facility staff are the ease of access to HCT, and increased opportunities for counseling with a variety of health staff—i.e., pharmacists, laboratory technicians, nurses, adjunctive staff, as well as by volunteer “patient experts,” who are trained to do both HCT and adherence counseling for PLWH. Decreased waiting time came up as a positive side effect of integration noted by clients, health staff, and evaluators, although not

uniformly. On the negative side, in an interview with a member of a focus group of PLWH at the specialist hospital in Jalingo, the member said, “We have only one doctor here to attend to us, and this means that we have to spend a lot of time in the hospital. And then there are other patients coming from other places to see the same doctor, further prolonging the time we have to spend here.”

MSH project staff in Taraba discussed the benefits of integration, combined with training all staff in the provision of HCT. They made the following points: "In order to integrate, we do not employ separate staff, but we build the capacity of already existing staff for provider-initiated counseling and testing. We do not provide separate service points other than that (usually) provided by the facility. At every service point we make sure that there is a trained service provider. We build capacity for providers in such a way that the knowledge will be useful to them in their day-to-day duties, and not necessarily only for HIV-positive patients." In a focus group interview with PLWH in Jalingo general hospital Taraba, 5 out of 5 of the participants said they were “very satisfied” with the services they received at the site. They all received or were aware of the existence of the following comprehensive services:

- Follow-up of infants exposed to HIV
- Postnatal services
- TB diagnosis and treatment
- Home-based care
- Laboratory services
- Education sessions/materials
- Livelihood support in terms of food and opportunities for income-generation activities (IGA)
- Basic ANC services
- Counseling and testing services
- Safe motherhood: maternity, labor, and delivery
- ARV and prophylaxis for mother and infant
- Access to antiretroviral (access, supplies, cost, etc.)

Local facility staff in both states and most beneficiaries interviewed reported shorter waiting times for all patients as a benefit of integration, although some of the PLWH complained that combined services sometimes increased waiting time in some sites when only one doctor was available for all patients.

IMPROVEMENTS IN COMMUNITY MAPPING AND REFERRALS

As evidenced in the quarterly report, community mapping and referral systems were a strong outgrowth of the process of integration. Facilities and CBOS formed referral systems that were not previously active, and with good referral systems, the potential for information exchange about patients and community health issues, as well as joint planning, is becoming a reality. In the last 6 months the CBOs doing prevention work have been doing community mapping to find MARPs, identify risks, and provide services for those at risk. (Quarterly Report).² This has been a bit of a disheartening process, as they have found that many of the previously identified CBOs are no longer in existence.

Interviews with USAID staff commended the development of community mapping and prioritization of functional referral systems for those on treatment or in need of support or care as an unexpected benefit of the ProACT activities in the states. The strongest referral systems reported by USAID are in Niger and Kogi. Building upon community knowledge of potential resources can be a powerful driver of sustainability, as planning and resources can be shared among more agencies, and resource information has a better chance of reaching those in need.

SUSTAINABILITY OF INTEGRATION

A promising development that speaks to the sustainability of integration is seen in Kogi, where the state government with mentorship from MSH and ICAP (International Center for AIDS Care and Treatment Programs) has established three HIV-comprehensive sites in the state solely funded by the state. In order to staff the new facilities, they have hired 50 doctors, 100 nurses, 20 lab scientists, 20 pharmacists, and several attendant staff. The past practice of hiring separate HIV focal people for PMTCT, HCT, lab, and pharmacy was burdensome, and a decision was made to dissolve these positions and have the heads of each department take responsibility for HIV-relevant issues as part of their routine duties, and bring them to an ongoing management committee headed by the medical director. Interviews with staff report reduced conflict and improved performance.

Interviews with NACA confirmed that the national strategic plan intends to integrate HIV, TB/HIV, and reproductive health as it pertains to PMTCT, and that all partners will be required to report integrated data by 2013. Full integration of primary care services remains a more distant but definite goal for the future. Their hope is that the successes experienced by MSH, as reported in this evaluation, will convince USAID to continue to support the strategies employed by the ProACT project, expand beyond the targeted states, and beyond the already integrated services to include family planning.

² MSH Quarterly Report, April–June 2012.

INTEGRATION AND TUBERCULOSIS

Integration and improved quality of the management of TB in PLWH is a challenge well recognized by the MSH staff, and many aspects of the effort are outside their control. The task of the HIV treatment component in integrated or joint TB/HIV programs is to screen all people who are HIV-positive for TB. A referral to a directly observed therapy, short-course (DOTS) center for treatment of TB occurs for the HIV-positive TB patient. Most of these patients receive the intensive phase of TB treatment while under the care of the TB clinics. Not until this early phase of treatment is completed will the patient start ARVs. The initial phase of TB treatment is carried out by facilities run by the GON and supported by TB CARE and WHO. Once referred to the ART site, MSH takes responsibility for quarterly TB screening for their HIV-positive patients.

The above describes the ideal treatment approach but various interruptions in this complex care plan can occur at any point for a multitude of reasons. The problem is not solely due to fragmented or vertical HIV programming, but also to the poor quality of TB services, at least in facilities evaluated from July to September 2011, and the inherent difficulties in diagnosing TB in PLWH. In June 2011 a joint supervisory visit to Kogi facilities made up of representatives from FMOH, MSH health workers, a representative of John Snow International, and staff from the Kogi TB control program, together with senior management from the health facilities under review, resulted in remedial actions. The following improvements were seen in the next reporting period: increased case detection and HCT coverage at DOTS units, which went from a low of 5 cases detected in the first quarter of 2011 to 22 cases in the following quarter. The HCT coverage at the DOTS unit also increased from 80% to 100% over the same period.³

MSH is expected to do the quarterly screening of all their HIV-positive patients for TB. When MSH conducted the continuous quality improvement exercise,⁴ they found that the rate of quarterly screening across their facilities varies, with some achieving 50% and others much lower. Based on this finding they decided to push all the doctors and nurses in their target facilities to increase the number of HIV patients who are screened for TB. The initial effort worked for a while, but along the line, MSH lost their TB focal person, and hence no one sustained the momentum. The situation is still the same to date.

Out of the 25 facilities assessed for quality of TB screening among co-infected patients:

- Only 1 (4%) facility was scored good (>70%)
- 9 (36%) facilities were scored average (60-69%)
- 15(60%) facilities were scored poor (≤59%)

³ This information is from the *MSH Quarterly Report* and cannot be easily substantiated using existing databases, as data collection is muddled by confusion around how TB and HIV co-infections are reported.

⁴ ProACT Project. Clinical report compiled by: Dr. Abubakar Abdulraheem. Designation: HIV Clinical Services Specialist, Kwara July–September 2011 Reporting Period.

Another contributory factor to the troubling data on HIV and TB integration is the fact that the target states either have a low level of comorbidity of TB and HIV, or it is underreported. A poor facility level integration strategy which placed known TB patients receiving DOTS and HIV patients, regardless of TB status, in the same room for services was reversed under MSH advocacy in Kogi, and a separate room for TB DOTS now exists.⁵

The project has demonstrated that many of the target facilities are capable of high quality TB/HIV integration, but quality remains variable and is affected by work stoppages, which result in lost training opportunities and poorer quality of services and data reporting. Lower levels of co-infection of HIV and TB than what is seen in sub-Saharan Africa appears to be partially responsible for the low numbers, but the ProACT project's staff continue to be concerned with the low enrollment of TB/HIV co-infected clients in general. A loss of key senior technical personnel at the state and home office in states over the last three quarters undoubtedly contributes to the failure to meet TB related indicators. Despite these challenges, there has been a consistent effort to improve case finding and treatment of co-infected patients with the strengthening of escort services to and from the DOTS clinic. In the MSH April–June report for 2012, the following data was reported, revealing good progress toward improved TB and HIV co-management:

1,549 (87%) of the newly enrolled clients were clinically screened for TB at enrollment, using the TB symptom checklist, and 40 clients began intermittent prophylactic therapy (IPT) in Taraba following the recently commenced IPT pilot in that facility. The period also witnessed an appreciable rise in the number of clients receiving HCT at a TB setting with a 50% increase on average achievements of the three previous quarters.⁶

CONCLUSIONS

Monitoring and evaluation and data management: Merging data for integrated service is a difficult and dynamic process and a necessary first step. While still a work-in-progress, there is ample evidence that MSH has evolved as an iterative process that does work over time. States do successfully graduate from close monitoring and technical support. A special cadre of data workers ensure integrated data flow. This may or may not prove to be a sustainable strategy after ProACT. The remarkable decrease in reported stigma is not due to service integration alone. Integration runs parallel to awareness raising among clinicians and health workers in the target sites. As it becomes harder to recognize the symptoms of HIV, people living with the virus naturally feel less self-conscious.

⁵ MSH Quarterly Progress Report. ProACT January–March 2011, p. 32.

⁶ MSH Quarterly Progress Report. ProACT April–June 2011.

Community mapping has been an unexpected and important side benefit of the integration process, and the key stakeholders such as SACA and facility heads are making good progress toward an effective referral system. The aforementioned added cadre of data workers appears to be one of the only factors working against organically sustainable integration, allowing for many synergies of efforts and labor, as well as improved patient and clinician satisfaction.

Integration of TB and HIV is a challenge and improving the quality of treatment is difficult. MSH staff recognize this challenge, and many aspects of improvement are outside their control. The problem is not only vertical programming, but also relates to the poor quality of TB service and the inherent difficulties in diagnosing TB in PLWH; at least this was the case in activities evaluated from July to September 2011. The loss of key senior technical personnel over the last three quarters undoubtedly contributes to the failure to meet TB-related indicators. Despite these challenges, there is a consistent effort to improve case-finding and treatment of co-infected patients through strengthening the DOTS program.

Other evidence of service integration observed consistently throughout all hospital-based evaluation sites include:

1. All departments (including laboratory and pharmacy staff) conduct HCT and HIV prevention education.
2. Laboratory services where HIV tests were done included other services such as testing for malaria, blood pressure, and other STIs, and it was common to see patients all waiting either to be tested or to collect their results.
3. Physicians use the same form for all laboratory testing requests.
4. There is uniform drug dispensing regardless of ailment, although whether or not a patient has to pay for a drug potentially serves as a clue to diagnosis, as HIV treatment is free and many other drugs are not.

Also important to note is the overwhelming positive response to integration from patients and staff interviewed. They report great appreciation for the fact that laboratory and pharmacy services no longer reveal the purpose of a patient's visit or the diagnosis. Task-shifting of laboratory staff trained to do HIV counseling is well received by many respondent PLWH. They report ease of testing with limited waiting.

IV. QUESTION 2:

WHAT HAS BEEN THE PROJECT'S LEVEL OF PERFORMANCE ON SET TARGETS?

Several questions in the Appendix of added questions fall under the broad category of project management and performance, but are more detailed than the overarching question as stated above.

In answering the detailed questions, the broader question of “Are the management systems facilitating the expected goals, and if not, why not?” will be addressed, as well as whether or not the project is going to meet its targets.

- What has been the project’s level of performance on set targets?
- To what extent has the project contributed towards furthering the goal of PEPFAR Nigeria?
- If specific targets set on performance indicators were not met, why was this the case?
- Which of the project’s intervention(s) had the most comparative cost advantage in implementation?
- Were the systems developed by the project for monitoring, evaluation, and knowledge application effective? How have these elements of the program supported the achievement of the overall project objective?
- To what extent was the project management team responsive and accountable to its client—i.e., USAID/Nigeria and key partners—i.e., Axios Foundation and the GON?
- FMOH, NACA, SACA, CBOs, and PLWH support group?
- How effective was USAID in managing the project?

WHAT HAS BEEN THE PROJECT’S LEVEL OF PERFORMANCE ON SET TARGETS?

The ProACT project has an uneven performance record toward meeting originally set targets. Following closely on the success of a period of impressive overachievement came a more recent slowing down of some project activities. The result may be that the project will not be able to deliver on some of the more ambitious activities and achievements set in the first project’s plan. This is most true in the particular nature of the new prevention work initiated under the follow-on ProACT project. These facts are not meant to detract from the rapid progress the ProACT project has made, particularly in creating evermore opportunities for PLWH to get quality care and treatment, as well as the evidence of extraordinary capacity-building through well-executed clinical training and mentoring efforts at local government facilities. A selection of results against illustrative PEPFAR indicators in care and treatment, counseling and testing, and prevention are discussed at length under the relevant sections below.

TO WHAT EXTENT HAS THE PROJECT CONTRIBUTED TOWARDS FURTHERING THE GOAL OF PEPFAR NIGERIA?

The ProACT team succeeded in many aspects of integrating vertical programs in many sites, and had less success in others. Kogi is an example of an unquestionable success. A series of training programs on integration in all six states, intended to be only an introduction followed by longer periods of hands-on mentoring, resulted in Kogi beginning a rapid integration in two facilities

without waiting for further technical assistance (TA) or mentoring. Reports are that their progress toward meaningful integration of HIV and other health services was rapid and, with few exceptions, especially with TB care, met quality care standards.

An uneven performance against targets and indicators over the last 6 to 9 months is multifaceted, and some reasons for a dip in performance are beyond the control of the project, although others less so. This will also be discussed later in this section.

Refer to page 14 in the Background section for a list of the objectives and nine broad action areas committed to at the onset of the ProACT project's additive funding and scope of work.

QUALITY OF MONITORING AND EVALUATION

The first and hardest task of integration of HIV care into primary care sites is that of data integration, and the reorganization of vertical data collection systems. The quality of leadership for the M&E teams at the national and state levels must be particularly strong, and this is the case for MSH. Uche Ikenyei, the Associate Director of Monitoring and Evaluation, is well trained and a particularly dynamic manager who has inspired one of the hardest-working cadres of staff, whether working at the national and state MSH level, local government health facilities, or SACA offices. His leadership has contributed to the buy-in and success of this core task of integrating healthcare systems. The evidence points to successful implementation of the following core tasks:

- Provision of the national Patient Management and Monitoring forms to align with the one national reporting of the UNAIDS “Three Ones”⁷;
- Capacity building through didactic and routine onsite supportive mentoring and supervision of data documentation and reporting;
- Capacity building of the SMOH and SACA M&E on data quality audits and other supervisory functions; and
- Supporting facility M&E units to drive data use for decision-making.

IMPROVING PROJECT ACTIVITIES WITH DATA FROM OPERATIONS RESEARCH

A study of the effectiveness of PMTCT was the first task of a newly hired Operation Research Advisor. The final stages of data analysis and report writing will result in its dissemination to the project staff during their next project review meeting in November. Currently, there are two more studies planned to start this month.

⁷ UNAIDS. "Three Ones: Coordination of National Response to HIV/AIDS."
http://data.unaids.org/UNA-docs/Three-Ones_KeyPrinciples_en.pdf

WERE THE SYSTEMS DEVELOPED BY THE PROJECT FOR MONITORING, EVALUATION, AND KNOWLEDGE APPLICATION EFFECTIVE?

The answer is resoundingly positive. Documentation of integration depends on successful data integration. At this point Niger and Kogi no longer need mentoring for data collection, and MSH only visits quarterly to look at the quality of data and troubleshoot any issues that arise.⁸

HOW HAVE THESE ELEMENTS OF THE PROGRAM SUPPORTED THE ACHIEVEMENT OF THE OVERALL PROJECT OBJECTIVE?

The graduation of states from the labor intensive support and mentoring by MSH speaks well for the future sustainability of other states, as well as the sustainability of this approach. The systems for M&E and data management in general are thoughtfully designed and dynamic in their ability to respond to differing circumstances. The amount of time allocated for training and mentoring is very short, in this evaluator's estimation. The newly graduated facilities at project end will no doubt struggle more those benefiting from a longer period of support.

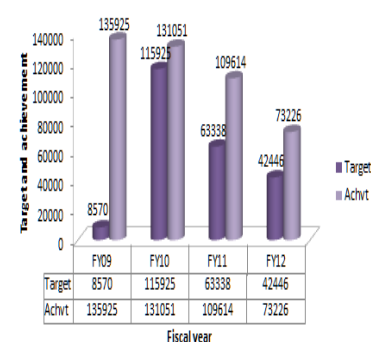
WHICH OF THE PROJECTS' INTERVENTION(S) HAD THE MOST COMPARATIVE COST ADVANTAGE IN IMPLEMENTATION?

Given the differences among the target states in prevalence and training efforts, this is not an easy question to answer. Apparent answers may be misleading, or have hidden ethical implications, etc. A recent costing study carried out by Uche Ikenyei for the MSH Monitoring and Evaluation Unit found the most cost-effective interventions to be (1) enrollment into HIV care for the first time and (2) PLWH initiating ART for the first time. The costing study looked at all six project sites, and it bears noting that these cost advantages were found in Adamawa, a state already impressive for its cost containment during the life cycle of this particular program.⁹

TESTING AND COUNSELING

Overall, MSH under the ProACT project has been very successful in creating a demand for testing and counseling for HIV. One of the biggest reasons for this is presumed to be related to integration of healthcare services, and improved quality of care at the facilities. This is discussed at greater length in the section on integration under Question No. 1. Another obvious reason is the rapid scale-up in treatment services, compared to what existed prior to the ProACT project. Elsewhere it is often true that testing when treatment is readily available is a

Number of individuals who received counseling and testing services for HIV and received their test results at HCT sites only



⁸ Project performance records reviewed in the field and at HQ confirm this finding.

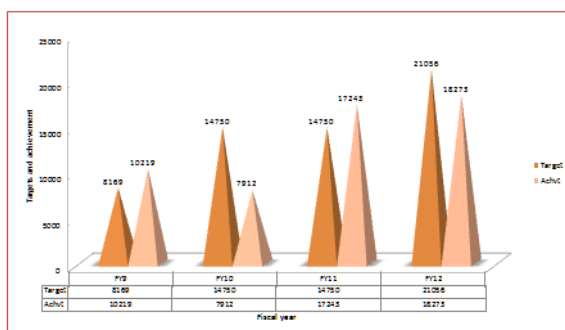
⁹ Economic Analysis of ProACT Fiscal Year 2011 Expenditure from a Program Perspective. Prepared by Ikenyei Uche for the M&E Team.

greater inducement to finding out one's status than routine testing outside a healthcare setting. There has not been a steady increase in demand for testing because of a strategic decrease in targets for fiscal year 2011, but the project has far exceeded PEPFAR targets and is on track to achieve their own project and PEPFAR targets for 2012.

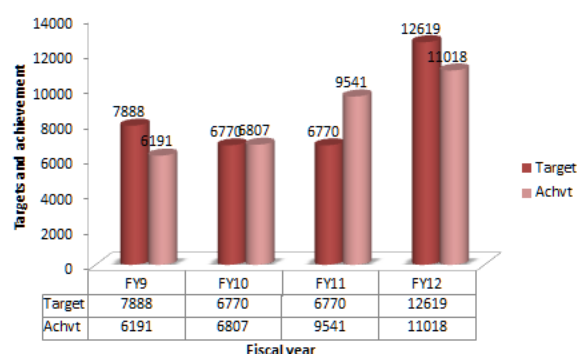
TREATMENT AND CARE

MSH has been on target and will most likely meet their target for FY 2012 for the treatment indicators for eligible adults and children provided with a minimum of one care service and provision of a minimum of one clinical service. A worrisome issue evident from looking at the MSH monitoring data is that one of the indicators used to look at treatment of PLWH who are at risk of TB has been misapplied due to an error in denominator definition. The resultant data is erratic and says nothing about how successful the TB/HIV program has been. This has been brought to the attention of NACA and PEPFAR/USAID. Corrections and retraining are underway. Issues with quality of TB services are discussed in other portions of this report

Number of HIV positive adults and children receiving a minimum of one clinical care service



Number of adults and children with advance HIV infection receiving ART therapy



PREVENTION FINDINGS

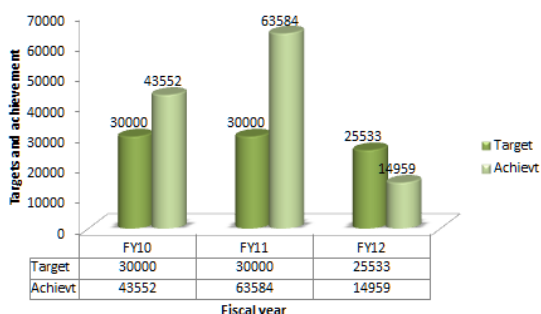
MARPS AND COMMUNITY PREVENTION

An area of project activity that stands out for its relatively low performance is that of the new prevention interventions that were rolled out in the ProACT project “add-on.” The LMS prevention approach, before the addition of interventions targeting MARPs, was a community-based prevention approach guided by the Office of the US Government AIDS Coordinator. The services included abstinence, and an education and behavior change methodology that had no clear evidence-based history of significant impact on prevention among lower-risk community populations. Under the ProACT project, following new guidance of the PEPFAR/USG and national program, the prevention approach was to identify, strengthen, and work through credible CBOs working with high-risk populations. The new strategy under the ProACT project, in line with changes in PEPFAR’s approach toward prevention in general, was to identify the actions that put groups at greatest risk of contracting HIV and intensively work at reducing risk.

Working through CBOs on the ground affiliated with high-risk groups proved to be difficult due to their lack of capacity or visibility. A new approach was taken by the ProACT project of implementing directly through MSH field-based teams, while strengthening the few local CBOs working directly with groups at a high risk of transmission. Over the last 18 months, there have been efforts at various strategies and modification of these approaches, but the results have been very modest. Currently there is a reengagement of some of the disbanded CBOs, with an anticipated startup in October 2012. The last quarterly report does confirm plans to ramp up STI education and referral to MSH primary care and comprehensive sites for treatment, especially among men who have sex with men and female sex workers.

Good MARPs programming takes time, and an atmosphere of trust among the target population, the CBOs, and the clinicians serving them. MSH has not been in the areas with high-risk populations long enough to be getting high-impact results, but there does seem to be an

Number of MARPs reached with individual and/or small group level intervention that based on evidence and/or meet minimum standard



understanding of what is needed to make an impact on transmission, but less clear leadership and consensus outside MSH about the critical importance of focusing on high-yield prevention activities. The plan for moving the intervention forward in the next year includes a midterm assessment of the prevention program and the deployment of a new set of tools across all the sites to enhance effective documentation of the intervention.¹⁰

The disappointing results of the work with MARPs is by no means due to MSH alone, but also reflects a failure of USG/PEPFAR and NACA to fully appreciate the difficulties of carrying out good risk-reduction programs among MARPs without a good community base in the CBOS that serve them. The legal and cultural challenges of working with high-risk populations only adds to the difficulties of achieving results among populations whose very activities can result in severe legal repercussions. National leadership and consensus about the urgency of effective prevention strategies is essential. (See discussion related to MARPs comments on page 48.)

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

The ProACT project has had a steady decline in achievement of testing pregnant women from 2009 to date. The reasons for this are multi-factor and have much to do with cultural birth preferences (outside of a facility) and reliance on traditional midwives. There is some difference between urban areas and rural areas. In urban settings women are more likely to go at least once to a facility during

¹⁰ USAID/Nigeria MSH/ProACT Quarterly Report, September 2012

a pregnancy. The states that MSH is working in are among the most traditional in the rural areas in terms of birth practices; hence, the likelihood of a pregnant women getting tested for HIV during a routine prenatal exam is low. The original ProACT target for testing pregnant women was based on the average antenatal prevalence of 4.1%; however, in the project target areas, the average ANC/HIV prevalence is between 2 to 1.8%. Despite this fact, PEPFAR targets for ANC testing continue upward. Continuing to use these inflated targets, given the low prevalence of HIV and limited trained PMTCT staff along with intermittent shortage of testing kits, the ProACT project needs to reevaluate care targets for PMTCT. The target for prophylaxis in FY10 and FY11 grossly underperformed, and FY12 is even further behind at 29%.

The current community mobilization for increasing demand for testing—especially in Taraba where the prevalence of positive pregnant women is higher—is a promising strategy. Another important strategy that has not been exploited in many places in Nigeria is to engage the traditional birth attendants in facility-mediated births, so that ARTs can be started in time, births can be done safely, and infant prevention and testing is done. From the national goals, all states are far off the unrealistic 90% access to PMTCT for all pregnant women. The following are the findings for the PMTCT program across the ProACT project:

- There is a steady decline in achievement on pregnant women counseling and testing from 2009 to date.
- At an achievement of 53%, 9 months into the year, it is unlikely that the FY12 target will be achieved.
- There was severe underperformance in reaching the indicator for numbers of HIV-positive pregnant women receiving prophylaxis in FY10 and FY11.
- Only 29% achievement in 9 months means that the target is not likely to be met at the end of FY12.

The following are the reasons MSH staff gave for the poor performance in PMTCT, and many are covered in the discussion above:

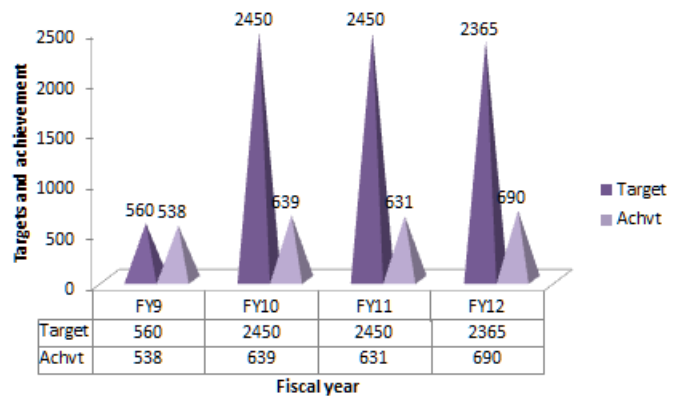
- They are working in low-prevalence states.
- The project began with extremely poor potential infrastructure and human resources to mount a large response to PMTCT.
- Understaffing in some facilities did not allow all pregnant women to be tested.
- The target was determined based on national ANC prevalence of 4.1%, but ProACT average program prevalence was 2%, and recently 1.8%.
- Four of the 6 states supported have prevalence below national prevalence.

- A significant increase has been achieved in the target by USAID without considering achievement capacity of ProACT over the year.
- There was a shortage of test kits in 2011.
- There was a strong reliance on volunteers for recruitment and a high attrition rate.

The current activity to correct the problem is to increase and improve services for pregnant women, with 23 new sites recently activated in Taraba, and to mobilize communities to create demand for PMTCT. There have been efforts at all levels to increase state-level government leadership.

Another prevention issue for the ProACT project, and an issue in many HIV treatment programs in sub-Saharan Africa, is low utilization of post-exposure prophylaxis (PEP) across the program. A site audit was conducted which revealed gaps in awareness and use of PEP services among health workers at ProACT-supported facilities. Interventions to address this gap were implemented during the reporting period.

Number of HIV positive pregnant women who received ART to reduce risk of mother to child transmission



PROJECT MANAGEMENT ISSUES OVER THE LAST 6 TO 9 MONTHS AFFECTING PROJECT PRODUCTIVITY.

As the previous section covering progress toward targets reveals, the productivity of the project has gone down. What had been known as a high-performing project with high morale while working in difficult circumstances changed over the last 9 months—i.e., at the end of 2011. The reasons for this decline are multifaceted, but hinge upon attrition of key technical personnel both in Abuja and in the states. The loss of key staff in itself starts a spiral of decreased morale, and often even the loss of a very few key staff can reverberate through a project in such a way that magnifies the effect of the loss.

In interviews with senior administrative staff and technical staff, some of the reasons put forward are: a lack of opportunity for ambitious staff to be promoted to positions with greater responsibilities, higher salaries, title, or all three. Unlike civil service or even the education system, projects are short lived and task specific, so promotion is less likely to occur in the lifespan of one or even two projects. Another endemic problem in Nigeria—and it is true about HIV projects in particular—technical staff get lured away to other projects where they may get better conditions of service, a promotion, or more pay. There is not much MSH can do about this, aside from assuring

salary equity to other similar foreign-funded development projects, which they do. A salary scan is done regularly, and salaries are kept somewhere in the middle range.

Severance packages are an issue related to short-lived projects as well. At present MSH does not provide severance pay. The staff feels this issue acutely and feels currently that there is little room to influence decisions. They want a forum where critical conditions of service, desires, and needs are discussed among all key staff. There was a discussion using veiled language about the organization's lack of appreciation of the unique field conditions that staff work under, stating security and housing as huge issues that affect productivity of workers. Work in remote regions is often associated with a high rate of attrition. Workers will change jobs once they gain marketable skills useful in more desirable locations accompanied by better family benefits.

An impressive system of checks and balances exists within the project's operations that tolerate zero irregularities on any front, from human relations to financial interactions. The office operates with no petty cash, even in remote regions, but has had little problem with keeping systems such as logistics running smoothly.

PROJECT MANAGEMENT TEAM RESPONSIVENESS AND ACCOUNTABILITY TO ITS CLIENTS

According to the NACA staff, the MSH/ProACT activities are predominantly in the states, but MSH sometimes steps in to support NACA activities, especially in strategic planning at the national level on behalf of the states. The NACA staff described the MSH staff as their “foot soldiers in the states.” The NACA staff do have concerns about the sustainability of the approach USAID has taken via MSH to house contracted staff in project offices at the state level, rather than in the SACA offices, sitting side by side with their counterparts. This seemed to be most important when speaking about the reliability of data reported to the national level from the state level. According to Hajia Maimuna Mohammed, NACA's Director for CSO Relationship and Coordination, “There is a need for clear deliverables that speak to the needs and capacities of the SACA—i.e., ‘By this time SACA should be able to do....’”

SACA's view is that data on the number of training programs and people trained is not as helpful as indicators directly speaking to capacity achievements of state HIV workers and other health stakeholders/actors. MSH, at this point, focuses on process indicators for capacity, rather than on the achievements of the implementing partner's demonstrated skills. Capacity building activities such as trainings need to be followed up with opportunities to practice newly learned skills and will help determine how effective training and mentoring activities are. According to Hajia Maimuna Mohammed, “Measurements of achievements such as implementing strategic plans, budgeting activities, and delivering services is what tells us the states have a higher degree of sustainable abilities. The process indicators, like numbers of workshops delivered, does not tell us about real capacity.”

Responsiveness to CBOs and PLWH support groups was impressively positive, according to those interviewed in focus groups, as well as the PLWH interviewed as key informants.

Project staff themselves talked about the uphill battle to work with CBOs when sustainability is so immediately on the horizon. They have been impressed with the CBOs' ability to understand the issue and work hard at finding a means of sustaining organizations and activities once MSH is no longer working in the area.

USAID feels MSH is a responsive partner, and evidence speaks to their ability to work with the GON and local government. The caveat, of course, is that USAID staff has not been able to go out to the field for more than 6 months, and in some cases a year, to personally determine what the situation is. MSH's ability to report on activities, spend appropriately, and manage small grants has been very strong throughout the life cycle of the project. The recent increased rate of attrition is a matter of concern to them, and at this point it is unclear how MSH and USAID might work together to address the issues in the remaining quarter of 2012, but there is discussion of mediation activities spearheaded by USAID.

USAID'S MANAGEMENT OF THE PROJECT BY REPORT OF BOTH PARTIES HAS BEEN POSITIVE AND SUPPORTIVE.

There is an awareness that USAID is limited by personnel and size of their portfolios to do as much oversight as MSH or USAID might find useful for the ProACT sites.¹¹ Security concerns also play a part in limiting oversight from USAID. These conclusions were taken from interviews with USAID staff with responsibilities for oversight of project areas under review.

AXIOS AND MSH RELATIONSHIP

The Axios Foundation is the commodities logistics partner to MSH on the ProACT project. Their key mandate as the supply chain management partner in the ProACT project is ensuring reliable availability of diagnostics, ARVs, and drugs for prevention and treatment, as well as other consumables at designated health facilities in the six states being supported by the project. The organization is also responsible for strengthening of pharmaceutical care, pharmacy best practice, and development of a pool of locally based health facilities leaders and managers.

Field visits to Axios sites and discussion with MSH reveal an excellent working relationship, with measures taken to avoid stock shortages and to resolve common issues and difficulties with partners whose capacities are not yet up to the task of smooth logistics and drug distribution.

¹¹ From interviews of key informants at USAID: *Please note that the North is currently off limits for USAID staff travel, so not much can be said regarding the weaknesses of the M&E systems at facilities.*

Specifically, their mandate is to mobilize stakeholders from across the health community to ensure local ownership, and to create sustainable health solutions. In fact, unique solutions are being created by the logistics team for dealing with local stock shortages. They have been notable for their responsiveness and ability to flexibly handle short-notice difficulties with logistics and stock outages.

Axios' strengths and weaknesses within this particular working coalition with MSH are listed as follows:

STRENGTHS:

- Existence of a robust logistics system with knowledgeable and experienced personnel.
- Availability of six additional state program depot warehouses at different locations with a robust electronic inventory management infrastructure to support the program.
- Efficient and effective distribution network throughout Nigeria.
- International and in-country experience in management of HIV commodity logistics.
- Productive collaboration with federal government and governments in all operational states to foster ownership and capacity transfer.
- Axios Foundation Nigeria receives technical support from their sister organization, Axios International, on mentoring, model pharmacy, and good pharmacy practice.

WEAKNESSES:

- Staff attrition at health facilities and, to a lesser extent, at the central warehouse.
- Limited support from the various state governments.
- Inadequate storage infrastructure at health facility level.
- Dearth of certified trainers on logistics management of HIV/AIDS commodities.
- Low IT proficiency among government personnel both at central warehouse and facility levels.

CONCLUSION

The findings support the conclusion that MSH, under the ProACT project, is performing exceptional work in some important areas in a very challenging environment, and that they have been further challenged in meeting some of the original goals of the project design. Their work to support the PEPFAR strategy of integration of services has been very successful. Their management of the very complex task of creating systems to harmonize health data has been outstanding. The rapid scale-up of treatment sites, working across governmental and private facilities, is impressive

and is reflected in the numbers of people being tested and started on treatment. The project management systems put into place in each state proved agile and responsive to both local government and state government constituencies.

The significant challenges are in the prevention arena. After a history of successful prevention work under older models of community-based prevention, MSH was not able to quickly adapt to the very different approaches needed for work with MARPs. There are a variety of reasons for this, but the primary reason appears to be the under-appreciation by all parties, from government to USG, of the difficulties of doing prevention among highly stigmatized groups in a threatening legal environment in areas where the project had little history or community relations. The early LMS work used an ABC approach and community-based prevention strategies among known populations, which is inappropriate for populations at particularly high risk. That shift takes a long period of community-based groundwork to build trust among vastly different communities than they had been working with previously.

The failure to reach targets in PMTCT appears to be the difficulty inherent in working in areas with low HIV prevalence. MSH will need to rethink their strategies as well as targets for interventions with women at risk of pregnancy and HIV in much the same fashion as they need to address their approach to MARPs. Again, with both population groups, mid-term is too early to say an approach has failed, as fundamental changes in birth practices, as well as attitudes toward high-risk activities, take time and extensive long-term work at the grass roots level. MSH is working on multiple fronts to step up their prevention interventions, but it is unlikely there is enough time remaining on this project to see real change in actual prevalence.

The project's management systems and procedures, as they relate to the tasks of project implementation, do appear sound. Even without the necessary changes in project strategies and adjustments of targets, MSH will meet many of the expected outcomes and the overall project goal. As discussed above, some of the targets are inappropriate and should not reflect on the success of management systems.

As a partner to all important counterparts, from national to state government to IPs and particularly to local government, MSH has been a solid and responsive partner and has contributed a great deal to the success of current PEPFAR strategies. The current issues with staff turnover are internal ones that may or may not be remedial through changes in management approach. As discussed, some of the attrition of senior technical staff is to be expected in projects with a set lifespan and attrition, due in part to a feeling of being excluded from significant management decisions that have a great impact on their work, and in some cases their personal lives, might be ameliorated with mediation and accommodation discussed at greater length in the recommendations.

V. QUESTION 3:

SUSTAINABILITY

MAIN QUESTIONS

What strategies and approaches did MSH/ProACT and its partners adopt and implement to facilitate the sustainability of the supported activities and programs beyond the project's funding period?

How do facilities, communities and government structures promote institutional, financial, and programmatic sustainability and ownership of the HIV response in their respective health facilities and states?

What support would they require from MSH/ProACT to ensure a seamless transition by the end of the project?

COMMUNITY-BASED STRATEGIES FOR SUSTAINABLE CHANGE

The history of successful mobilization for change on a large scale follows an often rocky yet predictable path from community to state to the national arena, and the work of MSH in Nigeria is no exception. The program began with the search for common cause in community dialogue, which swiftly moved into plans for community action. Actions foster broader mobilization and advocacy and can lead to meaningful, often profound change in the social contract. It is an unrealistic expectation that a program enjoying external support over 4 to 5 years can make a “seamless transition” to self-sufficiency. The transition to other donors, small enterprise support or even new channels of governmental support will bring with it various degrees of unpredictable instability, and what aspects of a program will be sustainable is unknown. The challenge for ProACT project is to anticipate some of those issues and work to shore up organizations and services while carrying out transitional efforts to build the scaffolding of fundamental institutional development. MSH articulated the expectation of sustainability from the very beginning of ProACT project. Clients from community members to national ministers know gradual withdrawal of support are the conditions of the ProACT project. The evaluation team found this transparency to be a project strength, and hope it will help make the transition to limited funding less painful (if not “seamless”—the expressed desire from USAID for the phase out of the ProACT project).

Some communities with better leadership and more greater of resources available were much more optimistic about being able to continue their activities without MSH support. There were more CBOs registered and raising funds from a variety of sources, including private and public partnerships with local businesses, faith-based organizations and grant funds from UNDP and the World Bank, and in some cases from GON revenues via appropriate ministries and services.

IMPLEMENTING PARTNERS AND SUSTAINABILITY

Implementing partners, such as support groups of PLWH, have registered as official CBOs and have begun receiving support, writing grants, and providing services. Testimony from a CBO support group of PLWH in Donga (CHCF) states that "MSH provides many services such as counseling, laboratory services, drugs, support group, OVC support, and community outreach. These have really helped our members to become stronger, and some of us who may have died are still living today because of the project. Some of our members have received training from the project so that we are able to support other members of the group."

Communities in the areas where MSH is working have generated meaningful support, without external inputs, such as pooling limited resources and learning to scan the broader environment for other internal resources such as opportunities for community seed-banking, donated labor to communal land to feed food-insecure households, approached schools to waive student fees in exchange for improving conditions in the schools, and in some cases approaching small businesses to donate shelter and emergency funding sources. In an interview with Alh Abubakar Salihu, Dan Bawuro, III, The Emir of Ibi, he said, "For example, the food bank I started in the community was my own personal initiative (which MSH and other visitors from Abuja have visited). In fact, I have converted one of my farms to be solely used for the purpose of the food bank (which feeds the OVCs)."

In communities with better leadership, as well (particularly leaders with resources) there was more optimism about being able to continue their activities without MSH support. The project's focus on engaging community leaders is clearly one that is critical to sustaining an effective response and demand for services. This was particularly evident in Taraba, where evaluation staff met with the Emir of Ibi (traditional leader) mentioned above, who has taken a high level of personal responsibility for the general well-being of the communities under his jurisdiction. When asked why he appreciated MSH, he said, "They came with a community-oriented program, and I am a community-oriented leader." Clearly, MSH did the necessary community mobilization to lay the groundwork for ownership of ongoing activities. In sites such as Ibi, communities have formed various service CBOs, raised money, and have been given money by traditional leadership to carry on activities to support PLWH and households supporting affected and vulnerable children.

SUSTAINING SERVICES TO BENEFICIARIES

The PLWH support group in Taraba uniformly agree on how important free, supportive services are in keeping people alive. They stress that core services of ART, laboratory and counseling around adherence, as well as general psychosocial support are life-saving. They mention bad experiences at other non MSH sites. Even if poorer quality services are closer, patients travel the extra distance to come to the project-supported site. Advocacy for uninterrupted HIV services is a critical sustainability strategy. HIV treatment more than any other service or action, sustains life, the life of children, and ultimately, the future of the community.

In an interview with the community care advisor at MSH, she explains their approach to OVCs in this way: grants for households supporting vulnerable children are available, and emphasis is placed on income generation, creation of small savings and loans enterprises, food security, and reinforcement of shelter. Specifically, the package of basic services for children is referred to as “6 plus 1,” which includes health, education, nutrition, psychosocial support, shelter, care and protection. The “1” consists of small enterprise endeavors. The project does not provide all these services, but works with communities to respond with this particular set of interventions as a guide. The project workers want the community members to appreciate what they can do for the dependent children from their own resources and, thereby, reduce dependence and further sustainability.

LEADERSHIP, MANAGEMENT, AND ADVOCACY TRAINING FOR SUSTAINABILITY AT LOCAL GOVERNMENT AND SACA

Sustained change that provides for basic needs rests on the assumption that the leadership is only as legitimate as its ability and willingness to protect its most vulnerable constituents. Good governance can and must work to disrupt inequities of power and resources, in order to create a more level playing field outside of market forces, by laying the groundwork for sustainable long-lasting change that protects the most vulnerable. Often left out of a social contract, the most vulnerable have little chance of surviving. There is a difference between sustainability of development. A sustainable development plan must include reliable care for the most vulnerable without extracting a cost from those least able to pay.¹²

In the communities surrounding the target facilities, MSH did advocacy work through leadership trainings to build on the skills of natural community leaders. These leaders, in turn, advocate for services from local government. Through leadership and advocacy, the demand for services from government agencies is legitimized. Activists for the rights of vulnerable children and PLWH, in the best of circumstances, can push the government to uphold the constitutional right of universal basic education. Advocacy educates citizens about their rights and explains the processes that make laws and generate policies to administer interventions critical to the lives of PLWH. When a traditional leader was questioned about his role in fighting HIV, he gave the following response, “We have been involved in sensitization and mobilization with government in order to get support for the project and the community. Before the decentralization of the drugs supply, I had to provide financial support in order assist the HF to get drugs. Our mobilization efforts has led to visitation of the community by high-ranking government officials. In fact, I had to personally take the test, and I publicly shared the test results with my community in order to dis-abuse their minds from the

¹² For more on this approach to development theory, see Cécile M Bensimon and Solomon R. Benatar, “Developing Sustainability: A New Metaphor for Progress,” *Theoretical Medicine and Bioethics*. (2006). Springer, 27(1): 59–79. DOI: 10.1007/s11017-005-5754-1.

prevailing belief system which was affecting us negatively.” In a closing statement, he said, “Once the leaders are sensitized, there is possibility of sustainability because it is not USAID that funds the leaders. The leaders will always be here.”

WORKING FOR SUSTAINABILITY BY SUPPORTING AND STRENGTHENING LOCAL AND STATE GOVERNMENT

The original LMS-ACT Project was able to gain the trust of SMOH, LGA officials, and facility management through responsive targeted TA, and some of the success of the add-on activities under the ProACT project is a result of this groundwork. Some of the tangible and intangible activities supported or implemented by MSH that contribute to sustainability of government health services include:

- Strategic planning workshops to encourage long-range planning, from IPs to government stakeholders, at multiple levels;
- Mentoring state planners through the development of a 5-year strategic plan for HIV and other health and human services;
- Worked closely with state actors to develop a two-year “costed” operational plan;
- Mentoring and working with SACA and SMOH carry out the daily activities necessary to the realization of the strategic plan; and
- Patient, galvanizing work to build bridges between NACA and SACA, especially in the states where geography and political instability can often restrict exchange of information and personnel.

Recognizing that civil society and longstanding care and support groups are needed to carry out activities, MSH has worked closely with key groups to get official recognition and funding from outside organizations. The CBOs could not have done this without the institutional strengthening that is a core component of the MSH sustainability strategy. At the time of this evaluation, there was growing evidence that state budgets will consider funding community-based project activities from their own budgets. The key informant for CBOs in Kogi, Ingra Lokoja, said, “With the training we got from MSH, we are able to source for a grant to continue what we are doing. Government support was maintaining the teachers we have trained in the various schools, making sure they are not transferred within the lifespan of the project. Another source of support was to give us the free hand to work to determine our programs in those schools. On the part of the community, too, they gave the enabling environment in which to work. They also allow us to use the existing structures in terms of the women’s groups and other groups in the community.”

In interviews with the National AIDS Coordinating Association (NACA), consistent funding at all levels of technical and institutional support to SACAs and the communities they serve is always a concern for NACA. This is the reason for the strong emphasis on the mentorship component of all projects at state levels, including those between MSH and the SACAs. When the ProACT project

comes to an end, the SACAs will have been mentored by MSH (and others), and the hope is they will be able to continue to function in similar capacities and with similar quality of care.

SUSTAINING QUALITY HEALTH DATA

There are consistent concerns pertaining to data quality at the remote state level. NACA officials discuss and problem-solve around how to increase capacity at the SACA level on a regular basis, but state that it is a continuous problem, and the capacity of the states vary considerably. Currently, MHS does routine review of the quality of data and services offered at the SACA and local level. There is a secondary review by MEMS II to look at global PEPFAR data concerns on a regular basis. NACA expressed the concern that they would be challenged to do a similar quality review, which definitely raises concerns regarding the sustainability of quality data, if nothing else. Along with data concerns are those related to service provision organizations relying on MSH support to sustain services to those most in need. In the case of maintaining ART supplies, this raises considerable concerns, because lives depend on daily medication, and without it, antiretroviral resistance will become a greater issue.

NACA places a high value on the mentorship component of all projects at state levels, including between MSH and the SACAs. In conversations with NACA officials, they point out that some donors have a similar role of capacity-building, but actually place people in the SACA offices working side by side with GON/SACA staff for the length of various projects. They felt the ability of SMOH and SACA staff to carry out activities after a project terminates would be stronger with this type of mentoring, rather than organizations such as MSH make regular visits from separate project-based offices in each state. An alternative point of view expressed by USAID staff was that placing project staff in government offices has the potential to create problems with pay inequity and perceptions of task/role ownership of job responsibilities. The higher-paid seconded staff can be viewed as the staff most responsible for deliverables, as they have better reimbursement and incentives for higher performance.

Another sustainability-related discussion concerned MSH's use of data clerks to help with the integration of information collection. There is little doubt that the data would be of poorer quality without this cadre of workers. There are also concerns that integrated data collection will continue to be a task few present-day cadre of health information specialists have had experience in. The sustainability concerns come into play around creation of a new class of worker that does not fit under any other supervision system, training institution, or certification process.

ADDITIONAL QUESTIONS RELATING TO SUSTAINABILITY FROM ANNEXES

WHAT ISSUES AND GAPS HAVE HAD SIGNIFICANT EFFECT ON SUSTAINABILITY?

- Work stoppages;
- Staff turnover at MSH;

- Absence of income-generating TA partner for the CBOS providing care to the poorest households
- lack of leadership from state government versus local;
- Further training for state-level budgeting exercises and advocacy for the release of funds;
- Need for ongoing job performance review and skills renewal for managers;
- Lack of cohesion of IP and donors at the state level for budgeting exercises;
- Inability of central SMOH to get and keep supplies and staff to local hospitals in a timely and reliable fashion;
- Leadership at the highest level of government to confront the presence and effect of HIV on the population;
- Reluctance of staff in key vertical programs to take most obvious low-cost steps toward integration of services and resources;
- Gender review of all health programming: Programs that target livelihood security of women are more successful at meeting the needs of the household; keeping girls in schools longer will markedly decrease the risk of contracting HIV at an early age;
- Push or promote employment and engagement of PLWH as volunteers and incentivized workers; and
- Explore small incentives that are meaningful to community based workers such as official registration as workers, certificates of training, identifying clothing or name tags on shirts, IEC materials to share with the community, community recognition ceremonies.

WHICH PROJECT INTERVENTION(S) HAD THE MOST COMPARATIVE COST ADVANTAGE IN IMPLEMENTATION?

- Clinical mentoring
- Thoughtful use of task shifting involving idea sharing with staff impacted by changing roles
- Integration of services
- Training all level of service providers in HIV counseling
- Trainers of training approaches (step-down training)
- Getting ARTs closer geographically to patients who are on them
- Concentrating work with CBOs closer to MARPs
- Better planning around shared laboratory services

CONCLUSIONS

GOOD PRACTICE IN SUSTAINABLE COMMUNITY DEVELOPMENT, HEALTH SYSTEMS, AND INSTITUTION-BUILDING

LMS-ACT, the predecessor to the ProACT project, was built upon demonstrated skillful and successful community mobilization in states that have not traditionally seen many external actors creating a climate for challenging large-scale community problems. The fact that MSH was able to enter these harder-to-reach communities and work at multiple levels to bring about major improvements in healthcare systems in a relatively short period is to their great credit, and reflects good development practice and committed staff. All key actions followed intensive community consultation and preparation and sought buy-ins from all key local and state actors vital to carrying out the tasks of an ambitious project aimed at building the capacity of local stakeholders at multiple levels. Without being as explicit about creating rapid sustainability in the early LMS phase, the strategies used when setting up and implementing early activities were sound ones. The LMS staff used existing structures such as local government when applying intensive mentoring, and training of local facility staff.

Because they were establishing centers of treatment for HIV for the first time, along with the integration of those services into primary care services, in many communities the first years were very action oriented, with a great deal of hands-on mentoring by MSH. With the advent of the ProACT project, sustainability strategies became more explicit, and many IPs and community organizations underwent institutional development and training aimed specifically at their sustainability beyond the life of the project. Facility staff underwent extensive training aimed at building skills to run integrated healthcare services that meet the needs of PLWH. Data quality has been a high priority, and appropriately so, despite the difficulties inherent in the work in states far from the capital with increasing degrees of political instability.

Efforts to build upon sustainable strategies to support CBOs, especially those targeting beneficiaries such as PLWH and their children, were rolled out in early 2011 and continued using a combination of approaches: skills-building and training; facilitating opportunities to link with small income-generation opportunities; advocacy among traditional and local government actors; recruitment of faith-based CBOs; assisting beneficiary groups to form registered entities; and helping CBOs leverage support from other donor-sponsored projects such as the World Bank.

However, sustaining community, local government, and state activities supported under the ProACT project does not rest solely with finding the correct strategy or design for transition to independent agencies. Sustainability lies in no small part outside the control of the “development partners,” and rests with government will and leadership in an unstable, yet not unpromising times, in Nigerian history. Nigeria, blessed and cursed with mineral wealth and a vast population, faces a critical moment in history. If it fails to mount a uniquely Nigerian strategy to combat HIV, this generation and those of the future will suffer needlessly. Sustainable socioeconomic and political systemic change is needed at every level of society from community to state, and at the national level. Because

of its potential wealth and high literacy levels, Nigeria could be a model for sustainable development that not only manages growth, but creates institutions and health systems that place the most fundamental needs of the vulnerable outside the forces of the market. One can argue the case that free access to ART for those PLWH is a perfect example of refusing to do business as usual, to step outside the usual forces of supply and demand otherwise known as the marketplace.

VI. QUESTION 4:

CAPACITY-BUILDING

MAIN QUESTIONS

How has MSH/ProACT capacity-building support improved the competence of service providers in providing quality services to patients?

How has the capacity-building support to governments (SACA and SMOH) strengthened their coordination and leadership capacity in leading the HIV response in their respective states?

What is the extent of beneficiaries' (patients, organizations, SMOH, FMOH, etc.) satisfaction with the project's interventions so far, and are there areas of modifications or changes necessary for the project to achieve its set objectives by the end of the life of the project?

MSH CAPACITY-BUILDING STRATEGIES

Capacity-building is directly and indirectly linked to achieving other key objectives of the ProACT project, namely, quality of health services, increased access to services, and health systems-strengthening. The capacity-building strategies adopted are three-pronged: (1) training of trainers (ToT) at all levels of government using the project's key thematic areas and standard revised curricular and manuals; (2) participatory and on the job training; and (3) step-down training at all levels. MSH implements these capacity-building strategies by identifying experienced health professionals at the states' FMOH HIV/AIDS department, SACAs, health facilities, health institutions, CBOs/Non-governmental Organizations (NGOs), and private hospitals who are jointly trained by ProACT and FMOH staff using updated curriculum and manuals. These master trainers use step-down training to train the IPs' employees, who in turn train other staff in their respective departments or agencies. Alongside the formal training, TA is provided at all levels of the project's implementation. The training approach was designed to ensure continuous updating of key stakeholders about new and emerging HIV/AIDS care issues, and the quality of services throughout the life of the project, which translates into systems-strengthening and sustainability.

Table: Stakeholders who Participation in Training and Reported Effects on Performance

Stakeholders	Kogi	Taraba	Total inter-ven-tions	Total received training	Percent received training (%)	Reported improved performance
MSH State Offices Staff	3	5	8	8	100%	✓
SACA/SMOH Staff	3	3	6	6	100%	✓
Health Facility Staff	12	21	33	29	88%	✓
CBOs Staff	9	12	21	14	67%	✓
CBOs Peer Educators	3	14	17	17	100%	✓
PLWH Support Groups Executives	6	11	17	17	100%	✓
PLWH Support Groups Members**	20	20	40	-	-	-
Caregiver**	12	8	20	-	-	-
OVC**	8	9	17	-	-	-
Total	76	103	186	71	-	

** Mostly received general information on personal hygiene and healthy living (few had training on IGA).

Responses to the evaluation questions on capacity building were provided using KIIs, FGDs, and GIs techniques of data collection. Responses were elicited from SACA/SMOH staff; MSH key project staff; healthcare providers; CBO staff and PEs; PLWH support groups, executives, and members; caregivers; and OVC. The table above shows the distribution of the different stakeholders who participated in training and reported about their perception in terms of job performance and services provided. This assessment was conducted with staff that were available at the time of the evaluation, and may be underestimating the total number trained through the project. Also, figures in the table may not represent all PLWH support group members or caregivers trained, since some were unavailable for the evaluation.

Among the different stakeholders interviewed, the lowest percent of trained sub-groups are CBOs staff (67%) followed by healthcare providers (88%). The reasons for this may be due to staff turnover in these two sub-groups and/or entrance of new staff that had not received training before the evaluation.

MSH STATE OFFICES STAFF TRAINING AND PERFORMANCE

The staff at the MSH offices located in Kogi and Taraba were asked about the types of training that they have received since joining the ProACT project, and how the training enhanced their job performance. The categories of staff who participated included state team leader, finance and accounts officer, clinical specialists, M&E specialists, and supply chain management systems specialists. Table 2 above shows that all eight senior MSH staff at the two states visited reported that they had received training geared to enhance the performance of their work. Key training programs were: human dynamics for team-building; Axios' mentoring scheme; logistics management and

information systems; quantification on healthcare community; family life education; OVC/caregivers 6-plus-1; HIV behavior counseling; laboratory management information system; budget and financial management; gender; seed training; and grant management. Other training include M&E; data quality; PLWH education plus; early infant HIV diagnosis; and health system strengthening, among others.

As to whether or not the training received improved performance on the job, all MSH staff who participated in the evaluation directly attributed improved job performance to the training. The staff reported that the human dynamics training enabled them to understand and appreciate team-building better. Also, their understanding and performance were reflected in the step-down training to other staff and colleagues at the health facilities, and CBOs. Combined responses of three MSH Kogi staff during a group interview attest to the types of training received and reflections on performance. “(Staff 1): I have done M&E training on HIV in South Africa; (Staff 2): I have done grant management trainings alongside with the CBOs, trainings on family life education with the teachers, PLWH education, plus training for out-of-school youth, women dynamics training sponsored by MSH; (Staff 3): Human dynamics training, seed training facilitated by a staff from Boston, and accounting training in South Africa.”

SACA/SMOH STAFF TRAINING AND PERFORMANCE

Six senior staff of SACA/SMOH in Kogi (3) and Taraba (3) were interviewed about the types of training that they received and how the training may have affected their performance on the job. Cadres of SACA/SMOH staff interviewed included the state coordinator on HIV/AIDS, directors, M&E officers, and financial officers. All six staff reported that they received training on ToT; work plan development; data quality; the importance of data for decision-making; leadership development; and management of programs, among others. They also reported that the training received has enabled them to perform their jobs better. A staff of KOSACA buttresses this fact: “There are great [sic] impact of capacity building on us. Before MSH came in, we know little about work plan, documentation, importance of data to this program; we are doing things anyhow. I think MSH has been the first partner to come and teach us on how to do things rightly, management of our program.”

Findings suggest that SACA/SMOH staff do accompany MSH staff to do step-down training at the health facilities, but the smooth implementation of this collaboration has often been hampered by funding of logistics. The main reason provided was that there was no state budget line item for project monitoring missions.

HEALTH FACILITY STAFF TRAINING AND PERFORMANCE

Twenty-nine staff at the six health facilities visited responded to the question on whether they received training and the effects on their job performance. The range of staff who responded to the questions included site coordinators, medical doctors, nurses, M&E officers, pharmacists, and laboratory officers. Results in Table 2 above suggest that the majority of the health facility staff

interviewed (88%) had formal training in one or more of the project's thematic areas. Health facility staff reported receiving training on HCT; TB case detection; HIV patients and malaria diagnosis; clinical HIV/AIDS management; adult ART; pediatrics ART; PMTCT training and update; pharmacy practice; M&E, including data generation and reporting; and drug logistics, among others.

All health facility staff, irrespective of their cadre and thematic areas, reported that the training received was useful in the performance of their jobs. Two opinions from facilities staff themselves supports this finding. A facility staff in Donga, Taraba said that, “[I received training in] HIV/AIDS commodities . . . and the second one is clinical HIV/AIDS management. . . . Actually, before I do (sic) not know the essence of this HIV drugs, but now I know. I know how to attend to patient, and I know how to keep my stock very well. It has made my work better.” Also, a health facility staff in Dekina, Kogi, corroborates this, “Many staff [in this facility] went through [trainings] on HIV services [nurses, lab, pharmacist]. I have attended training on ART and physicians conference sponsored by ProACT. The training(s) were very helpful because our knowledge has been improved and we are better able to manage HIV patients.”

Also, evidence suggests that staff at the health facilities, in conjunction with MSH staff, also stepped-down the training that they received to those who were not able to attend. The step-down training strategies enabled a wider spectrum of facility staff to participate in providing integrated HIV services to clients, thereby fostering the “task-shifting” objectives of the project, and reducing workload per staff.

CBOS MANAGEMENT STAFF TRAINING AND PERFORMANCE

Only 14 (67%) of the 33 CBOs staff who participated in this evaluation reported that they attended formal training to enhance their capacity on the job. CBO staff who reported receiving training included CEOs, accounts and admin officers, program officers, M&E officers, and volunteers. Types of training received included proposal development; project implementation and management; report-writing; financial management; bookkeeping and accounts; family life health education; HIV knowledge; counseling and testing; basic care and support; grants management; organizational development; stigma reduction; and peer education. Also, training was provided for OVC caregivers 6-plus-1, and business entrepreneurship for caregivers. The staff also reported receiving refresher training in some of the courses.

All CBOs staff who participated in the training programs reported that their performance on the job improved substantially. Also, they were able to step-down the training received, especially those on HIV/AIDS knowledge and family life education, to PEs and caregivers. A CBO staff in Lokoja, Kogi, had this to say on gains from the trainings received: “We had proposal development workshop, (FLHE) family life health education training of teachers, HIV education by MSH, and peer education-plus training. It has built our capacity to be adequately fairly objective. It has enabled us to manage issues around grants, and then reporting. We will appreciate more training.”

Although all CBOs staff who participated in ProACT project's training programs reported enhanced job performance, some staff (33%) had not been trained. Reasons may be that some staff that were trained by the project had already left at the time the evaluation team visited, and those that newly joined had not had the opportunity to go for training. Whatever the reason, it is important that more CBOs key staff be trained and retained to ensure consistent impact of HIV prevention intervention at the community level.

CBOS PEER EDUCATORS TRAINING AND PERFORMANCE

The PEs who participated in this evaluation were a mix of both those working with in-school and out-of-school youths under the tutelage of the CBOs providing HIV prevention intervention in the communities. All 17 PEs who participated in this evaluation reported receiving training that enhanced the performance of their job. This finding was expected since training is a mandatory requirement for qualifying as a PE. Key trainings stepped-down by CBOs staff to PEs were on knowledge about HIV/AIDS, stigma reduction, positive living, hygiene and sanitation, HCT, family life education, M&E activities, and report-writing.

Findings showed that PEs' involvement in the ProACT project through their local CBO not only enhanced their ability to do outreach in the community but also transformed their lives to become more self-confident, a better role model, and become more responsible in their community. Also, the PEs influenced their friends and colleagues to adopt more responsible sexual behavior. The following statement from a PE in Jalingo, Taraba, summarizes the view of most PEs interviewed. "As a peer educator I have benefitted financially and academically. Through the trainings I have received, I have improved my own life. I have better time management as a result of training from MSH. Even though I engage in sexual activities, I do it each and every time with the proper use of condom, and I do not engage in oral sex. . . . I have the knowledge and ability to speak in public; my self-confidence has improved greatly. I have also improved my sense of humor, and use humor as a point of entrance for the message that I have to give them. . . . My knowledge level of HIV/AIDS and the methods of infection has helped me to know how to protect myself, and most of my peers also know how to protect themselves, and most of them have reduced their risky behaviors."

PLWH SUPPORT GROUP TRAINING AND PERFORMANCE

The PLWH support groups included in this evaluation were those attached to the health facilities visited by the evaluation teams at Kogi and Taraba. The PLWH support groups were mainly divided into executive members and ordinary members. The executive members (chairman, secretary, and finance and accountants) are those elected to take-up managerial functions, including catering for the needs of members.

Support Group Executive Members: Table 2 above shows that 17 executive members of the support groups participated in the evaluation exercise, all reported that they were trained, and the training enhanced their performance. Types of trainings stepped-down by health facility staff in conjunction with MSH staff included HIV/AIDS knowledge, drug adherence, HCT, stigma reduction, and

positive living through confidence building. Findings of this evaluation suggest that the executive members of the support groups in most cases go the extra mile to help their members to stay alive by ensuring that they strictly adhere to drug regimens prescribed by the health facility. Also, the executive members champion HIV/AIDS knowledge and advocacy against stigma and discrimination in their community. The following statement from a support group executive member in Donga, Taraba, attests to the role that executive members play in the lives of PLWH and their community. “I gained a lot of information as a result of the project. I am now an advocate for people to come out and test, take their drugs.... I have helped two couples to get married (who are all HIV-positive). I like the fact that I am able to help people with the information that I have received. I have appeared on TV, I have met the governor’s wife, and I am PRO of our support group, so this has given me a lot of confidence.”

Support Groups Members: Findings of this evaluation suggest that most ordinary members of the support group were not directly involved in formal trainings that are jointly conducted by MSH and health facility staff. But they are exposed to regular weekly health talks organized in the health facility, and information shared during their own group meetings. Health topics discussed at the facilities include HIV/AIDS; family life education; personal hygiene; sanitation; and types of food to eat to stay healthy. A member of PLWH support group in Dekina, Kogi, captures the opinions of others, “There is an immense improvement in the area of support group. We are aware that adherence to drugs will not make one to fall sick. He [facility staff] has given us the clue of what to eat, the variety of food to be eating, [including] local produce, ingredients that can nourish your body. The importance of vegetables and fruits—from here we learnt about these things and take it home to practice with our family.”

CAREGIVERS AND OVC TRAINING AND LIFE IMPROVEMENTS

20 caregivers from the two states participated in the evaluation. Training for caregivers was in the form of providing general health information to them, on HIV prevention, OVC care, nutrition, sanitation and hygiene, and some were trained on IGA. Excerpts from one of the participants in an FGDs with caregivers in Jalingo, Taraba, attest to the training received: “We have received the training on care of OVC. We have also been trained on how to take our drugs and how to make sure we keep in touch with our volunteers to make sure we keep them updated on the state of health of our children so that if there is need for them to be taken to the hospital, we will act in good time to save their lives.”

The 17 OVC who participated in this evaluation did not receive any formal training, but received information from their caregivers and CBO staff and volunteers on a regular basis. The information that OVC received were mainly on HIV prevention and personal hygiene. An OVC buttressed this point in an FGDs conducted in Jalingo, Taraba, “We used to drink water from the well without parboiling and treating it. But with the information from uncle Harrison [CBO staff], we started boiling and treating our water. Before, we used to stack dirty plates and leave them and go and play, but Uncle told us that we should wash them immediately so that we don’t fall sick, and he told us to clear the surroundings of the house to avoid mosquito.”

LINKAGES BETWEEN CAPACITY-BUILDING AND QUALITY OF CARE, SYSTEMS STRENGTHENING AND SUSTAINABILITY

Capacity building at all levels is central to the successful implementation of the ProACT project. Training is implicit in the realization of better quality of health services provided, health systems strengthening, and sustainability of project activities. This section examines evidence (from the various stakeholders interviewed) suggesting linkages between capacity building and other key project objectives. The project employed two techniques for implementing capacity building strategies, namely, formal/informal training, and continuous TA at all levels. The continuous TA approach may have resulted in linkages feeding into system strengthening, quality of care and increased access, and sustainability components of the project.

EVIDENCE OF TRAINING LINKAGES WITH SYSTEMS STRENGTHENING AND SUSTAINABILITY

The following is evidence directly linking effects of training to systems strengthening and sustainability at the government, health facility and community levels:

- Staff of SACA/SMOH reported that they had acquired skills that enabled them to prepare annual work plans, reports, and to organize and coordinate functioning TWG meetings, based on their involvement in the ProACT project.
- The evaluation team observed the smooth daily operations of the health facilities that were following the standard procedures suggested by MSH without close supervision. In general, the challenges were not on human capacity to provide services, but rather on the shortage of staff to meet increasing demand. Excerpt from interviews with a staff member at the specialist hospital in Kogi summarizes the linkages between training, systems strengthening and sustainability at the government agencies and health facilities, “1) The knowledge acquired by staff from the training will continue to be useful in patients’ care. 2) There are various technical committees set up at the state level which will help the state to be more focused. 3) The state [Kogi] now has an action plan for HIV/AIDS, which all partners have been asked to use for their plan for supporting the state.”
- Evidence suggests that the training programs and TAs enabled the CBOs staff to implement their yearly work plan activities successfully, which led to an increase in their fixed grant from \$10,000 to \$15,000 USD. Also, skills acquired from the training resulted in many of the staff writing successful proposals, which attracted funding from other sources for their activities. A MSH staff from Kogi staff succinctly summarized the linkages between skills acquired from the training programs and strengthening and sustainability: “When we came in here the CBOs reporting to us now were without form. I make sure that they have offices, computer, staff. We put their accounting system in place. They were invited to Abuja for training on ABC of accounting system. And at state level, I do a lot of step-down training (TAs) on what we approve, and how to apply. . . . The level of grant given to them is small; the first year it was just \$10,000. If you are unable to finish it, we will use that as benchmark

and deduct it from the second quarter. But, because many of them performed, it has increased to \$15,000.”

EVIDENCE OF TRAINING LINKAGES WITH QUALITY CARE, AND INCREASED ACCESS TO HEALTH SERVICES

The evidence on linkages between training, quality of care and increased access can be demonstrated in the health facilities and the community prevention program implemented by the CBOs.

- Evidence from staff at the health facilities suggests that: (1) numerous new patients who looked emaciated on their first few visits to the health facilities recovered and became very healthy; (2) pregnant women who participated in the PMTCT program reported having HIV- negative children; and (3) there were reported cases of discordant couples who remained together, and the negative partner did not convert. A health facility staff at Ibi, Taraba, corroborates the findings: “Like, when we did our assessment, I think the last two months or so, we did an assessment around June, so we discovered that out of 79 [pregnant] women that were positive that were on treatment here, we discovered that some of them that delivered in the hospital here, that access the services and then delivered in the hospital, 39 of them delivered here, it was only one of them that delivered a positive baby—only one, the rest were negative. So, you see, that is a good thing.”
- The project over the years expanded from providing services at the model specialist hospitals to general hospitals and PHC. This expansion was accompanied by training the staff as well. Evidence suggests that more staff at the health facility and CBOs were able to provide basic services like HCT, and drug adherence. CBO staff reported being able to do what they were not capable of doing prior to the ProACT project’s intervention, such as home-based care, including counseling and testing, which increased access to such services. A comment by an MSH staff in Taraba stresses this point further, “Clinically, most of our pioneer projects that we run, we start it from there [specialist hospital]; it is one of our model sites. From that model site, we have decentralized ART services to three places in Jalingo here. All patients that are eligible don’t need to come to the hospital to pick up their drugs; they can just go to the primary health center close to them and just pick up their drugs from there.”
- Caregivers reported that they were able to venture into economic activities and were able to feed and pay children’s school fees from business earnings. A PLWH caregiver in Jalingo, Taraba, had this to say on the transformation that has taken place in her life and that of her children, “As a result of this project, I am looking much better than I was looking before. No one can see me and say that I am an HIV-positive person [buttressing the first point above on physical recovery]. The way I look after myself is the same way I look after my children. I don’t want them to feel rejected. I look out for good things to buy for them. I have started my little small business, which helps me to take care of myself and my children much better than I was able to do before.”

CONCLUSIONS

Capacity building is a key component contributing directly or indirectly to other components of the ProACT project. Findings of this evaluation show that most stakeholders working on the ProACT project, irrespective of their cadre, received training relevant to their jobs either formally, informally, or through continuous TA. Training consistent with the main thematic areas of the project use national standard curriculums and manuals. However, evaluation findings suggest inconsistencies in training opportunities across all service sites. Training occur inconsistently for the various levels of staff (vertically) and among the same cadres of staff (horizontally). For example, statistics show that CBO staff report the lowest percentage of trained staff, followed by health facility staff. In addition, while some staff attended many trainings some reported attending a few, while others have had no training.

Evidence suggests that the training received at the state agencies, health facilities, and communities translated into improved performance on the job. However, linkages between training received and performance across the different levels of implementation differ. It seems that linkages between the training received and performance was weakest at the SACA/SMOH staff level, and strongest at the health facility and CBOs level, in that order. The reasons for the differences in performance may be due to differences in bottlenecks (i.e., bureaucratic) for translating training received into performance, which may be more at the SACA/SMOH level than at other levels. For example, evidence showed that there was no budget line item for monitoring and evaluating HIV/AIDS activities at the state level. This bottleneck makes it difficult for staff at the HIV divisions at SACA/SMOH to carry out regular joint missions with MSH to health facilities and CBOs.

Findings of this evaluation also showed that stepped-down training at all levels in the health facilities and CBOs enhanced the decentralization of basic services like HCT, drug pick-up, and adherence counseling at the community level. Also, training and continuous TAs enabled the health facilities and CBOs to run smoothly, providing quality services with little supervision from MSH staff, thereby reinforcing systems strengthening and sustainability.

VII. QUESTION 5:

CHALLENGES, LESSONS LEARNED AND INNOVATIONS

MAIN QUESTIONS

What are the major challenges, lessons learned, and innovative approaches that MSH/ProACT and its partners have implemented that could be adopted and scaled up in the PEPFAR program?

KEY ISSUES AND CHALLENGES

The section highlights key challenges to the implementation of the ProACT project, cutting across the different levels of implementation.

ISSUES AND CHALLENGES: MSH HEADQUARTERS AND STATE OFFICES

Findings of this evaluation showed that the MSH offices in the states we visited were understaffed, probably because some have left to go to other agencies, and their positions have not been filled. Most of the staff interviewed complained of being overworked, spending extra hours every day, and working on weekends as well. For example, at the time of this evaluation field visit, Taraba had 14 regular staff and 4 volunteers to cater to projects spread across five LGAs, with the possibility of expanding to three additional states before the end of this year.

Another issue raised was frequent changes in the M&E tools in data collection at the grassroots for informed decision-making. This does not encourage internalizing the tools and the M&E systems in place for maximum effectiveness. Frequent changes to the tools may open data collectors at the point of service to avoidable errors.

The staff interviewed mentioned there were no phone or Internet facilities at some work sites, and a key challenge is the difficult terrain and topography of the local government agencies (LGAs) that they work with. Four-wheel drive vehicles that are in good shape are needed to canvass the area.

Another aspect of the challenges expressed by staff was unplanned or unbudgeted urgent activity or visits from MSH HQ in Abuja, which disrupts other planned state-specific activities. This often leads to logistical conflicts which may not have straightforward resolutions.

ISSUES AND CHALLENGES: SACA/SMOH

On the government front, a major challenge coming from the evaluation is a lack of political will and inadequate funds to support HIV/AIDs prevention and care activities in the respective states. This position is expressed in lack of funds to do M&E work by staff of SACA/SMOH, inadequate manpower and funds to run health facilities on a daily bases, and general weak ownership strides made so far on the project.

Consistent with the general lack of political will are weak or nonexistent Local Agencies for Control of AIDS (LACAs) to bring about full-scale actualization of one of the ProACT project's key objectives of health systems strengthening and sustainability at the community level.

ISSUES AND CHALLENGES: HEALTH FACILITY

The staff at the health facilities (similar to MSH staff) reported that they were short-staffed in carrying out their responsibilities for the project despite the considerable assistance provided by volunteers, most of which were directly paid by MSH. Key staff are needed in all the facilities visited, including doctors, nurses, and M&E staff. The extent of need varies across the facilities. A staff member at the Specialist Hospital Lokoja, Kogi, provides insights into the type of staff needed, "There are no adequate staff; e.g., doctors. The new doctors employed have no accommodations, and so their services are irregular, because some have to travel from far places to work. Number of nurses is not enough. Sometimes only one nurse could be on duty at night (to cover three wards)."

The state government, who is the employer of health facility staff, has not been able to adequately respond to these needs, which ties into the lack of political will described above.

A key challenge in most health facilities visited is the lack of or inadequate funds to meet full operations costs needed to provide the range of services demanded. Operations costs include funds to pay for security, volunteers, cleaners, and other recurring expenses like reagents, fuel for generators, etc. A staff member at the Specialist Hospital, Lokoja, Kogi, summarizes challenges of limited funds, “Lack of reagent in the laboratory has delayed some testing, because government is not providing enough reagents; power supply has been very erratic to the extent that we have to charge patients extra 100 naira to be able to offset diesel.” Charging fees for much-needed services may reduce access to the very poor subgroups, and this is contradictory to the goals of the ProACT project.

The findings of this evaluation also suggest weak links between the ProACT project implementation at the health facilities and the TBAs, who have been adjudged closest, care providers to pregnant women in the community. A large proportion of pregnant women, who were involved in the PMTCT program, end up not delivering at the health facility for reasons due mainly to distance and the challenge of getting transport to the health facility at the time of delivery. Anecdotal evidence suggests that most women who gave birth at home were assisted by TBAs, and information about their newborn’s HIV status was not reflected in health facility statistics. The linkages between the ProACT project and TBAs need to be established to improve on PMTCT results, HIV prevention, and the health of mother and baby in general.

Also, evaluation results indicate challenges with drug adherence, despite efforts of health facility staff and PLWH members to improve adherence. A staff member at the Specialist Hospital in Lokoja, Kogi, corroborates this finding, “Defaulters are many, and this is not good for the program. We do not know what happen to those patients who defaulted. Also, some patients need to be switched to second-line drugs, which is more difficult to manage because of cost.” This behavior has implications on drug resistance and the cost of sustaining patients.

A key challenge reiterated by most health facilities staff is that the ProACT project responsibilities were additional to their normal duties. It was not quite clear how this perception came about. Perhaps ProACT project staff should request some form of encouragement, either in cash or in kind, since the work done by the health facilities staff demands extra hours of their time. It is important that the project respond swiftly to clarify this perception and propose solutions to ensure that motivation and enthusiasm to work at the health facilities are sustained for maximum effectiveness.

There are situations when lack of transportation keeps a PLWH from getting to the health facility in time for them to get ARVS before they run out. “Our patients will not come at their appointment day. When they come, they say transport was not available. Some are from typical places where vehicles cannot reach” (Staff at Donga Hospital, Taraba).

Aside from frequent changes to the M&E forms and other materials (buttressing findings from MSH field staff), some materials, like the hospital record cards, files, and registers were in short supply in some facilities. Shortage of M&E materials may hamper the smooth implementation of the project, especially with respect to the integration of services. A staff of Specialist Hospital, Jalingo, Taraba, corroborates shortage of materials by stating, “I am having challenges in the side of some of our stationeries; like, in fact, export card, we are lacking even that.... Also, pre-ART cards (on whether notifications were sent) yes, they even told me even up to Abuja, they do not have it, so we are filling this in the file and give them a number (without a card).”

ISSUES AND CHALLENGES: CBOS

The key challenges mentioned by CBO’s management interviewed are: the inability to retain staff that have been trained by the project, lack of funds to continue their prevention activities and scale-up to meet ever increasing demand in their respective communities.

ISSUES AND CHALLENGES: BENEFICIARIES

Although indicators of stigma and discrimination against PLWH have been attenuated to a large extent at the health facilities visited, it is still quite evident in the communities, as evidenced even among close relatives and community members. The following testimony from a caregiver in Jalingo, Taraba, suffices: “My brothers and my sisters have deserted me, and they don’t want to do anything with me. They don’t come to my home, and they don’t relate with me. This is very painful. But for my children, they are not experiencing any discrimination.” This information shows that, although stigma and discrimination is decreasing, it is quite evident and should be tackled aggressively.

Results of FGDs conducted among OVC suggests that some OVC households in the communities visited lacked basic amenities to cater to the children. OVC lacked funds to enable them stay in school, clothe themselves adequately, and even food to eat was difficult to find for some. The following captures the situation of OVC at the time of the evaluation: OVC1: “I would have loved to go to school, but there is nobody to help. There is no money to pay our school fees.” OVC2: “Sometimes food is difficult to come by, and we stay hungry from morning to evening.” OVC3: “Sometimes even clothes to put on is difficult to come by, but we manage anything we have, and even the ones we have, it is difficult to get detergents to wash them” (OVC in an FGDs in Jalingo, Taraba).

KEY LESSONS LEARNED

Key lessons learned in the course of implementing the ProACT project are expressed below.

- More retention of LGA seconded staff at the health facilities over a long period of time than state employees and other staff. This is an interesting trend that may be explored to the benefit of the project, and for maximum results at the community level.

- The project’s focus on training and capacity building of all cadre of staff may have contributed to attrition of well-trained staff, that became more competitive as their skills developed.
- Some health facility staff were impressed by how the project was able to sustain quality services for a considerable period of time without much cost to beneficiaries.
- Integration of services has, in general, contributed to increased intakes for HIV/AIDS services in all the health facilities visited.
- Consistent collaborative review of data from the field by program staff helped to provide insights into difficult issues on data quality and programming.
- Minor incentives, like providing ID cards to PEs and volunteers, may translate into easy access to community stakeholders.

UNEXPECTED OUTCOMES AND INNOVATIVE APPROACHES

The ProACT project recorded some unexpected outcomes and innovative approaches that may have boosted its overall effectiveness and performance.

Unexpected Outcomes

- CBOs emanating from communities of intervention are welcoming developments that factor into systems strengthening and sustainability of the project in the long run. Findings show that many PLWH and PEs now have registered functioning CBOs that provide much needed services to their local communities. An MSH staff in Taraba supports this assertion: “Peer educators and support groups that we have worked with and built their capacity are now coming together to form CBOs. The four support groups that we work with are now duly registered with the relevant agencies and can access funds from donors.”
- The level or depth at which integration would need to be implemented to reduce stigma and discrimination was not expected. However, findings of this evaluation showed that full integration of HIV services with other healthcare services starting from health information systems to point of service delivery dramatically decreased the stigma and discrimination experienced by PLWH.

INNOVATIVE APPROACHES

- A key innovative approach employed in the implementation of the ProACT project is the complete leveraging of existing communities’ opportunities of scale—i.e., community structures, which have low human, financial, and other costs to the project. Examples of community structures are health facilities, traditional rulers, chieftains, caregivers, and schools, and other “significant others” in the localities. By capitalizing on existing

community structures, and buy-ins from a variety of local stakeholders, the project has been able to make in-roads toward community participation ownership and sustainability.

- Redistribution challenges were experienced at the beginning of the project, and the LAMIS software was designed to forecast the need for drugs and materials, especially with respect to issues of inventory management. According to an MSH staff in Taraba, “We have an MIS system which our partners use to forecast what they will need in the next 2 to 4 months. The system was introduced by the project, as it was not in existence before. We provide training on management of healthcare logistics in order to provide them with the skills to carry out this forecast” (Staff, MSH office, Taraba). The success of this software at the model health facilities may assist its scaling-up to cover all facilities across all implementing states in the country.
- Mobile outreach clinic is a new innovation that was introduced to make community outreach more effective and provide on-the-spot solutions to immediate problems. Reports from this evaluation suggest that this innovative approach has had positive effects on the intervention communities with respect to increased knowledge and attitudes about HIV/AIDS; increased HCT; HIV/AIDS drug supply and adherence counseling; detection and treatment of opportunistic infections; and immediate response to other community needs.
- Based on a series of trial and errors, laboratory staff in the health facilities visited reported gains in skills and experience on how to maintain the project’s equipment, including the CD4 and other machines. A better understanding and management of project laboratory equipment implies better adaptation of the equipment, more accurate diagnosis and results, more tests per patient conducted at reasonable shorter time frame, and more confidence, reliability, and quality of tests results.
- Political will may be gaining traction in some states with the establishment of three comprehensive health facilities in Kogi, and one in Taraba. This implies that government stakeholders are receptive to the ProACT project model. The next steps will be for strong advocacies to scale-up this initiative in other health facilities in the states where this has taken off and, perhaps, introduced in other implementing states as well.

CONCLUSIONS

Key challenges at every level of implementation include shortage of staff; lack of political will and financial backing at both the national and state levels of government and frequent changes to M&E tools and materials. MSH field offices and health facilities suffered more from staff shortages than the government agencies or CBOs. Although lack of government political will and financial support permeated the entire project implementation, it was more evident at the SACA/SMOH where coordination and monitoring responsibilities have been seriously challenged, and at the LACA level that is currently not functioning in the states visited. Complaints over frequent changes to the M&E tools echoed from the MSH field offices, health facilities, as well as the CBOs.

Challenges specific to MSH include difficult terrain or topography, which made implementation in certain areas of the states challenging with respect to transportation and communication. Also, specific to MSH is unplanned activities from HQ in Abuja, which sometimes led to logistical nightmares that had to be resolved alongside other planned activities.

Challenges observed at health facilities include

- Weaknesses in the systems meant to ensure drug adherence among PLWH
- Unmet need for daily operating costs, partly defrayed by a small patient fee (between 100 to 500 naira)
- Perception among health facility staff that the project's responsibilities are additional to their primary functions
- Poor or non-existent links to TBAs in their respective communities.

The project will have to address these issues in order to strengthen and improve services to pregnant women in their communities.

A key challenge specific to project beneficiaries is the stigma and discrimination at the household level in the intervention communities despite efforts to reduce it by CBOs, PLWH support groups, and health facility staff. Specific challenges common to OVC families interviewed were mentioned by the OVC themselves included: school fees; clothing; and food, which are basic needs that should be examined and met by the project or referred to sister projects that deal directly with this challenge.

Key unexpected outcomes or innovative approaches demonstrated in the course of project implementation and are directly or indirectly contributing positively to the project implementation process are: community participation; holistic integration of services; introduction of LAMIS for better forecasting; mobile outreach clinic; better understanding and maintenance of laboratory machines; and establishment of comprehensive health facilities by the state governments, which factors into systems strengthening and sustainability. Finally, community mapping and referrals increased through the process of integration.

RECOMMENDATIONS AND FUTURE DIRECTIONS

RECOMMENDATIONS ON INTEGRATION

The model used by ProACT MSH for developing the capacity of state, local and health facility teams to lead and manage integrated health services, including HIV/AIDS, demonstrates good program design, step-down training, and mentoring capacities. Because of the diversity of project states, some sites have made the transition more quickly, and successful systems are already in place. Other areas move at a slower pace where capacity may be lower, and need more time beyond the remaining lifespan of the project. It is too early to say how much more time is needed, and the evaluation itself was not detailed enough to indicate where those areas might be. If a decision is made to continue similar project activities after the lifespan of this project, attention to areas with higher prevalence should be a higher priority.

More attention needs to be paid to TB and HIV comorbidity integration efforts. The weaknesses of the local, state, and national TB programs were cited as an obstacle to addressing HIV and TB comorbidity. Lessons learned in South Africa, Swaziland, and Zimbabwe clearly point to early intervention as the only way to prevent serious epidemics of multiple drug-resistant MDR-TB. This is a critical moment in time for Nigeria to avoid a crisis that can drain resources and derail both their TB and HIV programs. All stakeholders from IPs, multilateral agencies, donors, and the GON should advocate for marked improvement in TB services throughout all health facilities.

MSH, through the ProACT project, has introduced a strong QA curriculum and standards of practice, and high priority should be given to deepening the practice and making a commitment to supporting QA through continued mentoring by an implementing partner beyond the lifespan of this project.

Early attention to data quality and laboratory integration has characterized the ProACT project's approach and should be viewed as best practice and incorporated into future integration strategies as they go to scale.

Consider keeping mentoring staff in place after the project's end to help with data review and quality care control.

Consider developing teams drawn from present staff that can put this model to use in other parts of Nigeria and replicate the integration actions.

The Ministry of Health and NACA plan to deepen the integration model to include malaria and reproductive health programming, child survival, and community management of communicable disease. This process will not be easy or swift, but USG support for these efforts should be

considered as part of the continuation of the integration process begun under LMS and ProACT projects.

A culture of ongoing QA and standards of practice review needs to be deepened and further imbedded into all facilities. It is recommended that coordinated mentoring among IPs continue after the lifespan of this project.

INTEGRATION AND VOLUNTEER ATTRITION

For many reasons, volunteer attrition needs to be addressed as soon as possible. Many of the successes of integration, such as getting people tested, recruiting PLWH into TB programs, getting PLWH into support groups, adherence support to pregnant women, and care of vulnerable children rely heavily on community volunteers. Incentives of all kinds can go a long way to keeping people involved, feeling recognized, and more committed to their roles. Identification materials such as T-shirts or name tags, certificates of training, transport allowances, and supplies they can give to those they are serving have been identified as powerful incentives for volunteers and are often components of programs that get forgotten or deemed too expensive or time consuming. There is a growing recognition that incentives other than salary can stabilize programs by retaining trained volunteers, and can become the backbone of a more sustainable system more easily funded than many larger project expenses.

DEVELOP BETTER LINKAGES WITH CBOS AND IPS DOING FOOD SECURITY AND LIVELIHOOD SECURITY WORK.

Work by Jill Donahue and John Williamson has demonstrated again and again that livelihood security such as IGAs are best done by groups linked up with health CBOS. Health CBOS have a bad track record of doing both activities well, and the introduction of poorly managed IGA to a successful health project has been the undoing of many community-based programs, especially in Africa. Supporting income generation is important, but HIV/AIDS project implementers do not have the best background for this. Mobilizing communities to respond to the impacts of HIV/AIDS is also crucial, but this is not the aim of microfinance. Attempting to design and manage a community mobilization initiative and deliver microfinance services according to state-of-the-art principles is probably beyond the capacities of most organizations.¹³ One very clear side effect in many parts of sub Saharan Africa is the marginalization of women when money or business opportunities are introduced, and along with that marginalization the health indicators for the family decline rapidly.

13 From USAIDS report, authored by Jill Donahue and Linda Sussman, "Building a Multi-Sectoral Response: Follow-Up Assessment of Programming for Children and Families Affected by HIV/AIDS in Kenya." November 2–19, 1999.

GREATER INVOLVEMENT OF PLWH IN KEY SENIOR POSITIONS ESPECIALLY AMONG MARPS

Once a high-risk target population has been identified look at ways for meaningful involvement of PLWH who are part of that community. Having a high profile PLWA staff member can build trust and decrease stigma, and ultimately improve uptake of services among these populations.

Look at transportation systems surrounding treatment sites, and explore new ways to integrate whatever medical service/social service transport systems already exist so that all patients can access available services. Links with malaria programs, supervision visits to programs such as community management of communicable disease, and family planning, etc., could be made with more planning and less jockeying for control of perceived “dedicated resources.”

RECOMMENDATIONS ON PROGRAM QUALITY AND MANAGEMENT

MOST-AT-RISK POPULATIONS (MARPS)

The difficulty ProACT MSH has with their MARPs programming is unlikely to be related to organizational weakness, but rather to the history of prevention interventions under prior PEPFAR constraints and the difficulties of working with new communities where target populations are engaged in behaviors that are considered criminal. MSH consulted widely with the Mission, PEPFAR, and GON on their MARPs project design and followed their lead. The work has not been successful for many of the same reasons that early prevention efforts did not succeed in other parts of the world. Lessons learned in other parts of Africa and around the world suggest that gaining the trust of marginalized, often criminalized populations, takes time and a practical focus on risk reduction, rather than elimination. The most successful work with MARPs has employed peer models and close long-term working relationships with trusted CBOS, as well as advocacy with the judicial systems. Given the time span of this intervention, the likelihood of the ProACT project being able to do more than early groundwork for future, more successful interventions is extremely unlikely. The introduction of a standard Minimum Prevention Package in Nigeria is a positive step but it is too early to see results in implementation.

The problem with the MARPs work in Nigeria is multifaceted. Some of the difficulties are with the design of the PEPFAR prevention program at inception.

State governments in a highly decentralized federal government have varying degrees of knowledge of where high-risk populations live and work. There are pressing political issues pulling at state and national agendas that easily overshadow a slow growing epidemic, despite the implications of inaction at this critical moment in the epidemic.

For the next phase of the MARPs program, the following suggestions might be considered where feasible:

Programmatic

- Better identification of the MARPs and concerted efforts to work with peer groups with access to high-risk populations.
- Limit the scope of the population receiving interventions, and increase services to those at greatest risk and in areas where risky behavior occurs such as near truck stops, bars, and formal and informal brothels.
- Work to create a MARPs friendly integrated health facility to serve clients where high-risk activities occur.
- Use variations on lessons learned in integration to decrease stigma and increase points of access for testing and STI treatment.
- Both within and outside of health facilities, reach out to groups with information and education that is more relevant to their lives. Provide very accessible, stigma-free HIV and STI treatment, condoms, lubricant, and ready access to testing.
- Do not confuse youth-focused interventions with MARPs. Some youth may very well be a part of high-risk groups, but most are not. The prevention programming needs for youth both in and out of school are different.
- Continue youth-focused prevention activities. Many of the interventions in CUBs are excellent and could be adapted. Lessons learned elsewhere stress the importance of careful adult supervision of youth peer group work.

Advocacy

- Work with NACA and other national bodies to develop advocacy strategies on behalf of high-risk populations at state levels.
- Educate police and judicial system workers to improve relations with MARPs and to better understand what drives high-risk behaviors.
- Improve identification of the risk groups and their behavior, what populations they are interacting with, followed by concerted work with peer-based support networks to develop institutional and fundraising capacity, and help make links with any other similar interest groups.

RECOMMENDATIONS FOR MOTHER-TO-CHILD TRANSMISSION PREVENTION

The problems MSH faces with PMTCT are experienced throughout most of Nigeria, as are prevention work among MARPs. The following recommendations are general and do not necessarily target the ProACT project's programming.

- MSH has only recently completed an operations research project on the subject, and it will be interesting to see what the findings are, and they should disseminate them widely.
- Follow-up on a planned study to examine issues that keep women from returning after a single ANC visit would be useful and highly recommended.
- Readdress issues of the attrition of volunteers who identified pregnant women in the community, and encouraged the women to seek and receive appropriate care.
- Provide more and better community messages about the effectiveness of prevention of transmission of HIV to the child. Target messages to known community leaders.
- Work with traditional birth attendants to explore all options to enlist them as allies in identifying women at risk for HIV and encouraging testing and interaction with care facilities.
- Focus limited resources on areas that have higher HIV prevalence among pregnant women.
- Provide follow-up home visits to all women who come for ANC.
- Explore ways for men to participate in ANC care by having clinics after hours or on weekends or off-facility site.
- Assess or readdress prior assessment of the gender responsiveness of the ProACT project's clinical care program.

AWARENESS OF THE IMPACT OF GENDER ON PROGRAM SUCCESS

This evaluation was limited in time and scope, and it is hard to fully assess this aspect of the project's work but, like many large-scale HIV interventions, gender appears to be more of an issue in project design than it is in reality. More attention needs to be paid to gender review and results of all health programming.

Although in original plans, there is not enough evidence that programming with measurable gender indicators was integrated into mainstream activities. For example, it is well established that in Africa programs that target livelihood security of women are more successful at meeting the needs of the household, and keeping girls in schools longer will markedly decrease the risk of contracting HIV at

an early age. A strategy that focuses on women's savings and loans for households with vulnerable children would be a good example of gender-responsive programming.¹⁴

The difficulty of getting women to come to the facilities for antenatal services generated a plan to do a review of facility services to see where gender insensitivities may play a part. The evaluation team was unable to find any documentation that this occurred, and if it did not, it should be followed up on.

I saw no evidence of links made with organizations that might have strengthened gender-based programming. If these links are not being made, they should be. The MSH/CUBs project looked like a fertile source for ideas and cross-programming in the area of gender and HIV.

SUPPORTING THE PROJECT WITH DATA FROM OPERATIONS RESEARCH

An Operation Research Advisor was hired and the Advisor's first project was a PMTCT study to look at effectiveness of interventions. Data is being analyzed, and report-writing is in its final stages. MSH plans to disseminate the report to the project staff during the next project review meeting that will take place in November. Currently, there are two more studies planned to start this month. The evaluation team recommends continuing this practice and sharing the findings outside the project and with other key stakeholders.

RECOMMENDATIONS FOR MANAGEMENT OF STAFF ATTRITION

An immediate mediation session is recommended, drawing on Abuja and state staff and, if reasonable and necessary, appropriate staff from headquarters. USAID participation in some parts of the mediation process would be appropriate as well. Issues that need to be addressed:

- A re-examination of how key management decisions affecting the working conditions of all senior staff would be helpful.
- MSH management also needs to address field offices staff shortage by examining options that will improve staff retention, including offering a more competitive remuneration package to current staff, and employing new staff to occupy vacant or new positions created

¹⁴ A common finding is that cash transfers to women enhance the anthropometric status of young children living in the household. Duflo (2003) finds that pension payments to elderly South African women increase the weight-for-height and height-for-age of young girls in the household by 1.19 and 1.16 standard deviations, respectively. Similarly, Aguëro et al. (2007) find that South Africa's Child Support Grant, a cash transfer given to mothers, significantly boosts the height of young children with an estimated rate of financial return between 160% and 230%. "Effects of Cash Transfers on Low Income Households in Developing Countries: A Review of the Evidence." GiveDirect, Inc. Danvers, MA, Nairobi, Kenya, August 22, 2010.

to meet increasing demands of project expansion in some states. This two prong approach may help reduce workload per staff, boost morale and improve performance.

RECOMMENDATIONS RELATED TO SUSTAINABILITY

The project needs to reflect greater involvement of PLWH in leadership positions. There were many signs of volunteerism among PLWH, but no information about actually recruiting and promoting PLWH for mainstream program positions.

Attrition of staff at all levels, but especially at volunteer and community levels, severely impacts sustainability. It is strongly suggested a radical policy review be conducted of the approach to incentives for community health work volunteers.

WHAT SUPPORT WILL BE NEEDED TO TRANSITION TO SUSTAINABILITY?

The following suggestions came from key informant interviews and a review of project related documents, including background reading about developments in Nigerian health systems development in general. Some have been discussed elsewhere:

- Data is key to all aspects of re-integration of healthcare systems with vertical HIV programs. Quarterly mentoring on data quality should be continued by a designated implementing partner.
- Exploring the possibility of adding permanent low-level data clerks to work at sites on a permanent basis might be a reasonable option, although it is a less sustainable strategy to pursue to ensure data quality.
- The TB care program is weak, and HIV/TB comorbidity cannot be addressed without addressing the weaknesses in the state- and national-level TB programs.
- Integrated TB and HIV programming needs ongoing QA and provisions made to continue to do remedial training.
- Continued training and follow up training of clinicians at local government health facilities and primary sites will be essential to retaining a cadre of healthcare workers able to practice integrated care, and train new health personnel.

TO WHAT EXTENT HAS THE CAPACITY-BUILDING EFFORTS OF THE PROACT PROJECT, THROUGH THE USE OF THE MODIFIED MSH LEADERSHIP DEVELOPMENT PROGRAM (LDP) AND OTHER MSH TOOLS, CONTRIBUTED TO THE SMOHS, SACAS, LACAS AND HEALTH FACILITY TEAMS' OVERALL CAPACITY TO LEAD, MANAGE, AND SUSTAIN HIV/AIDS PREVENTION, CARE, AND TREATMENT SERVICES?

This is a difficult question to answer as leadership and capacity building experience gained in workshops or mentoring is difficult to measure. According to NACA staff, no effective tools have been developed or put into use to measure these results. Therefore, in the absence of more data the following recommendations are made:

- The issue of a useful means for measuring management capacity training, such as post training on the job, assessment tools, and opportunities for refresher training needs to be addressed.
- Opportunities need to be provided for SACA members to practice the new management and leadership skills they are learning—i.e., costing state plans and strategic planning.
- Key donor and IPs could join a NACA-led forum of SACA officials to identify ways to fund/support these officials carry out the tasks for which they are being trained. An example might be supporting strategic planning and budgeting exercises.
- Efforts should be made to include SACA staff in all relevant training, followed by strategic inclusion of interested staff in ToT schemes for greater buy-in.

RECOMMENDATIONS RELATED TO CAPACITY-BUILDING

Results of this evaluation showed that stakeholders at the different levels of implementation received training, and the training enhanced their performance on the job, but there were constraints with respect to accessing training along vertical and horizontal paths of the project's implementation. Considering the vertical path across the different levels of implementation, CBOs and health facilities staff reported the lowest proportion of staff trained by the project. On the horizontal path, health facilities, M&E, and pharmacy staff reported less training than other staff.

Constraints to accessing training on both the vertical and horizontal paths of implementation may be rooted in the overall managerial strategies employed. It may be necessary to conduct a capacity needs assessment, or do an update if one had been done in the past, and factor the results into the design of a comprehensive training schedule for all staff of the project. The training schedule should be managed by MSH staff, and it should match employees at the different levels by the types of training available. It should include updates to ensure that all staff is continuously improving in knowledge and skills. Also, the training schedule should be dynamic and continuously updated to include new staff.

Linkages between training and job performance differ across levels of project implementation, but the linkage is weakest at the SACA/SMOH level. Translation of training to performance was less obvious at the SACA/SMOH than at health facilities and CBOs, due to possible bureaucratic nuances in the system. In order to ensure that training at the SACA/SMOH level are translated to performance, it will be necessary for MSH key officers and SACA/SMOH representatives to jointly identify key bottlenecks hampering performance, and forge a way forward. Solutions to this constraint may involve forming a strong advocacy committee, whose primary responsibility will be to secure adequate funds for HIV/AIDS planning, coordination, and monitoring in the intervention states. The advocacy committee will need to identify and solicit funds from a wide spectrum of possible funders, including national or state government agencies, international or local funding organizations, and private philanthropists.

Step-down training is a strong component of the capacity-building strategies, and should be encouraged and strengthened further. Key successes of step-down training at all points of implementation enabled “task-shifting” and decentralization of services, and increased access to services by the target population with respect to basic services like HIV/AIDS knowledge, HCT, drug re-supply, and drug adherence counseling. More step-down training should be encouraged at the health facilities and CBOs levels to make up for and augment steps been taken to eliminate training shortfalls, since health facilities and CBOs are the two main frontlines of the project implementation at the community level.

A review of the training strategies in the project’s implementation may need to skew all training in the main thematic areas (formal or informal) towards the health facilities and CBOs staff in order to increase the impact in terms of systems strengthening and sustainability of the project in the long run.

It may be necessary to conduct a capacity needs assessment or do an update, if one had been done in the past, and factor the results into the design of a comprehensive training schedule for all staff of the project. The training schedule should be managed by MSH staff, and it should match employees at the different levels by the types of training available. The schedule should include updates to ensure that all staff are continuously improving their knowledge and skills. Also, the training schedule should be dynamic and continuously updated to include new staff.

RECOMMENDATIONS RELATED TO CHALLENGES

The challenges identified in this evaluation may be broadly divided into the general and the specific. Challenges classified as general are echoed more than once across the different implementation levels. Key general challenges are shortage of skilled staff at MSH field offices and health facilities; the lack of political will and financial backing from the government at the SACA/SMOH, health facility and CBOs; and frequent changes to the M&E tools and materials was reported at all levels. Specific challenges include difficult terrain/topography, and unplanned activities at the MSH level; daily operating costs, weak links between the project and TBAs at the health facilities; and stigma and discrimination at the beneficiary level.

GENERAL CHALLENGES

MSH management may need to address field offices staff shortage by examining options that will improve staff retention, including offering a more competitive remuneration package to current staff, and employing new staff to occupy vacant or new positions created to meet increasing demands of project expansion in some states. This two prong approach may help reduce workload per staff, and boost their morale to improve performance.

Advocacy steps taken by MSH (before this evaluation) had already forestalled, to a large extent, transfers of skilled staff from the intervention health facilities to non-intervention facilities. This advocacy should be continued to ensure that the intervention states' government staff who received training through the project are retained at their respective health facilities. The other alternative is to switch staff within project health facilities to increase knowledge and gain more professional experience. Also, it is important to explore the possibility of increasing the number of trained LGA staff, since findings suggest that they were more likely to stay on the job for the long haul than staff from other LGAs or state who may contemplate moving to their LGA or state of origin.

The advocacy committee mentioned above may also need to address the weak or lack of political will expressed in this evaluation. The committee should have representatives from all of the levels of implementation and be coordinated by MSH. The key mission of the advocacy committee will be to increase and sustain on continuous bases the interest of the state executive, the legislature, and the judiciary arms of government in HIV/AIDS issues in their respective states. This may be achieved by providing updates, and highlighting challenges about HIV/AIDS in the state communities, and requesting financial and other forms of support.

The challenge posed by frequent changes to the M&E tools and materials already has the attention of USAID/Nigeria and key staff at the MSH HQ. It may be necessary to provide IPs at the state level with information on the reasons for frequent changes to the M&E tools and materials and their usefulness to the project implementation process. The other alternative is to reduce modifications to the tools to a minimum, and send all changes at the same time perhaps, once a year. There should be a way to balance frequency of changes and getting improved tools to the field in good time without dampening the morale and motivation of the staff involved in the actual collection of data and collation of the statistics.

The general challenges highlighted above should be addressed promptly since they may have more impact on project performance because of the frequency of their occurrence along the implementation process.

SPECIFIC CHALLENGES

Challenges specific to MSH such as difficult terrain/topography, and unplanned activities from the HQ may be eliminated or attenuated by more communication between the MSH HQ and the field offices to fashion a way out.

Another challenge that may be eliminated by the advocacy committee is operating cost at the health facilities. The committee in each implementing state may be able to dialogue with their respective health commissioner to channel more funds and attention to the intervention health facilities.

With respect to drug adherence, health facility staff and PLWH support group executive may need to intensify interpersonal adherence counseling among PLWH focusing on individual challenges and how to address them, and continuous follow-up to ensure attitudinal change.

A key challenge cutting across all health facilities visited is the perception by the staff that the ProACT project's responsibilities were additional to their primary functions. This perception may have been reinforced by late hours spent by the ProACT field staff, as compared to their counterparts with other duties in the same department. It may be necessary for MSH field staff to meet with each health facility implementation team and provide information to change this perception. Also, MSH may need to fashion out other forms of motivation (aside from formal training) to encourage and motivate health facility staff for their contributions to the implementation process.

Weak linkages between health facilities and TBAs, and stigma and discrimination, are two key challenges that were not adequately addressed by the ProACT project's design at the community level. Findings of this evaluation showed that the health facilities did not incorporate TBAs into their PMTCT activities, whereas anecdotal evidence suggest that in Nigeria the majority of deliveries are conducted by them. This is a major project gap that needs to be addressed in order to increase PMTCT in-take and, more important, the proportion of newly born HIV-negative babies in the intervention communities. The ProACT project may need to borrow a leaf from sister USAID IPs that have successfully incorporated TBAs in their programming in the past. A key step to incorporating TBAs may be to invite them for HIV and reproductive health talks, the "hand-glove rule," and draw up a plan to monitor their activities without being invasive.

Also, findings showed that stigma and discrimination against PLWH is still evident in the intervention communities. While considerable successes have been recorded on stigma and discrimination in the health facilities, findings suggest that stigma and discrimination is still pervasive, and activities focused on this problem have not gained much traction in the intervention communities. For better performance, ProACT CBOs working on prevention may be asked to focus their activities in the same communities where health facilities are located. Also, for synergy and maximum impact, MSH may constitute a working committee at the community level, including health facilities staff, CBOs staff, PLWH support group executive and community leaders, to come-up with strategies to continuously engage and desensitize the intervention communities on HIV/AIDS stigma and discrimination.

OVC households interviewed reported not having the wherewithal for school fees, clothing, and food. These concerns need to be addressed by the ProACT project directly or indirectly by referring OVC with such needs to sister USAID IPs who may be able to address each of these needs.

RECOMMENDATIONS RELATED TO UNEXPECTED OUTCOMES AND INNOVATIVE APPROACHES

A better understanding and maintenance of laboratory machines for effectiveness and efficiency, and government establishment of state comprehensive health facilities were key unexpected outcomes of the project. Some of the key innovative approaches reported in this evaluation are: leveraging on existing community structures and opportunities; holistic integration of health facility processes and services; the use of LAMIS for better forecasting of demand and supply of commodities; and mobile outreach clinics. These unexpected outcomes and innovative approaches should be developed further, perfected, and perhaps, scaled-up during the remaining phase of the project implementation.

Most importantly, it will be well deserved if the government owned comprehensive health facilities (through advocacy) can be scaled-up in the next phase of ProACT project implementation to further broaden its systems strengthening and sustainability objectives.

A SUCCESS STORY

CHAIRMAN OF OKADA RIVERS AND PLWH SUPPORT GROUP COORDINATOR

LOCATION: GASHAKA, TARABA

Situation Before: Considered a dead man by relatives and friends because he was co-infected by HIV and TB. A neighbor once told him that they will soon conduct his burial ceremony. The man had lost all hope because his situation was very bad. That was before the ProACT project's intervention came to their community.

Steps Taken: Stopped his business and functions as chairman of Okada Riders and focused on his treatment.

Transformation: Gained back his health and married.

Community Responsibilities: An adherence counselor volunteer, support group coordinator, role model to other PLWH. Loves tracking for lost to follow up; he moves around to sensitize his community; very useful as gatekeeper to any USAID IPs or CBOs working in his community on PLWH.

A Spectacular Testimony of Courage: During one hospital's strike action in the state, he singularly mobilized executives of PLWH support group to go and get authorization from the police division that was guarding the hospital in his community. He then reached out to the service providers and mobilized PLWH to go pick up their drugs while the hospital was still on strike action. Throughout the period that the hospital was on strike, he used his motorbike to visit the communities where PLWH are located to transport them to pick up their drugs, and he called those that were able to transport themselves to ensure that they could access their drugs uninterrupted.

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United Nations General Assembly Special Session special report (UNGASS) on Nigeria
USAID/NIGERIA. (March 27, 2011). "Best Action Plan: Improving the Health Status of Women
and Children through the Scale-Up of Best Practices in the Home, Community and
Facility."

ANNEXES

PROJECT DOCUMENTS REVIEWED

The ProACT Project
Revised technical application final
Management Science for Health
Nigeria's AIDs Treatment and Care Follow-on
July 7, 2009

The ProACT Project Quarterly Reports
Management Science for Health:

MSH ProACT quarterly report for Jan–March 2012
MSH ProACT quarterly report for April–June 2012
MSH ProACT quarterly report for April–June 11 (final)
MSH ProACT quarterly report for Jan–Mar 2011
MSH ProACT quarterly report for July–Sept 11 (final)

MSH ProACT Workplan 2010-2011 2011–12
MSH ProACT PMP 12_7_12
MSH pro-act PMP 09-29-2009

Overview of MEMS DQA Process.docx
MSH ProACT DQA Report Formatted 15062011
Copy of MEMS DQA – Team comments copy

All available CQI Quarterly reports from states including:

Report Of Quality Systems Assessment Ta Visit To Kogi State Held From September 14–24, 2008

TB HIV facility Performance Q2 2011

TRIP REPORT MSH Sites Kogi Kwara Dec 2011

MSH ProACT Grantee Assessment Kogi and Taraba June 11

Report on the status of the Nigerian National HIV Monitoring and Evaluation System
Assessment Using 12 Component Systems Strengthening Tool
Capacity Tool 2010 Measure Evaluation

CUBs Report Developing a Program Framework Approach to Activities to address the vulnerability of girls young women and female headed households within the context of OVC and risk reduction july 2010 USAID MSH AFRICARE.

BIOGRAPHIES OF THE EVALUATION TEAM

Deborah Bickel served as the team leader for this evaluation. She is a public health practitioner whose technical skills and areas range from clinical primary care practice, health systems research, HIV/AIDS prevention mitigation and treatment including HBC and OVC programming, gender analysis and direct clinical services, research in all the above areas, creation of health information and educational materials, training of trainers at many levels, clinical faculty training to complex program development and management. She has lived and worked for more than 17 years in developing countries and the last 10 of the last 14 years in sub Saharan Africa. Previous to completing her MPH at University at California, she studied at Stanford University Primary Care Associate program, practiced as a primary care associate and taught for seven years on the faculty of the Stanford University in the Department of Family Medicine. She is currently based between the US and Mozambique.

PEPFAR Advisor: Dr. Richard Ugbenwa is serving as the PEPFAR Advisor. Dr Richard has over 15 years of medical experiences which includes working with Federal Ministry of Health, National Agency for the Control of AIDS, NGOs and PEPFAR implementing partners to provide technical support for the national HIV/AIDS programs in the area of HIV/AIDS research, surveillance, program monitoring and evaluation. His role as a focal person for surveillance and HIV/AIDS research has accorded him the knowledge of both qualitative and quantitative research methodology. As a member of USG strategic information team, he has been involved in country operational plan, monitoring achievement by USG implementing partners and compiling their achievement for program evaluation and reporting.

Muyiwa Oladosun acted as the local consultant for the evaluation. He is an international expert in research, monitoring, and evaluation of development projects around the world. He has over 25 years experience, conducting evidence based monitoring and evaluation of development projects in several countries of Africa, Asia, Europe, North America, and South America. His unique expertise include; conceptualization and modeling, and the combination of both qualitative and quantitative methodologies in providing solutions to issues of human condition. He has strong expertise in baseline, mid-term, and end of project evaluation, participatory research and rapid appraisal, expenditure tracking survey, service provider survey, consumer/client satisfaction survey, key informant interviews, case studies, focus group discussion, participant observation, and panel reviews among others. He holds a PhD in Demography/Rural Sociology from Pennsylvania State University, Pennsylvania, USA, and MA in Social Research Methods from Mahidol University, Thailand.

Anne Udoh (Programme Officer, Organisation Development): Technical Associate. B.Sc. (Physics), M.Sc.(International Relations and Strategic Studies) from Jos, Diploma (Community Development) from the Coady International Institute Nova Scotia, Canada. Ms Udoh has over 10 years of development work experience from program units in UNICEF and UNDP providing

support in the areas of Health, Nutrition, Education, Water and Sanitation, Civil Society and Gender. She has also worked as the Training and Research Officer at the Leadership Institute in Jos, Plateau State.

Oladosu Femi participated in the evaluation as a data collector. He is a Technical Officer at MiraMonitor Consulting, Abuja, Nigeria. He has skill and experience in quantitative and qualitative research methodology including development of tools, survey, focus group discussion (FGD), key informant interviews (KII), among others. He has special interest in the disadvantaged and high-risk populations. He is computer literate with proficiency in Microsoft Word, Excel and PowerPoint. He holds a B.Sc. degree in Sociology from Lagos State University, Lagos, Nigeria.

APPENDICES FOR METHODOLOGY

Table Showing Completed Focus Group Discussion (FGD), Group Interview (GI) & Key Informant Interviews (KII)*

Stakeholders	Kogi State			Taraba State			Abuja FCT		
	FGD	KII	GI	FGD	KII	GI	FGD	KII	GI
PLWH	3	-	-	3	-	-	-	-	-
PLWH Support Group	3	-	-	2	1	-	-	-	-
Community Leader	-	2	-	-	1	-	-	-	-
Health care facility Staff	-	7	1	-	8	2	-	-	-
CBO Staff	-	-	2	-	-	3	-	-	-
CBO Peer Educator	-	5	-	2	-	-	-	-	-
OVC Caregiver	1	-	-	1	-	-	-	-	-
OVC	1	-	-	1	-	-	-	-	-
MSH Field Staff	-	-	1	-	-	1	-	-	-
SACA & SMOH	-	3	-	-	1	1	-	-	-
MSH HQ	-	-	-	-	-	-	-	5	1
Axios								1	
NACA	-	-	-	-	-	-	-	-	1
USAID	-	-	-	-	-	-	-	2	-
Total	8	17	4	9	11	7	0	8	2
Summary	FGD = 17, KII = 36, and GI = 13								

*FGD = focus group interview, KII = key informant interview, and GI = group interview

SURVEY QUESTIONS FOR INTERVIEWS WITH KI AND FG

LMS-ProACT Mid-Term Evaluation

OVC Caregiver/Guardian Consent Form

[Moderator/Interviewer: Read/explain the following to the caregiver]

We are using this opportunity to request for the participation of (name of OVC) in a focus group discussion on the provision of services that you/your child have received from this facility (name of health facility/CBO). The objective of this evaluation is to provide more information that will be useful for improving the services provided to you and your family in the future. All information obtained in this exercise will be kept strictly confidential and anonymous. The results of this study will be presented collectively and no individual participants will be identified without their permissions.

Caregiver Consent and Agreement:

[Moderator/Interviewer—Read/explain the following to the caregiver/guardian].

I have been informed of, and understand the purpose and procedures of this evaluation and the purpose and procedures of the data to be collected from the OVC. I understand that I am free to withdraw my consent and discontinue the participation of my child from this exercise at anytime.

By signing this consent form, you are indicating that you fully understand the above information and agree that your child can participate in this study.

Caregiver/Guradian's signature (thumb impression) _____

Date: _____

Researcher's signature: _____

Date: _____

LMS—ProACT Project Evaluation

FGD for Caregivers

1. How were you or your household selected to participate in this project?
2. What benefits have you received since you got involved with the ProACT projects (Probe: for specific home based care received-- health, education, psychosocial support, rights & protection, nutrition, economic, benefits etc)?
3. What were your conditions and that of your household before joining this project?
4. Could you explain how your child/ren, and household situation have changed since participation in this project (Probe: specific changes)?
5. What training have you received since your involvement in this project?
6. Could you mention areas that your community has benefited from this project?
7. What are the constraints or challenges that you, or your household have in participating in this project (probe: stigma or discrimination, access to health services etc)?
8. Any suggestions to improve the project in future?

THANK YOU FOR TAKING THE TIME TO TALK WITH US.

LMS—ProACT Project Evaluation

FGD for OVC

1. How did you or your household know about this project (CBO/ProACT)?
2. What benefits have you received since you got involved with the projects (Probe: for specific home based care received-- health, education, psychosocial support, rights & protection, nutrition, economic, benefits etc)?
3. What were your conditions and that of your household before joining this project?
4. Could you explain how your situation and that of your household have changed from your participation in this project (Probe: specific changes)?
5. What training have you received since your involvement in this project?
6. Could you mention areas that your colleagues in this community has benefited from this project?
7. What are the constraints or challenges that you or your household are experiencing as a result of your participation in this project (probe: stigma or discrimination, access to health services etc)?
8. Any suggestions to improve the project in future?

THANK YOU FOR TAKING THE TIME TO TALK WITH US.

LMS-ProACT Mid-Term Project Evaluation

Group Interview: Health Care Provider/Other Personnel

1. Could you describe how your facility got involved with this project? (**Probe:** when, and specific circumstances etc.)

2. What are the types of services that your facility provides to your clients?

Moderator: probe specifically for the following:

- Basic Antenatal Care services
- Counseling and Testing services
- Safe Motherhood: Maternity, Labor and Delivery
- ARV & prophylaxis for mother and infant
- Logistics with antiretroviral (Access, Supplies, Cost, etc.)
- Support for infant feeding
- Follow up of infants exposed to HIV
- Post natal services
- Orphans and vulnerable children
- Tuberculosis
- Home based care
- Laboratory services
- Referral support
- Traditional Birth Attendants (TBAs) and/or Community Extension Health Workers (CHEWs)

3. What are the steps taken or activities implemented/put in place to integrate HIV and other health services in this health facility (**Probe for effects on: reduction** in stigma, and discrimination, quality of services provided, and satisfaction of clients)?

4. Describe the referral system that you have in place to ensure that they receive the services that they desire (**Probe:** in and out referral with specific examples)

5. What are some of the challenges and constraints that you may have experienced in the implementation of this project (**Probe:** specific challenges and constraints)?

6. What types of capacity building/trainings have you received since you joined the ProACT project (**Probe:** how trainings have enhanced job performance, quality of service, satisfaction of clients)?

7. What types of trainings have you provided to beneficiaries of your project? How have these trainings change their behaviours to health issues if any—give examples?

8. From your knowledge of the project so far, to what extent do you think implementation is furthering this state's health care goals?

9. What are key tangible or intangible steps or activities implemented to ensure sustainability of the services provided after the end of ProACT (**Probe specific:**

1. Tangible—funding, materials/supplies, activities,

2. Intangible—GoN moral and open commitment, conducive community environment, CBOs, and other stakeholders initiatives etc)?

10. What are some of the unintended outcomes or innovative ideas resulting from the implementation of the ProACT project if any?

11. Other comments or suggestions that you may have to improve project performance and effectiveness in the future?

THANK YOU FOR TAKING THE TIME TO TALK WITH US.

ProACT Mid-Term Project Evaluation:

Group Interview for CBOs

1. Could you describe how your organization got involved with the ProACT project?
2. What are the main achievements of your project implementation so far? Specifically in terms of home based care (HBO), OVC, and Prevention activities (Probe: how targets are met (delay if any), best practices, lessons learnt, etc)?
3. Could you explain the management systems of your CBO, and how it is influenced by the ProACT project (Probe: organizational structure & functions, coordination, and communication)?
4. What are the strengths and weaknesses of the ProACT program strategies especially with respect to your involvement since inception (Probe: reasons for each strengths and weaknesses mentioned)?
5. Describe the financial systems put in place to ensure accountability in the disbursement and spending of project funds (Probe for: lease explain key components)?
6. Describe the data collection and collation put in place in your organization (Probe: effectiveness of the M&E system, and challenges)?
7. What types of capacity building/trainings have you received since your CBO joined the ProACT project (probe: how trainings have enhanced job performance, quality of service, and satisfaction)?
8. What types of trainings have you provided to beneficiaries of your project? How have these trainings enhanced the performance (Probe: training of peer educators, caregivers, community leaders etc)?
9. What are the key tangible or intangible steps or activities implemented to ensure sustainability of your activities after the end of ProACT (Probe specific: 1. Tangible—funding, materials/supplies, activities, 2. Intangible—GoN moral and open commitment, conducive community environment, CBOs, and other stakeholders initiatives etc?)
10. What are some of the unintended outcomes or innovative ideas resulting from your participation in the ProACT project if any?

11. Other comments or suggestions that you may have to improve project performance and effectiveness in the future?

THANK YOU FOR YOUR TIME.....

LMS-ProACT Mid-Term Project Evaluation

Group Interview: Health Care Provider/Other Personnel

1. Could you describe how your facility got involved with this project? (**Probe:** when, and specific circumstances etc.)

2. What are the types of services that your facility provides to your clients?

Moderator: probe specifically for the following:

- Basic Antenatal Care services
- Counseling and Testing services
- Safe Motherhood: Maternity, Labor and Delivery
- ARV & prophylaxis for mother and infant
- Logistics with antiretroviral (Access, Supplies, Cost, etc.)
- Support for infant feeding
- Follow up of infants exposed to HIV
- Post natal services
- Orphans and vulnerable children
- Tuberculosis
- Home based care
- Laboratory services
- Referral support
- Traditional Birth Attendants (TBAs) and/or Community Extension Health Workers (CHEWs)

3. What are the steps taken or activities implemented/put in place to integrate HIV and other health services in this health facility (**Probe for effects on: reduction** in stigma, and discrimination, quality of services provided, and satisfaction of clients)?

4. Describe the referral system that you have in place to ensure that they receive the services that they desire (**Probe:** in and out referral with specific examples)

5. What are some of the challenges and constraints that you may have experienced in the implementation of this project (**Probe:** specific challenges and constraints)?

6. What types of capacity building/trainings have you received since you joined the ProACT project (**Probe:** how trainings have enhanced job performance, quality of service, satisfaction of clients)?

7. What types of trainings have you provided to beneficiaries of your project? How have these trainings change their behaviours to health issues if any—give examples?

8. From your knowledge of the project so far, to what extent do you think implementation is furthering this state's health care goals?

9. What are key tangible or intangible steps or activities implemented to ensure sustainability of the services provided after the end of ProACT (**Probe specific:**

1. Tangible—funding, materials/supplies, activities,

2. Intangible—GoN moral and open commitment, conducive community environment, CBOs, and other stakeholders initiatives etc)?

10. What are some of the unintended outcomes or innovative ideas resulting from the implementation of the ProACT project if any?

11. Other comments or suggestions that you may have to improve project performance and effectiveness in the future?

THANK YOU FOR TAKING THE TIME TO TALK WITH US.

ProACT Mid-Term Project Evaluation:

Group Interview for Project Staff (HQ & State)

Program Management

12. What are the main achievements of your project implementation so far? Specifically from the services point of view (**Probe:** how targets are met (delay if any)? Describe any best practices, and lessons learnt emanating from the project implementation?
13. What are the steps taken or activities implemented/put in place to integrate HIV and other health services in the project (**Probe for effects on:** reduction in stigma, and discrimination, quality of services provided, and satisfaction of clients)?
14. Could you explain the management systems of the ProACT project and how this has in anyway influenced performance (**Probe:** organizational structure & functions, coordination, and communication)?
15. What are the strengths and weaknesses of the ProACT program strategies especially with respect to your involvement since inception (**Probe:** reasons for each strengths and weaknesses mentioned)?

Grants & Financial Management

1. Describe the financial systems put in place to ensure accountability in the disbursement and spending of project funds (**Probe for:** lease explain key components)?
2. What are the strengths and weaknesses of the past or current financial systems if any (**Probe:** reasons for each strengths and weaknesses mentioned)?
3. Have you been audited by USAID or their representative? What was the outcome of the audit? (**Probe:** sight copies of report, how many times, who did it, challenges etc.)

Monitoring & Evaluation

1. Describe the ProACT M&E systems and how this has ensured adequate reporting and collating of project information and decision making?
2. Is the M&E system in line with standard guidelines from USAID? Please explain if there are any differences?
3. What are the strengths and weaknesses of the current M&E system (**Probe:** reasons for each strengths and weaknesses mentioned)?

General Issues (all Staff questions)

1. What types of capacity building/trainings have you received since you joined the ProACT project (**Probe:** how trainings have enhanced job performance, quality of service, satisfaction of clients)?
2. What types of trainings have you provided to partners/CBOs and beneficiaries of your project? How have these trainings enhanced the performance of their job—give examples?
3. From your knowledge of the project so far, to what extent do you think implementation is furthering the goal of PEPFAR Nigeria?
4. What are some of the challenges and constraints that you may have experienced in the implementation of this project (**Probe:** specific challenges and constraints)?
5. What are the key tangible or intangible steps or activities implemented to ensure sustainability of the services provided after the end of ProACT (**Probe specific:**
 1. Tangible—funding, materials/supplies, activities,
 2. Intangible—GoN moral and open commitment, conducive community environment, CBOs, and other stakeholders initiatives etc)?
6. What are some of the unintended outcomes or innovative ideas resulting from the implementation of the ProACT project if any?

7. Other comments or suggestions that you may have to improve project performance and effectiveness in the future?

THANK YOU FOR YOUR TIME.....

LMS—ProACT Project Evaluation

KII for Community Leaders

1. How did you get to know about this community organization (or CBOs/ProACT) working with your community? (probe: source, year project came to the community, and how etc.)
2. Could you explain your community's involvement in the project's activities?
(probe for specific activity initiated or involved in)
3. What are the key achievements of the project that you know of since they started working in your community if any? (probe: benefit to OVC, caregivers, the family and community, stigma and discrimination etc.)
4. What are some of the steps or activities (if any) put in place to continue the services/activities received from the CBOs/the project (Probe: community efforts if any)?
5. What are some of the challenges encountered with your community getting involved in the project?
6. Other suggestions on how best to improve the project implementation in your community?

THANK YOU FOR TAKING THE TIME TO TALK WITH US.

LMS-ProACT Mid-Term Project Evaluation

Group Interview: Health Care Provider/Other Personnel

1. Could you describe how your facility got involved with this project? (**Probe:** when, and specific circumstances etc.)

2. What are the types of services that your facility provides to your clients?

Moderator: probe specifically for the following:

- Basic Antenatal Care services
- Counseling and Testing services
- Safe Motherhood: Maternity, Labor and Delivery
- ARV & prophylaxis for mother and infant
- Logistics with antiretroviral (Access, Supplies, Cost, etc.)
- Support for infant feeding
- Follow up of infants exposed to HIV
- Post natal services
- Orphans and vulnerable children
- Tuberculosis
- Home based care
- Laboratory services
- Referral support
- Traditional Birth Attendants (TBAs) and/or Community Extension Health Workers (CHEWs)

3. What are the steps taken or activities implemented/put in place to integrate HIV and other health services in this health facility (**Probe for effects on: reduction** in stigma, and discrimination, quality of services provided, and satisfaction of clients)?

4. Describe the referral system that you have in place to ensure that they receive the services that they desire (**Probe:** in and out referral with specific examples)

5. What are some of the challenges and constraints that you may have experienced in the implementation of this project (**Probe:** specific challenges and constraints)?

6. What types of capacity building/trainings have you received since you joined the ProACT project (**Probe:** how trainings have enhanced job performance, quality of service, satisfaction of clients)?

7. What types of trainings have you provided to beneficiaries of your project? How have these trainings change their behaviours to health issues if any—give examples?

8. From your knowledge of the project so far, to what extent do you think implementation is furthering this state's health care goals?

9. What are key tangible or intangible steps or activities implemented to ensure sustainability of the services provided after the end of ProACT (**Probe specific:**

1. Tangible—funding, materials/supplies, activities,

2. Intangible—GoN moral and open commitment, conducive community environment, CBOs, and other stakeholders initiatives etc)?

10. What are some of the unintended outcomes or innovative ideas resulting from the implementation of the ProACT project if any?

11. Other comments or suggestions that you may have to improve project performance and effectiveness in the future?

THANK YOU FOR TAKING THE TIME TO TALK WITH US.

MSH Pro-Act Evaluation

KII Guide for USAID Staff (AOTR, COR and SI)

1. What are your role/s in facilitating the implementation of the LMS Pro-Act project?
2. How has LMS Pro-ACT project contributed towards achieving PEPFAR goal in Nigeria.
 - What are the effort of LMS Pro-ACT project in integration of health services
 - What are the effects of heath service integration?
2. What are the main achievements of the LMS Pro-ACT project? Any best practices and lessons learnt emanating from the project implementation?
3. What are the strengths and weaknesses in the implementation of the LMS Pro-ACT project?
4. How would you describe the financial and administrative regulations put in place by LMS Pro-ACT projects (Probe: adherence to regulations, audit etc.)?
5. In what ways has the project being adhering to the USAID M&E standard procedures and regulations (compliance, such as timeliness and accuracy of reporting)?
6. What are the key challenges and constraints in the implementation of the LMS ProACT project?
7. What are your suggestions on how the project can be improved?

THANK YOU FOR YOUR TIME.....

LMS-- ProACT Mid-Term Evaluation

Key Informant Interviews with Partner: AXIOS

1. In what capacity have you and your organization been involved with the ProACT project?
2. Could you mention and explain key achievements of the ProACT project since your involvement (Probe: specific for achievements including best practices, and lessons learnt)?
3. Could you explain the distribution and logistical systems in place for your products getting to the health care facilities were project is implemented?
4. In your experience, what are the main strengths and weaknesses of the ProACT products distribution and logistics systems in place (Probe: for products stock-outs, and storage issues if any)?
6. Could you explain any capacity building/training that you may have attended through the project, and how this has enhanced your performance?
7. Any other comments and issues on how to improve the ProACT project in the future?

THANK YOU FOR TAKING YOUR TIME TO TALK WITH US.

LMS-- ProACT Mid-Term Evaluation

Key Informant Interviews with MDAs (NACA/NASCAP, SACA/SASCAP, SMOH, & Other Stakeholders)

1. In what capacity have you and your organization been involved with the ProACT project?

2. Could you mention and explain key achievements of the ProACT project since your involvement (**Probe:** specific for achievements including best practices, and lessons learnt)?

3. What are some of the efforts made through the project to integrate health care delivery at the states (**Probe:** for specific activities or steps made towards integration)?

4. From your knowledge of the project so far, to what extent do you think implementation is furthering the goal of PEPFAR Nigeria?

5. What are the main strengths and weaknesses of the ProACT program approach and management systems?

6. Could you explain any capacity building/training efforts/activities provided by the project, and how this may have influenced or improved the following:
 1. Your job performance,
 2. Project sustainability,
 3. Quality of services provided

7. What are some of the challenges and constraints based on your knowledge of the project implementation (**Probe:** specific challenges and constraints)?

7. Any other comments and issues on how to improve the ProACT project in the future?

THANK YOU FOR TAKING YOUR TIME TO TALK WITH US.

Key Informant Interviews with MDAs (NACA/NASCAP, SACA/SASCAP, SMOH, & Other Stakeholders)

1. In what capacity have you and your organization been involved with the ProACT project?

2. Could you mention and explain key achievements of the ProACT project since your involvement (**Probe:** specific for achievements including best practices, and lessons learnt)?

3. What are some of the efforts made through the project to integrate health care delivery at the states (**Probe:** for specific activities or steps made towards integration)?

4. From your knowledge of the project so far, to what extent do you think implementation is furthering the goal of PEPFAR Nigeria?

5. What are the main strengths and weaknesses of the ProACT program approach and management systems?

6. Could you explain any capacity building/training efforts/activities provided by the project, and how this may have influenced or improved the following:

1. Your job performance,
2. Project sustainability,
3. Quality of services provided

7. What are some of the challenges and constraints based on your knowledge of the project implementation (**Probe:** specific challenges and constraints)?

7. Any other comments and issues on how to improve the ProACT project in the future?

THANK YOU FOR TAKING YOUR TIME TO TALK WITH US.

LMS—ProACT Mid-Term Evaluation

FGD Guide: Peer Educators (PE)

1. What is the name of the organization through which you are providing information about HIV and other support to your friends and colleagues?
2. How did you become a peer educator and what are your roles and responsibilities?
(**Probe** for motivation, drive, and reasons for becoming a PE, specific activities carried out)?
3. What was your situation before becoming a peer educator, and what is your situation now (**Probe:** about information received, activities involved in etc.)
4. In what ways have you contributed to your friends/colleagues way of life based on the training you received as a peer educator (**Probe:** specific examples)?
5. In what ways have you benefitted from your role as a peer educator?
6. Any suggestions on how best to improve your performance as a peer educator in the future?

THANK YOU FOR SPENDING YOUR TIME WITH US.

LMS ProACT Mid-Term Project Evaluation

FGD Guide: PLHIV

1. Could you describe how you got involved with this project (call name of organization i.e. CBO or ProACT)?
(**Probe:** when, specific reasons, situations, and circumstances etc.)

2. What types of services have you received from this health care facility?

Moderator: probe specifically for the following:

- Basic Antenatal Care services
- Counseling and Testing services
- Safe Motherhood: Maternity, Labor and Delivery
- ARV & prophylaxis for mother and infant
- Logistics with antiretroviral (Access, Supplies, Cost, etc.)
- Support for infant feeding
- Follow up of infants exposed to HIV
- Post natal services
- Orphans and vulnerable children
- Tuberculosis
- Home based care
- Laboratory services
- Education sessions/materials
- Economic support
- Referral support
- Traditional Birth Attendants (TBAs) and/or Community Extension Health Workers (CHEWs)

3. Which of these services is making the most difference in your life and that of your family (**Probe:** reasons for mentioning the services that made the most difference)?

4. How will you describe the quality of the services that you have received from this facility (**Probe:** access to services on time, receiving multiple services at the same location, been treated with respect, confidentiality during visits, stigma and discrimination, frequency of external interruption, etc.)?

5. How would you rate your satisfaction with the services that you received at this health facility (**Probe:** for specific ratings—not satisfied, satisfied, very satisfied)?

Moderator— Count FGD participant according to their ratings.

6. Please tell us how this project has affected you in any one of the following:

- Your health and general wellbeing
- HIV knowledge attitudes, practices, and behavior (KAPB)

- Your Child's health
- Reduced stigma and discrimination
- Personal self worth and confidence
- Relationship with your spouse/partner
- Your community's HIV knowledge, attitudes, practice, and behavior (KAPB)

7. Comments on other things that can be done to improve quality of care and satisfaction of services provided by this facility in the future?

THANK YOU FOR TAKING WTH US.

LMS ProACT Mid-Term Project Evaluation

FGD Guide: PLHIV Support Group

1. Could you describe how you got involved with this project (call name of organization i.e. CBO or ProACT)?
(**Probe:** when, specific reasons, situations, and circumstances etc.)
2. Could you describe the activities of this project (name CBO or health facility or ProACT) and how these have positively affected members of your group?
3. Describe specific assistance that you and your members may have received from the project?

Moderator: probe specifically for the following:

- Changes in HIV KAP
- ARV and other treatments
- Education session/education materials
- Economic support
- Nutrition & food
- Other support (mention specify)

4. Which of these services is making the most difference in the life of you and your members (**Probe:** reasons for mentioning the services that made the most difference)?
5. How will you describe the quality of services that you have received from this facility (**Probe:** access to services on time, receiving multiple services at the same location, been treated with respect, confidentiality during visits, stigma and discrimination, frequency of external interruption, etc.)?
6. Please tell us how this project (name) has affected your life and that of your members in any one of the following:
 - Health and general wellbeing (members & their families)
 - Members & community's HIV knowledge attitudes, practices, and behavior (KAPB)
 - Reduced stigma and discrimination
 - Personal self worth and confidence
 - Relationship with your spouse/partner
7. Comments on other things necessary to improve quality and satisfaction of services provided by the project in the future?

THANK YOU FOR TAKING WTH US.

1. Focus Group Discussion

1.1 Definition of FGD

FGD is a qualitative data collection technique that provides a forum for a group of people (usually 8 – 10 in number) of similar characteristics to discuss issues of importance to their group or community.

1.2 Essential features:

- Group members share key characteristics
- Similar characteristics enable participants to discuss freely
- The discussion is focused on specific issues or topics
- Group dynamics during discussion
- Agreements or disagreements may occur
- Large amount of information is gathered in a short time

2. FGD participant

Definition: The people (adults or children) invited to a venue to discuss specific issues.

Key Characteristics: Characteristics are defined attributes that participants should have to ensure homogeneity among them thus, ensuring dynamic discussion.

2.1 The FGD moderator

Definition: S/he coordinates the discussion for the group (acts like a referee in a soccer game)

2.1.1 Essential Qualities

- Must have good knowledge of the subject of interest

- Must be familiar with each question and why each is in the guideline
- Must maintain a lively discussion
- Must ensure that the rules of the discussion are followed, only one participant should speak at a time, all participants should use nicknames etc
- Must be able to move the discussion forward in a timely fashion
- Must be a good listener
- Must keep the discussion focused
- Must be able to communicate very well
- Must have leadership skills
- Must be non-judgmental, not take side
- Must be patient and flexible
- Must listen to the discussion carefully
- Must follow leads when relevant

2.1.2 Tips on good moderating

- Concentrate on one topic at a time
- Always have the objectives of the discussion in mind
- Give each participant time to talk
- Talk less than 10% of the entire time
- Avoid a question and answer series
- Avoid leading questions
- Know when to stray from the discussion guide and when to probe
- Avoid asking “why,” (avoid this word and all confrontational words specific to the context)
- Be aware of body language and surroundings
- Expect the unexpected
- Encourage the shy to talk
- Talk only about people “like” the participants
- Practice how to rephrase participants’ opinions or comments without being judgmental
- Know how to link one participant’s opinion to that of another participant and follow-up with a question or clarification
- Follow the “5-seconds rule” for waiting on a participant before following up with a probe (participants do not always have a ready response, they need some time to think)

2.2 Roles of the note takers or assistants

Definition: A good note taker is someone who records, as much as possible, all information that transpired during the discussion. S/he accomplishes this task by writing down (usually on a notebook) what s/he hears and what s/he sees during the discussion session.

The note takers or assistants do the following:

- Tape record the discussion
- Take notes on what is said during the discussion
- Take notes on non-verbal cues/actions during the discussion. There should be double note taking where possible

2.2.1 Tips on good note taking

Note taking should be done by two people who should meet immediately after the discussion session, together with the moderator, to fill in gaps in notes and do some editing. And two tape recorders should run concurrently, the second beginning five minutes after the first to ensure that there are no breaks in recording the discussion (e.g. while changing a tape etc).

- Use pencil and notebooks (not sheets of paper)
- Write down as much as possible what you hear and what you see or observe
- Don't rely on your tape recorder because it may not be clear or there may be a mechanical fault
- Do double note taking to ensure completeness and accuracy (two note takers, if is possible)
- Let the tape recorder be your backup
- Use shorthand or paraphrase
- Use numbers or nick names to identify participants
- Draw the positions of participants and write their numbers or nicknames on their positions
- Type all field notes as soon as possible after the FGD session.

3. Seating arrangement

It is best to have participants and the field team members sit in a circle, so that everyone can feel part of the group discussion and have eye contact with everyone else. Circular seating arrangement is helpful to the field team. The moderator can easily face and engage any of the participants, and the note taker/s can easily follow the dynamics of the discussion.

4. The discussion guide and the FGD session

4.1 Introduction

The moderator should begin the discussion in the following fashion:

- Prepare a conducive sitting arrangement e.g. around a table, in a circle (avoid a classroom type of set-up)
- Help participants determine the language of the discussion
- Explain the reasons for conducting the discussion
- Ask participants to respond to questions honestly
- Stress confidentiality
- Explain that there are no right or wrong answers
- Ask everyone to speak one at a time
- Acknowledge tape recorder (the reasons for tape recording, and stress confidentiality again)
- Introduce note taker(s) and the purpose of notes
- Have each participant introduce themselves using a nick name
- Explain that participants should use a nick name (we DO NOT WANT THEIR ACTUAL NAMES mentioned at any time during the discussion)

4.2 Content of the guide

The researcher should go through each section of the FGD guide with the trainee/data collector. S/he should:

- Explain the meaning of each question and probes
- What each question intends to achieve (the kind of information that we would like to elicit with each of them)

4.3 Questions and Intentions

The researcher should go over each of these questions in detail. The explanations below each of the questions and probes are meant to enable a detailed discussion. Each member of the field team should be very familiar with each question and the corresponding probes, and be clear about what each of them intends.

5. Hints on problems and solutions during the FGD session

Note: Is a good idea to tell prospective participants that they should not come with anyone to the venue of the discussion. But if they came with someone, we must not show any sign of annoyance but find a way out as described below.

- **A participant aggressive/dominating the discussion:** The moderator should reduce eye contact with the participant and encourage others to speak

- **A participant is shy or quiet:** Moderator should maintain eye contact with her/him and politely ask her/him to speak.
- **A participant asks a question during the discussion:** If the question is relevant to the topic being discussed, the moderator should politely rephrase the question back to the participant or to another participant; if the question is totally off the track, politely tell the participant that he/she will answer the question at the end of the discussion (NEVER answer a participant's question during the discussion session, remember your response may be taken by a participant as your opinion or been judgmental).
- **Many participants are bored or sleepy:** This may be a good time to throw in a joke, humor or change the topic.
- **Restless or disruptive participants:** This type of participant must be handled carefully because they may be annoying other participants and can do something that may lead to abrupt end of the discussion. Politely reiterate the importance of the discussion to everyone (while maintaining eye contact with the participant concerned). Also try engaging her/him in the discussion by asking her/him questions (may be s/he feels left out of the discussion).
- **A participant came late to the venue of the discussion:** Politely welcome the participant to join in and briefly update her/him on what has been discussed (only topics, no explain other participant's contributions). Note takers should note the time that the participant came in and the topic that was being discussed. A participant MUST not be asked to leave the venue of the discussion because s/he came late.
- **A participant came to the venue of the discussion with friends, relatives, children or an unexpected visitor came to join the discussion:** This is an unfortunate situation; one of the note-takers/assistants should take the un-invited guest to a safe location and engage her/him till the end of the discussion. If a participant came with an infant, the note-taker/assistant should take the child to a safe place to play. But if this is not possible, the note taker should politely ask the participant to come with her child to a safe place and engage her until the discussion ends.
- **Moderator lost focus of the discussion:** One of the note takers/assistants should bring the discussion back on course (this is one reason why every member of the field team must be familiar with the FGD guide)
- **A participant had an emergency during the discussion (health problems, attention urgently needed at home):** The participant should be excused from the discussion with minimal disruption but if other participants are upset by the incident, it may be a good time to stop the discussion and ask the participant for a convenient time (not the same day) to continue the discussion.

- **We invited more than required number of participants and they all came:** Is a good idea not to invite many participants with the hope that some may not show up (one or two extra is fine). But if for some reason we have many participants than required, those who came early up to the number required (8 - 10) should be in the actual discussion session. The rest of them should be engaged by one of the note takers/assistants in a mock session, at a safe distance.

Tips for both FGD & KII

6. Hints on how to ask questions

Types of questions: There are two types (open-ended vs. closed-ended). The first word that starts a question makes it to be either open or close. An open-ended question is likely to make participants describe or provide explanations while responding to a question. A closed-ended question is likely to make participants provide a short answer e.g. “yes” or “no.” “Yes” or “no” answers are not good enough responses in qualitative study.

6.1 Examples of open-ended questions

- What are the types of services that your facility provides to your clients?
- What benefits have you received since you got involved with this project?

6.2 Examples of closed-ended questions

- Do you know where to get HIV testing and counseling?
- Have you received any benefit from the ProACT project?

Note: Closed-ended questions are likely to elicit short responses unless put within a general question or are followed by a probe.

7. The art of probing

Definition: The act of exploring a question more fully by asking a follow-up open-ended question.

7.1 Essential skills

- Don't accept the first response as the complete response.
- Always follow “don't know” with an open-ended question.
- Don't take for granted that you know what is being said, ask for clarifications.

7.2 Examples of how to probe for clarifications

- What do you mean by that?

- Could you explain a little bit more, I don't understand?
- Could you be a little more specific in your explanations?

7.3 How to ask for examples to clarify

- Could you give an example?
- Could you give an instance that this can happen to people your age?

7.4 Using probes to crosscheck for consistency

- Earlier you said, ...could you explain the situation or the reasons for this?
- How is this related to the point on.... you made earlier on....

8. Language of FGD/KII

The language of discussion/interview should be determined from the beginning. The discussion or KII should be conducted in the language that most participants (interviewee) are fluent in. Is a good idea (especially in the rural area) that a FGD moderator be fluent in the language predominantly spoken in the locality just in case some participant prefer to talk in that language. The moderator (and if possible, other field team members) (or interviewer) should practice reading the questions in the local language just in case they need to use it.

9. Venue of FGD/KII

This MUST be a neutral quite place, not a church, mosque or market place. A school is ideal (that is if the evaluation is during the weekend). Field team must arrive at least 30 minutes to the venue for the FGD/KII. They MUST be there early to ensure that there are adequate sitting arrangements and that all materials for the FGD/KII are ready. The venue MUST be ready by the time beneficiaries starts arriving.

10. Transcribing and translation

Transcribing is the act of listening to a tape-recorded discussion and writing down verbatim (usually on a notebook) what was heard from the tape. Translation is the act of expressing in words information from one language to another (the information may be tape-recorded or not)

- Members of the field team should take turns or assign someone to transcribe tapes
- Field teams should start transcribing the day of the discussion
- Transcription should follow the discussion guide format (from introduction and each topic as it is introduced)
- Transcription should follow the way participants contributed to the discussion, first, second etc using nicknames.
- Explain colloquial phrases
- Use () and [] to note verbal and non-verbal expressions e.g. laughter, high pitch voice, tone of emphases, and your own comments
- Double-check transcription from tapes and note takers' transcripts and resolve discrepancies when they are still fresh
- Do back translation (where this is applicable)

11. Pre-testing Instruments

Note: The researcher must answer these questions with the assistance of the field team.

Pre-testing should be on a small scale. People having similar characteristics as the project beneficiaries are invited to participate in a mock FGD/KII to test the questions (as long as they are not part of the actual FGD). One mock FGD with about four participants is sufficient. The researcher should observe the conduct of this mock interview and take notes. S/he should discuss the following with the field team:

- Are the questions understandable, clear?
- Are any questions misleading?
- Is any question close -ended?
- Is the discussion guide too long?
- Are we obtaining the kind of information we expect?

12. Ethical principles

The researchers should explain the following ethical considerations to the trainees:

- Voluntary participation
- For minors (less than 17 years old) parental/caretaker consent is a must
- Field team members must be polite in dealing with participants
- Team members must respect each of the participants (no matter their age)
- Views and opinions of participants, and whatever they say are valuable

- Questions on OVC issues should be referred to appropriate office that can answer
- Reassure them that the information will be kept in confidence

13. Checklist for the fieldwork

Everything in the checklist should be obtained before going to the evaluation sites. It is a good idea to serve refreshments mid way through an FGD to energize participants while the discussion is in progress.

- Lodging and meals
- Transportation (Car hire/fuel)
- Laptop (or typewriter, for transcribing)
- Writing materials (notebooks, pencils, pens)
- A tape recorder with digital chips
- Batteries (with some backups)
- Copies of the FGD/KII instruments (three copies each)
- This training guide (three copies)
- Medicines (headache, pain fever reliever, cold, fever, dysentery etc)
- Refreshments (snacks, soda etc)

Appendix 1: Detailed evaluation questions

Additional questions to be addressed include, but are not limited to (these are illustrative and will be finalized by the team during the TPM):

1. To what extent has LMS ProACT activities being implemented been integrated in the health care system delivery in the targeted areas?

- What has been the project's level of performance on set targets?
- To what extent has the project contributed towards furthering the goal of PEPFAR Nigeria?
- To what extent has the project been innovative and creative in its approach to program implementation
- How sustainable are the project's activities

2. To what extent have the capacity building efforts by LMS ProACT project contributed to the overall performance and sustainability of the delivery of comprehensive HIV/AIDS prevention, care & treatment and TB services?

- To what extent have the capacity of LGs been developed to decentralize HIV services to PHC?
- What is the organizational capacity of selected sites to deliver effective care and to deliver care with less USG support and more GoN support?
- To what extent has the capacity building efforts of LMS ProACT through fixed-cost small grants contribute to the CBOs overall performance and sustainability of the delivery of HIV/AIDS services (prevention, care & support & OVC) linked with health facilities in the selected communities of the project states?
- To what extent has the capacity of CBOs been developed through fixed-cost small grants and how has these capacity building efforts contribute to the CBOs overall performance and sustainability of the delivery of HIV/AIDS services (prevention, care & support & OVC)?
- To what extent did the capacity building efforts of LMS ProACT through the use of modified MSH Leadership Development Program (LDP) and other MSH tools contribute to the SMOHs, SACAs, LACAs and health-facility teams overall capacity to lead, manage and sustain HIV/AIDS prevention, care and treatment services.

3. Is the project's management systems and procedures facilitating the achievement of expected outcomes and overall project goal?

- How effective and efficient was the project's organizational and management structure in achieving results?
- To what extent was the project management team responsive and accountable to its client (i.e. USAID/Nigeria) and key partners (i.e. Axios Foundation, GoN (FMoH, NACA, SACA), and CBOs and non-governmental organizations including networks of PLWHA support groups)? What could have been done to make the partnership more effective?
- Were the systems developed by the project for monitoring, evaluation, and knowledge application effective? How have these elements of the program supported the achievement of the overall project objective?
- If specific targets set on performance indicators were not met, why was this the case?
- How effective was USAID in managing the project?

4. Which projects' intervention (s) had the most comparative cost advantage in implementation?

- Are there any demonstrations of cost-effectiveness in project implementation?
- What are some more cost efficient and effective approaches for achieving the results (evaluate from both a short and long-term perspective)?

5. What is the extent of beneficiaries' satisfaction on the project intervention interventions?

6. What are the project's major challenges and lessons learned so far?

- What specific technical approaches or outputs have demonstrated the greatest result?
- What are the factors that contributed to or hindered progress towards achieving results, including those linked to program design, implementation, management and partnerships?
- What issues and gaps have had significant effect on sustainability?
- What strategies are needed to further strengthen the efficiency, effectiveness, management and sustainability of the project?
- What components of the LMS ProACT project strategy should be maintained in their current form? What components should be retained, but modified? Are there components or approaches that are no longer needed?

- What are some promising new developments in the area of HIV care and support of PLWHA that should be explored in possibly future activities?

Leadership, Management and Sustainability– Prevention Organizational Systems AIDS Care and Treatment (LMS- ProACT) Project.

MID-TERM PROJECT PERFORMANCE EVALUATION SCOPE OF WORK

I. BACKGROUND INFORMATION

A. Project Identification Data

Development Objective

Project Title

Investing in People	Leadership Management Sustainability – Prevention organizational systems AIDS Care and Treatment Project (LMS - ProACT)
Implementing Partner: Management Sciences for Health (MSH)	Award Number: 620-A-00-09-00013-00
Award Start Date: July 16, 2009	Award end Date: July 15, 2014
Total Estimated Amount \$60,797,873.00	Obligations to Date \$34,896,478.00
Expenditures to Date: \$27,224,115.00	Expended Life of Award in Months: 34 Months
Activity Objective:	To build the capacity of Nigeria’s public, private and community sectors for sustainable HIV/AIDS and TB prevention, control, care and treatment integrated with the health system 1. To increase demand for HIV/AIDS and TB services and interventions especially among target groups. 2. To increase access to quality HIV/AIDS and TB services, practices, and products in selected states 3. To strengthened public, private and community enabling environments
COR/AOR	Emeka Okechukwu

B. Development Context

The HIV epidemic in Nigeria is a mixed epidemic. Generalized prevalence is 4.1%, but there are significantly higher rates among most-at-risk populations (MARPs), including commercial sex workers, injecting drug users, and men having sex with men. Nigeria's 2.98 million HIV positive individuals constitute the second greatest burden of HIV/AIDS care and treatment worldwide. Adding to this burden are 1.2 million children orphaned by HIV/AIDS. Heterosexual transmission accounts for up to 95% of HIV infections and women account for close to 60% of all adults living with HIV. Fewer than five percent of pregnant HIV-positive women are reached by services to prevent mother-to-child transmission (PMTCT), and more than 73,000 children are born with HIV each year.

Approximately 300,000 individuals are currently on anti-retroviral treatment (ART) nationwide, but the estimated 750,000 HIV positive individuals needing ART but not receiving it constitute an unmet demand of over 70%.

Nigeria has been slow to recognize the gravity of the epidemic and to mobilize the commitment and resources required for a sustainable national response. While progress has been made in policy development and strategic planning at Federal level, provision of care, treatment, and prevention services remains inadequate and the level of unmet need is enormous. The expansion of HIV/AIDS services over the past five years has been due almost in its entirety to donor support, particularly from the USG through PEPFAR. In order to assist Nigeria to develop and implement a comprehensive national response to HIV/AIDS, PEPFAR partners will establish a Partnership Framework with Nigerian stakeholders, including Federal government bodies, state and local governments, faith-based organizations, civil society, the private sector, and development partners, including the Global Fund Nigeria Country Coordinating Mechanism. The goal of the Partnership Framework is to advance Nigeria's ownership of the fight against HIV/AIDS. The Partnership Framework will outline the mutual commitments and responsibilities of the partners and identify strategies for expanding prevention, care, and treatment services; strengthening the health care system and better integrating the HIV/AIDS response into that system; and improving the environment for HIV/AIDS service delivery at all levels.

LMS - ProACT project is a five-year, USAID-funded project that aims at building the capacity of Nigeria's public, private and community sectors for sustainable HIV/AIDS and TB prevention, control, care and treatment services integrated with the health system.

The project is being implemented in 6 states in Nigeria namely Adamawa, Taraba, Kogi, Niger, Kwara & Kebbi. LMS - ProACT project is implemented in partnership with Axios Foundation who manages the project's commodity logistics. The project supported 13 CBOs for care and support services, care for Orphan & Vulnerable Children (OVC) and HIV prevention services. LMS ProACT is currently supporting 25 secondary health facilities for delivery of comprehensive HIV services including antiretroviral therapy. The project also supports 31 facilities serving as feeder sites of which 26 are primary health care (PHC) facilities and 5 are secondary health care facilities. 3 of these PHC centers are piloting ART decentralization (ARV refill services).

C. Results

The goal of LMS ProACT project is to build the capacity of Nigeria's public, private and community sectors for sustainable HIV/AIDS and TB prevention, control, care and treatment integrated with the health system. Thus, the project contributes towards achieving Assistance Objective (AO) - reduced impact of HIV/AIDS in selected states, through the following Intermediate Results (IRs):

IR 1: Increased demand for HIV/AIDS and TB services and interventions, especially among target groups

IR 2: Increased access to quality HIV/AIDS and TB services, practices, and products in selected states

IR 3: Strengthened public, private, and community enabling environments

The Result Framework is attached as annex to this document.

D. Approach and Implementation

The project aims to affect the IRs above through provision of the following range of quality HIV/AIDS prevention, care and treatment services:

HIV Prevention Services

- Prevention of mother-to-child HIV transmission (PMTCT): This includes 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 (AB) activities: This involves training to promote abstinence, a delay in the onset of sexual activity, fidelity, partner-reduction messages, and related social and community norms.
- Other Prevention (OP) activities: This is aimed at preventing HIV transmission, including the purchase and promotion of condoms and STI management in non-palliative care settings.
- Injection safety activities: To reduce the nosocomial transmission of blood-borne pathogens, including HIV.

Care and Support

This involves provision of facility and community based care and support services which includes prevention and treatment of OIs (excluding TB) and complications, nutrition assessment, counseling and support; adherence support, provision of commodities such as OI drugs and laboratory reagents, ITNs and water guard. Psychosocial care is provided during individual or group counseling and linking clients to facility or community based support groups and IGA Services

TB/HIV Services

This includes examinations, clinical monitoring, related laboratory services, treatment and prevention of tuberculosis in HIV clinical care settings (including pharmaceuticals). Also, screening and referral for HIV testing; and clinical care related to TB clinical settings.

Orphans and Vulnerable Children (OVC)

OVC activities are 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; including basic health care support

HIV Testing and counseling (HTC)

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

Treatment

HIV/AIDS treatment includes infrastructure, training of service providers, clinical examinations and monitoring, related laboratory services and medication adherence activities.

ARV drugs

This includes distribution/supply chain/logistics & pharmaceutical management of ARV drugs; and other commodities

Laboratory Services

Support comprehensive laboratories with capacities to conduct CD4 T-lymphocyte monitoring, HIV serology, clinical chemistries and hematology investigations. Also, supporting laboratory systems strengthening activities that improve the quality of laboratory service delivery, build local capacity for efficient laboratory program implementation and management.

Strategic Information

This involves supporting the national government to strengthen health information management systems; monitoring program implementation; use of program data to inform program implementation; developing and disseminating best practices to improve program efficiency and effectiveness; testing implementation models.

Existing Performance Information sources

The evaluation team will have access to the vital documents relevant to the midterm evaluation. These documents would include the project's Quarterly Performance Reports, approved Project Performance Management Plan (PMP), approved Yearly Work Plan, financial documents, reports from assessments and self-assessments, sub-grantees engagement documents, official USAID correspondence and feedback (e.g. from portfolio reviews) and any other relevant materials documenting the management, implementation process and results. The project technical proposal and award modifications may be made available on request from the evaluation Team. Other relevant documents essential for review by the Evaluation Team would include: Annual and Semi Annual PEPFAR Reports, National frameworks, policies and program implementation guidelines from the National Agency for the Control of AIDS (NACA) and Federal Ministry of Health (FMoH).

II. EVALUATION RATIONALE

A. Evaluation Purpose

As stipulated in the subject award Corporative Agreement, Mid-Term Evaluation is anticipated during the life of the award, and USAID requires that this be conducted by an independent Team(s). This independent evaluation would include a detailed assessment of the project organization, management, performance and the overall implementation and sustainability of the project and make recommendations on areas of improvements, changes and or modifications, and to document lessons learned.

The overall purpose of the mid- term evaluation is to determine how effective the LMS ProACT project implementation has been and specifically;

- To determine the extent to which the capacity building efforts by LMS ProACT project has contributed to the overall performance and sustainability of the delivery of comprehensive HIV/AIDS prevention, care and treatment and TB services.
- To determine how successful the project's management systems and procedures has been in facilitating the achievement of expected outcomes and overall project goal.
- To document lessons learned that will assist the project, PEPFAR Nigeria, and the GON in the continuous improvement of its projects and future comprehensive HIV/AIDS, TB programs in Nigeria.

B. Audience and Intended Users

The primary users of the findings of this midterm evaluation are the project implementers and USAID for the purpose of improving implementation effectiveness going forward. The secondary users would be other implementation partners (GON health related institutions) on how best to synergize with MSH to improve on implementing the ProAct interventions.

C. Evaluation Questions

The key evaluation questions are:

- 1) To what extent has MSH/ProACT and its Partners supported the integration of HIV/AIDS and TB services into the health care service delivery system in the targeted states and facilities. What are the demonstrable effects of the integration efforts in reducing stigmatization, increasing uptake of HIV and non-HIV services, and improving the quality of care provided to patients seeking medical attention? Are there lessons that can be learned to strengthen integration?
- 2) Are the project's management systems and procedures facilitating the achievement of expected outcomes and overall project goal, and is the project likely to meet its set objectives and targets by the end of the life of the project?
- 3) What strategies and approaches have MSH ProACT and its partners adopted and implemented to facilitate the sustainability of the supported activities and programs beyond the project's funding period? How do facilities, communities and government structures promote institutional, financial and programmatic sustainability and ownership of the HIV response in their respective health facilities and states? What support would they require from MSH ProACT to ensure a seamless transition by the end of the project?
- 4) How has MSH/ProACT capacity building support improved the competence of service providers in providing quality services to patients? How has the capacity building support to governments (SACA&SMOH) strengthened their coordination and leadership capacity in leading the HIV response in their respective states? What is the extent of beneficiaries' (patients, organizations, SMOH, FMOH, etc), satisfaction with the project's interventions so far, and are there areas of modifications or changes necessary for the project to achieve its set objectives by the end of the life of the project?

- 5) What are the project's major challenges, lessons learned and innovative approaches that MSH-ProACT and its partners have implemented that could be adopted and scaled up in the PEPFAR program.

III. EVALUATION DESIGN AND METHODOLOGY

This evaluation will use a mixture of quantitative and qualitative approaches to gain insight into the questions above. A variety of methods including review of key and relevant documents; team planning meetings; in-depth interviews with key informants; site visits; data analysis; cost-effectiveness analysis will be used. The evaluation will be conducted by a team of external evaluators to be identified by NMEMS II in consultation with USAID/Nigeria. Data will be collected using primary and secondary sources.

A. Data Collection Methods A detailed methodology matrix is provided in Table 1. The key approaches that will be used to collect and analyze data for the evaluation are as follows:

1. Review of documents

The LMS ProACT project will provide the evaluation team with historical project documents before the team planning meeting. The evaluation team will be responsible for collecting and reviewing any other relevant documents throughout the evaluation, these include project tools, technical reports and trip reports. The team will review all available materials prior to conducting key informant interviews and as necessary throughout the course of the assessment to be able to determine the extent and nature of their use.

2. The evaluation team will hold an initial two-day team planning meeting (TPM).

The evaluation team will start their work with a planning meeting with the team members only, and work with NMEMS II, USAID and others. During this meeting and in the further meetings the time will be used to clarify team roles, and responsibilities, deliverables, development of evaluation tools, and approach to the assessment and refinement of the team schedule. In the meeting the team will:

- Share background, experience, and expectations of each of the team members for the assignment
- Formulate a common understanding of the assignment, clarifying team members' roles and responsibilities
- Agree on the objectives and desired outcomes of the assignment
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Revisit and finalize the evaluation timeline and strategy for achieving deliverables
- Develop and finalize data collection methods, instruments, tools, and guidelines and obtain Mission approval before implementation.
- Develop preliminary outline of the team's report and assign drafting responsibilities for the final report.

As part of this meeting, the team will meet with USAID project staff to determine the purpose and scope of the evaluation and finalize the evaluation questions, methods,

deliverables and timeline. The outcome of the team planning meeting will be a detailed work plan report for the evaluation.

3. In-depth interviews with key informants

The evaluation team will conduct in-depth interviews with key informants selected among the stakeholders and partners of the LMS ProACT project. The evaluation team will develop a structured guide that will be used to conduct the interviews. The interviews should be loosely structured, but following the list of questions in the guide. The interviewer will probe for additional information related to each question and document the responses. Interviews will be conducted through face-to-face contact or by telephone as is necessary, subject to the availability of the respondent which could be determined by time or space. Respondents to the interviews will be identified by USAID in collaboration with LMS ProACT. A list of potential respondents will be developed prior to the start of the evaluation process. Potential respondents will include but not limited to:

- USAID/Nigeria staff
- LMS ProACT project and support staff (both at state offices and Country office)
- GoN staff (HAD/FMoH, NACA, SACA & SMoH)
- Axios staff
- Sub – grantees (CSOs & CBOs)
- Other partner organization including the staff from collaborating USAID projects (e.g. FHI/SIDHAS)
- Services providers in the supported facilities
- Service beneficiaries
- Staff of other USG agencies in PEPFAR Nigeria program (CDC & DOD)

4. Site visits

The evaluation team will make site visits to project sites and offices of key partners. Decisions on the sites to be visited will be made jointly prior to the start of the evaluation process. The sample of sites to be visited will constitute a representative mix of both successful sites and sites with limited project successes.

To be able to truly assess the realities on the ground, a considerable amount of the evaluation team's time will be spent not only visiting LMS ProACT's offices and the offices of the partners, but also observing the actual delivery of services to beneficiaries. This will entail visiting community centers, supported health facilities and other sites where services are delivered. In collaboration with the LMS ProACT project, the evaluation team will determine an adequate sample of sites where services are delivered to be visited.

Table 1: Methodology Matrix

Evaluation Questions	Type of Answer Needed (Descriptive, Comparative, Cause & Effect)	Data Collection Methods	Data Sources	Sampling or Selection Criteria	Data Analysis Methods
To what extent has MSH/ProACT and its Partners supported the integration of HIV/AIDS and TB services into the health care service delivery system in the targeted states and facilities. What are the demonstrable effects of the integration efforts in reducing stigmatization, increasing uptake of HIV and non-HIV services, and improving the quality of care provided to patients seeking medical attention? Are there lessons that can be learned to strengthen integration?	Comparative	Document review and beneficiaries KII	Documents and KII	Purposive	Quantitative and qualitative

Evaluation Questions	Type of Answer Needed (Descriptive, Comparative, Cause & Effect)	Data Collection Methods	Data Sources	Sampling or Selection Criteria	Data Analysis Methods
Are the project's management systems and procedures facilitating the achievement of expected outcomes and overall project goal, and is the project likely to meet its set objectives and targets by the end of the life of the project?	Descriptive	Document review and KII	Projects periodic reports and KII	Purposive sampling of sites and key informants	Quantitative data analysis using descriptive statistics, Qualitative data analysis
What strategies and approaches have MSH/ProACT and its partners adopted and implemented to facilitate the sustainability of the supported activities and programs beyond the project's funding period? How do facilities,	Descriptive	Document review and KII	Projects periodic reports and beneficiaries testimonies	Purposive sampling of key stakeholders	Quantitative and qualitative data analysis using descriptive statistics

Evaluation Questions	Type of Answer Needed (Descriptive, Comparative, Cause & Effect)	Data Collection Methods	Data Sources	Sampling or Selection Criteria	Data Analysis Methods
communities and government structures promote institutional, financial and programmatic sustainability and ownership of the HIV response in their respective health facilities and states? What support would they require from ProACT to ensure a seamless transition by the end of the project?					
How has MSH/ProACT capacity building support improved the competence of service providers in providing quality services to patients? How has the capacity building support to governments (SACA&SMOH)	Comparative	Document review, KII, FGD	Projects periodic reports and Stakeholders	Purposive sampling of key stakeholders	Quantitative and qualitative data analysis using descriptive statistics

Evaluation Questions	Type of Answer Needed (Descriptive, Comparative, Cause & Effect)	Data Collection Methods	Data Sources	Sampling or Selection Criteria	Data Analysis Methods
strengthened their coordination and leadership capacity in leading the HIV response in their respective states? What is the extent of beneficiaries' (patients, organizations, SMOH, FMOH, etc), satisfaction with the project's interventions so far, and are there areas of modifications or changes necessary for the project to achieve its set objectives by the end of the life of the project?					
What are the project's major challenges, lessons learned and innovative approaches that	Descriptive	Document review and KII	Projects periodic reports and KII testimonies	Purposive sampling	Quantitative and qualitative data analysis using descriptive statistics

Evaluation Questions	Type of Answer Needed (Descriptive, Comparative, Cause & Effect)	Data Collection Methods	Data Sources	Sampling or Selection Criteria	Data Analysis Methods
MSH-ProACT and its partners have implemented that could be adopted and scaled up in the PEPFAR program.					

B. Data Analysis Methods

The type of analysis required will vary depending on the purpose, evaluation questions, methods used in the data collection, the complexity of the evaluation design, and the type of programmatic and managerial decisions to be made. Analysis of the data using descriptive and inferential statistics will involve computation, as needed, of averages, means, standard deviation and tables and graphs to present the evaluation findings. Content analysis will be the primary method of qualitative data analysis.

C. Methodological Strengths and Limitations

The methodology strength lies in the various stakeholders that are going to be contacted. This will give various inputs in to the evaluation findings especially with regards to synergy between implementation partners and possible modification of activities that are being implemented. Key limitations include sampling methodology and budget constraints.

5. EVALUATION PRODUCTS

A. Deliverables

The following deliverables will be submitted to USAID Nigeria. The timeline for submission of deliverables will be finalized and agreed upon during the team planning meeting:

1. Team Planning Meeting: the evaluation team will conduct a team planning meeting, which will include a meeting with USAID/Nigeria and NMEMS II Project staff to discuss the scope of work, and finalize the evaluation questions, methods, deliverables, and timeline. The outcome of the team planning meeting will be an **approved work plan** for the evaluation. The work plan will include,

but not limited to, a timeline for key activities, due dates for deliverables, and schedules for key informant interviews, site visits, and debriefing meetings.

2. A Debriefing will be organized for the team leader and the team to present key highlights of the evaluation findings to USAID staff using a PowerPoint presentation format. The team leader is expected to lead the debriefing on the date and time agreed to by USAID/Nigeria. The Team will consider USAID comments and revise the draft report accordingly, as appropriate.
3. A Draft report (in both hard and electronic formats) will be submitted by the team leader to USAID/Nigeria for review and feedback
The report will provide a comprehensive assessment of the strengths and weaknesses of the LMS ProACT project; identify successes and achievements, including what worked and what did not work. The report should also include recommendations that will both provide guidance for USAID/Nigeria to make decisions on future programming directions and for MSH in implementation of the remaining part of the project. . USAID/Nigeria will provide comments on the draft report within 10 working days of receiving the document.
4. Final report in both hard (**6 copies**) and electronic format. The team leader should submit a final report within 10 working days after receiving written feedback from USAID/Nigeria. Findings will be shared with LMS ProACT and will be sent to USAID's Development Experience Clearing House.

B. Reporting Guidelines

The format for the evaluation report is as follows (number of pages is illustrative):

- Executive Summary (2 pp.)
- Table of Contents (1 pp.)
- Introduction (1 pp.)
- Background (2-3 pp.)
- Methodology (1 pp.)
- Findings and Conclusions (17- 20 pp.)
- Issues and Challenges (5 pp.)
- Recommendations/Future Directions (10 pp.)
- References
- Annexes

6. TEAM COMPOSTITION

The evaluation team will comprise One international consultants and One local consultants. The team is expected to divide the evaluation tasks in order to maximize the available time and to ensure that all aspects of the project (monetization, partner relationships, project implementation, etc.) are covered in the evaluation.

The **Team (International) Leader** and his/her deputy will have the overall responsibility for the administration of the final evaluation. They will specifically undertake the following:

Technical:

- a) Train all the supervisors and data collectors on FGD and KII methodologies
- b) Design and develop all data collection instruments and guides
- c) Supervise field administration of all data collection instruments.
- d) Supervise the data entry and analysis process.

Preparations:

- a) Finalize and negotiate the team work plan with the client.
- b) Establish roles, responsibilities, and tasks for each team member.

Management:

- a) Facilitate preparations and agenda for the TPM.
- b) Take the lead on preparing, coordinating team member inputs (submitting, revising and finalizing their assignment report).
- c) Manage report writing process.
- d) Manage team field coordination meetings.
- e) Coordinate all workflow and tasks to ensure the team is working on schedule.

Communications:

- a) Manage team conflicts.
- b) Serve as primary interface with the client and spokesperson for the team.
- c) Keep NMEMS II staff apprised of challenges to progress, work changes, team travel plans in the field, and report preparation via phone conversation or email
- d) Serve as primary interface with USAID/NMEMS II for the submission of draft and final reports/deliverables.

Make decisions about the safety and security of the team, in consultation with USAID/Nigeria and NMEMS II.

The Team Leader position qualifications are:

- a) More than 10 years experience working in the field of HIV/AIDS prevention, care and treatment programs and services.
- b) Post graduate degree in medicine, public health or a related discipline.
- c) Excellent understanding of evaluation methodology, as well as a good understanding of project administration and management skills, including USAID program management.
- d) Excellent writing and communication skills.
- e) Past experience in leading a team for health project evaluations or related assignments.

The local consultant's qualifications are:

- a. In-depth understanding of HIV/AIDS prevention, care and treatment programs and services in a public health context.
- b. Proven evaluation skills such as sampling, participatory evaluation methodology, appreciative enquiry methods, focus group interviews, etc A basic degree in health or related discipline. Post graduate degree in health education with emphasis on HIV is desirable.
- c. Individual(s) with an in-depth understanding of USAID and PEPFAR procedures and reporting frameworks.
- d. Excellent communication and interpersonal skills.

Other team members will primarily comprise of NMEMS II staff and depending on their availability, USAID and other USG & GON stakeholders may participate in some aspects of the evaluation- and two (2) independent data collectors.

The level of effort (LOE) for the international consultants, the local consultants and data collectors is indicated in Table 2

Table 2: Level of Effort (LOE) (Work days)¹⁵

Tasks	International Consultants	Local Consultants	Data Collectors and entry clerks
Travel Time for International Consultant Team Leader	4		
Review of Project documents and USAID-NMEMS II consultations	3	3	
Hold team planning meetings ; develop evaluation work plan and timeline; develop data collection instruments and list of people to be interviewed, data analysis methods, report outline; and finalize logistical/administrative arrangements	3	3	
Conduct field visit for data collection and interviews (TL, LC and 2 data collectors)	8	8	8
Review data collected, analyze and prepare a presentation and debrief for USAID/Nigeria and FMOH, NACA and SACA.	5	5	
Finalize report	3		
Total	26	19	8

7. EVALUATION MANAGEMENT

A. Logistics

¹⁵ Activities could occur simultaneously

The Evaluation Team will work under the technical direction of USAID/Nigeria, the client.

USAID/Nigeria will:

- Provide names and contact information for possible evaluation team members to NMEMS II and consult with USAID's Evaluation Officer and NMEMS II on final selections - approve final team composition and members;
- Approve final evaluation scope of work and final evaluation report;
- On being provided by NMEMS II with names and arrival dates of selected evaluation team members, approve country clearances for team members and approve all subsequent internal travel by road and air by team members – this is particularly important given security concerns – also keep NMEMS II and Team Leader informed regarding security or other travel concerns;
- Through NMEMS II, provide the evaluation team with USAID, GON, MSH and other essential contacts and contact information, and facilitate initial and subsequent communications and introductions;
- Through NMEMS II, provide the evaluation team with background documents and project documentation;
- If travel by USAID and NMEMS II staff to the north is permitted, provide guidance regarding their participation in the evaluation.

NMEMS III Roles and Responsibilities (in collaboration with USAID/Nigeria)

- Submit suitable evaluation team members to USAID
- Contract with the team members and the administrative/clerical/logistics assistant
- Logistics: Coordinate all assignment-related expenses for their consultants incurred in carrying out this review including travel, transportation, lodging, and communication costs, etc.
- Brief the team on external evaluation requirements and work with USAID to answer any questions
- Organizing meetings: Working with USAID, assist team in arranging key meetings and appointments
- Ensure Team Leader and members meet the requirements of the external evaluation scope of work and their contracts, including timely submissions of draft and final evaluations
- Consult USAID and approve any necessary changes to the evaluation team's work plan and travel and consultations schedules

In the first instance, the Team Leader will communicate with NMEMS II on arrangements and direction of the evaluation. If needed, however, the Team Leader may contact USAID/HIV/AIDS & TB Team directly.

B. Scheduling

The schedule for the evaluation will involve three categories of tasks as outlined in Table 3

Task	Schedule
Pre-field Travel Tasks	
Review project documents and reports	May

Design evaluation framework	May
Develop data collection tools	May
Identify sample to be interviewed	May
Develop a schedule for data collection	May
Field Tasks:	
Review additional project documents and reports; meetings in Abuja	May
Visit field sites and interview beneficiaries and other key stakeholders	May
Review data collected and draft report	May
Send out first draft of report	May
Presentation/debrief to USAID/NMEMS II	May
Presentation/debrief to Other key stakeholder	June
Post-field Travel Tasks	
Review report and address comments	June
Finalize report and submit	June

Appendix 1: Detailed evaluation questions

Additional questions to be addressed include, but are not limited to (these are illustrative and will be finalized by the team during the TPM):

1. To what extent has LMS ProACT activities being implemented been integrated in the health care system delivery in the targeted areas?

- What has been the project's level of performance on set targets?
- To what extent has the project contributed towards furthering the goal of PEPFAR Nigeria?
- To what extent has the project been innovative and creative in its approach to program implementation
- How sustainable are the project's activities

2. To what extent have the capacity building efforts by LMS ProACT project contributed to the overall performance and sustainability of the delivery of comprehensive HIV/AIDS prevention, care & treatment and TB services?

- To what extent have the capacity of LGs been developed to decentralize HIV services to PHC?
- What is the organizational capacity of selected sites to deliver effective care and to deliver care with less USG support and more GoN support?
- To what extent has the capacity building efforts of LMS ProACT through fixed-cost small grants contribute to the CBOs overall performance and sustainability of the delivery of HIV/AIDS services (prevention, care & support & OVC) linked with health facilities in the selected communities of the project states?
- To what extent has the capacity of CBOs been developed through fixed-cost small grants and how has these capacity building efforts contribute to the CBOs overall performance and sustainability of the delivery of HIV/AIDS services (prevention, care & support & OVC)?
- To what extent did the capacity building efforts of LMS ProACT through the use of modified MSH Leadership Development Program (LDP) and other MSH tools contribute to the SMOHs, SACAs, LACAs

and health-facility teams overall capacity to lead, manage and sustain HIV/AIDS prevention, care and treatment services.

3. Is the project's management systems and procedures facilitating the achievement of expected outcomes and overall project goal?

How effective and efficient was the project's organizational and management structure in achieving results?

- To what extent was the project management team responsive and accountable to its client (i.e. USAID/Nigeria) and key partners (i.e. Axios Foundation, GoN (FMoH, NACA, SACA), and CBOs and non-governmental organizations including networks of PLWHA support groups)? What could have been done to make the partnership more effective?
- Were the systems developed by the project for monitoring, evaluation, and knowledge application effective? How have these elements of the program supported the achievement of the overall project objective?
- If specific targets set on performance indicators were not met, why was this the case?
- How effective was USAID in managing the project?

7. Which projects' intervention (s) had the most comparative cost advantage in implementation?

- Are there any demonstrations of cost-effectiveness in project implementation?
- What are some more cost efficient and effective approaches for achieving the results (evaluate from both a short and long-term perspective)?

8. What is the extent of beneficiaries' satisfaction on the project intervention interventions?

9. What are the project's major challenges and lessons learned so far?

- What specific technical approaches or outputs have demonstrated the greatest result?
- What are the factors that contributed to or hindered progress towards achieving results, including those linked to program design, implementation, management and partnerships?
- What issues and gaps have had significant effect on sustainability?
- What strategies are needed to further strengthen the efficiency, effectiveness, management and sustainability of the project?

- What components of the LMS ProACT project strategy should be maintained in their current form? What components should be retained, but modified? Are there components or approaches that are no longer needed?
- What are some promising new developments in the area of HIV care and support of PLWHA that should be explored in possibly future activities?

Documents Reviewed

The ProACT Project

Revised technical application final

Management Science for Health

Nigeria's AIDs Treatment and Care Follow on

July 7 2009

The ProACT Project Quarterly Reports

Management Science for Health

Nigeria's AIDs Treatment and Care Follow on Project

MSH ProACT quarterly report for January –March 2012

MSH ProACT quarterly report for April-June 2012

MSH ProACT quarterly report for April-June 11_final

MSH ProACT quarterly report for Jan-Mar 2011.docx

MSH ProACT quarterly report for July-Sept 11 final

MSH ProACT Workplan 2010-2011 2011-12

MSH ProACT PMP 12_7_12

MSH pro-act pmp 09-29-2009

Overview of MEMS DQA Process.docx

MSH ProACT DQA Report Formatted 15062011

Copy of MEMS DQA- Team comments copy

All available CQI Quarterly reports from states including:

REPORT OF QUALITY SYSTEMS ASSESSMENT TA VISIT TO KOGI STATE HELD FROM SEPTEMBER 14 - 24, 2008

TB HIV facility Performance Q2 2011

TRIP REPORT MSH Sites Kogi Kwara Dec 2011

MSH ProACT Grantee Assessment Kogi and Taraba states June 11

Report on the status of the Nigerian National HIV Monitoring and Evaluation System

Assessment Using 12 Component Systems Strengthening Tool

Capacity Tool 2010 Measure Evaluation

Improving the Health Status of Women and Children through the Scale-Up of BEST Practices in the Home, Community and Facility

USAID/NIGERIA BEST Action Plan 3/27/2011

MID-TERM/OUTCOME EVALUATION UNDP NIGERIA COUNTRY PROGRAMME ACTION PLAN (CPAP) 2009 – 2012 GOVERNANCE OF HIV AND AIDS

SUBMITTED BY Prof. Umaru Pate PhD. OMunirat Ogunlayi

Government of Nigeria HIV/AIDS National Strategic Framework for Action (2005-2009)

Government of Nigeria HIV/AIDS National Strategic Framework for Action 2010-2015UN

United Nations General Assembly Special Session special report (UNGASS) on Nigeria NATIONAL AGENCY FOR THE CONTROL OF AIDS

REPORTING PERIOD: JANUARY 2008–DECEMBER 2009

Roadmap towards repositioning the HIV/AIDS M&E system in Nigeria

August 2008

Product from a workshop with states supported by Strengthening Nigeria's Response to HIV/AIDS (SNR). SNR is a 5 year DFID funded Programme managed by FHI, ActionAid and VSO.

AIDSTAR-One Case Study. Nigeria's Mixed Epidemic/ Balancing Prevention Priorities Between Populations

(Prof R Beaglehole DSc, Prof R Bonita PhD) Coming to terms with Complexity www.thelancet.com Vol372 December6, 2008

[Federal Republic of NIGERIA - UNAids](#)

www.unaids.org/.../Nigeria%202012%20GARPR%20Report%20Revi...

NATIONAL AGENCY FOR THE CONTROL OF AIDS (NACA). 2012. Federal Republic of. **NIGERIA**. GLOBAL AIDS RESPONSE. Country Progress Report ...

CUBs Report Developing a Program Framework Approach to Activities to address the vulnerability of girls young women and female headed households within the context of OVC and risk reduction july 2010 USAID MSH AFRICARE

DEVELOPING SUSTAINABILITY: A NEW METAPHOR FOR PROGRESS Theoretical Medicine and Bioethics (2006) 27: 59–79 Ó Springer 2006 DOI: 10.1007/s11017-005-5754-1authors CE' CILE M. BENSIMON and SOLOMON R. BENATAR

UNAIDS Three Ones Guiding Principles for National AIDS Strategies

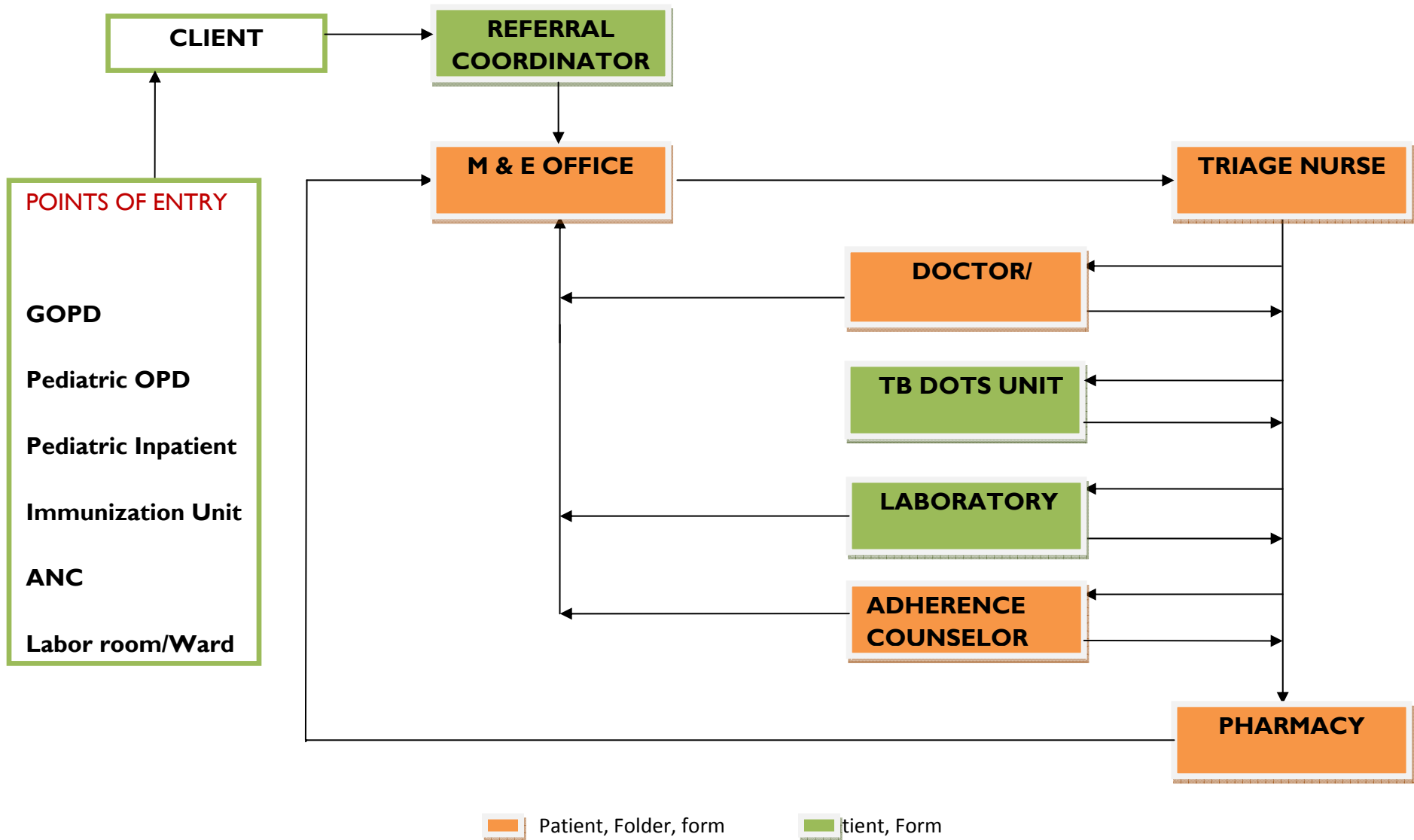
http://data.unaids.org/una-docs/three-ones_keyprinciples_en.pdf

Economic Analysis of ProACT Fiscal Year 2011 Expenditure from a Program Perspective. Prepared by Ikenyei Uche for the MSH LMS ProACT M&E Team.

Abuja Transcripts (separate zip files)

Koji

Taraba



MSH NIGERIA Program Sites



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