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Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS) Project

Mid-term Evaluation Final Report

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List of Acronyms

AHNI	Achieving Health Nigeria Initiative
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
AOP	Annual Operational Plan
AOR	Agreement Officer Representative
ARFH	Association for Reproductive and Family Health
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
CD4	Cluster of Differentiation 4
CDC	Center for Diseases Control
CHAI	Clinton Health Access Initiative
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
DBS	Dried Blood Spot
DEC	Development Experience Clearinghouse
DFID	UK Department For International Development
DHIS	District Health Information System
DOTS	Directly Observed Therapy Shortcourse
DPRS	Department of Planning, Research and Statistics
DR-TB	Drug-Resistant Tuberculosis
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother-To-Child-Transmission
FCT	Federal Capital Territory
FGD	Focus Group Discussion
FHI 360	Family Health International 360
FMOH	Federal Ministry of Health
GF	Global Fund
GHAIn	Global HIV/AIDS Initiative Nigeria
GHI	Global Health Initiative
GLRA	German Leprosy and TB Relief Association
GON	Government Of Nigeria
HAART	Highly Active Antiretroviral Therapy
HFG	Health and Finance Governance
HIV	Human Immuno-Virus
HMIS	Health Management Information System
HPCC	Health Partners Coordinating Committee
HR	Human Resource
HRH	Human Resources for Health
HSS	Health System Strengthening
HTC	HIV Testing and Counseling
HU-PACE	Howard University Pharmacists And Continuing Education Center
IDI	In-Depth Interview

IEC	Information, Education and Communication
IHDMT	Integrated Health Data Management Team
IPT	Intermittent Preventive Treatment
KII	Key Informant Interview
LACA	Local Agency for the Control of AIDS
LAMIS	Logistic Management Information System
LGA	Local Government Area
LIT	Local Implementation Team
LLIN	Long-Lasting Insecticide Net
LOE	Level of Efforts
M&E	Monitoring and Evaluation
MDAs	Ministries, Departments, and Agencies
MEMS II	Monitoring and Evaluation Management Services II
MNCH	Maternal, Neonatal & Child Health
MoV	Means of Verification
MSH	Management Sciences for Health
NACA	National Agency for the Control of AIDS
NASCP	National AIDS and STIs Control Program
NGO	Non-Governmental Organization
NNRIMS	Nigeria National Response Information Management System
NSP	National HIV/AIDS Strategic Plan
OI	Opportunistic Infections
OPD	Out-Patient Department
OR	Operations Research
OVC	Orphans and Vulnerable Children
PABA	People Affected By AIDS
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan For AIDS Relief
PHC	Primary Health Care
PITT	Prevention Intervention Tracking Tool
PLHIV	Person Living With HIV
PMP	Performance Management Plan
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public-Private Partnership
QA	Quality Assurance
RH	Reproductive Health
SACA	State Agency for the Control of AIDS
SASCP	State AIDS and STIs Control Program
SIDHAS	Strengthening Integrated Delivery of HIV/AIDS Services
SIT	State Implementation Team
SMOH	State Ministry of Health
SMT	State Management Team
SOP	Standard Operating Procedure
SOW	Scope Of Work

SPHCMB	State Primary Health Care Management Board
TA	Technical Assistance
TB	Tuberculosis
TB/DOTS	TB Directly Observed Treatment, Short-course
TBAs	Traditional Birth Attendants
TOT	Training Of Trainers
TPM	Team Planning Meeting
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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- Chief of Party and staff of the SIDHAS project
- Governments of Akwa-Ibom, Anambra, Lagos, and Rivers States
- Community/Support Groups visited

EXECUTIVE SUMMARY

Evaluation Purpose

The purpose of the Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS) external mid-term evaluation is to assess the implementation of the five-year project at its mid-point and determine how it has been affected by the President's Emergency Plan for AIDS Relief (PEPFAR) rationalization strategy. The evaluation also addresses the project's likelihood of reaching planned targets; sustaining interventions and performance; and suggests adjustments for the remaining two years. Performance was assessed for each intermediate result (IR), including the quality of HIV and Tuberculosis (TB) services; the integration of services; and the availability of Nigerian resources to sustain the work once the project ends. The evaluation was carried out in Nigeria in four of the SIDHAS Project's fifteen program regions in January and February 2015. The Evaluation Team included international and Nigerian HIV/AIDS, TB, and public health experts.

Project Background

Nigeria has the second highest HIV disease burden in the world (behind South Africa) with an estimated 3.2 million people infected and living with HIV. Nigeria's estimated HIV prevalence is 3.2% (UNAIDS 2013). The country also has the highest TB burden in Africa and one of the highest TB burdens in the world at 311/100,000 population (WHO 2012). Nigeria has made steady progress towards a reduction in HIV incidence and prevalence. The number of people living with HIV (PLHIV) who already need treatment and care, however, poses a continuous challenge for Nigeria's health delivery system. A troubling persistent trend is that the total number of new infections in women continues to surpass that of men with a growth of 20% every year.

SIDHAS was designed to support the Government of Nigeria's (GON) goal to decrease HIV infection rates including prevention of mother-to-child transmission (PMTCT) of HIV and TB as a part of a comprehensive approach to treatment and care for those currently infected and prevention of new infections. SIDHAS has three main objectives: 1) Increase access to high-quality comprehensive HIV/AIDS and TB prevention, diagnosis, treatment, care and related services through improved efficiencies in service delivery; 2) Improve integration of high quality HIV and TB services; and 3) Improve Nigerian stewardship of the provision of comprehensive HIV/AIDS and TB services. SIDHAS is an important element of the United States Government's (USG) HIV/AIDS and TB assistance portfolio. The project builds on the lessons learned from the first generation of USAID HIV/AIDS treatment and care programs, which supported the GON in its rapid nationwide scale-up of HIV/AIDS and TB treatment and care services. The main focus of SIDHAS is to transfer the ownership and sustainability of technical support and financing of HIV/AIDS and TB treatment services to the GON and other Nigerian partners (including the private sector) through capacity building; state-level leadership; greater financial commitments; health systems strengthening specifically for supply chain management of HIV/AIDS and TB

commodities and supplies; the health information management system (HMIS); and improved and sustained quality of care.

Evaluation Questions, Design, Methods, and Limitations

1. To what extent is the SIDHAS Project on course towards achieving its key results?
 - 1a. Did the Project do what was proposed in the cooperative agreement with the appropriate level of inputs and outputs?
 - 1b. How has rationalization impacted the ability of the Project to achieve its results?
 - 1c. Is the project timeframe sufficient to achieve the longer-term results?
 - 1d. Did the Project revise the program framework as experience has been gained through implementation of the intervention?
2. To what extent have specific strategic changes related to PMTCT Scale-up and Public-Private Partnerships impacted project implementation?
3. Have the Project's capacity building efforts contributed to increasing the effectiveness of the GON and CSOs to sustainably provide HIV/AIDS services?
 - 3a. Did participants, both individuals and organizations, apply their learning and with what results?
 - 3b. Does collaboration and cooperation exist between the Project and other implementing partners, donors, and stakeholders and how has this contributed to project implementation?
4. What adjustments in the Project's implementation should be made to enhance its effectiveness and efficiency? Discuss how lessons learned from SIDHAS can help improve the design of future comprehensive HIV/AIDS and TB projects?
 - 4a. Are the internal project management and the relationship with the mission effective for program implementation?
 - 4b. Are there alternative approaches that may have achieved different levels of benefit at the same cost?

Design

The Evaluation Team developed a work plan and methodology and obtained prior approval from the GON and USAID/Nigeria for the sample of HIV and TB facilities in four of the fifteen States where SIDHAS operates. The Team assessed project results against defined PEPFAR targets, assessed the impact of rationalization on reaching the Project's targets, highlighted lessons learned, and provided suggestions for adjustments in the remaining years of the Project.

Methodology

The Evaluation Team used a variety of methods and approaches to address the evaluation questions and the accomplishment of the IRs and indicators found in the SIDHAS Project's Results Framework (RF). The methodology consisted of a desk review and analysis of background materials and secondary sources; a review of project baseline data and health facility reports; site visits to eighty-four facilities in four southern States representing 12% of the

total population; and 800 key informant interviews with Federal, State, Local Government, civil society organizations, health facility providers and managers, community groups, and HIV and TB patients. A purposeful stratified sample of facilities was used to provide the evidence required to address the evaluation questions. Twenty-nine focus group discussions with PLHIV were also carried out. This methodology permitted triangulation of findings from multiple sources.

Findings

Achievement of Key Results: The SIDHAS Project has contributed to increased access to HIV and TB treatment services and improved integration of some of these services in public primary care facilities and is on track to meet most of its service delivery targets. The Project has effectively trained 90% of the providers across the 15 states and strengthened some important elements of the supply chain and HMIS to ensure that HIV and TB drugs are stocked and available for patients and that data are reported by States and the Federal HMIS. At the sites visited, the Project did not demonstrate substantial Government of Nigeria leadership and stewardship nor sustained financial commitment to the program once PEPFAR funding ends. The Project is on course to meet its service delivery access targets and needs to work on the next level of HIV and TB service integration, particularly at secondary and tertiary care facilities. The SIDHAS Project can accomplish these objectives within the time allotted. The project will not meet financial sustainability and technical support objectives unless those components are redesigned and negotiated with extensive high-level Nigerian involvement and State Management Teams (SMTs) from each participating SIDHAS State and new approaches to organization-wide quality assurance and systems improved are embraced.

Impact of Rationalization, GON Organizational Changes, and SIDHAS Response: Rationalization with the requirements for rapid scale-up of PMTCT and ART services and the GON-led introduction of SMTs derailed and delayed the SIDHAS team's ability to build capacity and sustainably deliver high-quality services in the four States visited. The GON State organizational shifts led to uncertainty and inaction at the State management level and the Evaluation Team found that rationalization was not well understood—particularly at the facility level. The transition from one USG implementing partner to another and the simultaneous handover of sites from the USG to the Global Fund resulted in a marked disruption in SIDHAS' delivery of its results for ART and PMTCT during FY 2013, the period covering rationalization. The 2014 results showed a recovery from the disruptions caused by rationalization. The Evaluation Team found the SIDHAS team has been highly responsive to these significant policy shifts and the project is on track to meet its service delivery access targets for HIV and TB and expansion of services to the private sector.

Improved Service Delivery and Access: The Project has proven to be highly effective at scaling up and integrating many elements of HIV and TB treatment, diagnosis, and care. Antenatal PMTCT services have been successfully integrated in public sector primary care settings in the four States visited. The Evaluation Team found well-trained providers who are sensitive to the needs of their patients across all four States. Exit interviews indicate that patients are satisfied with their care and are receiving ART and TB treatment on a consistent basis. This fact was confirmed by interviews with focus groups of PLHIV. Overall, the Project has nearly met its

service access targets for the percent of adults and children with HIV receiving ART; has exceeded its HIV testing target for pregnant women; and is on course to meet other PEPFAR service delivery targets related to enrollment of new patients on ART and TB screening.

Improved Integration of Services, PMTCT Scale-up, and Private Providers: The Project has supported some important improvements in the integration of HIV and TB services and has demonstrated progress in many areas of quality of care. HIV counseling and testing (HCT) and antenatal PMTCT services have been integrated into public sector primary care settings in all four States visited. HCT and PMTCT services are offered by public secondary and tertiary care facilities, but the only fully integrated services across the four States at this higher level of service are TB-HIV services. HCT is offered in higher level facilities on a “one stop shop” basis by providers other than those providing clinical care or laboratory services. PMTCT is not yet integrated at the secondary and tertiary level beyond antenatal care and there are major gaps in PMTCT services during delivery and postnatal care. There is room for greater integration of family planning services and in postnatal follow-up of HIV positive mothers and their exposed infants as mother-infant pairs. For functional integration to fully succeed and be sustained over the long-term, integrated services need to be incorporated into the formal MOH in-service training curricula; revised MOH protocols; and to be reviewed and reinforced during MOH supervisory, health inspection, and certification visits.

Effectiveness of Approach to Quality of Care: SIDHAS has adopted a model for continuous quality improvement (CQI) that has been effectively applied by community-based non-profit providers but has not yet been widely applied by the larger public sector, State-led institutions surveyed. The Project has a proven model for the delivery of community-based services with referral links to health facilities that includes involvement of community volunteers in the tracing of persons in HIV and TB treatment who were lost to follow-up using adherence or M&E teams who carry out phone calls and occasional home visits. Many of the volunteers are PLHIV. This model offers excellent potential to address PMTCT in the community and further decentralize directly observed therapy short course (DOTS) to the primary care and community levels. Providers interviewed believe adherence to treatment by their patients is improving and patients report they are satisfied with the quality of care, particularly the compassion of the providers working on treatment and care. The Evaluation Team was not able to independently verify the information on treatment adherence because the SIDHAS project currently does not have access to longitudinal cohort data on treatment adherence or survival necessary to determine whether the expanded HIV and TB treatment and care services are translating into better patient health outcomes. The Project needs to investigate new approaches to system-wide quality assurance and effective and supportive supervision that rewards excellence and supports improvements where barriers to better service are identified. Public sector facilities and comprehensive faith-based facilities are offering a consistently higher quality of care than the limited number of private-for-profit facilities visited; however, evaluators found few facilities having surpassed the basic minimum requirements for quality of care. The training of faith-based staff is unlikely to be sustained by the SMOHs/SASCPs after the end of SIDHAS. Not for profit faith-based services can only continue and expand access if they receive ARVs, reagents and consumables as they cannot source these themselves and their clients cannot afford to pay replacement prices for these items. Additionally, there are many CSOs that have sub-grants and deliver prevention

services—particularly to high risk/vulnerable populations, diagnosis and referral, and home-based care including for orphans and vulnerable children. The CSOs that the evaluation met with were small, some quite nascent, and without the ability to generate income or access funding from elsewhere to sustain their programs after the end of their sub-grants.

Improved Supply Chain Management and HMIS: SIDHAS is facilitating the important link between health facilities and the Central Medical Stores that receive the requests for the resupply of drugs, commodities, and consumables. The Project also calculates restocking needs in order to avoid stock-outs. The laboratories and pharmacies in public sector facilities are better maintained and function with fewer stock-outs than those in the private, for-profit sector. A key area of quality assurance that needs to be strengthened is a lack of secure storage for patient medical records and registers during clinic days. The Evaluation Team found that more needs to be done to develop a culture of service delivery quality improvement in both the public and private facilities. This requires strong leadership and a total organization-wide commitment to quality and accountability for results. While data is now being reported through the HMIS the HIV and TB treatment sites need to make better use of the data to make improvements in services. The Evaluation Team saw some excellent examples of nursing staff using the data to reorient services and improve performance. This approach needs to be shared and used as the platform for a culture of continuous quality improvement.

Improved Stewardship and Sustainability of High-Quality Comprehensive HIV/AIDS and TB Services: Based on the review of the performance of the four States visited, the Project has not met its stewardship, ownership, and sustainability objectives. One of the key outcomes expected from the SIDHAS project is strong leadership, governance, and ownership by the SMOH and the LGAs to lead, manage, and coordinate HIV and TB programs at the State and local levels. This leadership is a prerequisite for improved, more efficient systems to sustain HIV and TB programs. Leadership and expertise in advocacy is also required to ensure greater commitment of financial resources and staff to sustain programs after SIDHAS funding and technical assistance ends. The organizational shift made by the GON from State Implementation Teams (SITs) overseeing HIV and TB programs at the State level to State Management Teams (SMTs) delayed SIDHAS' planned organizational development work as the lines of authority shifted. Consequently, there are no handover plans or comprehensive sustainability plans in the four States surveyed. Despite the presence of co-located SIDHAS technical assistance in some States, technical supervision of HIV and TB programs by SIDHAS with the SMOH is sporadic. In terms of strengthening key systems, there is evidence that the Project has supported improvements in assuring the resupply of life-saving HIV pharmaceutical diagnosis and treatment drugs, commodities, and supplies at the facility level. Patients report that they rarely experience any problems in the timely receipt of their medication. While, the SIDHAS project has strengthened the production and dissemination of essential data from the HMIS at the State level for use at the Federal level, the Project has not effectively trained SMT/SIT managers and health providers how to routinely use and apply this data for technical and management decision-making.

Effective Capacity Building: The Project-supported technical capacity building for health providers has led to well-trained clinicians with up-to-date knowledge. The Project has done a good job of engaging, mobilizing, and training private sector providers and facility managers, a

key target for SIDHAS. A consistent finding by the Evaluation Team across all four States is that the Project's approach to capacity building for key management skills, including financial management and budgeting, has been highly effective for CBOs and CSOs but has not been applied systematically in the public health facilities, including SITS and SMTs. The capacity building approach has been geared more toward addressing improvements in each individual's skills rather than organizational development. This approach has, therefore, not advanced the Project's overall goal of institution building.

Suggested Adjustments, Lessons Learned and Alternative Approaches for the Remainder of the Project:

The Project needs to fully integrate HIV and TB services by addressing the key gaps where integration opportunities are being missed. Important target groups missed are women following delivery; postnatal HIV positive women and newborn pairs; men; and non-pregnant women. Assuring that family planning services are offered to HIV and TB patients and that routine testing for HIV and TB is offered to family planning clients should be top priorities and will advance service delivery access and improve cross-sector performance objectives. A key lesson learned is that better use of the HMIS platform for decision-making is critical to making quality improvements and moving average services to above average and above average services to excellent care. The SIDHAS Project's third key result (KR3), which includes sustainability planning, leadership, governance, ownership, and capacity building, needs to be rethought and renegotiated with the GON. Clear agreements need to be reached on GON and USG expectations including the expected role the private sector should play in service provision in the future. USAID may want to assign staff in each State to oversee these agreements and advance state-level partnerships. This may require a redesign of this component of the Project. The redesign should be led by the GON and draw upon best practices gleaned in the SIDHAS Project in the two States where there has been a successful handover to the SMOH of all technical and financial support to HIV and TB services and other successful health sector development projects. The project should support effective networking between successful graduating states and others which are moving towards this objective. Sustainability plans, training, and capacity development plans should be linked to these overall agreements. In order to assess the financial viability of alternative service delivery approaches the project needs to document costs per patient served for the delivery of HIV and TB treatment and care services. This is an important element for the future sustainability strategy for each state and should be incorporated into the state-level sustainability plans. The most cost-effective alternatives for delivery systems need to be determined. This may not be the same for each state. Costs should be obtained for the delivery of care through the private sector to determine if contracting out some services to the private sector in the long-term might present a cost-effective alternative or significant complement to public sector service delivery.

Conclusions

The Project has proven to be highly effective at scaling up and integrating many elements of HIV and TB treatment, diagnosis, and care including well-trained providers who are sensitive to the needs of their patients. Despite the setbacks from rationalization and other organizational and policy changes, the Project has met or is on track to meet its scale-up targets for expanded access to PMTCT, ART, and TB services. The supply chain is adequate and operational in most of the facilities surveyed and SIDHAS has played a role in strengthening this system. The HMIS is

producing more streamlined and consistent data and better reporting. The Project's model for service delivery includes an important link to CSOs and volunteers. The lack of integration of PMTCT into postnatal services seriously compromises elimination of pediatric AIDS in Nigeria. The lack of readily available family planning at HIV and TB treatment sites for PLHIV and TB is also a serious problem which can be readily addressed. Functional integration of total services needs to be improved. Integration is a long-term process and in-service training, revising protocols, reinforcing integration through certification and supervisory visits are required for integration to fully succeed.

A better balance is needed between increasing access and improving quality and comprehensive services. Currently, the Project's emphasis appears to be on increasing access. More care and effort needs to be placed on improving quality and comprehensive services and creating a culture of service delivery quality improvement which focuses on the client; teamwork; use of data for improving service delivery; and seeking more efficient and cost effective service delivery. Best practices of higher performing facilities need to be replicated across the Project. PMTCT and HCT scale-up in the private, for-profit sector is important as the private sector delivers 60% of antenatal care in the country. This process has met challenges in terms of the quality and consistency of service delivery and reporting, which need further effort for resolution.

Current public health HIV and TB treatment programs are not structured for sustainability. Sustainability is not solely a SIDHAS function. USAID and PEPFAR also have important responsibilities. Lack of political will appears to be the principle source of the issues regarding sustainability. Unless State governments are willing now and in the future to fund and support high-quality comprehensive HIV/AIDS and TB programs, no single project will have a long-term impact. USAID needs to take a more direct role with national and State political leaders and develop strategies for sustainability. These strategies should contain information on costs of service provision through various public private sector partnerships. This is probably not something that can be done solely at the technical level. Senior USAID management needs to take the leading role in these discussions. This could be done in cooperation with the Council General in Lagos for the four focal States. If there is not adequate support at the political level, States should be dropped, or USAID should recognize that long-term impact measures related to sustainability, leadership and governance will not be met during the life of this Project and will take much more time.

The SIDHAS model for community HIV activity—CBOs support volunteers that link communities to facilities—has potential for expansion, with the inclusion of mentor mothers, to improve PMTCT, crucially including postnatal PMTCT, in the community. The SIDHAS model for capacity building has not focused enough on institution-wide, organizational strengthening and supportive supervision and follow-up by the regions and districts. Supervision and accountability for results and positive recognition for results needs to take place but is currently sporadic. The SIDHAS Team includes organizational development capacity building, community linkages, resource development, and M&E expertise. A careful assessment by the GON/USAID needs to be made if the actual long and short-term technical assistance requirements of the HIV and TB services are being adequately met by the SIDHAS model, or should be modified and more tailored to specific State needs.

SIDHAS has invested heavily in HMIS technology and computer applications and less so in training the facility staff to use the data to do their work. The HMIS data currently collected is not routinely used by facility managers, providers, or state MOH officials for key management and clinical decisions, including financing services. There are some excellent examples of nursing staff trained by the SIDHAS project using data to drive service improvements. This should be a model encouraged and promoted across the program. Data are, however, being reported more effectively up the chain of command and this is a major improvement leading to better national case reports.

One of the key outcomes expected from the SIDHAS project is strong leadership and governance structures at the State level to manage HIV and TB programs. The evaluation found that there are no systematic SIDHAS-supported leadership plans in place to move toward that objective. A careful assessment needs to be made of the best practices in leadership development, which have shown positive results in other sectors and in neighboring countries.

Stigma and discrimination continue to be a problem across the States surveyed and are likely to be problematic nationwide. Support groups are an important outlet for PLHIV and are an excellent tool to promote adherence to HIV and TB treatment regimens. The SMTs must address the employment discrimination that PLHIV face.

Recommendations

1. The USG, SIDHAS, Nigerian officials at the national and State level, CBOs, and private care providers need to develop a plan of action to operationalize this evaluation's findings and conclusions in terms of service delivery, integration and improved stewardship. The evaluation report can serve as a focus for wide discussion of ways to improve performance. Lessons learned from successful programs in States should be incorporated into plans. Visits to these States should be undertaken to see what works and to develop workable networks with successful officials.
2. USAID should develop Strategic Frameworks with each State which outline key expectations of both the GON and the USG for SIDHAS objectives. These agreements could describe the objectives, activities, and resources to be provided by both parties as defined in the Action Plans. Duties and responsibilities of the State should include: identifying and providing funding; co-financing for training and local government support from State budgets; identifying and supporting key state, local, and private sector entities involved in the project; ensuring funding to LGAs from the Joint State/LGA account; and development and phased implementation of funded State Sustainability Plans linked to State Handover Plans. Implementation of the Strategic Frameworks would be monitored by USAID staff. It is recommended that the USAID Mission Director and Governors meet annually to discuss progress and resolve issues.
3. The Project needs to research and adopt a different approach to leadership and governance, which provides incentives to attract and retain outstanding administrative and technical talent to work on the very sensitive area of HIV and TB program management. Experience from high-performing States should be documented and these States should lead the work on this critical component. Incentives and recognition for excellent leadership as well as barriers to effective leadership, including salaries and benefits, must be addressed.

4. The support for PLHIV might be deepened in the next two years with some attention to linking support groups with small businesses and sympathetic, supportive employers.
5. The Project needs to ensure that patient retention rates and survivability are measured to evaluate the ultimate success of SIDHAS on improving health outcomes. Obtaining reliable longitudinal HIV and TB patient cohort data should be a priority for PEPFAR funding and could be carried out and led by the GON with either SIDHAS project funding or other PEPFAR program funds.
6. In order to move HIV and TB treatment sites from simply meeting minimum standards toward a standard of excellence, a focus on the client and teamwork must be instilled. In the remaining two years, SIDHAS should work with the SMTs/SITS to specifically identify new clinical and management leadership trained in quality assurance and leading high-performing teams. The service quality improvement process should be incentivized from the state level with recognition and awards for facilities with better than average performance and those that show the greatest improvement in service quality. The GON and SIDHAS can benefit from the experience of other countries in the region.
7. While the HMIS is fully operational, the next very critical step is to ensure that health facility managers, providers, and supervisors have the skills to use and apply the data for their management and patient care decisions. On-the-job training on the use of data for decision-making should be carried out. The shift in orientation on HMIS work should begin as soon as possible so that the GON can fully benefit from the presence of the SIDHAS HMIS technical assistance.

EVALUATION PURPOSE & EVALUATION QUESTIONS

EVALUATION PURPOSE

The purpose of the Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS) mid-term evaluation is to assess the implementation of the five-year project at its mid-point as well as determine how it has been affected by the President's Emergency Plan for AIDS Relief (PEPFAR) rationalization strategy. The evaluation also addresses the project's likelihood of reaching planned targets; sustaining interventions and performance; and suggests adjustments for the remaining two years. Performance was assessed for each intermediate result (IR), including the quality of HIV and Tuberculosis (TB) services; the integration of services; and the availability of Nigerian resources to sustain the work once the project ends.

The SIDHAS Project was launched on September 12, 2011 and runs until September 11, 2016. The Project is led by Family Health International (FHI) 360 with a team of Nigerian and international partners. The Project initially covered all 36 States and the Federal Capital Territory (FCT), but was modified by USAID in July 2013 to cover 15 states and the FCT as part of a United States Government (USG) portfolio-wide rationalization process of its HIV/AIDS and tuberculosis (TB) programs, funded under PEPFAR. The overall vision for rationalization was to improve programmatic outcomes and accountability through geographical consolidation, and create a more locally manageable package of clinical services to transition to the Government of Nigeria (GON). The evaluation findings will be used to make mid-course corrections and help guide implementation during the second half of the project as well as to inform future project design. The primary users of the mid-term evaluation are USAID/Nigeria, USG implementing partners, and other stakeholders. This evaluation may also be used to inform future strategies for other similar programs.

EVALUATION QUESTIONS

The mid-term evaluation will seek answers to the following four questions:

1. To what extent is the SIDHAS Project on course towards achieving its key results?
 - 1a. Did the Project do what was proposed in the cooperative agreement with the appropriate level of inputs and outputs?
 - 1b. How has rationalization impacted the ability of the Project to achieve its results?
 - 1c. Is the project timeframe sufficient to achieve the longer-term results?

- 1d. Did the Project revise the program framework as experience has been gained through implementation of the intervention?
2. To what extent have specific strategic changes related to PMTCT scale-up and Public-Private Partnerships impacted project implementation?
3. Have the Project's capacity building efforts contributed to increasing the effectiveness of the GON and CSOs to sustainably provide HIV/AIDS services?
- 3a. Did participants, both individuals and organizations, apply their learning and with what results?
- 3b. Does collaboration and cooperation exist between the Project and other implementing partners, donors, and stakeholders and how has this contributed to project implementation?
4. What adjustments in the Project's implementation should be made to enhance its effectiveness and efficiency? Discuss how lessons learned from SIDHAS can help improve the design of future comprehensive HIV/AIDS and TB projects?
- 4a. Are the internal project management and the relationship with the mission effective for program implementation?
- 4b. Are there alternative approaches that may have achieved different levels of benefit at the same cost?

PROJECT BACKGROUND

The Development Context

The combination of a large population (173 million) and estimated HIV prevalence of 3.2% (UNAIDS, 2013) result in an estimated 3.2 million people infected with HIV in Nigeria. In addition, the country has one of the highest tuberculosis (TB) burdens (311/100,000 population, (WHO 2012) in the world and the largest TB burden in Africa. Many TB cases go undetected, resulting in high rates of TB/HIV co-infection which is costly and complicated to treat.

Nigeria has a generalized HIV epidemic; however, prevalence varies widely across States and rural and urban areas. Concentrated epidemics occur in particular geographic regions and within certain segments of the population. Four of the States located in the South-South geo-political zone have seven percent or higher estimated prevalence while none of the States from the South-West and the North East zones have comparable prevalence rates. Nigeria's epidemic is largely fueled by heterosexual and mother-to-child transmission. The main driver of the HIV epidemic is a high rate of multiple, concurrent sexual partners and low and inconsistent condom use. Other key factors contributing to HIV prevalence are informal transactional and cross-generational sex. Lack of effective services for diagnosis and treatment of sexually transmitted infections (STIs) with late detection and poor quality of health services aggravate the problem. Gender inequalities, poverty, and HIV/AIDS-related stigma and discrimination also contribute to the continuing spread of the infection. While the majority of new HIV infections occur among adults above the age of 25, a large proportion occurs among young women and adolescent girls; adolescent boys and young men are also impacted. In Nigeria, HIV prevalence among adolescent boys aged 15–19 years was already 2.9% according to a Nigerian national HIV and reproductive health survey from 2012. The age group 30–34 has the highest HIV prevalence.

Nigeria has the second highest HIV disease burden in the world (behind South Africa). Overall, the country is making steady progress towards reduction in the HIV incidence, prevalence and the number of people living with HIV (PLHIV). Recent estimates indicate that the annual number of new infections in the country has been on a slow, but steady decline between 2009 and 2013. The decline in new infections was 24% during this period: decreasing from 288,870 in 2009 to 274,367 in 2011. Similarly, the number of PLHIV decreased from 239,706 in 2012 to 220,394 in 2013. Prevalence has declined from 4.3% in 2009 to 3.2% by 2013: a 26% decline. Nonetheless, HIV and TB continue to be compelling public health and development problems for Nigeria. A troubling persistent trend is that the total number of new infections in women continues to surpass that of men with a growth of 20% every year. This was a key reason the GON sought to intensify its strategy to prevent the epidemic's spread to women and children by effectively preventing mother-to-child transmission (PMTCT).

The SIDHAS Project

The USG's objective is to support the Government of Nigeria's goal to decrease rates of HIV through an intensified, comprehensive response to the epidemic which includes treatment and care for those currently infected and prevention of new infections.

The goal of SIDHAS is to sustain cross-sectional integration of HIV/AIDS and TB services in Nigeria by building Nigerian capacity to deliver sustainable, high-quality, comprehensive prevention, treatment, care, and related services. The SIDHAS Development Hypothesis is if support is provided to the GON, civil society organizations (CSOs), and communities to implement continuous quality improvement plans and interventions in an integrated manner at all levels' and if the health system, technical, financial and institutional management capacity for implementing high quality HIV/AIDS service deliver are strengthened, then access to high-quality HIV/AIDS services will be increased.

The SIDHAS results framework on page 11 depicts both the service delivery and health systems strengthening objectives directly linked to improving HIV/AIDS and TB services. USAID's Health Sector Development Objective (DO); the Intermediate Results (IRs) and Sub-IRs; and indicators are the framework upon which this evaluation was developed and conducted.

SIDHAS is the second generation of HIV/AIDS prevention and treatment services funded by USAID/Nigeria through PEPFAR. The first generation program, GHAIN, also led by FHI, ran until 2010, and was designed to deliver the rapid scale-up of HIV/AIDS and TB services. SIDHAS represented a major shift in focus from GHAIN towards greater institution and capacity building from direct service delivery provision. The main focus of SIDHAS is to transfer the ownership and sustainability of HIV/AIDS and TB treatment services to the GON and other Nigerian partners, including the private sector through capacity building; state-level leadership; greater financial commitments; health systems strengthening specifically for supply chain management of HIV/AIDS and TB commodities and supplies; the health information management system (HMIS); and improved and sustained quality of care.

The SIDHAS cooperative agreement was modified in July 2013, as a result of rationalization objectives, but also in direct response to the GON's Presidential Comprehensive Response Plan (PCRP), issued in 2011, which called for a massive scale-up by the government in the provision of antiretroviral treatment (ART) to pregnant women and domestic investment in HIV to rise 73% overall. The modification increased SIDHAS' service delivery, outreach, and testing targets from 252,000 people on treatment to 325,000; from 1.7 million pregnant women tested for HIV to 3 million; and from 41,220 HIV-positive pregnant women provided with ARV prophylaxis to 90,000. In addition, 125 new USAID-funded PMTCT sites in FY2013 and 700 in FY2014, and 50 new ART sites in FY2013 and 100 in FY2014 were added. The agreement also called for SIDHAS to expand the on-going GON integration of TB/HIV services.

SIDHAS shifted its strategy and rationalized use of USG resources. Consistent with the GON and National AIDS & Sexually Transmitted Infections Control Program (NASCP) plans, HIV/AIDS and TB treatment services were delivered within the context of a chronic care model, with increased emphasis on the role of communities and individuals in improving health outcomes. SIDHAS focuses on strengthening Nigerian capacity to deliver HIV and TB treatment and care and helps the GON increase access, coverage, efficiency, quality, integration, and sustainability of HIV and TB services. Priorities of the USG Nigeria Global Health Initiative (GHI) and PFIP strategies include: improved human resources for health; greater focus on women and children; delivery of highest-impact service interventions, particularly at the primary health care (PHC) level; and

strengthened leadership, management, governance, and accountability for program ownership and sustainability.

USAID's Assistance Objective 3 (AO 3): A sustained, Effective Nigerian-led HIV/AIDS and TB Response

SIDHAS Project Goal: To sustain cross-sectional integration of HIV/AIDS and TB services in Nigeria by building Nigerian capacity to deliver sustainable high-quality, comprehensive prevention, treatment, care and related services.

Outcome/Impact Indicators

- % Retention on Care (Pre-ART) at 6, 12, 24, 36, 48, 60 and 72 months after enrolment
- % Facilities experiencing stock out of any ARV drug in the past 1 month.
- Survival at 6, 12, 24, 36, 48, 60 and 72 months after initiation on ART
- Percent of supported States with demonstrable strong Leadership & governance structure (L&G) for implementing and managing large HIV and AIDS Program
- Percent of supported States with strengthened Procurement Supply Chain Management Systems (PSCMS) for managing large HIV and AIDS Program
- Percent of supported States with strengthened Health commodities Logistics Management Information Systems (CLMIS) for managing large HIV and AIDS Program
- Percent of supported States with Centralized Health Management Information System (HMIS) and Data Quality Assurance process

Key Result 1: Increased access to high-quality comprehensive HIV/AIDS and TB prevention, treatment, care, and related services through improved efficiencies in service delivery.

Key Result 2: Improved cross sectional integration of high quality HIV/AIDS and TB services.

Key Result 3: Improved stewardship by Nigerian institutions for the provision of high-quality comprehensive HIV/AIDS and TB services.

Performance Monitoring Indicators for Key Result 1:

P11.1D – Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results
 SIDHAS 1.1 - Number of MARPs counseled, tested and received their test results
 SIDHAS 1.2 – Percent of HIV positive individuals who are enrolled into care and treatment
 P1.1D – Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)
 P1.2D – Number of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission
 SIDHAS 1.3 – Percent of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission
 NC4.3D – Number of HIV exposed infants provided with ARV prophylaxis
 NC4.1D – Number of infants tested for Early Infant Diagnosis (EID)
 SIDHAS 1.4 – Percent of infants born to HIV+ women who received an HIV test within 12 months of birth during the reporting period.
 T1.1D – Number of adults and children with advanced HIV infection newly enrolled on ART
 C2.2D - Number of HIV-positive persons receiving Cotrimoxazole (CTX) prophylaxis
 SIDHAS 1.5 – Number of SIDHAS-supported sites in targeted states
 SIDHAS 1.6 – Number of PLHIV receiving ART refills at PHCs
 SIDHAS 1.7 - Number of supported sites providing TB lab services (microscopy for AFB)
 P8.3D - Number of MARPs reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards
 T1.2D - Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) (Current)
 T1.3D - Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy
 C1.1D – Number of eligible adults and children provided with a minimum of one care service
 C2.1D – Number of HIV-positive adults and children receiving a minimum of one clinical service
 P7.1D - Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions
 SIDHAS 1.8 - Percent of pre-ART patients lost to follow up during the past six months
 NC5.5.2D - Number of OVC currently served
 SIDHAS 1.9 - Number of sites implementing PEP services that meet national guidelines
 P6.1D - Number of persons provided with post-exposure prophylaxis (PEP)
 SIDHAS 1.10 - Number of service outlets carrying out injection safety activities
 C5.1D - Number of eligible clients who received food and/or other nutrition services

Performance Monitoring Indicators for Key Result 2:

SIDHAS 1.12 Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings
 C2.5D - Number of HIV-positive patients in HIV care who started TB treatment
 SIDHAS 1.13 - Percent of TB patients started TB treatment with known HIV status.
 H1.2D - Number of supported testing facilities (laboratories) that are accredited according to national or international standards
 SIDHAS 1.14 - Percent of labs with IQC system in place
 P2.1D - Number of Blood units screened for 4TTIs (HBV, HIV, HCV, Syphilis)
 SIDHAS 1.15 - Number of service providers trained in screening and counseling of GBV survivors
 SIDHAS 1.16 - Number of service providers trained on PHDP
 SIDHAS 1.17 - Number of sites with HIV services integrated into general hospital services delivery
 NC2.4.1D - Number individuals receiving HIV counseling, testing and their results in TB setting
 SIDHAS 1.18 - Number of individuals receiving HIV counseling, testing and their results in FP setting

Performance Monitoring Indicators for Key Result 3:

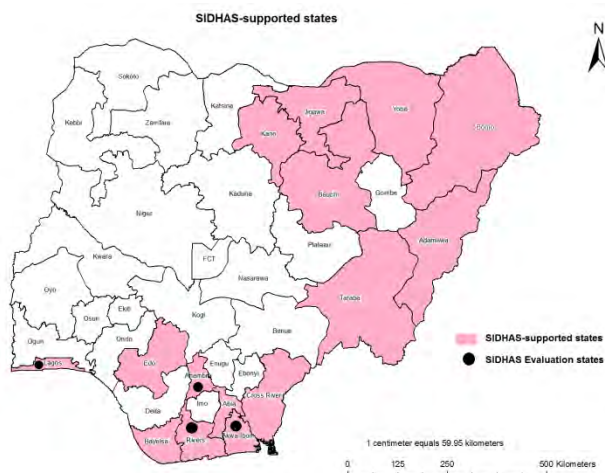
SIDHAS 1.19 - Number of states with PPM system in place to maintain Information Technology (IT) equipment
 SIDHAS 1.20 – Number of sites with PPM system in place to maintain medical and laboratory equipment
 SIDHAS 1.21 - Percent of entities submitting completed and timely Sub-recipient's Financial Reports (SFRs)
 SIDHAS 1.22- Number of entities whose capacity was built on Institutional-domain related topics that address gaps in the Capacity Building Plan (CBP)
 SIDHAS 1.23- Number of entities whose capacity was built on Financial -domain related topics that address gaps in the Capacity Building Plan (CBP)
 SIDHAS 1.24 - Percent of entities with CQI process established (disaggregated by entities)
 SIDHAS 1.25- Percent of entities meeting CQI scores (80%) in each of the 3 domains (Financial, Institutional and Technical) disaggregated by entities category (SASCPs, CBOs, HCCs)
 SIDHAS 1.26: Percent of supported States with demonstrable strong Leadership & governance structure (L&G) for implementing and managing large HIV and AIDS Program
 SIDHAS 1.27: Percent of supported States with strengthened Procurement Supply Chain Management Systems (PSCMS) for managing large HIV and AIDS Program
 SIDHAS 1.28: Percent of supported States with strengthened Health commodities Logistics Management Information Systems (CLMIS) for managing large HIV and AIDS Program
 SIDHAS 1.29: Percent of supported States with Centralized Health Management Information System (HMIS) and Data Quality Assurance process.
 P1.2D - % of health facilities that experienced stock-outs of ARV in the last three months
 SIDHAS 1.30 - Percent of HIV comprehensive sites transmitting data electronically (using DHIS)
 SIDHAS 1.31 - Number of SIDHAS-supported States with a functional referral network
 H2.3D - Number of health care workers who successfully completed in-service program (disaggregated by technical area)

Critical Assumptions:

- The Nigerian State government's counterparts through the GoN-SIT will deliver on their obligations as contained in the sub-agreements signed between FHI360 and the various states and to a greater extent demonstrate substantive commitments to co-implement the project.
- Conflict situation and/or political unrest will not constitute disruption to the progress of implementation of the project.
- Required resources/financial aids needed to implement the set programs and activities will be made available in good time.
- High quality data and strategic information needed to guide direction and/or re-direction of the program will be available.

EVALUATION METHODS & LIMITATIONS

The evaluation was conducted in Nigeria in January and February 2015 by an eight-person team (including two MEMS II staff). The Evaluation Team consisted of two international and six Nigerian advisors. Together, the Team provided both national and international HIV/AIDS, TB and public health expertise and knowledge of PEPFAR programs and the Nigerian health service delivery system. The evaluation was carried out in four of the project's 15 States, all selected by USAID (Anambra, Akwa Ibom, Rivers, and Lagos). The Evaluation Team interviewed more than eight hundred people in the four evaluation states, national institutions, and USAID officials.



The Evaluation Team conducted a five-day Team-Planning Meeting (TPM) upon arrival in Nigeria and before starting the in-country portion of the evaluation. During the TPM, the Team reviewed and clarified questions on the evaluation SOW, clarified USAID's expectations about the evaluation, determined detailed logistics to carry out the proposed methodology, presented an initial work plan, determined how data were going to be collected, reviewed the data collection tools prepared by the Team prior to the arrival in-country, clarified team members' roles, and assigned responsibilities for writing the evaluation report. The TPM outcomes were shared with and approved by USAID/Nigeria. The Team met with USAID at the beginning and conclusion of the assignment and presented team findings in a full exit meeting debrief with the USAID Management Team, including the USAID Mission Director.

The Evaluation Team used both quantitative and qualitative approaches to gain insight into SIDHAS' activities, accomplishments, and the processes that led to their results. A variety of methods and approaches were used to collect and analyze information relevant to the evaluation's objectives, and questions outlined in the Scope of Work (SOW). The evaluation methods and approaches include:

1. Review and Analysis of Background Materials: Documents relevant to the SIDHAS Project were identified and assembled for review and analysis. These included SIDHAS Program Descriptions; Quarterly and Annual Reports (ARs); PMP; annual project work plans; technical and training materials; past program evaluations and assessments; project database data on service utilization and facilities; PEPFAR/Nigeria County Operational Plans; USG Nigeria Global Health Initiative (GHI) Strategy 2010-2015; and other documents related to the project. A complete list of documents consulted is included as Annex IV(b).

2. Review of Project Baseline Data and Health Facility Reports: The Evaluation Team reviewed baseline data and routine health records and reports collected by the Project and the State Ministries of Health (SMOH), GON national statistics and reports, and other stakeholder reports. This provided both quantitative and qualitative data in order to answer the evaluation questions.

3. Site Visits: The four evaluation States have a total of 1,153 SIDHAS-supported health facilities, out of which 120 were randomly selected. The Evaluation Team visited 84 of the 120 facilities identified in the sample, an additional four comprehensive secondary level sites in Akwa Ibom and an additional comprehensive site in Lagos.

4. Key Informant Interviews: The Team interviewed more than 800 key informants from the National Agency for the Control of AIDS (NACA), Federal Ministry of Health (FMOH), National Planning Commission (NPC), State Ministries of Health (SMOH), and Local Government Areas (LGA) from the four evaluation States; health facility staff; civil society organizations; and community groups. A complete list of persons contacted during the evaluation is in Annex IV(a). *(Please note that in order to ensure confidentiality, the list does not include names of the 173 clients interviewed at health facilities or the 124 participants in the focus group discussions as they are people living with HIV.)* The list of questionnaires, survey protocols, guides, and facility checklists are in Annex III.

5. Focus Group Discussions: A total of 29 focus group discussions were carried out with 14 existing, community-based HIV support groups and small groups of women, consisting of between eight and twelve participants living with HIV. For a list of the support groups and the results of the focus group discussions, see Annex IV(a) and Annex VIII respectively.

6. Secondary Sources: The secondary sources consulted included databases from state governmental entities; SIDHAS Project records; the Global Fund and other health donors and partners; and State-level information on health conditions, health interventions, service coverage, and State social initiatives. The health facility reports were reviewed and recorded by the Evaluation Team related to HIV Testing and Counseling (HTC), PMTCT, ART, and TB/HIV. See Annex VII for an analysis which validates the data collected between the health facilities' registers and the SIDHAS reports.

Sample Design and Fieldwork

The four States under evaluation represent nearly 12 percent of the total population of Nigeria. Four teams, one for each State, were responsible for the fieldwork and data collection. Two steps were followed in the sampling process:

1. Agreement on the Sample Frame: The first step was to define and obtain USAID agreement on a sample of HIV facilities considered in this evaluation study. Given the need to evaluate the interventions by State as well as aggregate the results, a State-specific sample was drawn to capture data at the State level. The State-specific data were aggregated to draw some Project-wide conclusions, while the State sub-sample confirmed the project evaluation final sample. MEMS II in collaboration with USAID proposed 30 facilities per State to be visited. This was a feasible number that could be covered in the time allotted. Thus, the evaluation proposed 120 of the 1,153 HIV health facilities in these four States, or 5 percent of the total. Facilities

presenting extreme logistical or other barriers were excluded from the final selection after consultation with USAID.

2. Construction of the sample: The second step in the construction of the sample was the selection of direct beneficiaries to be interviewed. The subjects for the exit interviews were chosen by their availability and willingness to be interviewed. Each interview lasted for approximately 45 minutes.

After several technical considerations, a sample of health facilities was drawn using the total number of HIV facilities supported by SIDHAS as a sampling frame. The table on page 14 depicts the final sample of HIV facilities that were visited by the Evaluation Teams to collect the required data for the evaluation.

There were substitutions of four secondary health facilities (3 public and 1 private) in Akwa Ibom, and 17 facilities in Anambra because of security issues. One facility in the Akwa Ibom sample had never been visited by SIDHAS staff as there was no road access. Of the facilities visited, the majority had at least one client exit survey, at least one provider interview, the facility-in-charge interview, and the quick assessment of the HMIS completed. Not all of the survey instruments were administered in rural primary health care facilities outside Lagos that often have only one public health nurse providing services. Additionally, in Akwa Ibom public facilities were closed or providing only minimal services with a skeleton staff due to a national nurses' strike and a local government workers' strike. Some other facilities in other States also had unforeseen closures. Further discussion of these challenges is provided in the section on "Limitations and Constraints of the Evaluation Methodology" below.

Table 1: Number of Facilities Planned and Visited According to Sample Design By Level of Service

Level	Akwa Ibom		Anambra		Rivers		Lagos		Total	
	Planned	Visited	Planned	Visited	Planned	Visited	Planned	Visited	Planned	Visited
Tertiary	1	1	3	2	3	1	0	0	7	4
Secondary	8	10	7	7	6	7	6	8	27	32
Primary	27	14	25	13	24	17	11	8	86	52
Total	36	25	35	22	33	25	15	16	120	88

Data were collected in each facility by a State Team of four persons including a physician familiar with the provision of health services in Nigeria, and two local data collectors, one male and one female, familiar with the languages and cultures in the State. Overall, 16 evaluators/data

collectors were trained on the survey instruments. On average, data collection was conducted at a rate of one (in Lagos) or two to three (outside Lagos) health facilities day per, and the visits took place on days when services were provided. Each State team developed a precise “visits” plan to facilitate data collection.

Evaluators/data collectors were trained centrally on the approach to the evaluation and administration of the questionnaires for a period of three days. This period included time for a pre-test of the evaluation tools, field practice for the evaluators/data collectors, and overall design testing for the evaluation procedures. The State Team leaders closely supervised and monitored the field work during the pre-test and the data collection in the four States.

Quantitative data from the completed evaluation tools were entered into a database using the EpiData software. The Evaluation Team developed a comprehensive Plan of Analysis. The survey was designed to include analysis at different levels (client, community, facility, and State level). Quantitative data analysis also focused on the comparisons between results from this evaluation and those from the SIDHAS baseline and other similar surveys. Data analysis was conducted using EpiData. Raw Disaggregated Data Tables Appear in Annex IV(c).

Limitations and Constraints of the Evaluation Methodology

A purposeful stratified sample was used to provide the evidence required to address the evaluation questions. The sample for Akwa Ibom did not include any public secondary sites: the backbone of ART provision in the State. Investigation showed that the classification of private sector sites providing standalone PMTCT services in Akwa Ibom was at secondary sites. However, in all three other States such private sector sites were classified as primary sites. Thus the sample in Akwa Ibom was skewed towards private stand-alone PMTCT sites at secondary level and towards public primary sites. The practicalities of the skewed sample at the primary care level, where all the public primary sites in Akwa Ibom were closed during the evaluation period by both the national nurses’ strike and a local government workers’ strike. This meant that obtaining valid data from clients, and using facility service assessments was compromised. In Akwa Ibom, the Evaluation Team substituted four facilities in the original sample to correct the imbalance. Three public primary health facilities were substituted with public secondary comprehensive sites and one of the private, faith-based stand-alone sites was substituted with a faith-based comprehensive site. This notionally provided four sites providing ART to the evaluation, although in practice, on the two days the Evaluation Team visited Methodist General Hospital, one of the public secondary sites substituted into the sample, there was no one providing ART services and no clients available to interview. Although the evaluation collected less than expected facility-in-charge data in Akwa Ibom, the provider and client interviews, focus groups, reviews of health facility registers and key informant interviews in the state provided rich and essential data, which are included in the findings section of this report. Seventeen originally sampled health facilities were substituted in Rivers state due to security concerns. Furthermore, there were quality concerns regarding the reviews of health facility registers in Rivers. Therefore, Rivers’ data is not included in the analysis of the comparison of health facility registers and monthly reports to SIDHAS.

Additionally, there were several issues and challenges related to the health facility register and monthly report data collected and analyzed. Some facilities had incomplete data. The reason

given by health facility managers was that the workload for the service providers precluded them from consistently recording data. Staff shortages were also cited as another reason for the incomplete facility health records. This problem was particularly acute at the private sector facilities visited. The private providers said they felt they needed to attend to their clients and hence some neglected completing patient health records or health visit registers which were described as “burdensome.”

The evaluators were not able to obtain or discern information on whether internal communication between USAID and the SMOH and SIDHAS was effective. The team was also unable to obtain cost information on patient care and approaches to treatment to assess various alternatives and the relative cost effectiveness of different approaches to patient care and follow-up.

The four SIDHAS States evaluated were in nascent stages of readiness to assume full responsibility for sustaining HIV and TB services without USAID technical and financial assistance. The Evaluation Team did not have the benefit of reviewing or seeing successful handover states. However, during the period of the evaluation, SIDHAS handed over the management, oversight and financing of HIV and TB services to the SMOH in Taraba and Abia States.

FINDINGS, CONCLUSIONS & RECOMMENDATIONS

FINDINGS

Question 1: To what extent is the SIDHAS Project on course toward achieving its key results?

SUMMARY FINDINGS

Key Result 1: Increased access to high quality, comprehensive HIV and TB prevention, treatment, care, and related services through improved efficiencies in service delivery.

SIDHAS has contributed to increased access to HIV and TB services, although it has not always met its PEPFAR targets. Reports demonstrate increased coverage and uptake of HIV and TB services, including the rapid scale up of PMTCT services. The vast majority of the service providers are meeting minimum service delivery standards or better. There were no services seen that stood out as exceptionally good. Three out of the fifteen health facilities which had full ART service assessments, were rated poor, 11 were rated adequate, and one was rated as good. PMTCT services were assessed in 51 facilities and rated adequate or good in 32 (63%). The HTC service was assessed at 30 facilities and rated adequate or good in 26 (87%). TB/HIV services were assessed in 15 facilities and rated adequate or good in 10 (67%) although 6 (40%) did not have Standard Operating Procedures (SOPs). Pharmacy services were assessed at 50 facilities and 37 (74%) rated adequate or good. The 19 of 51 facilities rated as providing poor PMTCT services reflect the relative poor standards of private for profit providers.

The Evaluation Team found that overall, standards are often poorer in private facilities compared to public facilities. In Akwa Ibom, Anambra, and Rivers States, comprehensive services are only found at the secondary and tertiary levels. In Lagos, many primary care sites are larger and a handful of facilities have medical officers, a nursing staff, and offer comprehensive HIV services. Comprehensive services are not integrated in larger, complex facilities but are offered as “one stop shops” with clients referred between different providers within a facility. SIDHAS is facilitating the important link between health facilities and the Central Medical Stores that receive the requests for the resupply of drugs, commodities, and consumables. The Project also calculates restocking needs and delivers the supplies in order to avoid stock-outs. Although there is some informal borrowing of drugs and commodities from well-stocked facilities by those that have run out of stock, this seems to be infrequent. Some facilities appear to leave it to the last minute to reorder rather than reordering before they have used their stocks, but these facilities reported that SIDHAS staff are very responsive and quickly provide restocks. Most clients were satisfied with the care they receive, and most report that they are treated respectfully by service providers. Clients complained about long waits for care at comprehensive sites, and sometimes being called back the following day. They also complained about charges for services. From a management perspective, there is not a culture of service delivery and quality improvement in the public or private facilities visited.

Key Result 2: Improved cross-sectional integration of high-quality HIV/AIDS and TB services. HCT and antenatal PMTCT services have been integrated into public sector primary care settings. In Akwa Ibom, Anambra, and Rivers States, the integration is physical, often with one provider delivering integrated services. HCT and PMTCT services have been integrated in public primary care settings, including outreach. Comprehensive HIV and TB services are provided at tertiary, secondary, and some larger, complex primary settings although the services are only integrated at a few secondary facilities. In Lagos, tertiary facilities, most secondary facilities, and large, complex primary facilities are not yet offering functional integration; instead, they deliver services through traditional medical specialists. The most concerning gap in terms of integration is the lack of postnatal follow-up of pairs of HIV positive mothers and their exposed infants.

Key Result 3: Improved stewardship by Nigerian institutions for the provision of high-quality comprehensive HIV/AIDS and TB services. The SIDHAS Project has not demonstrated substantial progress in advancing improved stewardship by GON institutions. Progress has been stymied in part by changes to the SIDHAS cooperative agreement that diverted SIDHAS efforts into delivery of rapid expansion of PMTCT and ART services with very high PEPFAR targets. Although SIDHAS was established to build the capacity of State Implementation Teams (SITs), these structures were subsumed into NACA mandated State Management Teams (SMTs) with wider scope and more senior participation under the chairmanship of the Commissioner for Health. This change occurred at the time when SIDHAS was refocusing its efforts on delivery of rapid expansion of PMTCT and ART services. In the four States visited, the SMTs are not fully functional. The GON has fallen behind in its financial commitments outlined in the project agreement. GON State Teams have not assumed the functions currently provided by the technical assistance team as planned.

DETAILED FINDINGS

Key Result 1: The Evaluation Team reviewed SIDHAS' program strategies and quantitative data from the Annual Reports, Quarterly Reports, and SIDHAS' statements regarding its Semi-Annual Reports). These reports detail the number of facilities providing services and the number of clients using services. The data demonstrate increased coverage and uptake of HIV and TB services, including the rapid scale up of prevention of mother-to-child transmission of HIV (PMTCT) services since 2012. Site visits and evaluation of field data confirmed outreach and delivery of services in the community; expansion to new facilities, including in the private sector; and provided qualitative data on how SIDHAS had delivered increased access, including the challenges and how these are being managed.

SIDHAS' principle strategies for increasing access are:

- Increasing points of entry to HIV and TB services by rolling services out to more facilities, particularly for HTC and PMTCT to the primary care level
- Inclusion of private sector providers for medical and maternity services
- Involvement of community providers, including community pharmacists, that offer primary prevention, particularly with vulnerable populations, and HTC services

- Outreach to Traditional Birth Attendants
- Strengthened integration of services so that:
 - o More health facility users are offered HCT
 - o Mothers and children receive comprehensive PMTCT services whether they present antenatally, in labor, or postnatally to mother and child health (MCH) services.
 - o Every person who has a reactive test for HIV is linked to comprehensive, long term, care, and treatment services

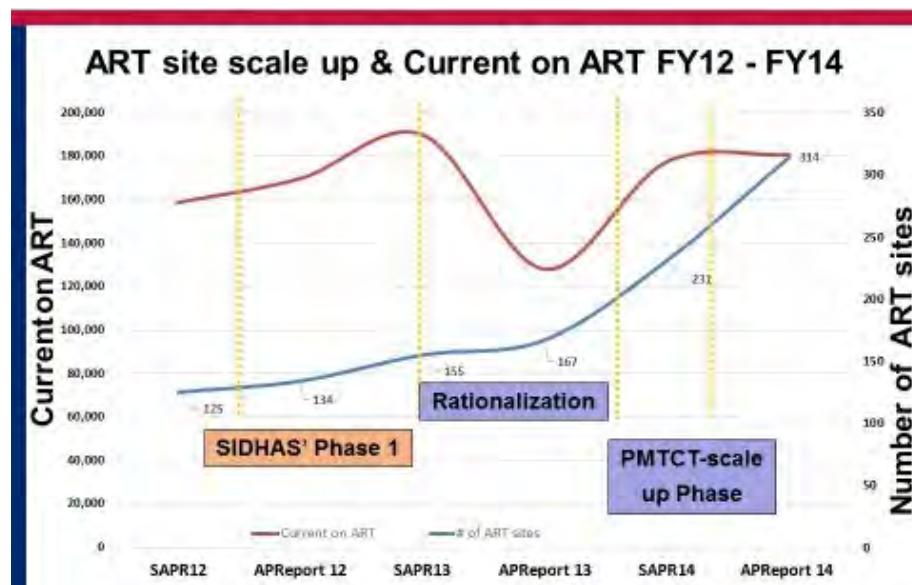


Figure 1: SIDHAS Scale up of ART

SIDHAS reported scale-up of sites providing ART from 125 sites in FY 2012 SAR to 314 in the FY2014 AR. During the same period, the number of persons currently on ART increased from 169,710 to 180,000. During FY2013, the PEPFAR program in Nigeria underwent rationalization, whereby one IP took the lead on HIV treatment in each State. SIDHAS gained treatment sites in the States where it became lead treatment partner and lost treatment sites in States where it was no longer providing treatment. Additionally, during FY2013, at NACA's request, SIDHAS ceased reporting on Global Fund sites that it had previously supported and reported on, resulting in a loss of more than 70,000 clients in ART. These clients were transitioned to the Global fund, based upon agreed modalities with USAID. This strategic decision was designed to ensure the success of the Global Fund program in priority areas that had previously received complementary service packages from both PEPFAR and Global Fund programs through FHI 360, and needed to be graduated to the GON for continued service provision. To make up for this reduction, the PEPFAR target for SIDHAS in 2014 was increased to get back to the original baseline level of patients served. These decisions led to a fall in performance against PEPFAR targets for FY2013 that was in part regained during FY2014. SIDHAS greatly exceeded its 2014 target for the number of pregnant women with known HIV status (this includes women who are

tested for HIV and receive their results) because the numerator (pregnant women with known HIV status) was far higher than the denominator (new ANC attendees). The Project reports that the limitation on enrolling new clients on ART in FY 2014 is the relatively low proportion of persons offered HTC who test reactive. This low proportion of reactive tests was noted by the Evaluation Team in the field for antenatal HTC, particularly at primary care level, with resulting low client volumes of pregnant women taking antiretrovirals (ARVs) for PMTCT at many sites.

Table 2: SIDHAS: Percentage Achievement of PEPFAR Targets by Financial Year

Indicator	FY 2012	FY 2013	FY 2014
Percent of adults and children with advanced HIV infection newly enrolled on ART	90%	61%	68%
Percent of adults and children with advanced HIV infection currently receiving anti-retroviral therapy (ART)	98%	62%	92%
Percent of pregnant women with known HIV status (includes women who tested for HIV and received their results)	100%	71%	155%
Percent other-positive pregnant women who received ARVs to reduce the risk of mother-to-child transmission [Target 100%]	87%	51%	85%
Percent of HIV-positive patients who were screened for TB at HIV care and/or treatment settings. [No PEPFAR target FY2012; Target 90% FY2013]	98%	(Not reported)	64%
Percent of HIV-positive clients in HIV care or treatment started on TB treatment during the reporting period	2%	1.86%	(Not reported)

Providers reported that adherence to treatment by their HIV and TB patients is improving. The GON HMIS however, does not support longitudinal follow-up of cohorts of clients and FHI 360's own LAFIYA Management Information System (LAMIS) was not fully functional at any of the facilities visited by the evaluators. Thus, SIDHAS cannot report accurately on adherence or loss-to-follow-up rates, and these are not indicators in the SIDHAS PMP. This information is important to determine whether the expanded access, outreach, and reliability of HIV/AIDS treatment and care services are translating into better patient health outcomes.

SIDHAS greatly scaled up the number of sites providing PMTCT services from 181 in FY2012, to 2593 at the end of FY2014. However, it also ceded 54 "mature" PMTCT sites to the Global Fund during FY2013, which contributed to an apparent fall in SIDHAS performance in FY 2013. For further information, please see Figure 2 that follows. In FY2014, SIDHAS introduced the chronic care model of care to PLHIV. Routine clinical screening for TB was an integral part of the established system undertaken through triaging for the range of clinical care. Although the Project had difficulty tracking clients' screening for TB and achieved only 64% of its assigned

target, 98% of clients who were “triaged” for chronic care were screened for TB. SIDHAS reported that there were leakages in the triage system at the comprehensive healthcare center level.

There was a rapid expansion of PMTCT sites at the primary care level and in the private sector. The Evaluation Team did not find TB DOTS services at the primary care level, although public health nurses at the primary care level reported that they do screen HIV reactive clients for TB. The lack of TB DOTS services—and ART services for men and non-pregnant women—at the primary care level results in referrals for confirmation of diagnosis and treatment to secondary or tertiary level with many difficulties in accessing these services. These include long waiting times in public secondary and tertiary facilities or payment for services at faith-based secondary facilities.

In Akwa Ibom¹, Anambra, and Rivers States, the Evaluation Team only found comprehensive services at the secondary and tertiary levels. In Lagos, many primary care sites are larger, have medical officers and a nursing staff, and offer comprehensive HIV services. Comprehensive services are not integrated in larger complex facilities but are offered as “one stop shops” with clients referred between different providers within a facility. This seems to be effective in smaller comprehensive sites, but some larger, complex sites didn’t offer all the services on the same day and clients reported that they were sometimes told to return the following day to complete their care and treatment. Providers of HIV care and treatment have integrated TB prescreening into their chronic care delivery, but a client who is found to have active TB is referred to the TB DOTS provider for treatment. Isoniazid prophylactic treatment for TB was not widely used at the facilities visited by the Evaluation Team. University of Uyo Teaching Hospital providers stated

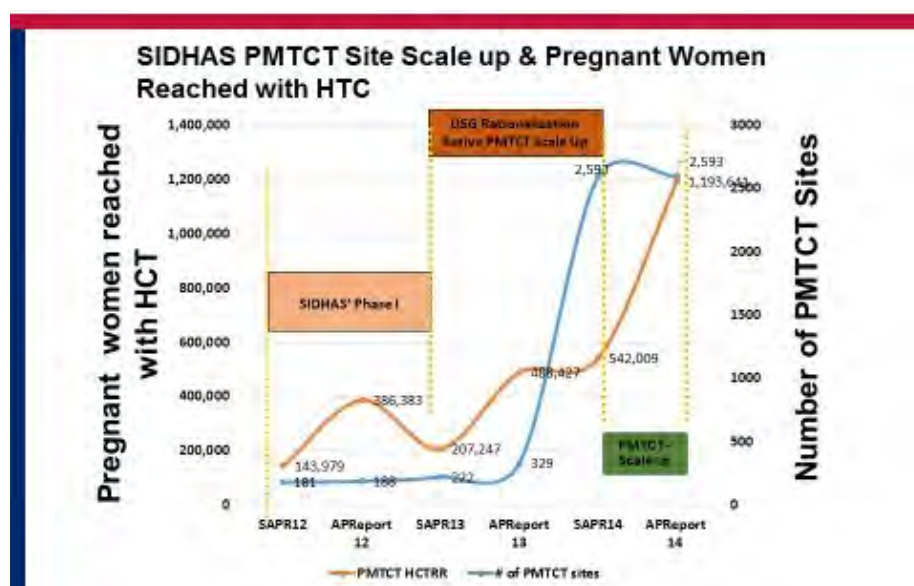


Figure 2: SIDHAS Scale up of PMTCT

¹ University of Uyo Medical Centre, a comprehensive site in Akwa Ibom, is classified by SIDHAS as a primary care site although it is a busy hospital. This contrasts to the large number of private sector stand-alone sites in Akwa Ibom that are classified as secondary level facilities.

that they introduced it on a trial basis but client compliance was low, so they stopped using it. A few clients reported in their exit surveys that they had received isoniazid prophylaxis in line with PEPFAR and WHO policy.

In most comprehensive sites visited, HIV positive pregnant women receive their antenatal care from nursing staff and are seen by a doctor in the facility for oversight of their antiretrovirals. However, the Evaluation Team did see examples of HIV pregnant women being followed up in the ART clinic, where the physicians described themselves as “general practitioners.” The Evaluation Team learned from USAID that SIDHAS has rationalized service delivery at some sites in Lagos so that HIV positive pregnant women are no longer required to travel between sites for their HIV care and antenatal care.

SIDHAS-supported innovations for increasing access to HIV services were reported by public health nurses at the primary level, faith-based health service providers, and civil society organizations (CSOs) that receive sub-grants from SIDHAS. Public health nurses routinely provide outreach immunization services to serve those living at a distance from the facility. Nurses reported that they have integrated HTC for the mothers of children receiving immunizations in the community; they also carry ARV top-ups for positive pregnant women and some of the nurses also work with traditional birth attendants (TBAs) in their area to ensure that women delivering with TBAs in the community receive HTC. Faith-based service providers report that they have SIDHAS-funded community volunteers who also do outreach to TBAs and churches that offer child-birthing services. The purpose of the outreach is to increase HCT for pregnant women, and increase facility deliveries for HIV positive pregnant women. Providers at public primary care facilities and faith-based facilities reported increased client flows since they began their outreach. The CSOs the evaluators met support men and women volunteers in the communities they serve who liaise with their local health facilities—mainly for tracing those lost to follow up, but also for increasing HIV awareness and motivating community members to accept HTC. The CSOs also offer HTC in the community and refer reactive clients to comprehensive health facilities.

In assessing whether the HIV and TB services delivered are “high quality,” the Evaluation Team considered quality from a technical/professional perspective; from the client perspective; and from the perspective of efficiency and cost effectiveness of services. Service delivery assessments across the range of HIV-TB services were conducted, including pharmacy and laboratory services delivered at all levels. The vast majority of the service assessments were scored as meeting minimum service delivery standards or better. There were no services seen that were standouts or exceptionally good overall. Concurrence between the HMIS registers and the monthly reports was good—with no consistent over reporting and just a few facilities underreporting. The clinical services assessed that were deficient were mainly deficient in the areas concerned with client privacy and confidentiality and the availability and use of Standard Operating Procedures (SOPs). Pharmacies with expired drugs on the shelves or other evidence of poor management such as lack of cleanliness and poor documentation—mainly in private facilities—were assessed as poor.

Standards of service delivery, and of completing M&E registers, was often worse in private, for-profit sector facilities than in private, faith-based and public sector facilities. “Laboratories” in

private, for-profit sector facilities were often rudimentary. For example, one PMTCT coordinator talked extensively about “his laboratory” but the laboratory turned out to be the table in the clinic where he provided HTC. Drugs were often dispensed from doctors’ desks or shelves in their consulting room in private, for-profit facilities, and intermittent preventative treatment (IPT) for malaria was generally not available in private facilities including faith-based facilities as it was not provided by SIDHAS. A few private facilities including faith-based facilities did provide IPT, and charged the client for it. A few private, for-profit facilities also sold long lasting insecticide treated bed nets (LLINs) whereas most public sector facilities distributed LLINs² free of charge.

Although the quality of antenatal PMTCT service delivery generally meets minimum standards or better, the Evaluation Team was unable to evaluate quality of care in labor and delivery as facility delivery rates are so low that there were no deliveries being conducted during the visits by the Evaluation Team. This is highly indicative that the quality of delivery services does not meet pregnant women’s requirements. Post-delivery PMTCT services are virtually nonexistent. According to nursing staff at public facilities and some private stand-alone PMTCT facilities, women who deliver in the community bring their infants to the facility to get infant nevirapine. The actual proportion of infants receiving nevirapine neonatally is not known as this is not reported by SIDHAS. Nationally, 27% of exposed infants received nevirapine³ and 4% of exposed infants received testing for EID in 2013⁴. Fewer women return to the facility at 6 weeks for a postnatal visit with their infant to get a dried blood spot (DBS) taken for DNA PCR. SIDHAS reports on exposed infants who are virologically tested for early infant diagnosis within 12 months of birth. SIDHAS achieved only 27% of their target of 17,103 infants tested in FY2014 because so few infants are brought back to a facility for follow up. However, SIDHAS does not collect cohort data and so it is not possible to track the actual proportion of exposed infants who are virologically tested in the first 12 months after birth. The Evaluation Team saw no published PMTCT cascades (antenatal or postnatal) for SIDHAS-supported sites and was unable to construct cascades from the SIDHAS annual reports. Many facilities reported problems getting the results back for the DNA PCR. Some private, for-profit facilities don’t do DBS and refer exposed infants to public facilities for testing and follow-up. Although providers who have received negative DNA PCR tests are proud that the infants were not infected, follow up of mother-infant pairs throughout breastfeeding is negligible. In tertiary sites in Akwa Ibom, Anambra, and Rivers and comprehensive sites in Lagos, HIV positive mothers are followed up in adult ART clinics and their infants are referred to pediatric ART clinics.

From the client perspective, the Evaluation Team gathered data from clients of exiting services at facilities and from community support group members. Most clients reported they were satisfied with the care they receive, and most report that they are treated respectfully by service providers. Clients and support group members complained about long waits for care at

² The exception to this was in Akwa Ibom where the State Ministry of Health held a community campaign distributing LLINs to all households in November 2014 and very few public facilities had any to distribute at the time of the evaluation.

³ Presentation (2014) Strengthening quality of PMTCT routine data and data use, Nigeria. IATT annual meeting, Johannesburg, RSA

⁴ UNAIDS (2014) *Nigeria Fact Sheet*. Draft shared at IATT annual meeting, Johannesburg, RSA, although the Nigeria MOH presentation to the IATT annual meeting gave the percentage as 5% exposed infants receiving DNA PCR testing at 2 months.

comprehensive sites (mainly secondary and tertiary level but including primary level in Lagos) sometimes being called back the following day. They also complained about charges for services—up to Naira 400 to obtain their registration card, Naira 400 for CD4 testing, and Naira 20-50 for the bag their drugs are dispensed in. At one TB DOTS center, the provider reported that there had been no stock-outs of TB drugs, but two clients during their exit surveys reported that they had been turned away without drugs on occasion. HIV infected parents and children are not seen together in clinics at comprehensive sites in Lagos and at tertiary sites in Akwa Ibom, Anambra, and Rivers.

From a management perspective, there is not a culture of service delivery and quality improvement which would require a focus on the client and teamwork, use of HMIS data for improving service delivery, and seeking more efficient and cost-effective service delivery. Although positive client flows are low in primary care level antenatal services, the integration of PMTCT services is not necessarily inefficient or not cost-effective as public health nurses are able to integrate HCT and PMTCT into their routine facility-based and outreach services. These nurses are also better positioned for providing postnatal follow-up of HIV positive mothers and their exposed infants throughout breast feeding and for providing family planning services integrated into their routine MCH service delivery. Because the nurses have often worked at their primary care facility for more than two years, and because positive client numbers are low⁵, they frequently reported to the Evaluation Team that they “know” their clients – they know which mothers are HIV positive, where they live, and whether or not they come back for follow-up care and treatment because they keep informal records in personal notebooks.

The Evaluation Team found that the Continuous Quality Improvement (CQI) approach was not consistently applied across the Project-assisted facilities and that in some sites, the quality of HIV services is below government standards. While the SIDHAS Project has provided training based on adherence to SOPs, the Project has not assured that best practices from higher performing health facilities are replicated across the project. Focus group discussions revealed that privacy issues were a problem, CD4 count and chemistry tests were often unavailable, and that patients are sometimes told to come back to be tested on another day. Focus groups also elicited that some PLHIV get side effects from ART drugs, but clients were not effectively counseled about how to deal with these side effects. Focus groups also reported stock-outs of some drugs. (See Annex VIII for the responses from focus groups discussions.)

⁵ Client numbers are low because the proportion of pregnant women who are found to be HIV positive is low, as is the proportion of adults at comprehensive sites who are found to be HIV positive. Several respondents including SIDHAS staff and SACA and SMOH personnel said that they believe the prevalence of HIV in Nigeria is much lower than official estimates.

Table 3: Selected SIDHAS' performance indicators 2012-2014 from the Annual Progress Reports (APR)

Akwa Ibom

#	Indicator	APR 12	APR 13	APR 14
NP1.1D	Number of service outlets providing the minimum package of PMTCT services according to national and international standards	4	96	271
P1.1D	Number of pregnant women with known HIV status (includes women who tested for HIV and received their results)	3,304	20,708	3,729
P1.2D	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission	371	1,057	221
NP11.3D	Number of sites providing counseling and testing according to national and international standards	4	107	281
P11.1D	Number of individuals who received counseling and testing services for HIV and received their test results	7,165	35,007	14,387
NT1.4D	Number of service outlets providing ART	4	14	27
T1.1D	Number of adults and children with HIV infection newly enrolled on ART	474	1,593	431
T1.2D	Number of adults and children with HIV infection receiving antiretroviral therapy (ART) [CURRENT]	2,753	2,879	17,098
C2.4D	Number of HIV+ patients screened for TB	3,968	-	14,098

Anambra

#	Indicator	APR 12	APR 13	APR 14
NP1.1D	Number of service outlets providing the minimum package of PMTCT services according to national and international standards	10	42	262
P1.1D	Number of pregnant women with known HIV status (includes women who tested for HIV and received their results)	6,173	51,619	4,268
P1.2D	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission	231	1,085	116
NP11.3D	Number of sites providing counseling and testing according to national and international standards	9	44	240
P11.1D	Number of individuals who received counseling and testing services for HIV and received their test results	15,083	106,829	11,741
NT1.4D	Number of service outlets providing ART	10	20	26
T1.1D	Number of adults and children with HIV infection newly enrolled on ART	584	1,975	220
T1.2D	Number of adults and children with HIV infection receiving antiretroviral therapy (ART) [CURRENT]	6,758	8,918	18,931
C2.4D	Number of HIV+ patients screened for TB	7,348	-	21,258

Lagos

#	Indicator	APR 12	APR 13	APR 14
NP1.1D	Number of service outlets providing the minimum package of PMTCT services according to national and international standards	15	32	120
P1.1D	Number of pregnant women with known HIV status (includes women who tested for HIV and received their results)	11,464	36,344	7,057
P1.2D	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission	290	1,095	94
NP11.3D	Number of sites providing counseling and testing according to national and international standards	14	36	109
P11.1D	Number of individuals who received counseling and testing services for HIV and received their test results	24,441	74,865	9,208
NT1.4D	Number of service outlets providing ART	8	9	13
T1.1D	Number of adults and children with HIV infection newly enrolled on ART	1,214	2,675	323
T1.2D	Number of adults and children with HIV infection receiving antiretroviral therapy (ART) [CURRENT]	14,395	16,442	18,265
C2.4D	Number of HIV+ patients screened for TB	15,558	-	15,590

Rivers

#	Indicator	APR 12	APR 13	APR 14
NP1.1D	Number of service outlets providing the minimum package of PMTCT services according to national and international standards	3	61	148
P1.1D	Number of pregnant women with known HIV status (includes women who tested for HIV and received their results)	589	17,819	2,306
P1.2D	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission	84	350	102
NP11.3D	Number of sites providing counseling and testing according to national and international standards	3	16	143
P11.1D	Number of individuals who received counseling and testing services for HIV and received their test results	1,371	21,853	5,817
NT1.4D	Number of service outlets providing ART	1	11	14
T1.1D	Number of adults and children with HIV infection newly enrolled on ART	201	1,120	338
T1.2D	Number of adults and children with HIV infection receiving antiretroviral therapy (ART) [CURRENT]	2,390	6,070	11,908
C2.4D	Number of HIV+ patients screened for TB	2,795	-	11,257

(Source: USG-DHIS)

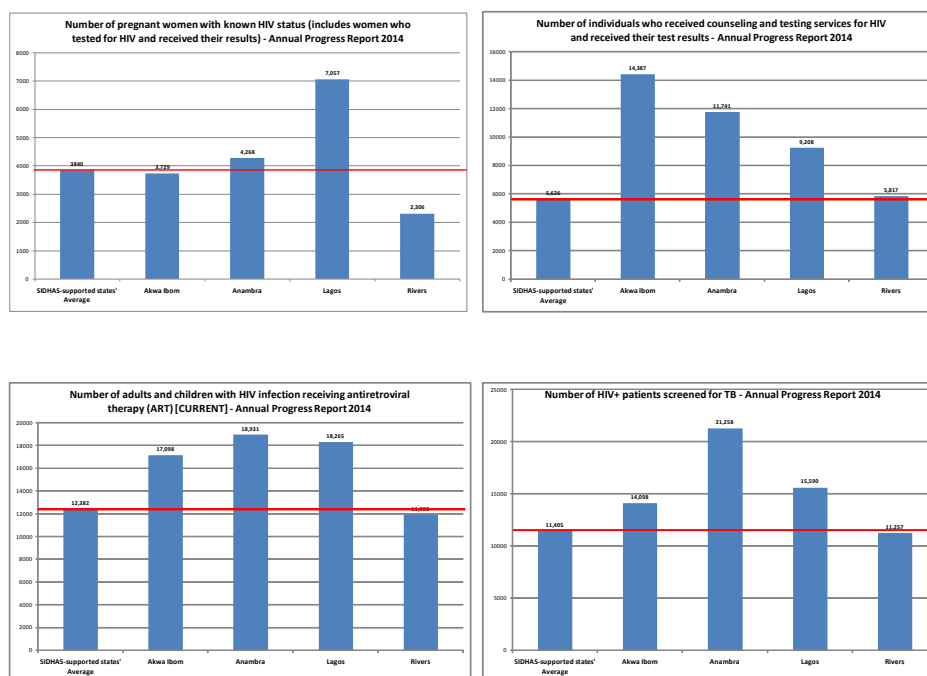


Figure 3: Comparison of indicators among the four evaluation states and the overall average of SIDHAS-supported states (Source: USG-DHIS)

Key Result 2: Antenatal PMTCT services have been integrated into public sector primary care settings in the four states. In Akwa Ibom, Anambra, and Rivers States, the integration of HIV services at primary care level is physical, often with one provider delivering integrated services. Services at large, complex facilities—including primary level facilities in Lagos—are often not physically integrated, but some are functionally integrated.

Public health nurses at the primary care level reported having integrated HTC into their services at the facility and during outreach into the community. They tested men as well as women but were compelled to refer men and non-pregnant women whose tests were reactive to secondary or tertiary facilities for confirmation of diagnosis and treatment. Primary care facilities have very low rates for facility deliveries, but public health nurses reported increased flows of women for antenatal care as a result of outreach to the community and, particularly to TBAs practicing in their areas. Faith-based, private sector providers of stand-alone PMTCT services and comprehensive services also reported increased uptake of HCT and antenatal care/PMTCT as a result of outreach with community volunteers to TBAs. Although faith-based providers had some community volunteers, more volunteers are managed by CSOs and community-based organization (CBO) sub-grantees. The CSO volunteers are the link between facilities and communities and play an important role by tracing those lost to follow-up for facility staff, providing community sensitization, and supporting facility outreach sessions. Many faith-based facilities provide integrated services—as one stop shops rather than by each provider delivering the range of integrated services. Most Catholic faith-based facilities do not integrate family planning or effective positive living guidance. Catholic facilities in Lagos and Rivers reported they do provide natural family planning guidance, as approved by the Catholic Church. At one

facility in Lagos, the director, a Catholic nun and a nurse, indicated that she referred clients to public facilities to obtain modern methods of contraception. One facility in Akwa Ibom assured the evaluators that HIV positive clients “know” they can get condoms from the nearby public General Hospital⁶. A Pentecostal faith-based facility did offer condoms.

In larger complex facilities including primary care facilities in Lagos, integration of services varied significantly across the facilities visited by the Evaluation Team. In some there was a high level of physical integration, particularly of HIV and TB treatment services, and in others services are delivered vertically by traditional medical specialism. The best example of functional integration in larger complex facilities was HCT integrated into overall clinical services; and the best example of physical integration was PMTCT integrated into antenatal care with PMTCT registers maintained in the ANC units. However, the clinicians in these two examples are not providing HCT directly but are referring clients for HCT. The laboratories in SIDHAS supported facilities are no longer “PEPFAR” or project laboratories: although some laboratories seen by the evaluators did have separate accommodation for SIDHAS provided chemistry and CD4 analyzers, most laboratories visited were delivering integrated services.

In general, the Lagos team found that whether a service was functionally integrated depended on the proactive action of an HIV services coordinator and it was difficult to determine whether these individuals were following SIDHAS initiated training or protocols. The general hospitals in Badagry and Gbagada were excellent examples of good functional integration of ART and MCH and could be models for best practices in integration in large facilities. In general, shared space arrangements encouraged integrated service delivery.

Nonetheless, the clinical services in larger secondary and tertiary facilities—most evident in chronic care for HIV positive clients—were not integrated. Patients attending general outpatient clinics might be referred to the laboratory or to HCT but were not tested by the clinician in the general outpatient clinic. Children living with HIV were seen in Pediatric ART clinics and their parents followed up in Adult ART. The exceptions seen by the Evaluation Team were faith-based, secondary facilities; some public secondary facilities; and University of Uyo Medical Centre, which reported that families are followed up together. There were no secondary and tertiary facilities seen that offered physical integration of all clinical HIV and TB services. The most troubling lack of integration found was in the follow-up of positive mothers and exposed infants. Private sector, stand-alone PMTCT services and large, complex public secondary and tertiary facilities, refer positive mothers for post-delivery follow-up to Adult ART, and exposed infants to pediatric ART. The WHO Guidelines, which call for mother-infant pairs, including mothers who test negative in pregnancy and their infants, to be followed up together, are not being followed.

All the providers at primary care facilities and in ART clinics stated that they screen their clients for TB at every visit. Clients reporting cough for more than three weeks, night sweats, or weight loss are referred to TB DOTS for diagnosis and treatment. The TB DOTS centers were at the secondary and tertiary levels. TB DOTS providers report that they offer HTC to their clients.

⁶ Clients may very well know they can obtain condoms at public facilities but whether they feel able to obtain and use condoms if they are Catholic is in doubt: the health workers avoided responding to questions on whether they encouraged their clients to collect and use condoms from public facilities.

Clients in TB DOTS confirmed either that they had been tested for HIV or that they had refused HCT. In contrast, in antenatal settings, providers were more likely to report that all pregnant women are tested and know their status. While pregnant women might be able to opt out, the norm is that they are tested. All antenatal clients interviewed had been tested and did know their status.

Integration of health services is a long-term process and requires the integration of functions. For example, integration of PMTCT and ANC has worked well since there have been joint training and guidance and revised protocols disseminated to the providers involved in these two services. This approach of in-service training, revising protocols, reinforcing integration through certification and supervisory visits will ensure that integration fully succeeds.

Table 4 below indicates that the project is moving toward meeting its targets for integration of HIV/TB and sexually transmitted infections (STI) services for both HIV and TB patients at laboratory testing facilities and treatment sites. Half of all patients in SIDHAS sites have their blood screened for sexually transmitted diseases (STDs) and HIV with a growing number of HIV patients in HIV care (19%) starting TB treatment.

Table 4: SIDHAS Accomplishments against Performance Management Indicators for Key Result #2

Indicator	Life of project target	Achievement as at Sept. 2014
Number of HIV-positive patients in HIV care and treatment who started TB treatment	71,052	13,543 (19%)
Number of supported testing facilities (laboratories) that are accredited according to national or international standards	WHO/AFRO=19 National=40	5 (8%)
Number of Blood units screened for STIs (HBV, HIV, HCV, Syphilis)	57,415	29,183 (50%)

(Source: SIDHAS PMP)

Key Result 3: The Evaluation Team triangulated findings from document reviews; analysis of health facility in-charge key informant interviews; and interviews with officials from the Local Government Area Implementation Teams (LITs), Local Government Authority Health Departments (LGAHD), SITs or SMTs, State Agencies for the Control of AIDS (SACAs), SMOH, Anambra State Ministry of Economic Planning and Budget (AMEPB), the Donor Coordinating Units/Agencies at the Office of the State Executive Governors, FHI360 (National and State Offices), HIV/AIDS Division, FMOH, NACA, NPC, and USAID/Nigeria.

SIDHAS is complex in design and challenging to implement. The competences and capacities required for technical assistance to improve stewardship by GON institutions necessitate a different mindset from that required for technical assistance for the provision of high-quality HIV service delivery. The attainment of improved stewardship by Nigerian institutions requires a long term sustained improvement in the management of health services and the sustained

appropriate allocation of financial and human resources. This entails unwavering commitment by USAID and FHI 360 to build and enable the capacity of GON institutions to become independent of both external funding and the implementing partner. Several perennial challenges—some known before the start of SIDHAS—are suggestive of limited progress towards improved stewardship by GON institutions. Unresolved challenges include:

- i. Powerlessness and abdication of responsibility by GON institutions to own and lead health programs that are externally financed. This was highlighted to the Evaluation Team by variations on the adage of “he who pays the piper dictates the tune” stated by national government officers and the SACA in one of the four States.
- ii. The current technical assistance approach, assumes that lack of knowledge of “what to do” by GON institutions is the primary strategic challenge, rather than the innate reluctance of GON Institutions to “want to” optimally deploy their existing capacity to lead. Consequently, resources are spent on inappropriate training workshops and tackling of other non-core failure points instead of identifying and addressing the critical underlying cause or barriers to change.
- iii. Mutual complicity between GON Institutions and FHI 360, including during discussions with the Evaluation Team, to identify and name the limiting causes and barriers to change which impede stewardship such as the mismanagement or alignment of health resources; and to discuss context-specific solutions to reduce and eliminate the challenges.
- iv. Electronic software platforms (DHIS and LAMIS), are not fully deployed and routinely used at the facilities. Where they exist, there are multiple different platforms in use. For example, the Evaluation Team identified four versions of DHIS (NACA, FMOH, MEMS II and FHI 360) which leads to inconsistencies in reported data; inefficient use of data collection resources and collation processes; and scant attention or resources devoted to data use at facilities by providers, managers, and state-level program managers or decision makers. That SIDHAS has been unable to focus on and resolve this challenge demonstrates significant lack of progress in scaling up electronic software applications—a specific sub-objective of the project.⁷
- v. An expressed sense of disenfranchisement by the National Planning Commission (NPC) in discussion with the Evaluation Team, which may work against sustainability through weak national coordination of development assistance and a failure to plan for follow-up and sharing of lessons learned.

Other challenges observed include:

- i. Implementing partners, including SIDHAS, do not regularly report to the Development Assistance Database (DAD) managed by the NPC. Regular analysis and review of an up-to-date DAD is needed for GON stewardship through better coordination and elimination of duplication of projects while enhancing efficiencies through timely sharing of reported best practices and lessons learned.

⁷ “.....FHI-360 will continue to support DHIS implementation and full migration of the system (from version 1.4 to 2.0 build 2.9) to ensure it is functional and inter-operable at federal/state GON offices and supported LGAs, comprehensive ART and secondary PMTCT sites”.

- ii. GON institutions are reluctant to request SIDHAS project's actual financial data (disbursements, budgets, financial control policies and procedures etc.) although they are required to oversee and sign off the planned and executed activities. FHI 360 does not proactively share financial data in sufficient detail as to enable full oversight by the GON.
- iii. Difficulty with disaggregation and attribution of achievements to a project or the GON institutions.
- iv. State Governments' embargo on recruitment of staff (with occasional politically-motivated exemptions) that adversely affect succession planning and quality of service delivery.

Nonetheless, some states have expressed determination to take over and sustain SIDHAS activities⁸ and two states—Taraba and Abia—were handed over to the GON in February 2015, during the evaluation period. The SIDHAS Team indicated that although the project interventions were going well in those two States, there may be a need to support the NACA and SACA monitoring teams for a period of time so that the lessons learned in these two States can be shared and replicated.

SIDHAS State Management Mechanism: SIDHAS established a SIT in each State with participation of technical counterparts from the SMOH and SACA, to "... be responsible for state-level planning, implementation, monitoring and supervision of SIDHAS-funded activities, as well as advising state governments on integrating SIDHAS activities into state work plans and budgets for eventual full ownership." The SITs were to review, develop, approve, and implement the continuous quality improvement strategies and checklist, capacity-building plans and other technical strategies. SIDHAS staff were co-located with their technical counterparts in some states—with SITs set-up and co-located within SIDHAS State offices. The co-location was reported to have enabled the SIDHAS State Offices to be more responsive to the GON as well as to have enhanced collaboration.

SIT members attended some training workshops, participated in joint monitoring and supervisory visits (when their schedule permitted), and signed off on the Annual Operational Work Plans. In Anambra, they reported to the Evaluation Team that consultations and informational meetings had occurred, but little strategic cooperation had taken place. Many members of the SIT had not read the Memorandum of Understanding (MoU) signed with the State Government and were not fully informed of the scope of the SIDHAS program. They were unaware of potential technical assistance available for improving the stewardship of the GON Institutions. Although NPC, NACA, FMOH, SITs/SMTs and health facility officials expressed a desire and willingness to lead and integrate the SIDHAS activities into the National or State HIV Response strategic plans, in practice, SITs/SMTs and facilities followed the leadership of SIDHAS program staff. Annual planning meetings held with the participation of all development partners in each state were information sharing platforms rather than strategic planning of development partner contributions to the State HIV response.

SIDHAS reviewed and prepared a concept paper for the "Development of State Management Teams (SMTs) in SIDHAS Supported States" in response to the mandate for SMTs enshrined in the Nigerian PCRP. However, the Evaluation Team did not find evidence of a rigorous review of

⁸<http://mohbayelsa.gov.ng/content/bayelsa-state-government-plans-sidhas-take-over> [accessed March 10, 2015]

the terms of reference or the rationale for any observed achievements and/or shortcomings of the existing coordination structures such as the State AIDS and Sexually Transmitted Infections Control Program (SASCP) before the introduction of the SMT. By following the GON lead, SIDHAS perpetuated the potential for duplication, conflict, and inefficiencies between the new SMT, the SIT, SASCP, and SACA, all of which have coordination roles. The new SMT structure was mandated by NACA, and all States were expected to inaugurate the new structure by incorporating or collapsing the SITs.

The Evaluation Team found in the four States visited that the new SMTs were not fully operational and some members of the SITs expressed misgivings about the new expanded SMTs. In Lagos, the SMT was still in a “planning” mode and the SIT was fully operational. An analysis of the job titles of the members of the SMT shows that the membership is top-heavy, with top management executives drawn from other parts of the State Government bureaucracy. The top management executives have challenges leading, managing, and delivering on their primary responsibility of their employing agency. Some are overstretched and unable to fully deliver on the SMT mandate, manifested by an inability to be available for oversight and assumption of SIDHAS program activity, including monitoring and supervisory visits with the State SIDHAS technical team; reordering from Central Medical Stores; and distributing ARVs, rapid test kits and other laboratory reagents and consumables. In addition, in some States, there is a lack of sufficient middle to senior cadre technical officers to act as technical back-stops within the SMTs. The SIDHAS State Offices are better resourced with more and higher quality mid-level technical officers than the SMOH members of the SMT.

Question 1a: Did the Project do what was proposed in the cooperative agreement with the level of input and output?

SIDHAS is doing what was expected in the original agreement and in the modifications to the scope and targets, within its financial obligations. Many factors beyond SIDHAS’ manageable interest limited its ability to fully deliver, including the changes in direction imposed by rationalization, state-level organizational changes introduced by NACA, and the very high targets for rapid scale up of PMTCT and ART services in the face of emerging evidence of unexpectedly low HIV prevalence among new clients using health facility services.

FHI 360 and its partners designed their interventions through a model that devolved their technical assistance from the “zonal office” delivery under the GHAIN project, to the state level. SIDHAS established state implementation teams (SITs) in collaboration with the SMOH and SACAs, chaired by the Chairman of Health Management Board. The implementation approach for building sustainable capacity was to strengthen the technical and management capacity of SITs. By the end of FY2012, SITs were in charge of implementing SIDHAS work plans in their respective States guided by SIDHAS technical staff. The SIDHAS staff was embedded with their state government counterparts in some states, and this was reported as a success story in the FY2012 Annual Report.

Through sub-grants to CSOs/ CBOs, SIDHAS conducts community-based prevention with vulnerable populations and provides basic home-based care and support, and OVC services. SIDHAS developed proposals for renovations and upgrades to 111 laboratories with budgets ranging from \$1,820 to \$59,963, with the average budget of \$33,000. Although these proposals

were approved, 12 renovations were not undertaken because of a change in renovation policy. The project achieved over 90% of its first-year targets for most indicators.

Modifications to the initial agreement accommodated changes in the geographic scope determined by rationalization, and increased targets for rapid scale up of ART and PMTCT services. Although the changes in 2013—from rationalization, loss of Global Fund sites, and rapid scale up of PMTCT—resulted in lowered performance against targets—SIDHAS

SIDHAS Budget, Obligation and LOP Expenditure by KRA through December 31, 2014				
		Planned Obligations	Actual Obligations	Disbursements
		\$	\$	\$
KRA 1	Access	158,053,437	145,024,238	142,274,148
KRA 2	Integration	58,107,881	53,317,735	52,306,672
KRA 3	Stewardship	16,270,206	14,928,965	14,645,868
Total		232,431,524	213,270,938	209,226,688

Source: SIDHAS 12/31/2014

performance increased again across most indicators in FY2014.

Question 1b: How has rationalization impacted the ability of the Project to achieve its results?

Despite evidence of extensive central-level discussions by the PEPFAR team with the GON on rationalization prior to its execution, key informants surveyed at the LGA level indicated that the rationalization policy was not well understood at the LGA level, and even less understood at the service delivery level. Some states like Lagos and Kano had the additional challenge of dealing with two different lead implementing partners and two US Agencies (USAID and CDC) following rationalization. Some key informants noted that this transition from one USG implementing partner to another was often rushed at the service delivery level without a thorough explanation to health facility managers and providers. The key informants also commented that they perceived rationalization to be a USAID-initiated policy shift without much consultation with the GON including the NPC. High-level GON HIV managers at the federal and state levels commented that rationalization meant a decline in USG resources. They indicated that they were concerned about the adverse effects of withdrawal or diminished donor funds for HIV and TB treatment services. A specific example that was cited was the reduction of modest incentives for volunteers that negatively impacted the tracking of those lost to follow-up for HIV treatment and completion of the monitoring and evaluation systems registers. Other examples were the withdrawal of IP clinical staff deployed by CDC implementing partners at tertiary facilities.

Data in the SIDHAS annual reports, as demonstrated in Figure 1 and Figure 2, demonstrate a marked disruption in SIDHAS delivery of its results for ART and PMTCT during FY2013—the period covering rationalization. The period also coincided with the handover of ART sites and “mature” PMTCT sites to Global Fund program management and reporting. The loss of ART and PMTCT clients probably had a greater effect than rationalization on delivery of ART and PMTCT

results in FY2013. Tertiary and some secondary sites visited by the Evaluation Team experienced a change in treatment partner as a result of rationalization. Some providers reported that there had been a brief hiatus in technical assistance, and stocks of drugs and consumables had become very low during the period of change. Some providers complained that they received less support from SIDHAS than from their previous treatment partner. IHVN, for example, had seconded physicians to the staff of tertiary facilities they had supported and had also paid allowances to facility staff that SIDHAS did not continue. However, more providers stated that there was no significant change in the technical assistance that SIDHAS provides compared with prior partners. Many commented that SIDHAS staff is responsive to the providers' needs and "always come" when they are needed. Although rationalization was disruptive of SIDHAS management and technical assistance in the short term, undoubtedly SIDHAS is now better placed for efficiency in its support to treatment in the states that it has become the treatment partner. SIDHAS delivery of results in FY2014 had recovered from the disruptions of rationalization.

The demands of rationalization, with the requirements for rapid scale up of PMTCT and ART services, and the NACA led introduction of SMTs, appears to have somewhat derailed SIDHAS approach to building capacity to sustainably deliver high quality services. The SITs have been subsumed into the larger SMTs. This has led to political rivalries and inaction in the States visited, such that none are actively taking ownership and leadership of the management of delivery of scaled up, high quality services with a quality improvement ethos. Theoretically, the expanded SMTs have the potential to mobilize funding for HIV and TB services in each state through greater visibility and high level political advocacy with the State Governors. Although this was not seen to be happening in the four states visited by the Evaluation Team. SIDHAS programs in two other states graduated to State management in February 2015. The graduation is indicative that the SMTs in the two States are active and able to take on full responsibility for SIDHAS activity in those states.

Question 1c: Is the project timeframe sufficient to achieve the longer-term results?

Delivery of longer-term results crucially depends on state ownership, leadership, and good governance. To date, two State programs have been handed over to states too recently for any evidence on whether results will be sustained in the longer term. In order for handover to take place across all SIDHAS states, SMTs need sustainability plans that dovetail into SIDHAS handover plans for each state. This was acknowledged by several state actors but SMTs and SIDHAS state teams in the four states visited do not have sustainability or handover plans. If SIDHAS prioritizes working with states on the negotiation and development of these related plans, their phased implementation over the remaining two years of the SIDHAS would enable handover of the SIDHAS activities to the GON. The remaining two years also afford time for USAID, SIDHAS senior management and SIDHAS state teams to negotiate respectively with the NPC, NACA and the FMOH, and State Governors for sustained funding of SIDHAS activities beyond the handover to States. Consistent with the SIDHAS results framework, these hand-over plans should include milestones such as evidence that financial commitments are taking place in a timely manner, that in-service training has been completed including the financial competencies and that the supply chain and health information system are functioning at a level which meets managers needs for program information to make decisions and health data to

inform local, state and central level public health authorities. Currently, none of the four States have strong leadership or governance at the state level, although the Evaluation Teams did observe some excellent examples of effective leadership at districts and facilities.

Question 1d: Did the Project revise the program framework as experience was gained through implementation?

To evaluate this question, the Evaluation Team met with senior management of the Federal and State Ministries of Health and the SIDHAS senior leadership team and reviewed the PEPFAR Country Operational Plan and the USG Global Health Initiative Partnership Framework and the series of FHI 360 cooperative agreement modifications. The findings were corroborated by evidence gathered in the field at facilities and meetings with providers in SIDHAS-supported facilities in the public and private sector. The Team found that the FHI 360 management team was highly flexible and made enormous adjustments and modifications in their scope of work, geographic concentration and strategy in response to Government of Nigeria and USG strategic changes in the direction of the HIV/AIDS and TB programs. Table 5 below outlines the magnitude of the changes which took place between the two stages of the SIDHAS program, before and after rationalization.

Table 5: SIDHAS Targets Changes between Phase I and Phase II

Outreach and testing targets increased from 252,000 people on treatment to 325,000
Pregnant women tested for HIV rose from 1.7 million to 3 million
HIV-positive pregnant women provided with ARV prophylaxis rose from 41,220 to 90,000
125 new USAID-funded PMTCT sites were added in FY2013 and 700 in FY2014
50 new Antiretroviral Treatment (ART) sites were added in FY2013 and 100 in FY2014

In addition to meeting the new annual service delivery targets which included a massive scale-up of PMTCT services, the project has provided commodity support and renovated 109 comprehensive health care sites, which offer HIV and TB services. In some cases, the rationalization necessitated handing over HIV facility sites to other donors such as the Global Fund. The process of handover required that it be done in a seamless manner so as not to disrupt or cause a hiatus in vital HIV and TB services. SIDHAS carried this out with only minor glitches reported by staff in charge of health facilities and other key informants.

SIDHAS project has engaged in sub-grants with 35 private, non-profit, faith-based, community, and civil society facilities providing HIV services. The Evaluation Team visited a sample of the private facilities. SIDHAS adapted its capacity building model to include assistance to both the public and private sector management teams and providers and the Federal Health Ministry. The private sector provides HCT and PMTCT only and they provide a significant proportion of PMTCT services as the private sector provides 60% of formal antenatal care in Nigeria. Any person prescreened as TB positive by a private standalone PMTCT site has to be referred to a public facility for treatment.

The evaluation demonstrated that the SIDHAS project management team and the technical assistance provided has been highly responsive to the policy changes by the GON, including the Nigerian Global Fund program, and by the USG/PEPFAR which took place in 2012-2013.

Question 2: To what extent have specific strategic changes related to PMTCT scale-up and Public-Private Partnerships impacted project implementation?

Scale-up of PMTCT services, in line with Government of Nigeria (GON) policy, required greater involvement of the private sector that provides 60% of antenatal services, and a significant proportion of delivery services for pregnant women in Nigeria⁹. Scale up also required rolling out of PMTCT services to the primary care level where there is the greatest potential to reach pregnant women who do not traditionally use public antenatal and delivery services. The Evaluation Team identified challenges to involvement of the private sector in terms of quality and consistency of both PMTCT services and reporting, particularly in private for profit facilities. Rolling out PMTCT services to public primary care level necessitated SIDHAS further decentralizing its technical assistance to local government level, with the establishment of Local Government Area Implementation Teams (LITs). Provision of PMTCT services at public primary care level has not yet been implemented long enough to evaluate its effectiveness in provision of PMTCT services to positive mothers and their exposed infants through to the end of breastfeeding. The Evaluation Team found that some of the faith-based, private sector, comprehensive service providers are able to follow up positive mothers and their infants postnatally; many private for profit providers only provide PMTCT services in antenatal care and to an extent during labor and delivery. Many do not take DBS for DNA PCR from the infant—instead referring the infant to public facilities—and many do not offer mother and child health services and so do not follow up positive mother-exposed infant pairs postnatally.

SIDHAS is currently working with 675 private sector facilities in the 15 SIDHAS States. SIDHAS also has 35 active sub-grants with faith-based/private-not-for-profit hospitals, CSOs, and CBOs. The Evaluation Team visited and interviewed private sector providers and beneficiaries to assess SIDHAS assistance and results. Although the private sector provides a large proportion of the formal midwifery services, it is reaching a relatively small segment of PLHIV and few TB patients. The Evaluation Team found that many of the private, for-profit PMTCT services visited were small and poorly equipped. One stand-alone PMTCT service in Lagos was found to be a fertility treatment center that added HIV services, but had not treated any pregnant women. The facility was serving mainly as an early detection and referral site. Many of the new private sector PMTCT sites, had minimal prior expertise in managing HIV and therefore require a greater level of capacity building and technical support than the public sector facilities which have been offering HIV services for many years. Less than half of the sub-grantees supported by SIDHAS provide HIV services beyond HCT; most provide primary prevention services to vulnerable and high risk communities, identify vulnerable OVC households and offer them community-based care, assist support groups for PLHIV and support links to social services and public health facilities for PLHIV and their families. The private sector provides a significant proportion of midwifery services and a further significant proportion of pregnant women are delivered in the community by TBAs or in churches. If pediatric AIDS is to be eliminated in Nigeria, these private sector providers have to be part of the Nigerian AIDS response. Until and unless the GON is prepared to effectively scale-up supervision of private providers including assuring that equipment

⁹ About 60% of pregnant women in Nigeria deliver in the community with TBAs, or in churches; private sector providers deliver a large proportion of those women who deliver in health facilities.

requirements are met, the private sector will not be able to ensure greater access to care and treatment of sufficient numbers of the at-risk population during the life of this project.

The focus group discussions provided some insights into the important role that community-level support groups play in dealing with HIV stigma and discrimination as well as in supporting adherence to treatment. Building sustainable networks of support which also does effective lobbying and advocacy is an important alliance that community-based volunteer network offers. Also, gaining support of the faith-based community is absolutely critical to reducing stigma and discrimination. In terms of active, structured public/private sector partnerships the team saw only a few examples of active well thought through strategic partnerships and alliances between the public sector and the CBO/CSOs in Akwa Ibom.

Question 3: Have the project's capacity building efforts contributed to increasing the effectiveness of the Government of Nigeria and Civil Society Organizations (CSOs) to sustainably provide comprehensive HIV/AIDS prevention, care and treatment services. If so, how? If not, why?

SIDHAS' efforts building the capacity of GON structures and personnel have only translated into short-term results. The Evaluation Team found no verifiable evidence for actions, such as a development of a sustainability plan, to support long-term outcomes. There are no articulated sources and means of continued funding for the SITs/SMTs by the states. Activities initiated by SIDHAS may not be sustained beyond the life of the project.

SIDHAS' capacity building approach hinges on its Continuous Quality Improvement (CQI) process, aimed at achieving sustainability. In its May, 2011 technical proposal, FHI provided a plan to conduct CQI baseline assessments; develop capacity-building plans with state entities, CSOs and health facilities, and support state- and LGA-level entities to implement those plans.

SIDHAS developed the terms of reference for the establishment of SITs, but later, in response to the Nigerian PCRP, SIDHAS had to further decentralize and establish Local Implementation Teams (LITs). However, SIDHAS was unable to establish LITs across all the states and LGAs in part because of limitations on funding. SIDHAS conducted a joint annual appraisal of the capacity of the SITs using the CQI tool, although it has no authorization to do this with the new NACA-mandated SMTs.

SIT members interviewed by the Evaluation Team, indicated that many health care providers and facilities have benefitted from SIDHAS project training. In Anambra and Rivers States, SIDHAS has trained a pool of Master Trainers from the Government staff who currently support SIDHAS' trainings, and are capable of continuing such trainings when SIDHAS exits. However, there is no capacity building or training plan to continue the training activities.

SIDHAS has conducted joint supportive supervision with the SMOH/SIT for mentorship of service providers, and other ad hoc visits to address issues arising at the facilities. However, the SMOH/SIT members have not regularly participated in the visits with SIDHAS because of failure to jointly plan the visits at times convenient to SMOH/SIT work schedules—personnel reported that they cannot just drop their work commitments at short notice to follow SIDHAS staff decisions to visit facilities—and lack of SMOH/SIT transport.

The project has provided equipment and commodities to improve laboratory services and the quality of health care. The capacity of facilities' and the Ministries of Health's staff who manage commodities have been built through training to improve reporting, which has also helped in the forecasting for drugs and commodities.

SIDHAS supports monthly M&E meetings at the LGA level, where data is collated and reviewed for all facilities. Members of the SIT participate in the M&E meetings to identify 'gaps' in reporting and address such with the respective facility. However, there was no verifiable evidence of use of data for decision making at the state level and most state level respondents indicated that they do not provide feedback to facilities on the data reported through the DHIS.

Staff of SIDHAS sub-grantees, including faith-based facilities, and CSOs interviewed by the Evaluation Team indicated that they found the CQI process helpful. Through the process, they developed their own capacity building plans with timelines and measurable indicators. Many sub-grantee staff were trained by SIDHAS in strategic planning, financial management, advocacy, and resource mobilization, as well as in HIV technical and programmatic issues. The SIDHAS CQI approach seems most fitting to the needs of CSOs and relatively small faith-based hospitals although most sub-grantees complained that their Memorandum of Understanding (MOU) with SIDHAS was inadequately funded for the level of activity and results required. The obligated sums have been scaled down by SIDHAS, and the CSOs have not been able to mobilize enough resources to expand their activities. This poses a very real challenge to their sustainability.

CSOs welcomed the quarterly quality improvement checklist administered jointly by SIDHAS and the CSOs. The checklist covers different areas including programming, M&E, financial management. While the checklists were intended to be administered by the SMOH that might not be possible as CSOs in general seek to avoid interference by government in their activities. Thus far, the SIDHAS team has administered the checklists.

The GON provides by far the largest proportion of HIV and TB diagnosis and treatment services and will continue to do so in the foreseeable future. However, until a culture of service continued quality improvement is introduced and sustained, the quality of service delivery will remain mediocre and services will continue to be interrupted by strikes and other avoidable situations such as stock out of drugs, reagents and consumables. This situation could deteriorate without the support of SIDHAS or another development partner to intervene, unless the GON puts in place systems improvements now.

The private sector includes private for profit PMTCT service providers, for profit community pharmacies providing HCT and referral services, and not for profit, faith-based comprehensive HIV & TB service providers.

The evaluation identified service quality issues in the for profit sector including poor quality data and reporting. Few for profit providers were providing services for altruistic reasons and most are unlikely to continue to provide services unless they are provided with ARVs, reagents and consumables. Some community pharmacies may continue HCT services, charging for the rapid test. A minority of community pharmacies sell ARVs to patients who come with private

prescriptions because they do not want to go to public facilities. This is unrelated to SIDHAS and is likely to continue because there is demand from more affluent patients.

The private, not for profit, faith-based facilities that have sub-grants from SIDHAS often provide the best quality services but with fee for service that excludes the poorest. Some have charity funds to help the poorest access services but several faith-based facilities said that their resources for this are very stretched. Several faith-based facilities had high turnover of medical staff, leading to a need for frequent trainings to ensure incoming medical staff have the right knowledge and skills. The training of faith-based staff is unlikely to be sustained by the SMOHs/SASCPs after the end of SIDHAS. Not for profit faith-based services can only continue if they receive ARVs, Reagents and consumables as they cannot source these themselves and their clients cannot afford to pay replacement prices for these items.

Additionally, there are many CSOs that have sub-grants and deliver prevention services—particularly to high risk/vulnerable populations, diagnosis and referral, and home-based care including for orphans and vulnerable children. The CSOs that the evaluation met with were small, some quite nascent, and without the ability to generate income or access funding from elsewhere to sustain their programs after the end of their sub-grants.

In conclusion, only the public services and community pharmacy will be sustained after the end of SIDHAS, and the quality of the public service delivery is likely to wane unless SIDHAS addresses management for delivery of continued quality improved service delivery at state level and supports the SMOH/SASCP to change the culture of service delivery at facility level.

Question 3a: Did participants, both individuals and organizations, apply their learning and with what results?

Over ninety percent of the service providers and managers interviewed at the various health facilities were trained by SIDHAS to enhance their ability to provide HIV & TB services to clients. The in-service training provided by SIDHAS included laboratory services, blood safety, HTC, PMTCT, TB/HIV, HMIS and quality management systems (QMS), which are all expected to translate into high-quality service delivery. The health facility service assessments conducted during the evaluation indicated that of the 15 health facilities visited across the four States that had ART service assessments, 1 was rated good, while 11 (73%) were rated adequate, and 3 (20%) were rated poor. PMTCT services were assessed in 51 facilities and rated adequate or good in 32 (63%). The HTC service was assessed at 30 facilities and rated adequate or good in 26 (87%), TB/HIV services were assessed in 15 facilities and rated adequate or good in 10 (67%) although 6 (40%) did not have SOPs. Pharmacy services were assessed at 50 facilities and 37 (74%) rated adequate or good. The 19 of 51 facilities rated as providing poor PMTCT services reflects the relative poor standards of private for profit providers.

The Evaluation Team found a working system in place in almost all of the health facilities visited for client tracking and tracing HIV clients who default from follow up. The system includes phone calls to clients who missed appointments and occasionally home visits by the facility “adherence team” or volunteers. Public health nurses providing PMTCT services at primary care facilities also occasionally conducted home visits to positive pregnant women who failed to return for antenatal care. Tracking of clients—either by the M&E team or the adherence team,

had in general been introduced in response to SIDHAS training and technical support. Where volunteers traced those lost to follow-up in the community, their stipends were paid by SIDHAS although the amount of the stipend was expected to be reduced in FY2015. Although 77% of the providers claimed that retention in care and treatment had increased over the last two years, 8% said it decreased, another 8% said it remained the same, while the last 9% said they do not know. Although tracking retention rates and patient survival rates would be key outcome and impact measures, the Nigeria DHIS is not set up to track cohort data over time.

A critical capacity which SIDHAS has worked to strengthen is supervision, oversight, and management (including performance management) for the entire HIV and TB program. While there is evidence that SIDHAS training transferred some skills related to the use of checklists and the deployment of adherence teams and the integration of services, the Project has not yet resulted in a fundamental change in the way health facility managers oversee or evaluate the performance of their staff or provide vital feedback and corrective action when a service is not meeting the standard of care or positive recognition when a service is carried out well. For example, the Evaluation Team did not see evidence of specific mentoring of hospital managers on their management/supervisory/oversight role. When asked “how do you know how well your department is performing?” there was no satisfactory answer from a majority of the health facility managers. Also, there was no evidence of managers being able to (in collaboration with other hospital staff) assess the performance of the various units in their facilities.

In terms of the application of quality improvements and translating this into new effective programs, some of the facility managers initiated some quality improvements including structural and operational integration of hospital services, by ensuring service providers are attending to all clients (anonymously) in the outpatient department every day of the week. This change was put in place to avoid having a specific ART clinic day, which led to less anonymity for HIV patients and greater stigmatization. There was one example where the SIDHAS training on advocacy led to some health facilities’ managers in Anambra state visiting a Local Government Women’s Group and traditional leaders to advocate for the expansion of their section of the hospital.

There was no evidence of feedback from the State and little evidence from SIDHAS to the health facilities on performance issues identified through the HMIS data. There was no verifiable evidence on the use of data for decision-making at the health facility level. In general, the only feedback was during monthly M&E meetings and that focused on the data quality and issues to do with reporting. The exception was that some comprehensive secondary sites in Akwa Ibom had performance charts on the walls that had been compiled to August 2014. Most of the performance indicators on the charts had been running at or very near to 100% completion for several months until August 2014. When asked “what changes have been introduced after analysis of the HMIS data for your department?” almost all the managers’ answers were ‘none.’ However, more providers indicated that they had made changes. For example, one private standalone PMTCT site had failed to meet its target for 100% of pregnant women to know their HIV status because the women were seen by the doctor in the antenatal clinic and then went home instead of returning to the laboratory for HIV testing. The antenatal nurses, in discussions with SIDHAS staff, added HIV testing to the raft of laboratory tests that pregnant women had at the time of registration, which are ordered by the nurses before the woman sees the doctor.

That change increased their performance on that indicator to 100%. Several facility HCT staff had introduced escorting positive clients to registration in medical records. They emphasized the clients' right to register and attend follow-up, but acknowledged that accompanying clients when they were distressed after receiving a reactive test result, was supportive to the client. One faith-based comprehensive secondary facility in Akwa Ibom had introduced a system where the master copies of the reports were kept by the M&E staff and all clients went first to M&E before going to their clinic appointment. At the end of each month, the M&E staff came around and completed the registers in each department from their master register, ensuring that each department register was perfectly and accurately complete. This was clearly introduced because SIDHAS staff had been providing feedback to clinic staff. These interventions however useful, did not result in any better use of the recorded register data for decision-making by the facility clinical staff or managers.

The Evaluation Team used a checklist to verify the level of accuracy of the data compilation between the registers and the monthly summary forms, for four indicators at the health facilities visited. The results were encouraging as there was no systematic over-reporting: three facilities had over-reported one indicator, and most reports were accurate within a margin of 10% and only a few facilities underreported occasionally on one or occasionally more indicators. The Evaluation Team visiting facilities in River State did not use the evaluation instruments. See Annex VII for more detailed information on the accuracy of data reported from health facilities.

Question 3b: Does collaboration and cooperation exist between the Project and other implementing partners, donors, and stakeholders and how has this contributed to project implementation?

There is evidence in all four States that the SITs are serving to bring together all of the key donors. There was evidence of joint planning and collaboration during the handover and transition of facilities from SIDHAS support to the Global Fund. Within districts and LGAs there are examples of cross donor collaboration but these are the exception and not consistently taking place in all districts in all states.

The Evaluation Team did not find evidence of a strategic commitment by implementing partners. For example SIDHAS does not regularly report to the Development Assistance Database (DAD) managed by the NPC. The regular analysis and review of an up-to-date DAD will enhance stewardship through better coordination and elimination of duplication of projects while enhancing efficiencies through timely sharing of reported best practices and lessons.

In Anambra, the government felt it has not shown much commitment to encourage FHI 360 to do more, such as adequately coordinating with UNICEF, World Bank, and UNDP.

Question 4: What adjustments in the Project's implementation should be made to enhance its effectiveness and efficiency? When answering this question, discuss how lessons learned from SIDHAS can help improve the design of future comprehensive HIV/AIDS and TB projects.

SIDHAS has a model for delivery of community-based services with referral links to health facilities and often with involvement of community volunteers in the tracing of those lost to follow-up from facility-based services. The model involves CBOs recruiting, training and

supporting men and women volunteers, and community support groups for PLHIV. Some, but not all, of the volunteers are PLHIV. The model offers potential for addressing PMTCT in the community, which will be necessary if Nigeria is to achieve elimination of pediatric AIDS. It also offers scope for decentralizing DOTS to primary care and community level.

Because Nigeria has very low facility delivery rates that are not going to change greatly in the near future, PMTCT—particularly postnatal care and follow up for HIV positive mothers and their exposed infants—has to be delivered at the primary care level and in the community if it is to be effective. Use of CBOs and community volunteers linked to primary care facilities is an efficient approach that might be adapted with CBOs supporting mentor mothers in the community. Mentor mothers could provide the link between HIV positive mothers and their exposed infants and facilities as well as provide motivation to positive mothers to remain in care and treatment.

Similarly, because Nigeria has an extremely low case detection rate for TB, it is likely that taking TB diagnosis and treatment to the primary care level—with DOTS delivery in the community—will improve the detection and treatment of people who have pulmonary TB. Use of CBOs and community volunteers linked to primary care facilities that offer TB diagnosis and treatment, might prove an effective way of significantly increasing the identification and treatment of people living with TB in Nigeria.

FHI piloted diagnosis and treatment of tuberculosis at the primary care level in the GHAIN project—through its HAST approach integrating delivery of services for HIV/AIDS sexually transmitted diseases and tuberculosis. Yet the HAST experience has not influenced TB service delivery in the four States visited by the evaluators. The SIDHAS approach of triaging all HIV chronic care clients to identify TB-HIV co-infection has not produced good results in terms of numbers of HIV positive persons being treated for TB co-infection, SIDHAS still has two years to influence expansion of TB service delivery to the primary care level bringing diagnosis and intensive treatment closer to where people live. Experience rolling out and delivering TB diagnosis and treatment at the primary care level would be valuable for future USAID/Nigeria program design.

Healthcare providers and the health facility managers shared a great concern about the future government commitment of resources to continue the successful HIV and TB diagnosis, treatment and case management response. Securing and communicating to providers and facility managers LGA and Federal Government commitment is key to allaying fears. Across all four States, few if any providers were familiar with the use of the M&E data to make better clinical decisions or the organization of services. They were also not sure about what to do with those lost to follow-up and who missed appointments and wanted better systems in place to handle and avoid missed appointments so there was not a discontinuity of care. HIV and TB providers indicated that they had good client retention rates for care and treatment. This is a potential area of support SIDHAS can reinforce during the remainder of the Project.

Finally, an important result which may warrant attention came out of the PLHIV focus groups. All of the groups reported some experience of workplace linked stigma once they had a positive diagnosis and some PLHIV reported a loss of employment following their diagnosis. Loss of employment was a main fear of PLHIV and one that USAID/Nigeria might be able to address through one of its PEPFAR programs.

Question 4a: Are the internal project management and the relationship with the mission effective for project implementation?

The overall management relationship between the mission and the project team appears to be effective. When the strategy changed, the SIDHAS team was consulted about the changes and was given the time to adjust. There are good lines of communication in place between USAID and the SIDHAS team. An area where more USG dialogue needs to take place to assure successful GON stewardship is to reinforce handover plans and key financial and management benchmarks at the state levels. Another area where the USG team can work closely with the GON is to clarify the different and specific roles of the various GON institutions and private sector partners working on HIV/AIDS and TB. Greater sharing of goals, budgets, workforce plans, and commitments would go a long way towards advancing implementation of the Government HIV/AIDS and TB response.

Question 4b: Are there alternative approaches that may have achieved different levels of benefit at the same cost?

Given the complexity and difficulties described in meeting key results to date SIDHAS just may be too large to adequately manage and monitor in the Nigerian context. Each of the key results is a project unto itself. Large projects such as SIDHAS require complex and strong management structures on the part of the contractor and equally strong monitoring capacity on the part of USAID to manage and coordinate the activities of sub- contractors and local organizations and to make sure that contractors and state and local governments are working together. Unless management and monitoring and supervisory systems are unusually strong, it is usually best to undertake smaller more focused activities. Smaller projects will allow management to focus and concentrate its resources more directly at achieving objectives.

Given security restrictions on travel it is not possible for USAID staff to effectively monitor the complex SIDHAS project from Abuja. If USAID plans on focusing its resources on the four focal States in the South, the mission may want to consider placing CCN staff in the respective States to provide a better opportunity to manage and monitor program implementation and to establish productive relationships with participating public and private sector institutions. The Mission should consider the issues involved of transferring Abuja based staff to key project States in the future. This could involve a regional approach based in Lagos or assigning staff to each of the focal states.

The project has not and was not requested to document costs per patient for the delivery of treatment and care services. This is an important element for the future sustainability strategy for each state and should be incorporated into the sustainability plans. The most cost-effective delivery systems need to be determined. Costs should be obtained for the delivery of care through the private sector to determine if contracting out some services in the long-term might present a cost-effective option. The evaluators did not review cost data generated by the Project.

CONCLUSIONS

1. The Project has proven to be highly effective at scaling up and integrating many elements of HIV and TB treatment, diagnosis, and care including well-trained providers who are sensitive to the needs of their patients. The supply chain is adequate and operational in most of the facilities surveyed. SIDHAS has played a role in strengthening this system. The HMIS is producing more streamlined and consistent data. The Project's model for service delivery includes an important link to CSOs and volunteers.
2. Rationalization had a short-term impact on service provision and particularly the build-up of PMTCT and ART. Rationalization appears to have derailed SIDHAS' approach to building capacity to sustainably deliver high-quality services. While generally understood at the national level, rationalization is not well understood at the state and local government levels and at the facility level.
3. A better balance is needed between increasing access and improving quality and comprehensive services. Currently, the project's emphasis appears to be on increasing access. More care and effort needs to be placed on improving quality and comprehensive services and creating a culture of service delivery quality improvement which focuses on the client and teamwork, use of data for improving service delivery, and seeking more efficient and cost-effective service delivery. Specific quality deficiencies observed include: adherence to cleanliness, comfort and privacy standards, and lack of standard operating procedures. Best practices of higher performing facilities need to be replicated across the Project. Focus groups consistently complained about privacy, stock-outs, and side effects of drugs not being adequately explained. Lack of joint postnatal follow-up of HIV positive mothers and their children is another health service delivery area that needs to be strengthened. Lack of TB Dots and ART services for men at the primary health care level is also a deficiency which needs to be addressed. Health workers, physicians in particular, in public and private facilities should understand and practice service delivery to SOP standards. PMTCT scale-up in the private for-profit sector has met challenges in terms of quality and consistency of service delivery and reporting that need further effort for resolution.
4. Current programs are not structured for sustainability. Sustainability is not solely a SIDHAS function. USAID and PEPFAR also have important responsibilities. Lack of political will appears to be the principle source of the issues regarding sustainability. Unless State governments are willing now and in the future to fund and support high quality comprehensive HIV/AIDS & TB programs no project will have a long-term impact. USAID needs to take a much more direct and forceful role with national and State political leaders and develop strategies for sustainability. This is probably not something that can be done at the technical level. Senior USAID management needs to take the leading role in these discussions. This could be done in cooperation with the Council General in Lagos for the four focal states. If there is not adequate support at the political level, States should be dropped or USAID should recognize that long-term impact measures related to sustainability, leadership, and governance will not be met during the life of this Project and will take much more time. SIDHAS' role will be to implement the USG strategy by working to improve stewardship by Nigerian institutions such as NPC,

NACA, FMOH, and State governments. Sustainability plans need to be built around the actual costs of delivering patient care and the relative efficacy of various approaches.

5. Cross-sectional integration of services has occurred for HCT and PMTCT at the public primary care level, including innovations by public health nurses integrating these services into outreach. Functionally integrated services are offered by some comprehensive sites but not at the tertiary level, nor by some large, complex secondary facilities, and not at the primary care level in Lagos state. The lack of postnatal integration of PMTCT services seriously compromises the elimination of pediatric AIDS in Nigeria. The lack of readily available family planning at HIV and TB treatment sites for persons living with HIV and TB is also a serious problem which can be readily addressed. Functional integration of services needs to be improved. Integration is a long-term process and in-service training, revising protocols, and reinforcing integration through certification and supervisory visits are required for integration to fully succeed.

6. SIDHAS is perceived to be a project that is designed to address a USG agenda. Discussions with four Nigerian State institutions revealed disenfranchisement, neglect, or disinterest. This is a function of political will, but also a perception that SIDHAS is an American program. Somehow the ambitious goals and objectives have been lost at the State and local levels where SIDHAS is supposed to be working. SIDHAS must become a Nigerian program. More constructive, and effective involvement of Nigerian officials must be developed in the remaining years of the project on key topics including financing HIV and TB services based on actual costs, and training and deploying qualified technical staff and administrators and representatives of SMTS. Costs studies should be carried out by SIDHAS to provide the GON with the costs of various outreach models, facility based care and support and community based approaches.

7. The SIDHAS model for community HIV activity—with CBOs supporting volunteers that link communities to facilities—can be expanded by the inclusion of mentor mothers to improve PMTCT, crucially including postnatal PMTCT, in the community. The SIDHAS model for capacity building has not focused enough on institution-wide, organizational strengthening and supportive supervision and follow-up by the regions and districts. Supervision and accountability for results and positive recognition for results needs to take place but is currently sporadic.

8. SIDHAS has invested heavily in HMIS technology and computer applications and less so in training the facility staff to use the data for their work. The HMIS data currently collected is not routinely used by facility managers, providers, or State MOH officials for key management and clinical decisions including financing services. Data are however, being reported more effectively up the chain of command and this is a major improvement leading to be national case reports. The Project is not consistently tracking patient retention rates—a key measure of treatment of adherence.

9. The SIDHAS team includes organizational development capacity building, community linkages, resource development, and M&E expertise. A careful assessment by the GON/USAID needs to be made if the actual long and short-term technical assistance requirements of the HIV and TB services are being adequately met by the SIDHAS model, or should a more focused model be introduced requiring additional contractor support.

10. One of the key outcomes expected from the SIDHAS project is strong leadership and governance structures at the State level to manage HIV and TB programs. There are no systematic SIDHAS-supported leadership plans in place to move towards that objective. A careful assessment needs to be made of the best practices in leadership development which are working in other sectors.

11. Stigma and discrimination continue to be a problem across the states surveyed and are likely to be a problem nationwide. Support groups are an important outlet for PLHIV and are an excellent tool to promote adherence to HIV and TB treatment regimens. The SMTs must address the employment discrimination that PLHIV are facing.

RECOMMENDATIONS

1. The USG, SIDHAS, Nigerian officials at the national and State level, CBOs and private care providers need to develop a plan of action to operationalize this evaluation's findings and conclusions in terms of service delivery, integration and improved stewardship. The evaluation report can serve as a focus for wide discussion of ways to improve performance. This is not a USG, SIDHAS, or Nigerian function, but an entire program-wide function. Action Plans for States using the SMT model should be supported and implemented. Key to the approach will be the review of the effectiveness of the SIDHAS capacity building approach. The emphasis needs to go beyond training and equipping providers toward building much stronger HIV facility organizations. This necessitates better human resource management systems in all facilities in the public sector and in most cases will require human resource reforms at the state level. It also requires the GON to hire and deploy sufficient qualified SMOH staff to the SMTs. The technical functions that the SIDHAS state technical assistance teams currently offer must be reflected in future SMT staffing plans. Linked to the capacity building component is the support for a dynamic HIV and TB quality service improvement approach which engages, empowers, and provides tangible incentives to the facility for innovation and excellence. Thus far, the use of standard supervisory checklists has not resulted in enormous quality improvements. Lessons learned from successful programs in states and best practices should be incorporated into plans. Visits to these states should be undertaken to see what works and to develop workable networks with successful officials.

2. USAID should develop Strategic Frameworks with each State which outline key expectations of both the GON and the USG for SIDHAS objectives. These agreements could describe the objectives, activities and resources to be provided by both parties as defined in the Action Plans. Duties and responsibilities of the State should include: identifying and providing funding, co-financing for training and local government support from State budgets; identifying and supporting key state, local and private sector entities involved in the project; ensuring funding to LGAs from the Joint State/LGA account; and the development and phased implementation of funded State Sustainability Plans linked to State Handover Plans. These agreements should also describe how the parties can resolve differences at both the administrative and political levels. The agreement should be part of Memorandums of Understanding signed by the Mission Director and each Governor. MOUs are not legal documents, but they do lay out understandings of the parties and are useful in providing and enforcing the focus necessary to establish political

will and advance governance, administrative and financial commitment. Implementation of the Strategic Frameworks would be monitored by USAID staff. It is recommended that the USAID Mission Director and Governors meet annually to discuss progress and to resolve issues.

3. The Project needs to research and adopt a different approach to leadership and governance which provides incentives to attract and retain outstanding administrative and technical talent to work on the very sensitive area of HIV and TB program management. Experience from high performing States should be documented and these States should lead the work on this critical component. Barriers to effective leadership including salaries and benefits and other forms of recognition must be addressed.

4. The support for PLHIV might be deepened in the next two years with some attention to linking support groups with small businesses and sympathetic, supportive employers.

5. The Project needs to assure that patient retention rates and survivability are measured to evaluate the ultimate success of the SIDHAS program on improving health outcomes. Obtaining reliable longitudinal HIV and TB patient cohort data should be a priority for PEPFAR funding and could be carried out and led by the GON with either SIDHAS project funding or other PEPFAR program funds.

6. In order to move HIV and TB treatment sites from simply meeting minimum standards or below minimum standards toward a standard of excellence, a focus on the client and teamwork must be instilled. In the remaining two years of the project SIDHAS should work with the SMTs/SITS to specifically identify new clinical and management leadership trained in quality assurance and leading high performing team. These new leaders will identify performance and other barriers through review of the HMIS and reports from supervisors and resolve issues. The service quality improvement process should be incentivized from the state level with recognition and awards for facilities with better than average performance and those that show the greatest improvement in service quality. The Republic of South Africa has introduced such a system which might be a model. SIDHAS should fund observational visits by participating SIDHAS states to other model quality improvement sites supported by PEPFAR and USAID that have embraced and executed a culture of quality across the government health delivery system.

7. The HMIS is now operational. The next critical step is to ensure that health facility managers and providers have the skills to use and apply the data to make better management and patient care decisions. On-the-job training on the use of data for decision-making should be carried out. Supervisors need to be trained to ask questions based upon the data. The shift in orientation should begin as soon as possible so that the GON can fully benefit from the presence of the SIDHAS HMIS technical assistance.

8. CSO/SACA and SIT partnerships need to be built with an eye towards sustainability. The SACAs should consider contracting out services to well functioning CSOs through clearly structured agreements with effective supervision by the GON in place. Without this supervision and attention to quality of care it will not be possible to further devolve expanded service provision to the CSOs or for-profit private sector.

ANNEX I: EVALUATION STATEMENT OF WORK

Evaluation Scope of Work for Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS) Project

I. BACKGROUND INFORMATION

A. Project Identification Data

Development Objective	Project Title
Increased Nigerian Capacity for a sustainable HIV/AIDS and TB Response	Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS)
Award Number	Award Date
620-A-11-00002	September 12, 2011 to September 11, 2016
Funding	Implementing Partner(s)
\$333,565,721.00	Family Health International 360
COR/AOR	Estimated Evaluation Budget
Dr. Ezekiel James (ejames@usaid.gov)	\$150,000.00

II. EVALUATION RATIONALE

A. Evaluation Purpose

In the first two years of its implementation, the SIDHAS project had activities in all 36 Nigerian states and Federally Controlled Territory (FCT), with a focus on expanding service delivery (mainly in the public sector) and Health System Strengthening. However, in its second year of implementation, the project underwent significant changes in its design, scope, and geographical coverage. Most of the changes were due to the rationalization of the HIV/AIDS programs in Nigeria, which impacted 109 co-located comprehensive care sites and the massive scale-up of prevention-of-mother-to-child-transmission (PMTCT) services. To accommodate these changes, the project description and cooperative agreement were modified in July 2013. In addition, the project's operations in Borno, Yobe and Adamawa states were significantly affected by insecurity and the declaration of a state of emergency by the federal government.

The purpose of this mid-term evaluation is to assess the implementation of the SIDHAS project and determine how rationalization has affected the project. Rationalization is defined as the reorganization of PEPFAR-supported services into consolidated networks under the management of single Implementing Partners—in distinct geographic localities (States or Local Government Areas (LGAs)) and is aimed at reinforcing the ability of the Government of Nigeria (GON) at Federal, State and Local levels to manage and deliver quality health services. The evaluation findings will be used to make any necessary mid-course corrections and help guide implementation during the second half of the project. The evaluation findings will also be used to inform future project design.

B. Audience and Intended Users

The primary users of the mid-term evaluation are USAID/Nigeria and our implementing partners. These finding will be used to improve project implementation. Additionally, the findings and recommendation may also be used by other stakeholders, including Government of Nigeria (GON),

U.S. Centers for Disease Control and Prevention, U.S. Department of Defense, the PEPFAR Coordinator's office, and other donor agencies to inform future strategies for other similar programs.

C. Evidence of Participatory Approach

The decision for a mid-term evaluation was part of the project's design. Family Health International (FHI), the HIV/AIDS Office, as well as other USAID/Nigeria Technical Offices were involved in developing the evaluation questions. It is expected that the evaluation team will include the officials from the GON.

I. DEVELOPMENT CONTEXT

A. Project Summary

SIDHAS is a five year project with an estimated budget of \$333,565,721 million covering the period September 12, 2011 to September 11, 2016. The project, which covered all 36 states and the FCT in its first two years of implementation, has since been scaled back to 15 states after the rationalization of the US Government's HIV/AIDS programs in Nigeria.

The SIDHAS project is assisting the GON to reduce the burden of HIV/AIDS. The project aims to sustainably build Nigerian capacity to deliver high-quality, comprehensive treatment, care and related services. FHI is leading a team of Nigerian and international partners, including those that implemented USAID's Global HIV Initiative Nigeria (GHAIN). SIDHAS represents a paradigm shift to a country-owned and country-led program to strengthen health systems. Under SIDHAS, the FHI team is building the technical, institutional and financial capacity of the GON and civil society organizations (CSOs) to coordinate, plan, manage and deliver HIV services. The project was designed to give the GON a central role in planning and implementing SIDHAS activities. To achieve this purpose, operations have been decentralized and focused at the state level, where SIDHAS staff and GON counterparts are working together on co-located teams. The size of the SIDHAS state staff has been reduced as the GON takes increasing responsibility for delivering and managing services, culminating in graduation when performance standards are met and maintained. SIDHAS activities will support increased GON financial commitment to HIV/AIDS services, a key component of Nigerian stewardship and long-term sustainability.

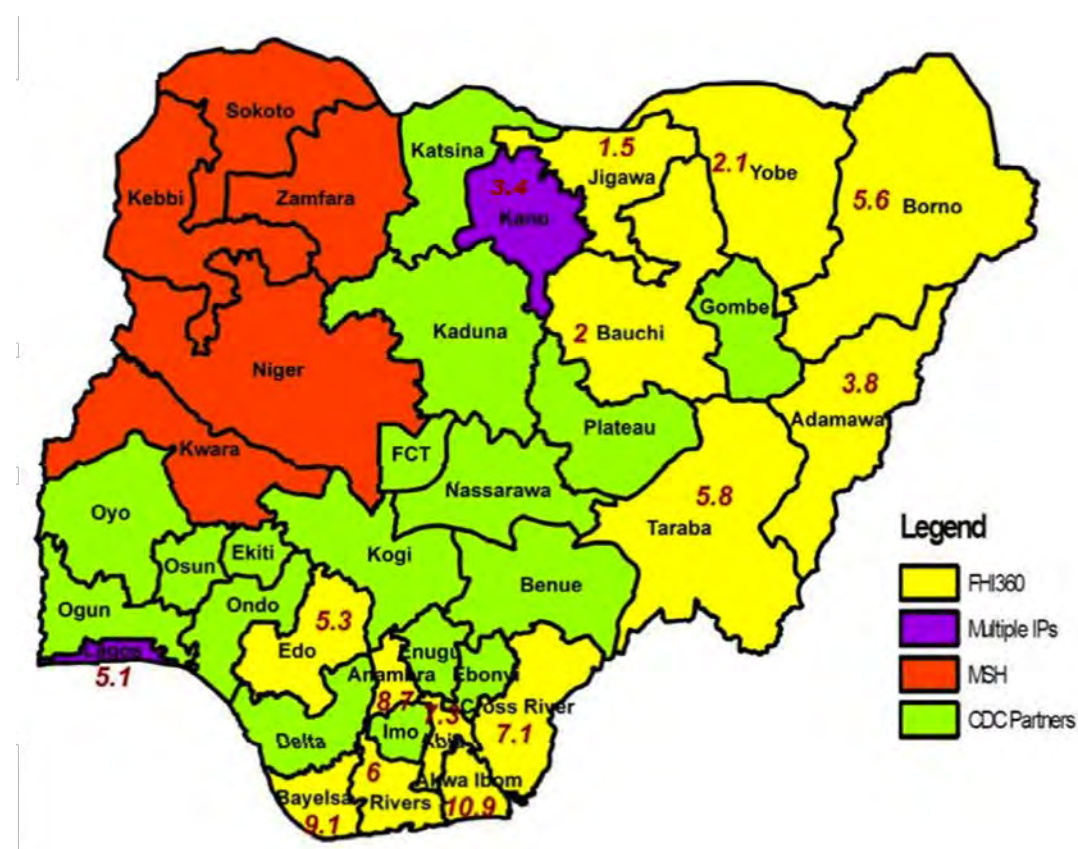
At the facility level, the SIDHAS team is supporting the GON to decentralize ART and PMTCT services to the primary health care (PHC) clinic level to increase access by bringing services closer to households. Within secondary facilities, HIV/AIDS services that were scaled up under GHAIN are being integrated into general hospital operations, which are intended to increase efficiency and GON ownership. All services are being delivered within the chronic care model, which puts increased emphasis on the role of communities and individuals in improving health outcomes. The theory being that the integration of chronic care into facilities and communities leads to improved health practices, which will reduce illness and strain on the health care system. Continuous Quality Improvement (CQI) is being implemented in all supported sites to improve quality. The SIDHAS team is assisting the GON to increasing access, coverage, efficiency, quality, integration, and sustainability in HIV/AIDS services

The goal of the SIDHAS project is to sustain cross sectional integration of HIV/AIDS and TB services by building Nigeria's capacity to deliver sustainable high quality, comprehensive, prevention, treatment, and care services.

In order to build capacity and provide technical assistance (TA), FHI has partnered with the following organizations: the Association for Reproductive and Family Health (ARFH) (community-based programs); Achieving Health Nigeria Initiative (AHNi) (lead implementer in one zone, gender), Deloitte, Inc. (financial and institutional capacity); the Axios Foundation (drug/commodity logistics

systems); and Howard University Pharmacists and Continuing Education Center (HU-PACE) (pharmacy systems and services). The four collaborating TA partners are: Health Policy Research Group, University of Nigeria (health economics and operations research [OR]); Clinton Health Access Initiative (CHAI) (pediatric care and treatment, procurement negotiations); German Leprosy and TB Relief Association (GLRA) (tuberculosis [TB]/HIV); and Population Council (community PMTCT, OR). Together, FHI and its partners is expected to offer the background, expertise and commitment necessary to assist the GON to achieve the impact and outcomes of the National HIV/AIDS Strategic Plan (NSP) 2010-2015.

The project will assist the GON to reach 325,000 people with ART; three million pregnant women with HTC in a PMTCT setting; and 90,000 pregnant women completing ARV prophylaxis by 2016. On the map below is the distribution of states by agency and implementing partners (the numbers represent HIV prevalence for SIDHAS supported states.)



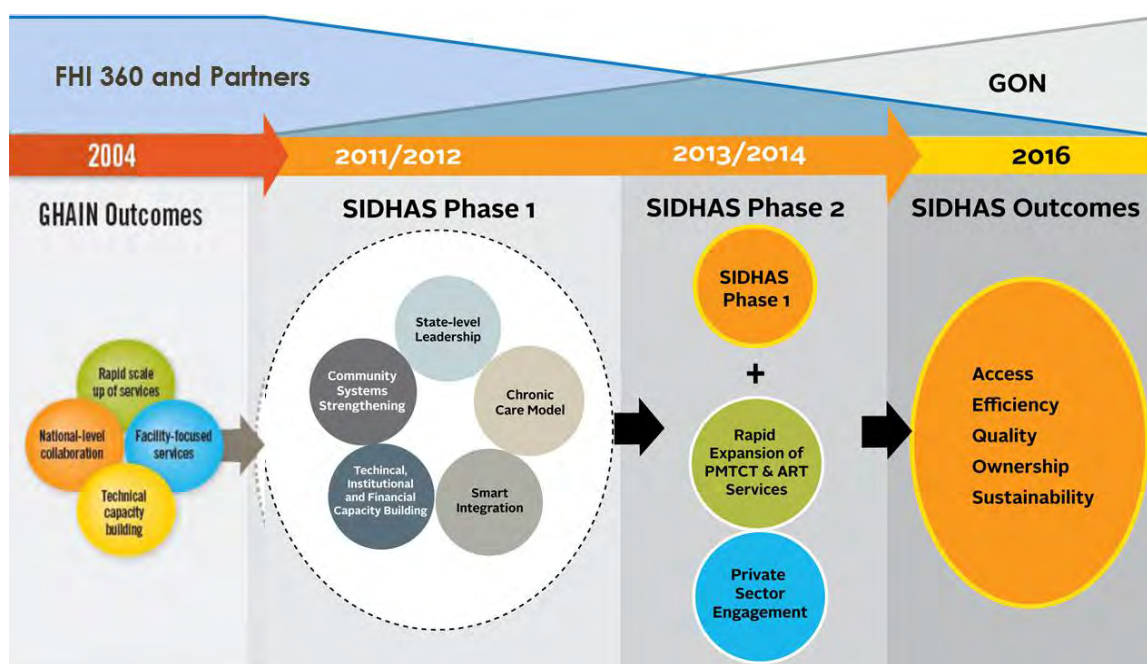
B. Results

The SIDHAS project has the following Key Result Areas:

- **Key Result Area 1:** Increased access to high-quality comprehensive HIV/AIDS and TB prevention, treatment, care and related services through improved efficiencies in service delivery.
- **Key Result Area 2:** Improved cross-sectional integration of high-quality HIV/AIDS and TB services.
- **Key Result Area 3:** Improved stewardship by Nigerian institutions for the provision of high-quality comprehensive HIV/AIDS and TB services.

SIDHAS Conceptual Framework

The following graphic illustrates the FHI-led team's overall approach to building on GHAIN to implement SIDHAS in collaboration with the GON, CSOs, and communities.



Project Development Hypotheses

If FHI collaborates with the GON, CSOs & Communities to implement continuous quality improvement plans and interventions in an integrated manner at all levels; and if the health systems, technical, financial and institutional management capacities for implementing high quality HIV/AIDS service delivery are strengthened, then access to high quality HIV/AIDS services will be increased.

C. Approach and Implementation

Since 2004 GHAIN, FHI and its partners (Axios, GLRA and HU-PACE) have played a crucial role in expanding HIV/AIDS prevention, care and treatment services in Nigeria. GHAIN is widely credited with pioneering ART delivery in secondary facilities in Nigeria – which greatly expanded access to treatment – and consistently has exceeded its major targets (see box at right). When GHAIN began, ART was available at only 26 tertiary hospitals; fewer than 10,000 Nigerians were receiving treatment. As part of PEPFAR's initial emergency response, FHI and its partners worked with the GON to decentralize ART to secondary hospitals, expanding coverage from zero to 124 comprehensive sites and treating nearly 155,000 people by November 2010.

FHI ensures that key lessons learned from GHAIN are incorporated into SIDHAS:

- By leveraging a relatively small amount of Global Fund resources, GHAIN has performed better than initially designed/planned and built strong relationships with GON in the process. SIDHAS continues with the principle of collaboration with GON and leveraging of Global Fund and other resources such as UNITAID to continue doing more with less (cost efficiency).

- GHAIN built synergy by scaling up the integration of RH, TB and malaria with HIV, and piloted cardiovascular disease and cervical cancer screening among PLHIV. SIDHAS ensures the integration effort is systematized through a chronic care model using the “smart integration” approach that supports integration where it is possible, feasible and makes sense to increase access, improve health outcomes and reduce stigma.
- While scaling up, GHAIN supported the establishment of unparalleled systems to support ART in the area of laboratory (public hospitals) and health commodity logistics located in GON structures (state warehouses). Their co-location within the GON structure makes a sustainable transition of ownership to the GON relatively seamless, thereby minimizing interruption in service.
- GHAIN supported the biggest service platform among implementing partners in Nigeria and a robust M&E system that monitors quality of care indicators monthly. This offers SIDHAS a solid foundation on which to build a CQI system that ensures quality of HIV and TB clinical care.
- Despite funding limitations and restricted mandate, GHAIN has built the capacity of community structures to provide care and support, Prevention, Care, and Treatment, and TB services through volunteers, with a strong referral coordination system. SIDHAS will harness these resources in the implementation of a chronic care model and further support HTC and PMTCT uptake.

Many elements of SIDHAS are being implemented in the revised geographic scope of 15 States where FHI is now the primary IP. Key SIDHAS strategies such as integration, HSS, capacity building for sustainability and CQI still continues. At the same time, SIDHAS supported a massive, rapid expansion of PMTCT and ART services in high-prevalence and high-volume facilities in the last one year. This approach has helped to close existing coverage gaps and increase access by saturating services in states and communities where HIV prevalence and unmet need are high.

D. Project Modifications

FHI presented a proposal for a modification of the project in 2013. The modified project – SIDHAS Phase 2 – reflects the joint GON and US Government priority of closing Nigeria’s substantial coverage gaps in PMTCT and ART services. The FHI team has assisted the GON to rapidly scale up PMTCT and ART services in eight priority states.

SIDHAS 2 is being implemented in 15 states, down from all 36 states and the FCT. Many elements of Phase 1 were not impacted by the modification. These include the project’s goal and three Key Results. Major SIDHAS strategies such as integration, Health Systems Strengthening (HSS), capacity building for sustainability and Continuous Quality Improvement (CQI) were continued within the revised geographic scope.

The project’s targets increased from 252,000 people on treatment to 325,000; from 1.7 million pregnant women tested for HIV to three million; and from 41,220 HIV-positive pregnant women provided with ARV prophylaxis to 90,000. In addition to the sites planned under the original SIDHAS, the second phase will add 125 new PMTCT sites in Fiscal Year (FY) 2013 and 700 in FY 2014, and 50 new ART sites in FY 2013 and 100 the following year. In addition, SIDHAS will support the expansion of community-based and drug-resistant TB (DR-TB) services along with the ongoing TB/HIV integration activities.

Major management and staffing changes include elimination of the SIDHAS zonal offices and increased staffing levels to support the rapid expansion.

II. EVALUATION DESIGN AND METHODOLOGY

A. Evaluation Design

This evaluation will use a **non-experimental design** with **mixed method** approach. The study design will rely on the baseline data collected by the project and other stakeholders to measure the contribution of the project to HIV/AIDS response at national and sub-national levels. The evaluation will collect, analyze and interpret both quantitative and qualitative data in order to answer the evaluation questions. The evaluation team will determine the appropriate quantitative and qualitative methodologies for each evaluation question.

B. Evaluation Questions

The mid-term evaluation will seek answers to the following questions:

1. *To what extent is the SIDHAS project on course towards achieving its key results? When answering this question, consider:*
 - a. *Did the project do what was proposed in the cooperative agreement with the level of input and output?*
 - b. *How has rationalization impacted the ability of the project to achieve its results?*
 - c. *Will the project timeframe be sufficient for the longer-term results?*
 - d. *Did the project revise the program framework as experience was gained through implementation of the intervention?*
2. *To what extent have the following strategic changes impacted project implementation?*
 - *PMTCT Scale-up*
 - *Public-Private Partnership*
3. *Have the project's capacity building efforts contributed to increasing the effectiveness of the Government of Nigeria and Civil Society Organizations (CSOs) to sustainably provide comprehensive HIV/AIDS prevention, care and treatment services. If so, how? If not, why?*
 - a. *Did participants- individuals and organizations- apply their learning and with what results?*
 - b. *What collaboration and cooperation exist between the project and other implementing partners, donors and stakeholders and how has this contributed to project implementation?*
4. *What adjustments in the project's implementation should be made to enhance its effectiveness and efficiency? When answering this question, discuss how lessons learned from SIDHAS can help improve the design of future comprehensive HIV/AIDS and TB projects*
 - a. *Are the internal project management and the relationship with the mission effective for program implementation?*
 - b. *Are there alternative approaches that may have achieved different levels of benefit at the same cost?*

C. Existing Documents

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

1. GoN:

- National Strategic framework and plan (2010-2015),
- Policies and program implementation guidelines from the National Agency for the Control of AIDS (NACA) and Federal Ministry of Health.

2. USAID:

- Original Request for the SIDHAS Proposal,
- President's Emergency Plan For AIDS Relief (PEPFAR) documentation,
- USAID program and financial reporting requirements,
- USAID Evaluation Policy;
- PEPFAR Evaluation Standards of Practice;
- USAID Checklist for Assessing Evaluation Reports
- USAID Evaluation Policy
- Concept notes and presentations on rationalization
- Other

3. SIDHAS:

- Baseline data
- Co-operative agreement and amendments,
- Performance Management Plan (PMP)
- Annual, semi-annual and quarterly reports
- Technical strategies, national guidelines, standard operating procedures (SOPs) IEC materials, etc.
- Internal performance reports, success stories, assessments and reviews
- Implementing agencies' sub-agreements
- Annual work plans
- Other

D. Data Collection Methods

Data will be collected using primary and secondary sources. A sample methodology matrix is provided in Table 1.

It is expected that the team will employ a mixed method approach that collects both qualitative and quantitative data about the project. In using this methodology, the team should consider how the evaluation questions will be investigated, data availability and quality, cost of collection, the rigor of the proposed methodology (validity and reliability of method, tools, sampling procedures), and any potential for bias. These considerations should be documented during the design process. The evaluation team will adopt the use of qualitative research to elicit information about the topical issues in line with the evaluation objectives. In-depth Interviews (IDI)/Key Informant Interviews (KII) will be conducted with relevant stakeholders while Focus Group Discussions (FGD) will be held among relevant target groups. The quantitative component of the evaluation will involve the collection of field data with the aid of structured questionnaires to elicit responses on knowledge, attitude and perception of People Living with HIV and AIDS. The questionnaire will also be used to collect information on relevant socio-demographic profile of respondents. The evaluation team will carry out a review of all relevant program documents. The team should perform analysis of the available data with the aim of understanding coverage, achievements, and possible impact of SIDHAS to the beneficiaries and other stakeholders.

Table 1: Methodology Matrix

Evaluation Question	Indicator/Assessment Criteria	Type of Answer Needed (e.g. Descriptive, Comparative, or Cause- and Effect)	Data Collection Methods	Data Sources	Sampling or selection Criteria	Data Analysis Method (s)
1. To what extent is the SIDHAS project on course towards achieving its key results?		Descriptive Normative	Structured/Semi-structured questionnaires Focus Group Discussion KII Desk Review	Project Documents; Beneficiaries; Key informants	Multi-stage Probability sampling technique for quantitative participants; Purposive/convenience sampling for qualitative participants	Qualitative and Quantitative data Analysis
2. To what extent have the following strategic changes impacted project implementation?		Descriptive Normative	Structured/Semi-structured questionnaires Focus Group Discussion KII Desk Review	Project Documents; Beneficiaries; Key informants	Probability sampling technique for Quantitative study participants and Purposive/convenience sampling for qualitative participants	Qualitative and Quantitative data Analysis
3. Have the project's capacity building efforts		Descriptive	Structured/Semi-structured	Project Documents;	Probability sampling technique for	Qualitative and Quantitative data Analysis

resulted in increasing the effectiveness of the Government of Nigeria and Civil Society Organizations (CSOs) to sustainably provide comprehensive HIV/AIDS prevention, care and treatment services.			questionnaires Focus Group Discussion KII Desk Review	Beneficiaries; Key informants	Quantitative study participants and Purposive/convenience sampling for qualitative participants	
4. What adjustments in the project implementation should be made to enhance its effectiveness and efficiency? When answering this question, discuss how lessons learned from SIDHAS can help improve the design of future comprehensive HIV/AIDS and TB projects.		Descriptive	Focus Group Discussion KII Desk Review	Project Documents; Beneficiaries; Key informants	Multi-stage Probability sampling technique; Purposive/convenience sampling	Qualitative and Quantitative data Analysis

E. Data Analysis Methods

For quantitative data analysis, initial tables will be generated and verified for all variables collected through structured questionnaires to ensure that information in the data set are consistent and are of plausible values. Where there is need for verification, the field return will be checked and appropriate correction will be done. Cleaned data will then be used for analysis and report writing. The final data file will also be converted to commonly used software packages such as Excel and SPSS for quick and easy manipulation. The evaluation team will develop an analysis plan and review with USAID/Nigeria for input as may be deemed necessary. Frequency Tables in line with the agreed analysis plan will be generated. For the qualitative data analysis, there will be transcription of all qualitative data collection materials and development of a matrix for coding and categorization. This can be done using ATLAS.ti software or any other qualitative data analysis software.

These analyses are expected to provide information on level of performance and achievement from SIDHAS program at mid-term. The evaluation team will disaggregate data by gender, ethnicity, region, age, or other important characteristics affected by the activity as necessary for each question. Special analysis is expected on the issues of gender apart from data disaggregation. The evaluation team will further develop a draft report which will be shared with the USAID/Nigeria for input. The report will be finalized by addressing all comments and any emerging issue from stakeholders.

• Methodological Strengths and Limitations

The strength of this evaluation is the availability of baseline information that will aid in measuring the changes made over time. Some of the limitations of this evaluation may include:

- Quality of data available
- Post-rationalization effects. After rationalization, the project had to make a number of adjustment which may or may not affect program strategy and implementation
- Measuring effects of Project modification very close to the mid-term evaluation. The project modification was done less than a year ago and this may limit the measurement of the effects of change in strategy.

III. EVALUATION PRODUCTS

A. Deliverables

The team will conduct a 2 to 5 day team planning meeting (TPM) in Abuja prior to the commencement of the evaluation. The TPM will review and clarify any questions on the evaluation SOW, draft an initial work-plan, develop an evaluation design and data collection plan, finalize the evaluation questions, complete the methodology matrix, develop the evaluation report table of contents, clarify team roles, and assign drafting responsibilities for the evaluation report. USAID/Nigeria Team will participate in sessions of the TPM. The following deliverable will be submitted to USAID/Nigeria. The timeline for submission of deliverables will be finalized and agreed upon during the TPM:

1. Evaluation work-plan and timeline: The evaluation work-plan and timeline will be developed during the initial TPM in consultation with USAID/Nigeria
2. Detailed Report Outline: This will be agreed upon during the TPM

3. Questionnaires/interview guides for conducting key informant interviews/Focus Group Discussions. These documents will be prepared during the TPM and submitted to the Mission for review and approval prior to the initiation of key informant interviews and site visits.

4. Sampling strategy/plan: This should be developed in conjunction with the Mission to determine what sites and how many will be visited, how many FGD and KII will be held and with whom, how many structured questionnaires will be administered, to whom, and how.

5. Interview Notes and completed questionnaires: All interview notes and completed survey instruments used for the evaluation will be submitted to USAID/Nigeria. The data used for analysis will also be submitted to USAID/Nigeria.

6. Debriefing(s): The Team Leader will weekly debrief the Mission AOR for the activity on progress being made with the evaluation during field work. At the end of field work, a debriefing meeting will occur with USAID/Nigeria and other stakeholders and include the evaluation team's preliminary findings, conclusions and recommendations, before they leave Nigeria. Power-point presentations (one electronic copy as well as hard copies) for the debriefing will summarize findings, conclusions, and recommendations and will be distributed during the meeting. USAID will provide feedback during both the in-briefing and debriefing(s).

7. Draft Evaluation Report: A synthesized draft report will include, at a minimum, the following: evaluation design, scope and methodology used; important findings (empirical facts collected by evaluators); conclusions (evaluators' interpretations and judgments based on the findings); recommendations (proposed actions for management based on the conclusions); and lessons learned (implications for future designs and for others to incorporate into similar programs). The evaluation team will provide USAID/Nigeria with a draft report that includes all the components of the final evaluation report before departure from Nigeria. USAID/Nigeria will provide written comments on the draft report to the evaluation team within 10 working days of receiving the draft report. USAID/Nigeria will provide the evaluation team with the USAID Evaluation Report Template to be used which will include all of the required components of an evaluation. USAID/Nigeria will also provide the team with the PEPFAR Evaluation Standards of Practice which dictates that standards that are required of all PEPFAR evaluations against which the USAID/Nigeria Mission will need to complete a standardized compliance checklist using the final evaluation report against the 11 standards.

8. Final Evaluation Report: The final report will address the comments provided by USAID/Nigeria and other stakeholders on the draft report. The Team Leader will revise the draft report and deliver a final revised version to USAID/Nigeria within three weeks of receiving USAID feedback. The final report in both hard and electronic format will be submitted to USAID/Nigeria and approval given before it is submitted to Development Experience Clearinghouse (DEC) by USAID.

B. Reporting Guidelines

USAID's evaluation policy requires that all evaluation SOWs include USAID's Criteria to Ensure the Quality of the Evaluation Report (see USAID Evaluation Policy Appendix I). The policy also indicates that the report will outline in detail, any additional expectations USAID has regarding a report's structure, format, and length.

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

- Cover Page
- Executive Summary - concisely state the most salient findings and recommendations (2 pp.)
- Table of Contents (1 pp.)
- List of Acronyms
- Introduction - purpose, audience, and synopsis of task (1 pp.)
- Background - brief overview of the program, USAID program strategy and activities implemented in response to the problem, brief description of program, purpose of the evaluation (2-3 pp.)
- Evaluation Design and Methodology - describes evaluation design and methods, including constraints and gaps (1 pp.)
- Findings/Conclusions - for each objective area; and also include data quality and reporting system that should present verification of spot checks, issues, and outcome (17-20 pp.)
- Issues and Challenges - provide a list of key technical and/or administrative, if any (1-2 pp.)
- Recommendations/Future Directions (10 pp.)
- Recommendations on project approaches and activities from within the project that could be scaled up or replicated, how and why?
- Recommendations on other approaches and strategies to use for a broader health advocacy activity
- References - including bibliographical documentation, meetings, interviews and focus group discussions
- Annexes - annexes that document the evaluation methods, schedules, interview lists and tables—should be succinct, pertinent and readable
- Data set

The draft and final reports will be submitted in two hard copies and one electronic copy. All reports will be in English language.

The report must:

- Distinguish clearly between findings, conclusions (based strictly on findings) and recommendations (based clearly on the evaluation findings and conclusions);
- Comply with USAID Evaluation Policy, specifically;
- Be submitted to the DEC after finalization by USAID;
- Include a Table of Contents, a list of acronyms, an Executive Summary of no more than three pages; a section describing the project to be evaluated and purpose of the evaluation; a section on the design and methodology employed, a section discussing the findings and conclusions, a section on recommendations and a Lessons Learned
- Annexes: Vital source documents consulted and any other relevant materials that cannot be part of the body of the report, including: this SOW; Tools/data; Sources cited.

C. Dissemination Plan

This is a mid-term evaluation and the aim is to aid USAID/Nigeria and its Implementing Partner in making informed decisions on the effectiveness and efficiency of the program at the first half of project implementation. The final report will also be posted, by the contractor conducting the evaluation, on the USAID Development Experience Clearinghouse website: dec.usaid.gov.

Dissemination of findings briefing will be done at two levels; Implementing partners and other relevant stakeholders, and USAID. This activity exercise will focus on the lessons learned from the project's implementation.

IV. TEAM COMPOSITION

The Evaluation Team will consist of eight members, including three (3) international consultants (one of which must be Team leader) and five (5) local consultants. The team members should represent a balance of several types of knowledge and expertise related to Prevention, Care, TB and Treatment service delivery in Nigeria and organizational/technical capacity development as well as versed in understanding of cultures and traditions of the various project states, LGAs and communities.

The technical members must all have significant national/international health program experience. They should have some Nigeria or Africa regional experience, along with comparative experience in Prevention, Care and Treatment programming and working with civil society organizations. At least one member of the team must have Nigeria experience and be familiar with the intricacies of the workings with Government at state and LGA levels.

Experience in conducting evaluations is expected of all members, and experience in developing HIV program strategies would be useful. All team members must have professional-level English speaking and writing skills.

Team Leader/Deputy Team Leader¹⁰: The Team Leader will be responsible for overall management of the evaluation, including coordinating and packaging the deliverables in consultation with other members of the team. The team leader will develop tools for the evaluation in collaboration with team members and share these with USAID/Nigeria. The team leader will develop the outline for the draft report, present the report and after incorporating USAID/Nigeria staff comments if necessary, submit the final report to USAID/Nigeria within the prescribed timeline.

In addition to the technical responsibility, other responsibilities of the team leader include:

Preparations

1. Finalize and negotiate with client for the team work plan for the assignment
2. Establish assignment roles, responsibilities, and tasks for each team member
3. Ensure that the logistics arrangements in the field are complete

Management

1. Facilitate the team planning meeting to set the agenda and other elements of the TPM
2. Take the lead on preparing, coordinating team member input, submitting, revising and finalizing the assignment report

¹⁰ The Deputy Team Leader is expected to have the requisite skills as the Team Leader and give technical and managerial support to the Team leader to have a successful evaluation.

3. Manage the process of report writing
4. Manage team coordination meetings in the field
5. Coordinate the workflow and tasks and ensure that team members are working to schedule

Communication

1. Handle conflict within the team
2. Serve as primary interface with the client and serve as the spokesperson for the team, as required
3. Debrief the client as the assignment progresses, and organize a final debriefing
4. Keep USAID/Nigeria apprised of progress challenges, work changes, team travel plans in the field, and report preparation via phone conversation or email at least once a week
5. Serve as primary interface with USAID/Nigeria for the submission of draft and final reports and deliverables to USAID/Nigeria
6. Make decisions in conjunction with USAID/Nigeria about the safety and security of the team, in consultation with the client

Direction

Assume technical direction lead, as required, in order to ensure quality and appropriateness of assignment and report content

Skills and Experience

The team leader should have:

- Advanced degree in public health, sociology or related field
- At least ten years of experience assessing or evaluating USAID-supported health projects
- Previous experience serving as an evaluation team Leader or deputy team leader of a USAID-supported HIV/AIDS project
- Previous experience working in Africa
- Experience in facilitation and providing leadership in collaborative and participatory evaluations with multiple stakeholders
- Excellent writing, communication and presentation skills
- Demonstrated ability to produce preliminary and final reports on time

Local Consultants: The additional four team members will be local staff and will assist in the design of evaluation instruments and will be responsible for reviewing the progress in accomplishing the evaluation's planned results and outcomes per their assigned roles and responsibilities. The team members will be responsible for drafting portions of the evaluation report and debriefing. They are expected to objectively understand the complex and dynamic health systems in Nigeria.

Qualifications for local consultants:

- Advanced degree in public health, sociology or related field
- At least five to eight years of experience in evaluating USAID-supported health projects
- Previous experience in USAID project management
- Previous experience working in Africa/Nigeria
- Individual(s) with program monitoring and evaluation experiences.
- One must be a TB program specialist

- Experiences in implementing or evaluating HIV Prevention, Care, and Treatment programs
- Excellent verbal and writing skills. At least one person should have capacity building experience

USAID and Partner Involvement

In addition, the team may be joined by two counterparts one each from the Federal Ministry of Health and National AIDS Control Agency. Two staff from USAID/Nigeria may also join the evaluation team. These members will participate in the team meetings, data collection and analysis but will not participate in report writing in order to eliminate biases.

Logistics

Level of Efforts and Duration

The expected in-country timeframe for this task is approximately August - October, 2014. Specific start and end-dates, travel dates, and due dates for deliverables will be determined in collaboration with USAID and based on the availability of the consultants, and detailed timeline will be produced during the team planning meeting.

The Level of Efforts (LOE) for the 2 international consultant and 4 local consultants is indicated in Table 2.

Table 2: Level of Efforts (LOE) (Work days)

Level of Effort (LOE)	Nigeria			U.S. /BASE	Total
	Travel	Abuja	Field		LOE
Team Leader	4	17	26	15	62
Deputy Team Leader	4	17	26	15	62
Local Consultants	0	9	26		35

V. EVALUATION MANAGEMENT

A. Logistics

The evaluation will be conducted by independent evaluators with NMEMS II providing logistic support. The NMEMS II team may provide assistance in travel logistics to the field, arranging meetings with key stakeholders as identified before and during the course of this evaluation, and advising the evaluation team on schedules prior to each of those meetings.

NMEMS II will:

- Submit list of suitable evaluation team members to USAID;
- Contract with the team members;
- Logistics: Coordinate and pay all assignment-related expenses incurred by the consultants including travel, transportation, lodging, and communication costs, etc.;
- Brief the team on external evaluation requirements and work with USAID to answer any questions;
- Work with USAID to assist the evaluation team in organizing key meetings and arranging 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; and
- Consult USAID and approve any necessary changes to the evaluation team's work plan and travel and consultations schedules.

B. Scheduling

It is expected that the period of performance for this evaluation will be from August 15, 2014 to October 14, 2014.

Date	Activity	Days	Location
August	Desk Review (Team Leader/second international consultant)	10	Base
	Schedule Meetings (USAID/SIDHAS)		Abuja
August	Arrival of Team Leader	2	Abuja
August	Prep work/Desk Review/Instrument Development/Division of Labor (Team)	6	Abuja
September	Travel to Field (Teams)	1	TBD
September	Field Work (Teams)-including traveling from one State to another.	24	TBD
September	Travel to Base (Team)	1	Abuja
September/October	Data Analysis/Wrap-up (Team Leader & other consultant)	12	Abuja
October	USAID De-brief (Team)/Departure of Team Leader	1	Abuja
October	Finalize and submit report to NMEMS II or Review (Team Leader)	3	Base
October	Review final report	1	Base
October	Submit final report to USAID	1	Abuja

Task	Timeline
Evaluation planning: review background documentation, design work plan with detailed methodology and data analysis plan, design survey instruments, prepare report template, train data collectors, and test survey instruments.	18 days (US for team leader)
Conduct fieldwork	26 days
Analyze data and findings; draft report for USAID comment; finalize report	12 days
De-brief USAID	1 day

Finalize and submit report to USAID for review	4 days

C. Budget

The Mid-term evaluation will be funded by USAID/Nigeria. The estimated budget is US\$150,000.00 (One hundred and fifty thousand US Dollars).

VI. CONTACT INFORMATION

Dr James Ezekiel (SIDHAS AOR), as well as Mr. Akinyemi Atobatele HIV/TB M&E Manager) will be the points of contact for this assignment at USAID/Nigeria.

ACRONYM LIST

ART-	ANTI-RETROVIRAL THERAPY
ARV-	ANTI-RETROVIRAL
PMTCT-	PREVENTION-OF-MOTHER-TO-CHILD-TRANSMISSION
PHC-	PRIMARY HEALTH CARE
NACA-	NATIONAL AGENCY FOR THE CONTROL OF AIDS
FMOH-	FEDERAL MINISTRY OF HEALTH
FHI 360-	FAMILY HEALTH INTERNATIONAL 360
GON-	GOVERNMENT OF NIGERIA
LGA-	LOCAL GOVERNMENT AREA
SIDHAS-	STRENGTHENING INTEGRATED DELIVERY OF HIV/AIDS SERVICES
GHAIN-	GLOBAL HIV/AIDS INITIATIVE NIGERIA
TA-	TECHNICAL ASSISTANCE
AHNI-	ACHIEVING HEALTH NIGERIA INITIATIVE
ARFH-	ASSOCIATION FOR REPRODUCTIVE AND FAMILY HEALTH
HU-PACE-	HOWARD UNIVERSITY PHARMACISTS AND CONTINUING EDUCATION CENTER
CHAI-	CLINTON HEALTH ACCESS INITIATIVE
GLRA-	GERMAN LEPROSY AND TB RELIEF ASSOCIATION
OR-	OPERATIONS RESEARCH
NSP-	NATIONAL HIV/AIDS STRATEGIC PLAN
HTC-	HIV TESTING AND COUNSELING
TB-	TUBERCULOSIS
CSO-	CIVIL SOCIETY ORGANIZATION
NGO-	NON-GOVERNMENTAL ORGANIZATION
GF-	GLOBAL FUND
PPP-	PUBLIC-PRIVATE PARTNERSHIP
PLHIV-	PERSON LIVING WITH HIV
RH-	REPRODUCTIVE HEALTH
M&E-	MONITORING AND EVALUATION
CQI-	CONTINUOUS QUALITY IMPROVEMENT
HSS-	HEALTH SYSTEM STRENGTHENING
DR-TB-	DRUG-RESISTANT TUBERCULOSIS
FCT-	FEDERAL CAPITAL TERRITORY
PEPFAR-	PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF
PMP-	PERFORMANCE MANAGEMENT PLAN
USAID-	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
MSH-	MANAGEMENT SCIENCES FOR HEALTH
SOP-	STANDARD OPERATING PROCEDURE
IEC-	INFORMATION, EDUCATION AND COMMUNICATION
KII-	KEY INFORMANT INTERVIEW
IDI-	IN-DEPTH INTERVIEW
FGD-	FOCUS GROUP DISCUSSION
DEC-	DEVELOPMENT EXPERIENCE CLEARINGHOUSE
TPM-	TEAM PLANNING MEETING

ANNEX II: EVALUATION METHODS AND LIMITATIONS

The evaluation was conducted in Nigeria in January and February 2015 by an eight-person team (including two MEMS II staff). The team consisted of two international advisors and six Nigerian advisors. Together the team provided both national and international HIV/AIDS, TB and public health expertise and knowledge of PEPFAR programs and the Nigerian health service delivery system. The evaluation was carried out in four of the project's 15 states, all selected by USAID (Anambra, Akwa Ibom, Rivers and Lagos). The evaluation team interviewed a total of eight hundred and eight people in the four evaluation states, including national institutions, and USAID officials. The team was assisted by eight data collectors/surveyors (four men and four women).

The Evaluation Team conducted a five-day Team-Planning Meeting (TPM) upon arrival in Nigeria and before starting the in-country portion of the evaluation. During the TPM, the team reviewed and clarified questions on the evaluation SOW, clarified USAID's expectations about the evaluation, determined detailed logistics to carry out the proposed methodology, presented an initial work plan, determined how data was going to be collected, reviewed the data collection tools prepared by the team prior to the team's arrival in-country, clarified team members' roles and assigned responsibilities for writing the evaluation draft report. The TPM outcomes were shared with and approved by USAID/Nigeria. The team met with USAID at the beginning and conclusion of the assignment and presented team findings in a full exit meeting debrief with the USAID Management Team, including the USAID Mission Director.

The Evaluation Team used both quantitative and qualitative approaches to gain insight on accomplishments under the SIDHAS Project's activities and the processes that led to those results. A variety of methods and approaches were used to collect and analyze information relevant to the evaluation's objectives, and questions outlined in the Scope of Work (SOW). The evaluation methods and approaches include:

1. Review and Analysis of Background Materials. Documents relevant to the Nigeria

SIDHAS Project were identified and assembled for review and analysis. These included SIDHAS Program Descriptions, Quarterly and Annual Reports (ARs), SIDHAS PMP, annual project work plans, technical and training material, past program evaluations and assessments, project data base data on service utilization and facilities, The PEPFAR/Nigeria County Operational Plans, USAID/Nigeria's Global Health Initiative (GHI) Strategy 2010-2015 and other documents related to the project. A complete list of documents consulted is in annex IV(b).

2. Review of Project Baseline Data and Health Facility Reports: The team reviewed baseline data and routine health records and reports collected by the Project and the State Ministries of Health (SMOH), GON national statistics and reports and other stakeholder reports. This provided both quantitative and qualitative data in order to answer the evaluation questions.

3. Site Visits: The four evaluation states have a total of 1,153 SIDHAS-supported health facilities, out of which 120 were randomly selected. The evaluation team was able to visit 88 out of the 120 facilities identified in the sample, although in Akwa Ibom 6 were locked and no one present [all had informed SIDHAS staff on the day prior to the visit that a striking member of staff would be present].

4. Key Informant Interviews. The team interviewed over 600 key informants from the Federal Ministry of Health (FMOH), National Agency for the Control of AIDS (NACA), National Planning Commission (NPC), State Ministries of Health (SMOHs), State Agencies for the Control of AIDS (SACA) and LGA officials from

the four evaluation states, health facility staff, and community groups. A complete list of persons contacted during the evaluation is in Annex IV(a) (*note that in order to ensure confidentiality, the list does not include names of clients interviewed at health facilities [173] and participants during the focus group discussions [124], as they are people living with HIV*). The list of questionnaires, survey protocols, guides, and facility checklists are in Annex III.

5. Focus Group Discussions. A total of seventeen focus group discussions were carried out with existing support groups for PLHIV, consisting of between eight to twelve participants with men and women in separate discussion groups. For a list of the support groups and the results of the focus group discussions see Annex IV(a) and Annex VIII respectively.

6. Secondary Sources: The secondary sources consulted included databases from state governmental entities, the SIDHAS Project records, the Global Fund and other health donors and partners and State level information on health conditions, health interventions and service coverage, and state social initiatives. The health facility reports were reviewed and recorded by evaluators related to HIV Testing and Counseling (HTC), PMTCT, ART and TB/HIV. See Annex VII for an analysis which validates the data collected between the health facilities' registers and the SIDHAS reports.

Sample Design and Fieldwork

The four states under evaluations represent nearly 12 percent of the total population of Nigeria. Four teams, one for each State, were responsible for the fieldwork and data collection. Two steps were followed in the sampling process:

1. Agreement on the Sample Frame: The first step was to define and obtain USAID agreement on a sample of HIV facilities considered in this evaluation study. Given the need to evaluate the interventions by State as well as aggregate the results, a state specific sample was drawn to capture data at the state level. The state-specific data was aggregated to draw some project-wide conclusions while the state sub-sample confirmed the project evaluation final sample. MEMS II in collaboration with USAID proposed 30 facilities per state to be visited. Thus, the evaluation proposed 120 of the 1,153 HIV health facilities in these four States, or 5 percent of the total. Facilities presenting extreme logistical or other barriers were excluded from the final selection after consultation with USAID.

2. Construction of the sample: The second step in the construction of the sample was the selection of direct beneficiaries to be interviewed. The subjects for this evaluation were randomly chosen and interviewed for approximately 45 minutes. After several technical considerations, a sample was drawn using the total number of HIV facilities associated with the SIDHAS project as sampling frame. The following table depicts the final sample of HIV facilities that were visited by the evaluation teams to collect the required data for the evaluation.

**Table 1: Number of Facilities Planned and Completed According to Sample Design
By Level of Service**

Level	Akwa Ibom		Anambra		Rivers		Lagos		Total	
	Planned	Done	Planned	Done	Planned	Done	Planned	Done	Planned	Done
Tertiary	1	1	3	2	3	1	0	0	7	4
Secondar	8	10	7	7	6	7	6	8	27	32

y										
Primary	27	14	25	13	24	17	11	8	86	51
Total	36	25	35	22	33	25	15	16	120	88

There were substitutions of 4 secondary health facilities [3 public and 1 private] in Akwa Ibom¹¹, and 17 facilities Anambra because of security issues. One facility in the Akwa Ibom sample had never been visited by SIDHAS staff as there was no road access. To reach the facility, SIDHAS staff would have to travel over open sea by a public ferry that does not have life jackets. Of the facilities visited, the majority had at least one client exit survey; at least one provider interview, the facility-in-charge interview, and the quick assessment of the HMIS completed.

Data was collected in each facility by a team of four persons including one man and one woman data collector from the state familiar in the local languages and cultures. Each team also included a physician familiar with the provision of health services in Nigeria. Overall, 24 interviewers and 8 supervisors were trained. On average, data collection was conducted at a rate of one health facility day per day, data was collected in between two and three facilities per day, and the visits took place on days when services were provided. A precise "field work" plan was developed by each state evaluation team to facilitate data collection.

Evaluators and data collectors were trained centrally on the administration of the questionnaires for a period of three days. This three day training period included time for a pre-test and field practice for the evaluators and data collectors as well as overall design testing for all evaluation procedures. Fieldwork was closely supervised and monitored during the pre-test and the data collection in all four States.

Quantitative data from completed evaluation tools were entered into a computer database using the EpiData software.

The evaluation team developed a comprehensive Plan of Analysis. The survey was designed to include analysis at different levels (patient, community, facility, and state level). The data collected was disaggregated by sex, age, district, community, rural/urban, and other characteristics that relate to health status and/or are required by the Mission. Data analysis also focused on the comparisons between results from this evaluation and those from the SIDHAS baseline and other similar surveys. Data analysis was conducted using the EpiData statistical package. Raw Disaggregated Data Tables Appear in Annex IV(c).

Limitations and Constraints of the Evaluation Methodology:

A purposeful stratified sample was used to provide the evidence required to address the evaluation questions. The sample for Akwa Ibom did not include any public secondary sites: the backbone of the ART provisions in the state. Investigation showed that the classification of private sector sites providing standalone PMTCT services in Akwa Ibom was as secondary sites. However, in all three other states evaluated such private sector sites were classified as primary sites. Thus the sample in Akwa Ibom was skewed towards private stand-alone PMTCT sites at secondary level and towards public primary sites. The practicalities of the skewed sample at the primary care level, where all the public primary sites in Akwa Ibom were closed during the evaluation period by both the National nurses strike and a local government workers strike in Akwa Ibom alone, meant that obtaining valid data from clients, and using facility service assessments was compromised. In Akwa Ibom, the evaluation team substituted four facilities in the original sample to correct the imbalance. Three public primary health facilities were substituted with public secondary comprehensive sites and one of the private, faith-based stand-alone sites was substituted with a faith-based comprehensive site. This notionally provided four sites providing ART to

¹¹ See the note on Akwa Ibom in the *Limitations and Constraint on the Methodology* section below

the evaluation, although in practice, on the two days the evaluation team visited Methodist General Hospital, one of the public secondary sites substituted into the sample, there was no one providing ART services and no clients available to interview. Although the evaluation collected less than expected facility-in-charge data in Akwa Ibom, the provider and client interviews, focus groups, reviews of health facility registers and key informant interviews in the state provided rich and essential data which was included in the findings section of this report. Seventeen (17) originally sampled health facilities were substituted in Rivers state due to security concerns. Further, there were quality concerns regarding the reviews of health facility registers in Rivers and so this data is not included in the analysis of the comparison of health facility registers and monthly reports to SIDHAS.

Additionally, there were several issues and challenges related to the health facility register and monthly report data collected and analyzed. Some facilities had incomplete data. The reason given by health facility managers was that the workload for the service providers precluded them consistently recording data. Staff shortages were also cited as another reason for the incomplete facility health records. This problem was particularly acute at the private sector facilities visited. The private providers said they felt they needed to attend to their clients and hence some neglected completing patient health records or health visit registers which were described as "burdensome".

The evaluators were not able to obtain or discern information on whether internal communications between USAID and the SMOH and SIDHAS was effective.

The four SIDHAS states evaluated were in very nascent stages of readiness to assume full responsibility for sustaining HIV/AIDS and TB services without USAID technical and financial assistance. and the evaluators did not have the benefit of reviewing or seeing successful handover states. However, during the period of the evaluation, SIDHAS handed over the management, oversight and financing of HIV and TB services to the SMOH in Taraba and Abia States.

ANNEX III: DATA COLLECTION INSTRUMENTS

NIGERIA SIDHAS EVALUATION Client Exit Questionnaire

Questionnaire ID Number _____ [*Allocated in Abuja, not allocated in field*]

Introduction

We are conducting an evaluation of assistance provided by the United States Government (USG) to health care services in Nigeria. We would be grateful if you would spend a short time answering a few questions about your experience using the health care services.

Consent and Confidentiality

This survey is completely anonymously (your name will not be used), and you will not be identified. Your participation is voluntary. You don't have to answer any questions that you don't want to answer: we can just skip questions you do not want to answer. We will analyze all the answers from many people in this and other states and **make recommendations on how USAID assistance can further strengthen your health care services over the next two years.**

A. Identification

1. FacilityName: _____
2. State: _____ 3.LGA: _____
4. Date of interview: _____
5. Interviewer: _____ 6. Supervisor: _____

B. Background Characteristics of Client

7. Sex: Male.....1, Female.....2. 8. Age as of last birthday: _____
9. Marital Status: Single: 1, Married: 2, Separated: 3, Divorced:.....4, Widowed: 5
10. Highest Education Completed: None-----1, Quranic: -----2, Primary-----3, Secondary-----3, Tertiary -----4, Other (*Specify*) _____98
11. Religion: Christianity -----1, Islam-----2, Other (*Specify*) _____98
12. Occupation: (*Specify*) _____98

C: HIV HEALTH CARE SERVICE EXPERIENCE

13. Department(s)from where clienthas received care and treatment today (*Record all that apply*)

ART/adult:..... 1, ART/family care:.....2, Pediatric ART:.....3
 TB/DOTS:.....4, PMTCT/eMTCT: 5, HIV Testing & Counseling: 6
 Pharmacy (including no outpatient care & treatment, collecting ART refill only).....7,
 Laboratory 8 other:(Specify) _____98

14. How long have you been coming to this health facility for HIV or TB services?

First visit:.....1, Less than 6 months: 2, 6 months to less than 2 years: 3,
 2 years to less than 5 year: 4, More than 5 years:.....5

15.a. Have you ever received HIV care and treatment from another health facility?

Yes: 1, No: 2

15.b. If yes: which other facility/facilities?: _____

15.c. If yes to 15.a.: Approximate how long ago?: _____

16. How long did it take you to get to this facility today?: _____

17.a. How did you get to the facility today?

17.b. If transportation used—transportation is anything other than walking or cycling: How much did it cost you to get to the facility today?

N _____

18. Have you had any out of pocket/cash expenses [in addition to any cost of your transport] as a result of coming to the facility today? Detail expenses for what and how much below. (Multiple responses possible)

1. For food & drink.....1, N _____
2. For childcare.....2, N _____
3. For registration at the facility.....3, N _____
4. To the doctor/health worker who provided care and treatment?: 4, N _____
5. To the laboratory or for lab tests?: 5, N _____
6. To the pharmacy or for medications?: 6, N _____
7. Any other expenses?: 7, N _____

19. Did you lose earnings/wages by attending the health facility today?

Yes: 1, No: 2

Details of lost earnings:

NEXT, move to the questions about the SPECIFIC DEPARTMENTS the client visited today (start with the department you met client in)

- D. HIV Testing and Counseling/ VCT: page 4**
- E. ART/Adult: page 7**
- F. ART/Family: page 13**
- G. Pediatric ART:, page 21**
- H. HIV/TB and TB/DOTS:, page 28**
- I. ANC (for PMTCT/EMTCT):....., page 32**
- J. Pharmacy [includes *all* use of pharmacy not just pharmacy only], page 37**
- K. Laboratory:, page 39**

D. HIV Testing and Counseling/ VCT

25. Were you tested for HIV today in this facility?

Yes: 1, No: 2; Returned to get testing result from earlier test 3

26.a. Did you have to pay for the HIV test or result?

Yes: 1, No: 2

26.b. *If yes, specify How much?:* N_____

27. How long did you have to wait before you had the HIV test?: _____

28. How long did you have to wait for the post test counseling and your result: _____

29.a. Did you have enough privacy receiving post test counseling?

Yes: 1 No: 2

29.b. *If No, what more could be done to increase privacy while being posttest counseled?*

30.a. Did you have enough privacy when you left the post test counseling room?

Yes: 1; No: 2

30.b. *If No, What more could be done to increase privacy while leaving the posttest counseling room?*

31. In your opinion, how good is the HIV Testing and Counseling service you received today? Why do you say that?

32. How might the HIV Testing and Counseling services in this facility be (further) improved?

33. Were you treated with respect / courtesy by the providers of HTC today?

Yes: 1, No: 2

Detail any negative response to 33:

34. Was there enough time during the Posttest Counseling for you to think about how your test result will affect your life?

Yes: 1, No: 2

35. Were you able to ask the Posttest Counselor any questions?

Yes: 1, No: 2

36. Did you receive enough information in the counseling or do you need more information?

Yes: 1, No: 2 Don't Know 3

37.a. Are you satisfied with the HTC service you received today?

Yes: 1, No: 2

37.b. If No, why not satisfied?

38. Were you asked about your family planning needs?

Yes: 1, No: 2

39.a. Were you given condoms? Yes: 1, No: 2

39.b. If yes, how many: _____

40.a. Did you receive any other family planning method?

Yes: 1 No: 2

40.b. If yes, which method: _____

41.a. Do you have a follow up appointment? Yes: 1 No: 2

41.b. If Yes, Where and when?: _____

42. Did you go to the laboratory today? Yes: ----- 1 No: -----2

If yes, if client willing to answer more questions go to the section for laboratory– do not pressure client to answer more questions

If No: We have completed the interview. Thank you for your time!

E. ART/Adult

43. For how long have you been attending ART at this facility?

First visit:.....1, Less than 6 months: 2, 6 months to less than 2 years: 3,

2 years to less than 5 year: 4, More than 5 years:.....5

44.a. Has your spouse/partner been tested for HIV?

Yes.....1, No: 2. Don't know: 3, Spouse deceased: 4

44.b. Is your spouse/partner living with HIV?

Yes.....1, No: 2. Don't know: 3, Spouse deceased: 4

45. How many children do you have?: _____ # male _____ # female _____ #Total

Use response to 45 and 46 to complete table below.

46.a. Have any of your children died? Yes.....1, No: 2

46.b. If any died, how old were they when they died? : _____

46.c. Have your children been tested for HIV?

Yes: 1, No *for each child*: 2

46.d If yes: Which of your children, if any, are living with HIV?

Child	Year born	Sex	If dead, age at death	HIV tested	Living with HIV

1st born

2nd

3rd

4th

5th

6th

47. If spouse/partner living with HIV, Where does your spouse/partner receive HIV care and treatment?

48. Do you ever attend for care and treatment together?

Yes.....1, No: 2

49. If children are living with HIV, Where do(es) your child(ren) receive HIV care and treatment?

50. *If children are living with HIV*, Is it possible for you and your child(ren) to receive HIV care and treatment together?

Yes.....1, No: 2

51. What do you think about providing HIV care and treatment to all family members together in one clinic, with one appointment?

52. How often do you come to the health facility for follow up care and treatment?

Weekly.....1; Two weekly.....2; 4 weekly/monthly.....3; two monthly.....4;

Quarterly.....5

53.a. Have you been screened for TB?

Yes.....1, No: 2, Don't know: 3

53.b. *If yes*, how have you been screened for TB?

Asked questions.....1, sputums test: 2; Chest X Ray.....3

54.a. Are you taking ART?Yes.....1, No: 2

54.b. *If yes*, Tell me about your ART, how many tablets do you take how many times a day?

55. What challenges do you have taking ART?

56. Have you ever had problems refilling your ART prescription?

Yes: 1, No: 2

If yes, details of the problems:

57.a. Have you ever had to pay for your ART?

Yes.....1, No: 2

57.b. *If yes*, when did you have to pay?: _____

57.c *If yes to 57.a., How much did you have to pay?:* N_____

58. What support have you had to help you to remember to keep taking your ART?

59.a Are you taking CTX (Cotrim/Septin)? Yes.....1, No: 2

59.b. *If yes, Do you have to pay for your CTX?* Yes.....1, No: 2

59.c. *If yes, How much do you have to pay?* N_____

60.a.Are you taking medication to prevent you getting TB? [IPT]

Yes.....1, No: 2

60.b. *If yes, Do you have to pay for your IPT?* Yes.....1, No: 2

60c. *If yes, How much do you have to pay?* N_____

61.aHow good do you think the HIV services are at this facility?

61.b. Why do you say that?

62. How long did you have to wait to be seen today?: _____

63.a.Are clients in HIV care treated with respect / courtesy by the health facility staff?

Yes.....1, No: 2

63.b. Why do you say that?

64. Who provided you HIV care today?

Doctor: 1; Nurse.....2; Other health worker.....3;Don't know.....4

65.a. Have you ever had blood taken for a CD4 test?

Yes: 1, No: 2, Don't know: 3

65.b. If Yes, when and how often have you had a CD4 test?

Before commenced on ART only.....1; Before ART plus one test while on ART.....2

Before ART plus more than one test while on ART.....3

66.a. Have you ever had blood taken for a virology/viral load test?

Yes: 1, No: 2, Don't know: 3

66.b. If Yes, how often have you had a virology/viral load test?

After commenced on ART.....1; Twice while on ART.....2

More than twice on ART.....3

67. Were the results from your blood tests available today in your patient folder to the health worker who provided your care?

Yes: 1, No: 2, Don't know: 3

68.a. Have there ever been problems obtaining the results of your blood tests?

Yes: 1, No: 2,

68.b. If yes, detail of the problems

69.a. Did you have any blood tests today?

Yes: 1, No: 2, Cannot afford tests.....3

69.b. If yes, where did you have the blood taken?

In the clinic.....1; At the laboratory.....2

70. Did they ask about your family planning needs today?

Yes: 1, No: 2,

71.a. Did you receive condoms today?

Yes: 1, No: 2,

71.b. If Yes, how many condoms?: _____

72.a. Did you receive any other family planning method today?

Yes: 1, No: 2,

72.b. If yes, which other method?: _____

73. Did you receive Malaria treatment today?

Yes: 1, No: 2,

74. Have you ever received Malaria treatment from the ART clinic?

Yes: 1, No: 2,

75.a. Did you receive ARVs today? Yes: 1, No: 2,

75.b. If yes, How many weeks supply?

One week.....1; two weeks.....2; four weeks (one month).....3;

more than four weeks.....4

75.c. If no to 75.a., why not?

76. If yes to 75.a., Where did you receive your ARVs? :

In the clinic.....1; From main pharmacy.....2; other (specify).....3

77. What are the challenges for people living with HIV in your community?

78.a. Are you or your family affected by stigma?

Yes.....1, No: 2, Don't know: 3

78.b. If yes: how are you or your family affected by stigma?

79. What could communities do to make life easier for people living with HIV?

If the client went to pharmacy or the laboratory today, and the client is willing to answer more questions, go to the section for that department

If No or unwilling: We have completed the interview. Thank you for your time!

87. How often do you come to the health facility for follow up care and treatment?

Weekly.....1; Two weekly.....2; 4 weekly/monthly.....3; two monthly.....4;

Quarterly.....5

88.a. Have you or your child(ren) been screened for TB?

Yes: 1, No: 2, Don't know: 3

88.b. If yes, how have you or your child(ren) been screened for TB

Asked questions.....1; Sputum test.....2

89.a. Are you taking ART? Yes: 1, No: 2

89.b. If yes, Tell me about your ART, how many tablets do you take how many times a day?

89.c. If yes to 89.a. What challenges do you have taking ART?

90.a. Is your child(ren) taking ART? – specify yes / no for each child in table below

90.b. If child(ren) yes, tell me about your child(ren)'s ART, how many syrups and/or tablets taken how many times a day specify for each child

Child	Taking ART yes =1 no =2	How many syrups and/or tablets, how many times per day?

1st born

2nd

3rd

4th

5th

6th

90.b. If child(ren) taking ART, What challenges do you have with your child(ren) taking ART?

91. Have you ever had problems refilling ART prescription?

Yes: 1, No: 2

91.a. If Yes to Q91, give details of the problems

92. Have you ever had problems refilling your child(ren)'s ART prescription?

Yes: 1, No: 2

92.a. If Yes to Q92 give the details of the problems

93.a. Have you ever had to pay for ART for yourself or your child(ren)?

Yes: 1, No: 2

93.b. If yes, when did you have to pay?: _____

93. c If yes to 93.a., How much did you have to pay?: N_____

94. What support have you had to help you to remember to keep taking your ART and to help your children keep taking their ART?

95.a. Are you taking CTX (Cotrim/Septrin)? Yes: 1, No: 2

95.b. Are your children taking CTX (Cotrim/Septrin)? Yes:.....1, No: 2

95.c. If yes to 95.a. or 95.b, Do you have to pay for CTX? Yes: 1, No: 2

95.d. If yes to 95.c, How much do you have to pay? N_____

96.a. Are you taking medication to prevent you getting TB? [IPT]

Yes: 1, No: 2

96.b. Are your children taking medication to prevent them getting TB? [IPT]

Yes: 1, No: 2

96.c. If yes to 96.a. or 96.b., Do you have to pay for IPT?

Yes: 1, No: 2

96.d. If yes to 96.c., How much do you have to pay?: _____

97.a. How good do you think the HIV services are at this facility?

97.b. Why do you say that?

98. How long did you have to wait to be seen today?: _____

99. Are patients in HIV care treated with respect / courtesy by the health facility staff?

Yes: 1, No: 2

99.a. Why do you say that?

100. Who provided you HIV care today?

Doctor.....1; Nurse.....2; Other health worker.....3; Don't know.....4

101.a. Have you or your child(ren) ever had blood taken for a CD4 test?

Parent: Yes: 1, No: 2, Don't know: 3

Child(ren): Yes: 1, No: 2, Don't know: 3

101. b. If Yes, when and how often have you/your child(ren) had a CD4 cell test?

Parent:

Before commenced on ART only.....1; Before ART plus one test while on ART.....2

Before ART plus more than one test while on ART.....3

Child(ren):

Before commenced on ART only.....1; Before ART plus one test while on ART.....2

107.b. If yes, which other method?: _____

108.a. Did you or your child(ren) receive Malaria treatment today?

Parent: Yes: 1, No: 2

Child(ren): Yes: 1, No: 2

108.b. If no to 108.a., Have you or your child(ren) ever received Malaria treatment from the ART/family care clinic?

Parent: Yes: 1, No: 2 **Child(ren):** Yes: 1, No: 2

108.c. If yes to 108.a. or 108.b. Did you or your children have a fever when you/your child(ren) received malaria treatment?

Parent: Yes: 1, No: 2 **Child(ren):** Yes: 1, No: 2

109.a. Did you receive ARVs today? Yes: 1, No: 2

109.b. If yes, How many weeks supply?: One week: 1; two weeks: 2;

four weeks [one month]: 3; more than four weeks: 4

109.c. If no, why not? Detail

110.a. Did you receive ARVs for your child(ren) today? Yes: 1, No: 2

110.b. If yes, How many weeks supply? One week: 1; two weeks: 2;

four weeks [one month]: 3; more than four weeks: 4

110.c. If no to 110.a., Why not?

110.d. If received ARVs, Where did you receive the ARVs?

In the clinic: 1; from main pharmacy: 2; other (specify): 3

111. Has the child(ren) been issued with a mosquito net (LLIN)? Yes: 1, No: 2

112.a. Are you or your family affected by stigma? Yes: 1; No: 2;

112.b. If yes: how are you or your family affected by stigma?

113. What are the challenges for families living with HIV in your community?

114. What could communities do to make life easier for families living with HIV?

If the client went to pharmacy or the laboratory today, and the client is willing to stay and answer more questions, go to the section for that department. Do NOT pressure a client to answer more questions: be sensitive to the client or their child(ren) getting tired or needing to go

If No or unwilling to stay: We have completed the interview. Thank you for your time!

G. Pediatric ART

115. *Specify who is accompanying the child(ren) to clinic today*

Mother: 1; Father: 2; both parents: 3;

Other caregiver (specify relationship to child(ren)) 4

116. **For how long has the child(ren) been attending pediatric ART at this facility?**

First visit: 1; Less than 6 months: 2; 6 months to less than 2 years: 3;

2 years to less than 5 years: 4; More than 5 years: 5

117. **For accompanying parent only: How many children do you have?**

male: _____ # female: _____ #Total : _____

For parent only, use the responses to Q 117 and Qs 118 to complete the table below

118.a. **Have any of your children died?** Yes: 1, No: 2

118.b. **If any died, how old were they when they died?**

118.c. **Have your children been tested for HIV?**

118.d. ***If any tested, Which of your children are living with HIV?***

Child	Year born	Sex	If dead, age at death	HIV tested Yes=1 No=2	Living with HIV
1 st born					
2 nd					
3 rd					
4 th					
5 th					
6 th					

119. To Parent only, What do you think about providing HIV care and treatment to all family members together in one clinic, with one appointment?

120. How often do you come to the health facility with the child(ren) for follow up care and treatment?

Weekly.....1; Two weekly.....2; 4 weekly/monthly.....3; two monthly.....4;

Quarterly.....5

121.a. Has the child(ren) been screened for TB? Yes: 1, No: 2, Don't know: 3

121.b. If yes, how has the child(ren) been screened for TB?

Asked questions.....1; Sputum test.....2

Is the child(ren) taking ART – specify yes / no for each child and complete table below

122 If yes, tell me about the child(ren)'s ART, how many syrups and/or tablets taken how many times a day specify for each child

Child	Taking ART: Yes = 1 no = 2	How many syrups and/or tablets, how many times per day?

1st born

2nd

3rd

4th

5th

6th

123. What challenges do you have with the child(ren) taking ART

124. Have you ever had problems refilling the child(ren)'s ART prescription?

Yes: 1, No: 2

124.a. If Yes to Q124, give the details of the problems

125.a. Have you ever had to pay for ART for the child(ren)? Yes: 1, No: 2

125.b. *If yes, when and how much did you have to pay?*

126. What support have you had to help the child(ren) keep taking ART?

127.a. Is the child/are the children taking cotrimoxazole (Cotrim/Septtrin)?

Yes:.....1, No: 2 Don't know.....3

127.b. *If yes, Do you have to pay for cotrimoxazole?* Yes: 1, No:.....2,

Don't Know.....3

127.c. *If yes to 127.b, How much do you have to pay?* N: _____

128.a. Is the child/are the children taking medication to prevent them getting TB? [IPT]

Yes: 1, No: 2

128.b. *If yes, Do you have to pay for IPT?* Yes: 1, No: 2

128.c. *If yes to 128.b., How much do you have to pay?* N: _____

129.a. How good do you think the HIV services are at this facility?

129.b. Why do you say that?

130. How long did you have to wait to be seen today?: _____

131.a. Are children living with HIV and their parents/caregivers treated with respect/courtesy by the health facility staff? Yes: 1, No: 2

131.b. Why do you say that?

132. Who provided the child(ren)’s HIV care today?

Doctor.....1; Nurse.....2; Other health worker.....3; Don’t know.....4

133.a. Has the child(ren) ever had blood taken for a CD4 test?

Yes.....1; No.....2; Don’t know.....3

133.b. If Yes, when and how often has the child(ren) had a CD4 cell test?

Before commenced on ART only.....1; Before ART plus one test while on ART.....2

Before ART plus more than one test while on ART.....3

134.a. Has the child(ren) ever had blood taken for a virology/viral load test?

Yes.....1, No: 2, Don’t know: 3

134.b. If Yes, when and how often has the child(ren) had a virology/viral load test?

Once while on ART.....1; twice while on ART.....2; More than twice on ART.....3

135. Were the results from the child(ren)’s blood tests available today in the patient folder to the doctor/nurse/other person who provided care?

Yes.....1; No.....2; Don’t know 3

136.a. Have there ever been problems obtaining the results of the child(ren)’s blood tests?

Yes.....1; No.....2; Don’t know 3

136.b. If yes, What problems have you had obtaining results of blood tests

137.a. Did the child(ren) have any blood tests today?Yes: 1, No: 2

137.b. If yes, where did the child(ren) have the blood taken?

In the clinic.....1; At the laboratory 2

138. For parent only, Did they ask about your family planning needs today?

Yes: 1, No: 2

139.a.For parent onlyDid you receive condoms today Yes: 1, No: 2

139.b. If Yes, how many condoms?: _____

140.a. For parent onlyDid you receive any other family planning method today?

Yes: 1, No: 2

140.b. If yes, which other method?: _____

141.a. Did the child(ren) receive Malaria treatment today? Yes: 1, No: 2

141.b. If No to 141.a., Has the child(ren) ever received Malaria treatment from the Pediatric ART clinic?

Yes: 1, No: 2, Don't know: 3

141.c. If yes to 141.a. or 141.b., Did the child/ren have a fever when they received malaria treatment?

Yes.....1; No.....2; Don't know 3

142. Has the child(ren) been issued with a mosquito net (LLIN)?

Yes.....1; No.....2; Don't know 3

143.a. Did you receive ARVs for the child(ren) today? Yes.....1; No.....2

143.b. If yes, How many weeks supply?

One week.....1; two weeks.....2; four weeks [one month] 3;

more than four weeks.....4

143.c. If no, why not?

143.d. If received ARVs, Where did you receive the ARVs?

In the clinic.....1; from main pharmacy.....2; other (specify) 3

144.a. Are you satisfied with the HIV service the child(ren) received today?

Yes: 1, No: 2

144.b. Why do you say that?

145. What are the challenges for families living with HIV around in your community?

146.a. Have you or the child(ren) been affected by stigma?

Yes.....1; No.....2; Don't know 3

146.b. *If yes, How have you or the child(ren) been affected?*

147. What could communities do to make life easier for families living with HIV?

If the client went to pharmacy or the laboratory today, and if the client willing to stay and answer more questions go to the section for that department. Do not pressure the client to stay and be sensitive to the client or child(ren) getting tired or needing to go.

If No: We have completed the interview. Thank you for your time!

H. TB/DOTS

148. How were you screened for TB?

Three early morning sputums.....1; three early morning sputums **and** Chest X ray.....2;
other [specify]: _____3

149.a. Have you been tested for HIV?

Yes.....1; No.....2; Don't know 3

149.b. If Yes, what was the result of your HIV test?

Non-reactive (HIV negative).....1; I Indeterminate (needs another HIV test) 2;
Reactive (HIV positive).....3

149.c. If No/ Don't know in response to 149.a., Have you ever been offered HIV testing and counseling?

Yes.....1; No.....2

150.a. Have you ever refused to have HIV testing and counseling?

Yes.....1; No.....2

150.b. If Yes, why did you refuse HTC?

If HIV-TB Co-infected:

151.a. Are you on ART? Yes.....1; No.....2

151.b. If yes, When did you start ART?

Before TB DOTS.....1; After 8 months intensive TB DOTS.....2;
Concurrently with TB DOTS.....3

If HIV-TB Co-infected:

152.a. Has anyone screened your spouse/children for TB?

Yes.....1; No.....2; Don't know 3

152.b. If yes, When and where were they screened for TB?

153.a. Has anyone screened your spouse/children for HIV?

Yes.....1; No.....2; Don't know 3

153.b. If yes, When and where were they screened for HIV?

154. How often do you have to attend TB DOTS?

155.a. How good are TB DOTS services at this health facility?

155.b. Why do you say that?

156. How long did you have to wait today before you were seen? _____

157.a. Did you receive TB drugs this morning? Yes.....1; No.....2;

157.b. if Yes, from where did you get your drugs:

TB DOTS department.....1, the pharmacy.....2; other 3 Specify.....

158.a. Have you ever had to pay for your TB drugs?Yes.....1; No.....2

158.b. If Yes, when and how much did you have to pay? N _____

159.a. Have you ever had to go away without getting your TB drugs?

Yes.....1; No.....2

159.b. If yes, why was that?

160. Are people with TB treated with courtesy and respect by the health facility staff?

Yes.....1; No.....2

Record details about any the negative experience

161. Are people with TB-HIV co-infection treated with courtesy and respect by the health facility staff?

Yes.....1; No.....2

Record details about any negative experience

162. Have health facility staff always treatedyou with respect/courtesy?

Yes.....1; No.....2

Record details of any negative experience

163. Did you have to go to the laboratory today?

Yes: 1, No: 2

164.a. Are you satisfied with the TB DOTS service you received today?

Yes: 1, No: 2

164.b. Why do you say that?

165. What are the challenges for people living with HIV and TB in your community?

166. What can communities do to make living with HIV and TB easier?

If the client went to pharmacy or the laboratory today, and is willing to stay and answer more questions, go to the section for that department

If No: We have completed the interview. Thank you for your time!

I. ANC [for PMTCT/ eMTCT]

167.a. Is this your first visit to ANC in this pregnancy? Yes: 1, No: 2

167.b. If No, which ANC visit is this? 2nd 1; 3rd 2; 4th 3

168. In how many more weeks is your baby due? _____

169. Where are you planning to deliver your baby?

At home.....1; In the community 2; In this health facility.....3;

In another facility [*specify*] _____98

170.a. Do you have a birth plan for getting to the health facility for delivery when the time comes?

Yes: 1, No: 2

170.b. If yes, ask for details of plan – particularly transportation availability and what planned if goes into labor at night

Complete the table below with the responses to Qs 171

171.a. Is this your first pregnancy or have you had other pregnancies?

171.b. If not first pregnancy, How many pregnancies have you had?:

171.c. If not first pregnancy, did your earlier pregnancies result in live infant or still birth?

171.d. If not first pregnancy, Record where you had the earlier deliveries and the outcomes of the deliveries in the table below:

Child	Year born	Sex M=1 F= 2	alive birth 1 still birth.....2	Home birth: 1 Community birth: 2 Facility birth.....3
1 st born				
2 nd				
3 rd				
4 th				
5 th				
6 th				

172. Were you offered an HIV test on your first visit to ANC in this pregnancy?

Yes 1; No 2; no as known to be living with HIV: 3

173.a. Have you refused an HIV test? Yes: 1, No: 2

173.b. If yes, why?

174. Has your spouse/partner been tested for HIV?

Yes.....1; No.....2; Don't know.....3

175.a. Have you been given any advice on how to prevent your baby from getting infected with HIV?

Yes.....1; No.....2

175.b. If yes, Detail advice on what to do during:

1. Pregnancy:

2. Delivery:

3. Breastfeeding:

176.a. It is very important that women who are HIV negative remain HIV negative during pregnancy and breast feeding. Have you heard any advice about HIV negative women using condoms when having sex during pregnancy?

Yes: 1, No: 2

176.b. Have you heard any advice about HIV negative women using condoms when having sex during breastfeeding?

Yes: 1, No: 2

176.c. If yes to Q176.a or Q176.b. who gave that advice?

Health worker this facility.....1

Mentor Mother or other woman living with HIV working in this facility.....2

Health worker elsewhere.....3

Woman living with HIV elsewhere.....4

Other source of information (Specify).....5

177.a. Have you received any condoms from the ANC clinic? Yes: 1, No: 2

177.b. If yes, how many?: _____

178. What do you think about using condoms for sex during pregnancy?

179. What do you think about using condoms for sex during breast feeding?

180.a. Are you taking any medicines to stop your baby getting HIV infection?

Yes: 1, No: 2

180.b. If yes, details of medicines:

Mother on ART before being pregnant.....1; Mother given ARVs for PMTCT.....2

181.a. Have you been given any medicines for your baby to take soon after birth to stop your baby getting HIV infection?

Yes: 1, No: 2

181.b. If yes, give details:

182. What advice have you received about breast feeding?

182.1. What advice have you received about feeding soon after delivery?

182.2. What advice have you received about feeding colostrum [colostrum is the first milk that a mother produces after delivery]?

182.3. About exclusively breastfeeding? [Exclusively means no pap; nothing but breast milk]?

182.4. How long should a mother exclusive breast feeding her baby?: _____

182.5. When should a mother introduce weaning foods?: _____

182.6. What advice have you received about continuing breast feeding in the second and third year of your infant's life?

183. Have you been given treatment for Malaria [IPT] on this ANC visit [or at earlier ANC visit if this visit not the first]?

Yes: 1, No: 2

184. Have you been issued amosquito net (LLIN) to sleep under? Yes:.....1 No:.....2

185.a. Have you had to pay for your ANC care? Yes: 1 No: 2

185.b. If yes, specify:

For your patient folder?: 1, N_____

For registration?: 2. N_____

For any medications you have received?:.....3 N_____

186. Did you go to pharmacy for any medications today? Yes: 1, No: 2

187. Did you go to the laboratory for any tests today? Yes:.....1, No:.....2

188.a. Are you satisfied with the ANC care at this health facility? Yes:.....1, No:.....2

188.b. Why do you say that?

189.a. Are health workers always polite and courteous? Yes: 1, No: 2

Detail any negative comments:

189.b. Do health workers always treat you with respect? Yes: 1, No: 2

Detail any negative comments:

If the client went to pharmacy or the laboratory today, and is willing to stay and answer more questions, go to the section for that department.

If No or unwilling: We have completed the interview. Thank you for your time!

J. Pharmacy [includes *all* use of pharmacy not just pharmacy only]

190. How long did you have to wait at the pharmacy to get your medications? _____

191.a. Was there anywhere for you to sit down while waiting? Yes: 1, No: 2

191.b. Describe waiting arrangements:

192.a. Did you have privacy while collecting your medications at the pharmacy?

Yes: 1, No: 2

192.b. If No, details [e.g. everyone in line behind could see and hear]

193.a. Were all your medicines available at the pharmacy today?

Yes: 1, No: 2, Partially: 3

193.b. If No or Partially, detail what not available

194.a. Did you have to pay anything at the pharmacy today? Yes: 1, No: 2

194.b. If Yes, details:

195.a. Did you receive any advice from the pharmacy about taking your medicines?

Yes: 1, No: 2

195.b. If Yes, what advice were you given?

196.a. Are you treated courteously/with respect at the pharmacy? Yes:.....1, No:.....2

196.b. Why do you say that? Details of any negative experiences:

197. When will you next visit the pharmacy?: _____

198.a. Are you satisfied with the pharmacy services at this health facility?

198.b. Why do you say that?*Details of any negative experiences:*

199. How could the pharmacy services be made better

If the client went to the laboratory **today**,and is willing to answer more questions, go to the section for the **laboratory**

If No: *We have completed the interview. Thank you for your time!*

K. Laboratory

200. How long did you have to wait at the laboratory to have your blood taken?:_____

201. Was there anywhere for you to sit down while waiting?

Yes: 1, No: 2

202.a. Did you have privacy while having your blood taken? Yes:.....1, No: 2

202.b. *If No, details* [e.g. everyone in line behind could see and hear]

203. Did the laboratory staff wear gloves while taking your blood? Yes.....1; No.....2

204. Did the laboratory staff talk to you or answer questions about your blood tests?

Yes: 1, No: 2

205.a. Did you have to pay anything at the laboratory today?

Yes: 1, No: 2

205.b. If Yes, details:

206.a. Are you treated courteously/with respect at the laboratory?

Yes: 1, No: 2

206.b. Why do you say that? Details of any negative experiences

207. When will you next visit the laboratory?: _____

208.a. Are you satisfied with the laboratory services at this health facility?

Yes...1, No...2

208.b. Why do you say that? Details of any negative experiences

209. How could the laboratory services be made better?

We have completed the interview. Thank you for your time!

Focus Group Discussion Guide

Participants:

NB: The facilitator should specify# of participants by gender and age

State:
Group Name:

LGA:

Support

Date:

Discussion questions for groups of 8-12 people living with HIV informal support groups: The survey team should assure focus group participants that they will not be identified in any report and that their experience is important feedback to assure quality client focused services are available in their own communities and across the country.

Introduction: “ I want to thank you for agreeing to participate in this important group discussion. Let’s begin by introducing ourselves using our first names and also indicating our favorite Nigerian food. When we finish this round of introductions I will ask the group some questions. You will all have an opportunity to speak. You are not obligated to answer every question. The facilitator should start with introductions using an icebreaking game such as, “I am xxx and my favorite food is fufu and groundnut soup”. Can you introduce yourself by your first name and tell us your favorite food?

Q1. How do people benefit from the HIV services in[name of LGA]?

Probe: What benefits are there from the HIV services?

Probe: Are people able to obtain the HIV services they need?

Probe: Do any of you have other thoughts about HIV services?

Probe: Are there other HIV services needed in [name of LGA]?

Probe: Are there other benefits of HIV services that are provided?

Probe: tell us about support groups – how do members benefit?

Q2. Are there any difficulties or challenges to using the HIV services?

Probe: What examples can you tell us?

Probe: Costs? Time/distance to come to the Health Facility? Problems with the service delivery? Waiting times?

Probe: Are these difficulties common? Have you experienced difficulties you can tell us about?

Probe: Are there any other difficulties or challenges?

Probe: How are people living with HIV (PLWH) treated in your community by other community members. Please describe specific examples of how you are treated and received in your community.

Probe: Do families Living with HIV have special needs that you can tell us about?

Q3. Have you noticed any changes in the HIV services over the last two years? Please tell us about these changes.

Probe: In your opinion what were the reasons for these changes taking place?

Q4. How have PLWH been involved in managing or organizing care and support services?

Probe: Do PLWH have a voice in the way services are run?

Q5. What more could be done to improve HIV treatment and support services for PLWH?

Probe: Is there a specific person in your health facility who is responsible for addressing challenges PLWH are facing?

Probe: Has anyone made suggestions about improving HIV treatment and support services? If so, what happened when they made these suggestions?

Q 6. What more could be done to improve the quality of life for people living with HIV and children orphaned by AIDS?

Probe: Are there ways that communities can use their own resources to improve the quality of life for PLWH?

Probe: Are there ways that local government and state government can better use their resources to improve the quality of life of PLWH?

NIGERIA SIDHAS MID-TERM EVALUATION

Provider Questionnaire for HTC/ART/TB-DOTS/PMTCT

Questionnaire ID Number _____ [To be allocated in Abuja, not in the field]

Introduction- We are conducting an evaluation of assistance provided by the United States Government to health care services in Nigeria. We would be grateful if you would spend a short time answering a few questions about your experience delivering HIV health care services.

Consent and Confidentiality- This survey is completely anonymous (your name will not be used), and you will not be identified. Your participation is voluntary. You don't have to answer any questions; that you don't want to answer: we can just skip questions you do not want to answer. We will analyze all the answers from many health care providers in this and other states and **make recommendations on how USAID assistance can further strengthen your health care services over the next two years.**

C. Identification

1. Facility Name:
2. State: 3.LGA:
6. Date of interview:
7. Interviewer: 6. Supervisor:

D. Characteristics of Health Worker Responding[specify the HIV service]:

ART/Adult:..... 1; ART/family care:.....2; Pediatric ART:.....3

TB/DOTS:..... 5; PMTCT/eMTCT:.....6; Testing & Counseling:.....7

Other (Specify).....98

8. Sex: Male.....1; Female.....2

9. Health Worker Type [specify one]: physician.....1; Registered Nurse.....2,

Midwife.....3; other[specify].....98

9. Job Title Respondent:.....

10. How long have you had your current function/position in this health facility?

Less than 6 months.....1; 6 months to less than 1 year.....2,

1 year to less than 2 years.....3; 2 or more years.....4

11. How long in total have you been working at this facility?:

Less than 6 months.....1; 6 months to less than 1 year.....2;

1 year to less than 2 years.....3; 2 or more years.....4

12. How long since you qualified/completed basic training?:

Less than 6 months.....1; 6 months to less than 2 years.....2

2 years to less than 5 years.....3; 5 or more years.....4

13.a. Have you had specific HIV/AIDS training since basic training?

Yes.....1; No.....2

13.b. If Yes in Q13.a., when did you have the training?

In the last 2 years.....1; More than 2 years ago.....2

13.c. If Yes in Q13.a Who provided the training?

SMOH: 1, SIDHAS: 2, Other (Specify):.....98

C. KNOWLEDGE OF SERVICE PERFORMANCE

14. How do you know how well your department [as specified in B, above] is performing?

15. How do follow up clients and their appointments?

16. What do you do if a client defaults from a follow up appointment?

17. How do you know what proportion of your department clients are retained in care and treatment?

18. Are your retention in care and treatment rates increasing, staying the same or decreasing?

Increasing 1, The same..... 2, Decreasing.....3, Don't know.....8

19. How often do you review the HMIS data for your department?

Daily.....1, Weekly.....2, Biweekly.....3, Monthly.....4, Quarterly.....5

Do not review HMIS data.....8

20. Who reviews the HMIS data for your department with you?

21. Do you and your colleagues use information from HMIS to review your programs targets and progress?

Yes.....1, No.....2

22. What analysis of your department HMIS data has SACA orSIDHAS provided to you?

23. What changes have been introduced after analysis of the HMIS data for your department?

24. What quality improvement activities have there been in your department?

25. What changes have there been in the package of services you provide during the last three years?

Added:

HTC.....1, ART.....2, PMTCT/eMTCT.....3, TB-HIV.....4,

FP/SRH.....5; Malaria prophylaxis.....6; TB prophylaxis.....7,

Chronic vascular disease [hypertension].....8; CvCx Direct colposcopy or PAP Smear.....5;

CD4 testing in facility lab.....6, Other added service.....98 [specify below]

.....

26. What integration of services have occurred during the last three years?

TB-HIV.....1, FP/SRH-ART.....2; FP/SRH-PMTCT.....3

HIV services-Malaria.....4; ART-Chronic vascular disease [hypertension].....5;

Other integration [specify below].....98

27. What changes have occurred in the SIDHAS support to your department over the last two years?*[Probe for specific and not just general support]*

28.a. What are the challenges to your department providing HIV services?

(Multiple Response)

Inadequate training for health workers.....	.1
Inadequate number of trained health workers for workload.....	2
Lack of supervision/support for health workers.....	3
Burnout of health workers	.4
Lack of job aids.....	5
Inadequate privacy for clients.....	6
No or inadequate child-friendly environment in clinic.....	.7
Challenges [including delays] obtaining CD4 counts:	8
Challenges [including delays] obtaining virology reports.....	9

Problems getting test reports into client dockets/folders.....	10
Stockouts of drugs [<i>specify which, when & for how long below</i>].....	11
<i>Probe as relevant: ARVs, pediatric formulations, OI drugs incl CTX, S-P IPT for malaria; isoniazid IPT for TB, TB drugs, MDR TB drugs</i>	
Which drug(s)?.....When.....	
For How long?.....	
Stockouts of consumables [<i>specify below which, when & for how long</i>].....	12
Which consumable(s)?.....When?.....	
For how long?.....	
Stockouts of LLINs [<i>specify below when & for how long</i>]:.....	13
When?.....;For how long?.....	
Other challenges [<i>detail on back of this sheet</i>].....	14

29. How has SIDHAS assisted you to manage the challenges you experience?

30. In the last two years of the SIDHAS project, what are your priorities for the assistance SIDHAS should provide your department?

NIGERIA SIDHAS MID-TERM EVALUATION

Key Informant Guide for Organizations with Subgrants

Civil Society & Community Groups (CSCGs)

Name of Organization:

Specific Goals of the Organization Related to Sub-grant:

Name of Interviewee(s):

Notes to Facilitator or Interviewer: This section will be conducted through interviews of leaders, managers or care providers of CSCGs (or CSOs) in order to examine their perspectives on Health Services organization and administration, and service categories represents an opportunity to assess and improve HIV/AIDS care, and treatment, in this State.

The purpose of the activity is to solicit opinions from leaders/managers regarding the utility, priority, impact, accessibility, and quality services.

The Objective of this activity is to better understand the role of these organizations in the care and prevention of HIV/AIDS through the execution of sub-grants.

- Their perceptions of the quality and readiness of HIV/AIDS programs and services in the State.
- Identify barriers to and facilitators of linkage to care among People Living with HIV in the four States.
- Most appropriate format for HIV/AIDS education at local level
- The most effective method to deliver health messages about HIV/AIDS
- The influence of gender roles and religion on beliefs about HIV/AIDS

Methods used will Interviews Managers and/or Leaders and/or Senior Health Service Providers

- 60-min semi-structured interviews to 2-3 people
- Manager/Administrator or Medical providers or Social service providers

The information could be collected through Leaders, Managers and Health Providers

1. List and description of HIV services provided this or through this Organization (HTC, PMTCY, Treatment, Others)

2. Volume of Services (number of people serves) they provide by *service category*

3. Assessment of Services on Relevance to HIV Care Utilization and Clients Needs

4. How helpful/useful/ important is a particular service for you to *access* HIV-related primary care? Why?

5. Access to HIV services of your clients: describe barriers. What do you think about psychosocial barriers such as stigma, lack of support, lack of disclosure?

6. Or tangible barriers such as lack of transportation, clinic too busy or not open at convenient times, cost of HIV medical care

7. How well do your services meet people needs?

Go through each service category. Identify criteria for “meeting needs” and ways in which meeting needs overall may differ from serving primarily to increase access to or engagement in HIV-related care.

- What is the biggest service need that your organization has met?
- What is the biggest service need that has not been met?
- Which services do you think have the most lasting effect on HIV-related care and health outcomes? Why?

8. Quality of Services. How satisfied are you with the medical care your organization is providing?

Probing questions: Do you have any challenges remaining in care for your other health concerns?

What, do you believe, are the providers doing right or wrong?

What aspects of HIV services can be made more satisfying, or at least agreeable, to clients? How?

What factors should be considered in judging the quality of a service?

Do you consider stigma to be a service quality issue? (If yes, how?). Is this true for some types of services or some types of providers more than for others?

9: Other Health Concerns. What is your most important health concern other than HIV in this area?

Instructions: Consider mental health and emotional health as well as physical health. Consider social functioning as well as basic physical functioning.

Probing questions:

1) What are some of your other health related challenges?

2) Are the other health concerns related to the HIV in some way? How?

3) Do you think the other health concerns relate to other factors such as age or gender?

4) Are these other health concerns more serious or important to you at times, compared to the HIV?

10. How could your organization also assist with that concern at the same time as managing HIV services?

Probing questions:

How do non-HIV conditions make it more or less difficult to cope with HIV?

Does care for these other conditions tend to get in the way of care for HIV, or vice-versa?

How do you prioritize these different needs and the different parts of your health care program?

11. Do your health care providers work at coordinating the care of the different needs of your clients? If so, how?

Probing questions: Do you have a health care provider who you are working with for other chronic or serious conditions aside from HIV?

Is it the same provider as your HIV care provider? Are there communication gaps or other gaps?

If so, where are the gaps?

12: Participating in Improvement and Planning. Does your organization participate or is it consulted in matter regarding this State’s HIV/AIDS program?

When you have a concern about the delivery of HIV/AIDS care and supportive services in this State, what do you think of as your options for making that concern known/heard (what actions do you think you could take)?

Probing questions: Before now, have you ever made your voice heard about the delivery of HIV/AIDS care and support services?

What was that experience like?

What happened as a result?

Were there repercussions, or did you feel things changed for the better?

Would you do it again?

If not (or for those participants who haven’t taken such an action before),

Have you ever had the experience of serving on advisory group of an HIV-services-providing agency in this State?

Probing questions: Can you talk about that experience?

Do you feel like you have been able to improve services through your participation?

Has your experience been disappointing or frustrating? Why?

What do you know about the HIV Health and Human Services Planning Council of this State?

Is there anything in particular you would want the Planning Council to be doing to improve HIV services and care for you?

13. Do you know about the Planning Council and its role in deciding priorities for Care, Treatment, and Service Delivery?

What do people think the Planning Council does now, and what do they think it should do, to ensure that PLWHA in this State could get the kinds of care/services they need?

14. Are there other things you would like to discuss?

KII QUESTIONNAIRE SIDHAS PROJECT EVALUATION

1. STATE MINISTRY OF HEALTH (SMOH/SASCP)	
1.	How does the SIDHAS Project fit into implementation of your State HIV response?
2.	What are the key results and accomplishments you have seen fromSIDHAS to date?
3.	What assistancehas SIDHAS provided to the SMOH for the state HIV response?
3.1	How useful has SIDHAS assistance for communication systems [phone email] been?
3.2	How effective has the support for transportation been in enabling transportation of staff/commodities/lab specimens/patients?
4.	How has SIDHAS contributed to your ministry staff development and training for key technical and administrative personnel? What plans are underway for the SMOH to fully take on these functions over the next two years and beyond the SIDHAS project?
5.	How has SIDHAS assisted in strengthening the State procurement and supply chain system for HIV?
6.	What assistance hasSIDHAS providedthe SMOH with planning and management of HIV services? <i>Probe:</i> human resource planning, monitoring and evaluation, technical oversight, staff supervision and quality assurance. What form should future assistance take?
7.	What support has SIDHAS providedto staff within your ministry for mentoring and supportive supervision; in-service training at health facilities; and for workshops and other off site training?
9.	Whatassistance has SIDHAS provided forsupporting HIV mentors and other community volunteers in your state?
10.	How has SIDHAS supported capacity building for SMOH staff and other health workers in your state?
11.	Does SIDHAS conduct joint supportive supervisory visits to health facilities <i>with</i> SMOH staff in your state?
11.1	What are the respective roles of SIDHAS and SMOH staff during these supervisory visits?
12.	Does SIDHAS staff ever provide direct service delivery on a routine or ad hoc basis [in an emergency or in health facility staffabsence]?
13.	Does your state have an Integrated Health Data Management Team? If Yes how does this differ from the State Health Data Consultative Committee. Do you have TORs for these structures?

14.	Does the SMOH receive the HMIS monthly reports on HIV services from health facilities?
14.1	How does the SMOH use these reports to monitor facility performance in the provision of HIV services? What support does SIDHAS give the SMOH for this?
15.	Does SMOH receive regular feedback reports from SACA, on the analysis of the monthly HMIS data on HIV services?
15.1	If yes, what changes have been implemented as a result of the analysis of the monthly HMIS reports on HIV services?
15.2	How has SIDHAS supported the SMOH on implementing the change resulting from analysis of the monthly HMIS data?
16	Does the SMOH have a copy of the SIDHAS MOU signed with the state governor? Do you have a copy of the subagreement signed between SIDHAS and the SMOH which applies to all program elements including training and procurement.
16.1	Are there budget details in these agreements?
16.2	How is the SMOH monitoring implementation of these agreements?
17	Has SIDHAS assisted the setup of the State Implementation Team/State Management Team? What are the terms of reference for these teams? How these differ from SASCP terms of reference
17.1	How has SIDHAS supported the activities of the SIT? Are there any performance appraisal processes for the SIT?
18.	Does the SMOH has a sustainability plan for continuing the contributions that SIDHAS is currently providing so that after the project ends in 2017, the HIV services will continue? <i>Probe: training/systems strengthening/transport/communication/commodities</i>
19.	During the remaining two years of SIDHAS, what are the other areas of assistance the SIDHAS Project could provide to support greater sustainability of quality HIV services by the SMOH?
20.	At the state level, what is needed to enhance the GON's coordination and strategic planning for HIV response?
21.	What changes, if any, has SIDHAS supported in the coordination roles of SACA, SMOH and LACAs?
22.	How has SIDHAS contributed to strengthening capacity for managing and delivery of quality HIV services at the State, LGA and CSO levels, and at all service delivery points?
23.	What support has SIDHAS given the SMOH to improve systems and capacity for HRH planning and management?

	Probe: Do you have a State HRH policy and plan that incorporate expanded service delivery for ART and PMTCT ? Probe: How have staffing levels at health facilities across the state changed?
24.	How have PMTCT and ART services become more accessible through SIDHAS support? <i>Probe coverage and utilization</i>
25.	How has SIDHAS supported SMOH advocacy with the State Government to secure future increased SMOH funding and staffing, for sustaining delivery of quality [expanded in Akwa Ibom only] ART & PMTCT services?
26.	How has PEPFAR rationalization of its support, which has involved changing PEPFAR Implementing Partners, affected HIV service delivery in your state?
27.	How has SIDHAS decentralization of SITs to LITs supported the state in increasing access to HIV services by those most in need?
28.	Has SIDHAS engagement of the private sector increased access by those most in need? <i>If yes, How?</i>

KII QUESTIONNAIRE SIDHAS PROJECT EVALUATION

2. Interview with Principal Official: State Agency for AIDS Control (SACA)	
1.	How has SIDHAS supported SACA's coordination role and activities in your state?
2.	How has SIDHAS assisted SACA with its planning and capacity building roles?
3.	How has PEPFAR rationalization of its support, which has involved changing PEPFAR Implementing Partners, affected coordination and delivery of HIV services in your state?
4.	How has SIDHAS decentralization of SITs to LITs supported the state in increasing coordination and access to HIV services by those most in need?
5.	What role has SIDHAS played in supporting health management information systems in this state?
6.	How have SIDHAS staff contributed to your interpretation and use of the HMIS data reported monthly by health facilities?
6.1	How does SACA ensure the quality of reporting by facilities? What role has SIDHAS played in this?
6.2	How are monthly HMIS reports transmitted from facilities to SACA?
6.3.	What analysis of the HMIS data is undertaken at the state level? How has SIDHAS assisted in this?
6.4	What changes to HIV services have been made in your state as a result of analysis of the reports?
6.5	How is feedback resulting from analysis of the HMIS data communicated to health facilities?
6.	Do SIDHAS staff conduct joint supervisory visits with SACA staff to health facilities?
7.	What are the different roles of SIDHAS and SACA on joint health facility visits?
8.	The SIDHAS project will end in 2017, only two years from now. What has SACA put in place or planned to continue the activities and training that SIDHAS now provides, after the project ends? What steps can SIDHAS take now to ensure that HMIS reporting continues to enable coordinated service delivery?

KII QUESTIONNAIRE

SIDHAS PROJECT EVALUATION

3. Interview with Principal Official: LGA-PHC Department

- 1 How has the SIDHAS project influenced the quality of HIV services in your LGA?
Probe: are HIV test kits and ARVs consistently available?
Probe: are trained health workers deployed and in post?
Probe: do you have reporting and supervisory systems in place?
- 2 SIDHAS was designed to work through the State structures to increase access to quality HIV services. What have been the different contributions of the GON and SIDHAS to the planning and implementation of HIV services in your LGA?
- 3 Have the HIV services in your LGA gone beyond health facility services? How has the private sector been involved? How have CSOs been involved?
- 4 What assistance has SIDHAS provided to your LGA for planning and management of HIV services? Do you have an LGA work plan that includes HIV services?
Probe: what support, has SIDHAS provided you, to HRH; to M&E; to supervision; and to assurance of clinical standards in service delivery.
- 5 How has SIDHAS decentralization of SITs to LITs supported increasing access to HIV services to those most in need in your LGA?
- 6 What is the best way for SIDHAS to promote greater ownership of HIV services by LGAs and communities?
- 7 Has SIDHAS engagement of the private sector increased access by those most in need in your LGA? *If yes, How?* Is private sector involvement sustainable?

KII QUESTIONNAIRE SIDHAS PROJECT EVALUATION

4. QUESTIONS FOR NACA, FEDERAL MINISTRY OF HEALTH, NASCP

- 1 The USG signed a partnership framework for supporting the national response to HIV with the GON. How has this supported the Nigerian response to HIV?
- 2 What are the GON priorities for strengthening stewardship by Nigerian institutions for the delivery of high quality HIV services?
- 3 What are the GON priorities for integration of health and social welfare provisions?
Probe: Priorities for involvement of civil society and PFP sector?
- 4 How does SIDHAS fit with the GON's Universal Health Coverage agenda? What are the future funding implications of this integration?
- 5 SIDHAS main strategies are CQI, capacity building with health systems strengthening, and working through the state government structures to deliver improved & sustainable access. Given the recently enacted National Health Act, how do the SIDHAS strategies support GON to manage the implementation challenges?
- 6 How has SIDHAS contributed to strengthening the coordination role of GON at the Federal level?
- 6.1 How has SIDHAS built the capacity of NACA/FMOH to lead and coordinate donor- and Government-funded projects? How has SIDHAS supported NACA/FMOH to lead this coordination?
- 7 How was NACA/ the National Planning Commission/ Federal Ministry of Health involved in setting the SIDHAS service delivery and capacity building targets?
- 8 How has the GON been involved in reviewing and critiquing the SIDHAS project performance?
- 9 How has SIDHAS contributed to harmonizing parallel reporting platforms into one unified national DHIS?
- 9.1 What are the effects of SIDHAS collecting additional PEPFAR required data from facilities?
- 9.2 How many project supported sites are reporting into the national DHIS?
- 9.3 Are all project supported sites using the approved, harmonized data collection and reporting tools?
- 10 Has the project supported capacity building of GON staff to conduct operations research as a basis for increasing efficiency & effectiveness of HIV service delivery?
- 10.1 How many OR studies are underway in collaboration with NACA & FMOH?
- 11 What is the current status of the Patient Management and Monitoring system, and Logistic Management Information System (LAMIS)? How has SIDHAS supported GON to own these systems?
- 12 Does FHI 360 share SIDHAS budgets and workplans with GON (NACA/FMOH)
- 13 In 2013, PEPFAR implemented rationalization of its support to Nigeria. How has this influenced expanding services? *Probe: for specific examples.*
- 14 To what extent has the SIDHAS support to expansion of PMTCT and ART services in

SIDHAS Tier 1 states, with limited expansion in Tier 2 states sustainably increased access to services by those most in need? Are there Nigerian resources [budgets & HRH] identified for this after the SIDHAS project ends in 2017?

Has the engagement of the private sector sustainably increased access by those most in need?

- 15 What are the best ways to promote greater ownership of SIDHAS activities by states, LGAs and communities?
- 16 Is there anything further that you think it is important that we should know about SIDHAS?

KII QUESTIONNAIRE SIDHAS PROJECT EVALUATION

5. Interview with Principal Official: USAID, PEPFAR, CDC, DOD, DFID&MSH

- 1 What is the degree of coordination and alignment between development projects, for example the Health and Finance Governance (HFG) Project and SIDHAS project? And DFID's Enhancing National Response project & SIDHAS.
- 2 Is there a requirement for PEPFAR IP's project data to be reported regularly to the Development Assistance Database managed by the National Planning Commission? Is this happening regularly?
- 3 How involved is NACA in the activities and planning of the Health Partners Coordinating Committee (HPCC)? Do they share experience/lessons learned etc?
- 4 Given the recently reported challenges with efficiency, effectiveness and accountability of donor funds, how are these risks to PEPFAR funds being mitigated and how are they addressed for the SIDHAS Project? Are these issues regularly discussed with donor's GON counterparts?

Has implementation of the PEPFAR Rationalization strategy improved performance of PEPFAR programs? Is there PMP data that supports this?

- 5 How has PEPFAR rationalization and GON decentralization to PHC impacted on access to and utilization of HIV services? How will these strategies assist in expanding services in areas of high HIV prevalence? Is there HMIS/program monitoring data that corroborates this?

KII QUESTIONNAIRE

SIDHAS PROJECT EVALUATION

6. Interview with Principal Official: National Planning Commission

We are interested in how far the US Partnership Framework has actually supported Nigerian leadership and stewardship of the HIV Response.

- 1 What are the total USG development fund allocations to Nigeria and what proportion is for HIV? Do you have figures for the last five years that you could share with us?
- 2 Are you at the NPC able to confirm the budget actually disbursed by USG for HIV activities in Nigeria over the last five years?
 - 2.1 Is the NPC informed of the actual disbursements for the SIDHAS project? [if not why not?]
- 3 How do you foresee the federal funding prospects for HIV services in the future?
- 4 What is the likelihood of the full range of HIV services now offered in the SIDHAS project states being sustained with Nigerian resources in the short and long term after the end of SIDHAS project?

Probe: Budget and HRH
- 5 What specific strategies are in place to bridge the potential funding gap between the National Planning Commission, Ministry of Finance, the NACA and FMOH?
- 6 USAID's Health Finance and Governance project recently supported a Healthcare Financing Capacity-Building Workshop for health officials from around Nigeria. To what extent were the objectives of this workshop and SIDHAS capacity-building objectives aligned with national plans and priorities for resources mobilization?

Probe: was the healthcare financing capacity building workshop held in response to a GON request

Probe: is there a national operational guideline for international cooperation projects

KII QUESTIONNAIRE

SIDHAS PROJECT EVALUATION

7. Interview with Principal Official: Training Institutions & Capacity Building

- 1 Given the degree of “training” conducted by donor-funded projects, how have the training institutions involved in the SIDHAS project training needs assessments, design and evaluation of its training programs?
- 2 Do you have an institutional training plan you can share with us?
- 3 Are newly designed training modules routinely integrated by GON Training Institutions? How are new curricula approved?
- 4 How many people have been trained using funds from SIDHAS?
- 5 Has there been a follow up to evaluate the results of SIDHAS-funded training? How are you verifying that new skills and knowledge are consistently applied? Do you conduct routine training needs assessments and follow up inspections in addition to supervisory visits?

NIGERIA SIDHAS Mid-Term EVALUATION
Health Facility In-Charge and Matron/Senior Nurse
KII Questionnaire

Questionnaire ID Number _____ [Not allocated in field. Allocated in Abuja]

Introduction- We are conducting an evaluation of assistance provided by the United States Government for HIV and Tuberculosis services in Nigeria. We would be grateful if you would spend a short time answering a few questions about your experience providing HIV health care services.

Consent and Confidentiality- This survey is completely anonymous (your name will not be used), and you will not be identified. Your participation is voluntary. You do not have to answer any questions that you don't want to answer. Your responses will be analyzed along with many others from health care providers and patients across the country to assure that the US resources and the partnership with Nigerian health care facilities reaches those in need.

E. IDENTIFICATION

1. Facility Name: _____
2. State: _____ 3. LGA: _____
8. Date of interview: _____
9. Interviewer: _____ 6. Supervisor: _____

**F. INFORMATION ON HEALTH FACILITY-IN-CHARGE AND THE
MATRON/SENIOR NURSE** [*interview separately and record responses on separate
sheets*]

6.a. Grade of Health Facility in Charge:

Medical Officer:.....1; Other: physician.....2 [specify grade]

Other health worker 3[Specify].....

6.b. Grade of Senior Nurse:

Matron.....1; Other:.....2 [Specify grade]

7. How long have you been in-charge /senior nurse at this facility?

Less than 6 months.....1, 6 months to less than 1 year.....2,

1 year to less than 2 years.....3, 2 or more years.....4

8. How long have you been working at the facility?

Less than 6 months.....1, 6 months to less than 1 year 2,

1 year to less than 2 years.....3, 2 or more years.....4

C. INFORMATION ON THE FACILITY: (Check the applicable box)

9. Type of facility

☐ Primary Health Care Clinic

- ☐ Comprehensive Health Center
- ☐ General Hospital
- ☐ Tertiary Hospital
- ☐ Other (Specify).....

10. Managing authority

- ☐ FMOH
- ☐ Federal Government not public (Military/Police/Etc.)
- ☐ SMOH
- ☐ NGO-Non-Profit
- ☐ NGO-Faith Based Organization
- ☐ Private-For-Profit
- ☐ LGA
- ☐ Other _____

C. NON-FMOH & SMOH ASSISTANCE [USAID, PROJECTS, OTHER DONORS]

11. Which organizations have provided assistance to your facility in the last three years?

12. What different sorts of assistance have these organizations provided?

(Record specific categories of assistance)

13. Are there any challenges to your facility staff receiving this type of support? If yes: please tell me about these challenges

14. Does your facility have a sub-agreement with SIDHAS?

If yes, Can you show us?

If no, Have you seen a copy of the agreement between the State and SIDHAS?

15.a. Has your facility experienced a change in the USAID or CDC partner providing the support?

15.b. How did the change in this assistance affect your staff and services they provide?

16. Have you been part of the effort to expand ART and PMTCT/eMTCT? If no, go to 22

17.a. Has this expansion been possible with the staff you have in this facility?

17.b. How have you managed your staff to accommodate expansion of services?

18. How have you managed the increased numbers of clients?

19. How have you managed the increased demand for drugs?

20. How have you managed the increase use of consumables?

21. What support have you and your staff had to manage these changes effectively?

22. How has the emphasis on integration of services affected your health facility?

Prompt: How has the integration of ART into your facility services affected your health facility?

Prompt: How has integration of PMTCT/eMTCT into your facility services affected your health facility?

Prompt: What support have your staff had to deliver the integrated services?

18. How can you sustain the changes that SIDHAS project has introduced at the end of the SIDHAS project in 2017?

19. Has SIDHAS started any activities for quality improvement in your health facility?

If yes, ask questions 20- 24;

If no, go to next section E. KNOWLEDGE OF SERVICE PERFORMANCE

20. Can you describe these quality improvement activities?

21. Was there an initial assessment conducted to determine your capacity building needs?

If Yes, Who conducted this assessment?

22. Do you have a copy of this assessment report? Can you show it to me?

23. Who set the quality improvement targets for your facility?

24. Did the assessment generate an action plan that addressed the specific capacity building needs for this facility? *If yes, can you show it to me?*

25. What activities have been conducted to implement the action plan?

25.1. Have you been trained in service gap analysis?

25.2. Have you updated your management and financial procedures as a result of training implemented through the capacity building action plan?

25.3. Have you updated any job descriptions to include leadership competencies?

25.4. Do you have examples of task shifting that has occurred resulting from implementing the action plan?

**26. Has there been a joint training for CSOs, your facility staff and State/LGA staff?
If yes, please tell me about the joint training**

27. Have there been any exchange visits organized between staff from your facility and other facilities?

28. How has the quality improvement process affected the delivery of HIV services in your facility?

E. KNOWLEDGE OF SERVICE PERFORMANCE

29. How do you assess how well your health facility is performing in providing HIV and TB services?

30. How do your facility staff know if HIV clients miss follow-up appointments?

31. What system does your health facility have for following up with an HIV client who misses one or more appointments?

32. How does the system track the number of HIV clients that consistently come for follow up and those that drop out?

33. Are your client retention rates for care and treatment going up, or down, or staying at the same level in your facility?

34. How often do you review the HMIS data for your health facility?

35. Who reviews the HMIS data for your health facility with you?

- 36. What analysis of your health facility HMIS data has SMOH, SACA or SIDHAS given you?**
- 37. What changes in service delivery have you made as a result of an analysis of the HMIS data for your health facility?**
- 38. In the remaining two years of the SIDHAS project, what are your priorities for the technical assistance SIDHAS should provide your facility?**

Thank you for your time and thoughtful responses to our questions.

NIGERIA SIDHAS EVALUATION

TB-DOTS Service Assessment Tool

Questionnaire ID Number _____ *[To be allocated in Abuja, not in the field]*

Introduction- We are conducting an evaluation of assistance provided by the United States Government to health care services in Nigeria. We would be grateful if you would spend a short time answering a few questions about your experience delivering HIV health care services.

Consent and Confidentiality- This survey is completely anonymous (your name will not be used), and you will not be identified. Your participation is voluntary. You don't have to answer any questions ;that you don't want to answer: we can just skip questions you do not want to answer. We will analyze all the answers from many health care providers in this and other states and **make recommendations on how USAID assistance can further strengthen your health care services over the next two years.**

A. Identification

1. Facility Name:

2. State: **3. LGA:**

4. Date of Assessment:

5. Evaluator: **6. Supervisor:**

Score 1-4 unless otherwise stated below	Score 1-4
1. Easy to follow, client-friendly, client flows [1 = poor ; 2 = adequate ; 3 = good ; 4 = exceptional]	
2. Waiting area with seats, protected from sun and adverse weather [1 = clients wait outside ; 2 = inadequate space ; 3 = too few seats ; 4 = good waiting facilities]	
3. Client privacy and confidentiality observed throughout [1 = poor ; 2 = adequate ; 3 = good ; 4 = exceptional]	
4. TB control procedures in place [1 = poor ; 2 = adequate ; 3 = good ; 4 = exceptional]	
5. All staff providing TB care are trained in TB/HIV management [1= none trained ; 2= some trained ; 3= > half trained ; 4= All trained]	
6. Availability of TB drugs [1= 1 or more TB drug out of stock throughout last 6 months ; 2= 1 or more TB drug out of stock for >1 <6 months ; 3= out of stock for less than 1 month ; 4= in stock throughout last 6 months contemporary records]	
7. Client waiting time [1= called back another day ; 2= >1 hour ; 3 <1 hour ; 4= minimum waiting]	
8. Chest X ray availability when required clinically [1 = no ; 2 = from private sector or other public facility ; 3 = in facility but often out of order ; 4 = available]	

NIGERIA SIDHAS EVALUATION

PMTCT/eMTCT Service Assessment Tool

Questionnaire ID Number _____ *[To be allocated in Abuja, not in the field]*

Introduction- We are conducting an evaluation of assistance provided by the United States Government to health care services in Nigeria. We would be grateful if you would spend a short time answering a few questions about your experience delivering HIV health care services.

Consent and Confidentiality- This survey is completely anonymous (your name will not be used), and you will not be identified. Your participation is voluntary. You don't have to answer any questions ;that you don't want to answer: we can just skip questions you do not want to answer. We will analyze all the answers from many health care providers in this and other states and **make recommendations on how USAID assistance can further strengthen your health care services over the next two years.**

B. Identification

1. **Facility Name:**

2. **State:** 3. **LGA:**

6. **Date of Assessment:**

7. **Evaluator:** 6. **Supervisor:**

Score 1-4 unless otherwise stated below	Score 1-4
1. Easy to follow, client-friendly, client flows [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
2. ANC Waiting area with seats, protected from sun and adverse weather [1 = clients wait outside; 2 = inadequate space; 3 = too few seats; 4 = good waiting facilities]	
3. Client privacy and confidentiality observed throughout [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
4. Private counseling room for posttest counseling positive mothers [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
5. Rapid testing with same day results [1= no; 2= testing in lab; 3= testing in ANC in batches; 4= testing individuals without delay]	
6. ANC Client registers in place & used, confidentiality observed, kept securely [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
7. All staff providing PMTCT are trained in PMTCT [1= none trained; 2= some trained; 3= > half trained; 4= All trained]	
8. Pretest counseling [includes information on window period/ ART/ PMTCT] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
9. Posttest counseling [includes advice on partner disclosure for all pregnant women/	

information on ART for positive clients/ safer sex/ exclusive breast feeding] [1 = poor ; 2 = adequate ; 3 = good ; 4 = exceptional]	
10. IEC materials in local language(s) [on HIV/AIDS/PMTCT/Positive living/safer sex/malaria in pregnancy/exclusive breast feeding] available and used [penile models and condoms for distribution available] [1 = poor ; 2 = adequate ; 3 = good ; 4 = exceptional]	
11. Partner disclosure & male involvement in PMTCT encouraged [<i>record how encouraged at end of questions below</i>][1= poor ; 2 = adequate ; 3 = good ; 4 = exceptional]	
12. Exclusive infant feeding counseling in OPD [1 = poor ; 2 = adequate ; 3 = good ; 4 = exceptional]	
13. Infant nevirapine stocks in ANC and postnatal wards [PNW] [1= out of stock throughout last 6 months ; 2= Out of stock for >1 <6 months ; 3= out of stock for less than 1 month ; 4= in stock throughout last 6 months contemporary records]	ANC: PNW:
14. Intermittent preventative treatment of malaria drugs—sulphadoxinepyrimethamine (S-P)—available used [1= out of stock throughout last 6 months ; 2= Out of stock for >1 <6 months ; 3= out of stock for less than 1 month ; 4= in stock throughout last 6 months contemporary records]	
15. LLINs available for pregnant womendistributed [1= out of stock throughout last 6 months ; 2= Out of stock for >1 <6 months ; 3= out of stock for less than 1 month ; 4= in stock throughout last 6 months contemporary records]	
16. Referrals for positive mothers for ART [1 = poor ; 2 = adequate ; 3 = good ; 4 = exceptional]	
17. Pregnant women living with HIV receive 1 = no ARVs if CD4 >500 2 = limited ARVs [Option A] for PMTCT at onset of labor/delivery 3 = ART during pregnancy, delivery and breast feeding[Option B] irrespective of CD4 4 = Life-long [Option B +] irrespective of CD4	
18. Client waiting time [1= called back another day ; 2= >1 hour ; 3 <1 hour ; 4= minimum waiting]	
19. SOPs and job aids readily available in ANC and used [1 = poor ; 2 = adequate ; 3 = good ; 4 = exceptional]	
20. Individual patient records/dockets [record of individual patient management] [1 = poor ; 2 = adequate ; 3 = good ; 4 = exceptional]	
Record observations below and overleaf:	



PMTCT/eMTCT Services Assessment Labor, Delivery and in Postnatal/ MNCH Clinic	
Score 1-4 unless otherwise stated below	Score 1-4
Labor, Delivery	
21. Care of birthing women observes mother's rights and respectful [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
22. Client privacy and confidentiality observed throughout labor, delivery and post natal wards [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
23. Private counseling room for posttest counseling positive mothers in labor and post natal wards [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
24. Rapid testing with same day results available in labor and postnatal wards [1 = no; 2 = testing in lab; 3 = testing in clinic in batches; 4 = testing individuals without delay]	
25. Exclusive infant feeding counseling with support post delivery [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
26. Safe delivery practices protecting health staff from contaminated fluids universal precautions [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
27. SOPs and job aids readily available and used in labor delivery wards [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
Post Natal /Child Welfare Clinic	
28. Early infant diagnosis DNA PCR testing with DBS at 6-8 weeks and linkages to ART [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
29. Exposed infants followed up and have repeat testing at end of breast feeding [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
30. Breast feeding mothers living with HIV provided with ART [Option B/Option B+] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
31. Cotrimoxazole prophylactic treatment for HIV exposed infants available [1= out of stock throughout last 6 months; 2= Out of stock for >1 <6 months; 3=out of stock for less than 1 month; 4= in stock & used throughout last 6 months contemporary records]	
32. HIV testing of children under 5 who present sick at Child Welfare Clinic [DNA PCR if aged under 9 months; Antibody test from age 9 months to 5 years with confirmatory DNA PCR if antibody test positive] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
33. Family planning counseling, commodities, referrals; condoms & penile models available]	



NIGERIA SIDHAS EVALUATION ART Service Assessment Tool

Questionnaire ID Number _____ [To be allocated in Abuja, not in the field]

Introduction- We are conducting an evaluation of assistance provided by the United States Government to health care services in Nigeria. We would be grateful if you would spend a short time answering a few questions about your experience delivering HIV health care services.

Consent and Confidentiality- This survey is completely anonymous (your name will not be used), and you will not be identified. Your participation is voluntary. You don't have to answer any questions; that you don't want to answer: we can just skip questions you do not want to answer. We will analyze all the answers from many health care providers in this and other states and **make recommendations on how USAID assistance can further strengthen your health care services over the next two years.**

C. Identification

1. **Facility Name:**

2. **State:** 3. **LGA:**

8. **Date of Assessment:**

9. **Evaluator:** 6. **Supervisor:**

ART Services Assessment [ART/Adult; Family ART; Pediatric ART]	
Score 1-4 unless otherwise stated below	Score 1-4
1. Easy to follow, client-friendly, client flows [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
2. ART Waiting area with seats, protected from sun and adverse weather [1 = clients wait outside; 2 = inadequate space; 3 = too few seats; 4 = good waiting facilities]	
3. Family ART service availability [1= No; 2= Waiting list; 3= mother & children only; 4=Full family ART service]	
4. <i>For facilities treating children:</i> waiting area has child friendly facilities [1 = no facilities; 2 = adequate; 3 = good; 4 = exceptional]	
5. Client privacy and confidentiality observed throughout [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
6. All staff providing Adult & Pediatric ART are trained in ART services [1= none trained; 2= some trained; 3= > half trained; 4= All trained]	
7. ART Client registers in place & used, confidentiality observed, kept securely [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	

8. <i>For facilities treating children:</i> pediatric dosing charts readily available [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
9. Treatment Adherence counseling [1 = none ; 2 = prior to commencing ART only; 3 = adherence counselor is available for client referrals; 4 = staff providing ART services provide adherence counseling at every contact]	
10. Availability of ARVs [1= 1 or more ARV out of stock throughout last 6 months; 2= 1 or more ARV out of stock for >1 <6 months; 3=out of stock for less than 1 month; 4= in stock throughout last 6 months contemporary records]	
11. Availability of pediatric ARV formulations [1= 1 or more ped. ARV out of stock throughout last 6 months; 2= 1 or more ARV out of stock for >1 <6 months; 3=out of stock for less than 1 month; 4= in stock throughout last 6 months contemporary records]	
12. OI drugs—(particularly CTX)—available used [1= out of stock throughout last 6 months; 2= Out of stock for >1 <6 months; 3=out of stock for less than 1 month; 4= in stock throughout last 6 months contemporary records]	
13. Referrals for TB-HIV confirmation/treatment of TB [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
14. Membership of support group encouraged [<i>record how encouraged at end of questions below</i>][1= poor; 2 = adequate; 3 = good; 4 = exceptional]	
15. People living openly with HIV volunteering in clinic [1 = none; 2 = positive persons working in clinic but not opening living with HIV; 3 = people openly living with HIV volunteering; 4 = people living openly with HIV receiving pay/honoraria for work in clinic]	
16. IEC materials in local language(s) [on HIV/AIDS/safer sex/nutrition/positive living] available & used [penile models and condoms for distribution available] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
17. Clients living with HIV receive 1 = ARVs if CD4 <350 2 = no ARVs if CD4 <500 3 = CD4 not available, ARVs commenced with clinical staging only	
18. Client waiting time [1= called back another day; 2= >1 hour; 3 <1 hour; 4= minimum waiting]	
19. SOPs and job aids readily available in ART Clinic and used [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
20. Individual patient files [record of individual patient management]	

[1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
21. Defaulter tracking [missed appointments and lost to follow up] [1= poor; 2= adequate; 3= good; 4= exceptional]	
22. Overall assessment [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	

Record observations overleaf

NIGERIA SIDHAS EVALUATION HTC Service Assessment Tool

Questionnaire ID Number _____ [To be allocated in Abuja, not in the field]

Introduction- We are conducting an evaluation of assistance provided by the United States Government to health care services in Nigeria. We would be grateful if you would spend a short time answering a few questions about your experience delivering HIV health care services.

Consent and Confidentiality- This survey is completely anonymous (your name will not be used), and you will not be identified. Your participation is voluntary. You don't have to answer any questions ;that you don't want to answer: we can just skip questions you do not want to answer. We will analyze all the answers from many health care providers in this and other states and **make recommendations on how USAID assistance can further strengthen your health care services over the next two years.**

D. Identification

1. Facility Name:

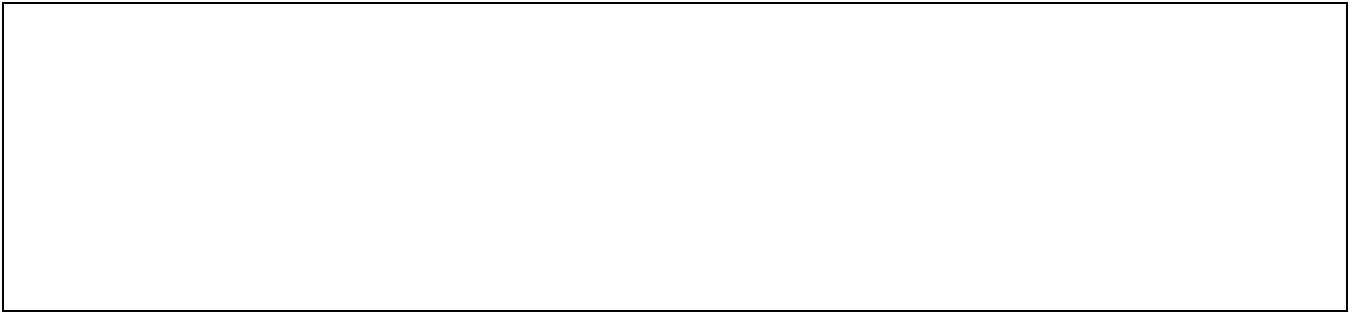
2. State: **3. LGA:**

10. Date of Assessment:

5. Evaluator: **6. Supervisor:**
.....

	Score 1-4 unless otherwise stated below	Score 1-4
1. HTC availability [1 = no service; 2 = 1-2/week; 3 = 3-4/week; 4 = 5/week]		
2. Easy to follow, client-friendly, client flows [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
3. Waiting area with seats, protected from sun and adverse weather [1 = clients wait outside; 2 = inadequate space; 3 = too few seats; 4 = good waiting facilities]		
4. Client privacy and confidentiality observed throughout [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]		
5. Couple counseling encouraged [1 = poor; 2 = adequate; 3 = good; 4 = exceptional] please provide notes on how encouraged overleaf		
6. Rapid testing with same day results [1= no; 2= testing in lab; 3= testing in clinic in batches; 4 = testing individuals without delay]		
7. Partner notification <i>note any unethical actions overleaf</i> [1 = staff notify partner of test results; 2 = staff notify partner that client has tested (but not divulging result) asking them to come for TC; 3 = staff provide client with invitation to partner to come in for couple TC;]		
8. Client registers in place & used, confidentiality observed, kept securely		

[1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
9. Pretest counseling [includes limitations of test & window period] [1 = none; 2 = group; 3 = individual; 4 = exceptional]	
10. Posttest counseling [includes advice on partner disclosure for all clients/ information on ART for positive clients/ advice on safer sex for all clients / pre- screening for TB] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
11. Condoms available in counseling room for distribution to clients & use demonstrated [penile models available/flipcharts of condom use available] [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
12. Positive clients referred to ART and to TB clinic if pre-screening suggestive of TB [1 = TC staff do not mention follow up; 2 = TC staff tell clients to go for follow up with no guidance on when and how to register; 3 = TC staff tell clients how to find registration for follow up; 4 = TC staff/volunteer go with client & help them register in follow up clinic]	
13. Stockouts of condoms in last 6 months [record number of days of stockouts]	
14. IEC materials in local language(s) [on HIV/AIDS/safer sex/positive living] available in counseling room & used [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
15. Client waiting time for HTC [1= called back another day; 2= >1 hour; 3 <1 hour; 4= minimum waiting]	
16. SOPs readily available and used [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
17. Overall assessment [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	
<i>Record observations below and overleaf</i>	



NIGERIA SIDHAS EVALUATION

Laboratory Service KII & Assessment Tool

Questionnaire ID Number _____ [To be allocated in Abuja, not in the field]

Introduction- We are conducting an evaluation of assistance provided by the United States Government to health care services in Nigeria. We would be grateful if you would spend a short time answering a few questions about your experience delivering HIV health care services.

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E. Identification

1. **Facility Name:**
2. **State:** 3. **LGA:**
11. **Date of Assessment:**
5. **Evaluator:** 6. **Supervisor:**

F. Characteristics of respondent

7. Lab Scientist:.....1, Lab technician:.....2, Other:.....3
8. Sex: Male.....1; Female.....2

9. How long have you been in current post?

- Less than 6 months.....1; 6 months to less than 1 year.....2,
1 year to less than 2 years.....3; 2 or more years.....4

10. How long have you been working at this facility?

- Less than 6 months.....1; 6 months to less than 1 year.....2;
1 year to less than 2 years.....3; 2 or more years.....4

11. How long since you qualified/completed basic training?:

- Less than 6 months.....1; 6 months to less than 2 years.....2
2 years to less than 5 years.....3; 5 or more years.....4

12.a. Have you had specific HIV training since basic training?

- Yes.....1; No.....2

12.b. If Yes in Q13.a., when did you have the training?

- In the last 2 years.....1; More than 2 years ago.....2

13.c. If Yes in Q13.a Who provided the training?

SMOH: 1, SIDHAS: 2, Other (Specify):.....98

Laboratory services assessment				M	F
Total number of Lab staff:					
Lab Scientists:	Lab technicians:	Lab assistants:	Lab attendants:		
Dedicated Driver:	Dedicated Cleaner:	Others:			
1= poor; 2 = adequate; 3 = good; 4 = exceptional				Score 1-4	
C. Laboratory Infrastructure and Capacity Building					
14. Has SIDHAS supported any infrastructural changes in the lab, including renovations , water and electricity supply, and lab benches					
15. Has SIDHAS supported work-flow improvement in the Lab (indicate changes made); has this improved Lab services; are specimen collection areas separate from lab processing area, is there a separate space for TB smear microscopy					
16. Has SIDHAS provided Lab equipment and reagents for: HIV testing, CD4 Count, Hematology, Clinical Chemistry, Malaria Microscopy, Pregnancy testing, Urinalysis, TB microscopy, others (list)					
17. Is there an organogram of the Lab management structure, does the lab team have a specific time of meeting, are minutes of the meeting kept. Is the Lab part of the Facility Project Management Team					
18. Has there been SIDHAS supported training on the following areas:					
Good Lab Practice:.....1 Lab safety:.....2 Lab Quality Assurance:.....3 SOP development:.....4 Hematology:.....5 Clinical Chemistry:.....6 CD4 Count:.....7 DBS for DNA PCR: 8TB Microscopy:.....9					

Malaria Microscopy: 10 Lab Logistics management:.....11 Others: 12	
19. Has SIDHAS made a supervisory visit in the last 6 months? Yes / No If yes, was this with the SMOH or independent of the SMOH? Is feedback provided to the site at the end of each visit? Is a standard checklist used during the visit? How are issues raised followed up?	
D. Documents and Records	
20. Are patients' data and results archived and retrieved according to Lab procedures	
21. Is a Lab safety and quality manual developed and updated, and accessible to lab staff	
22. Is there a controlled access to Lab data (un-accessible by unauthorized personnel)	
E. Quality of Service	
23. Are Standard Operating Procedures (SOPs) available, for all Lab processes? List available SOPs; When were they updated? Are they easily accessible and used by all lab staff?	
24. Indicate days and hours the Lab is open for service and to patients / clients	
25. Are all the equipment on the bench functional and calibrated?Is equipment service log maintained for all equipment?	
26. How often has lab services been interrupted/suspended due to equipment brake-down in the last 6 months? How long did it take to resolve (average time)?	

27. Who is the designated Lab quality supervisor and how often does s/he monitor internal quality processes?	
28. Does the lab maintain routine quality control chart/log? How often are these reviewed? Are the outcomes of the reviews discussed with the Lab staff? How are corrective actions taken?	
29. Is the lab enrolled in any External Proficiency Testing Program? List the tests with a PT program (review PT performance in the last cycle)	
30. Are quality issues brought up for discussion in the Lab staff/management meetings?	
31. How are patients complaints handled?	
F. Lab management	
32. What is the system for forecasting lab reagents and commodities needs?	
33. Is there a routine budgeting projection process for the lab?	
34. Is the lab management involved in making recommendations for lab equipment specifications and procurements?	
35. Which lab requests and services are referred to this lab, which tests and to which labs does this facility refer services to? 1. Haematology: 2. Chemistry: 3. DBS:	

4. CD4: 5. Virology: 6. TB Smear Microscopy: 7. PAP Smear Microscopy: 8. Other:	
<i>Observations below & Overleaf:</i>	

NIGERIA SIDHAS EVALUATION Pharmacy KII & Assessment Tool

Questionnaire ID Number _____ *[To be allocated in Abuja, not in the field]*

Introduction- We are conducting an evaluation of assistance provided by the United States Government to health care services in Nigeria. We would be grateful if you would spend a short time answering a few questions about your experience delivering HIV health care services.

Consent and Confidentiality- This survey is completely anonymous (your name will not be used), and you will not be identified. Your participation is voluntary. You don't have to answer any questions ;that you don't want to answer: we can just skip questions you do not want to answer. We will analyze all the answers from many health care providers in this and other states and **make recommendations on how USAID assistance can further strengthen your health care services over the next two years.**

G. Identification

1. **Facility Name:**
2. **State:** 3. **LGA:**
12. **Date of interview:**
13. **Interviewer:** 6. **Supervisor:**

H. Characteristics of respondent

8. Pharmacist:.....1, Pharmacy technician:.....2,
Other:.....3
8. Sex: Male.....1; Female.....2

9. How long have you been in current post?

- Less than 6 months.....1; 6 months to less than 1 year.....2,
1 year to less than 2 years.....3; 2 or more years.....4

10. How long have you been working at this facility?

- Less than 6 months.....1; 6 months to less than 1 year.....2;
1 year to less than 2 years.....3; 2 or more years.....4

11. How long since you qualified/completed basic training?:

- Less than 6 months.....1; 6 months to less than 2 years.....2
2 years to less than 5 years.....3; 5 or more years.....4

12.a. Have you had specific HIV/ART training since basic training?

- Yes.....1; No.....2

12.b. If Yes in Q13.a., when did you have the training?

In the last 2 years.....1; More than 2 years ago.....2

13.c. If Yes in Q13.a Who provided the training?

SMOH: 1, SIDHAS: 2, Other (Specify):.....98

C. KNOWLEDGE OF SERVICE PERFORMANCE

14. How do you know if clients do not come back for ART prescription refills?

15. What actions do you take if a client doesn't return for their prescription refill?

16. How often do you review the HMIS data for your department?

17. Who reviews the HMIS data for your department with you?

18. What analysis of your department HMIS data has SACA or SIDHAS provided to you?

19. What changes have been introduced after analysis of the HMIS data for your department?

20. What quality improvement activities have there been in your department?

21. Do you have a quality improvement plan?
If yes, can you show it to me?

22. How has the introduction of ART and PMTCT services affected the work of your department?

23. What training have you or you staff had to help you manage the effects on you pharmacy of increasing numbers of clients requiring ARVs and OI drugs?

[Detail the training receive, who provided training and when:]

24. What have been the challenges to your department of the increasing number of clients requiring ARVs and OI drugs?

25. How has SIDHAS assisted you to manage challenges?

26. In the last two years of the SIDHAS project, what are your priorities for the assistance SIDHAS should provide your department?

Pharmacy Services – in OPD and Main Hospital Pharmacy	
Unless stated otherwise: 1= poor; 2 = adequate; 3 = good; 4 = exceptional	Score 1-4
1. Main drug storage of ARVs hygiene security/temperature control & monitoring/etc [1= poor ; 2 = adequate ; 3 = good ; 4 = exceptional]	
2. Main drug store stock control & management [1= poor ; 2 = adequate ; 3 = good ; 4 = exceptional]	
3. Main drug store minimum and maximum ARV stock levels [1= stockouts, or excess stock >6 months ; 2 = 3 months , 3 = >3 months < 6 months]	
4. Main drug store minimum and maximum CTX stock levels [1= stockouts, or excess stock >6 month ; 2 = 3 months , 3 = >3 months < 6 months]	
5. Main drug store minimum and maximum TB drug stock levels [1= stockouts , 2 = 8 months for each enrolled client]	
6. Main drug store stockouts of ARVs in the last 6 months [1= 1 or more ARV out of stock throughout last 6 months ; 2= 1 or more ARV out of stock for >1 <6 months ; 3= out of stock for less than 1 month ; 4= in stock throughout last 6 months contemporary records]	
7. Main drug store stockouts of TB drugs in the last 6 months [1= 1 or more TB drug out of stock throughout last 6 months ; 2= 1 or more TB drugs out of stock for >1 <6 months ; 3= out of stock for less than 1 month ; 4= in stock throughout last 6 months contemporary records]	
8. Dispensing pharmacy dispensing hours [1= open less than clinic hours ; 2 = open clinic hours clinic days only ; 3 = open clinic hours Mon-Fri ; 4 = open throughout facility opening hours Mon-Sun]	
9. Drug storage and security in dispensing pharmacy [1= poor ; 2 = adequate ; 3 = good ; 4 = exceptional]	
10. Availability of pediatric formulations [1= none available in last 6 months ; 2 = 1 or more pediatric formulations available in last 6 months but long periods out of stock ; 3= 1 or more pediatric formulation usually in stock but have been stockouts of <1month in last 6 months ; 4 = >1 pediatric formulation in stock throughout last 6 month period.]	

11. Client registers in place & used, confidentiality observed, kept securely [1= poor; 2 = adequate; 3 = good; 4 = exceptional]	
12. IEC materials in local language(s) & pictorial [on how to store drugs at home, when to take drugs, adherence, side effects and management etc] available in dispensing pharmacy & used [1= poor; 2 = adequate; 3 = good; 4 = exceptional]	
13. Client waiting time [1= called back another day; 2= >1 hour; 3 <1 hour; 4= minimum waiting]	
14. Frequency of return to top up their prescriptions [1 = weekly between clinic appointments; 2= 2weekly between clinic appointments; 3= monthly between clinic appointments; 4= on day of clinic follow up only]	
15. Availability of condoms for distribution to positive clients <u>in dispensing pharmacy</u> [1= not available; 2= sometimes available but out of stock for long periods; 3= condoms generally available; 4= condoms always available for distribution]	
16. Overall assessment [1 = poor; 2 = adequate; 3 = good; 4 = exceptional]	

Record observations overleaf

SIDHAS EVALUATION

QUALITY CHECK ON REPORTED DATA

Guideline to Evaluators

- a. Request for facility registers and National Monthly Summary Forms (NMSF) for the different HMIS tools for November 2014

<u>PMTCT</u>	<u>ART</u>	<u>HTC</u>	<u>HBC</u>	<u>OVC</u>
PMTCT Registers National	Pre-ART Register National ART MSF	Facility-based HTC Registers HTC MSF National Prevention MSF	CSO HBC MSF	National Vulnerable Children MSF

- b. Count, check and record data reported for November 2014 from the registers
- c. Check and record the corresponding entries for each of the indicators in for November 2014

Programme	SIDHAS Performance Indicators	Indicator as captured in HMIS National Monthly Summary Form (NMSF)	Period to check	Reported Data using HMIS Tools	
				Facility	
				Register	Monthly Summary Form (NMSF)
PMTCT	No of pregnant women who are tested and receive their test result at first ANC visit during the last months	No. of pregnant women HIV tested, counseled and received results	Nov. 2014		
ART	No of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) (Current)	Number of persons currently on 1st line ARV during the reporting period + Number of persons currently on 2nd line ARV during the reporting period	Nov. 2014		
HIV/TB	Number individuals receiving HIV counseling, testing and their results in TB setting	No. of TB patients tested HIV negative + No. of TB patients tested HIV positive	Nov. 2014		
HTC	No of individuals receiving TC and their test results during the last 6 months	No of individuals HIV counseled & test & result	Nov. 2014		
PHARMACY SERVICES	# of clients receiving ARVs in last 6 months		Nov. 2014		

SIDHAS EVALUATION - M&E QUESTIONNAIRE FOR SIDHAS, SACA/SASCP & HEALTH FACILITIES

STATE/ORG: _____ NAME OF FACILITY/MDA: _____

NAME OF INTERVIEWEE: _____

STATUS OF INTERVIEWEE: _____ PHONE NO: _____

DATE OF INTERVIEW: _____ TIME OF INTERVIEW: _____

Introduction

I am _____ (**Name of Interviewer**), one of the Evaluators engaged by USAID/ NMEMSII to conduct a Mid-Term Evaluation for Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS) Project. The 5-year project is been implemented in the 36 states (and FCT) of the country since 2012 (although has been modified subsequently) and technically should be assessed for progress and possible improvements. Your state has been selected for data collection exercise for the evaluation and by virtue of your status as the **Record/M&E/Data Officer or Data Manager of HEALTH FACILITY/LACA/SACA/SASCP/SIDHAS**, I am here to interact with you on some aspects of HIV/AIDS data management system (including HMIS) in the facility/state/org. The interview will not be more than **30 minutes**. Your responses shall be treated with utmost confidentiality and will ONLY be used for the purpose of the evaluation. Feedbacks from the evaluation exercise shall be provided to stakeholders, through dissemination of the evaluation report, by USAID in conjunction with her Implementing Agency/ Partners in the state. Do you have any questions or concerns before we begin?

Thank you.

FHI - SIDHAS (M&E Unit – Director/Officer)

1. Briefly describe the implementation of M&E components of SIDHAS project? (**Probe for structure at all levels, tools, databases, reporting, data quality challenges, capacity building, in-country mentoring at all levels, etc.**)
2. How have M&E functions contributed to achievements in the three key result areas (KRA) of SIDHAS (**Probe for contribution to – Access, Integration and Stewardship key result areas**)
3. What has been the impact of USAID rationalization strategy on the implementation of M&E activities of SIDHAS (**Probe for transition of baseline regimes, before and after rationalization, attribution, reporting platform etc.**)
4. How has SIDHAS contributed to strengthening of HIV/AIDS responses at national/ sub-national levels? (**Probe for specific activities targeted at M&E Departments/Units of NACA (NNRIMS)/SACA/FMoH/NASCP/SMoH/SASCP, capacity building, DQA exercises, National M&E tool harmonization/availability etc.**)

5. What has been done by SIDHAS to strengthen use of HMIS for HIV/AIDS data management in the country? **(Probe for contributions to capacity building, availability of tools, harmonization of MIS etc.)**
6. What are the main challenges in strengthening use of HMIS at all levels HIV/AIDS responses in the country? **(Probe for availability of tools, harmonization of MIS, attrition/retention of trained staff etc.)**
7. What can be done better to improve SIDHAS M&E system to support better delivery of project objectives?

SACA/SASCP (M&E Officer)

1. How has HMIS been supported in the State? **(Probe for: Responsible organizations and what has been done)**.
2. How have you been supported by SIDHAS in the collection and reporting of data for State response to HIV/AIDS?
3. Briefly describe how the HMIS tools are being used to record and report data from the State? **(Probe for: Data entry procedure, data quality check, data transfer, data security, and knowledge of data flow)?**
4. How have you been using data collected to contribute to decision making in the State?
5. How has rationalization of USAID projects impacted on the State HIV/AIDS data management? **(Probe for effect on HMIS, DHIS and data flow)**
6. How has SIDHAS supported coordination of HIV/AIDS data management in the State?
7. What are the other processes in place to ensure quality data reporting from the state? **(Probe for source of support for the processes, conduct of data quality assessment (DQA) in the state)**
8. Do you receive any feedbacks from NACA/SASCP in respect of data submitted to them? If YES, how have you been feedback? **(Request for evidence and what was done with such feedback)**
9. What other challenges have you experienced in collecting and reporting data from the state? **(Probe for what has been done to address this challenges)**

HEALTH FACILITY (Record/Data Officer)

1. Have you been trained on HMIS or any aspect of data management? If YES;
 - a. When were you trained?
 - b. Who supported the training?
2. How has HMIS been supported in the facility? **(Probe for: Responsible organizations and what has been specifically done)**.
3. Briefly describe how the HMIS tools are being used to record and report data from the facility **(Probe for: Data entry procedure, data quality check, data transfer, data security, and knowledge of data flow)?**
4. Do you have any challenge(s) to understand/interpret/report any of the indicators in any of the HMIS tools? If YES;
 - a. What are these indicators and challenges?
 - b. How have these challenges been addressed?

5. How have you been using data collected to contribute to decision making in the facility?
6. Do you receive any feedbacks from SACA/SASCP in respect of data submitted to them? If YES, how have you been feedback?
7. What other challenges do you experience in collecting and reporting data from this facility? (**Probe for what has been done to address this challenges**)
8. In your opinion, which aspect M&E training do you still need?

SIDHAS PROJECT EVALUATION COMMUNITY & PRIVATE PROVIDERS KII QUESTIONNAIRE

Questionnaire ID Number _____ [Not allocated in field. Allocated in Abuja]

Introduction- We are conducting an evaluation of assistance provided by the United States Government for HIV and Tuberculosis services in Nigeria. We would be grateful if you would spend a short time answering a few questions about your experience providing HIV health care services.

Consent and Confidentiality- This survey is completely anonymous (your name will not be used), and you will not be identified. Your participation is voluntary. You do not have to answer any questions that you don't want to answer. Your responses will be analysed along with many others from health care providers and patients across the country to assure that the US resources and the partnership with the government of Nigeria reaches those in need.

I.

J. IDENTIFICATION

1. Type of Community/Private provider premises: _____
2. State: _____ 3. LGA: _____
14. Date of interview: _____
15. Interviewer: _____ 6. Supervisor: _____

K. CHARACTERISTICS OF RESPONDENT

9. Pharmacist:.....1, Physician:.....2, Nurse:.....3
 . Other.....4 specify:.....
8. Sex: Male.....1; Female.....2

9. How long have you been providing HIV/TB/PMTCT services? [Ask Qu appropriate to provider]

- Less than 6 months.....1; 6 months to less than 1 year.....2,
 1 year to less than 2 years.....3; 2 or more years.....4

10. How long since you qualified/completed basic training?:

- Less than 6 months.....1; 6 months to less than 2 years.....2
 2 years to less than 5 years.....3; 5 or more years.....4

11.a. Have you had specific HIV training since basic training?

- Yes.....1; No.....2

11.b. If Yes in Q11.a., when did you have the training?

In the last 2 years.....1; More than 2 years ago.....2

11.c. If Yes in Q11.a Who provided the training?

SMOH: 1, SIDHAS: 2, Other (Specify):.....98

Community & Private Sector Practitioners [HTC, ART, Community TB, PMTCT]	
13.	How long have you been collaborating with SIDHAS?
14.	What services do you provide? [all services not just as part of your SIDHAS collaboration]
15.	How are you working with SIDHAS?
16	Do you have an MOU or other formal signed agreement? [Specify]
17.1	How did your collaboration start?
17.2	What training, if any, has SIDHAS provided?
17.3	What equipment, consumables, drugs has SIDHAS provided? [<i>not for TBs</i>]
17.4	What [other] support have you received from SIDHAS?
18.	When and why do you refer clients to a [public] health facility?
18.1	Which facility(ies) do you refer to?
18.2	How do you know if the referred client goes to the facility?
18.3	What feedback do you get from the facility?

19.	What links – formal & informal – do you have with the communities you serve?
19.1	What links – formal & informal – do you have with the public health facilities in your area?
19.2	What links – formal & informal – do you have with state regulating and supervising authorities? [<i>not for TBAs</i>]
20.0	What family planning discussions do you have with your clients? <i>Probe</i> , what discussions do you have on dual protection?
20.1	Do you provide, for free or for a fee, condoms? <i>Probe</i> , from where do you get your condom supplies
21.0	Do you provide treatment or IPT for malaria? <i>Probe</i> , from where do you get your IPT S-P?
21.1	Do you distribute LINNs <i>Probe</i> , from where do you get your LINNs
22.0	What data do you collect & report? Who do you report to? Can we see your record/register? <i>Record details of # and gender of clients in last three months</i>

Table for HIV services provided at the facility

How long has this facility provided the following HIV services?

	Less than 6 months = 1	6 months to less than 2 years = 2	2 years to less than 5 years = 3	5 or more years = 4
HTC				
ART for adults				
ART for families				
ART for children				
PMTCT/EMTCT				
TB-HIV services				
TB DOTS				
Laboratory services supporting HIV diagnosis and treatment				
Laboratory services for TB diagnosis and treatment				
Pharmacy services dispensing ARVs				
Pharmacy services dispensing TB drugs				

ANNEX IV: SOURCES OF INFORMATION

(a) List of Persons Interviews

(Total 519)

Abuja:

USAID/Nigeria (10)

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Michael Harvey	Mission Director	USAID/Nigeria	mharvey@usaid.gov	
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ANAMBRA STATE (155)

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LAGOS STATE (93)

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1 AkwaIbom	Blissful Life support group
2 AkwaIbom	WOCLIF support group
3 Anambra	Igwedimma support group (females)
4 Anambra	Agape trust support group (females)
5 Anambra	Agape trust support group (males)
6 Anambra	Anyi Ga adi support group (males)
7 Lagos	Better Life support group (female)
8 Lagos	Fortunate Fellow support group (female)
9 Lagos	Samaritan Platform (male)
10 Lagos	Community Health support group (male)
11 Lagos	Community Health support group (female)
12 Rivers	Udur-BgushiEting (female)
13 Rivers	Life Line support group (female)
14 Rivers	Fortune support group

(b) Bibliography of Documents Reviewed

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- 10) Lagos State-wide Rapid Health Facility Assessment (2013)
- 11) Lagos State Operational Plan for EMTCT 2013-2015
- 12) Rivers State-wide Rapid Health Facility Assessment (2013)
- 13) Rivers State Operational Plan for EMTCT 2013-2015
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- 24) SIDHAS Sustainability Framework – Revised
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- 26) KRA3 Indicator Table
- 27) Ensuring Sustainability in Community Engagement
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- 29) SOPs - Training Protocol for SIDHAS
- 30) Alternative Training Approaches
- 31) Collaboration framework HFG-FHI
- 32) CQI - Baseline Report Anambra
- 33) CQI - Baseline Report Akwa Ibom
- 34) CQI - Baseline Report Lagos
- 35) CQI - Baseline Report Rivers
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- 48) Akwa Ibom State Sub Modification #5

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- 56) APR14 Narratives Template_SIDHAS
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- 59) CQI Q1 2014 Analysis
- 60) CQI Q3 2013 Analysis
- 61) CQI Q3 2014 Analysis
- 62) CQI - ANAMBRATechCBP
- 63) CQI - Lagos HCC TechCBP
- 64) CQI - Akwa IbomCBPIncomplCBO
- 65) CQI - RiversTech CBP COMPL
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 - b. Adult and Pediatric ART Technical Strategy
 - c. Care & Support Technical Strategy
 - d. Gender Strategy
 - e. Health Systems Strengthening Technical Strategy
 - f. HIV Testing and Counseling Technical Strategy
 - g. Laboratory Technical Strategy
 - h. Monitoring and Evaluation (M&E) Technical Strategy
 - i. Orphans and Vulnerable Children (OVC) Technical Strategy
 - j. Pharmacy Services Technical Strategy
 - k. Prevention of Mother-to-child Transmission of HIV (PMTCT) Technical Strategy
 - l. Reproductive Health Technical Strategy
 - m. Sexual and Medical Prevention Strategy Technical Strategy

(c) Databases

ART Service Assessment

q1a	q1 b	q2	q3	q4	q5	field1	b1	b2	b3	b4	b5	b6	b7	b8	b9	b10	b11	b12	b13	b14	b15	b16ie c	b17	b18	b19	b20	b21	b22
St Joseph Rehabilitation Centre		1	Essien Udim	29/01/2015	Dr Ruth		2	4	4	1	2	1	2	2	3	4	4	4	2	1	1	1	2	2	2	2	2	2
Palmer Memorial Hospital, Ikot		1	Ibiono Ibom	02/02/2015	Dr Ruth		2	2	4	1	2	3	2	2	4	4	4	2	1	1	1	3	3	3	2	2	2	2
St JosephRehab Centre		1	Essien Udim	29/01/2015	DR Ruth		2	4	4	1	2	1	2	2	3	4	4	4	4	1	1	1	1	2	2	2	2	3
Nnamdi Azikiwe University TH		2	Nnewi North	26/01/2015	Iheadi Onwukwe		2	4	1	1	3	2	2	3	3	4	4	4	3	4	4	1	2	2	2		3	3
Immaculate Heart hospital		2	Idemili North	27/01/2015	Iheadi Onwukwe		3	4	3	1	3	2	3	3	4	3	3	4	3	3	2	1	2	3	3		4	3
Anambra State University TH		2	Awka South	28/01/2015	Iheadi Onwukwe		2	2	4	1	2	3	2	3	4	2	2	4	4	3	4	1	2	2	2		3	2
Nimo General Hospital		2	Njikoka	05/02/2015	Iheadi onwukwe		1	3	4	1	2	2	2	1	4	4		4	1	1	1	1	2	4	2		2	1
BADAGRY GENERAL HOSPITAL		3	BADAGRY	29/01/2015	DR.SAN USI	DR.J AIME	2	4	4	1	2	4	2	2	4	4	4	4	4	2	3	1	3	1	2	2	2	
RANDLE MCC,GBAJA		3	SURULERE	02/02/2015	DR.SAN USI	DR.J AIME	2	4	1	1	2	2	2	1	2	4	4	4	3	1	1	1		2	1	2	1	
ONIKAN HEALTH CENTRE		3	LAGOS ISLAND	22/01/2015	DR.SAN USI	DR.J AIME	2	4	1	1	2	2	2	1	4	4	4	4	2	1	4	1	2	2	1	2	1	
MAINLAND GENERAL HOSPITAL		3	MAINLAND	09/02/2015	DR.SAN USI	DR.J AIME	2	4	4	1	1	2	2		4	4		2	4	2	1	1	2	2	1	2	2	

General hospital Isiokpo		4	Ikwere	02/02 /2015	Richard	Oged engb e	3	3	4	1		4	4	4	4	4	4	4	3	1	1	2	2	2	3	3	3	
General hospital Umuebule		4	Umuebu le	03/02 /2015	Richard	Oged engb e	4	4	3	1	4	3	4	4	2	4	4	4	4	1	4	1	2	2	1	4	3	3
Pope John Paul hospital		4	Khana	04/02 /2015	Richard	Oged engb e	4	4	4	2	4	4	4	3	4	4	4	3	4	2	2	2	2	2	1	1	4	3
Braithwaite Memorial Hospital		4	Phalga	22/01 /2015	Richard	Oged engb e	3	4	1	4	4	3	4	4	4	3	3	4	3	4	1	1	1	2	4	4	3	3
Obio Cottage Hospital		4	Obio- Akpor	30/01 /2015	Richard	Oged engb e	2	4	1	1	4	2	3	4	4	4	3	4	4	4	1	1	2	3	4	4	4	3

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q1a	q1 b	q 2	q3	q4	q5	field1	q6 a	q6 b	q 7	q 8	q 9	n1 0
Cottage Hospital Ukana		2	Ukana	29/01/2015	Ruth Hope	Ruth Hope	2		3	4	5	3
Ubongabasi Specialist Clinic		2	Uyo	03/02/2015	Ruth Hope	Ruth Hope	2		4	4	5	6
University of Uyo Teaching Hosp			Uyo	03/02/2015	Ruth Hope	Ruth Hope	2		4	4	4	8
AfahaEket Holifield Spectl Hosp		2	Eket	26/01/2015	Adewale Adeogun	Ruth Hope	3		4	4	5	6
Comprehensive Health Ctr Idoro		2	Idoro	04/02/2015	Adewale Adeogun	Ruth Hope	3		4	4	2	7
Divine Love Hospital		2	Etim-Ekpo	28/01/2015	Adewale Adeogun	Ruth Hope	3		4	4	3	8
General Hospital Etim Ekpo		2	Etim Ekpo	28/01/2015	Adewale Adeogun	Ruth Hope	3		4	4	3	3
Health Centre Adiosin		2	Essiem Udim	06/02/2015	Adewale Adeogun	Ruth Hope	3		4	4	5	7
Ikot Edibon PHC		2	Nsitubium	26/01/2015	Adewale	Adeogun	3		4	4	1	7
St. Joseph Rehabilitation Centr		2	Essein Udim	29/01/2015	Adewale Adeogun	Ruth Hope	3		4	4	2	8
Palmer Memorial Hospital		2	Ibiono Ibom	02/02/2015	Ruth Hope	Ruth Hope	3		4	4	3	5
University of Uyo Medical Centr		2	Uyo	27/01/2015	Ruth Hope	Ruth Hope	2		3	4	5	8
Nri Primary Health Care Center		2	Anaocha	22/01/2015	Iheadi Onwukwe		3	1	3	3	1	7
Police Comprehensive Health Cen		2	Awka South	22/01/2015	Iheadi Onwukwe		3		1	2	2	2
Immaculate Heart Hospital		2	Idemili North	27/01/2015	Iheadi Onwukwe		3	1	4	4	3	5
Nnamdi Azikiwe UT Hospital			Nnewi North	26/01/2015	Iheadi Onwukwe		2		3	4	4	1
Emecourt PHC		2	Nnewi North	29/01/2015	Iheadi Onwukwe		1	1	3	3	1	7

Madueke Memorial Hospital		2	Idemili North	05/02/2015	Iheadi Onwukwe		1	2	4		1	6
Anambra State University Teachi		2	Awka South	28/01/2015	Iheadi Onwukwe		2		4	4	4	3
Ojoto-Uno Primary Health Centre		2	Idemili South	04/02/2015	Iheadi Onwukwe			2	4	4	1	3
Aguluuzoigbo Primary Health Cen		2	Anaocha	30/01/2015	Iheadi Onwukwe		2	2	4	4	1	7
Winners Hospital Onitsha North		2	Onitsha North	03/02/2015	Ezeh Bishop	Iheadi Onwukwe	1		4	4		6
Mmate Anam PHC		2	Idemili South	04/02/2015	Ezeh Bishop	Iheadi Onwukwe	3	1	4	4	1	7
Nimo General Hospital			Njikoka	05/02/2015	Iheadi Onwukwe						3	3
Kanayo Specialist Hospital		2	Onitsha North	03/02/2015	Ezeh Bishop	Iheadi Onwukwe	3		4	4	9	6
BADAGRY GENERAL HOSPITAL		3	BADAGRY	28/01/2015	DR.SANUSI	DR.JAIME		1	4	4	3	3
R-JOLAD PRIVATE HOSPITAL		3	SHOMOLU	05/02/2015	DR. SANUSI	PROF.JAIME BENAVENTE	1	1	3	4	5	6
MAIDAN PHC		3	KOSOFÉ	04/02/2015	DR.SANUSI	DR.JAIME		1	2	2	1	8
DURO OYEDYOIN PHC		3	SURULERE	03/02/2015	DR.SANUSI	DR.JAIME			4	4	5	8
OMNI MEDICAL CENTRE		3	LAGOS ISLAND	26/01/2015	DR.SANUSI	DR.JAIME	2		4	4	5	6
OMNI MEDICAL CENTRE		3	LAGOS ISLAND	26/01/2015	DR.SANUSI	DR.JAIME		2	4	4	5	6
ALLI DAWODU		3	MAINLAND	09/02/2015	DR.SANUSI	DR.JAIME	3	1	4	4	1	8
									4			
Island maternity		4	Okrika	05/02/2015	Richard	Ogedengbe	1	2	2	2	1	2
Primary health center Okrika		4	Okrika	05/02/2015	Richard	Ogedengbe	1	2	4	4	1	3
Primary health center Ubima		4	Ikwere	02/02/2015	Richard	Ogedengbe	1	2	3	3	1	3

Primary health center Beerli		4	Khana	04/02/2015	Richard	Ogedengbe	1	2	3	3	1	3
General hospital Isiokpo		4	Ikwere	02/02/2015	Richard	Ogedengbe	2	2	4	4	3	3
Primary health center MbodoAluu		4	Ikwere	04/02/2015	Tumini	Ogedengbe	3	1	4	4	1	7
Primary health center Rumeme		4	Obio-Akpor Rumeme	04/02/2015	Tumini	Ogedengbe	1	2	3	3	1	3
Pope John Paul hospital		4	Khana	04/02/2015	Richard	Ogedengbe	3	1	4	4	3	3
MODEL PHC AHOADA		4	AHOADA WEST	28/01/2015	CHRIS	RICHARD	1		2	2	1	3
OBIO COTTAGE HOSPITAL		4	OBIO/AKPOR	30/01/2015	CHRIS	RICHARD	1		4	4	3	3
MODEL PHC RUMUKWURUSI		4	OBIO/AKPOR	30/01/2015	CHRIS	RICHARD	1		4	4	1	3
MORNING STAR		4	PHALGA	26/01/2015	CHRIS	RICHARD	2		4	4	3	4
UNIV. OF PH TEACHING HOSPITAL		4		27/01/2015	CHRIS	RICHARD	1		4	4	4	1
MODEL PHC RUMUIGBO		4	OBIO/AKPOR	26/01/2015	CHRIS	RICHARD	1		2	2	1	3
BRAITHWAITE MEMORIAL HOSPITAL		4	PHALGA	27/01/2015	CHRIS	RICHARD	2		4	4	4	6
PHC CHURCH HILL		4	PHALGA	29/01/2015	CHRIS	RICHARD	1		1	1	1	3
GENERAL HOSPITAL AHOADA		4	AHOADA EAST	28/01/2015	CHRIS	RICHARD	1		2	2	3	3
AKINIMA MODEL PHC		4	AHOADA WEST	28/01/2015	CHRIS	RICHARD	1		2	2	1	3

HCT Service Assessment

q1a	q 1 b	q 2	q3	q4	q5	field1	b 1	b 2	b 3	b 4	b 5	b 6	b 7	b 8	b 9	b 1 0	b 1 1	b 1 2	b 1 3	b 1 4	b 1 5	b 1 6	b 1 7
Divine Love Hospital		1	Etim Ekpo	28/01/2015	Dr Ruth		2	3	4	3	2	4	3	3	3	2	1	4	1	1	4	1	1
General Hospital Etim Ekpo		1	Etim Ekpo	28/01/2015	Dr Ruth		4	3	4	2	1	4	3	3	2	3	2	3		1	3	3	3
Operational Base NsitUbiom PHC		1	Nsit Ubiom	26/01/2015	Dr Ruth		4	2	4	2	2	4	3	2	3	3	2	3		1	3	2	2
OJOTO PHC		2	IDEMILI SOUTH	04/02/2015	UGWU NGOZI	DR. IHEADI	4	2	2	2	3	4	3	3	3	3	3	4	0	3	3	2	3
GENERAL HOSPITAL NIMO		2	NJIKOKA	05/02/2015	UGWU NGOZI	DR. IHEADI	4	1	3	3	3	4	2	3	2	3	3	4	0	1	2	2	2
POLICE CLINIC AWKA		2	AWKA SOUTH	22/01/2015	UGWU NGOZI	DR. IHEADI	4	2	4	1	3	3	3	3	2	2	1	4	0	2	1	2	3
AMAKU, ANSUTH		2	AWKA SOUTH	28/01/2015	UGWU NGOZI	DR. IHEADI	4	2	4	1	3	3	3	2	2	2	1	4	0	2	1	2	3
NKWELLE UMUNNACHI PHC		2	DUNUKOFI A	30/01/2015	UGWU NGOZI	DR. IHEADI	2	2	2	2	1	4	3	2	3	2	3	3	0	3	2	2	3
AGULU UZOIGBO PHC		2	ANIOCHA	30/01/2015	UGWU NGOZI	DR. IHEADI	4	1	2	2	2	3	3	2	3	2	2	3	0	3	2	2	2
ONIKAN HEALTH CENTRE		3	LAGOS ISLAND	22/01/2015	STEPHEN OHUNENI	PROF(DR.)JAMIE BENAVENTE	4	3	4	4	3	4	3	3	2	4	3	3	4	3	4	3	3
SURA PHC		3	LAGOS ISLAND EAST	23/01/2015	STEPHEN OHUNENI	PROF(DR.)JAMIE BENAVENTE	4	4	4	4	4	4	3	4	3	3	3	4	0	2	4	4	3
BADAGRY GENERAL HOSPITAL		3	BADAGRY	28/01/2015	STEPHEN OHUNENI	PROF(DR.)JAMIE BENAVENTE	4	3	2	3	3	4	3	3	3	4	3	4	0	3	4	3	2
ILOGBO EREMI PHC		3	BADAGRY	29/01/2015	STEPHEN OHUNENI	PROF(DR.)JAMIE BENAVENTE	2	1	2	3	2	4	3	2	3	2	3	3	0	2	4	1	1
RANDLE GENERAL HOSPITAL		3	SURULERE	02/02/2015	STEPHEN OHUNENI	PROF(DR.)JAMIE BENAVENTE	3	2	4	3	3	4	3	3	2	2	2	4	0	2	4	3	3
GBAGADA GENERAL		3	KOSOFE	04/02/2015	STEPHEN OHUNENI	DR. JAIME BENAVENTE	4	3	2	2	3	4	3	3	2	3	3	4	0	3	4	3	3

HOSPITAL																							
R-JOLAD HOSPITAL		3	SHOMOLU	05/02/2015	STEPHEN OHUNENI	DR.JAIME BENAVENTE	4	3	3	4	3	4	3	1	3	3	2	3	0	2	4	3	3
COKER AGUDA PHC		3	SURULERE	05/02/2015	DR.SANUS I	DR.JAMIE	4	2	2	1	2	2		2	2	2	1	3		1	4	1	
MAIDAN PHC		3	KOSOFE	04/02/2015	DR.SANUS I	DR.JAIME	4	2	2	2	2	4		2	3	2	2	3	0	1	4	1	
DURO OYEDOYIN PHC		3	SURULERE	03/02/2015	DR.SANUS I	DR.JAIME	3	2	1	1	1	4	3	1	2	1	2		0	1	4	1	
OMNI MEDICAL CENTRE		3	LAGOS ISLAND	26/01/2015	DR.SANUS I	DR.JAIME	4	2	4	2	2	2	3	2	3	2	1	3	0	1	4	1	
Braithwaite memorial hospital		4	Phalga	05/02/2015	Kelvins	Ogedengbe	4	3	4	3	3	4	3	3	3	3	4	3	4	4	4	3	3
Primary health center Okrika		4	Okrika	05/02/2015	Richard	Ogedengbe	4	4	4	4	3	4	3	3	4	3	4	4	4	2	3	2	3
Primary health center Eleme		4	Eleme	03/02/2015	Tumini	Ogedengbe	2	3	3	3	3	2	2	3	3	3	3	2	4	1	3	2	3
Primary health center Ubima		4	Ikwere	02/02/2015	Tumini	Ogedengbe	2	3	4	3	3	2	1	3	3	3	1	2	4	3	1	3	3
General hospital Isiokpo		4	Ikwere	02/02/2015	Richard	Ogedengbe	4	4	4	4	4	4	3	4	4	3	4	4	2	2	4	3	3
General hospital Umuebule		4	Umuebule	03/02/2015	richard	Ogedengbe	4	4	4	4	3	4	3	4	4	4	4	4	2	3	3	3	3
Primary health center Mbodo-Alu		4	Ikwere	04/02/2015	Tumini	Ogedengbe	4	3	4	3	3	2	3	3	3	3	1	4	2	3	3	3	3
Primary health center Beerli		4	Khana	04/02/2015	Richard	Ogedengbe	4	4	4	4	4	4	3	4	4	4	2	3	2	2	4	2	3
Pope John Paulhospital		4	Khana	04/02/2015	Richard	Ogedengbe	4	4	4	4	3	4	3	4	4	4	1	4		4	4	4	3
Primary health center		4	Obio-Akpor	29/01/2015	Richard	Ogedengbe	4	4	4	4	4	4	3	4	4	4	4	3	2	3	3	3	3
Primary health center		4	Phalga	29/01/2015	Richard	Ogedengbe	4	4	4	4	4	4	4	4	4	3	4	3	2	1	2	1	3

Laboratory Service Assessment

q1 a	q1 b	q2	q3	q4	q5	field1	q7	q8	q9	q10	q11	q12a	q12b	q13c	q13d	q13d1	q13d2	q13e	q13e2	q13e3	q13e5	q13e6	q13e7	q14	q15	q16	q17	q18	q19	q20	q21	q22	q23	q25	q26	q27	q28	q29	q30	q31	q32	q33	q34	q35		
PALMER MEMORIAL HOSPITAL		3	IBIONO	02/02/2015	IRENE OKOSUN	DR. RUTH HOPE	2	1	4	4	3	1	1	2	6	1	5	1		5					3	2	3	2	11	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	
UNIVERSITY OF UYO TEAC		3	UYO	03/02/2015	IRENE OKOSUN	DR. RUTH HOPE	1	2	4	4	4	1	2	2	18	10	8	12	2	1	1	1	1	4	3	4	4	11	3	4	3	3	4	4	1	4	4	4	4	4	4	4	4	4	4	3

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Divine love hospital, Etim Ekpo	1	Etim Ekpo	28/01/2015	Kokoe te Mkpang	Dr Ruth Hope	1	1		1	3	2			2	1	1	1	1					3	3	2	1	41	2	1	3	1	3	1	2	3	1	1	1	1	3	3	1	1
Hofield specialist hospital ...	1	Ek et	26/01/2015	Kokoe te	Dr Ruth Hope	3	2		4	4	2			1		1						1	1	1	1	13	3	1	3	1	2	3	3	1	1	1	1	1	1	1	1	1	1
St Joseph Rehabilitation Centre	1	Esien Udin	29/01/2015	kokoe te	Dr Ruth	1	2		2	3	2			5	3	2	1	2	1		1		3	3	2	4	3	1	4	2	3	3	3	3	4	4	3	3	3	2	3	3	3

Ubong Abasi Specialist Clinic		1	Uyo	03/02/2015	Koko	Dr Ruth	2	2		4	4	1	1	2	2	1	1	1	1					1	1	1	1	1	2	1	2	1	2	3	2	2	1	1	1	1	1	1	2	2	
Police Comp Clinic			Awka South	22/01/2015	Ezeh Bishop	Dr . Ih eadi	2	4		4	4	1	2	98	3		3		2	1				2	2	2	2		2	1	2	1	2	1			2	2	1			2	1		
St. Patrick Hosp			Aguluzi	29/01/2015	Ezeh Bishop	Dr . Ih eadi	2	4		4	4	1	1	2	1	1			1					2	2	2	2	2	1	1	2	2	2	2	1	0	0	2	2	1			2	1	
Aguluzi gb o PH C			Anaocha	30/01/2015	Ezeh Bishop	Dr . Ih eadi	3	3		3	4	1	1	2	2		2						2	2	2	2	2		2	2	2	2	2	2			2	2	2			2	1		
Vict			Ogb	30/	Ezeh	Dr .	3	4		4	4	1	1	98	1		1						1	2	2	2	2		2	2	2	2	2	1			2	2	1			2	1		

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Pharmacy Service Assessment

q1a	q1b	q2	q3	q4	q5	field1	q7	q8	q10	q11	q12a	q12b	q13c	c1	c2	c3	c4	c5	c6main	c7	c8	q9	q12	q13	q14	q15	q16	q17	q16over
METHODIST GENERAL HOSPITAL ITUK		1	URUAN	04/02/2015	IRENE	DR RUTH HOPE	1	4	4	4	1	1	2	2	3	3	3	2	4	1	3	3	3	2	3	1	4	3	3
PHC IKOT EDIBON		1	NSIT UBIUM	26/01/2015	IRENE	DR RUTH HOPE	3	4	4	4	3	1	2	2	3	3	2	1	4	1	3	2	1	1	1	3	3	1	2
COTTAGE HOSPITAL UKANA IBA		1	ESSIEN UDIM	29/01/2015	IRENE OKOSUN	DR RUTH HOPE	1	2	2	2	2	1	2	4	3	3	3	3	3	3	3	4	1	3	3	4	3	1	3
ST JOSEPH REHABILITATION CENTRE		1	ESSIEN UDIM	29/01/2015	IRENE OKOSUN	DR RUTH HOPE	3	3	4	1	1	1	2	2	3	2	1	2	4	3	3	3	4	3	1	4	3	1	3
DIVINE LOVE HOSPITAL		1	ETIM EKPO	28/01/2015	IRENE OKOSUN	DR RUTH HOPE	1	3	4	4	1	2	2	3	3	2	2	2	2	2	4	3	4	1	1	4	3	1	2
General Hospital Etim Ekpo		1	Etim Ekpo	28/01/2015	Koko	Dr Ruth	1	4	3	4	1	1	2	3	2	2	3		4		4	2	3	3	1	4	3	3	3
Palmer Memorial Hospital, Ikot		1	Ibiono Ibom	02/02/2015	Koko	Dr Ruth	3	2	3	3	2	1	12	2	2	1	2		4		4	2	4	2	1	4	4	1	2
Ubong Abasi specialist Clinic,U		1	UYo	03/02/2015	Koko	Dr Ruth	3	4	4	4	2			2	2	2	1		4		4	2	4	3	1	4	3	1	2
University of Uyo Medical Centr		1	Uyo	27/01/2015	Koko	Dr Ruth	1	4	2	4	1		2	3	3	3	1		4		4		3	4	3	1	4	4	1
UUTH		1	Uyo	03/02/2015	Koko	Dr Ruth	1	4	4	4	1	1	2	3	3	3	3	3	3	2	4	3	3	3	1	4	4	1	3
Golden Pharmacy,		1	Uyo	25/01/20	Dr Ruth		1	1	4	4	1	1	2																

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Nri PHC		Anaocha	02/02/2015	Nura Nasir		3	2	3	3	1	1	2	2	2	2	3	1	4	1	4	4	3	4	2	2	3	3	2
Nwajiaku Inland Hosp.		Aguata	02/02/2015	Nura Nasir		3	2	3	3	1	1	2	2	1	2	3		4		4	3	2	4	2	2	3		2
Ijeoma Hospital & Maternity		Aguata	02/02/2015	Nura Nasir		3	1	3	3	1	1	2	2	2	2	3		4		4	3	3	4	3	2	3	3	2
Winners Hosp. & Maternity		Onitsha North	03/02/2015	Nura Nasir		3	2	4	4	1	1	2	2	2	3	1		4		4	4	1	4	1	2	3		2
Kanayo Spec. Hosp.		Onitsha North	03/02/2015	Nura Nasir		2	2	3	4	2			2	3	3	1		4		4	4	3	3	1	2	3	3	2
Ujotu Uno PHC		Idemili South	04/02/2015	Nura Nasir		3	2	3	4	1	1	2	2	2	2	2		2		4	3	2	4	2	2	3	3	2
Edmund Specialist Hosp.		Ogbaru	04/02/2015	Nura Nasir		3	2	4	4	1	1	2	2	2	1	1		1		4	4	2	4	2	2	2	3	2
Beke Memorial Hosp.		Njikoka	05/02/2015	Nura Nasir		3	2	4	4	1	2	9 8	3	2	3	3		3		3	4	3	4	3	2	3		3
Nimo General Hospital		Njikoka	05/02/2015	Nura Nasir		3	2	4		1	1	2	1	1	1	1		4		3	4	2	4	2	1	3	3	1
ILOGBO EREMI PHC	3	BADAGRY	29/01/2015	STEPHEN OHUNE NI	PROF(DR.)JAMIE BENAVENTE	3	3	4	4	1	1	2	2	1	2	1	0	4	0	4	3	4	3	3	4	3	4	2
RANDLE GENERAL HOSPITAL	3	SURULERE	02/02/2015	STEPHEN OHUNE NI	PROF(DR.)JAMIE BENAVENTE	1	2	4	4	1	2	2	3	3	3	3	2	3	3	4	3	4	4	3	4	4	1	3
GBAGADA GENERAL HOSPITAL	3	KOSOF E	04/02/2015	STEPHEN OHUNE	DR.JAIME BENAVENTE	1	4	4	4	1	1	2	2	3	2	3	1	4	1	4	3	4	3	2	3	3	1	2

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				15																										
Genera hospital Umuebule		4	Etche	03/0 2/20 15	Richard	Ogedengbe	1	2	2	3	1	1	2	3	3	2	2		4	4	3	2	3	3	4	3	3	3	3	3
Primary health center Obio-Akpo		4	Obio-Akpor Rumeme	04/0 2/20 15	Tumini	Ogedengbe	2	2	3	4	1	1	2	3	3	3	3		4		3	4	4	4	3	1	2	3	3	3
Primary health center Beeri		4	Khana	04/0 2/20 15	Richard	Khana	2	2	3	4	1	1	2	4	4	2	2	2	4	4	4	3	4	4	3	1	4	4	3	3
Pope John Paul hospital		4	Khana	04/0 2/20 15	Richard	Ogedengbe	2	1	3	2	1	1	2	3	3	2	1	1	4	1	4	3	3	2	4	1	3	4	3	3
Univesity of Port teaching hosp		4	Obio-Akpor	27/0 1/20 15	Richard	Ogedengbe	1	2	4	4	1	1	2	4	4	3	2	4	4	3	4	4	3	4	4	4	4	4	4	3
Braithwaite memorial hospital		4	Phalga	22/0 1/20 15	Richard	Ogedengbe	1	2	4	3	1	1	2	4	3	2	3	2	3	4	4	3	4	3	4	2	4	4	4	3
General hospital Ahoada		4	Ahoada East	28/0 1/20 15	Richard	Ogedengbe	1	1	4	3	1	1	2	3	3	2	2		3		4	4	3	3	4	3	2	4	3	3
Morning star hospital		4	Phalga	25/0 1/20 15	Richard	Ogedengbe	1	2	4	4	2			4	4	3	3	2	3	3	4	4	4	3	3	2	4	3	3	3

PMTCT Service Assessment

q1a	q1b	q2	q3	q4	q5	field1	b1	b2a	b3c	b4p	b5r	b6	b7q	b8p	b9p	b10i	b11p	b12e	b13i	s	b15l	b16r	n17p	b18s	b19i	b20i
BEKE MEMO. HOSP. URUM NIMO		2	NJIKOKA	05/02/2015	UGW U NGOZ I	DR. IHEAD I	3	4	3	3	3	3	2	3	2	1	2	3	4	4	1	2	3	2	3	3
EDMUND SPECIALIST HOSPITAL		2	OGBARU	04/02/2015	UGW U NGOZ I	DR. IHEAD I	3	3	2	2	2	3	4	3	2	2	1	2	4	4	1	2	3	2	2	2
KELECHU HOSPITAL & MATERNITY		2	OGBARU	04/02/2015	UGW U NGOZ I	DR. IHEAD I	1	1	1	1	4	2	2	2	2	1	1	2	4	1	1	3	3	1	1	2
NRI PHC		2	ANAOCHA	02/02/2015	UGW U NGOZ I	DR. IHEAD I	2	2	3	2	3	3	2	2	3	1	2	2	4	4	4	3	3	3	2	2
KANAYO SPECIALIST HOSPITAL		2	ONITSHA SOUTH	03/02/2015	UGW U NGOZ I	DR. IHEAD I	2	4	3	3	2	3	2	2	2	2	3	2	4	4	4	2	3	2	2	2
WINNERS HOSPITAL		2	ONITSHA NORTH	03/02/2015	UGW U NGOZ I		2	4	2	2	3	3	3	3	3	2	2	3	4	1	1	3	1	4	2	2
NAU TEACHING HOSPITAL		2	NNEWI NORTH	26/01/2015	UGW U NGOZ I	DR. IHEAD I	3	2	3	3	3	2	2	3	2	1	2	3	4	1	2	3	2	2	2	2
AMAKU, ANAMBRA ST. UNIV.T/HOS		2	AWKA SOUTH	28/01/2015	UGW U NGOZ I	DR. IHEAD I	3	4	3	1	3	1	1	1	1	3	2	3	4	1	2	3	3	1	1	1

P.																										
ST. PATRICKS HOSPITAL		2	AGUATA	29/01/2015	UGW U NGOZ I	DR. IHEADI	1	3	1	1	4	2	2	2	2	1	2	2	4	4	1	2	3	2	1	2
AGULU UZOIGBO PHC		2	ANAOCHA	30/01/2015	UGW U NGOZ I	DR IHEADI	1	2	2	2	1	2	4	2	2	3	2	3	1	4	4	2	1	2	2	2
VICTORY HOSP & MATERNITY ODEKPE		2	OGBARU	30/01/2015	UGW U NGOZ I	DR IHEADI	1	3	1	1	1	2	1	1	1	1	2	1	1	1	1	1	3	2	1	1
Oron Christ Victory Medical Cen		1	Oron	23/01/2015	Dr Ruth		2	4		2	2	2	2	22	1	2	2	4	4			1	3	3	2	2
Ukuda Health Post.....		1	Urue Offong Uruko	23/01/2015	Dr Ruth		2	4	2	2	4	3	4	24	1	2	2	4	4			3		2	2	
: St Joseph's Rehabilitation Ce		1	Essien Udim	29/01/2015	Ruth		2	4	1	1	4	2	3	21	1	1	1	2	4	4			3	3	1	2
Operational Base NsitUbium PHC		1	Nsit Ubium	26/01/2015	Dr Ruth		2	3	2	3	4	2	2	31	2	3	4		1	3	2	2	2			
Divine Love Hospital		1	Etim Ekpo	28/01/2015	Dr Ruth	2423	2	4	2	3	4	2	4	2	2	1	2	2	4	4		1	3	2	1	2
Operational Base Ikot Edibon		1	Nsit Ubium	26/01/2015	Dr Ruth		2	3		3	4	2	4	2	3	1	2	3	4		1	3	2	2	2	2
General		1	Etim Ekpo	28/	Dr		2	4	1	2	4	2	3	2	2	1	1	2	4			2	3	2	1	2

Hospital Etim Ekpo				01/ 20 15	Ruth																						
University of Uyo Medical Centr		1	Uyo	27/ 01/ 20 15	D Ruth		1	1	2	2	2	2	4	22	1	2	2	2	4	4		3	3	2	2	2	2
University of Uyo Teaching Hosp		1	Uyo	03/ 02/ 20 15	Dr Ruth		2	3	2	2	2	2	2	1	1	1	1	1	4	4		2	3	2	1	2	2
SURA PHC		3	LAGOS ISLAND	23/ 01/ 20 15	DR SANU SI							1															
SACRED HEARTS HOSPITAL		3	BADAGRY LOCAL GOVERNMENT	29/ 01/ 20 15	DR.S ANUS I							1															
GBAGADA GENERAL HOSPITAL		3	KOSHOFELGA	04/ 02/ 20 15	DR. SANU SI							2															
ILOGBO EREMI PHC		3	BADAGRY	29/ 01/ 20 15	STEPHEN OHUNENI	PROF(D R.)JAMIE BENAVENTE	2	2	3	2	4	2	4	3	3	2	2	3	4	4	3	2	4	4	3	2	2
COKER-AGUDA PHC		3	SURULERE	05/ 02/ 20 15	DR.S ANUS I	DR.JAMIE	2	2	1	1	2	1	2	1	2	1	2	2	4	4	4			1	2	2	2
BADAGRY GENERAL HOSPITAL		3	BADAGRY	28/ 01/ 20 15	DR.S ANUS I	DR. JAIME	2	4	1	1	3	1	1	2	2	2	1	1		3	4	3		1		2	2
R-JOLAD PRIVATE HOSPITAL		3	SHOMOLU	05/ 02/ 20	DR.S ANUS I	DR.JAIME		4	2	2	4	2	4	2	2	1	2	2	4	4	4	2	3	4	2	2	2

				15																						
RANDLE MCC,GBAJA		3	SURULER E	02/ 02/ 20 15	DR.S ANUS I	DR.JAIM E		4	2	1	2	2	2	2	2	1	1	2	4	3	4	3	3	2	2	2
MAIDAN PHC		3	KOSOFE	04/ 02/ 20 15	DR.S ANUS I	DR.JAIM E	2	4	2	2	4	2	2	2	2	1		2		4	4	2	4	1	2	2
OMNI MEDICAL CENTRE		3	LAGOS ISLAND	26/ 01/ 20 15	DR.S ANUS I	DR.JAIM E	2	4	2	2	2	2	2	2	2	1	2	2	4	4	1	2	3	1	2	2
ONIKAN HEALTH CENTRE		3	LAGOS ISLAND	22/ 01/ 20 15	DR.S ANUS I	DR.JAIM E	2	2	3	2	2	2	2	2	2	1	2	2	4	4	4	3		1	2	2
ALLI DAWODU PHC		3	MAINLAN D	09/ 02/ 20 15	DR.S ANUS I	DR.JAIM E	2	4	2	2	4	2	2	2	2	1	2	2		4	4	2	3	4	1	2
New mile one hospital		4	Phalga	09/ 02/ 20 15	Richar d	Ogedeng be	4	4	4	4	4	4	2	3	3	2	3	3	4	4	4	4	3	2	2	4
General hospital Umuebule		4	Umuebule	03/ 02/ 20 15	Richar d	Ogedeng be	4	4	4	4	4	4	4	3	3	2	3	3	4	4	3	4	3	2	2	3
Primary health center Ubima		4	Ikwere	02/ 02/ 20 15	Richar d	Ogedeng be	4	4	4	4	4	4	4	4	3	2	3	4	4	4	2	4	3	2	2	2
Primary health center Mbodo-alu		4	Ikwere	04/ 02/ 20 15	Tumini	Ogedeng be	3	4	3	3	2	3	2	3	3	1	3	3	4	4	4	3	3	3	3	3
Primary		4	Khana	04/	Richar	Ogedeng	4	4	4	4	4	4	2	4	4	1	3	4	4	4	4	4	3	2	1	3

[illegible]

Health Facility Provider data

q1a	q1b	q2	q3	q4	q5	field1	hiv	q7	q8	q9	q10	q11	q12	q13a	q13b	q13c	q18	q19	q21	q25	q26	q28a
HIV		1	Uyo	22/0	Ruth		7	2	2	HIV	4	4	4	1	1	9		8	2			1

Counselling& Test cntre Uyo			1/20 15						counselling/PMTC T Nurse						8						4
University of Uyo Medical Centr	1	Uyo	22/0 1/20 15	Ruth		9 8	2	1	doctor ART Coordinator	2	4	4	1	1	2	1	8	2	1	1	1
Mbokpu Oduobo PHC	1	Okobo	23/0 1/20 15			6	2	2	Public Health Nursing Officer & PMTC	3	4	4	1	1	9 8	2	8	2	1	4	3
Ukuda Health Post	1	Urue ofong Uruko	23/0 1/20 15	Ruth		6	2	3	Health Post in Charge and PMTCT Coor	3						2	8	2	3	3	1
Immaculate Heart Hospital	2	Idemili North	27/0 1/20 15	Iheadi Onwukwe		1	2	1	ART Focal Person	4	4	4	1	1	9 8	1	4	1	9 8	9 8	
Nimo General Hospital	2	Njikoka	05/0 2/20 15	Iheadi Onwukwe		1	2	9 8	Chief Nursing Officer	4	4	4	1	1	2	1	8	2	9 8		
Nkwelle PHC	2	Dunukofia	30/0 1/20 15	Iheadi Onwukwe		6	2	9 8	Matron i/c	2	2	4	1	1	2		4	1	3	3	
Anambra State University TH	2	Awka South	28/0 1/20 15	Iheadi Onwukwe		1	1	1	ART Physician	4	4	4	1	2		1	4	1			
Nnamdi Azikiwe University TH		Nnewi North	26/0 1/20 15	Iheadi Onwukwe		1	2	1	Senior Medical Officer	4	4	4	1	2	9 8	8					
Mmiate Anam PHC	2	Anambra West	05/0 2/20 15	Ezeh Bishop		7	2	2	Officer i/c	4	4	4	1	1	2	1	4	1	1	1	
Comprehensi ve HC Achina	2	Aguata	02/0 2/20 15	Ezeh Bishop		6	1	1	Medical Director	4	4	4	2			1		1	3	4	
ONIKAN HEALTH CENTRE	3	LAGOS ISLAND	22/0 1/20 15	MRS ENIGBOKAN FUNMILAYO	DR SANUSI ABUBAKAR	7	2	2	MATRON	4	4	4	1	2	9 8	1	4	1	6	4	2
SURA PHC	3	LAGOS ISLAND	23/0 1/20	MRS.ENIGB OKAN	DR SANUSI ABUBAKAR	6	2	3	NURSING OFFICER	4	4	4	1	1	2	1	1	1	3	2	2

[illegible]

BADAGRY GENERAL HOSPITAL		3	BADAGR Y	28/0 1/20 15	DR.SANUSI	DR.JAMIE	6	2	9 8	CHIEF MATRON I/C POSTNATAL&DEL IVERY	4	4	4	1	2	2	2	8	2	9 8		2
MAINLAND GENERAL HOSPITAL		3	MAINLAN D	09/0 2/20 15	STEPHEN OHUNENI	PROF.JAIM E	5	2	2	CHIEF MATRON	4	4	4	1	2	2	3	2	1	4	1	1
MAINLAND GENERAL HOSPITAL		3	MAINLAN D	09/0 2/20 15	STEPHEN OHUNENI	PROF.JAIM E	7	2	2	CHIEF MATRON VCT	2	4	4	1	2	9 8	3	5	1		1	7
RANDLE MCC, GBAJA		3	SURULE RE	02/0 2/20 15	DR.SANUSI	DR. JAIME	6	1	1		4	4	4	1	2	9 8	1	2	2	3	3	2
RANDLE MCC,GBAJA		3	SURULE RE	02/0 2/20 15	DR.SANUSI	DR.JAIME	3	2	1	PAEDIATRIC ART	4	4	4	1	2	9 8	1	4	2	2	3	1
MAIDAN PHC		3	KOSOFE	04/0 2/20 15	DR.SANUSI	DR.JAIME	7	2	9 8	HCT/DOTS FOCAL PERSON	4	4	1	1	1	2		4	2	3	3	
OMNI MEDICAL CENTRE		3	LAGOS ISLAND	26/0 1/20 15	DR.SANUSI	DR.JAIME	6	2	2	THEATRE IN CHARGE	4	4	4	1	1	1	2	8	2	3	3	1
ONIKAN HEALTH CENTRE		3	LAGOS ISLAND	22/0 1/20 15	DR.SANUSI	DR.JAIME	1	1	1	ART COORDINATOR	3	4	4	1	2	9 8	2	8	2		2	1
ONIKAN HEALTH CENTRE		3	LAGOS ISLAND	22/0 1/20 15	DR.SANUSI	DR.JAIME	6	1	1	PMTCT DOCTOR	4	4	4	1	2	9 8	3	8	2	2	5	1
MAINLAND HOSPITAL YABA		3	MAINLAN D	09/0 2/20 15	DR.SANUSI	DR.JAIME	1	1	1	ART/DOTS DOCTOR	4	4	4	1	1	9 8	8	8	2			2
General hospital Isiokpo		4	Ikwere	02/0 2/20 15	Richard	Ogedengbe	1	2	1	Medical officer	1	4	3	1	1	2	1	8	2	1	1	
General hospital Umuebule		4	Umuebule	03/0 2/20 15	Richard	Ogedengbe	1	2	1	Medical officer	2	2	4	1	1	9 8	1	4	2	1	1	
Pope John		4	Khana	04/0	Richard	Ogedengbe	1	1	1	Medical officer	3	3	3	1	1	2	1	4	2	0	1	

Paul				2/20 15																				
University of Port-Harcourt TH		4	Obio- Akpore	27/0 2/20 15	Richard	Ogedengbe	1	2	1	Consultant Physician	4	4	4	1	1	2	1	4	1	0				
Obio cottage hospital		4	Obio- Akpore	30/0 1/20 15	Richard	Ogedengbe	1	2	1	Medical officer	4	4	4	1	1	2	1	4	1	0	0			
New mile hospital		4	Phalga	09/0 2/20 15	Richard	Ogedengbe	6	2	3	Matron	3	2	4	1	1	9 8	1	4	2	1	1			
Island maternity		4	Okrika	05/0 2/20 15	Richard	Ogedengbe	6	2	3	Matron	4	4	4	1	1	2	1	4	2	1	1			
Genera hospital Umuebule		4	Umuebule	03/0 2/20 15	Richard	Ogedengbe	6	2	3	Matron	3	4	4	1	1	2	1	4	2	1	1			
Primary health center, MBODO		4	Ikwere	02/0 2/20 15	Richard	Ogedengbe	6	2	1	Medical officer	3	3	2	1	1	2	1	4	2	1				
Model Primary health center		4	Eleme- Owne	03/0 2/20 15	Tumini	Ogedengbe	6	2	9 8	Medical officer	3	3	3	1	1	2	1	2	1	1				
Primary health center Okrika		4	Okrika	05/0 2/20 15	Richard	Ogedengbe	6	2	9 8	Community health officer	4	4	3	1	1	2	1	4	1	1	1			
Generl hospital Isiokpo		4	Ikwere	02/0 2/20 15	Richard	Ogedengbe	6	2	3	Midwife	4	4	4	1	2	2	1	4	2	1	1			
Primary health center Mbodo-alu		4	Ikwere	04/0 2/20 15	Tumini	Ogedengbe	6	2	3	Matron	4	4	2	1	2	1	1	2	1	1				
Pope John Paul		4	Khana	06/0 2/20 15	Richard	Ogedengbe	6	2	3	Midwife	3	3	2	1	1	2	1	4	1	1	1			
University teaching hospital		4	Phalga	23/0 1/20 15	Richard	Ogedengbe	6	2	9 8	PMTCT volunteer	3	3	3	1	1	9 8	3	4	2					

Primary health center Akinima		4	Ahoada West	28/01/2015	Richard	Ogedengbe	6	2	98	Medical lab scientist	3	4	4	1	1	2	1	4	2	1	1	
Primary health center Okakri		4	Ahoada West	28/02/2015	Richard	Ogedengbe	6	2	3	Matron	4	4	4	1	1	2	1	4	2	1		
General hospital Ahoada		4	Ahoada East	28/01/2015	Richard	Ogedengbe	6	2	3	Chief nursing officer	4	4	4	1	1	2	1	4	1	1	1	
Primary health center Rumukrush		4	Obio-Akpor	29/01/2015	Richard	Ogedengbe	6	2	98	M&E (focal person PMTCT)	2	2	2	1	1	2	1	4	1	1	1	
Island maternity Okrika		4	Okrika	05/02/2015	Richard	Ogedengbe	7	2	98	Community health officer	4	4	4	1	1	2		4	2	1		
General hospital Isikpo		4	Ikwere	02/02/2015	Richard	Ogedengbe	7	2	3	Midwife	4	4	4	1	1	2	8	4	2	1	1	
General hospital Umuebule		4	Umuebule	03/02/2015	Richard	Ogedengbe	7	2	98	Volunteer lab scientist	3	3	3	1	1	2	1	4	2	1	1	
Primary health center Mbodo-Alu		4	Ikwere	04/02/2015	Tumini	Ogedengbe	7	2	98	Laboratory scientist	3	3	4	1	1	1		4	1	1		
ModePrimary health center, Beera		4	Khana	04/02/2015	Richard	Ogedengbe	6	1	1	Medical officer	4	4	4	1	1	2		4	1	1	1	
Primary health center Beeri		4	Khana	04/02/2015	Richard	Ogedengbe	7	1	1	Laboratory scientist	4	4	4	1	1	2		4	2	1	1	
Pope John Paul hospital		4	Khana	04/02/2015	Richard	Ogedengbe	7	1	98	Laboratory technologist	3	4	4	1	1	1	1	4	1		1	
Mode P. H. center Akinima		4	Ahoada West	28/01/2015	Richard	Ogedengbe	7	2	98	Laboratory scientist	3	4	4	1	1	2		4	2	1		
Primary health center		4	Obio-Akpor	29/01/20	Richard	Ogedengbe	7	2	98	Monitoring and evaluation officer	3	3	2	1	1	2		4	1	1	1	

				15																		
Primary health center Churchil		4	Phalga	29/0 1/20 15	Richard	Ogedengbe	7	2	9 8	Laboratory technician	4	4	4	1	2	9 8		4	2	1	1	
Primary health center Rumu-igbo		4	Obio-Akpor	26/0 1/20 15	Richard	Ogedengbe	7	2	9 8	Laboratory scientist	4	4	4	1	1	2		8	2	1		
pope John Paul		4	Khana	04/0 2/20 15	Richard	Ogedengbe	6	2	3	Nurse Midwife (PMTCT Focal Person)	2	3	2	1	1	2	1	4	1	1	1	7
Model PHC Rumuokwusi		4	obio Akpor	29/0 1/20 15	chri	Ogedengbe	5	2	1	Principal Medical Record Technican	4	3	4	2			1	4	1		1	1
New Mile One Hospital		4		06/0 2/20 15	chris	Ogedengbe	7	1	9 8	focal officer HTC	4	4	4	1	1	2	1	8	2		1	1
Pope John Paul		4	Pluga	04/0 2/20 15	Richard	Ogedengbe	7	1	9 8	Techanican (Focal Person HTC)	3	4	4	1	1	2	1	4	1		1	1
Spring Hospital		4	Obio/Akpor	06/0 2/20 15	Chris	Ogedengbe	7	1	9 8	HTC FOCAL PERSON	1	1	4	2			1	8	2		9 8	8
Meriedan Hospital		4	PHALGA	06/0 2/20 15	CHRIS	Ogedengbe	7	2	9 8	Focal Person HTC	4	4	4	1	2	2		4	2			1 5
Braitthusrate Medical Hospital		4	PHALGA	05/0 2/20 15	CHRIS		5	2	9 8	Medical Lab Scien. (Focal Person TB)	2	4	4	1	2	2	1	8	2		1	1
Model PHC Churchi		4	phalga	29/0 1/20 15	Richard	Ogedengbe	5	2	9 8	Lab technican	4	4	4	1	2	2						
Obio Cottage Hospital		4	Obio/Akpo	30/0 1/20 15	Richard	Ogedengbe	1	2	1	Medical Offical	4	4	4	1	1	2	1	4	1			2
General Hospital Ahoada		4	Ahoada East	28/0 1/20 15	Chris	Ogedengbe	2	1	9 8	ART Focal Person	2	4	4	1	2	2	1	4	1			1

Meridan Hospital		4	phalga	06/02/2015	CHRIS	Ogedengbe	2	1	98	ART Focal Person	4	4	4	1	1	2	1	4	2		1	1
Obio Cottage Hospital		4	Obio-Akpor	30/01/2015	Chris	Ogedengbe	6	2	98	PMTCT Focal Person	3	4	4	1	1	2	1	5	1			1
Morning Star Hospital		4		28/01/2015	Chris	Ogedengbe	6	1	98	focal person PMTCT	2	3	4	1	2	2	8	8	2			1
General Hospial Ahoado		4	Ahoado East	28/01/2015	Richard	Ogedengbe	6	2	2	Chief Nursing Officer	4	4	4	1	1	2	1	4	1	1	1	1
Lizendic Pharmacy		4	.		Richard/Chris	Ogedengbe	1	2			3			1	1	2						
Beulah Clinic		4	Ahoada	06/02/2015	Tumini	Ogedengbe			98	Lab scientist	3	3	2	1	1	2						
Meridan Hospital		4	PHALGA	09/02/2015	Chris	Ogedengbe		1	2	Physican	4	4	4	1	1	2						
zion Maternity		4	Phalga	05/02/2015	chris	Ogedengbe		2	3	Nurinf Officer	3	4	3	1	1	2						
Meridan Hospital		4		09/02/2015	Richard	Ogedengbe	6	2	3	Matron	3	3	3	4	2	2	1					

TB-DOTS Service Assessment

q1a	q1 b	q2	q3	q4	q5	field1	b1	b2	b3	b4	b5	b6	b7	b8	b9	b10	b11	b12	field2	b14	b15
Cottage hospital Ukana		1	Essien Udim	29/01/2015	Kokoete Mkpang	Dr Ruth Hope	3	4	3	3	1	3	4	4	3	1	1	4	3	2	2
Palmer Memorial Hospital,Ikot U		1	Ibiono Ibom	02/02/2015	Kokoete Mkpang	Dr Ruth Hope	1	1	2	3	4	2	4	2	3	1	1	4	1	2	1
University of Uyo Yeaching hosp		1	Uyo	03/02/2015	Kokoete Mkpang	Dr Ruth Hope	3	4	2	4	4	2	4	4	3	4	3	2	4	3	4
ASUTH			Awka South	28/01/2015	Ezeh Bishop	Dr. lheadi	4	4	4	4	4	4	2	4	3	1	3	4	4	4	4
NAUTH			Nnewi North	26/01/2015	Ezeh Bishop	Dr. lheadi	3	3	3	3	3	4	2	4	3	1	4	4	2	2	3
RANDLE GENERAL HOSPITAL		3	SURULERE	03/02/2015	STEPHEN OHUNENI	PROF(DR.)JAMIE BENAVENTE	3	4	2	3	4	3	4	4	4	1	3	4	3	3	3
GBAGADA GENERAL HOSPITAL		3	KOSOF E	04/02/2015	STEPHEN OHUNENI	DR.JAIME BENAVENTE	3	3	3	3	3	3	4	4	3	3	3	4	2	2	3
COKER-AGUDA PHC		3	SURULERE	05/02/2015	DR.SANUSI	DR.JAMIE	1	1	2	2	2	3	4	2	2	1	1	1	2	2	
BADAGRY GENERAL HOSPITAL		3	BADAGRY	27/01/2015	DR. SANUSI	DR.JAIME	1	2	1	2	3	4	4	4	1	1	1	3	2	1	
MAINLAND GENERAL HOSPITAL		3	MAINLAND	09/02/2015	STEPHEN OHUNENI	PROF.JAIME	1	4	3	2	4	4	4	4	3	1	1	4	2	2	3
MAIDAN PHC		3	KOSOF E	04/02/2015	DR.SANUSI	DR.JAIME	1	1	2	1	2	4	4	2	3	1	1	3	2	1	
Primar health center Okrika		4	Okrika	05/02/2015	Richard	Ogedengbe	3	4	4	3	3	4	3	1	4	1	1	3	3	3	3
Primar health care Beerli		4	Khana	04/02/2015	Richard	Ogedengbe	4	4	4	3	3	4	3	1	3	1	1		4	3	3
Pope John Paul hospital		4	Khana	04/02/2015	Richard	Ogedengbe	3	3	3	3	1	3	3	1	4	2	2	2	3	4	3
Primary health center Churchil		4	Phalga	29/01/2015	Richard	Ogedengbe	4	4	4	4	4	3	1	1	4	1	3		4	4	3
Morning star hospital		4	Phalga	26/01/2015	Richard	Ogedengbe	4	4	3	3	4	4	1	4	3	1	4		3	3	3

				2015																	

Clients Exit Interviews (first 25 columns)

q n u m	q1a	q 1 b	q2	q3	q4	q5	field1	q 7	q 8	q 9	q 1 0	q 1 1	q 1 2	q 1 3 a	q 1 3 b	q 1 3 c	q 1 3 d	q 1 3 e	q 1 3 f	q 1 3 g	fi el d 2	q 1 3 i	q 1 4	q 1 5 a
1	cottage hospital ukana iba		AK WA IBO M	Essien udim	29/ 01/ 201 5	irene okosun	Dr. Ruth Hope	2	2	2	9	1		1						1			3	2
2	ST JOSEPH REHABILITATIO N CENTRE		AK WA IBO M	ESSIEN UDIM	29/ 01/ 201 5	IRENE OKOSUN	DR. RUTH HOPE	2	2	2	3	1	9	1									4	2
3	ST JOSEPH REHABILITATIO N CENTER		AK WA IBO M	ESSIEN UDIM	29/ 01/ 201 5	IRENE OKOSUN	DR RUTH HOPE	2	4	5	3	1	9	1									4	2
4	COTTAGE HOSPITAL		AK WA IBO M	ESSIEN UDIM	29/ 01/ 201 5	IRENE OKOSUN	DR RUTH HOPE	2	2	2	3	1	3	1									1	2
5	PALMER MEMORIAL HOSPITAL		AK WA IBO M	IBIONO IBOM	2/2/ 201 5	IRENE OKOSUN	DR RUTH HOPE	2	2	2	3	1	9	1										
6	THE UNIVERSITY OF UYO TEACHING		AK WA IBO M	UYO	3/2/ 201 5	IRENE OKOSUN	DR RUTH HOPE	2	4	2	3	1		1									3	2
7	PALMER MEMORIAL HOSPITAL		AK WA IBO M	IBIONO IBOM	2/2/ 201 5	IRENE OKOSUN	DR RUTH HOPE	2	4	3	4	1	9	1									3	2
8	COTTAGE HOSPITAL		AK WA IBO M	ESSIEN UDIM	29/ 01/ 201 5	IRENE OKOSUN	DR RUTH HOPE	2	2	2	9	1	9	8				1		1				

9	DIVINE LOVE HOSPITAL		AK WA IBO M	ETIM EKPO	28/01/2015	IRENE OKOSUN	DR RUTH HOPE	2	2	2	4	1	9	8	1								1	2	
10	HOLIFIELD HOSPITAL		AK WA IBO M	EKET	26/01/2015	IRENE OKOSUN	DR RUTH HOPE	2	3	5	2	5	1									9	8		
11	GENERAL HOSPITAL ETIM EKPO		AK WA IBO M	ETIM EKPO	28/01/2015	IRENE OKOSUN	DR RUTH HOPE	2	3	2	2	9	8	1								1			
12	GENERAL HOSPITAL ETIM EKPO		AK WA IBO M	ETIM EKPO	28/01/2015	IRENE OKOSUN	DR RUTH HOPE	2	2	5	2	9	8	1					1					2	
13	UNIVERSITY OF UYO , MEDICAL CEN		AK WA IBO M	UYO	27/01/2015	IRENE OKOSUN	DR RUTH HOPE	2	3	5	2	3	1	9	8								9	8	
14	ubong Abasi __specialist clinic		AK WA IBO M	UYO	3/2/2015	IRENE OKOSUN	DR RUTH HOPE	2	3	8	2	5	1										9	8	
15	ubong Abasi __specialist clinic		AK WA IBO M	UYO	3/2/2015	IRENE OKOSUN	DR RUTH HOPE	2	3	2	2	5	1	9	8								9	8	
16	the university of uyo teaching		AK WA IBO M	UYO	3/2/2015	IRENE OKOSUN	DR RUTH HOPE	2	2	4	2	9	8	1	9	8				1				2	2
17	university of uyo medical centr		AK WA IBO M	UYO	27/01/2015	IRENE OKOSUN	DR RUTH HOPE	2	3	5	2	9	8	1	9	8							9	8	
18	university of uyo medical centr		AK WA	UYO	27/01/	IRENE OKOSUN	DR RUTH HOPE	2	3	9	2	5	1	9	8								9	8	

			IBO M		2015																					
9 1	UTIBE ABASI CLINIC		AK WA IBO M	EKET	9/2/ 2015	IRENE OKOSUN	DR RUTH HOPE	2	8	2	4	1	9	8											9	8
1	St Joseph Rehabilitation Centre		AK WA IBO M	Essien Udim	29/ 01/ 2015	Koko	Dr Ruth	1	4	2	3	1	9	8		2									5	2
2	UUTH		AK WA IBO M	Uyo	3/2/ 2015	Koko	Dr Ruth	1	6	1	4	1	9	8	1										4	2
3	UUTH		AK WA IBO M	Uyo	3/2/ 2015	Koko	Dr Ruth	1	3	2	4	1					4								2	2
1	PHC Ikot Edibon		AK WA IBO M	Nsit Ubium	26/ 01/ 2015	Koko	Dr Ruth	1	8	3	3	1					4								2	2
	Immaculate Heart Hospital			Onitsha North	27/ 01/ 2015	Ezeh Bishop	Dr. Iheadi	1	8	1	4	1	9	8	1										3	2
	Immaculate Heart Hospital			Idemili North	27/ 01/ 2015	Ezeh Bishop	Dr. Iheadi	1	2	2	3	1	9	8							7				4	2
	Immaculate Heart Hospital			Idemili North	27/ 01/ 2015	Ezeh Bishop	Dr. Iheadi	1	1	1	3	1	9	8										8	2	2
	NAUTH			Nnewi North	26/ 01/ 2015	Ezeh Bishop	Dr. Iheadi	1	8	2	3	1	9	8							7				5	2

	NAUTH			Nnewi North	26/01/2015	Ezeh Bishop	Dr. Iheadi	1	4	2	2	3	1		1	2						3	2	
	NAUTH			Nnewi North	26/01/2015	Ezeh Bishop	Dr. Iheadi	1	5	2	2	3	1	9	8							8	5	2
	NAUTH			Nnewi North	26/01/2015	Ezeh Bishop	Dr. Iheadi	1	7	1	1	1	9	8			3						3	2
	NAUTH			Nnewi North	26/01/2015	Ezeh Bishop	Dr. Iheadi	1	3	9	2	4	1	9	8	1							3	2
	ASUTH			Awka South	28/01/2015	Ezeh Bishop	Dr. Iheadi	1	4	0	2	1	1	9	8		2						5	2
	ASUTH			Awka South	28/01/2015	Ezeh Bishop	Dr. Iheadi	1	4	5	2	3	1	9	8				7				5	2
	ASUTH			Awka South	28/01/2015	Ezeh Bishop	Dr. Iheadi	1	3	1	2	4	1	9	8							8	2	2
	ASUTH			Awka South	28/01/2015	Ezeh Bishop	Dr. Iheadi	1	6	7	2	4	1	9	8				6				1	2
	ASUTH			Awka South	28/01/2015	Ezeh Bishop	Dr. Iheadi	1	2	4	1	3	1	9	8	1							4	2
	BEKE MEM		ANA	NJIKOKA	5/2/	UGWU	DR. IHEADI	2	3	2	3	1						6						

	HOSPITAL URUM NIMO		MBR A		201 5	NGOZI			6		1												
	BEKE MEM HOSPITAL, URUM NIMO		ANA MBR A	NJIKOKA	5/2/ 201 5	UGWU NGOZI	DR IHEADI	2	2	2	3	1					5						
	GENERAL HOSP NIMO		ANA MBR A	NJIKOKA	5/2/ 201 5	UGWU NGOZI	DR IHEADI	2	3	4	2	3	1					6					
	GENERAL HOSP. NIMO		ANA MBR A	NJIKOKA	5/2/ 201 5	UGWU NGOZI	DR IHEADI	2	2	2	2	3	1					5					
	GENERAL HOSPITAL NIMO		ANA MBR A	NJIKOKA	5/2/ 201 5	UGWU NGOZI	DR IHEADI	2	3	1	2	3	1					5	2				
	EDMUND SPECIALIST HOSPITAL		ANA MBR A	OGBARU	4/2/ 201 5	UGWU NGOZI	DR IHEADI	2	2	6	2	3	1					5					
	EDMUND SPECIALIST HOSPITAL		ANA MBR A	OGBARU	4/2/ 201 5	UGWU NGOZI	DR. IHEADI	2	3	0	2	3	1					5					
	OJOTO PHC		ANA MBR A	IDEMILI SOUTH	4/2/ 201 5	UGWU NGOZI	DR IHEADI	2	2	2	2	3	1					6					
	KELECHI HOSPITAL AND MATERNITY		ANA MBR A	OGBARU	4/2/ 201 5	UGWU NGOZI	DR IHEADI	2	2	5	2	3	1					5					
	KANAYO SPEAILIST HOSPITAL		ANA MBR A	ONITSHA NORTH	3/2/ 201 5	UGWU NGOZI	DR IHEADI	2	3	5	2	4	1	9	8			5					
	WINNERS HOSPITAL		ANA MBR A	ONITSHA	3/2/ 201 5	UGWU NGOZI	DR. IHEADI	2	3	1	2	4	1	9	8			5				4	2
	NRI PHC		ANA MBR A	ANAOCHA	2/2/ 201 5	UGWU NGOZI	DR IHEADI	2	2	4	2	3	1	9	8			5					
	NRI PHC		ANA MBR A	ANAOCHA	2/2/ 201 5	UGWU NGOZI	DR IHEADI	2	2	8	2	3	1	9	8			5					

	NRI PHC		ANA MBR A	ANAOCHA	2/2/ 201 5	UGWU NGOZI	DR IHEADI	2	2 5	2	1	1	9 8					5							2	2
	IJEOMA HOSP. & MATERNITY UMUONA		ANA MBR A	AGUATA	2/2/ 201 5	UGWU NGOZI	DR IHEADI	2	2 5	2	3	1	9 8					5							2	2
	IJEOMA HOSP. & MATERNITY		ANA MBR A	AGUATA	2/2/ 201 5	UGWU NGOZI	DR IHEADI	2	3 5	2	3	1	9 8					5							3	2
	NAU TEACHING HOSP. NNEWI		ANA MBR A	NNEWI SOUTH	26/ 01/ 201 5	UGWU NGOZI	DR IHEADI	2		1	3	1	9 8				3								5	2
	NAU TEACHING HOSP. NNEWI		ANA MBR A	NNEWI NORTH	26/ 01/ 201 5	UGWU NGOZI	DR IHEADI	2	4	1	1	1	9 8				3									
	NAU TEACHING HOSP. NNEWI		ANA MBR A	NNEWI NORTH	26/ 01/ 201 5	UGWU NGOZI	DR IHEADI	2		2	4	1	9 8	1											5	2
	NAU TEACHING HOSPITAL		ANA MBR A	NNNEWI NORTH	26/ 01/ 201 5	UGWU NGOZI	DR IHEADI	2	3 4	2	3	1	9 8					5								
	NNEWI TEACHING HOSPITAL	2		NNEWI NORTH	26/ 01/ 201 5	UGWU NGOZI		2		2	9 8	1	9 8					6							5	2
	IHH, OKPOR	2		IDEWILI NORTH	27/ 01/ 201 5	UGWU NGOZI		2	5 2	5	9 8	1 9	9 8													1
	IHH, NKPOR	2		IDEMILI	27/ 01/ 201 5	UGWU NGOZI		2	3 7	2	9 8	1	9 8				4									2
	IHH, NKPOR	2		IDEMILI	27/	UGWU	IHEADI	2	2	1	9	1	9	1											4	2

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	HOSPITAL				2015		BENAVENTE																		
	BADAGRY GENERAL HOSPITAL		LAG OS	BADAGRY	27/01/2015	STEPHEN OHUNENI	PROF(DR.) JAMIE BENAVENTE	1	42	3	3	2	98				4							2	2
	BADAGRY GENERAL HOSPITAL		LAG OS	BADAGRY	27/01/2015	MRS ENIGBOKAN FUNMILAYO	DR SANUSI ABUBAKAR	2	41	2	4	1	98	1										5	2
	RANDLE GENERAL HOSPITAL		LAG OS	SURULER E	2/2/2015	STEPHEN OHUNENI	PROF. JAMIE BENAVENTE	1	42	2	4	1	98					6						1	1
	RANDLE GENERAL HOSPITAL		LAG OS	SURULER E	3/2/2015	STEPHEN OHUNENI	PROF(DR.) JAMIE BENAVENTE	1	45	2	3	1	98				4							3	2
	RANDLE GENERAL HOSPITAL		LAG OS	SURULER E	3/2/2015	STEPHEN OHUNENI	PROF(DR.) JAMIE BENAVENTE	1	35	2	1	1	98	1										3	2
	GBAGADA GENERAL HOSPITAL		LAG OS	KOSOFE	4/2/2015	STEPHEN OHUNENI	DR. JAMIE BENAVENTE	1	39	1	3	1	98					6						1	2
	GBAGADA GENERAL HOSPITAL		LAG OS	KOSOFE	4/2/2015	STEPHEN OHUNENI	DR. JAIME BENAVENTE	2	45	5	3	1	98	1										2	2
	MAIDAN PHC		LAG OS	IKOSI/ISHERI	5/2/2015	STEPHEN OHUNENI	DR.JAIME BENAVENTE	2	29	2	4	1	98				5							2	2
	MAIDAN PHC		LAG OS	IKOSI/ISHERI	5/2/2015	STEPHEN OHUNENI	DR.JAIME BENAVENTE	2	33	2	3	1	98				5							2	2
	MAILAND GENERAL HOSPITAL		LAG OS	MAINLAND	9/2/2015	STEPHEN OHUNENI	PROF JAIME	1	41	2	4	1	98				4							3	2

	MINALAND GENERAL HOSPITAL		LAG OS	MAINLAND	9/2/ 201 5	STEPHEN OHUNENI	PROF.JAIM E	1	4 9	4	3	2	9 8	1							5	2
	BADAGRY GENERAL HOSPITAL		LAG OS	BADAGRY	29/ 01/ 201 5	REKIA	DR. SANUSI	2	3 8	2	3	1	9 8					5				
	BADAGRY GENERAL HOSPITAL		LAG OS	BADAGRY	28/ 01/ 201 5	REKIA	DR. SANUSI	2	3 4	2	3	1	9 8					5			4	2
	BADAGRY GENERAL HOSPITAL		LAG OS	BADAGRY	29/ 01/ 201 5	REKIA	DR. SANUSI	2	3 5	2	9 8	2	9 8					5				
	SACRED HEARTS		LAG OS	BADAGRY	30/ 01/ 201 5	REKIA	DR.SANUSI	2	3 1	2	3	1	9 8					5				
	SACRED HEARTS		LAG OS	BADAGRY	30/ 01/ 201 5	REKIA	DR. SANUSI	2	3 2	2	4	1	9 8					5			3	2
	SACRED HEARTS		LAG OS	BADAGRY	30/ 01/ 201 5	REKIA	DR.SANUSI	2	3 3	2	4	1	9 8					5	7			
	RANDLE GENERAL HOSPITAL		LAG OS	SURULER E	2/2/ 201 5	REKIA	DR.SANUSI	2	3 8	2	4	1	9 8					5				
1	RANDLE GENERAL HOSPITAL		LAG OS	SURULER E	2/2/ 201 5	REKIA	DR. SANUSI	2	2 7	2	4	2	9 8					5				
	RANDLE GENERAL HOSPITAL		LAG OS	SURULER E	3/2/ 201 5	REKIA	DR. SANUSI	2	2 9	1	3	1	9 8	1							3	2
	RANDLE GENERAL		LAG OS	SURULER E	3/2/ 201	REKIA	DR. SANUSI	2	3 7	3	3	1	9 8	1							3	2

	HOSPITAL				5																				
	GBAGADA GENERAL HOSPITAL		LAG OS	KOSHOFE	4/2/ 201 5	REKIA	DR. SANUSI	2	3 7	2	3	1	9 8					5					3	2	
	GBAGADA GENERAL HOSPITAL		LAG OS	KOSHOFE	4/2/ 201 5	REKIA	DR.SANUSI	2	2 4	2	9 8	1	9 8					5					3	3	
	COKER AGUDA HEALTH CENER		LAG OS	SURULER E	5/2/ 201 5	REKIA	DR. SANUSI	2	2 6	2	1	2	9 8					5							
	COKER AGUDA HEALTH CENTER		LAG OS	SURULER E LOCAL GOVT	5/2/ 201 5	REKIA	DR. SANUSI	2	4 1	2	4	2	9 8					5							
	COKER AGUDA HEALTH CENTER		LAG OS	SURULER E	5/2/ 201 5	REKIA	DR. SANUSI	2	3 4	2	4	1	9 8					5							
	R-JOLAD HOSPITAL		LAG OS	SHOMOLU LGA	5/2/ 201 5	REKIA	DR. SANUSI	2	3 1	2	4	1	9 8					5							
	R-JOLAD HOSPITAL		LAG OS	SHOMOLU	5/2/ 201 5	REKIA	DR. SANUSI	2	2 9	2	4	1	9 8					5							
	MAINLAND HOSPITAL YABA		LAG OS	MAINLAND LOCAL GOVT	9/2/ 201 5	REKIA	DR.SANUSI	2	3 5	2	3	1	9 8				4						2		
	MAINLAND HOSPITAL YABA		LAG OS	MAINLAND LGA	9/2/ 201 5	RFEKIA	DR.SANSU SI	2	5 2		2	1	9 8	1									5	2	
	BRAITWAITH MEMORIAL SPECIALIST		RIV ERS	PORTHAR COURT	22/ 01/ 201 5	EJIMAH KELVINS		1	4 2	1	4	1		1									2	2	
	BRAITHWAITH MEMORIAL SPECIALIST		RIV ERS	PORTHAR COURT	22/ 01/ 201 5	EJIMAH KELVINS		1	3 2	1	1	1				4							2	1	
	BMSH		RIV ERS	PORTHAR COURT	22/ 01/ 201	EJIMAH KELVINS		2	3 0	1	3	1						6					2	2	

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GENERAL HOSPITAL AHOADA	RIV ERS	AHOADA EAST	28/ 01/ 201 5	EJIMAH KELVINS		2	3 8	2	3	1			2						5	2
GENERAL HOSPITAL AHOADA	RIV ERS	AHOADA EAST	28/ 01/ 201 5	EJIMAH KELVINS		1	4 0	1	3	2						6			2	1
GENERAL HOSPITAL AHOADA	RIV ERS	AHOADA EAST	28/ 01/ 201 5	EJIMAH KELVINS		1	4 6	2		1						7			2	2
GENERAL HOSPITAL AHOADA	RIV ERS	AHOADA EAST	28/ 01/ 201 5	EJIMAH KELVINS		1	5 0	3	4	1		1							4	2
PRIMARY HEALTH CENTRE UBIMA	RIV ERS	IKWERRE	2/2/ 201 5	EJIMAH KELVINS		1	3 6	2	3	1								8	3	2
PRIMARY HEALTH CENTRE UBIMA	RIV ERS	IKWERRE	2/2/ 201 5	EJIMAH KELVINS		1	4 1	2	3	1						7			3	2
PRIMARY HEALTH CENTRE UBIMA	RIV ERS	IKWERRE	2/2/ 201 5	EJIMAH KELVINS		1	3 6	2	3	1						6			2	2
PRIMARY HEALTH CENTRE UBIMA	RIV ERS	IKWERRE	2/2/ 201 5	EJIMAH KELVINS		2	3 9	2	3	1		2							3	2
GENERAL HOSPITAL ISIOKPO	RIV ERS	IKWERRE	2/2/ 201 5	EJIMAH KELVINS		2	3 4	2	3	1		2							2	2
GENERAL HOSPITAL ISIOKPO	RIV ERS	IKWERRE	2/2/ 201 5	EJIMAH KELVINS		1	3 1	2	3	1								8	2	2

	GRNERAL HOSPITAL ISIOKPO		RIV ERS	IKWERRE	2/2/ 201 5	EJIMAH KELVINS		1	2 6	2	3	1		1							2	1
	COTTAGE HOSPITAL EMUEBULE		RIV ERS	ETCHE	3/2/ 201 5	EJIMAH KELVINS		1	4 3	2	3	1					7				3	2
	COTTAGE HOSPITAL UMUEBULE		RIV ERS	ETCHE	3/2/ 201 5	EJIMAH KELVINS		1	7 0	2	3	1					6				2	2
	COTTAGE HOSPITAL UMUEBULE		RIV ERS	ETCHE	3/2/ 201 5	EJIMAH KELVINS		2	2 0	1	3	1					6				2	2
	COTTAGE HOSPITAL UMUEBULE		RIV ERS	ETCHE	3/2/ 201 5	EJIMAH KELVINS		2	4 0	5	3	1		1							2	2
	COTTAGE HOSPITAL UMUEBULE		RIV ERS	ETCHE	3/2/ 201 5	EJIMAH KELVINS		1	4 1	2	3	1		1							2	2
	COTTAGE HOSPITAL UMUEBULE		RIV ERS	ETCHE	3/2/ 201 5	EJIMAH KELVINS		1	5 5	2	4	1					7				4	2
	MBODO ALUU PRIMARY HEALTH CENTR		RIV ERS	IKWERRE	4/2/ 201 5	EJIMAH KELVINS		2	4 7	2	4	1		1							3	1
	BRAITHWAITH MEMORIAL SPECIALIST		RIV ERS	PORTHAR COURT (PHALGA)	5/2/ 201 5	EJIMAH KELVINS		2	3 0	1	3	1								8	1	2
	BRAITHWAITH MEMORIAL SPECIALIST		RIV ERS	PORTHAR COURT(P HALGA)	5/2/ 201 5	EJIMAH KELVINS		1	3 9	2	3	1									8	1
	BRAITWAITH MEMORIAL SPECIALIST		RIV ERS	PORTHAR COURT(P HALGA)	5/2/ 201 5	EJIMAH KELVINS		1	2 7	1	3	1					6				2	2
	POPR JOHN PAUL II CLINIC		RIV ERS	KHANA	4/2/ 201 5	IBELEMA ALLISON		1	4 5	1	4	1					7				3	2
	POPE JOHN		RIV	KHANA	4/2/	IBELEMA		2	2	2	3	1					7				4	1

	PAUL II CLINIC		ERS		201 5	ALLISON			5															
	POPE JOHN PAUL II CLINIC		RIV ERS	KHANA	4/2/ 201 5	IBELEMA ALLISON		1	2 9	1	3	1						6				1	2	
	POPE JOHN PAUL II CLINIC		RIV ERS	KHANA	4/2/ 201 5	IBELEMA ALLISON		1	2 7	1	3	1									8	2	2	
	POPE JOHN PAUL II CLINIC		RIV ERS	KHANA	4/2/ 201 5	IBELEMA ALLISON		2	3 0	1	4	1		1								4	1	
	POPE JOHN PAUL II CLINIC		RIV ERS	KHANA	4/2/ 201 5	IBELEMA ALLISON		1	4 5	2	4	1		1								3	2	
	POPE JOHN PAUL II CLINIC		RIV ERS	KHANA	4/2/ 201 5	IBELEMA ALLISON		1	2 2	1	2	1				4						2	2	
	POPE JOHN PAUL II CLINIC		RIV ERS	KHANA	4/2/ 201 5	IBELEMA ALLISON		2	9	1	1	1				3						4	2	
	POPE JOHN PAUL II CLINIC		RIV ERS	KHANA	4/2/ 201 5	IBELEMA ALLISON		2	3 9	2	3	1					5					2	2	
	PRIMARY HEALTH CENTRE BEERI		RIV ERS	KHANA	4/2/ 201 5	IBELEMA ALLISON		2	3 2	2	1	1					5					3	1	
	PRIMARY HEALTH CENTRE OGAN-AMA		RIV ERS	OKIRIKA	5/2/ 201 5	IBELEMA ALLISON		2	2 3	2	3	1					5					3	2	
	PRIMARY HEALTH CENTRE OGAN-AMA		RIV ERS	OKIRIKA	5/2/ 201 5	IBELEMA ALLISON		1	3 5	2	3	1						6				1	2	
	BRIEGHTWITH MEMORAL HOSPITAL		RIV ERS	PHALGA	22/ 01/ 201 5	TUMINI GREEN		2	5 3	2	5	1	9 8	1								4	2	

	BRIEGHTWATH MEMORAL HOSPITAL		RIV ERS	PHALGA	22/ 01/ 201 5	TUMINI GREEN		1	3 5	2	3	1	9 8					7		5	2
	BRIEGHTWITH MEMORAL HOSPITAL		RIV ERS	PHALGA	22/ 01/ 201 5	TUMINI GREEN		2	3 0	2	4	1	9 8					7		2	1
	OBIO COTTAGE HOSPITAL		RIV ERS	OBIO AKPOR	23/ 01/ 201 5	TUMINI GREEN		2	2 7	2	4	1	9 8				5			2	2
1 1 1	111		RIV ERS	OBIO AKPOR	23/ 01/ 201 5	TUMINI GREEN		2	3 4	2	4	1	9 8					7		3	1
	OBIO COTTAGE HOSPITAL		RIV ERS	OBIO AKPOR	23/ 01/ 201 5	TUMINI GREEN		2	2 2	1	3	1	9 8				6			1	1
	OBIO COTTAGE HOSPITAL		RIV ERS	OBIO AKPOR	23/ 01/ 201 5	TUMINI GREEN		2	3 5	2	3	1	9 8					7		3	1
	OBIO COTTAGE HOSPITAL		RIV ERS	OBIO AKPOR	23/ 01/ 201 5	TUMINI GREEN		2	3 3	2	4	1		1						4	2
	UNIVERSITY OF PH TEACHING HOSPI			OBOI AKPOR	27/ 01/ 201 5	TUMINI GREEN		2	5 5	5	1	1	9 8	1						4	2
	UNIVERSITY OF PH TEACHING HOSPI		RIV ERS	OBIO AKPOR	27/ 01/ 201 5			2	2 8	2	4	1				5				5	2
	UNIVERSITY OF PH		RIV ERS	OBIO AKPOR	27/ 01/ 201 5	TUMINI GREEN		2	6 0	2	5	1						7		2	2

	TEACHING				2015																		
	AHOADA GENERAL HOSPITAL		RIV ERS	AHOADA EAST	28/ 01/ 2015	TUMINI GREEN		2	2	4	4	1	9 8					7			5	2	
	AHOADA GENERAL HOSPITAL		RIV ERS	AHOADA EAST	28/ 01/ 2015	TUMINI GREEN		2	3	1	3	1				5					3	2	
	AHOADA GENERAL HOSPITAL		RIV ERS	AHOADA EAST	28/ 01/ 2015	TUMINI GREEN		2	3	2	1	3	9 8	1							4	2	
	AHOADA GENERAL HOSPITAL		RIV ERS	AHOADA EAST	28/ 01/ 2015	TUMINI GREEN		2	5	1	3	1									5	2	
	PRIMARY HEALTH CENTER		RIV ERS	UBIMA IKWERRE	2/2/ 2015	TUMINI GREEN		2	3	2	3	1	9 8			5					2	2	
	GENERAL HOSPITAL		RIV ERS	ISIOKPO IKWERRE	2/2/ 2015	TUMINI GREEN		2	3	0	2	3	1				7				3	1	
	GENERAL HOSPITAL		RIV ERS	ISIOKPO IKWERRE	2/2/ 2015	TUMINI GREEN		2	3	0	1	3	1		1						5	1	
	PRIMARY HEALTH CENTER		RIV ERS	IKWERRE MBODO ALUU	4/2/ 2105	GREEN TUMINI		2	3	5	2	4	1			5					3	1	

Clients Exit Interviews (contd...)

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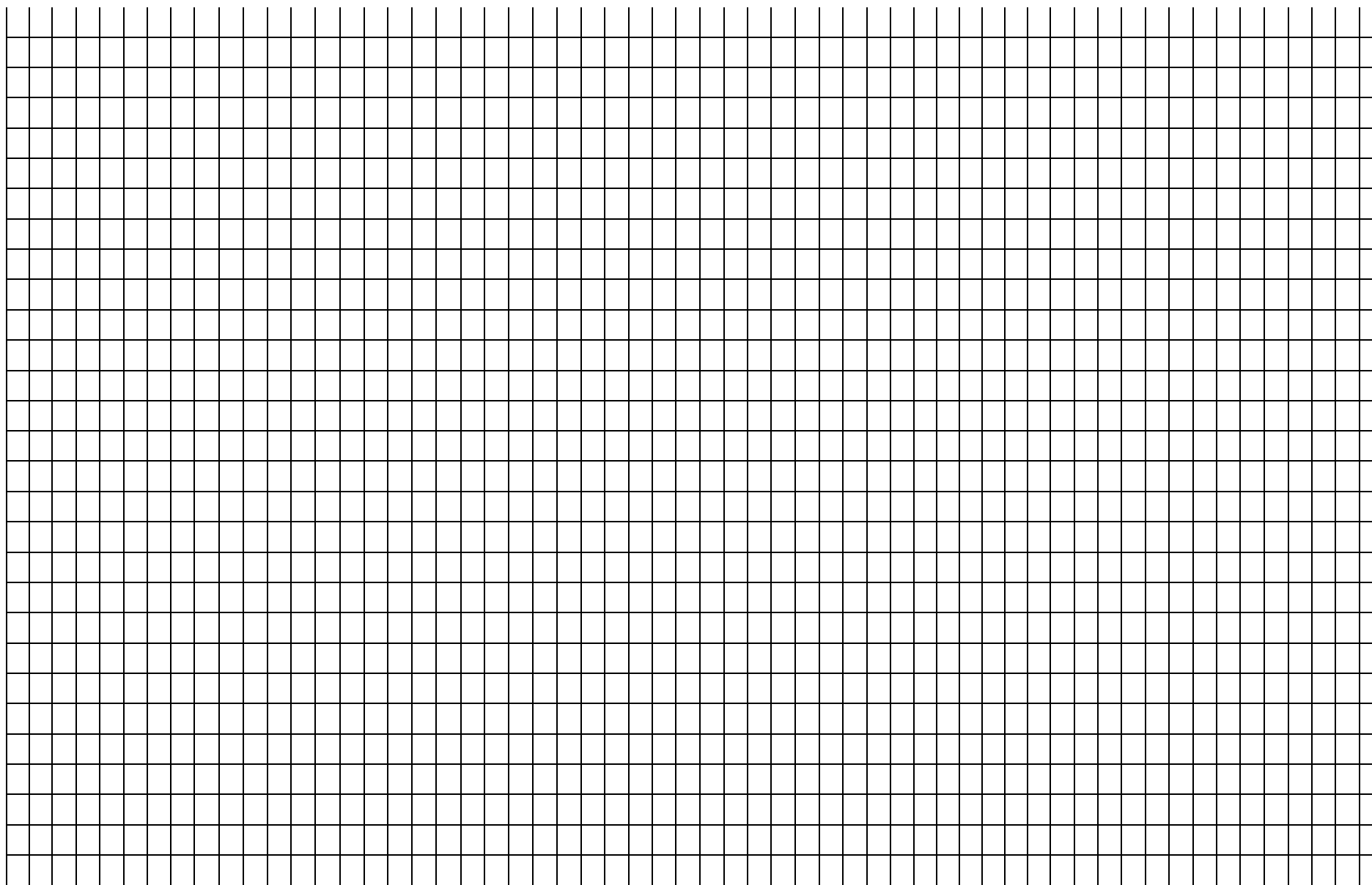
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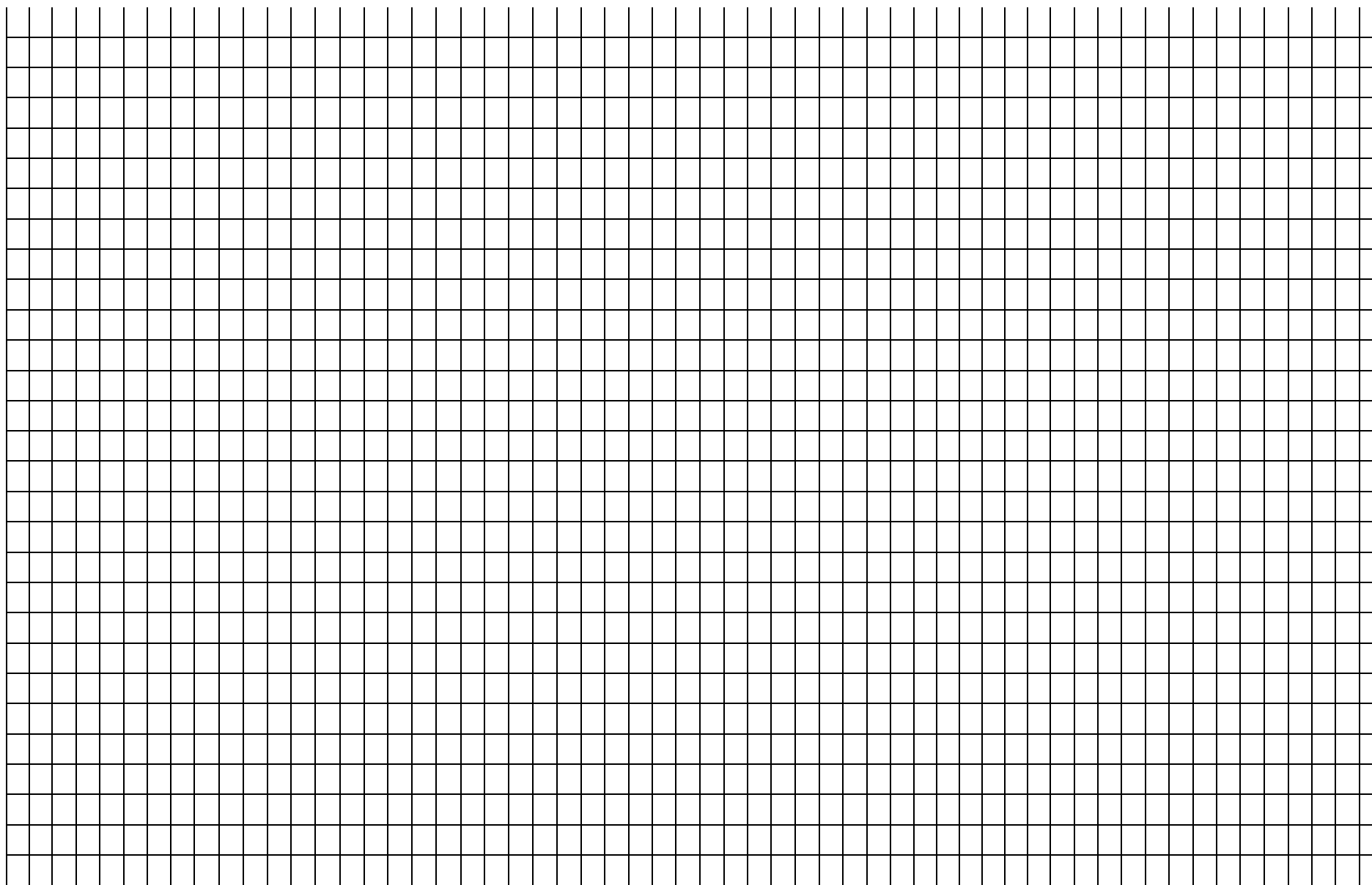
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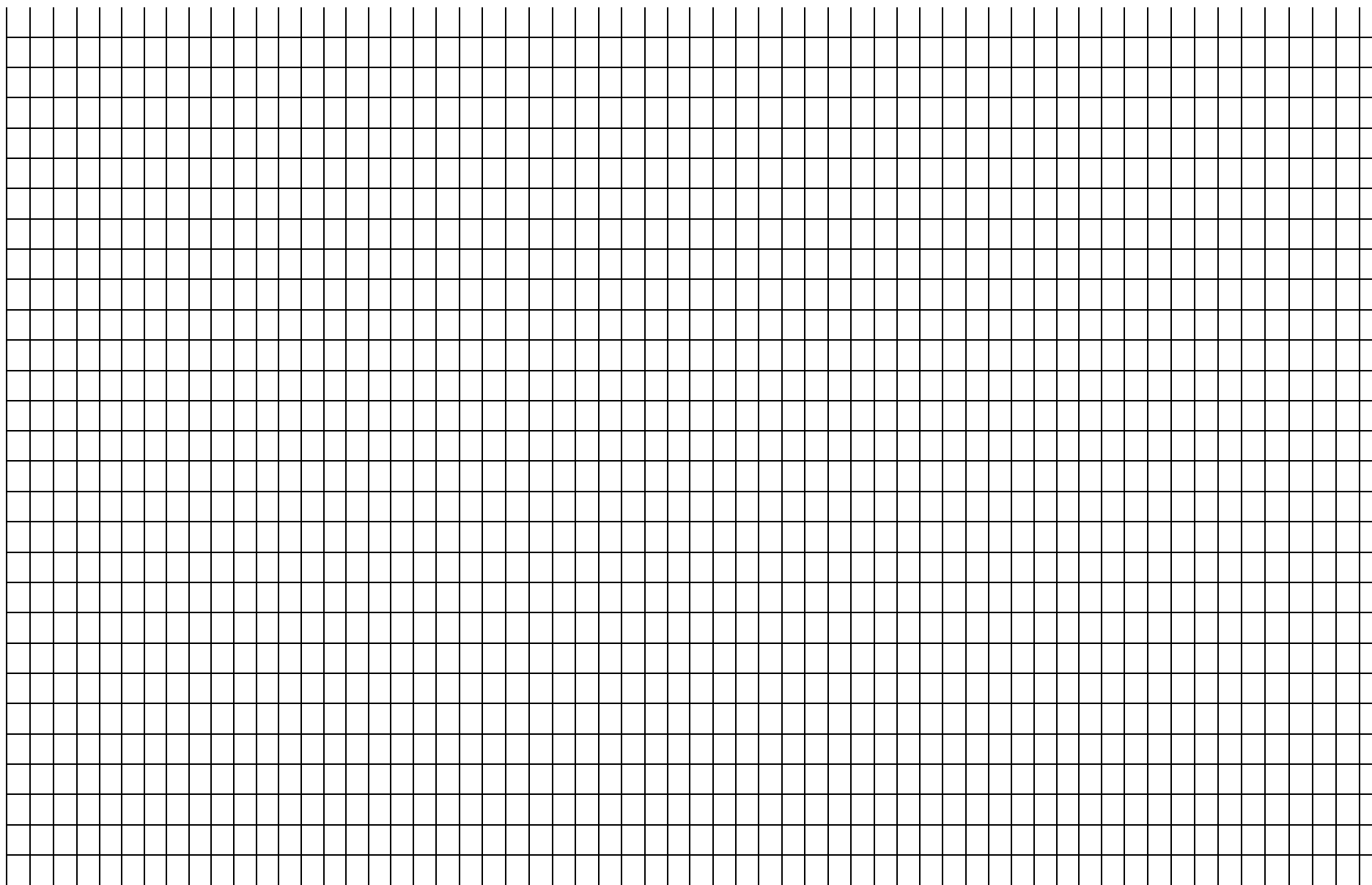
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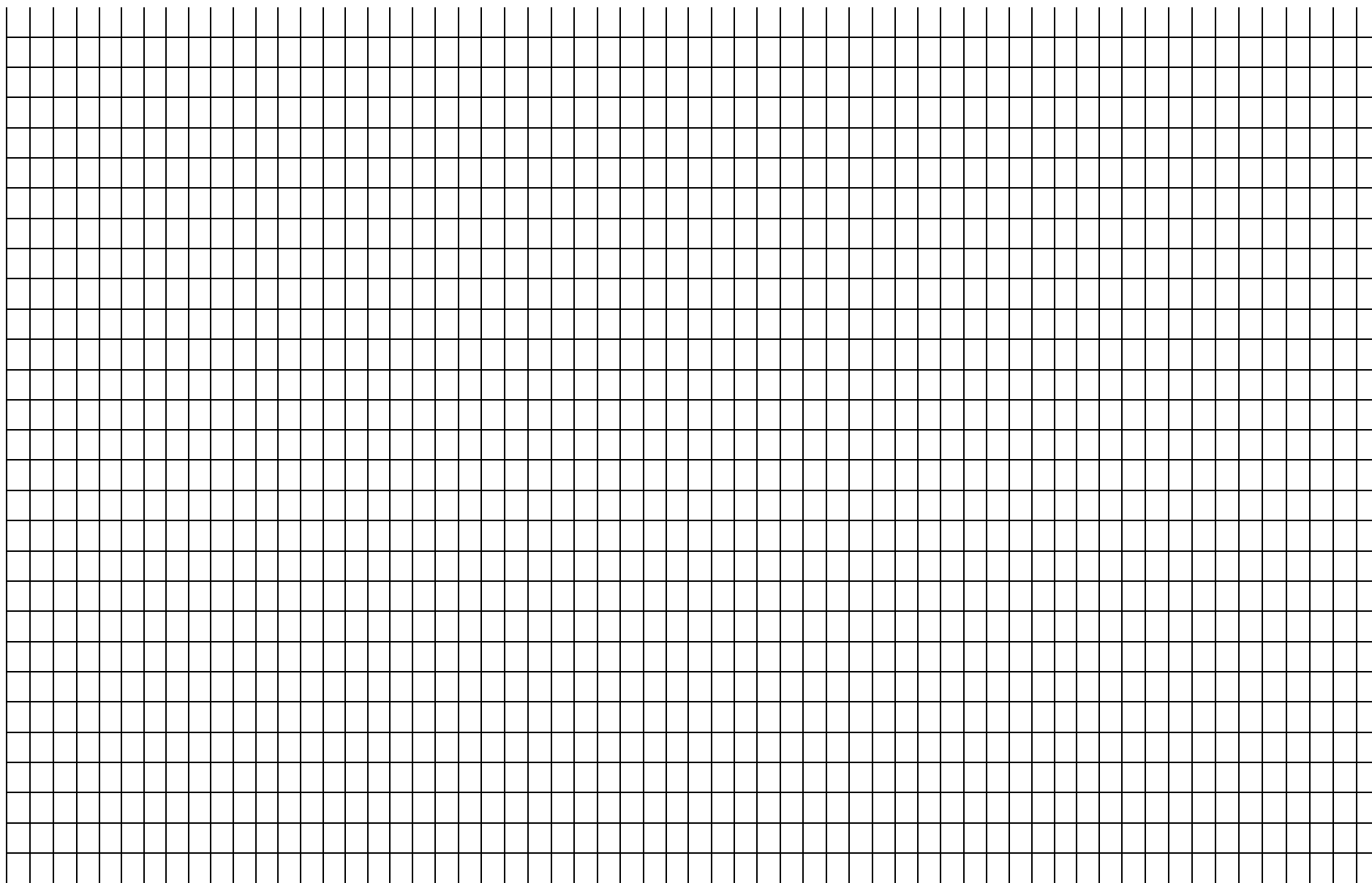




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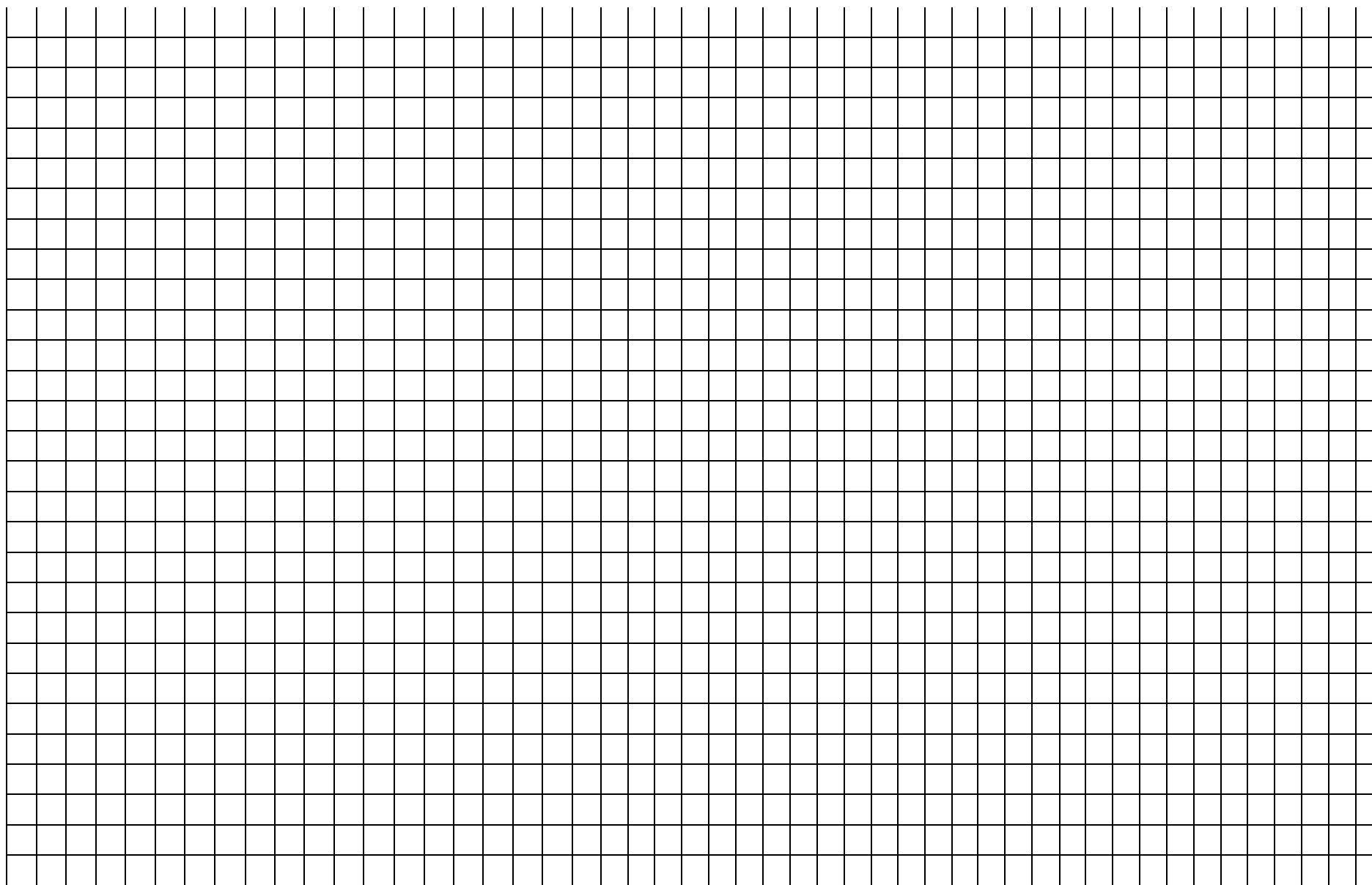


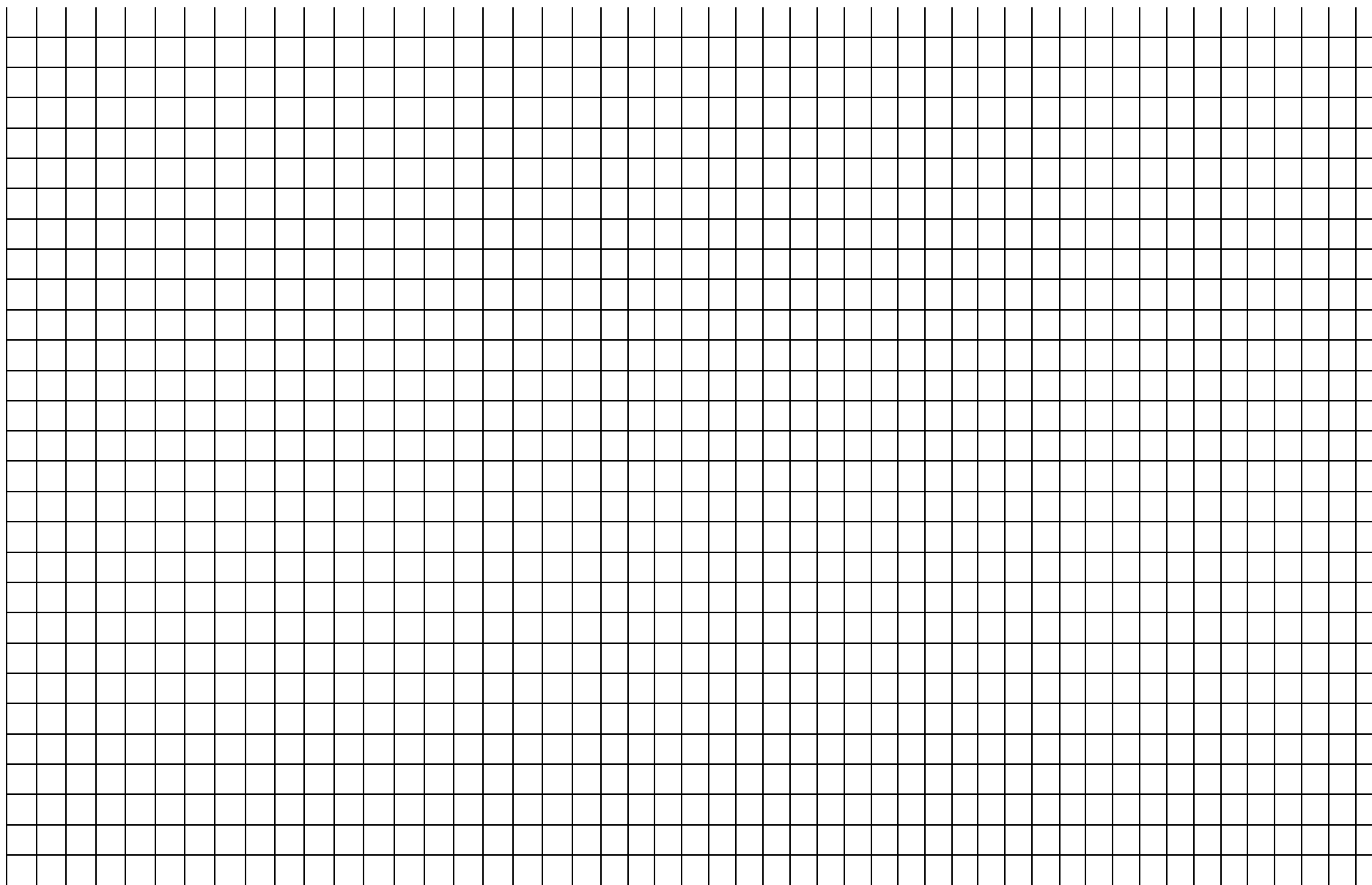


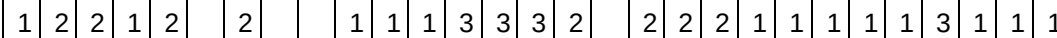
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Clients Exit Interviews (contd...)

q1 81 a	q1 83	q1 84	q1 85 a	q18 5b1	q18 5b1 a	q18 5b2	q18 5b2 a	q18 5b3	am oun t	q1 86	q1 87	q1 88 a	q1 89 a	q1 89 b	q1 90	q1 91	q1 92 a	q1 93 a	q1 94 a	q1 95 a	q1 96 a	q2 00	q2 01	q2 02 a	q2 04	q2 05 a	q2 06 a
1	2	2	2	2				2			2	1	1	1													
2	1	2	1			1	98					1	1	1													
2	2	2	2							2	2	1	1	1													
2	2	2	2								1	1	1	1													
	1	2	2							2	2	2	2	1													
2	1	2	1			1	750 0	1				1	1	1													
2	1	2	1			1	750 0					1	1	1													
2	2	2	1			1	200 0				1	2	1	1													
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			2							2	2	1	1	1												
2			2							2	2	1	1	1												
	2	2	2							2	2	1	1													

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2	1	2	1	1	700	2	260 0	3	500 0	2	2	1	1	1												
	1	2	1	1	700	2	260 0			1	2	1	1	1												
	1	1	1								2	2	2	2												
	2	1	1							2	2	2	2	2												
2	1	1	1					3		2	2	1	1	1												
1	1	1	1			2	500 0	3		2	2	1	2	2												
	1	2	1							2	2	1	1	1												

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ANNEX V: LIST OF HEALTH FACILITIES SAMPLED/VISITED

Akwa Ibom state:

LGA	facility	Service Level	Ownership	Ownership2	HT C	PMTC T	Treatment	Senatorial Zone	Comments
Oron	Oron Christ Victory Medical Centre	Secondary	Private	Private For Profit	1	1	0	S	Visited
Eket	Afaha Eket Holifield Hospital	Secondary	Private	Private For Profit	1	1	0	S	Visited
Ibendo	Okoroutip Health Centre	Primary	Public	Public	1	1	0	S	
Eastern Obolo	Ikonta Health Centre	Primary	Public	Public	1	1	0	S	Visited
Oron	Operational Base Primary Health Centre	Primary	Public	Public	1	1	0	S	Visited
Mkpat Enin	Ikot Inyang Okop Primary Health Centre	Primary	Public	Public	1	1	0	S	Visited
Eket	Utibe-Abasi Clinic	Primary	Private	Private For Profit	1	1	0	S	Visited
Okobo	Mbokpu Oduobo Primary Health Centre	Primary	Public	Public	1	1	0	S	Visited
Urue Offong/Oruko	Ukuda Health Post	Primary	Public	Public	1	1	0	S	Visited
Oruk Anam	Family Foundation Clinic	Secondary	Private	Private For Profit	1	1	0	NW	Visited
Etim Ekpo	Utu Etim Ekpo Divine Love Hospital	Secondary	Private	Private Not For Profit	1	1	0	NW	Visited
Etim Ekpo	Utu Etum Ekpo Health Centre	Primary	Public	Public	1	1	0	NW	
Abak	Ukpom-Abak Primary Health Centre	Primary	Public	Public	1	1	0	NW	
Obot Akara	Nto Edino Primary Health Centre	Primary	Public	Public	1	1	0	NW	
Ini	Ikpe Ikot Nko Health Centre	Primary	Public	Public	1	1	0	NW	Visited
Essien Udim	Adiasim Health Centre	Primary	Public	Public	1	1	0	NW	Visited

LGA	facility	Service Level	Ownership	Ownership2	HT C	PMTC T	Treatment	Senatorial Zone	Comments
Etim Ekpo	Ikot Mboho Health Centre	Primary	Public	Public	1	1	0	NW	
Ikono	Nung Imo Primary Health Centre	Primary	Public	Public	1	1	0	NW	Visited
Ikono	Ediene Atai Health Centre	Primary	Public	Public	1	1	0	NW	Visited
Uyo	Uwakmfon Specialist Hospital	Secondary	Private	Private For Profit	1	1	0	NE	
Uyo	Ubong Abasi Specialist Clinic	Secondary	Private	Private For Profit	1	1	0	NE	Visited
Uyo	Our Lady of Lourdes Infirmary	Secondary	Private	Private For Profit	1	1	0	NE	
Ibiono Ibom	Ibiono Palmer Memorial Hospital	Secondary	Private	Private Not For Profit	1	1	1	NE	Visited
Uyo	University of Uyo Medical Centre	Primary	Public	Public	1	1	1	NE	Visited
Nsit Ubium	Nsit Ubium Primary Health Centre	Primary	Public	Public	1	1	0	NE	Visited
Nsit Ibom	Afaha Abia Primary Health Centre	Primary	Public	Public	1	1	0	NE	Visited
Uruan	Ibiaku Isshiet Primary Health Centre	Primary	Public	Public	1	1	0	NE	
Ibiono Ibom	Ikot Etim Health Centre	Primary	Public	Public	1	1	0	NE	
Ibiono Ibom	Ikpa Ikot Uneke Primary Health Centre	Primary	Public	Public	1	1	0	NE	
Ibiono Ibom	Nsan Health Centre	Primary	Public	Public	1	1	0	NE	
Nsit Ibom	Ikot Obio Etan Primary Health Centre	Primary	Public	Public	1	1	0	NE	Visited
Uyo	Uyo HIV Counselling and Teasting Centre	Primary	Public	Public	1	1	0	NE	Visited
Ibiono Ibom	Idoro Road Comprehensive Helath Centre	Primary	Public	Public	1	1	0	NE	Visited
Uruan	Ekpene Ibia Primary Health Center	Primary	Public	Public	1	1	0	NE	
Nsit Ubium	Ikot Akpan Abia Health Clinic	Primary	Public	Public	1	1	0	NE	Visited
Uyo	University Teaching Hospital	Tertiary	Public	Public	1	1	1	NE	Visited

LGA	facility	Service Level	Ownership	Ownership2	HTC	PMTC	Treatment	Senatorial Zone	Comments
Uruan	Methodist Primary Health Center	Public	Secondary	Public	1	1	1	NE	Visited (not in original sample)
Essien Udim	St. Joseph Rehabilitation Centre	Secondary	Private	Private Not For Profit	1	1	1	NW	Visited (not in original sample)
Essien Udim	Cottage Hospital	Secondary	Public	Public	1	1	1	NW	Visited (not in original sample)
	Ikot Edibon PHC	Primary	Public						Visited (not in original sample)
Eket	Holifield Specialist Hospital Eket	Secondary	Private	Private For Profit	1	1	0	S	Visited (not in original sample)
Etim Ekpo	General Hospital Etim Ekpo	Secondary	Public	Public	1	1	1	NW	Visited (not in original sample)

Anambra state:

LGA	facility	Service Level	Ownership	Ownership2	HTC	PMTC	Treatment	Senatorial Zone	Comments
Anaocha	Nri Primary Health Centre	Primary	Public	Public	1	1	0	C	Visited
Anaocha	Agulu-Uzoigbo Health Centre	Primary	public	public	1	1	0	C	Visited
Awka North	Urum Primary Health Centre	Primary	public	public	1	1	0	C	
Awka South	Climax Specialist Hospital	Primary	Private	Private For Profit	1	1	0	C	Visited
Awka South	Nworah's Hospital	Primary	Private	Private For Profit	1	1	0	C	
Awka South	Police Comprehensive Hospital Awka	Secondary	public	public	1	1	0	C	Visited
Awka South	mbra University Teaching Hospital	Tertiary	Public	Public	1	1	1	C	
Dunukofia	Nkwelle Umunachi Primary Health Centre	Primary	Public	Public	1	1	0	C	Visited
Dunukofia	Ukwulu Primary Health Centre	Primary	Public	Public	1	1	0	C	
Idemili North	Ezim Memorial Hospital Obosi	Primary	Private	Private For Profit	1	1	0	C	

LGA	facility	Service Level	Ownership	Ownership2	HTC	PMTC T	Treatment	Senatorial Zone	Comments
Idemili North	Madueke Memorial Hospital and Maternity	Primary	Private	Private For Profit	1	1	0	C	Visited
Idemili North	Ndubisi Clinic	Primary	Private	Private For Profit	1	1	0	C	Visited
Idemili North	Immaculate Heart Hospital (Nkpor)	Secondary	Private	Private Not For Profit	1	1	1	C	Visited
Idemili South	Ojotu Uno Primary Health Centre	Primary	Public	Public	1	1	0	C	Visited
Njikoka	Beke Memorial Hospital Nimo	Primary	Private	Private For Profit	1	1	0	C	Visited
Njikoka	Nimo General Hospital	Secondary	Public	Public	1	1	1	C	Visited
Anambra West	Mmiata Anam Primary Health Centre	Primary	Private	Private Not For Profit	1	1	0	N	Visited
Ogbaru	Somtoochukwu Maternity Clinic	Primary	Private	Private For Profit	1	1	0	N	Visited
Ogbaru	Kelechi Hospital and Maternity	Primary	Private	Private For Profit	1	1	0	N	Visited
Ogbaru	Iyiowa Odekpe Model Hospital and Maternity	Primary	Private	Private For Profit	1	1	0	N	Visited
Ogbaru	Edmund's Specialist Hospital	Primary	Private	Private For Profit	1	1	0	N	Visited
Onitsha North	Winners Hospital and Maternity	Primary	Private	Private For Profit	1	1	0	N	Visited
Onitsha North	Shalom Foundation Specialist Hospital and Maternity	Primary	Private	Private For Profit	1	1	0	N	
Onitsha North	Kanayo Specialist Hospital and Maternity	Secondary	Private	Private For Profit	1	1	0	N	Visited
Aguata	Nwajiaku Inland Hospital	Primary	Private	Private For Profit	1	1	0	S	Visited
Aguata	St. Patrick Hospital and Maternity Uga	Primary	Private	Private For Profit	1	1	0	S	Visited
Aguata	Umuona Ijeoma Hospital/Maternity	Primary	Private	Private For Profit	1	1	0	S	
Aguata	Achina Comprehensive Health Centre	Secondary	public	public	1	1	0	S	
Ekwusigo	Ibollo Primary Health Centre	Primary	public	public	1	1	0	S	
Nnewi North	Okpunor Nnewichi Rose of Sharon Specialist Hospital	Primary	Private	Private For Profit	1	1	0	S	

LGA	facility	Service Level	Ownership	Ownership2	HTC	PMTC T	Treatment	Senatorial Zone	Comments
Nnewi North	Emecourt Health Centre Nnewi	Primary	public	public	1	1	0	S	Visited
Nnewi North	Nnamdi Azikiwe University Teaching Hospital	Tertiary	Public	Public	1	1	1	S	Visited
Orumba South	Owerre Ezukala I Primary Health Centre	Primary	Public	Public	1	1	0	S	

Lagos State:

LGA	facility	Service Level	Ownership	Ownership2	HTC	PMTC T	Treatment	Senatorial Zone	Comments
Lagos Island	Omni Medical Centre	Primary	Private	Private For Profit	1	1	0	C	Visited
Badagry	Sacred Heart Catholic Clinic (Badagry)	Primary	Private	Private For Profit	1	1	0	W	Visited
Badagry	Anthony Cardinal Okogie Maternity Hospital	Primary	Private	Private Not For Profit	1	1	0	W	Not Visited
Lagos Island	Onikan Health Centre	Primary	Public	Public	1	1	1	C	Visited
Surulere	Havana Specialist Hospital	Secondary	Private	Private For Profit	1	1	0	C	Not Visited
Surulere	Coker Aguda Primary Health Centre	Primary	Public	Public	1	1	0	C	Visited
Lagos Mainland	Mainland Anglican Hospital	Secondary	Private	Private Not For Profit	1	1	0	C	Not Visited
Badagry	Great Phys Clinic	Secondary	Private	Private For Profit	1	1	0	W	Not Visited
Badagry	Ilogbo Primary Health Centre	Primary	Public	Public	1	1	0	W	Visited
Surulere	Surulere Able God Hosital	Primary	Private	Private For Profit	1	1	0	C	Not Visited
Surulere	Duro-Oyedoyin Primary Health Centre	Primary	Public	Public	1	1	0	C	Visited
Kosofe	Maidan Primary Health Centre	Primary	Public	Public	1	1	0	E	Visited
Ojo	Ijagemo Primary Health Centre	Primary	Public	Public	1	1	0	W	Visited
Surulere	Randle General Hospital	Secondary	Public	Public	1	1	1	C	Visited

LGA	facility	Service Level	Ownership	Ownership2	HT C	PMTC T	Treatment	Senatorial Zone	Comments
		y							
Shomolu	R Jolad Hospital	Secondary	Private	Private For Profit	1	1	0	E	Visited
Lagos Island	Sura PHC	Primary	Public	Public	1	1	0	C	Visited (not in original sample)
lagos mainland	Mainland Hospital, Yaba	Secondary	Public	Public	1	1	1	C	Visited (not in original sample)
Kosofe	General Hospital Gbagada	Secondary	Public	Public	1	1	1	E	Visited (not in original sample)
Surulere	Randle MCC, Gbaja	Secondary	Public	Public	1	1	0	C	Visited (not in original sample)
lagos mainland	Alli Dawodu PHC	Primary	Public	Public	1	1	0	C	Visited (not in original sample)
Badagry	General Hospital Badagry	Secondary	Public	Public	1	1	1	W	Visited (not in original sample)

Rivers state:

LGA	facility/substitute	Service Level	Ownership	Ownership2	HT C	PMTC T	Treatment	Senatorial Zone	Comments
Ogba/Egbema/Ndoni	Omoku General Hospital/ Ahoada General Hospital	Secondary	Public	Public	1	1	1	W	Replaced due to security challenges
Ahoada West	Ubeta Primary Health Centre	Primary	Public	Public	1	1	0	W	

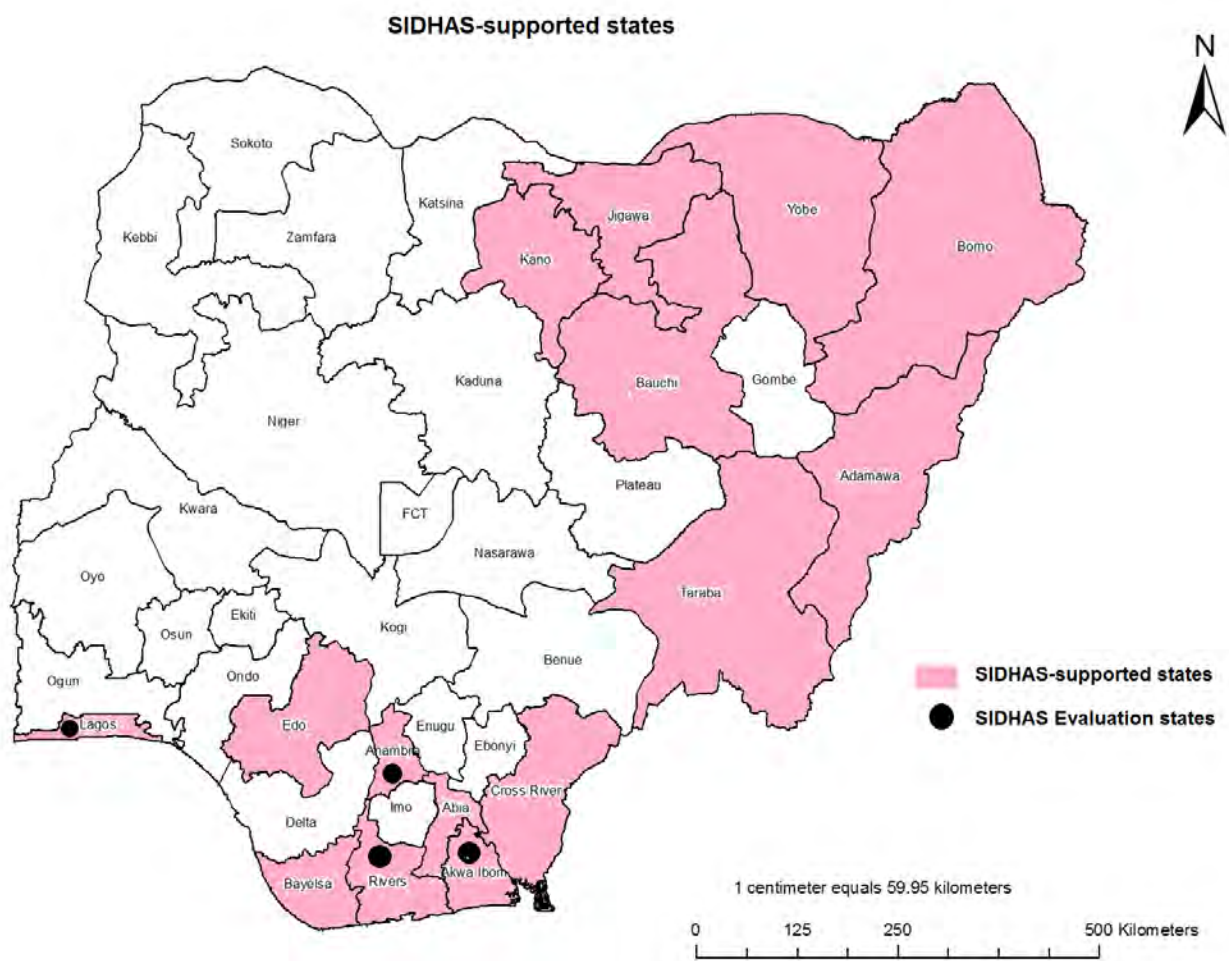
LGA	facility/substitute	Service Level	Ownership	Ownership2	HT C	PMTC T	Treatment	Senatorial Zone	Comments
Ahoada West	Ikodi-Engeni Model Primary Health Centre/ Okarki PHC	Primary	Public	Public	1	1	0	W	Replaced due to security challenges
Degema	Oguru-Ama Primary Health Centre/ Ubima PHC	Primary	Public	Public	1	1	0	W	Replaced due to security challenges
Ahoada West	Udawu Health Centre/ Akinma PHC	Primary	Public	Public	1	1	0	W	Done
Ahoada West	Mbiama Primary Health Centre/ Ahoada PHC	Primary	Public	Public	1	1	0	W	Done
Abua/Odual	Aminigboko Cottage Hospital	Primary	Public	Public	1	1	0	W	
Ogba/Egbema/Ndoni	Amah Health Centre/ Rumukrushi PHC	Primary	Public	Public	1	1	0	W	Replaced due to security challenges
Asari-Toru	Buguma General Hospital/ Churchill PHC	Primary	Public	Public	1	1	0	W	Replaced due to security challenges
Gokana	Terrebor General Hospital/ Pope John Paul Hospital	Secondary	Public	Public	1	1	1	SE	Replaced due to security challenges
Khana	Beeri Model Primary Health Centre	Primary	Public	Public	1	1	0	SE	Done

LGA	facility/substitute	Service Level	Ownership	Ownership2	HT C	PMTC T	Treatment	Senatorial Zone	Comments
Andoni	Inyong-Orong Primary Health Centre/ Mbodo Aluu PHC	Primary	Public	Public	1	1	0	SE	Replaced due to security challenges
Eleme	Onne Model Primary Health Centre	Primary	Public	Public	1	1	0	SE	Done
Oyigbo	Salem Hospital	Primary	Private	Private For Profit	1	1	0	SE	Done
Khana	Bori Inadum Medical Centre/ New Mile One Hospital	Primary	Private	Private For Profit	1	1	0	SE	Replaced due to security challenges
Tai	Kpite Model Primary Health Centre	Primary	Public	Public	1	1	0	SE	
Oyigbo	Obeakpu Model Primary Health Centre/ Beulah Clinic	Primary	Public	Public	1	1	0	SE	Replaced due to security challenges
Khana	Kpean Model Primary Health Centre	Primary	Public	Public	1	1	0	SE	
Ogu Bolo	Ogu General Hospital / Isiokpo General Hospital	Secondary	Public	Public	1	1	1	E	Replaced due to security challenges
Etche	Umuebule Cottage Hospital	Secondary	Public	Public	1	1	1	E	Done
Obio/Akpor	Obio Cottage Hospital	Secondary	Public	Public	1	1	1	E	Done
Obio/Akpor	Spring Hospital	Primary	Private	Private For	1	1	0	E	Done

LGA	facility/substitute	Service Level	Ownership	Ownership2	HT C	PMTC T	Treatment	Senatorial Zone	Comments
				Profit					
Port-Harcourt	Zion Maternity	Primary	Private	Private For Profit	1	1	0	E	Done
Okrika	Okujagu Health Centre	Primary	Public	Public	1	1	0	E	
Obio/Akpor	Elelenwo FSP Health Centre	Primary	Public	Public	1	1	0	E	
Okrika	Ibaka Model Primary Health Centre / Ogan-ama PHC	Primary	Public	Public	1	1	0	E	Replaced due to security challenges
Okrika	Ogbugo Primary Health Centre / Rumuigbo MPHC	Primary	Private	Private For Profit	1	1	0	E	Replaced due to security challenges
Obio/Akpor	Moni Medical/Rumueme PHC	Primary	Private	Private For Profit	1	1	0	E	Done
Okrika	Island Maternity	Primary	Private	Public	1	1	0	E	Done
Obio/Akpor	Samstel Clinic Rumuokokro/Morning Star Hospital	Primary	Private	Private For Profit	1	1	0	E	Facility closed as was affected by Ebola incidence in Rivers.
Port-Harcourt	Paragon Clinic and Imaging/ Meridian Hospital	Primary	Private	Private For Profit	1	1	0	E	Done
Emuoha	Oduoha Model Primary Health Centre	Primary	Public	Public	1	1	0	E	
Obio/Akpor	Eli Johnson Specialist Hospital	Primary	Private	Private For	1	1	0	E	

LGA	facility/substitute	Service Level	Ownership	Ownership2	HT C	PMTC T	Treatment	Senatorial Zone	Comments
				Profit					
Obio/Akpor	University of Port Harcourt Teaching Hospital	Tertiary	Public	Public	1	1	1	E	Done
Port-Harcourt	Braithwaite Memorial Specialist Hospital	Tertiary	Public	Public	1	1	1	E	Done

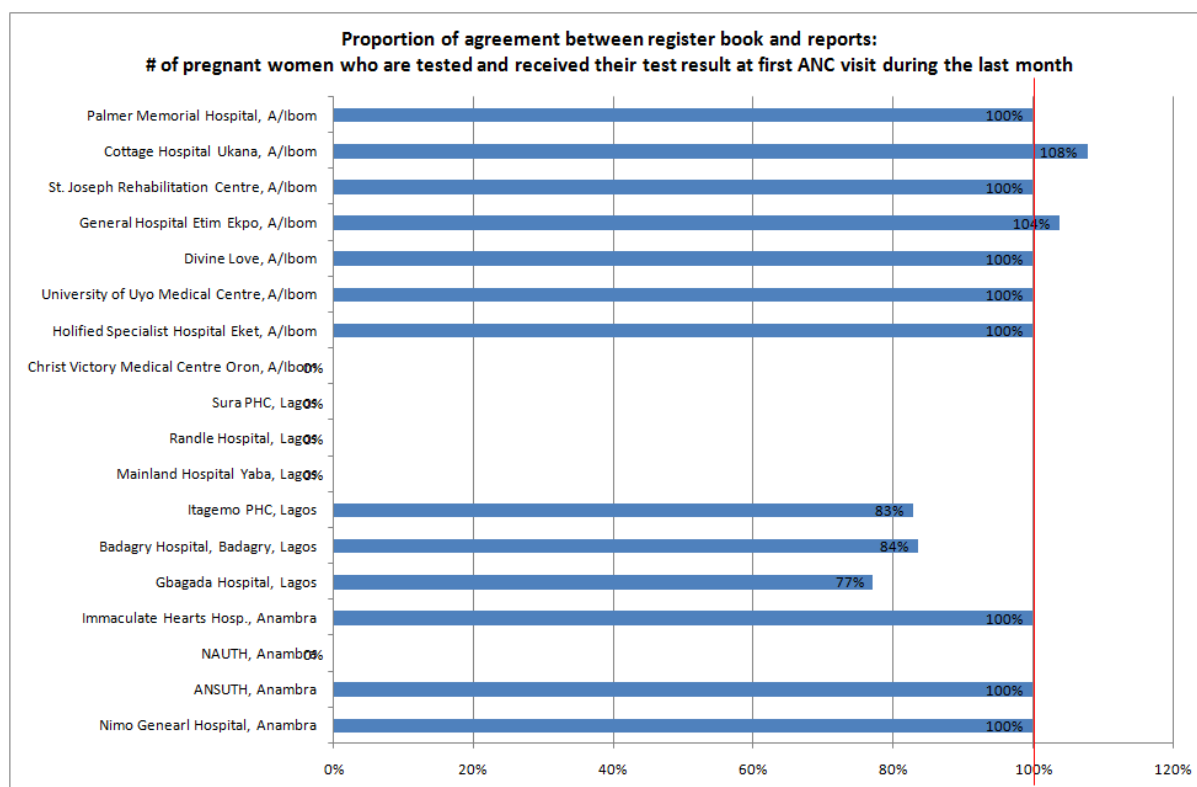
ANNEX VI: MAP OF SIDHAS-SUPPORTED STATES HIGHLIGHTING THE FOUR EVALUATION STATES

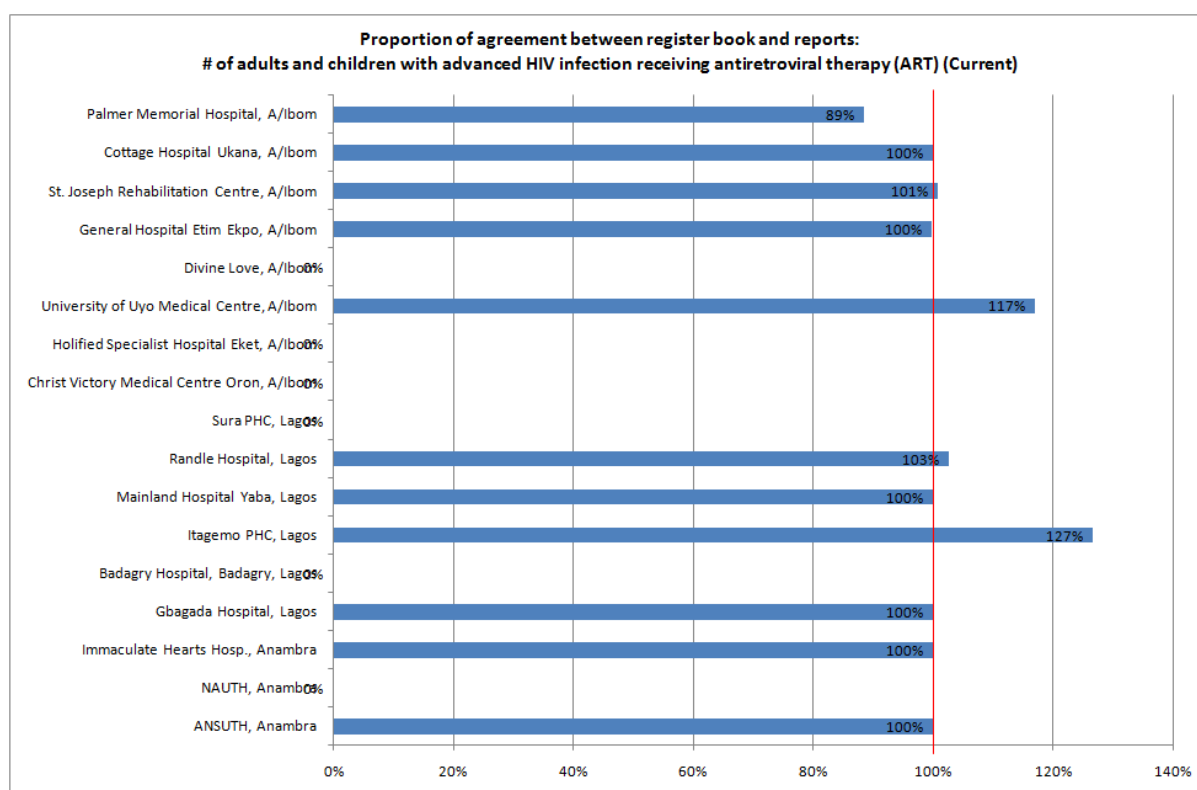


ANNEX VII: CHARTS ON ACCURACY OF DATA REPORTED FROM HEALTH FACILITIES

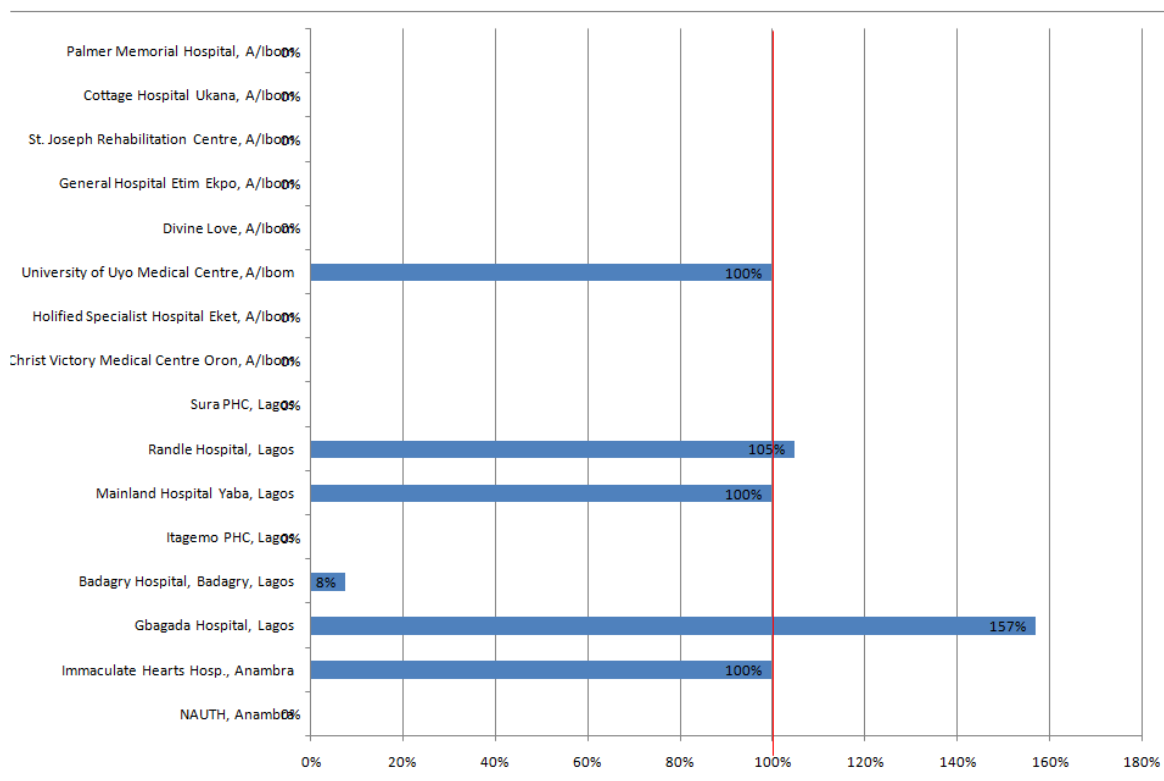
(The Rivers state evaluation team did not verify reported data, hence data from the state is not included in the charts)

Comprehensive/Secondary Sites

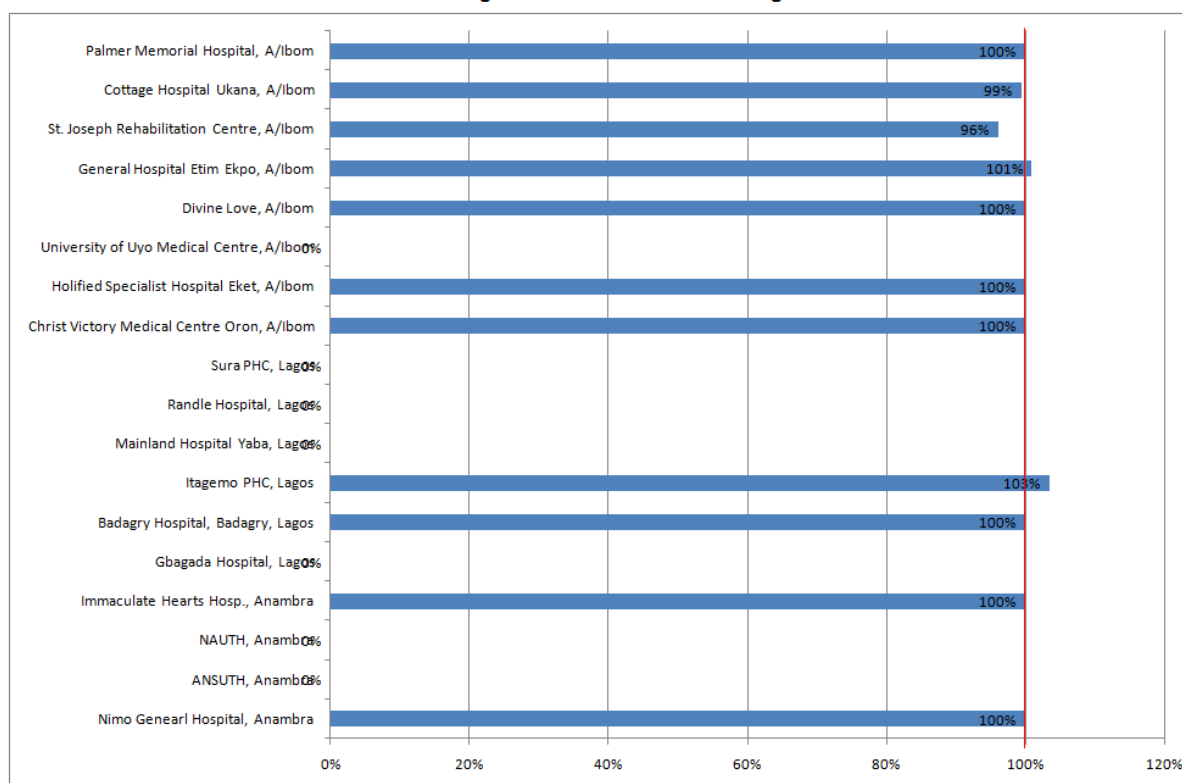




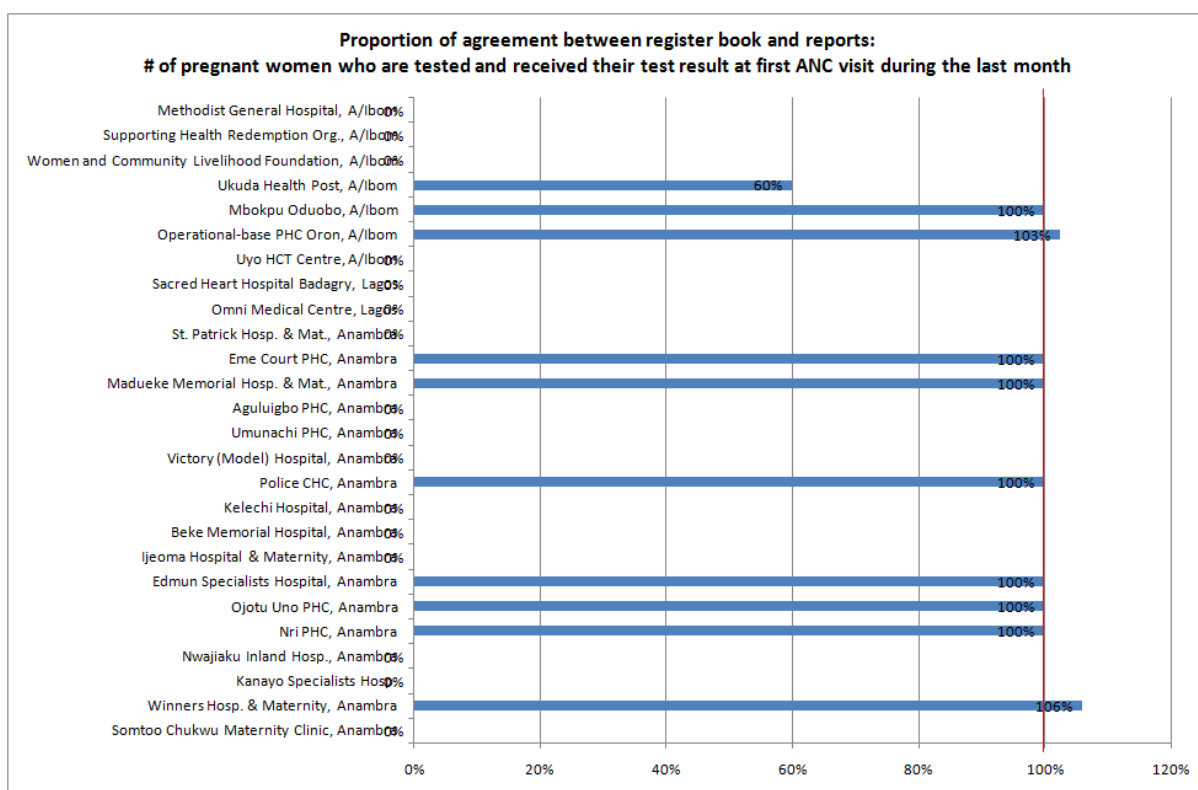
**Proportion of agreement between register book and reports:
Number individuals receiving HIV counseling, testing and their results in TB setting**



**Proportion of agreement between register book and reports:
No of individuals receiving TC and their test results during the last 6 months**



PMTCT Stand-Alone Sites



ANNEX VIII: SUMMARY OF RESPONSES FROM KIIS, FGDS

KII QUESTIONNAIRE SIDHAS PROJECT EVALUATION INTERVIEW WITH STATE AGENCY FOR CONTROL OF AIDS (SACA)

Lagos State/Rivers State/Anambra State

1. How has SIDHAS supported SACA's coordination role and activities in your state?

- They support SACA's work in the Technical Working Group
- Support data analysis at HF level, policy, support events such as World AIDS Day or MNCH week
- SIDHAS does not support them to do trainings directly although previous projects had direct funding for them for these activities. Eg they did training for DHS in the past
- They supported the harmonised AOP development and reviewed the implementation of the AOP
- The partnership framework reduced the community component of the HIV work in the state
- There is HAF which funds the activities of 9 CSO under a world bank project but they integrate with SIDHAS CSOs at the level of prevention TWG coordinator TWG meetings
- LACAs exist in the state but they are not all at the same level of technical capacity and motivation
- LSACA has a budget line from LASG and has its sustainability, capacity building and work plans. There was procurement of test kits by the state government
- SIDHAS supported the setting up of State Implementation Team "SIT" and extended SIT which SACA is a member. The SIT is responsible for HIV/AIDS implementation in the state
- SIDHAS has conducted several training in the state that includes staffs from SACA. We routinely conduct joint site supervisory visits with SIDHAS to health facilities and in the process has mentored SACA staff to be able to conduct independent site supervision
- Currently SACA is able to print the national M&E tools which are distributed to all facilities in the state
- Where SIDHAS has helped in coordination, it has been more on the lower sent of supporting facilities and coordinating implementation at the lower level.

2. How has SIDHAS assisted SACA with its planning and capacity building roles?

- SIDHAS does not support them but they do conduct trainings directly although previous projects had direct funding for them for these activities. Eg they did training for DHS in the past
- FHI supported the harmonised AOP development and reviewed the implementation of the AOP
- There is no concerted effort for institutional capacity building
- They conduct community based activities such as 1.HCT trucks usually staffed by NGOs, 2. TBA engagement for sensitization HIV testing,

- SACA participate in the annual work plan by SIDHAS and it is in this forum that SACA will come up with annual state plan
- SIDHAS as a member of the state logistics management technical working group, M&E Technical working group and SIT provide guidance on planning and implementation of M&E activities in the state and commodity quantification and logistics
- SIDHAS conducted several training for SACA among which are M&E training including DQA, resource mobilization, organizational assessment and report writing
- Supported by SIDHAS, SACA has been able to conduct training of 23 LGA M&E officers across the state
- Occasional support from the SIDHAS project on report writing, is work planning

3. How has PEPFAR rationalization of its support, which has involved changing PEPFAR Implementing Partners, affected coordination and delivery of HIV services in your state?

- The rationalization left Lagos with two partners with different work plans, funding etc, and the challenge once any of the IP rolls out a package for its 10 LGAs, then the government is now left scrambling to fill in the gap by replicating the package across the state
- There is a state work plan to help in coordination
- Rationalization has enable SACA to know which development partners is responsible for what. In the past when more than one comprehensive partner was in the state, it was difficult to say which partner was performing better. It makes coordination simpler for SACA
- The coming of SIDHAS has led to rapid expansion of facilities providing HIV/AIDS services
- With rationalization, SIDHAS has been able to create a state office with all the compliment of staffs that cover all thematic areas which has allowed response to request to be faster instead of going through the zonal offices
- One disadvantage of rationalization is the abandonment of the development of Gene Expert Laboratory. Since IHVN left further development in the laboratory has stopped
- it made a lot of things quite easy. It helped to deal with lower partners to co-ordinate. It simplified processes. Because partners used to move into the state work.

4. How has SIDHAS decentralization of SITs to LITs supported the state in increasing coordination and access to HIV services by those most in need?

- Not applicable, because the LITs have largely not taken off due to lack of funding
- Even though LIT was created to bridge the gap between the state and LGA, it has never played any significant role at LGA. LIT should be strengthened to be able to coordinate services at that level
- A number of partners e.g measure evaluation supplied the state on HMIS
- Use of different platform for data is still a challenge.
- FHI-360 has its own platform which SACA cannot access

5. What role has SIDHAS played in supporting health management information systems in this state?

- FHI SIDHAS trains and mentor M&E staff in the state but they do not support the harmonization of data reporting systems in the state (they have a parallel system)
- SIDHAS supported the trainings on M&E tools and how to capture data. Initially, SIDHAS was providing the M&E tools but currently the state is able to print their tools and distribute to the facilities
- SIDHAS submit duplicate of monthly summary data from facilities to SACA however, in some months report is delay thus affecting the monthly analysis
- SACA should have had access to viewing all the sites, but SACA can't do that.
- FHI has its own DHIS 2.0 which is different from the NACA or FMOH DHIS 2.0
- FHI-360 then gives a summary page to the SACA M&E officer.
- Has had a number of discussion around it.

6. How have SIDHAS staff contributed to your interpretation and use of the HMIS data reported monthly by health facilities?

- The use of data for decision making is still very poor generally although LSACA has the technical capacity and willingness to do that
- SIDHAS has supported monthly data validation meeting when data from facilities are presented by facilities for validation. In this forum, SIDHAS has always use the opportunity to provide update to participant on M&E
- SIDHAS has also supported us to analyze data submitted to SACA and currently we are able to carry out analysis ourselves - sample shown
- The SACA Executive Director. Participates as a member of the joint- SIT to interpret SIDHAS project. This is done as part of the SIDHAS project.
- Getting the whole state data is still a challenge.
- The problem is not quite with capacity; for a while the state did not employ new staff so a lot of trained people who were trained have left.
- The technical person in ANSACA is World Bank project staff (6) so the workload is much more than the staff available.
- The real issue of data analysis and use is not really attended to.
- Prior to now, sees the SIDHAS project as mainly targeted at the SMOH but sees SACA as peripheral 6.4 at the service delivery lent.

6.1 How does SACA ensure the quality of reporting by facilities? What role has SIDHAS played in this?

- There are joint DQAs particularly targeting hotspots with SMOH & partner
- The role of LSACA in SIT is not very strong, SIT is top heavy, with inadequate trained manpower
- SACA conduct data quality assessment at facilities every quarter an activity that is supported by SIDHAS

6.2 How are monthly HMIS reports transmitted from facilities to SACA?

- Through the DHIS

- The facilities submit to LACA and LACA to SACA. World Bank provided laptop computers, internet modem with 12 subscription to each of the 23 LGA for the purpose of monthly reporting

6.3. What analysis of the HMIS data is undertaken at the state level? How has SIDHAS assisted in this?

- Some analysis is made but not for decision making
- SIDHAS has trained SACA on reporting writing including analyzes of data. Currently, we have capacity to carry out analysis of data that are reported from the LGAs

6.4 What changes to HIV services have been made in your state as a result of analysis of the reports?

- Not applicable
- An audit of ART patients in 2013 indicated a huge drop out of patients that were ever enrolled into treatment. We have since strengthened documentation on status of ART patient and facility to intensified tracking of patients and clients
- Also in 2013, analysis of HIV prevalence at LGAs showed very high prevalence in some LGAs. Base on this finding, the Governor called senators from the affected LGAs to work with their constituencies to step up prevention activities. Some of the affected senators went to their various communities to meet with the community leaders

6.5 How is feedback resulting from analysis of the HMIS data communicated to health facilities?

- Yes, via the monthly meetings with M&E officers
- SIDHAS used to provide stipends for communication to facilities. When we notice gap in the form submitted from each facility, we call the facility M&E staff directly. Also during quarterly DQA exercise and routine site monitoring, we provide feedback to the staff on any observed gap in documentation and reporting. Also in a round table meeting during the monthly state M&E meeting we also provide feedback to the facilities

6. Do SIDHAS staff conduct joint supervisory visits with SACA staff to health facilities?

- They mainly go for joint quarterly visits to HF's for DQAs for SACA
- Yes

7. What are the different roles of SIDHAS and SACA on joint health facility visits?

- They both administer the DQA tools
- Through the support by SIDHAS, SACA is now able to carry out annual work plan, print and distribute HMIS tools, conduct independent facility visit and mentoring, able to step down training on M&E to facilities
- SACA is also planning on developing resource mobilization strategies for the state
- SIDHAS should focus on advocacy to the highest authority in the state for the state to be able to own and drive the program

- We didn't see a lot of SIDHAS activities as part of what ANSACA ought to be doing.
- SACA is supposed to give direction such as ensuring that the SMOH does what it is supposed to do.
- Encouraging all the line ministries to have a live budget for HIV in their annual budget.
- Every year there is a budget of about 200 million on the governor's office budget, but the release of the budget is a problem.
- The state could potentially deliver and or maintain services at a much lower cost.
- Believe that if the right advocacy to the governor is made a lot of difference could be made.
- Even when the bottleneck analysis was done, the former governor did not believe that the lack of human resources was not done.

8. The SIDHAS project will end in 2017, only two years from now. What has SACA put in place or planned to continue the activities and training that SIDHAS now provides, after the project ends? What steps can SIDHAS take now to ensure that HMIS reporting continues to enable coordinated service delivery?

- The FHI-SIDHAS PMTCT services scale up did not carry along other project areas requirements e.g. HMIS/M&E capacity requirements. So the scale was not phased and the quality of service provided in some cases was questionable. Even the national PMTCT plan & reporting systems are not adhered to by partners
- Re-orienting support groups away from dependency on financial tokenism

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- Capacity building on negotiation will help to equip the state offices to negotiate with the 360
- FHI-360 was eventually the one who did the baseline assessments and / or picked staff from the hospitals to conduct the assessment, resulting in the shifting of the burden.
- Virtually all the facilities that were assessed didn't meet the standard, but nevertheless the sites were activated to enable FHI-360 meet its target rather than using the opportunity to negotiate with the state to increase the human resources and hold government accountable.
- There should be a costed plan whereby the state's contributions should increase as the donor's part decreases.
- The political hierarchy in the state is more important. Therefore the political opportunities are made more important.
- It should be as part of the initial preparation to sign an agreement.
- SMOH (ask for the SASCP work plan), they are even overwhelmed by the FHI-360 support.
- In practice, many of the activities are carried out by the FHI-360 staff.
- The issue of corruption needs to be addressed and identified as a fact militating against implementation.

- There are still very weak systems in awareness which need to be addressed.
- Even if you put a dog as a governor, the benefits of the corrupt system will accrue to the governor.
- Because the ministry is overwhelmed with responsibility it is often unable to deal with it's responsibilities.

KII QUESTIONNAIRE
SIDHAS PROJECT EVALUATION
STATE MINISTRY OF HEALTH (SMOH/SASCP)
Anambra State/Lagos State/Rivers State

1. How does the SIDHAS Project fit into implementation of your State HIV response?

- The SIT/ SASCP office has no conference room to enhance committee members participation
- The SIDHAS project is perceived as a HIV/AIDS project funded by USAID. A project that succeeded the GHAIN project, however, the SIDHAS approach of integrating both structural and technical services is highly commendable and the SIDHAS project was keen to get government involved hence the SIT. The SIDHAS project is thus seen as a project which is strengthening the capacity of the government institutions to achieve the goals of the HIV/AIDS program in State.
- The project is also perceived as helping the government stakeholders to have ownership of the HIV/AIDS program in the State, as the stakeholders consider themselves being prepared to be able to take over from SIDHAS.
- The chair gave a good understanding of the SIDHAS project, including Scale-up of PMTCT.
- Government capacities have been enhanced
- Talked about sustainability
- Mentioned integration of services; integrating HIV support into the SMOA in a seamless way.
- This has also been demonstrated in step down capacity-building
- Ownership of the project and emphasis on sustainability
- Capacity has been built – master trainers in pharmacy, Lab etc. they have been able to step-down training.
- Also the project has shown the gaps in the existing HR capacity of the SMOH.
- At the facility level, there has been a lot of charges in rendering basic services etc; referral management.
- SIDHAS has also taught people to be conscious of the financial expenses - focus on reports from the field before refund of expenses.
- The massive scale up into the private sector – the PMTCT scale-up
- The collaboration with the private sector is a key outcome of the SIDHAS project.
- The state is now better able to manage commodities.
- Supported the Director Planning, Research & Statistics (DPRS) in printing and using HMIS tools

- In the area of Laboratory services - during GHAIN project, there used to be a 'GHAIN' Lab in comparison to a hospital lab in the same hospital: gave a vivid comparison between the GHAIN lab and the usual hospital Lab.
- Gave a good example of integration of services, for example use of laboratory services for all services
- Integration of personnel: The trained persons in HCT often work across different service points in the facility.
- Indeed. "Where will we be without FHI-SIDHAS?"
- The state AOPs are usually initiated by FHI-SIDHAS because of their technical expertise. In this instance, they facilitate the drawing of the unified annual operational plans by all partners working in the state. The plan for 2014 is available while that for 2015 is ongoing.
- SIDHAS is providing HIV/AIDS prevention, care and treatment which are the necessary services to combat HIV/AIDS epidemics

2. What are the key results and accomplishments you have seen from SIDHAS to date?

- The scaling up of PMTCT facilities has increased access to services in the entire state.
- There is remarkable reduction in the level of stigma due to the SIDHAS educational programs, which has also increased access to services
- SIDHAS support has helped highlighted the HRH gap in the Ministry of Health of the State
- The massive scale up into the private sector has helped the state to improve coordination of the private sector facilities as some of them now report on the National platform
- The State is better able to manage Health Commodities Logistics as capacity has been built to ensure that the staff of the Ministry of Health can better manage their commodities
- Reporting of HIV/AIDS data has greatly improved with SIDHAS, the capacity of Facility and Ministry staff have been built by SIDHAS to improve reporting
- The facilities have greatly benefitted from SIDHAS, during GHAIN, 'the project did their thing' while SIDHAS has ensured integration such that infrastructure and commodities provided by SIDHAS is used for any client even when the client is not accessing SIDHAS supported services.
- FHI major accomplishment in this regard is program coordination of HIV services between MDAs, IPs and other partners
- They also sponsor HIV M&E data collation through hosting TWG meetings etc
- They also do health systems strengthening, capacity building and infrastructure development with supply of lab equipment and lab QA
- They also do integrated mentoring and monitoring using CQI
- They jointly with the state, developed a sustainability plan which have even

been costed, however they acknowledged that Nigeria is not ready to take up the lab services transited under the agreement with GoN. Even though Lagos state is potentially one of the states in the country which has the financial might to bear the cost

- Technical capacity building SMOH, SACA, Hospital management board, facility staffs,
- Increase access to HIV services because the number of services outlets for various HIV/AIDS services has increased tremendously
- Better coordination of HIV/AIDS services in the state

3. What assistance has SIDHAS provided to the SMOH for the state HIV response?

- SIDHAS supported the institution of the SIT, and has provided funds to support some of her activities thereby empowering the State to take charge of the HIV/AIDS program. SIDHAS also supports facilities with necessary equipment and commodities to provide services including Outreaches, Client Tracking, Sample Transfer etc
- They helped the state in training service providers, M&E staff, ISS
- The setting up of SIT chaired by SASCP is a good thing. It has increased our technical capacity to better implement HIV/AIDS services
- We have attended several trainings organized by SIDHAS
- SIDHAS has guided the ministry in terms of planning and implementation of HIV/AIDS services in the state

3.1 How useful has SIDHAS assistance for communication systems [phone email] been?

- SIDHAS provides monthly funds for telephone communication. A laptop computer, a scanner and a printer have also been provided to improve reporting, while the SASCP office/SIT Secretariat has access to SIDHAS internet services that is house next door.
- SIDHAS provides monthly communication's support of about N40000 to the SIT. Also provides support to facilities for communication.
- They seem to pay some money for staff as a reimbursement of expenses.
- Has a Scanner in the office which has not been connected because they have not been trained.
- Provision of internet services for the SIT
- Not applicable
- SIDHAS provided training to SIT and were providing stipends to SIT for phone until October 2014 when payment was stopped

3.2 How effective has the support for transportation been in enabling transportation of staff/commodities/lab specimens/patients?

- SIDHAS provide funds for sample transfer, which has increased the effectiveness of the HIV/AIDS program in the state.

- Provides transport subsidies to members of the SIT for attendance at meetings
- Gave examples of the procurement of supply chain system.
- Fairly effective with use of the requisition (CRIEF) form system
- We requested for a vehicle from SIDHAS to support movement of staffs for supervision and transportation of commodities but the request was not granted
- However SIDHAS provided vehicle to convey seed stocks to facilities during sites activations
- Currently facility staffs come the ministry to pick their commodities

4. How has SIDHAS contributed to your ministry staff development and training for key technical and administrative personnel? What plans are underway for the SMOH to fully take on these functions over the next two years and beyond the SIDHAS project?

- Many people and institutions in the State have benefitted from various capacity building programs of the SIDHAS project such that there are Master Trainers from the Government Staff who currently support SIDHAS trainings and are capable of continuing such when SIDHAS exits.
- There is no defined plan yet for continuing these capacity building activities.
- None, although FHI has done lots of training and supported them to draw up a sustainability plan
- SIDHAS conducted a lot of training for ministry staffs including TOT. Currently we have pool of trainers who can conduct training in PMTCT and HTC as an outcome training of TOT by SIDHAS

5. How has SIDHAS assisted in strengthening the State procurement and supply chain system for HIV?

- The capacity of staff in the facilities and the Ministry of Health who manage commodities have been built by SIDHAS to improve reporting which has also helped in the forecasting for drugs and commodities
- CRIBBS report collection
- The state & LSACA once did a joint procurement for test kits but that has not been possible for ARVs partly because of their cost
- SIDHAS started the state technical working group on commodity logistics before the takeover by SCMS
- SIDHAS has trained facilities on the use of combined report, requisition, issue and receipt form (CRRIRF) which is used for retirement and requisition for commodities

6. What assistance has SIDHAS provided the SMOH with planning and management of HIV services?

Probe: human resource planning, monitoring and evaluation, technical oversight, staff supervision and quality assurance. What form should future assistance take?

- With SIDHAS support the SIT has been able to address HRH issues that arise in facilities.
- No specific initial capacity building assessment: no joint action plan;
- There were clearly identified gaps within the SIT
- Only the chairman saw the initial MOUs and sub-agreement
- The work plan is available to members of the SIT.
- On a monthly basis, the financial transactions reports are available to the chair for SIT to review and sign off.
- They coordinate the joint state AOP
- In the first year we were invited to participate in the annual work plan by SIDHAS. In that process we also learnt how to develop state annual work plan. Currently we are able to develop overall work plan for the state that guide HIV management and services
- Even though we are able to develop the state work plan, we have not been able implement them because of lack of funding. Our government has not shown the desire financial commitment therefore we will appreciate if SIDHAS can help advocate for more political will and financial commitment

7. What support has SIDHAS provided to staff within your ministry for mentoring and supportive supervision; in-service training at health facilities; and for workshops and other off site training?

- SIDHAS has supported the conduct of Joint Supportive Supervision in the past as well as visits to address issues that arise in the facilities. However, the schedule of the SIT members does not allow them to participate in the visits regularly.
- SIDHAS has built the capacity of Ministry staff as Master Trainers, and they facilitate SIDHAS supported trainings in the facilities.
- FHI staff provides mentoring support to staff of health facilities in the state
- We have been involved in joint supervision to health facilities with SIDHAS during which facility staffs are mentored base on findings during the visit and any other issues that need to be addressed in the facility
- Many of the facility staffs ranging from laboratory, pharmacist, M&E , Nurses, Doctors etc have attended several trainings supported by FHI

9. What assistance has SIDHAS provided for supporting HIV mentors and other community volunteers in your state?

- They have facilitated their employment by the state although FHI pays their stipend
- In the past SIDHAS had engaged, trained, and pay stipend to community volunteers who helped to augment shortage of manpower at the facilities. Currently SIDHAS is no longer supporting the volunteers and many of them have left the services although a few are seen in the some facilities

10. How has SIDHAS supported capacity building for SMOH staff and other health workers in your state?

- Training and Capacity needs assessment was not conducted by SIDHAS, but Training plans are made during joint annual workplan development that identifies the trainings that particular individuals will be attending based on their perceived need as related to their job positions
- **Mainly, through trainings and on site mentoring visits**
- **SIDHAS has conducted series of trainings for SMOH staffs as well as staffs from facilities**

11. Does SIDHAS conduct joint supportive supervisory visits to health facilities with SMOH staff in your state?

- The SIDHAS staff accompanies the Supervisory team during visits, but because the SIT members are frequently engaged at dates designated for such visits, SIDHAS staff are encouraged to conduct the visits on their own in such circumstances. The SIDHAS staff also co-opted LIT members during the visits.
- the supervisory visits are joint: gave an example of a transfer of a key staff whose capacity had been built.
- gave an example of financial charges for CD4 at St. Charles Borromeo Hospital. There are joint supervisory visits with SIDHAS project
- the supervisory visits is in the work plan but often.
- there was an attempt to get the local team involved through the LIT.
- LITs were inaugurated in three different locations ---- in Zones
- **Occasionally**
- **Yes, but sometimes they go on their own**

11.1 What are the respective roles of SIDHAS and SMOH staff during these supervisory visits?

- There are no defined roles and responsibilities, the team members usually take up roles and responsibilities as required during the visits.
- **We both walk through the facilities, review records, mentor staffs and provide feed back at the end of the visit**

12. Does SIDHAS staff ever provide direct service delivery on a routine or ad hoc basis [in an emergency or in health facility staff absence]?

- No, SIDHAS staff do not provide direct services
- **Yes**
- **No**

13. Does your state have an Integrated Health Data Management Team? If Yes how does this differ from the State Health Data Consultative Committee. Do you have TORs for these structures?

- The State has an IHDMT exists in the State. It is a team with representation from all Ministries that have programs related to health of which the data is relevant to the MoH.
- The SHDCC is a smaller team with 23 members and all of them are members of the larger IHDMT. The SHDCC held once in 2012 and other attempts at holding meeting failed. The committee is supposed to discuss health issues as it relates to the state and proffer strategies for addressing health problems.
- YES; the HDCC has a wider team of members. the IHDMT is made up of more technical.
- HDCC- is wider than the IHDMT.
- SIDHAS conducts monthly M and E meetings in the facilities. The HMIS officers from the DPRS is part of those monthly meetings.
- The reporting rate from the facilities was low until the SIDHAS trained the staff at the facilities.
- The monthly data meeting are held at the LGA including the private sector facilities; it has helped the reporting rate. Has been tremendous.
- They also ensure the provision of tools for the facility
- FHI- 360 prints the tools and sends it directly to the facilities; the tool are national tools.
- TOT
- No, only an M&E TWG
- The Integrated Health Data Management Team is supported by SIDHAS with the aim of bringing all the stakeholders in the states to triangulate data generated from all service area. The idea was conceived because all the arms of government agencies were reporting different figures every month. At the end of the monthly meeting, each agency is served the same data.
- The state Health Data Consultative Committee was formed by DPRS who is the custodian of the platform for reporting FMOH

14. Does the SMOH receive the HMIS monthly reports on HIV services from health facilities?

- The SMOH receives HIV data from the facilities on monthly basis on HMIS
- Yes
- Yes, during the monthly M&E meeting the final monthly report is shared with all stakeholders

14.1 How does the SMOH use these reports to monitor facility performance in the provision of HIV services? What support does SIDHAS give the SMOH for this?

- SIDHAS supports monthly M&E meetings at the LGA level where data is collated and reviewed by facility basis. Members of the SIT review the HIV data on monthly basis to identify gaps in reporting and address such with the

respective facility. The TWGs also utilize data to review and address facility issues.

- E.g. issues of poor laboratory performance. E.g. Ekwulobia general hospital
- **Mainly, the data is not used for the purpose stated**
- We usually perform analysis using the data to evaluate HIV services within the state
- SIDHAS as part of M&E training taught on data analysis and use

15. Does SMOH receive regular feedback reports from SACA, on the analysis of the monthly HMIS data on HIV services?

- linkage between SACA and SMOH has been weak. SACA tends to use NNRIMS.
- There has been attempts to enhance linkage between the SACA and SMOH
- SACA occasionally sends feedback. MoV
- **No, although they together in the M&E TWG are usually invited to a joint AOP meeting**
- No, SMOH does not report to SACA but report directly to FMOH. There no feedback is expected from SACA. Feed back to SMOH is usually from FMOH

15.1 If yes, what changes have been implemented as a result of the analysis of the monthly HMIS reports on HIV services?

- **Not applicable**
- A query was raise that there is very prevalence of prevalence among expose babies in University of Port-Harcourt Teaching Hospital. This prompted further review of the data reported over the months. It was found out that most of the HIV positive expose babies were infants born outside the hospital but came to the hospital for immunization from where they were referred for EID.

15.2 How has SIDHAS supported the SMOH on implementing the change resulting from analysis of the monthly HMIS data?

- The M&E meeting supported by SIDHAS, provides the opportunity for addressing issues that arise from data analysis.
- **Not applicable**
- As a result, HIV testing recommended for infants delivered outside the hospital who came for immunization or other services

16 Does the SMOH have a copy of the SIDHAS MOU signed with the state governor? Do you have a copy of the sub-agreement signed between SIDHAS and the SMOH which applies to all program elements including training and procurement?

- The current copy of the sub-agreement is not with the SIT, but with the Commissioner for Health. It has not been sighted by any members of the SIT, except the Chairman of the SIT.

- Yes, but we did not sight them because the agreement has not being finalised to the satisfaction of state stakeholders. The current one is up for renewal
- Yes

16.1 Are there budget details in these agreements?

- The agreement is not in place
- Not applicable
- The copy I have does not have budget in it

16.2 How is the SMOH monitoring implementation of these agreements?

- During the annual workplan development, the agreement is reviewed to identify the status of project attainment and plans are made for the next year
- The SMOH is responsible for overall coordination while the HSC and SPHCMB implement at level of secondary & PHC facilities. The SIT alone is incapable of overseeing all aspects of HIV services in the state
- We have not been able to monitor the agreement because we do not the financial obligation and we are not involve in the financial management of SIDHAS project

17 Has SIDHAS assisted the setup of the State Implementation Team/State Management Team? What are the terms of reference for these teams? How these differ from SASCP terms of reference?

- SIDHAS facilitated the formation of the SIT in the State, while a UN agency is facilitating the formation of a SMT. The SIT is just being integrated into the MoH as it had been domiciled in SACA and the constitution had been challenged by personality issues between some staff of the MoH.
- There is a SIT which was established in June 2012. Trainings were conducted for members according to the agreed AOP. They play a mainly supervisory role in the state.
- The SIT has no budget line from SMOH but the Director Disease Control has asked for that to be included in the 2015 budget
- The recommendations of SIT are not enforceable and their number is inadequate to cover the state. This leads to the plan to decentralise and form LITs. However, LITs have been difficult to establish across the state partly because of the issue of funding
- Yes
- SASCP is responsible for HIV/AIDS program in the state, the SIT is involved in running the program, oversee the facility and the stakeholder activities

17.1 How has SIDHAS supported the activities of the SIT? Are there any performance appraisal processes for the SIT?

- SIDHAS provides funds for communication. Funds being provided for transportation and refreshment of the members of the SIT for meetings has stopped.
- The SIT is appraised by SIDHAS local and national offices through the data of the state.
- through reports in form of supervisory roles.
- currently done jointly with SIDHAS
- certain things were not clear.
- SIT was a "stand- alone" unit, the immediate past director of primary health care to the program late.
- By supporting the work of the M&E TWG
- The SIT is also instrumental in developing the state work plan
- SIDHAS has built the technical capacity of SIT through series of training and mentoring. Annual work plan is jointly carried out by SIDHAS and SIT and SIT has been involve in joint supportive supervision to facilities
- CQI tool was used by SIDHAS to assess the capacity of SIT at the beginning and base on that we have continuously review our performance to determine the level of our improvement

18. Does the SMOH has a sustainability plan for continuing the contributions that SIDHAS is currently providing so that after the project ends in 2017, the HIV services will continue?

Probe: training/systems strengthening/transport/communication/commodities

- The current status which SIDHAS has helped the State attain serves as a baseline for planning for when SIDHAS exits.
- There is no documented plan in place.
- Yes there is a sustainability plan
- Yes, the SIT will be able carry on the activities of SIDHAS but the challenge if funding

19. During the remaining two years of SIDHAS, what are the other areas of assistance the SIDHAS Project could provide to support greater sustainability of quality HIV services by the SMOH?

- FHI-SIDHAS should advocate for the re-negotiation of the partnership framework so as not to erode the hard earned gains made over the years
- Harmonization of the different reporting platforms
- Continue with the current support to SIT and not SMT

20. At the state level, what is needed to enhance the GON's coordination and strategic planning for HIV response?

- SACA should be in a position to be an overarching role
- There is a problem at the national level.
- In practice the control of HIV/AIDS is now worsened.

- Better political will at the federal and state level
- We require international exposure to be able to measure up to international standards
- We need vehicle for regular supervision

RECOMMENDATION:

- SIT should remain but let's see and hope that SMT will be much better
- Those who have access to state funds are in SMT.
- SIDHAS has made a huge investment in the management of HIV/ AIDS.
- Senior Special Assistant to the governor on Donor Funded projects will enhance political connectedness
- "our leaders listen more to international partners than to the staff".

21. What changes, if any, has SIDHAS supported in the coordination roles of SACA, SMOH and LACAs?

- FHI supports the TWG component of SIT which is headed by the LSACA head of M&E and they meet regularly

22. How has SIDHAS contributed to strengthening capacity for managing and delivery of quality HIV services at the State, LGA and CSO levels, and at all service delivery points?

- SIDHAS has provided equipment and commodities to improve laboratory services and access to quality health care for the population of the State. The capacity of persons who deliver services in the facilities has been greatly enhanced to deliver quality services while the capacities of the staff of the MoH have been enhanced to be able to support and supervise the facilities.
- FHI SIDHAS has conducted lots of training at service delivery points for a variety of service providers especially for lab staff in collaboration with SMOH
- This is in addition to a strong on site mentoring approach by FHI SIDHAS staff
- They also work with sub-grantees to provide community services

23. What support has SIDHAS given the SMOH to improve systems and capacity for HRH planning and management?

Probe: Do you have a State HRH policy and plan that incorporate expanded service delivery for ART and PMTCT ?

Probe: How have staffing levels at health facilities across the state changed?

- The staffing level is still critical, but FHI has supported the recruitment of volunteers at health facilities across the staff who were given letters of appointment by state government but whose stipend are paid by FHI last year. Although there is currently a halt in the payment in the last 3-4 months
- No, The state HRH policy development is vested in the HR department and it is generic (not only for HIV services). The state HRH policy was concluded last year but its implementation is still ongoing
- HRH is the responsibility of head of services who is the administrative director for all civil services and are responsible for all issues related to staffing

24. How have PMTCT and ART services become more accessible through SIDHAS support?

Probe coverage and utilization

- With the engagement of the private facilities, SIDHAS succeeded in providing HIV/AIDS services to the 70% of the State's population who access health services in private health facilities. The coverage has also increased by the increased number of health facilities that have been engaged to provide PMTCT services in the public sector.
- With the reduced stigma resulting from the educational activities of SIDHAS, people access services freely now compared to the past.
- The reporting rate of health facilities listed on the electronic NHMIS has greatly increased as more facilities report monthly on the electronic system, 'improving the image of the State' in National meetings where Anambra State had hitherto performed poorly in reporting. The contribution of the private sector to the State report has also enhanced the effectiveness of the reporting system in the State.
- SIDHAS ensures that reporting tools are always available in the facilities, the tools are delivered directly to the facilities by SIDHAS. They also review indicators with the facility staff during monthly M&E meetings to ensure that all the staff are conversant with the indicators the reporting.
- There has been expansion especially at PHC level but the utilization maybe low because of the strike
- Before SIDHAS, we had only very facilities providing PMTCT and ART in the states but currently some many facilities in the state are providing these services

25. How has SIDHAS supported SMOH advocacy with the State Government to secure future increased SMOH funding and staffing, for sustaining delivery of quality [expanded in AkwaIbom only] ART & PMTCT services?

- SIDHAS has supported several advocacy visits to the past governor of the state but no results as the former governor is perceived as not being interested in funding health programs.
- To improve the outcome of future advocacy visits, there will be need to identify persons who are close to the governor, and go through them to the governor, since it is clear that some persons can influence governors better than the Commissioners.
- No
- The country director of SIDHAS was in the state last year to meet with the commissioner of health and other stakeholders

26. How has PEPFAR rationalization of its support, which has involved changing PEPFAR Implementing Partners, affected HIV service delivery in your state?

- The rationalization has strengthened the support being provided by SIDHAS, with the cohabitation of SIDHAS and the MoH, it has been interaction between the bodies better. Support from SIDHAS is more readily available unlike when the support was coming from a zonal office.
- The rationalization exercise helped in establishing a lead USG partner in Anambra state
- PEPFAR rationalization has helped in the availability and responsiveness of the partner to the state government.
- The initial concept was to get in directors as members of SIT
- There should be a renegotiation of the partnership framework so as to return the earlier transited lab (chemistry tests) to the package of tests conducted free for patients because patients are now having to pay for those tests
- This is a positive change. It has reduce conflict among IPs and allow for quick response by SIDHAS

27. How has SIDHAS decentralization of SITs to LITs supported the state in increasing access to HIV services by those most in need?

- With the LITs support for the facilities has increased.
- The decentralization of SITs to LITs has largely not occurred in the state because of challenges of funding. But this has not necessarily prevented expansion of access from taking place
- It allows for stronger participation of stakeholder participation and commitment at the grass route even though competency is very low at that level. Unfortunately the support for SIT and LIT has stopped

28. Has SIDHAS engagement of the private sector increased access by those most in need? If yes, how?

- Very much
- 70% of the population of State access health care services from private facilities, these persons are now being reached by the State HIV/AIDS program unlike in the past without SIDHAS.
- Other matters arising
- Employ more staff for the SASCP
- High-level advocacy to manage the balance of members of the SIT for example, the requirement of directors to be members of the SIT has led to less and inadequate time for their primary assignments (e.g the Chair of SIT is the Administrator of the Hospital Management Board).
- Advocacy briefs – about 3 previous high-level advocacy were conducted in the past without much success.
- Mobilise the individual who are close to the governor
- Need
- FHI-360 SIDHAS is there pushing hard to help with advocacy

- Advocacy to LGA
- Governor believes that a lot of partners are in health and that more are coming so they tend to move their resources to other areas of the state that do not have funding.

Service –Gap Analysis:

- SIDHAS has trained two staff in Planned Preventive Maintenance (PPM) ---- one has retired: there is a secular that prohibits a retired staff on PPM--- most of the equipments are in the lab, which are usually in the facilities.
- The facilities keep records on when the PPM will take place and communicate to the SIDHA and FHI-360
- Most of the equipment have back-up
- SIDHAS call their contractors to maintain the equipment
- The trained ppm of the state
- The ppm policy does not include training given seems not to be enough to deal with the case
- “Mobilisation of the SIT to go for supportive supervision/ mentoring seems not to be coming”
- “Support for communication is diminishing”
- “It is now becoming challenging for the SIT to meet up with its responsibilities”
- “Recently, the provision for the comfort of members of SIT has decreased, No provision for lunch after long meetings,” etc.
- SIDHAS should step-up to meet with the governor.
- The current governor of the State has soft spot for health and is already given approval for the training of private facility staff on DHIS. A Special assistant to the governor has been appointed for Donor funds
- Unless there is sitting allowance, it will be difficult to get the Commissioners to attend stakeholder meetings on HIV/AIDS
- Yes, but at a price. The private health facilities were a major alternative in the state during the current strike action by health workers. Bearing in mind that PMTCT & HCT services are free in FHI supported private facilities
- Yes
- Particularly some patients for privacy prefer the use of private facilities. This group of people are assessing services from the private facilities

NIGERIA SIDHAS MID-TERM EVALUATION
Key Informant Guide for Organizations with Subgrants
Civil Society & Community Groups (CSCGs)

Lagos state/Anambra state/Rivers state/Akwa Ibom state

1. List and description of HIV services provided this or through this Organization (HTC, PMTCY, Treatment, Others)

- **BLYSON:** They cover Ojoo, Apapa and Kosofe LGAs in Lagos and are linked to dedicated health facilities in those areas where they work eg Ojoo PHC which are in turn linked to facility and community support groups. The services they provide include community HCT, Sexual & Medical Prevention for MARPS, Community Care & Support and community OVCs.
- There are annual targets for the community HCT services that they mainly provide at hotspots & FHI supplies them with test kits. They are also linked to the LGA health educator for their work with HCT, OVCs & MARPS
- The support group meets monthly and are provided with moral and peer adherence counseling, with emphasis on living positively with dignity. They send text reminders for meetings to support group members but this is not very effective except at highly committed sites such as Gbagada & Apapa where at least 20 out of 30 support group members tend to respond to their reminders. Their target for the establishment of support group is at least 1 support group per LGA, however Ojoo is yet to have a support group, the current one is nascent
- They are planning to facilitate the engagement of support group members as volunteers wherever such opportunities arise between now and March 2015
- They are also working to re-orient support group members from dependency on financial handouts. FHI also supplies LLINs to pregnant women and conducts de-worming of PABAs as well as home visits so as to encourage members to attend support group meetings
- They also conduct sexual prevention which targets BCC to commercial sex workers so as to address their challenges. For example, when they became aware of the series of levies imposed on CSWs by hotel owners which may put them at risk unsafe sex practices. They paid advocacy visits to the hotel owner and were able to convince him to waive some of the imposed levies
- They also supply condoms to MARPs

- **RAPAC:** They provide HCT (at camp & Ebutte Meta) & PMTCT (at maternities) services and are thinking of upgrading the hospital in the Redemption Camp and Ebutte Meta to provide ART services. The hub at Ebutte Meta collates all the stats from all sites in Lagos & Ogun which are then fed into Mainland LGA & LSACA
- Targets were agreed with SIDHAS and they were able to achieve 75% of the targets
- They don't do DOTS
- FHI go to their facilities for DQA & QI visits to RCC sites
- A needs assessment of their capacity was not conducted at the onset of the project
- As part of their sustainability plan, they have received trainings and their lab was renovated
- They participate in the monthly referral focal persons meeting which serves as the linkage pathway for referrals in all LGAs

- They also have a referral directory
- They receive no support from the government
- Suggestions
- More trainings
- Additional lab capacity at sites
- Scale up from PMTCT to ART sites
- There is an organogram
- **RAPAC:** Established May 1997, funding started 1998 through IMPACT project, PMTCT & HTC started May 2008 by FHI GHAIN, by December 2011 it changed to SIDHAS. MOU and modification was signed.
- **BGF:** Implement the OVCs project in the communities and the LGAs, Anambra north senatorial zones (Anyanelu, Anambra E&W, Onitsha North, Ogbaru).
- Sexual prevention program Onitsha and Ogbaru LGA, north and south
- Care and support program in collaboration with health facilities focussing on client tracking of defaulters – collaborate with 5 facilities – Oyi LGA, Anambra East, Onitsha North, Ogbaru LGA
- Implement care and support facilities support group meetings- work with 3 support groups—God’s care support group in Onitsha North; health solution SG- ogbaru LGA; Healthlinks in Umunya, Oyi, LGA.
- Medical prevention- collaborate NBTS (National blood transfusion services) SIDHAS fund—the advocacy component of the service.
- Implement PEP at the community level – OVCs and sexual prevention package
- **ADONHACDC:** CAPACITY- BUILDING SUPPORT receives from FHI-360
- Started initially with a 3-day training by FHI-360
- Care givers support training
- Entrepreneurship training
- Project MX training
- PITTS
- **David Bassey Ikpeme Foundation:** HIV prevention program
- HIV Testing and Counseling
- Care and support
- Family planning
- TB services
- PMTCT/ANC/OVC
- **Support for Mankind Development Initiative:** HTC, OVC enrollment/service provision, PHDP PLWH, Referrals, tracking of TB/HIV clients, Advocacy/ community sensitization
- **Youth Pro-file:** HTC, OVC enrollment/service provision, Referrals, tracking of TB/HIV clients, Advocacy/ community sensitization, PMTCT, care and support
- HCT; OVC C&S; primary sexual prevention with CSWs; community PMTCT with TBAs and have a pregnant women support group; awareness raising on RH/HIV and

TB/HIV in community; also go to the facility and identify defaulters from the register and then track them to their homes. NB they do not have a written service agreement with the facility for this work and, frankly, should not have access to confidential registers in health facilities "We introduce ourselves; we do refer clients to the facility so they know us".

- Comprehensive HIV services:
- Primary prevention ART TB-HIV
- HCT, PMTCT laboratory
- Psychosocial support pharmacy
- Comprehensive HIV services

2. Volume of Services (number of people serves) they provide by service category

- **RAPAC:** We offer PMTCT/HTC in health facilities, community outreaches to maternity centers. Over 40 maternities in Sabo Ikorodu, Akowonjo, Shomolu, Ojota, Ketu, Agric Ikorodu, Ori-Okuta Ikorodu, Sango Otta, Agege, Oko-Oba, Badagry-3 maternities, Adaloko etc. These maternities are called RCCG maternity, we also have CAC maternities which are embedded in churches.
- **BGF:** OVC – 2500 children (Child protection and Birthday celebration, HTC)
- The need to obtain consent from the care giver often limits
- Stigma- care givers often withhold consent for testing the OVCs.
- Financial constraints often prevent consent for referral of the children.--- cost of transportation
- **David Bassey Ikpeme Foundation:** 94 OVC Caregivers trained on skills acquisition
- 4 VC Caregiver cooperatives empowered with HES ongoing
- 6 Support Groups supported across 5 LGAs
- 18 Peer Educators trained
- 75 CVs trained
- 10 Kids clubs established
- 1 ECCD centres established
- 12 Graduating VC currently undergoing skills acquisition training
- 3 CPC committees inaugurated
- **Support for Mankind Development Initiative:** 1095 OVCs enrolled
- 2 graduating OVCs
- Supported 5 support groups
- 24 CV trained
- 9 kids clubs established
- 7 caregivers forum established
- 1 PLHIV empowered
- **Youth Pro-file:** Enrolled and served 864 (429 Male and 435 Female) Vulnerable Children
- Supporting 3 support group

- 2 graduating VC trained on Hair Dressing
- 6 Caregiver provided with start up items for trading
- Formed Kids club and Care givers Forum in 8 Project Communities
- Formed Child Protection Committee in 8 Project Communities
- See targets and achievements under goals
- Currently > 3000 clients enrolled in preART and ART [including PMTCT]
- More than 3000 enrolled in pre-ART and ART

3. Assessment of Services on Relevance to HIV Care Utilization and Clients Needs

- **RAPAC:** Maternity Services and Labour/Delivery we have referral to Redeemers Hospital which takes care of Caesarian Sections and other surgeries. It's a full fledged hospital.
- We have M&E officers that go round on supervisory visit. We are linked to LACA mainland, Ebute-Metta is the hub and it is fixed into LSACA also.
- **BGF:** Provision of the birth certificates- attempt to help prevent the extortion of money for the certificate
- Income generation for about 52 care-givers
- Sexual prevention- managed to convince a FSW who was able to change her carer.
- Economic strengthening is the service that seems to have the most lasting effect on HIV related care and health outcomes
- **David Bassey Ikpeme Foundation:** Most of the services we render are HIV related. The HIV services are seen as a priority. Meeting the need of our clients is also a goal that must be achieved.
- **Support for Mankind Development Initiative:** The care for HIV clients is seen as a priority to this organization. From the beginning of this project till date all hands have been on deck to see to meeting the needs of clients that is why as part of our functions the community sensitization has been one key area of focus.
- **Youth Pro-file:** All the services we provide are relevant to HIV care as they are within the range of the services needed for the HIV clients
- Services are v. relevant but the targets result in very "thin" service delivery: they use a vulnerability index to identify the most vulnerable OVC households but can only offer tangible services to very few. When they return the next time to identify more vulnerable household, communities ask why they should cooperate when nothing useful was given to the households already identified
- Very necessary and relevant but clients also have nutritional needs
- All relevant but clients also have nutritional needs

4. How helpful/useful/ important is a particular service for you to access HIV-related primary care? Why?

- **BLYSON:** Membership of the support group is useful to members because they provide support to each other to navigate the course of this chronic disease. Whoever, most are unemployed and face a double burden

- **RAPAC:** We have targets given as part of sub-agreements and we have been reaching and achieving the targets. PMTCT target is about 75% met.
- **BGF:** Client tracking – poor documentation on the facilities – often non-defaulters are included as defaulters.
- As referred from the community are often treated disdainfully at the facilities which often affects the attendance of the facility staff which lead to default.
- 7b. shelters care for OVCs- the gap has not been met – Odakpe in ogbaru LGA – where the accommodation for the OVCs is quite poor.
- The birth certificates is not quite valuable to the care givers.
- There is a gap in understanding of the care giver with the service that is provided by the CBO. The service provided by the CBO is not quite what the care givers wanted
- There is poverty which is a challenge to providing OVC service; and affects compliance to the services.
- Educational support is often a key need.

Priorities

- Economic strengthening (bold in their capacity on how to access loan -schemes)
- Education
- **David Bassey Ikpeme Foundation:** It has been very helpful having access to the primary care as clients are most times referred to facilities in their area for easy access especially the comprehensive sites.
- **Support for Mankind Development Initiative:** It has been helpful. This is because our service providers in the comprehensive sites are able to help on issues of HIV-related primary care and we ensure that clients are not treated negatively.
- **Youth Pro-file:** Having access to a HIV-related primary care has been helpful. This is because our service providers in the comprehensive sites are able to help on issue of HIV-related primary care and we ensure that clients are not treated negatively. Clients are easily referred to facilities close to them.
- Don't understand question: they provide care in the community
- Sister reach out to primary care and TBA providers to strengthen their PMCT services and
- enhance referral links to St Joseph's for PMTCT and ART care and support
- We reach out to PHCs to collaborate and strengthen referrals for ART care and PMTCT

5. Access to HIV services of your clients: describe barriers. What do you think about psychosocial barriers such as stigma, lack of support, lack of disclosure?

- **RAPAC:** Challenges- there are some PMTCT services we render like prophylaxis but HAART, TB/HIV, STI are referred. Family planning is also done here but it's not supported by FHI. Our staffs are trained but we have little or no funding for commodities.
- **BGF:** Re-check visits
- Criteria for determining quality service
- Waiting time

- Appointments been seen on time
 - Large volume hospitals – St. Charles borromeo hospital, Onitsha; NAUTH –Ukpo or Umunnaya are a turn-off for parent's ANSUTH;
 - To help correct the problem; liaising with volunteers to use their influence to ensure a patient is seen on time
 - In Amaku Hospital – using contacts/ volunteers to help support
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- **David Bassey Ikpeme Foundation:** Psychosocial barrier has been a major challenge to client. Some persons see PLWH as people not religious or not faithful to their partners. Some are not properly taken care of especially those not leaving with their parents. Level of stigmatization is a little reduced due to the level of awareness at present compare to previous year though at some quarters this is still experienced even among health workers and offices.
 - Lack of support even from the immediate families of clients is one major barrier as this has led to some clients not disclosing their status for fear of stigmatization. Some clients at a time pulled out after the pre-test counseling because they don't want to be identified as PLWH if tested positive. Most clients don't like their status disclosed to the public for fear of stigmatization.
 - **Support for Mankind Development Initiative:** Access to HIV services in of our clients have in a way been brought under control since the inception of the SIDHAS project with persons having access to facilities closer to them in their communities or the nearest community. Despite this, the issue of psychosocial barrier such as stigma still stands out in some quarters as some persons still see PLWH as non-religion or persons not been faithful to his/her partner and so many are dejected by their immediate neighbor and close relatives. Lack of support from the communities/local/state government has also been a thing of concern as PLWH gets little or no support at all. Many are even afraid to disclose their status to relatives
 - **Youth Pro-file:** Accesses to HIV services of our clients have been very moderate. They have been accessing facilities within their immediate communities with ease. Thanks to the free medical care that is been provided by government and USAID. These successes were not without barriers. There is the psychosocial barrier. Some persons have been dropped from their places of work for the fact that they tested positive. Apart from this, lack of support from the public is also a barrier. Some clients want to stay away from where they are known even to receive cares at facilities. Just to avoid some level of stigmatization. Most people living with HIV don't want their status disclosed to others all in the name of trying to avoid the psychosocial barrier.
 - WOCLIF do stigma reduction in the community, self stigma is the problem
 - Social barrier: Communities do not think it is their responsibility to offer care and support to vulnerable children and do not offer support to vulnerable households identified
 - Cultural barrier: most women prefer TBA delivery to facility delivery
 - Religious and cultural beliefs – in “ancestral spirits as cause of illness” and preference for TBA and/or church deliveries – sisters conduct outreach and “enlightenment” campaigns to address these barriers, Self-stigma remains an important barrier to accessing care and some clients will not disclose. Sisters have a situation today where a positive woman has disclosed to her negative husband now after many years

of concealing her diagnosis but has profound psychological distress as she fears she will be abandoned – husband has declared the diagnosis makes no difference and he will stand by her.

- psychosocial barriers such as stigma, lack of support, lack of disclosure?
- Cultural barriers as women prefer to deliver with TBAs – they have cultural and religious beliefs in “ancestral spirits” that TBAs understand, as a cause for ill health and problems in labour and delivery. St Joseph’s sisters conduct campaigns to “enlighten communities”.
- Self stigma still exists in local communities

6. Or tangible barriers such as lack of transportation, clinic too busy or not open at convenient times, cost of HIV medical care

- **BLYSON:** Most important barrier is financial, followed by stigma and fear of disclosure
- **RAPAC:** We have M&E coordinator that coordinates the activities of several M&E. we fill into DHIS through LACA Ebute-metta and we attend M&E meetings together with FHI.
- **BGF:** Health education on malaria is supported by the SIDHAS project but other activities to enhance the prevention/ elimination and or treatment of malaria is not supported
- **David Bassey Ikpeme Foundation:** Financial support has been a major constrain to most clients due to distance from their home to the facilities and the lack of government support. Sometimes clinics are crowded with clients due to the number of available personnel to attend to them on a clinic day. Some ends up not seeing their doctors on such days and will have to go back home not attended to until the next clinic day which in most cases takes a week.
- Before now the cost of HIV medical care was high as client will have to pay for test and their drugs. This aspect is been worked on though we still get complaints from some units that they are still been asked to pay money for one thing or the other at some facilities especially at the local community levels.
- **Support for Mankind Development Initiative:** Lack of transportation means has been seen as one great challenge as some clients have to travel long distances to get to facilities to access the medical services. Some have to go these distances just to avoid some level of stigmatization in their communities of domicile. Some spend more than ₦100 to ₦2000 for transportation to the facilities. Also clinics get too busy on the clinic days because most health centre use one day in a week as clinic days so with the increasing number of PLWH and considering the number of doctors available sometimes is also a serious challenge. In some quarters we also heard that clients are been asked to pay money for some class of services rendered by some service providers at their unit. Before now accessing HIV medical care was expensive as persons have to pay for the test and drugs.
- **Youth Pro-file:** In view of the fact that many want to attend services where they are not known, some of them have to travel from other communities outside Port

Harcourt LGA (their own LGA). Just to access services. Due to the cost of transportation from these areas into the city many clients sometimes don't meet up with their appointment dates. Some arrive at facilities on clinic days are usually a day in a whole week except for some quarter where clinics are opened throughout the whole days of the week. On the cost of medical care, we give thanks to the SIDHAS project which has seen a positive side as many are benefiting now compared to the past when two or three or more persons will have to contribute together to afford the drugs but now it's not like that anymore.

- The health worker strike is the biggest barrier
- The cost of traveling to the health facility is a problem as women depend on their spouse for money
- Lack of financial resources to pay for transport, lab tests and nutritional supplements [additional food] a major barrier
- Tangible barriers are financial – funding for transportation lab tests and food for good nutrition

7. How well do your services meet people needs?

Go through each service category. Identify criteria for "meeting needs" and ways in which meeting needs overall may differ from serving primarily to increase access to or engagement in HIV-related care.

What is the biggest service need that your organization has met?

What is the biggest service need that has not been met?

Which services do you think have the most lasting effect on HIV-related care and health outcomes? Why?

- **BLYSON:** The work HUPPED is doing is meeting needs & she thinks it is sustainable. The most successful is counseling & testing
- Most of our medical needs are met except during strikes and the withdrawal of some free lab tests such as chemistry tests which affect the quality of the treatment we are receiving because of us can't afford it
- **RAPAC:** Monthly feedback is gotten about Quality Improvement carried out by M&E and Program officer/PMTCT coordinator.
- **BGF:** Poor nutrition makes it more difficult to cope with HIV – stigma – when patients are identified at a health facility by people who know them, they often decide not to go there.
- **RWF:** OVC- trained and empowered 40 care givers in the area of entrepreneurial and economic empowerment.
- Based on their choice of business – trained for 5 days on liquid soap-making.
- After the training they were supported to form a cooperative
- Prosper cooperative society – Nkpor
- JecimaAdazi-nukwu, Oka OluAmaka – Ukwulu, Dunukofia LGA (Making Nylons)
- Sexual Prevention:
- Were able to identify and refer about 10 HCT positives who have been placed on ART and who are regularly attending the clinic
- Some of the FSWs have started learning other trades.

- PEP (condom breaking during sex, fight with an infected person)
 - Child protection committees: have been able to resolve and support some children.
 - Care and support- client tracking
 - Least successful services:
 - Medical prevention: not much success in getting volunteers for blood donation: many barriers to informed consent.
 - **ADONHACDC:** Blood donation drive- the NBTC has not quite trained them; FHI-360 directed the CBO to the NBTC Nnewi
 - No advocacy brief prepared with the STO is the FHI-360
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- **David Bassey Ikpeme Foundation:** On the level of services we are offering as an organization, I think we are trying. I believe that one of the most important concerns is sensitization which is one key area that we are also paying great interest to.
 - One of the biggest service needs of client that we have met I believe is the area of sensitization and empowerment through the skill acquisition programs organized by our organization. The biggest need that we have not met is our inability to empower our clients financially.
 - Among the services we have been able to provide to clients the one that have the most lasting effect on HIV- related care and health outcome is the sensitization to get them informed and that of the skill acquisition empowerment which is a sustainable tool.
 - **Support for Mankind Development Initiative:** So far the level of services provided by our organization has been able to meet the needs of people to some extent but not in totality as finance is a constrain.
 - 1095 OVCs have been enrolled so far. 70% have been tested and counseled. We have been able to help these kids to be registered with the National Population Commission and 30% of those registered have their birth certificates at present. We have 2 graduating OVC. We have supported 5 support groups. 24 CVs trained. We have been able to established 9 kids clubs, and 7 caregiver forums have also been established and 1 PLHIV has been empowered. We have been able to track persons with TB and referred to the appropriate quarters for care. We have also trained peer educators and advocacy and community dialogue and sensitization has been very successful, community dialogue has help to get committees to donate halls for our regular meetings.
 - The biggest service need that our organization has met is the empowerment of PLWH through the skill acquisition program such as soap making; some students have been enrolled back to school. The biggest service need that has not been met is not having enough financial resources to empower some of those trained since most are not working. The services that will have the most lasting effect on HIV-related care and health outcomes are the skill acquisition training empowerment and ensuring the availability of the drugs when needed by clients. This is because when they are trained it is empowering them economically to stand the challenges ahead and availability of drug to help to keep life going.
 - **Youth Pro-file:** On our part as an organization, we take HIV care and support as a priority. We have been able to reach out to a large number of persons living with HIV and meeting their need to some extent. I think we are doing well in our efforts to

meet the needs of our clients. As part of the biggest service needs that our organization has met, I believe the first and primarily area is the sensitization of the general public on their health status. Helping the public to know their health status and creating this awareness that is required is our priority.

- The other part is the skill acquisition programme where clients are engaged in one learning to see to how they can assist themselves without depending on the government for all their needs. Just as these are great successes achieved finance has been one major obstacle that has slowed down the pace at which our organization would like to move in this programme. Therefore, empowering most clients financing even after the training has been the biggest service need that has not been met. Our organization sees the skill acquisition training as a key to nation building and this will have the most lasting effect on the clients.
- Economic empowerment is the biggest service need that WOCLIF meets
- Stigma reduction is the biggest need that is not met
- Which services do you think have the most lasting effect on HIV-related care and health outcomes? Why?
- Care and support for OVCs is the most sustainable as WOCLIF provides a means of livelihood (to the few homes it can, with its resources)
- What is the biggest service need that your organization has met?
- Access to HIC care and treatment with secure availability of drugs
- What is the biggest service need that has not been met?
- Poverty alleviation and provision of nutritional support
- Which services do you think have the most lasting effect on HIV-related care and health outcomes? Why?
- Counseling because it helps clients to accept their diagnosis, to adhere faithfully to their medication, remain in care and treatment, and live positively for the rest of their lives
- What is the biggest service need that your organization has met?
- access to HIV care and treatment with reliable availability of drugs
- What is the biggest service need that has not been met?
- Financial and nutrition needs of PLHIV
- Which services do you think have the most lasting effect on HIV-related care and health outcomes? Why?
- Counselling because it helps clients to know where they are and what they must do for the rest of their lives

8. Quality of Services. How satisfied are you with the medical care your organization is providing?

Probing questions: Do you have any challenges remaining in care for your other health concerns?

What, do you believe, are the providers doing right or wrong?

What aspects of HIV services can be made more satisfying, or at least agreeable, to clients? How?

What factors should be considered in judging the quality of a service?

Do you consider stigma to be a service quality issue? (If yes, how?). Is this true for some types of services or some types of providers more than for others?

- **BLYSON:** The quality of medical care especially waiting times and stock outs has improved
- Income generating activities are urgently needed or should be strengthened. Our CBO does not have the financial strength or capacity like FHI to do this even though it is badly needed by PLWAs. Even the few income generating activities that have been organized was called by FHI, and we just helped them to mobilize people for the event
- **RAPAC:** No formal training on CQI, we do Quality Improvement visits is now quarterly.
- Clients do not pay for services.
- **BGF:** Art /family care – disclosure to Partners.
- **RWF:** Linkage with public and private facilities is strong
- When the facilities have lost to known people, the defaulters are sent to the RWF who then contacts.
- The chain of communication is such that the defaulter at the hospitals are notified to the RWF who then contacts the community volunteers.
- Cluster coordination meetings: has stopped holding since October 2014.
- The facilities are responsible for convening and servicing the cluster meeting.
 - Reasons for Default:
 - Non-challant attitude of health worker
 - Clients are referred to the facilities for their clinical care.
 - Perception of quality of service
 - Shortage of staff for the workload (e.g NAUTH has a lot of clients compared to Reginald Chelli)
 - Long waiting time.
 - Waiting times is a key quality indicator
 - Charges for services
 - Distance from their location: FSWs prefer to go a facility that is away from their base
 - Charges:
 - CD4 count – N1500 @NAUTH
 - But higher than N1,500.00 at Iyi-enu hospital
 - The charges for CD4 count seen to have begun recently.
 - FHI-360 are aware of the charges for CD4 counts
- **David Bassey Ikpeme Foundation:** With the help of our health care providers we are doing well but limited by financial constrain. Our organization still believes it can improve as time goes on. We don't have challenges in remaining in care for our other health concerns.
- I believe that the providers are doing well in the area of the free medical care it is providing as test and drugs are free as we hear in most quarters but they need to step up their commitment in the area of finance to empower PLWH financially too. The aspects of HIV services that can be made more satisfying are the issue of sensitization, creating more awareness especially at the local levels and the continuous supply of the free drugs. This is because the awareness will keep people

informed the more and if tested positive they will still have the hope of surviving knowing that the drugs are there for them to access freely.

- In judging the quality of a service, level of service rendered within a particular time frame and the quality of the service delivery and personal commitment should be used. I don't see stigma as a service quality issue rather I see it as an individual thing and level of one's awareness
- **Support for Mankind Development Initiative:** I think our organization is satisfied with the level of the medical it is providing because we are doing well so far. Aside the HIV care offered by our organization, I don't think we have much challenges remaining in care for our other health concerns. The service providers are trying in their path by providing care for PLWH; but it is wrong to have them charged to be attended to and some level of stigmatization been experienced by some client in the facilities at some quarters. Availability of drugs/awareness are services that should be made more satisfying to clients, lack of awareness has led to early death of persons in the past even at present and when drugs are always available clients will be willing to get them to survive haven known that they can still live their normal lives.
- To judge the quality of a service, issues such as time put in, outcome of services rendered, such as confidentiality, response from the general public, commitment, availability of materials needed to achieve a desired goal should be looked at amongst others.
- I think stigma is a service quality issue. This is because the quality of services we render to people gives an outcome of issues; though it is true for some types of services than others.
- **Youth Pro-file:** Even with the challenges around, the success of our organization is high, so talking of satisfaction, I am satisfied because now is better than some years back. The other health care area of concern is the challenge we have in achieving an integrated body to achieve a common goal to ensure good health for all.
- The service providers are doing very well but that does not mean that there are no negative experiences. This negative experience, in most times is tied to behaviour of some clients. The aspects of HIV services that can be made more satisfying are the sensitization programme. To judge the quality of any services, time, operational procedures, level of services rendered are key factors to be used. I see stigmatization as a service quality issue; this is because if the general public is well sensitized on issues related to their every day health and it is well delivered then the level of stigmatization will be reduced. Stigmatization has to do with some type of service provider than others.
- Personnel. Providers qualified and committed: not just trained on the job. This includes doctors nurses lab, counselling and pharmacy staff
- The environment. The setting for care and treatment must be conducive to clients – and must separate immunocompromised clients from TB clients to reduce cross infection. Must provide privacy and good information materials to the client
- Availability of tests and drugs. Analysers must be serviced and working, reagents must be available, rapid test kits and drugs [ARVs and for OIs] must be securely available

- Close supervision and monitoring – Sister Rosaline does not have anyone “at her back” [supervising her clinical work] and so she welcomes evaluations that provide feedback
- An implementation plan and monitoring progress against the plan
- Feedback from clients on service quality
- Client and community education to address barriers to access and retention in care and treatment
- Self stigma remains a barrier to access and to retention in care and support
- Personnel qualified and not just trained on the job; doctors, nurses counsellors, lab and pharmacy staff
- environment: our setting is conducive to clients; separating TB patients from other to decrease cross infection ; privacy; IEC
- Availability of drugs, testkits, reagents, analysers [Hb chemistry, CD4] and maintenance of the equipment in working order
- close supervision and monitoring. Sister Roseline doesn’t have anyone “at her back” and so it is good to have evaluations
- plan program and monitor delivery against the plan
- feedback from clients on service quality
- client and community education
- Self stigma is a factor in accepting services and remaining in care and treatment follow up

9: Other Health Concerns. What is your most important health concern other than HIV in this area?

Instructions: Consider mental health and emotional health as well as physical health. Consider social functioning as well as basic physical functioning.

Probing questions:

1) What are some of your other health related challenges?

2) Are the other health concerns related to the HIV in some way? How?

3) Do you think the other health concerns relate to other factors such as age or gender?

4) Are these other health concerns more serious or important to you at times, compared to the HIV?

- **BLYSON:** We are worried about our children falling sick and what will happen to them when we are not around
- **BGF:** Cluster meetings have stopped holding – they are facility –initiated and the facilities last cluster meeting was held in August 2014.
- The cluster meeting tend to including a comprehensive, the ART, the PMTCT, the community pharmacists, CBOS sitee
- Only discuss with referrals client tracking:
- Quarterly CBO peer- review meeting
- Last meeting was held in fourth quarter of FY14
- **RWF:** Diabetes Mellitus especially for PHLIV. High blood
- **David Bassey Ikpeme Foundation:** Our most important health concern other than HIV in this area is malaria. This is because malaria is closely related to HIV and most people die of this disease if they are not properly taken care of an on time. Most

PLWH are easily depressed and pulled down by malaria when they are exposed to unhygienic environment like not sleeping under a mosquito treated nets. So this is a serious challenge that must be looked at with care, so we also see it as a priority. This health concern does not relate to factors such as age or gender it cut across all areas.

- This other health issue is not more important or serious at times compared to the HIV issues but both require maximum attention.
- **Support for Mankind Development Initiative:** Our most health concern other than HIV is malaria, TB and family planning. Our other health challenges revolve round these three key areas mentioned. These are areas related to HIV in some ways. PLWH can easily be put down with malaria if exposed. Family planning on the other hand is a strong factor too because the quality of life can be tied to the size of a household. Malaria can compromise the immune system and can therefore put pressure on persons. TB is found commonly among PLWH. I don't see these other health concerns as been related to age or gender thing. I think it cut across all quarters. Sometimes these other health concerns gives me course to worry about especially the area of family planning, compare to HIV because I believe that if this can be controlled to some level then HIV can also be controlled to a better extent.
- **Youth Pro-file:** Our most important health concerns other than HIV are the issues of reproductive health, sexually transmitted infections, TB and diabetes. I believe that these areas are all related to the HIV in some ways. Like the STIs, it is closely related and it is presently on the scale of health chart as a priority. This health concerns doesn't have to do with either age or gender. Amongst these diseases mentioned, they all get equal attention but base on the current project with SIDHAS, HIV is taken as a priority.
- Lack of family planning
- Poor women having >7 children
- Child headed households 1 sib caring for 5 or 6 others; cannot afford health care; can't provide good care in the home
- To gender and women's low status in the family and in society. GBV also an issue
- HIV more important as it keeps spreading
- Hypertension and stroke; diabetes; cerebral palsy, malaria
- TB and malaria are related to immunosuppression in HIV disease
- Hypertension and stroke, and diabetes are related to age
- HIV infection leads to chronic disease – so it is similar to Hypertension and stroke and diabetes in that they all need lifelong medication care and treatment
- HIV is more serious but it affects less people than hypertension and diabetes
- TB and malaria
- immune suppressed people are more susceptible to severe malaria and to TB
- Hypertension stroke and diabetes are more common as people get older
- Hypertension, stroke, diabetes, cerebral palsy are all chronic conditions like HIV infection that require lifelong medications. HIV infection is more serious but affects fewer people

10. How could your organization also assist with that concern at the same time as managing HIV services?

Probing questions:

How do non-HIV conditions make it more or less difficult to cope with HIV?

Does care for these other conditions tend to get in the way of care for HIV, or vice-versa?

How do you prioritize these different needs and the different parts of your health care program?

- **David Bassey Ikpeme Foundation:** To help manage this challenge and others our organization has been involved in the sensitization of PLWH on the need to sleep under the treated mosquito nets that were distributed to them and their immediate families.
- A non-HIV condition doesn't make it more or less difficult to cope with HIV. So far we have been able to handle both cases whenever it arises without one getting more attention than the other since these two are somehow related.
- **Support for Mankind Development Initiative:** We have been able to manage all these areas over the years. The level of integration has been working well for us. It is the level of financial strength that has been a major challenge in achieving our desired goals.
- Non-HIV conditions are sometime difficulty to manage especially those that are hypertensive or high blood pressure or diabetic clients. There are cases where a client with HIV is also hypertensive sometimes or difficult to manage as such client will be unable to access the ARVs. But I think the HIV is more difficult to manage. We have been able to manage both non-HIV and the HIV cases adequately without difficulties. Base on the present project SIDHAS, our major priority has been the HIV cases.
- **Youth Pro-file:** With the help of our health care providers, our organization has been able to manage both cases. The non-HIV condition doesn't make it more or less difficult to cope with HIV cases. The major target is meeting good health at the end. None of these care classes gets in the way of the other, all the cases are handled with care. As I said earlier, our concerns based on the SIDHAS project are to strengthen the services rendered for PLWH. This is taken as a priority.
- It is not HIV infection that will kill a patient it is the other conditions that have to be taken care of for all patients; infections have to be taken seriously in immunocompromised clients. We have to take care of psychological issues associated with chronic illness – counselling for acceptance of lifelong medication and a chronic disease lifestyle.
- We provide for other conditions including rehabilitation after stroke
- It's not HIV that will kill you its other conditions and infections, so you have to take care of other conditions /infections. We have to take care of psychological issues with counselling for acceptance of the condition and long chronic illness lifestyle

11. Do your health care providers work at coordinating the care of the different needs of your clients? If so, how?

Probing questions: Do you have a health care provider who you are working with for other chronic or serious conditions aside from HIV?

Is it the same provider as your HIV care provider? Are there communication gaps or other gaps? If so, where are the gaps?

- **David Bassey Ikpeme Foundation:** Yes. At the various facilities that are accessed by our clients the health care providers are always up doing in their path. They provide pep talks at meetings and handle other health challenges of our clients ensuring the availability of drugs and all that are needed. These same health care providers handle HIV issues of our clients. Our interactions with these service providers has been good

without gaps until the recent strike that lasted for some months where clients goes to facilities some days, number of personnel present to attend to them are few sometimes doctor are not available.

- **Support for Mankind Development Initiative:** Yes. Aside the HIV services our health care providers take other chronic health issue as a priority to save life. The same health care providers handle both cares. We have not experience communication gaps as we have always been in contact.
- **Youth Pro-file:** Our health care providers are also working hard hand in hand with our organization to ensure success in all areas. When issues of other chronic disease breaks out, clients are referred to the facilities for immediate attention and it has been successful. So the service providers handle both the HIV and other related issues. We have never had any negative experience with our health care providers not until the ongoing strike where some clients go to facilities without seeing the personnel. This is the only time we have experience gaps, but we have always been in contact with Doctors in the interest of our clients that requires attention.
- St Joseph's provides integrated care for all patents and so providers coordinate care for all the different needs of clients. Sister Rosaline and Sister Esther provide psychological and spiritual needs of the patient and family in addition to other 'medical' care.
- Chronic integrated care provided by all providers at St Josephs , co communication or other gaps as it is the same staff
- Comprehensive integrated care: nurses and sisters provide psychological care and spiritual care
- No, same staff [provider]

12: Participating in Improvement and Planning. Does your organization participate or is it consulted in matter regarding this State's HIV/AIDS program?

When you have a concern about the delivery of HIV/AIDS care and supportive services in this State, what do you think of as your options for making that concern known/heard (what actions do you think you could take)?

Probing questions: Before now, have you ever made your voice heard about the delivery of HIV/AIDS care and support services?

What was that experience like?

What happened as a result?

Were there repercussions, or did you feel things changed for the better?

Would you do it again?

If not (or for those participants who haven't taken such an action before),

Have you ever had the experience of serving on advisory group of an HIV-services-providing agency in this State?

- **HUFPEd:** Most of the PLWAs we work with are now empowered because no PHC health worker can "ride on them" easily like before i.e. they have become aware of their rights to medical care in the facility and are likely to complain if they perceive that they are not being treated well. However, I do not know of an example whereby they have planned and organized themselves to speak out to the government in our area
- **BGF:** NA quite involved in the LIT in awka south

- o Recommendation: CBO have extensive reach In house to house contact with the patients
- Involvement in community data collection and analysis
- Example of where data analysis has led to change in practice
- **RWF:** States validation meeting quarterly
- (MOWA & SI)
- ASUBER – Anambra state university basic education project
- HAF project and the FHI-360 SIDHAF project
- The projects coverage are not in the same communities or LGAs.
- Due to the stakeholders meeting and the TWGs, the HAF project communities are different from the FHI-360 SIDHAS project communities
- There are joint training sessions.
- The SIT have visited the RWF service now
- Supportive suspension

FINANCES:

- FHI-360 reimburses based on what is spent and is regular.
- No Expenses of PEPFAR allowable has led to instances where the organisation was not reimbursed for expenses incurred in the cost of renovation of a home for an OVC and child-learn home.

RESOURCE MOBILIZATION:

- Capacity building on advocacy to GON institution and Philanthropists
- Often attempt to mobilise resources through fund raising
- Sell water
- The SIDHAS project is doing well and they have built capacity on resource mobilisation advocacy
- **David Bassey Ikpeme Foundation:** Our organization has always participated in different aspect of programs related to HIV/AIDS to improve the quality of services rendered. When have concerns about the delivery of HIV/AIDS care and supportive services in the state and think we should be had we channel our information through the appropriate quarters within the state. For instance we collaborated with bodies such as CISHAN as an advisory group during the last world AIDS day celebration. We initiated the idea of conducting free HIV testing and counseling for female street hawkers during this period and the experience was fantastic. Through this medium many of the girls on the street of Port Harcourt were privileged to be tested and counseled freely and those that tested positive were referred to facilities where they can be attended to. I see this as a positive effort and an achievement.
- **Support for Mankind Development Initiative:** As a member of the civil society coalition of HIV/AIDS and member of the state implementation team, we have always participated in health/HIV related issues in the state. When issues arise we do well to pass them through the appropriate quarters within the state. We had our voice heard in programs in the past such as on world's AIDS Day and during other days such as

valentine and children's days programs within the state, and the experience has been very educative and has always turned out positively on the lives of PLWH

- **Youth Pro-file:** Our organization has been a part of the HIV services-providing agency in the state where issues on delivery of HIV/AIDS care and supportive services are organized and we have had our voice heard. We have been able to collaborate with other bodies within the state like the centre for health university of Port Harcourt in conjunction with NLNG to carry on awareness programs down to schools and even in the communities to educate the elderly. The experience gotten from the programs has been very interesting and educative. We had issues where some never believed that a HIV person can live a normal life and that there is no hope for them anymore but it took time and much sensitization to convince such persons. These programs have yielded positive results as so more many lives have been transformed.
- Wants to and has tried to be involved by SACA. Although the sisters have the phone number for the Infectious Diseases doctor at SASCP and can call her any time for advice, they are "blocked" from a close relationship with SACA. Sister is very frustrated by this as her facility has, from the beginning of the epidemic, paid a key public role in caring for the sick and dying before treatment was available, providing technical support to public facilities [Cottage Hospital and PHCs] starting up PMTCT through the 'hub and spoke' model where St Joseph's was the centre /hub under the Partners for Development project. St Joseph's provided HMIS data through PDF to the government but she refused to pass the data directly to SACA as that was for "results inflation" [double counting]. SACA has refused to involve St Joseph's in their plans saying that the church should provide for St Joseph's needs. When pressed the person at SACA said that he would meet Sister Rosaline but it would be at a break during a conference he was attending. Sister Rosaline refused that meeting as she wanted a one on one face to face in the SACA officer. Sister Rosaline says she will again open up communication with SACA after the election. The present person obstructing may be gone depending on the results of the election, but she will contact SACA even if it is the same person after the election. She is very willing to provide accountability, including HMIS data for any resources that SACA provides.
- CQI for technical & financial areas; waiting for institutional area
- N8,500, 035.00 for first year but the last modification decreased this
- Only at PHCs not LGA but make voice heard at state level. We have SASCP doctor's phone number and call when need to talk with them or need help. We refused to send our stats to SACA because we send them to SIDHAS and SIDHAS sends to SACA. They wanted data inflation. We went to see SACA about the duplication of effort and inflating the figures as we were giving our stats to PDF first and then PDF gave them to SACA.
- It's frustrating working with SACA. I have tried to make contact with SACA when SACA was making plans for the State to get St Joseph's included in the plans but SACA ignored and said "let the church provide". Sister Roseline planning to try again after the election when there is a new administration

Probing questions: Can you talk about that experience?

Do you feel like you have been able to improve services through your participation?

Has your experience been disappointing or frustrating? Why?

What do you know about the HIV Health and Human Services Planning Council of this State?

Is there anything in particular you would want the Planning Council to be doing to improve HIV services and care for you?

13. Do you know about the Planning Council and its role in deciding priorities for Care, Treatment, and Service Delivery?

What do people think the Planning Council does now, and what do they think it should do, to ensure that PLWHA in this State could get the kinds of care/services they need?

- No
- **David Bassey Ikpeme Foundation:** I believe this is the body that access organizations on the ongoing activities by means of a checklist. They also evaluate by means of analysis and makes efforts to close gaps in the level of services rendered by organizations.
- I think one of the things the planning council should do is to involve the federal and state government deeply in the program to improve the level of services and care for PLWHA in the state.
- **Support for Mankind Development Initiative:** No, I have no idea of the planning council in the state.
- **Youth Pro-file:** Most people especially PLWH believe the council is trying but not doing enough to meet their needs. Most want the awareness level to be raised and they should be empowered economically.
- Is this SASCP? Knows about SASCP and has contacts. Wants MOH to pay the salary and allowances of one on the two doctors providing HIV care and treatment at St Joseph's

14. Are there other things you would like to discuss?

- **HUFPEd:** There is good technical support provided to HUFPEd by FHI and we have easy access to FHI staff but we believe that the aspect of the establishment of income generating schemes or activities for PLWAs especially at household level need to be put in place if sustainability for PLWAs/support groups is to be achieved
- The administration of the CQI checklist by FHI to HUFPEd is done quarterly and it cover different areas or categories (such as program areas, M&E, finance etc)
- HUFPEd has adopted and adapted the CQI process and conduct it internally within the organization on a monthly basis using a checklist modified from that used by FHI
- **BLYSON:** There was a capacity building plan at the onset of their partnership with SIDHAS. They were trained in writing grant applications, use of IT, presentation skills, awareness raising/community mobilization, report writing, M&E, data reporting
- They were also trained and their institutional capacity was further developed through training and mentoring in financial management, filing, administration etc
- There was signing of an MoU at the onset but the budget was extremely tight especially on salaries and transport related expenses eg the transport stipend is 1000/day to cover such a large area. This greatly hampers the extent of what we can do. They face a salary freeze for the next 3 years under the present terms that they are working with
- In addition there is little to nothing that is set aside for the OVCs and their care givers eg for their school meals, kids club meeting etc

- The biggest challenge faced by PLWAs is stigma and disclosure generally, and poor financial power. The quality of medical services that they receive in the public sector is fair except for isolated incidents eg when most clients were placed on efavirenz even though they were complaining about its side effects at Gbagada GH. They need economic empowerment so as to strengthen the support group membership and activities
- Stigma and disclosure are the biggest challenges preventing the support group from having a "voice"
- The CBO attended a meeting with LSACA, WAPA to develop a sustainability plan which is essentially based on developing public private partnerships and leveraging corporate social responsibility inputs from big industries

- **BGF:** Capacity- building of the staff – technical aspect, Institution
- Finance – the grant
- The budgeted funds are often not sufficient for the activities
- What capacity Building, service- gap Analysis
- Financial& management Procedure
- The budget envelope seems not be informed
- Sustainability plan not yet developed.
- **ADONHACDC:** ANSACA has not been doing well – no meeting of the CBOs
- got involved through the CISHAN
- Have been involved in mentoring other dioceses to develop their HIV/AIDS program

SUCCESS STORIES

- Nine dioceses have been supported.
- Able to get other Bishops to fund the diocesan HIV/ AIDS programme.

SUSTAINABILITY

ENHANCING FACTORS:

- Has trained over 1000 out of each school OVCs on competences
- Limiting factors; the obligated sums have been scaled down, issue of funding.

Questions from ANDOH

- Are there plans for scaling up?
- "FHI – 360 is just assisting"
- **Support for Mankind Development Initiative:** I think the government should be more involved in the provision of services PLWHA
- **Youth Pro-file:** We will appreciate it if the project could be extended.
- The targets were agreed with SIDHAS and have dates and how their achievement will be recognized
- SIDHAS staff – principally Deloitte's has visited and worked with them on financial matters and strategic planning
- SIDHAS staff write in the CQI log when they visit and acknowledge results verified and any issues found and actions WOCLIF should take for their resolution
- WOCLIF particularly like this capacity building as they think it is essential to their organizational growth

HCT Assessments: IEC materials in local languages poor across the board

	Akwa Ibom	Anambra	Lagos	Rivers
1	1 cottage Hosp Run by untrained volunteer in strike No condoms; no SOPs	Poor client privacy No condoms Called back another 1	PHC 2	3
2	2 Divine love No condoms no SOPs	3 --PHC	PHC 1	3
3	2 GHETimEkpo No SOPs no couple counseling in otherwise good services	Poor client flows 2	PHC 2	2 no condoms
4	2 Op Base NisitUbium PHC [some good points]	No condoms for a year Call back another Poor client privacy 1		3
5	3 Stand alone VCT	2		2 no condoms
6		2		3
7				3
8				1 no condoms & notify partners
9				3
10				3
11				3
12				2 no condoms
13				3
14				3
15				3
16				3

PMTCT Assessments IEC materials a problem across the board

	Akwa Ibom	Anambra	Lagos	Rivers Option B
1	2 Adiasim HC registers & SOPs locked during strike Only asks husbands of +ves to come	3	GH 2	3 On strike Few SOPS No LLINs
2	2 Divine Love No SOPs Poor referrals	2	GH 2	3
3	2 GHETimEkpo strike No SOPs Drs not trained; 2 docs in 1 room otherwise 2-3	1	GH 1 but without explanations for score	3
4	2 Op Base NsitUbium PHC	2	PHC 2	3 No LLINs
5	Oron Christ Victory 2-3	2		3 No LLINs < 6/12
6	Palmer Memorial 3; pts have to pay for S-P Have done 2 DBS	No S-P for 6/12 No LLINs No ART if CD4 > 500 1		2 Poor partner disclosure/involvement
7	1 St Joes Staff not trained No SOPs	2 no LLINs		3 No LLINs < 1/12

	Akwa Ibom	Anambra	Lagos	Rivers Option B
	No privacy No condoms			
8	2 Ubong Abasi Specialist Clinic	1 [3 ^o facility]		2 No SOPs <i>only</i> some trained
9	2-3 Ukuda HP Very good referrals No referrals yet	1 Just awful		3 some trained
10	2 Utibe-Abasi Clinic no handwashing poor ARV measures HCT behind screen	1 no same day testing No ARVs if CD4 >500		3 No LLINs <6/12
11	2 UUMed Centre good service in overwhelmed premises. Long waits sitting on ground or outside	1 – just awful		2 Clients wait >1 hr No SOPS in delivery room
12	1 UU Teaching hospital Poor service poor referrals			3 Client waits >1 hr
13				3 Option B+ LLINs <1 month IEC 3
14				3 IEC 3
15				

ART Assessments Teaching hospitals do not integrate even adult/paed Art; no child friendly

	Akwa Ibom	Anambra	Lagos	Rivers
1	3 Palmer memorial No support group	1	GH1	2 No family no volunteers Rx <500
2	2 St Joe's Rx CD4 <350 Drs not trained No vols	2	GH2	2 No family no vols Rx <350 stockouts
3	3 ^o 2 Doctor no concerned with defaulters	2	GH1	2 No support group vols no open Rx <500 No SOPs
4	[none for UUMed Centre]	2		2 No SOPs No support Rx <500
5	[none for Methodist]			2 No Vols Rx <500
6				
7				
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TB-HIV Assessments IEC an issue across the board.

	Akwa Ibom	Anambra	Lagos	Rivers
1	2 GHETim Ekpo well planned new service no clients yet	3 ^o Many scores 3-4 but 2 clients c/o no TB	PHC 2	3 called back Xray avail

	Akwa Ibom	Anambra	Lagos	Rivers
	No SOPs during strike	drugs		
2	2UUTH		GH ?1 No explanations	3 called back
3	1Palmer Memorial			2 none trained HIV ART after TB
4	2Cottage hospital no SOPs and no trained staff during strike			3 no SOPs
5	2PHC IkotEdibon No SOPs during strike			3 No SOPS ART after intensive TB
6				Some trained staff ? ART concurrently
7				No SOPs Sputums >4 weeks ? ART concurrently
8				
9				
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Pharmacy assessments: IEC and issues across the board

	Akwa Ibom	Anambra	Lagos	Rivers
1	2Holifield Specialist Unable to access locked drug store Dispensing service by nurse 2-3	1 poor stock control Poor security; poor client registers	PHC 2	3
2	1Utibe-Abasi Clinic private PHC Just awful	2	GH2	3
3	2PHC IkotEdibon	3 but stockouts TB		3
4	2 Cottage Hosp good pharmacy run by Corpser; stockouts TB drugs; no condoms during strike	1 poor stock control Stockouts ARVs sell condoms		3
5	2 St Joes stockouts CTX & condoms	2 [some ARV stockouts]		2
6	2 Divine Love	1 multiple poor		3
7	3GH EtimEkpo	1 multiple poor		2
8	2Palmer Memorial	1 multiple poor		3
9	2UbongAbasi specialist Clinic	1 multiple poor		2 stockouts ARVs
10	2UU Medical Centre	2 [ask Nura]		3
11	3UUTH	2		3
12		2		3
13		2 but no condoms		2
14		1 multiple 1		3 no condoms
15		1 No CTX		2Stockout ARVs

		Poor client registers No condoms		<1/12
16		2		3
17		1 stockouts ARVs and CTx		3
18		2 no condoms		2No condoms Weekly top ups
19		1 multiple 1		

Laboratory Assessments

	Akwa Ibom	Anambra	Lagos	Rivers 24 hours: 12/16
1	3PHC IkotEdibon Docs 3 Qual3 Manage 3	1PHC infrastruct1 Docs no lab safety manual, 2 Qual no processes Manage no oversight no DBS no Z-N stain Limited services	2Infrastruct 3 Docs 2 Qual2 Manage 1 Problem with no ZN stain & delays in microscopy	1PHC infrastruct 1 Docs 2 Qual 1 Manage 3
2	1 Cottage Hosp Poor lab	2°only RTKs Poor lab Private Hospt		2PHC infrastruct 3 Docs 2 Qual 2-1 Manage 3
3	1Divine love Minimal lab	PHC 1Poor lab		2PHC infrastruct 1 Docs 3 Qual 2 Manage 2
4	1Holifield specialist Minimal lab No support from FHI	Victory Hosp 1Poor lab		2PHC infrastruct 1 Docs 2 Qual 3 Manage2
5	3 St Joe's Good lab not supported by FHI	3°Lots infrastruct 3Exceptional lab		2PHC infrastruct 1 Docs 3 Qual 3 Manage 2
6	1UbongAbasi Specialist minimal lab—RTK only	2Private Small, poor safety processes but otherwise good		2PHC infrastruct 1 Docs 3 Qual 3 Manage 2
7		2KanayospecialitHosp Small lab good except for lack quality processes		2PHC infrastruct 3 extention Docs 3 Qual 3 Manage 2
8		1Private hosp No qual processes no SOPS no lab safety manual		2PHC infrastruct 1 Docs 3 Qual 2 Manage 2
9		1St Edmunds Hosp No qual processes no SOPs no safety manual		1PHC infrastruct 1 Docs 3 Qual 1 Manage 2-1
10		PHC – empty lab Not functional		1PHC infrastruct 1 Docs 2 Qual 2-1

	Akwa Ibom	Anambra	Lagos	Rivers 24 hours: 12/16
				Manage 2
11		Madueke Memorial Hosp Only do HB; HIV RTK		2PHC infrastruct 2? Docs 2 Qual 2 Manage2
12				1PHC infrastruct 1 Docs 2 Qual 1 Manage ?
13				2PHC infrastruct 1 Docs 3 Qual 1 Manage 2
14				2PHC infrastruct 1 Docs 3 Qual 2 Manage3
15				2PHC infrastruct 1 Docs 2 Qual 2 Manage 2
16				2PHC infrastruct 1 Docs 2 Qual 2 Manage 2

Summary Findings of Focus Group Discussions across four SIDHAS Mid-Term Evaluation States of Anambra, Akwalbom, Lagos & Rivers State

MAIN FOCUS FOR GROUP DISCUSSIONS

Access	Satisfaction	Stigma
1. All of them live within reasonable distance of the health facility and those that lived far away were referred to facilities close to them (Anambra, Rivers) 2. Some philanthropists pay for clients if they don't have money (Anambra) 3. Some sites have staff that are welcoming (private faith based health facility that charge modest sums) while the staff of some centres (public health facility) are very abusive. The strike has also made access to services more difficult. Some clinics are overwhelmed and some face stock out of ARVs (Anambra, Rivers) 4. Some have difficulty in coming to pick up their drugs because of lack of money (Anambra, Akwalbom, Lagos, Rivers) 5. Provision of HIV services by PHCs have made access easier (Anambra) 6. There are long waiting times for collection of drugs at the pharmacy in some health facilities (Anambra, Akwalbom, Rivers) 7. Some facilities charge a small amount for consultation and purchase of drugs for opportunistic infections (Anambra, Rivers) 8. PLWAs should be employed in centres that provide HIV services so as to ease discrimination (Rivers) 9. Most times we are requested to pay 100(hundred naira) before the nurses bring out our card (Akwalbom) 10. So many people living with HIV hide in the church to receive prayers(Akwalbom)	1. They get good attention & gift items from the hospital staff without stigmatizing them (this is a facility based support group?) (Anambra) 2. There was dissatisfaction with CD4 count & chemistry tests which are unstable and patients are told to go and come back without considering the distance they are coming from. Some also have difficulties sometimes in opening folders because of lack of money (Anambra, Lagos) 3. Membership of the support group has made them to have companionship and they no longer feel alone (Anambra, Lagos, Rivers) 4. The support group members called for loans or support for income generating activities (Anambra, Rivers, Lagos) 5. One of the new ART drugs (? efavirenz) gave us a lot of side effects which really bothered us but our doctors said we should continue using it (Rivers) 6. PLWHAs have been managing and organizing home base care and visiting their fellow PLWHAs, they also advocate for skill acquisition activities for their members. (Rivers) 7. From this support group she has learnt skills acquisition and these skills have helped put food on her table. (Akwalbom) 8. <i>"before, I do get ARV that covers a period of 3-4 months but now the supply is been reduced to last between</i>	1. All have experienced stigma although they are well accepted within their families (Anambra, Lagos, Rivers) 2. Some people leave the venue of any meeting in the community if they know that PLWAs are there in attendance (Anambra, Akwalbom, Rivers) 3. Our government see investment in PLWH as a waste of time and they kick us out immediately they realize we are HIV positive (Lagos) 4. "A colleague of ours was laid off from a company called Chiso Transport because of her status. Many others are laid off from their informal jobs too for the same reason." (Lagos)

11. Many times the nurses would abandon one's card and start discussing amongst themselves their personal issues at the end of the day, we would spend more time than necessary and our businesses will be neglected, one gets the same treatment at the point of refill at the pharmacy
 12. "We plead for FHI to assist with their doctors on Mondays and Tuesdays (clinic days) because work overload is affecting the efficiency of the doctors. The pharmacists are doing a wonderful job, the problem is with the doctors" (Lagos)
 13. "At NIMER we pay for the services been rendered; #1000 for drug, #2000 for consultation, #2900 for lab tests all these for those on first line drugs while those on second line drugs pay #11,000 for the drugs which is not always available" (Lagos)
 14. "I passed through hard time when my wife was about to deliver our 4th child, I was rejected at a Government hospital because I did not have enough money, eventually my wife gave birth at a private hospital which is not very safe. If we can be helped and supported especially during delivery we would be grateful" (Lagos)
 15. "We are about 50 in number before in the support group but now we have reduced to about 20 to 25" (Lagos)
9. *"Any time I miss my appointment date, I suffer the stress of getting the attention of the service providers" (All states)*
 10. We are given our drugs free of charge although we want other drugs like malaria drugs to be free as well (Lagos)
 11. The local health center closest to our support group has issues of drug availability though it's free. They drugs are either expired or not available hence we use other health facilities(Lagos)
 12. We had a meeting with NEPLWHA about the challenges we faced with the charges on drugs and tests. (Lagos)