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USAID/NIGERIA: CENTRE FOR DEVELOPMENT AND POPULATION ACTIVITIES (CEDPA) POSITIVE LIVING PROJECT

FINAL EVALUATION

July 2010

This publication was produced for review by the United States Agency for International Development. It was prepared by Munirat Ofunlai, Mary Chigumira, Adedayo Olufunso Adebayo, Fadiya Temitope, and Charles Toriola through the Global Health Technical Assistance Project.

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This document was submitted by The QED Group, LLC, with CAMRIS International and Social & Scientific Systems, Inc., to the United States Agency for International Development under USAID Contract No. GHS-I-00-05-00005-00.

ACKNOWLEDGMENTS

The generation of this final evaluation report has involved the concerted collaborative efforts of the evaluation team following a systematic consultation with various stakeholders. The evaluation team wishes to express our appreciation to the USAID Nigeria team, Centre for Development and Population Activities (CEDPA) staff at headquarters, country office, and field offices, staff of multiplier organizations (MOs), staff of various implementing agencies (IAs) visited in the states, various stakeholders consulted at national level and in the six states of Lagos, Cross River, Enugu, Kano, Bauchi, and Kogi states, and beneficiaries of the Positive Living (PL) Project who came forth and participate in one way or the other in the evaluation.

The cooperation of everyone has contributed immensely to the success of the evaluation.

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ACRONYMS

ACAP	Anglican Communion on AIDS Program
ADF	African Development Foundation
AFB	Acid fast bacillus (screening test)
AIDS	Acquired immune deficiency syndrome
APMU	AIDS Program for Muslim Ummah
ART	Antiretroviral therapy
CAIV	Conscientising Against Injustice and Violence
CBO	Community-based organization
CD	Country Director
CEDPA	Centre for Development and Population Activities
CHBC	Community home-based care
COP	Country Operational Plan
CoP	Chief of Party
CBC	Community-based TB care
DOTS	Directly Observed Treatment Short Course
FGD	Focus group discussion
FSW	Female sex worker
GHAIN	Global HIV/AIDS Initiative in Nigeria
GHARF	Global Health and Awareness Research Foundation
GH Tech	Global Health Technical Assistance Project
HBC	Home-based care
HIV	Human immunodeficiency virus
HQ	Headquarters
HVAB	HIV Prevention Abstinence & Be Faithful
HVOP	HIV Other Preventions
IA	Implementing agency
IDU	Injecting drug user
IGA	Income generating activity
ITN	Insecticide treated net
MPPI	Minimum package of prevention intervention
M&E	Monitoring and evaluation
MAGA	Muslim Action Guide Against AIDS
MARKETS	Maximizing Agricultural Revenue and Key Enterprises in Targeted Sites
MARP	Most-at-risk population
MoH	Ministry of Health

MO	Multiplier organization
MSM	Men who have sex with men
NACA	National Agency for the Control of AIDS
NASCP	National AIDS & STD Control Program
NGO	Non-governmental organization
NIM	Nigerian Institute of Management
NSF	National Strategic Framework
OGAC	Office of the U.S. Global AIDS Coordinator
OI	Opportunistic infection
OPR	Output to Purpose Review
OVC	Orphans and vulnerable children
PABA	People affected by AIDS
PC	Palliative care
PDF	Positive Development Foundation
PEPFAR	President's Emergency Plan for AIDS Relief
PL	Positive Living (Project)
PITT	Prevention Interventions Tracking Tools
PLWHA	People living with HIV and AIDS
PM&E	Program monitoring and evaluation
PMT	Project management team
PwP	Prevention with Positives
RAHAMA	Rahama Women's Group
RH	Reproductive health
SACA	State Action Committee on AIDS
SFH	Society for Family Health
SGC	Support group coordinator
SOP	Standard operating procedure
SOW	Scope of work
SWAAN	Society for Women and AIDS in Africa Nigeria
SWATCH	Support for Women and Teenage Children
TB	Tuberculosis
TBLCP	Tuberculosis and Leprosy Control Programme
UNDP	United Nations Development Program
USAID	United States Agency for International Development

INTRODUCTION

USAID/Nigeria requested that the Global Health Technical Assistance Project (GH Tech) conduct an evaluation of the process, outcome, and possible impact of the Positive Living (PL) Project implemented by the Centre for Development and Population Activities (CEDPA) in Nigeria under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program. Five GH Tech Project consultants, Munirat Ofunlai, Mary Chigumira, Adedayo Olufunso Adebayo, Fadiya Temitope, and Charles Toriola, conducted the evaluation from June 1, 2010 to June 22, 2010.

The focus of the evaluation addressed the following overarching questions:

1. What are the greatest achievements made by the project both toward expected outcomes and toward the overall goal of improving the quality of life of people living with HIV/AIDS (PLWHA) in communities targeted by the project?
2. To what extent has the project improved the quality of life of PLWHA and their families and catalyzed change of behavior within target communities?
3. How successful were the project's management systems in facilitating the achievement of expected outcomes and goal?
4. What are the project's major challenges and lessons learned?
5. What strategies should USAID/Nigeria pursue in future programming of interventions addressing the needs of PLWHA, their families, and communities?

The evaluation covers PEPFAR Country Operational Plan Years 2006–2009. The evaluation team depended on reliable secondary data and consultations with stakeholders at various levels in order to respond to the above overarching questions.

I. BACKGROUND

A. THE NIGERIA HIV AND AIDS CONTEXT PRIOR TO POSITIVE LIVING PROJECT

Prior to the award of PL Project cooperative agreement in 2006, Nigeria was reported having the third largest number of HIV infections in the world, an ever-increasing number of PLWHA, poor health infrastructure, and low level capacity of community-based organizations (CBOs) to provide prevention, care, and treatment services.

To address some of the gaps and issues, CEDPA proposed the PL Project to expand gender sensitive, comprehensive community-level HIV/AIDS awareness and home-based care (HBC) support services for people living with and affected by HIV/AIDS in the country.

The PL Project proposed applying a strategic approach in implementing the project to:

1. Expand gender-sensitive access to community prevention, stigma reduction and HBC and support services for PLWHA through enhancing current programs and strengthening multi-sectoral response, collaboration, and referral networks and linkages;
2. Strengthen multi-level institutional management and technical capacity of the national and regional multiplier organizations and local PLWHA serving NGOs, FBOs, support groups; and
3. Support community safety nets and livelihood programs (e.g., income/employment generation and business development opportunities services for PLWHA and care givers).

For each of these approaches, CEDPA emphasized women, in particular, their health support, and care needs as well as their mobilization assuming a role in the delivery of services, as well as involvement of PLWHA in services provision.[1]

B. RELEVANCE OF STRATEGY AND PL PROJECT

The home and community-based care and support programs are critical in providing widespread access to essential physical, psychological, social and spiritual services to individuals and families infected or affected by HIV/AIDS in Nigeria. The situation in the country revealed that facility-based programs are not enough to keep up with or meet the needs and demand of infected and affected people. Hence, the strategy developed by the PL Project is relevant and useful in meeting the critical needs through the development of capacity in the community and homes to provide physical, psychosocial, and support services at these levels since the community-based programs being implemented are not comprehensive enough to provide full range of services and are limited in coverage.

Also, there is limited capacity to deal with the fluctuating and clinical needs of PLWHA at the facility, home, and community levels. PL Project's strategy of establishing triage centers within the communities was a unique idea that complements facility-based clinical care by bringing services closer to PLWHA and reducing the cost of clinical care in terms of accessibility to free essential palliative and opportunistic infections (OI) drugs as well as travel time and cost which have been the major impediments to orphans and vulnerable children (OVC) and PLWHA access to quality healthcare within their own localities.

[1] *Positive Living: Expanded Compassionate Gender Sensitive Care and Support for People Living with and Affected by HIV/AIDS*. Project proposal submitted by CEDPA on March 31, 2006.

Women and girls are commonly the primary care givers at home but lack or have limited capacity to deal with the issues of HIV and AIDS. Thus the strategy of capacity development of volunteers for the initiation and expansion of HBC services is vital in increasing access to life-sustaining treatment and quality care and support services for individuals and families within the confines of their own homes and communities. Evidence from the field has emerged that these family-centered comprehensive community HBC activities have helped more PLHWA live positively and empowered enough to minimize the frequency of hospital visitation and bouts of opportunistic illnesses.

The National Strategic Framework (NSF) (2005–2009) prioritized the need to increase access to community-based care and support programs, and mitigates the impact of HIV/AIDS on the health sector. Equally, the PL Project supported the goal of the OVC National Plan of Action[2] which stated that, "By 2010, mechanisms for the protection, care, and support of orphans and vulnerable children are in place and facilitating the provision of basic services within a supportive environment from national to household level." The Plan takes into account the fact that children from the poorest areas, girls, children with disabilities, and children affected by HIV and AIDS are the most discriminated against, and many face multiple forms of discrimination. In Country Operational Plan (COP) year 2009, the PL Project also aligned with the minimum package of the National Prevention Plan which has stimulated propensity for quality behavior change.

[2] *Orphans and Vulnerable Children National Plan of Action 2006–2010*. Child Development Department, Federal Ministry of Women Affairs, Nigeria.

II. EVALUATION APPROACH, METHODOLOGY, TOOLS, AND LIMITATIONS

A. EVALUATION APPROACH

The evaluation of PL Project was based on the "theory of change," which according to Anderson (2000) is a description of how and why a set of activities—be they part of a highly focused program or a comprehensive initiative—are expected to lead to early, intermediate, and long-term outcomes over a specified period. The theory of change informed the adoption of a Program Action Logic Model. This assesses what the situation was before changes that have taken place following implementation of activities as a result of the uptake, adoption, or use of project outputs by project beneficiaries and other external stakeholders in a manner that verifies the underlying causal chain of the development intervention (outcome).

A combined approach was adopted in order to address the evaluation's overarching findings. The elements of the approach are:

- Objective Oriented: to make clear the goals and objectives of the evaluation and the review of what has been supported by the USAID/CEDPA PL Project in Nigeria in relation to the expected outcomes and the relevance of the support.
- Participatory Oriented: this approach placed participating respondents at the centre of the evaluation design and influenced the data collection tools that were used to ensure a participatory approach to the evaluation process. The collective participation also involved the implementing agencies (IAs), the multiplier organizations (MOs), the CEDPA and USAID to ensure transparency and served as a learning process for the participating stakeholders in the conduct of the evaluation.

B. EVALUATION METHODS

Both quantitative and qualitative methods were adopted for the evaluation. These methodologies and the tools were selected to ensure that the specific evaluation questions are addressed and to enable cross referencing or "triangulation" of findings across different sources. Methods are listed first, followed by tools.

1. Document Reviews – Various documents were collected from National Agency for the Control of AIDS (NACA), National AIDS and Sexually Transmitted Disease (NASCP), USAID, CEDPA Washington, CEDPA country office and zonal and state offices, the multiplier organizations (MOs) the implementing agencies (IAs), and beneficiaries. Secondary data were synthesized from these documents for analysis to review inputs, output level results, contributions to the outcomes, and changes in the key outcomes indicators during the period.
2. Key Informant Interviews – Short interview topic guides were developed by the team on a day-to-day basis focusing on the issues appropriate to the various stakeholders. This enabled the evaluation team members to elicit information consistently and to clarify issues or areas of concern as required. The questions were developed based on the scope of work and focused specifically on answering the key evaluation questions.
3. Focus Group Discussions (FGDs) – These were used mostly for implementing institutions and beneficiaries. Group discussion enabled a mix of views to emerge, enabling the team to ensure consistency with the contents of documents reviewed and information gathered from other sources.

4. Field Visits – Field visits were conducted to CEDPA field offices, implementing organizations and beneficiaries in the six states visited: Lagos, Cross-River, Enugu, Kano, Bauchi and the Kogi states. Selection of states for the final evaluation was based on the following:

   - Combination of thematic areas implemented to achieve the goal of the project,
   - Zonal representation across the geo-political zones in the country, and
   - Closure of project to assess process of closure and plans for continuity and sustainability of the project.

The purpose of the field visits was to validate information elicited from documents and explore perceptions and experiences not recorded in formal reports to enable the mission to assess the outcomes and possible impacts of the project with some primary beneficiaries where such opportunity was available.

C. EVALUATION TOOLS

Two key tools were developed for the evaluation to explore the various expected outcomes of the project. The tools were:

1. The Organizational Capacity Assessment Tool (adapted from Chemonics International Inc. & International HIV/AIDS Alliance NGO Capacity Analysis Tools); and
2. Various structure-guided questions for the conduct of FGDs, key informant interviews, and to explore the significant changes that have happened as a result of the project's interventions at all levels of project management, implementation, and beneficiaries.

The evaluation has drawn heavily on available data and documentation from existing progress reports, self-evaluations using the organizational capacity assessment tool, independent mid-term project review and other reviews performed by USAID. Sources are referenced throughout the text and a bibliography appears in Appendix C. Interviews were held with a wide range of key informants as stated above. A list of people the team consulted is in Appendix B.

D. LIMITATIONS OF THE STUDY

Because PEPFAR began as an emergency program requiring immediate implementation of services, baseline studies were discouraged. This has led to a lack of definitive baseline data within the selected intervention sites/communities where the PL Project was implemented. The evaluation team had to rely on information provided by the community respondent and primary project implementers (CEDPA and IAs) as the proxy indication of the status prior to the PL interventions.

Other limitations included:

- Data Quality–With no monitoring and evaluation (M&E) system in place for this project, the quality of data used in this evaluation is unknown.
- Time–There are also the inherent limitations in quantifying result (outcomes) from the qualitative data due to issue of general applicability to the whole project population and possible biases (such as sampling bias, measurement bias, and recall bias on the part of the respondents). The survey method that would have been adopted was also impossible due to limited time for the data collection and analysis as indicated in the SOW and closure of some of the PL Project sites (in Lagos, Niger, and Taraba) which might eventually lead to bias in the sampling frame (or size) for a survey.

- Measuring Improved Quality of Life – The evaluation had to rely on perceptions of improved quality of life since using the standard methods for measuring quality of life were not possible given the limitations of the evaluation.

III. EVALUATION FINDINGS

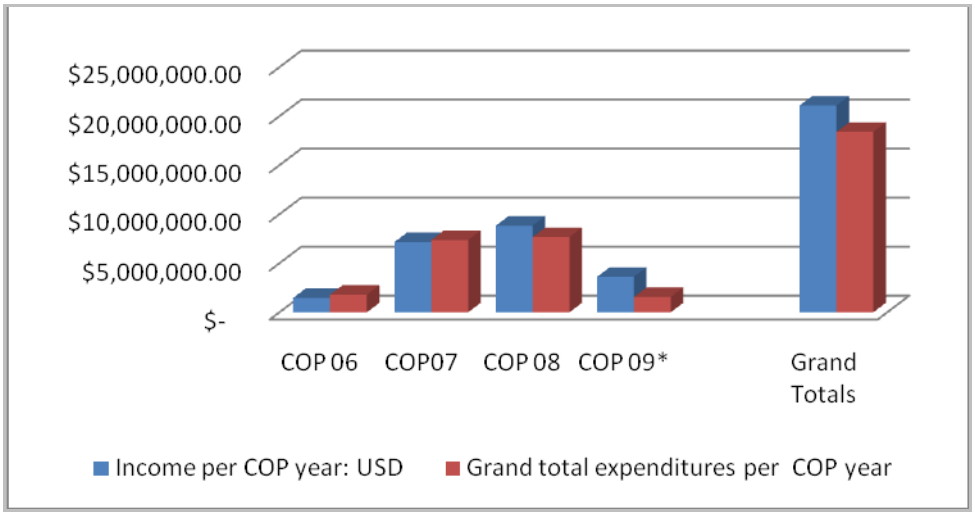
A. PROJECT INPUTS

This section presents a summary and analysis of the funding to CEDPA by USAID for the implementation of the PL Project, analysis of staffing, equipment and other infrastructures, as well as effects on the project. The main source of the data analyzed is from CEDPA offices in Washington and country offices.

1. Financial Inputs

Total funds reported for the PL Project up to March 2010 was $21,098,791 and $18,408,305 was expended until that date. The figure below shows the income and expenditure per COP year.

Figure 1: Income/Expenditure per COP Year



Consultation with CEDPA staff revealed that budget was based on per capita cost, and the amount disbursed was based on the target for each COP year, for which CEDPA subsequently managed to cover 12 budget lines: salaries and wages, fringe, allowances, trainings, sub-grants, equipment, commodities, purchased Services/ODC, operations, renovations, meetings/workshops/travel, and administration. A key to the quality of life of the beneficiaries is assessing the actual amount of funds that get to the communities for implementation of activities. This basically occurs through the sub-grants, commodities, and some components of training, especially to the staff of IAs and the volunteers.

Analysis shows that 25% of the total expenditure gets to the IAs through which they covered various budget lines which include activities to be implemented by thematic areas, personnel, administration, office costs, travel, and monitoring. It is also worth noting that the 25% was shared amongst 49 IAs and two MOs during this period. Also, only 1.86% of the budget covered the commodities utilised in the various thematic areas except for income generating activities (IGAs).

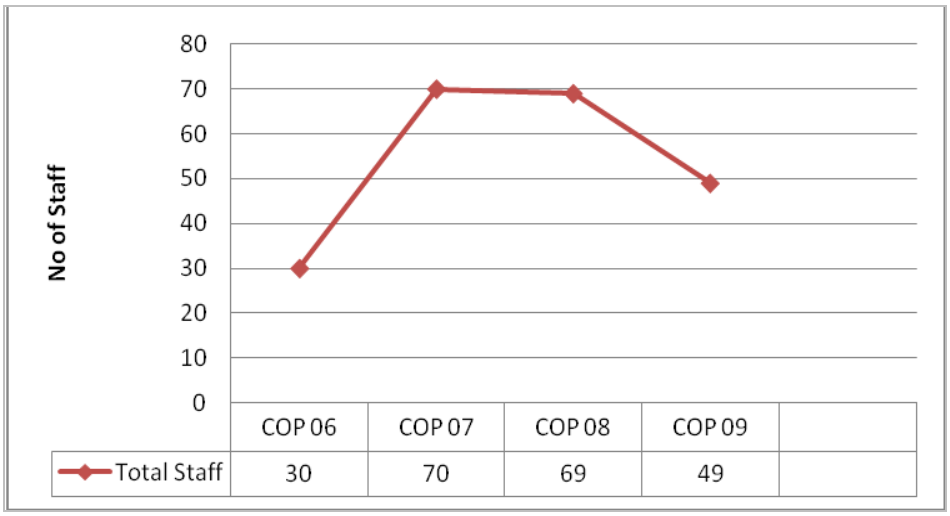
There is a general view that the amount that gets to the communities for implementation of activities was insufficient to really make a substantial impact as expected. For example, the budget only covered single initial visits, with no money allocated to subsequent follow-up visits even in cases of very sick clients at household level. Also there were no funds allocated for

program monitoring and evaluation (PM&E) to monitor services delivered especially by the volunteers. PM&E would have been helpful in detecting issues such as lack of refill contents for HBC kits, non-adherence to drugs by some clients, etc., and in taking corrective measures. PM&E also provides the opportunity to provide on-the-job training, supportive supervision, and motivation to volunteers who are doing this important work in the communities. The analysis presented above seems to share some lessons in terms of per-capita-cost budget allocation. It also possibly demonstrates the need to come up with the cost of management processes separately and what is needed to reach the beneficiaries in such a way that will ensure quality delivery of interventions.

2. Analysis of Staffing and Structure of PL Project

The staffing of the PL Project varies during the life of the project. This is because the project experienced a high level of staff attrition. More staff (535) worked on the project in COP 2008 at the level of the IAs, while more volunteers (17,190) were on board in COP 2007. Review of the staff list revealed that the staff attrition experienced was managed by the project through replacement of staff, but has effect in terms of having to get new staff stabilized on the job for effective performance and sustenance of the momentum of technical activities.

Figure 2: Total Staff per COP Year



3. Other Equipment and Infrastructure

Review of inventory list for CEDPA county office and state offices revealed that tangible investment was made as basic equipment required for functioning of offices and delivery of project activities were provided. Despite this, the evaluation also shows that there was late delivery of some equipment such as motor vehicles. Some vehicles were delivered midway in the life of the project while some were delivered in the last year of the project. Consultation with staff at the country office attributed this to non-availability of funds for procurement of these vehicles.

No motor vehicles were procured before the commencement of the project and in COP 2006. However, CEDPA inherited two vehicles that were in use under the Global HIV/AIDS Initiative in Nigeria (GHAIN) Project. These are the 2006 vehicles, one was based in Abuja, and the other in Lagos from inception of the project. CEDPA's initial budget request was slashed by almost half by USAID at the inception of the project and therefore no vehicles could be purchased. The Ford Foundation stepped in and donated a vehicle for the project to use. CEDPA considers this part of the cost share that CEDPA was required to invest in the project. The project also had

one Packard Foundation vehicle that was stationed in Kano for use by the PL Project in 2006. Four motor vehicles were acquired in 2007 and four were acquired in 2009, the last year of the project.

B. DELIVERY OF OUTPUTS OF THE PL PROJECT

Outputs are defined as the products, goods, and services that result from an intervention. A key element is that management can be held fully accountable for delivery of outputs.

Up till the end of COP year 2008, CEDPA PL Project operated in 14 states across the six geopolitical zones in Nigeria, and, as at COP 2009 CEDPA Positive Living Project, operated in 11 states with a total of 16 IAs and two multiplier organizations in the six geo-political zones. These IAs have been able to mobilize the communities within which they work through the activities of volunteers to implement various thematic components of the PL Project following series of trainings to their respective trainers and service providers. Also, some IAs in Enugu and Cross River states came up with the initiative of training and engaging volunteers who possess leadership skills to serve as focal persons or cluster coordinators and act as supervisors to the volunteers.

The subsequent sub-sections discuss the outputs (activities implemented and stakeholders reached in the various thematic areas of the PL Project), as well as performance against the targets for each thematic area. Because of a lack of an M&E system, the data summarized below must be considered questionable in terms of data quality and accuracy.

1. Performance Against Targets

i. Gender-sensitive, Community-based/Home-based Adult Care and Support Services to PLWHA and their Families

Persons living with HIV/AIDS and their families were reached with palliative care services and CEDPA staff at the country office for Nigeria. State level and staff of the IA said that the HBC component has, in particular, been a success considering the progress made toward the attainments of targets for this specific thematic area. Also, beneficiaries consulted confirmed receiving basic items such as insecticide treated nets (ITN), WaterGuard, and water containers. Most importantly, they also received physical, medical and psychosocial support.

CEDPA's community-based care and support service was a unique model in Nigeria. The traditional style of door-to-door home visits was typical and unique to CEDPA PL Project. The project pioneered the provision of HBC care activities to PLWHAs and their families using trained volunteers, the majority themselves living with HIV. This approach helped promote positive living within the communities, reducing stigmatization. In the states visited, CEDPA had trained volunteers and positioned them within comprehensive sites being managed by the GHAIN project. These volunteers acted as counselors and testers at the Heart-to-Heart Centres, adherence counselors, and medical records assistants, especially in Enugu and Lagos states.

With this strategy in place, clients were linked to various supports groups within the communities for the continuum of care and support services in the communities. This was typical for states like Lagos, Enugu, Cross River, Bauchi, Kogi, and Kano. The CEDPA PL Project had been innovative in its community home-based palliative care services by redefining the concept of "home." With the PL Project, e.g., in Lagos and Cross River states, the concept of "home" has been redefined from just a place where the client is domiciled to any place where the client feel comfortable enough to receive the care and support services. This was particularly stressed by an IA, Women and Children of Hope, in Lagos state.

In addition, CEDPA's model of community-based care and support services ensured that medications for the treatment of common opportunistic infections, for example, co-trimoxazole prophylaxis, are made available through HBC. For instance, Rahama Women Development Program in Bauchi placed drugs for OIs and other minor ailments at the triage centre established under the PL Project, and clients from one of PL CEDPA's IA in Lagos, Women and Children of Hope, benefited from a Triage Centre said to have been set up by STOPAIDS, a former CEDPA IA. These triage centers has also served as points of basic healthcare and further referral for PLWHA and many OVCs enrolled in the project.

In terms of performance against targets in this thematic area, on training, CEDPA reported a two-fold increase at end of Q2 and Q4 of COP 2006 and COP 2007 respectively for the training of volunteers on palliative care (PC)/HBC services, and 5% at the end of Q5 of COP 2008. Delayed release of funds in COP 2007 and COP 2008 contributed to the low results eventually recorded.

As for the number of individuals provided with palliative care, CEDPA reported achieving 78% of its target at the end of Q2 of COP 2006 given that the project had just commenced, and 89% and 71% at the end of Q4 of COP 2007 and Q5 of COP 2008 respectively.

ii. HIV Sexual Prevention Services and Interventions

The PL Project reported highest achievement in the HIV Prevention Abstinence & Be Faithful (HVAB) prevention services training— 82% in COP 2007, and total achievement of 48% before the shift to a minimum prevention package. Between COP 2006 to COP 2008, CEDPA has, through the various IAs, provided HIV/AIDS preventive intervention to the communities in states using A-only, AB, and HIV Other Prevention (HVOP). From COP 2009, CEDPA keyed into the implementation of the minimum package of prevention intervention (MPPI) as prescribed by the national response.

The provision of age-appropriate HIV/AIDS preventive intervention was one of the core performances of the CEDPA PL Project Prevention Program as observed in all the six states visited by the evaluation team. For example, Society for Women and AIDS in Africa Nigeria (SWAAN) Lagos, one of the closed-out IAs in Lagos State, provided in and out-of-school HVA and/or AB preventive services to selected public schools as pilot sites. The SWAAN Lagos IA was able to train "peer educators" and establish "Anti-AIDS" club in 12 public schools in Lagos state. The same performance was recorded by the "Positive Development Foundation" in Calabar, Cross River State, where the IA had trained and built the capacity of volunteers as peer educators and had established Anti-AIDS clubs in three public schools. These schools, in turn, mentored two additional Anti-AIDS clubs in other schools.

CEDPA reported achieving almost 100% of its target for HVA for Q2 and Q4 of COP 2006 and COP 2007 respectively, and 70% for Q5 of COP 2008. For HVAB, CEDPA reported 149% and 127% at the end of Q2 and Q4 of COP 2006 and COP 2007 respectively, and 40% for Q5 of COP 2008. Furthermore, for HVOP, over 300% and 97% at the end of Q4 and Q5 of COP 2007 and COP 2008, respectively, were accomplished. (Delayed release of funds between COP 2007 and COP 2008 affected program activities and many of the volunteers trained opted out due to lack of funding).

CEDPA staff maintained that the Positive Living Project was the first to train volunteers and support group members on "Prevention with Positives" (PwP). Many of these volunteers are now state trainers in the various CEDPA-supported states. Due to a call for modifications to the target groups expected to be reached by IAs implementing the HVOP, efforts were made by CEDPA and its IAs to reach the female sex workers (FSWs), men who have sex with men

(MSM) and injecting drug user (IDU) communities in addition to the groups such as Okada riders[3], road transport workers, out-of-school youth, and religious groups.

Since COP 2009, CEDPA had gradually moved into the implementation of the National Prevention Guideline on the minimum package for prevention intervention. In Q1 of COP 2009, CEDPA reported 0% in the number of PLWHA reached with PwP and 51% for Q2, while 86% achievement was reported for the number of volunteers trained on HVAB with a focus on the minimum package for Q2. (Since the minimum package entails a minimum of the service contacts before counting, this accounts for the low achievements recorded for the targets).

The same trend was seen in both Q1 and Q2 of COP 2009 for the number of most at risk populations (MARPs) reached with the minimum package and volunteers trained on HVOP with focus on minimum package.

In the states visited, the staff of the IAs and volunteers demonstrated fairly good understanding of the programming of the minimum package of prevention intervention. For example, in Calabar, Cross River, staff and volunteers of the Positive Development Foundation and Conscientising Against Violence and Injustice (CAIV) were tested on the minimum package of prevention and the level of their understanding was assessed to be good. Bills were also posted on the walls and the reception area to educate people on the content and steps for conducting the minimum package. However, the Prevention Interventions Tracking Tools (PITT) software for tracking the minimum package was yet to be deployed for reporting at the IA level. In Bauchi, the trained peer educators were able to record the data on people reached using the PITT paper-based copy but because of technology challenges with the software, the IA Prevention Coordinator could not easily use the PITT. CEDPA has reported some PITT issues to USAID.

Even though the change to minimum package was initially a challenge to the volunteers, they confirmed that this approach was more effective when compared to the generic approach used in COP 2006–2008, taking into consideration the repeated contacts made with the clients by the peer educators.

iii. TB Diagnosis, Treatment Support Services and TB Management among PLWHA and their Families

The community tuberculosis (TB)/HIV service is an integral part of the community-based care and support services of PL Project. Volunteers were trained on the TB/HIV clinical screening using standard questions to identify the signs and symptoms of TB. Clients are then referred for further services using the client referral forms.

The training of volunteers did not happen in Q3 of COP 2007 and surpassed the target set for both Q4 of 2007 and 2008 respectively. Overall, 91% achievement was recorded against the target set for the training of volunteers in this thematic area.

Staff and volunteers were trained to use a simple checklist screening for the most sensitive symptoms for TB, for example cough, fever, noticeable weight loss, and night sweats. Patients were referred to Directly Observed Treatment Short Course (DOTS) centers. While community TB/HIV services were offered by volunteers at the home level in some of the states visited, the challenge remains to capture the number of complete referrals, as completed referrals of clients help to determine how many of those referred for further TB services actually arrived and were registered at the referral center and how many were lost. This helps to justify the inputs in terms of resources for this thematic area, and to an increase the likelihood that clients will receive TB treatment, which contributes to improved health and

[3] Motorcycle transport workers

related quality of life. The number of such clients referred for further services from the community could not be ascertained. For example, Positive Development Foundation (PDF) in Calabar, Cross River state maintained that the IA had intensified efforts in TB case finding through clinical TB screening among the persons affected by AIDS (PABAs) of the people living with HIV/AIDS. In addition, the IA has received recognition as the organization pioneering the TB network in the South-South geopolitical zone. Furthermore, CEDPA had been active in training focal persons from CEDPA-supported DOT centre. CEDPA reported an achievement of 47% and 715% in Q3 and Q4 of COP 2007 as against 0% in the first two quarters of COP 2007. In COP 2008, the highest achievement toward target was 46% in Q3.

In addition, in COP 2009, the CEDPA-supported DOTS centre reported an achievement of 7.9% in the number of HIV-positive individual screened for TB and 9.6% in the number of HIV positives newly initiated on TB treatment. Follow-up visits were done after screening. Trained volunteers and ordinary community members refer patients to a triage centre and they are linked to a local hospital. One of the IA in Bauchi, the Rahama Women Development Centre, managed to establish a triage centre that employed a lab technician who is responsible for TB Acid Fast Bacillus (AFB) sputum screening. When these PLWHA are found to be AFB-sputum positive they are referred to other secondary health facilities for further TB treatment. However, the Bauchi State Tuberculosis and Leprosy Control Programme (TBLCP) has given an assurance that it will scale up this triage centre into a full community-based TB-DOTS centre. Volunteers also monitored for adherence and other OIs. However, the CEDPA monitoring system does not capture the number of HIV positives screened for TB that tested positive or negative to tuberculosis.

iv. Care and Support to Orphans and Vulnerable Children

CEDPA PL Project implemented the OVC program in five states in Nigeria (Cross River, Kano, FCT, Bauchi, and Imo). These OVCs are mostly identified by the volunteers trained by the IAs to ensure that they have lost one or both parents due to AIDS. The OVC component of the project used the child status index to guide the services being provided. Psychosocial support was provided through trainings and site visits, as was health, education, shelter, education and nutrition support. Kids clubs were also established and managed by trained staff. Children of age heading households in some cases were trained in sewing, knitting, and were linked to micro-finance companies.

The Bauchi Diocese Anglican Communion on HIV and AIDS (BDACA) in Kogi State has taken a lead in the provision of care and support for OVC, in the form of a community-based care program and provision of psychosocial support. It has also provided basic support in form of food and education support, and distributed mosquito nets to 1100 OVCs. BDACA enrolled 30 OVCs in school in the second year, paid school fees, and facilitated the issuing of birth certificates to more than 100 OVCs. The OVC program being implemented by PDF in Cross River state has also had remarkable success.

About 148 of their children have received capacity building training, while about 995 have been provided with education and health services, including birth certificates and nutritional support. The staff of this IA said that they have been able to engage these OVCs through the various "Dance Groups" established in the state, which has provided psychosocial support. Linkages have also been established with USAID supported Maximizing Agricultural Revenue and Key Enterprises in Targeted Sites projects (MARKETS)[4] for the provision of food support.

[4] The USAID-funded Maximizing Agricultural Revenue and Key Enterprises in Targeted Sites (MARKETS) project is implemented by Chemonics International and its sub-partners.

Overall, the CEDPA PL Project reported an achievement of over 200% in reaching the target as at the end of COP 2008, and over 400% for the number of OVCs provided with psychosocial support in COP 2009.

However, in an OVC state like Cross River, there seems to be a weak link with the State Ministry of Women Affairs and Social Development. The CEDPA Cross River field office seems to be interacting more with low-cadre staff and not the policymakers that could influence policy and make tangible decisions for the success of the program in the state.

v. Livelihood Programs Including Sustainable Income-generating Activities or PLWHAs and Affected Vulnerable Families and Children

Increasing livelihood and income generation activities by CEDPA/Nigeria has been a particular challenge. In COP 2007, CEDPA/Nigeria hired an independent consultant with clearly defined Terms of Reference to conduct a feasibility study and recommend how best the IGA could be implemented by IAs on board the CEDPA PL Project. The consultant trained PLWHAs and caregivers of OVCs on the following skill areas: fish farming, local manufacturing of groundnut oil, and poultry farming. She facilitated the formation and registration of cooperative clusters with some of the project's beneficiaries in Kano, Bauchi and Cross River. Although the consultant made efforts to link CEDPA to micro-finance institutions, management issues at CEDPA in COP 2008 hindered the launch of this program, and thus the seed grant was never released nor capitalized.

A second consultant who was hired in COP 2009, and worked between February and March 2010, proposed setting up the "Economic Support Foundation for Northern States" and the "First Global Finance for Southern States." This consultant organized the training of PLWHAs and caregivers of OVCs. However with instruction from USAID, the program was discontinued.

Although the livelihood and IGA scheme was not able to capitalize a revolving fund through CEDPA/Nigeria, the linkage and collaboration with USAID MARKETS helped make some contribution to this thematic area. Even though no loan or micro-credit was made available to the beneficiaries from the PL Project, there were evidences of linkage to other micro-credit facilities in Bauchi State which contributed to the economic strengthening of a number of PLWHAs, OVCs, and caregivers. Eight of the OVCs on graduation also received sewing machines procured by the PL Project.

In spite of the above challenges, Rahama Women's Group (RAHAMA) managed to link 350 beneficiaries to a micro-credit scheme funded by African Development Foundation (ADF) for capital, and introduced a revolving fund scheme for women living with HIV and AIDS and their families who are working as cooperatives although not yet registered. Beneficiaries were also linked to a United Nations Development Program (UNDP) micro-credit scheme. CEDPA PL Project also provided the beneficiaries with seven sewing machines and 50 women were trained in tailoring.

vi. Institutional Capacity of Multiplier Organizations (MOs), Community-based Organizations (CBOs) and/or Implementing Agencies (IA)

Capacity-building of implementing agencies and communities was one of the major thrusts of the PL Project in the first year of programming. Capacity-strengthening activities included regular technical support visits by CEDPA and capacity-training programs to ensure that programming was informed by and responding to HIV and gender-related issues in the various components of the PL Project. Continued technical support by CEDPA enhanced the skills of staff of MOs, IAs, and individual volunteers in implementing some of the PL Project activities.

The two MOs, Anglican Communion on AIDS Program (ACAP) and AIDS Program for Muslim Ummah (APMU) maintained that they had benefited immensely from institutional capacity-building from CEDPA/Nigeria. The institutional capacity-development included one week of training followed by a week of mentoring conducted by the Nigerian Institute of Management (NIM).

The management team of ACAP and APMU also confirmed that they have benefited from other trainings in the area of financial management, M&E, peer education training, and other subjects. A graphic example cited by ACAP as an effect of the training was when the accounting officer from ACAP was commissioned to give technical support and training to the accounting staff of APMU on financial management and reporting. However, the training on grant and proposal writing was offered to them by the Nigerian Institute of Management (NIM). CEDPA had hired NIM to conduct a full course on organizational development that included grant and proposal writing. Support was also provided to renovate office space, equipment, and staffing to help facilitate the activities of the MOs and delivery of project objectives.

For the delivery of the various thematic areas of the PL Project, CEDPA trained state trainers who then trained IAs within the states. It was noted during field visits to all the selected IAs that they have benefited from various types of trainings in the thematic areas: HBC, TB, OVC, and prevention services. Capacity of the volunteers in the various thematic areas was also achieved through the step-down trainings. Analysis of the number of staff and volunteers on the project confirmed that this is huge investment for the country if maintained to provide continuous provision of the services.

CEDPA PL Project also encouraged the idea of bringing program staff on board Project Management Team (PMT) of the IAs to manage the activities of the organization. There were complaints that cut across all the IAs visited about poor remuneration for the program staff and staff attrition which have had an adverse impact on their operations.

2. Progress toward Outcome and Impact

With the implementation of various activities, and the performance against targets documented above, this section documents the various outcomes and possible impact of the PL Project by thematic areas.

Clients expressing appreciation of the HBC interventions.

i. Expanded and Comprehensive Gender-Sensitive Community-based/Home-based Adult Care and Support Services to PLWHA and their Families

The provision of HBC focused on PLWHA who were bedridden as a result of AIDS. Individuals with or without the virus were trained as volunteers to provide this care. For care givers infected with HIV, the services provided a two-fold advantage: in addition to creating voluntary jobs, it provided an opportunity for HIV-infected individuals to extend love and care to others who needed the same type of support as they did. The HBC beneficiaries interviewed acknowledged that they would probably be dead were it not for the HBC interventions. Out of 35 beneficiaries interviewed, 15 of which were visited at home, 91% reported improved health and quality of life as compared to their previous status before being reached by the project. A number of the clients' beneficiaries, ranging from being bed-bound to home or community-bound, reported improved health. This was attributed mainly to HBC support. Some of the success stories shared by beneficiaries are stated below:

"One of the beneficiaries confirmed that his health improved because of care and support from care givers, he now knows the importance of adhering to drugs, and how to live positively by eating balanced meals and vegetables. Before the PL Project my CD4 count was at 29 and this has increased to 572 because of the benefits that I derived from the PL Project."

The Support Group Coordinator of ACAP reported: "Before the PL Project, I was very ill and no-where to go and already lost my wife to AIDS. While thinking of what next for me, I was lucky to listen to a radio programme by the Head of Anglican Church on AIDS and the various programmes in the church. It took me four days to get to the church because of fear. But eventually, I summoned courage and visited the facility where I was counseled, tested and placed on ARV drugs. With the treatment, my CD4 rose from 166 to 640. Thereafter, I was trained as a volunteer and used my experience to counsel and encourage people who are positive to obtain services at the centre. I can confirm that I have saved many people who wanted to commit suicide as a result of AIDS.

In addition to improved health, PL had contributed meaningfully to my livelihood. Before I was living in a village, sleeping on mat and found it difficult to feed my children. I was in this situation when ACAP advertised for the position of SGC under the PL Project, I applied and I got the job. I was later trained as a Master Trainer and also coordinated the SG activities. Now I work as consultant facilitating trainings, earn good money from the process and now able to feed and take care of my family. In fact, we now live in a flat. The activities of the PL Project have been of great strength and tremendous benefits to me. I have also succeeded in giving hope to so many people as a result of this experience."

The biggest difference that HBC made to the lives of the beneficiaries is that they are now able to perform household chores and socio-economic services. They are also getting emotional support from families and the community, as disclosure has been enhanced.

HBC has also strengthened relationships among spouses through counseling as prevention with positives was encouraged amongst discordant couples. Many are no longer concerned about stigma, encouraging those who are ashamed of their HIV status to come out, seek treatment, and start to live normal life. One CEDPA partner in Niger, Physicians for Social Justice, just won the Red Ribbon award for being the first organization to bring HIV awareness and services in Niger and to debunk the myths about witchcraft. PLWHA are now going to hospitals and taking their medicines and not losing hope. Dignity was restored through the HBC program, which helped to de-stigmatize HIV and AIDS by confronting stigma in communities.

The care and support services provided made a positive impact on people's lives. During focus group discussions, both male and female PLWHA revealed that the CEDPA PL Project provided

them with love and attention that strengthened their sense of security and enabled them to withstand the stress caused by their circumstances.

> *"Before the CEDPA PL Project, social stigma deprived them of their social worth, motivation and the will to live."*

Also a participant in the group made the following point:

> *"I have never heard senior government officials speaking about the needs and circumstances of PLWHA but CEDPA PL Project came to our rescue."*

The support groups formed as a result of the PL Project offered clients an opportunity to meet other PLWHAs, to share experiences, and to be able to meet in a supportive environment. It created an opportunity to learn new skills through volunteering.

It is interesting to note that the project created awareness and increased the number of cases seeking and adhering to treatment in the states visited for this evaluation. The IAs and the volunteers attributed this to the PL program outreach interventions, and the initiative of recruiting clients at the health facilities. The Ummah support group confirmed that *"our centre became a drop-in centre, as people in the community would carry bed ridden clients and drop them off."*

Community leaders viewed HBC very positively. It was seen as an area that was gaining ever greater importance as it created voluntary jobs, shared experiences and sentiments, and was supportive to those it served. Community leaders in focus group discussions reported that:

> *"CEDPA through its partners played an important role in the provision of care and support services to PLWHA and their families."*

The CEDPA triage center model is worth mentioning. These centers, which are located in selected communities in selected states, enabled clients to access drugs within their proximity, instead of walking long distances to could get medications for opportunistic infections. In addition, most clients who are poor were able to access the drugs for free at the triage centers. This makes the process cost-effective for the clients.

The evaluation also revealed that gender has been mainstreamed into HBC, as both sexes benefitted from HBC training and provided services, which reached both male and female beneficiaries. This outcome contributed to the shift in the traditional way of seeing only females as the primary care givers of the sick.

Having stated the above, there are issues relating to quality of services observed during field visits, especially at the household level. This is explored further below.

ii. Increased Access to HIV Sexual Prevention Services and Interventions

The prevention interventions have increased access to HIV sexual prevention services through the awareness-creation activities of the peer educators (PE). The PEs interviewed during the evaluation were found to be knowledgeable and committed. The PL Project has also achieved positive outcomes with some sex workers as there is an apparent realization that protection is crucial. Many are now using and insisting on condoms for any sexual transactions. This project has also resulted in some sex workers changing the focus and means of their livelihoods.

One of the success stories shared in Kano was: *"A former commercial sex worker who gave up sex work following her training as a peer educator, and started a business. She also employed other sex workers in order to get them out of the sex trade. She is also paying for vocational trainings so that the women do not retreat to sex work."*

The PL Project has succeeded in establishing extensive programming for in-school youth in the selected areas of operation in the selected states. The project provided peer education in cooperation with anti-AIDS school clubs on various HIV and AIDS-related subjects. These groups used different entertaining and creative activities such as drama, poetry, health talks, focusing on prevention methods. Peer educators reported that they raised awareness regarding HIV and AIDS, though it is difficult to judge the impact this program had on the youth. Here are some comments from some of the youths reached with the peer education program:

> *"When I was introduced to this program, I was very excited because my mentality changed completely. I was illiterate about the program; my idea was that if I should have a boyfriend just like that I will become HIV positive. Through the training program I now have a better idea of what HIV/AIDS is all about, I know how to prevent myself from being infected and I acquired skills on how to encourage people who are HIV/AIDS positive to live positively and educate others who are not positive to abstain or to use condoms. Let me say the happiest moment for me is year 2008, when I was empowered to be a peer educator through trainings provided by CEDPA PL Project." Reported by a peer educator from Kogi State.*

> *"Before, I have four girl friends, but this program has empowered me to relinquish three and I am now stable with one. Even with the one, I do control my emotions not to have sex since I now have knowledge of all the implications."*

> *"Prior to meeting one of the PEs on this project, I do live a reckless life. But the sessions I attended on decision making made me to have clear focus and now determined to go back to the university." Reported by a youth during a focus group discussion at CAIV, Calabar.*

The PL Project activities were also found to attract the interest of teachers, benefitting them as well. Many teachers were trained as master trainers, and supervise the young PEs. A teacher in Lagos State reported that:

> *"It was a privilege for me to be trained and disseminate the message to my students. My experience with the project is information is power, and ignorance cannot be compared with knowledge. My knowledge of HIV/AIDS following the training has also changed my wrong perception that AIDS is not manageable. I have been able to reach other 12 schools aside my own school with this program and also educate young people in churches. The program is very useful and should be expanded."*

In Kano, the PL Project has enabled TAMAKO support group and Support for Women and Teenage Children (SWATCH) to penetrate other vulnerable groups such as the IDUs and MSM. They managed to engage these groups because of the capacity they got from CEDPA through trainings. These groups need to be trained as PEs rather than just giving them condoms, as this would strengthen the prevention methods appropriate for these special groups.

Another outcome is the strengthening of collaboration with other organizations such as the Society for Family Health (SFH), which has helped to supply condoms, ITN, and WaterGuard, providing wide distribution in the various areas of operation of these projects.

iii. Facilitate Prompt and Efficient TB Diagnosis, Treatment Support Services and TB Management among PLWHA and their Families

The PL Project managed to increase awareness and sensitize communities on TB issues. Even though the target for this component of the project was not met, it was clear that people benefitted from the project as they were able to access drugs and restore their health. Few of the beneficiaries that were randomly selected and visited at home were seen with the TB drugs, and appreciated the advice and care provided by the caregivers.

iv. Expanded Care and Support to Orphans and Vulnerable Children

This component of the PL Project was expected to deliver quality services to OVCs and their caregivers at all levels. The extent of implementation varied across IAs, as did the outcomes and possible impacts. The trainings conducted by the CEDPA PL Project resulted in enhancing the livelihoods of some beneficiaries, as some who received trainings on Microenterprise Fundamentals through USAID/MARKETS were able to transform their original business. For example, a member of Tamaiko Support Group in Kano confirmed that:

> *"I am now the main contributor to my household and we are making up to N3,000 profit each month, and I am able to allocate my income between my business expenses, personal expenses and savings."*

Also, in RAHAMA Bauchi State, groups of PLWHAs were formed and connected to other microfinance loans; most of these groups demonstrated 100% repayment and were able to transform their respective business and the economic life of their families. Analysis of those interviewed on gains from IGA revealed that 100% of the respondents were trained by CEDPA consultants and USAID/MARKETS but only 23% received a grant to implement what they learned (even though from other sources) and 34% reported that the economic lives of their families were turned around. These beneficiaries reported that they are able to pay school fees and provide basic needs to their children through IGA projects they are implementing. The food supplement provided by USAID MARKETS for OVCs and clients resulted in some cases having meals, while the health and education program enabled the kids to remain in school.

The kids clubs that was established resulted in empowered children being able to sensitize others on HIV and AIDS and child abuse issues. Some children benefiting from the project were very positive about it because of the care they received and pleaded that it should be extended to other children.

Beneficiary of the OVC program displaying school items provided by the PL Project

A custodian of two orphans visited reported that*: "The supplies provided by the project is a relief on me as it would have been difficult to care for the children with the number of children that I have already–the support has helped the children to remain in school."*

The project also encouraged family adoption of OVCs in some communities. A community leader in Akamkpa LGA said: *"The project has sensitized us on the need to care for these orphans. I have three in my household in addition to my own four children. The materials provided have been helpful, but it would have been better if all the custodians of these children could be supported with IGA to sustain the support especially now that the project is rounding up. We see this as a missed opportunity."*

v. Provide Livelihood Programs Including Sustainable Income Generating Activities for PLWHA and Affected Vulnerable Families and Children

Most IAs reported that they did not do well on this intervention. Even though the CEDPA PL Project provided IGA trainings, most people who were trained are sitting on their knowledge and skills because they could not get the capital to utilize what they acquired from the training. However, other people have been able to be linked with other organizations that enabled them to access resources and utilize their knowledge.

For example, the Tamaiko support group in Kano—a well-established and well-organized group of men and women living with HIV and AIDS—managed to link trained beneficiaries to micro-credit schemes and 50% of the beneficiaries are earning a living through IGA activities such as buying and selling food, oil processing, and tailoring. Most of the beneficiaries reported that they are able to eat three meals a day as a result of support from the CEDPA PL Project. A Director in Ministry of Health, Kano reported: *"The support group has been very active, and because of their remarkable achievement in this PL Project, the ministry has now earmarked N16 million to assist Tamaiko SG in their activities."*

vi. Strengthened Institutional Capacity of Multiplier Organizations (MOs), Community-based Organizations (CBOs) and/or Implementing Agencies (IAs)

The institutional strengthening of the MOs resulted in active leveraging of funds from alternative sources. For instance, ACAP has been able to secure funding for the OVC program from Christian Aid in late 2009, and currently submitted a proposal to NACA. They are also looking inwards to raise funds for HIV/AIDS activities for the church. ACAP noted: *"Without CEDPA PL Project, we would not be where we are today. The project tarred the road for us to move on. CEDPA raised ACAP to get some standards to implement and manage program. Most things done today were learnt from the CEDPA PL Project. Honestly, it is difficult to quantify our benefits."*

In the same way, APMU confirmed *that "partnership with CEDPA resulted in improvement of APMU over the years in terms of building the capacity of our management team."* This and others have enhanced their ability to secure funding from Winrock International for the OVC program and IGA activities.

The IAs and CBOs were very positive about the capacity-building workshops, as they have improved some implementing agencies with no structure or previous experience in implementing HIV and AIDS activities. Such IAs are now active and have successfully implemented PL Project activities through enhanced capacity-building from the project. The Director of CAIV noted that *"In the past, we were only interested in working, no report at all. But now we are structured, with the constitution of PMT in place, keeping monthly project and financial reports, developing workplans, etc. The CEDPA PL Project has made us to be more organized and structured."*

Support groups were also strengthened as a result of the project, they are now registered as CBOs, and those working on IGA are in the process of registering as cooperatives. RAHAMA reported that five groups managed to source funding from other donors after submitting a proposal. TAMAKO support group has managed to engage the Ministry of Health (MoH) into their programs and will be receiving N16 million for their activities.

IV. PROJECT ORGANIZATION AND MANAGEMENT

A. ORGANIZATION

This section covers the organization management of CEDPA at all levels and how this has affected the management of the PL Project. This section also reports on the management of finance and administration, partnership strategy, and the effectiveness and role of USAID in managing the project.

Several documents[5] have been developed to describe in detail the programmatic content and expectations of CEDPA and USAID in the overall delivery of the expected six key outcomes of this project. USAID (Washington and Nigerian Mission) served as the technical control and monitor for this cooperative agreement in line with the dynamics and paradigm shift within PEPFAR programming and funding context under the directive of Office of the U.S. Global AIDS Coordinator (OGAC). CEDPA (Washington and Nigeria Country Office) was the award recipient and the direct implementer of the program. In general, funds disbursement for this program is made from USAID in Washington to CEDPA Headquarters Office, also in Washington, prior to disbursement to the grassroots implementers in Nigeria: the CEDPA Nigerian Offices, MMOs and IAs. Conversely, it was clear that CEDPA Washington has the responsibility to institute a solid institutional arrangement for efficient and effective technical delivery of all the key outcomes expected of the project in Nigeria.

At the onset of the PL Project, CEDPA Nigeria had additional resources through funding support from the Packard, MacArthur Foundation to implement a reproductive health (RH) Program, from the Ford Foundation for capacity-building and Voluntary Counseling and Testing centers in Bauchi, and from the CIDA for a gender and HIV program. CEDPA appointed the Project Director for the RH program as Country Director overseeing the RH portfolio and reporting directly to the Director of Programs at CEDPA/HQ. For the PL Project, a Chief of Party (CoP) was recruited with dual reporting responsibilities: one to the Country Director (CD) and the other to the Vice President at CEPDA/HQ.

The organograms used by CEDPA for the management of the four-year PL Project are presented in Appendix B. A key issue for example in COP years 2006 and 2007, was how the CD was more or less excluded in the management of the PL Project, even though the organogram shows certain level of connection in terms of reporting line. This observation was confirmed by consultation with the CEDPA headquarters which stated the reason as: *"The PL Project is the biggest project of CEDPA and needs to be managed with all the full attention required to achieve the desired results."* This approach resulted in loggerheads between the CoP and the CD.

CEDPA reports that by mutual agreement the CoP was replaced by a Technical Advisor from CEDPA Washington as interim CoP. This experience resulted in the third organogram, where in the positions of CD and CoP was merged. This effort still did not yield the desired result because the Finance and Administration Director was reporting directly to the headquarters. Also according to CEDPA, initially the Finance and Administration Director reported directly to the CoP. But the CEDPA/Abuja office faced continual financial management challenges. CEDPA/HQ observed performance issues and late financial reporting. HQ was concerned by the continued weak and consistently late financial reporting and urged the Finance and Administration Director and CoP to identify the skills and staff needed to properly oversee the project. No additional staff was requested. When problems persisted, HQ changed the

[5] Original Positive Living Project SOW and Contract Agreement–June 4, 2006.
Approved modification of Program Statement– March 13, 2009.
De-scoping Strategy document – December 2009.

reporting so that the Director of Finance reported directly to HQ, with the intent of providing better oversight and help fix the problems.

The high staff turnover also had its effect on the project. It affected continuity in some areas, leading to the use of consultants who seemed to be expensive for the project and also lacked the institutional memory required for the continuity of any project. The high staff turnover—especially amongst the key technical staff—was traced to leadership problems, an unfriendly working environment, and issues with the human resource policy. In addition, the staff had concerns about the technical direction of CEDPA and the fulfillment of their career objectives should they continue with CEDPA.

B. POSITIVE LIVING PROJECT MANAGEMENT

At the onset of the project, especially in COP 2006 and 2007, certain technical systems, such as grant making and management, were lacking. This created undue bureaucracy in the management and administration of sub-grantee awards. This was indeed evident in the way that key project management staff handled misunderstandings with their two MOs and some IAs when there was the need to make shifts from the institutional capacity building component to actual service delivery in response to pressures from USAID for CEDPA to deliver on set program targets.

Regarding the effectiveness and efficiency of the technical implementation of the key program areas (HIV prevention, basic care and support/HBC, TB/HIV and community TB care, OVC, and others) as it links to the direct outcomes of the project, CEDPA made a tremendous effort to implement these program strategies in line with the established National Guidelines for respective program areas. Of a great significance was changing the HIV prevention strategies to the Minimum HIV Prevention Package of Intervention (MPPI) and the implementation of the Prevention with Positives (PwP) at the community level. However, for a community-based program of this magnitude, it is expected that standard operating procedures (SOPs) detailing the standardized process and key steps for providing community-based services should have been extracted from the existing national guidelines so that they serve as easy reference materials for the literate community HBC. CEDPA points out that it is important to note that Nigeria had no set national guidelines for community home-based care (CHBC). CEDPA was very active in the development of the manual. Also, the MPPI and PITT were only fully rolled out last year by the government. The PwP manual was not ready until this March, when the first training was done by CEDPA and Winrock volunteers, while a pictorial format is being developed for non-literate users. Despite this challenge, the PL Project was able to keep track of its technical deliverables in HIV prevention, OVC, HBC/Basic Care & Support (BC&S) and Community TB Care (CTBC). However, the project was unable to conclude the process and deliver an essential component of the livelihood and income generating activities (IGA) whose sole aim is to strengthen household economy and increase access to finances for OVCs and PLWHA, which would have sustained the poor and vulnerable benefitting from the project.

Although the program put in place systems for routine program monitoring and data verification, this did not work out as planned largely due to lack of vehicles at the IAs, and the capacity of staff in the state offices to cope with these challenges.

C. FINANCIAL AND ADMINISTRATIVE MANAGEMENT

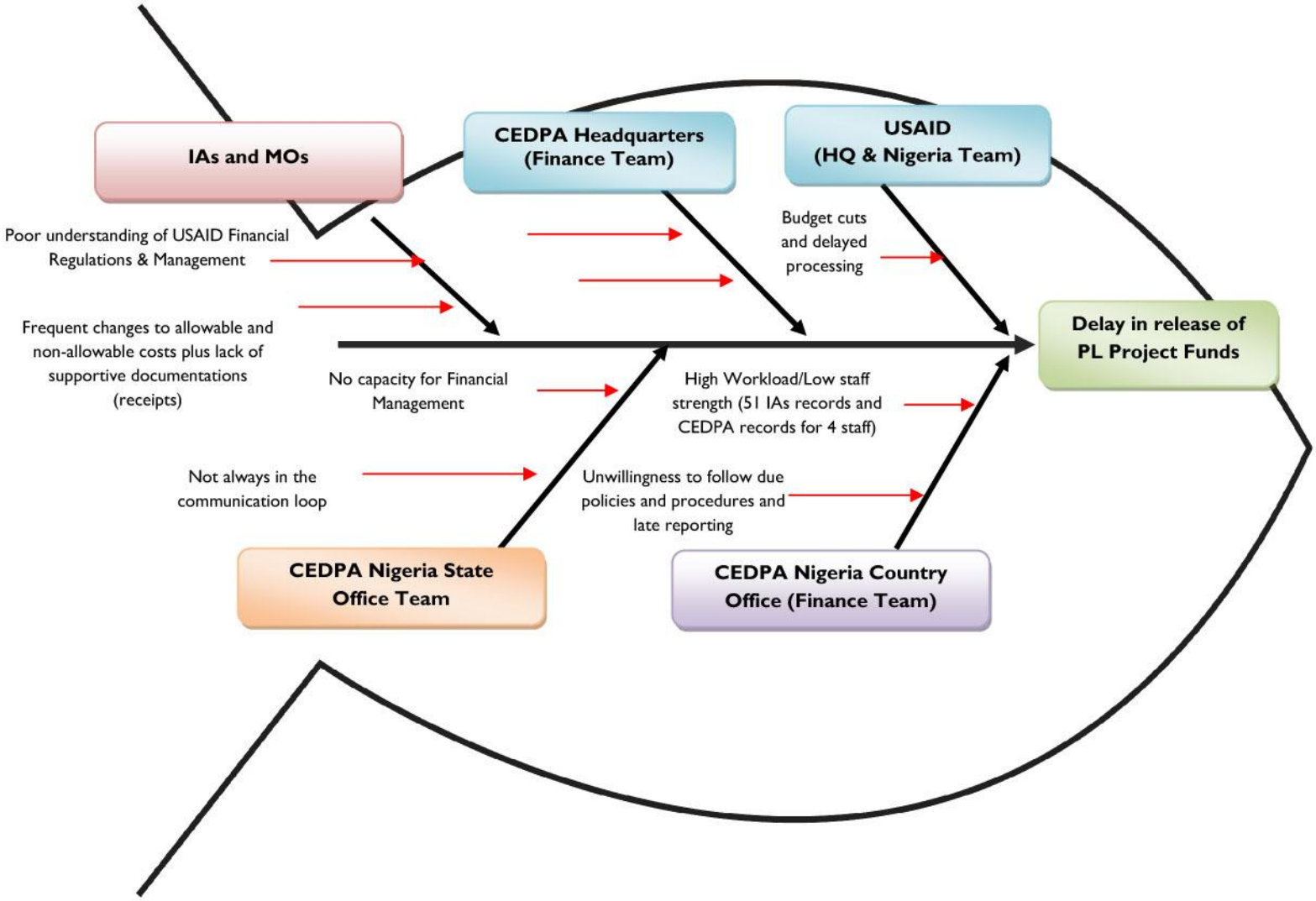
This evaluation revealed that the finance and administrative component of the project faced some key challenges. The overall financial and administrative management of the PL Project dwells within the CEDPA Washington and the CEDPA Nigeria Country Office. An explanation for this is seen in Section A (Organization) above.

Neither the state field offices nor the regional structure had any finance personnel in place to promptly review and process the financial reports from IAs. As such the "lean" finance staffing at the CEPDA Country Office had to deal with reviewing and processing the financial reports of 50 IAs and 2 MOs, which in most cases resulted in backlogs creating bottlenecks for program implementation and financial reporting to CEDPA /Q. This resulted in incessant delay in the release of project funds which often scuttle the timelines and flow of project activities, and subsequently created distrusts and embarrassments amongst the volunteers and the IAs.

USAID conducted a financial review in 2008, and CEDPA/HQ responded to these issues through recruitment of grants and a compliance officer, organizing appropriate trainings and relevant technical support to CEDPA Nigeria country finance team. This produced some progress but with residual challenges at the grassroots level, mainly due to lack of systems and capacity at the CEDPA State Offices level to review and certify the MOs' and IAs' financial records and reports before submission to the Country Office Finance Team. The causes of delay in the timely release of project funds at all levels are summarized in Figure 3 on the following page.

Overall, the Positive Living Project's organizational structure was not thought out in a way that optimizes program implementation and management in a timely, effective, and efficient manner that would in-turn maximize the results of key performance objectives and the outcome of the project. Strategic directions and proactive change management processes with respect to the program implementation and management were mostly sporadic, and often based on response to feedback from USAID annual portfolio reviews. This is more apparent in the areas of financial management. Beyond the PL Project itself, other factors that limited the optimal achievement of the outcome result were ever-changing policies, procedures, and guidelines as well as the performance-based driven nature of the PEPFAR funding mechanism globally.

Figure 3: Cause-Analysis of the Incessant Delays in Release of PL Project Funds using the Fishbone Diagram



D. PARTNERSHIPS STRATEGY, COLLABORATION, AND EFFECTIVENESS

Various levels and tiers of partnerships were stated in the project documents. However, conspicuously missing is the collaboration with key stakeholders at the national level—namely NACA, the National AIDS & STD Control Program (NASCP) and The National TBLCP—which might have informed minimum engagement with these vital stakeholders. Engagement of government and relevant agencies was weak at both the Country and State level. This made it difficult for the government to take ownership and plan for the sustainability of the Positive Living project, whether through the budgetary or donor coordination process.

This evaluation revealed that CEDPA had contact with NACA to obtain a concurrence letter as part of the application process. However, there was no collaboration with the department of Partnership, Coordination, and Support within NACA which takes responsibility for the coordination of CSOs response to that national response. The Director in charge noted that:

> *"I am aware of the focus and activities of the CEDPA PL Project through the IAs they work with in the states. There is no doubt that the project generated outside facility data since they focused on community response. This is unique but they failed to carry NACA along, and now that they are rounding up, NACA would have explored continuity with the states involved now that they are about to sign HIV/AIDS Funds (HAF) 3 grants."*

The M&E focal person in NACA confirmed that CEDPA is a member of the M&E Technical Working Group and has contributed to various efforts in harmonizing indicators at national level. However, this is not perceived as sufficient to build an active working relationship for this kind of a laudable project.

Consultation with NASCP also revealed that the collaboration and partnership was not active. The Director confirmed that *"the CEDPA PL Project invited NASCP to the Project Advisory Committee (PAC) three years ago, but there was no information thereafter. Our only involvement was when we were invited to be part of the mid-term review conducted in 2008."* Attempts have been made to invite CEDPA to annual partners' forum, but this was not acknowledged and limited the extent of collaboration with the PL Project.

The partnership and collaboration at state level too was limited as noted above. Only Kano state reported active collaboration with State Ministries of Health (SMoHs) and State Action Committee on AIDS (SACA) out of the six states selected for the evaluation.[6] The state MoH in Kano and Cross River states also confirmed their awareness of the PL Project. For other relevant line ministries such as the Ministry of Women Affairs and Child Development, collaboration did exist but with low-level cadre officers who have limited ability to influence changes or any decisions as may be required especially for the continuity of the PL Project.

Collaboration with other USAID implementing partners such as GHAIN, MARKETS and SFH demonstrated that resources could be leveraged to produce a quantum effect with respect to improving the quality of life of PLWHA and their families.

GHAIN's partnership with PL Project in some of the coverage states helped in identifying clients for the CHBC, which eventually gave many of the beneficiaries' opportunity to access psychosocial support, supportive counseling, and especially drug-adherence counseling. In the case of MARKETS and PL Project partnership, some OVC caregivers and PLWHA (HBC beneficiaries) increased their ability to attain sustainable household economic strengthening through organized entrepreneurial and income generating activities (IGA) trainings. There have

[6] The CEDPA focal person in Lagos State also confirmed active collaboration with SACA but not ascertained as LSACA was not reached during the evaluation.

been a number of success stories involving families and individuals who have turned around their economic prospects as a result of the trainings.

Through the SFH partnership in all the states visited, SFH provided the procurement and logistics support to the PL Project whereby many PLWHAs, through COP 2007, have been receiving basic self-care kits comprised of ITNs, WaterGuard, buckets, and jerry cans. This has resulted in many beneficiaries experiencing dramatic reduction in illnesses such as malaria, diarrhea, and other opportunistic infection, as well as hospital visits and travel costs. Another major area is the procurement and distribution of condoms for the HVOP activities.

The partnership with MOs and IAs yielded the desired result especially in building and strengthening the capacities of these organizations. Organizations such as CAIV in Calabar and Tamaiko SG in Kano were supported from the beginning and have now gained recognition in the various communities where they are working. The PL Project has succeeded in supporting them in putting in place structures and systems so that they can function effectively and efficiently not only in managing the project but also in running the operations of their organizations. The evaluation also noted that the concerns and issues raised by the IAs, especially SWAAN and Muslim Action Guide against AIDS (MAGA) were not well managed by the PMT of the CEDPA PL Project.

E. ROLE OF USAID IN MANAGING THE PROJECT AND EFFECTIVENESS

The evaluation team understands that USAID had substantial minimal involvement in managing the PL Project to ensure achievement of results because the award of the PL Project was based on a cooperative agreement. USAID was involved in the approval of key personnel recruited by CEDPA and the replacement of the Chief of Party. USAID also conducted Annual Portfolio Reviews of their programs, but this was found to be limited to desk reviews and verbal conversations with the respective IPs. This evaluation found that these reviews are not enough, especially in dealing with management issues that have arisen and affected the performance of this project.

The USAID key officers were of the opinion that they were unable to go beyond the various efforts made considering the challenges faced by the project because they are limited by the cooperative agreement award of the PL Project. The evaluation team considered this opinion to be a barrier for USAID in managing its funded projects to ensure that it gets value for the resources invested.

V. ISSUES AND CHALLENGES

The evaluation of the PL Project has identified a number of interesting issues concerning the leadership and management of CEDPA as an organization, the PL Project, the capacity of staff to deliver, the timeliness and quality issues in project delivery, and partnership, etc. Some lessons also emerged from the evaluation, but the issues themselves are germane to guide future efforts.

A. LEADERSHIP & ORGANIZATIONAL MANAGEMENT

There are issues with the organizational management and leadership of CEDPA at the country and state offices regarding the management of the PL Project. There were frequent changes in the positions of Chief of Party (CoP) for the project as well as that of Country Director. Although these changes were attributed to many factors, they were largely due to:

- A weak functional system in place to manage and run the field office. The system in place was found to be ineffective and inefficient in managing the project and the organization as a whole. This created loopholes for staff to implement and carry out activities without reference to established rules and procedures. The ineffective management also created division amongst staff, resulting in the management of people based on loyalty. In general, consultation with staff of CEDPA PL Project revealed that there was lack of unity, team work, cohesion, and cooperation amongst staff, which subsequently compromised the project and full attainment of the expected project outcomes.

- Weak reporting lines which reduced the ability of the CoP and CD to have input and make decisions regarding the management of the project. For example, the CoP of PL Project reports directly to CEDPA home office without the involvement of CD, and the Finance Director reports to the Home Office without the knowledge of the CoP's activities. No CoP or Country Director can function well without a functional reporting system, which an organization must create and adhere to. The previous leaders of the organization at country level noted that:

  "There is no continuity of vision from the founders of CEDPA to the subsequent leaders, thus making the organization to lose focus and failing to maintain the philosophy of the organization which is about empowerment."

  This evaluation revealed that CEDPA failed to put system in place to ensure the empowerment of the leaders of the organization at the country and state level so that they could function and contribute maximally to the delivery of the project.

- Initially the lack of, and then the non-adherence to the staff personnel manual made available in April 2008. This made it difficult to manage the staff as required. In addition, staff believed that their inputs and contributions to the personnel manual were not given adequate consideration. This also contributed to staff attrition.

- Weak communication with various levels of CEDPA offices. The country office believes that all information resides with CEDPA/HQ, and that it is only provided the information that CEPDA wants it to have.

B. HUMAN RESOURCES MANAGEMENT ISSUES

Many key technical staff left the CEDPA/Nigeria PL Project between COP years 2008 and 2009. This was partially attributed to a staff personnel policy perceived to be unfriendly because it did not provide a gratuity and terminal severance package, lack of motivation for staff, and the way

in which staff appraisals were managed. It was felt that these factors had a negative impact on staff growth and advancement. Some staff of the organization noted that:

> *"We never had feedback on annual appraisals that were conducted twice in the life of the project, no incentives or pay raise whatsoever and nobody provides feedback on your performance, not to talk of having plans in place for staff performance improvement."*

Some staff expressed the lack of opportunity for technical and managerial capacity-building. According to some staff members, this and the other factors discussed here limited motivation and commitment to the project.

Another major factor is lack of an enabling and friendly environment where staff members to work to maximize their potential. *"There are camps within the organization, if you do not belong to the camp of CoP, then it is that of DCoP,"* noted PL Project staff at country level. The evaluation team attributed this to a lack of and non-adherence to a functional system, which is not healthy for any organization working to maximize the potential of its staff.

Another major issue was the inadequate staff in the finance department. The lack of staff with expertise in finance at state level compromised the provision of much-needed technical oversight to the two MOs and 50 IAs spread across all the CEDPA-supported PL Project states. This has had grave consequences in terms of non-retirement of funds and the resultant delay in the release of program funds.

C. ORGANIZATIONAL STRUCTURE AND DECENTRALIZATION

The evaluation team observed that the PL Project's management organizational structure did not allow for adequate, effective, and efficient decentralization to advance the project in Nigeria. This was attributed to weak leadership and CEDPA's inability to get the right personnel recruited for the key positions at country level due to the various PEPFAR projects implemented in the country, which attracted many talented potential employees. The result of this lack of effective recruitment was that most tasks were conducted and decisions made at the headquarters.

> *"We realized the need to get things right for the management of the project, hence the need for the CoP and Finance Director to report directly to the headquarters – noted the CEDPA Washington team."*

But the fact is that there is no way management of programs could be done effectively without adequate power and authority at country level for timely decision-making.

> *"A CoP noted, we developed costed workplan, but not followed by the headquarters, and do not get what they applied for in the budget. I do not have control of the finance of the project, how then do you expect me to manage project without knowledge of how the finances are managed?"*

Key informants strongly believed that there were serious challenges to both vertical and horizontal communication channel at CEDPA/Nigeria. There were no clear cut communication lines and where they existed, the flow of information was strongly influenced by the poor internal management system. The CEDPA staff in the country office consulted noted the weak communication and in most cases did not know when activities would happen. Field staff reported that sub-agreements were between headquarters, the country office, and IAs—mostly from Washington up until COP year 2008— and they were only informed by email of the amount remitted, which they expected to follow up.

> *"This they considered as wrong as it dented their integrity and prevented them from managing the project in a participatory way."*

D. NON-TIMELINESS IN DELIVERY OF PROJECT ACTIVITIES

The evaluation team noted project activities' implementation was skewed to the third and fourth quarter of the COP year. This happened because of delay in the release of funds to implement activities. CEDPA attributed this to late financial reporting by some IAs, as the sub-grantees do not have adequate capacity to do accurate financial reporting, as well as inadequate financial experts on the ground to build capacity and deal with the backlog of retirement. The lack of timeliness resulted in inconsistency in the delivery of activities, as well as in the quality of services delivered, as IAs and volunteers worked toward attaining their program targets and skimped on quality. This was termed *"Touch and Run Programming Style"* by ACAP.[7]

E. QUALITY ISSUES IN CEDPA PROGRAMMING

Although CEDPA seems to have attained targets in some program areas, the quality of the programming remains an issue. Most of the targets seem to be achieved through a rush of activities. This is quite obvious in Q4 of the sexual prevention intervention through HVOP and HVAB. The delayed funding in COP years 2007 and 2008 explained this. When funds were eventually released, IAs were still made to work round the clock to achieve targets with little premium placed on quality.

All the IAs visited in the course of the consultation maintained that the quality of the data and programming remains a big issue as funds were released in quite untimely way, and afterwards, the focus remains on meeting the targets. This happened in COP year 2007. In COP year 2008, funding was halted and most of the activities slowed down drastically, resulting in high attrition amongst the volunteers whose stipends could no longer be paid by most of the IAs.

In COP years 2007 and 2008, due to the dearth of funding, most IAs gave the volunteers a transport allowance based on the number of visits made to the clients. There was a decline in the number of volunteers trained while the number of PLWHAs reached with PC/HBC services increased. Quality remains an issue under this type of arrangement in which most of the volunteers would rather visit more clients and collect a higher allowance in return. Focus group discussions with care facilitators in Kogi and Bauchi (BDACA) states revealed that two out of 10 care facilitators reported that instead of receiving basic training, they had been oriented by their colleagues.

The numbers of those who had refresher courses also varied from group to group. The general observation was that these courses were not held regularly and that many care givers had only been trained once. It is important to note that ongoing training establishes the credibility of care facilitators. A key finding is that commitment and support varies by area. For example, during FGDs in some communities, clients reported very irregular contacts with care givers even when they were bed-ridden. It was also noted during consultation that clients and caregivers gave food-related needs more emphasis than health needs. Both men and women beneficiaries pinpointed lack of necessary follow-up as another major deficiency in the quality of service provision. They explained that there was no consistent effort by some of the IAs to make sure that services and provisions had actually reached their targets.

In COP years 2007 and 2008, there was a decline in the number of volunteers trained due to the lateness or interruption in the release of funds. This obviously affected service delivery in terms of people reached with preventive intervention since many of the volunteers quit.

The CEDPA M&E system for the TB/HIV collects data on the number of HIV-positive individuals screened for TB and the number of HIV-positives newly initiated on TB treatment. With these indicators, it would be difficult to assess the quality of the linkages between screening and

[7] Anglican Communion HIV/AIDS Project Management Team.

treatment activities. The indicator on the number of HIV positives screened for TB, and then tested positive and negative, is missing because the referral hospitals are responsible for reporting this information.

F. PROJECT MONITORING AND EFFECTIVENESS

The project M&E system of CEDPA/Nigeria— which entails the tracking of the inputs, processes, outputs, outcomes, and the possible impact of the PL Project in order to inform decision-making—needs to be strengthened. For example, the CEDPA/Nigeria country office hosts the Director of M&E and only one M&E officer was recruited in COP 2008. The CEDPA/Nigeria field offices host technical officers who were designated as M&E officers. The technical competencies of these field M&E officers remain an issue, which in itself has adversely impacted the overall functionality of the CEDPA/Nigeria M&E system.

Furthermore, CEDPA/Nigeria lacks well-documented technical procedures and practices. For instance, there are no "Standard Operating Procedures" for all the thematic areas to guide the CEDPA IA staff, including the volunteers and focal persons who deliver these services at the community level. Thus, monitoring of program quality is compromised because the quality of data emanating from such a system is compromised. Also, there is no standardized data verification or data-quality assessment systems or tools in place for each of the thematic areas, nor is there a system in place for assessment of the quality of the programming.

During the state field visits to the IAs, M&E data collection tools were quickly examined for data availability and consistency. It was observed that the tools were usually completely filled in and missing fields were very minimal. This applies from the low to high level of data flow, that is, from the client service forms to the registers, then to the summary forms. However, there was no clearly defined mechanism or evidence for data use in place to influence decision-making or re-programming. Most of the data are collected and then exported to the CEDPA field office.

The M&E focal persons at the IAs expressed frustration that there were too many forms to be completed and that the tools were frequently changed. However, they said that the introduction of new tools was usually preceded by training. The focal persons strongly prefer that the data collection tools be "streamlined" to collect the minimum standardized data set for reporting, which will reduce data redundancy.

Furthermore, most of the volunteers engaged to deliver community services are not completely literate and the data collection forms they must complete seem too complicated for their level of education. For instance, a volunteer with Global Health and Awareness Research Foundation (GHARF) Enugu who was interviewed revealed that, due to her illiteracy, she usually completes the forms with the help of her son. This will affect the consistency and validity of information that is transcribed into the forms. The use of the forms in local languages, or in pictorial forms with a checklist, may be helpful.

The lack of program monitoring, especially by the IAs to assess quality of services provided by the volunteers, was also an issue cited. This deficiency was attributed to a lack of vehicles to ensure program monitoring: although CEPA had a travel allowance that is calculated per visit, it is unable to provide vehicles to every local partner. The annual portfolio review conducted by USAID also needs to be deepened beyond a desk review in order to gather evidence-based information to guide decisions to be taken re-project performance. The annual review also needs more flexibility to avoid the limitation that the cooperative agreement has on USAID in managing their IPs.

G. PARTNERSHIPS AND COLLABORATION

The partnerships and collaboration of the PL Project with key stakeholders were weak at various levels: this was explored above. There was no active collaboration with NASCP at the national level. The Deputy Director of NASCP noted:

> *"NASCP was approached three years ago to serve on the advisory body for the project, but there has not been any information thereafter, except their involvement in the mid-term review."*

To enhance the collaboration, NASCP invited CEDPA PL to annual partners meeting but with no response whatsoever.[8]

> *"Our involvement in this important project should go beyond participation in mid-term review or final evaluation, as there are other benefits that both NASCP and the PL Project could enjoy."*

Equally, NACA, the coordinating body for all HIV/AIDS activities in the country, reported that CEDPA has not collaborated with them. The Director of Partnership, Coordination and Support noted that:

> *"I have not seen CEDPA since they came for the concurrent letter to enable them apply for the grant four years ago. This project is very key to the national response considering the community centered approach adopted. But we don't see them and do not know much about their work."*

The same observation was noted in terms of collaboration with SACAs in some of the participating states. The engagement with the line ministries was also found to be at low level, and not where the program could gain recognition or advocate effectively for meaningful support. This is very challenging and has implications for the continuity and sustainability of the project. This is missed opportunity, as most SACAs would soon access the HAF 3, which could be utilized for the continuity of the project.

Although the evaluation noted good collaboration with GHAIN and SFH, especially at the state level, the collaboration with GHAIN was not working as expected up until the end of 2008, as both CEDPA and GHAIN seemed to be operating independently. A corrective measure was taken in early 2009 to develop a collaborative strategy which facilitated meetings at the country office, zonal, and at facilities level. At the time this evaluation was conducted, a transitional plan was not in place so that GHAIN could take up their IAs to ensure continuity of services in the CEDPA sites. This was the case even though selected GHAIN offices at the state level noted that they are already talking to some of the IAs, but had nothing concrete on ground yet.

H. LIMITED ADVOCACY AND COORDINATION

Despite the shortcomings in managing the project, there is no doubt that it has touched the lives of the people at the community level—and of course there are some success stories. But the PL Project lacked effective advocacy and coordination with the necessary bodies in the country—such as NACA, the SACA and line ministries—to create awareness about the achievements of the project and its challenges. This is especially true in the area of continuity or leveraging of resources expected to be available for the same purpose in the country.

> *"This project would have provided the national response data on outside facility response, but not sure if this is captured in the national response. Also I am not sure if they also send report to SACA at state level thus limiting the knowledge of coordinating bodies on their activities. Such*

[8] Invitation letter was cited by the evaluation team.

information would have been helpful for the SACAs to bring the OVCs on board when they receive the HAF money which is expected to be signed soon."[9]

During the explorative interview with key officials of CEDPA/Nigeria, the evaluation team learned that although there have been many remarkable achievements, they have not been properly showcased or published by the CEDPA/Nigeria office. This seems to have masked the positive effect that the project has had on the lives of people living with HIV/AIDS (PLWHA) and their families, and across all the six thematic areas. The key informants of CEDPA/Nigeria attested to the fact that CEDPA has not really projected the image and accomplishments of the organization in the course of implementing the PL Project to key national coordinating bodies charged with HIV/AIDS coordination in Nigeria.

I. ISSUES WITH THE IMPLEMENTING AGENCIES

Many of the IAs viewed their relationships with CEDPA as that of an unequal partnership, in which CEDPA can give instructions without recourse to their concerns. When the budget was slashed in COP year 2008 sub-agreements, the IAs protested that this would be unrealistic for the project. MAGA and SWAAN Lagos had these issues documented[10'11] and sent to CEDPA, but received no feedback. This resulted in SWAAN Lagos pulling out of the project, with the remaining IAs continuing implementation on the basis that "half bread is better than none." Some CEDPA staff, especially at state level, pleaded with the IAs to manage and see how they could implement the project within the available funds. This also resulted in some IAs cutting from certain budget lines to make up for the salary of staff on the project. For example, the highest salary for IAs' project staff, which was N15,000 ($100) per month in sub-agreement signed in COP years 2006 and 2007, was slashed almost in half in COP years 2008 and 2009. This resulted in most staff leaving the project.

The delay in the release of funds in COP year 2008 also resulted in litigation cases against SWAAN, Lagos, where volunteers took action with claims that money were owed them. This betrayal of trust amongst the volunteers also had a serious backlash on the image and operations of CEDPA.

J. CLEANLINESS AND REFILLING OF HBC KITS

During the evaluation, HBC kits provided to volunteers were examined. While some kits were empty—a sign of inactivity by the volunteers concerned—some lacked some contents such as gloves, calamine lotion, etc. Also the evaluation team noted that contents of some kits were very dirty. This raises concerns about the prevention of infection to clients and cross infection amongst clients and care providers, as well as quality of care provided to clients and the quality of protection provided by care providers to prevent HIV transmission. One of the volunteers randomly selected noted:

"My kit was last refilled in 2007, I provided care to the clients by talking to the client and support with my bare hands for clients to sit up."

This particular volunteer is a cluster coordinator who takes responsibility for distributing refilling items for HBC kits and collecting reports for onward submission to the IA. The evaluation team attributed this to lack of monitoring and supervision following the delivery of services by the volunteers. The PL Project coordinator of the IA responsible for this volunteer noted:

[9] Extracts from in-depth interview with Director, Partnership Coordination & Support, NACA.
[10] SWAAN Lagos, *Memorandum on Issues for Further Discussion on CEDPA Project COP 2008*.
[11] Maga-Apic Letter dated 6th January 2009 on Notification of Discrepancies in COP 2008 sub-agreement on the Positive Living Project.

"I don't monitor the volunteers as there is no budget line for this, but we have the kits' contents and I am surprised that she does not have the contents in her bag."

K. CHANGE IN PERCEPTION AND UNDERSTANDING OF VOLUNTEERISM

The understanding of volunteerism seems to differ in developing countries when compared to the developed countries. This may be due to the level of vulnerability and poverty. The volunteers working on the project believed that a certain amount of money catering to their own needs should be considered as a way of motivating them because the time they spent caring for sick people in the community would have been used to make money for their own purposes.

"We know it is good for one to be your brother's keeper, but at the same time minimum wage should be considered to enhance our commitment to the job. At times, we spend our own money for the clients – psychosocial support is not enough as the client expect you to drop something before you leave them. The level of poverty is very profound in the villages," noted some volunteers during FGDs.

The evaluation noted the fact that in as much as people volunteered to do the job and saved people's lives, they also saw it as an avenue to make some money. However, in southern and eastern states this did not happen and was discouraging to the volunteers. In the northern states, on the other hand, volunteers did not complain about the transport allowances awarded them, and in fact started a savings scheme to help support each other.

L. CONNECTIVITY, CONTINUITY AND SUSTAINABILITY OF PROJECT ACTIVITIES

Lagos state was selected to assess the plans put in place for the continuity of the project before project closure. Consultation with stakeholders confirmed that there were no solid plans on ways the project could continue with the IAs working in the communities or the volunteers following to abrupt closure of CEDPA Lagos office. A former CEDPA staff noted that:

"We planned to do this, but we were stopped working with a very short notice. The process we initiated could not continue and the organization (CEDPA) seems not to think how essential the process is."

The IAs consulted also noted that:

"Although we planned to continue the project initiatives, but it would have been great if a proper winding up process was conducted before the closure of the Lagos office."

Consultation with GHAIN offices in selected states confirmed that they already initiated discussions with the IAs on the need to continue to work together, but there are no clear plans in place for this to happen. In addition, GHAIN Abuja was surprised to hear about the near closure of the project as neither the headquarters nor the country office have contacted GHAIN about this, despite the fact that they jointly developed a strategy early in COP 2009 to ensure a workable partnership. To date, there is no written sustainability plan of action for the project in all the states and at the national level. Another missed opportunity, as noted above, is the lack of a proper handing over of the project to SACAs or concerned line ministries in the states. This has implications for the continuity of care for the vulnerable groups who are benefitting from the project.

VI. LESSONS LEARNED

The key lessons learned in the course of implementing and managing the PL Project as revealed by this evaluation are:

1. Pre-designed concepts and budgets without the involvement of implementers, especially in community-based service programs, may result in challenges at the level of implementation.
2. Building sustainable community-based HIV interventions may not work without the economic empowerment component in the project.
3. Active participation of stakeholders at all levels is essential to ensuring continuity and sustainability of any community-based project.
4. Institutional capacity of IAs is vital to overcoming the challenges that prevented the effective management of this project, especially the financial management. Good practice should be based on pre-implementation to build capacity of the IAs, in order to develop good skills to cope with the management of the project.
5. Resistance to change should not be allowed to discourage new initiatives, as these may work out well for any interventions. This is the case with the minimum prevention package, which volunteers initially resisted but found to be very useful in terms of its impact on beneficiaries.
6. Active involvement of PLWHA in HIV/AIDS activities, especially HBC, may enhance continuity and the spirit of volunteerism as compared to non-infected persons.
7. Putting in place systems for program monitoring is vital for quality delivery of services, especially at the community level.
8. Effective communication is essential in ensuring effective management of any project. Lack of clarity in communication and reporting lines will always result in information distortion and weak management.

VII. CONCLUSIONS

This chapter draws together the conclusions from this evaluation. The findings summarized at the end of each chapter are synthesized here. The structure of this section of the report follows the five substantive overarching questions stated in the scope of work, and reproduced in Appendix A.

What are the greatest achievements of the project both in terms of expected outcomes and toward the overall goal of improving the quality of life of PLWHA in communities targeted by the project?

The analysis of project outputs in section four and project outcomes in section five showed clearly that the project made some remarkable achievements in achieving the expected outcomes. The HBC model was unique and CEDPA was innovative in re-defining the concept of "home" within the context of care and support services to PLWHA. The HBC interventions helped many clients to be resuscitated from the point of death, to access treatment, to adhere to drug therapy, and to get back on their feet. It generated clients for the antiretroviral therapy (ART) program and treatment for opportunistic infections. The CTBC component of the project succeeded in creating awareness and sensitized communities on TB issues. Most clients who benefitted also had their health restored back to normal. The HBC interventions contributed to the general improvement in the quality of life of clients who were reached and benefitted from the project.

The prevention interventions have also resulted in some level of behavior change as a result of the knowledge acquired during training and peer education sessions. The PL Project encouraged openness and motivated people to go for HCT. It also contributed to the reduction in stigma and discrimination, and created an enabling atmosphere for disclosure, especially amongst discordant couples, who were also empowered on PwP. "*The project provided the opportunity to learn and inform the standardization of PwP,"* noted the Head of Prevention, USAID.

The OVC component of the project resulted in many children being in schools and fewer burdens on their guardians or caregivers. The establishment of the kids club empowered the children and uplifted them. The project also encouraged family adoption in the communities. Even though the livelihood component of the project was inconclusive in its implementation, the trainings conducted empowered some beneficiaries to access loan facilities or connect with other micro-finance projects.

Institutional strengthening of the MOs enhanced their capacity to mobilize resources from other sources and has also empowered and prepared them to tackle future challenges. Most individuals, especially PLWHAs who benefitted from the trainings, also worked as volunteers on the project, and rose to be recruited as project staff in some IAs. Some individuals confirmed that they are working as consultants facilitating trainings as a result of the knowledge and skills acquired from the PL Project. This has also contributed to the economic empowerment of PLWHA.

To what extent has the project improved the quality of life of PLWHA and their families and catalyzed behavior change within target communities?

Quantitative measures were not applied to measure the extent in which the PL Project has improved the quality of life of PLWHA and their families. But there are clear evidences from the field that the project contributed to improved quality of life for PLWHAs and PABAs. The health of some PLWHA who were bedridden was restored and they were able to care

for themselves and their wards. Even though the IGA component of the project was not fully implemented, the PLWHA who were cared for benefitted from trainings that empowered them to work as volunteers and subsequently be employed by IAs to work on the project. Because some have been able to become self-employed providing consultancy services, the project has improved not only the health of the infected but also their economic status. Most commodities provided such as WaterGuard and ITNs reduced the incidence of malaria and diarrheal diseases.

The project has recorded achievements in the area of behavior change. Most people reached with prevention and HBC interventions confirmed how the project has helped to develop a positive attitude that will reduce HIV transmission, contributed to stigma reduction in the community, and acceptance of PLWHAs. This also contributed to enhanced status of PLWHA in the communities and recognition of the support groups formed as a result of the project.

How successful were the project's management systems in facilitating the achievement of expected outcomes and goals?

It was clear from the evaluation that the project would have maximized the potential to achieve the expected outcomes to the utmost if not for the challenges and issues discussed in section six of the report. The management systems in place for the PL Project had serious challenges. These include frequent changes in leadership of the project, staff turnover coupled with weak managerial and technical capacity, and a lack of adequate systems to manage the organization as a whole. All these challenges, and others, affected the project's achievement of expected outcomes.

What are the project's major challenges and lessons learned?

The major challenge faced by the project was mainly in the area of organizational management. The frequent changes of the leadership of the organization at country level and high staff turnover were key factors that limited the project's achievements. Lessons learned from the project are stated in section seven. But it is vital to consult with would-be implementers of any project in order to guide development of a clear concept and budgeting for effective and efficient implementation and management of the project. This would also guide the proper definition of program content, coverage, and the delivery of quality program to beneficiaries.

What strategies should USAID/Nigeria pursue in future programming of interventions addressing the needs of PLWHA, their families and communities?

There is no doubt in the uniqueness of the PL Project as a community-based project. But it needs to be streamlined, and focus on the specific components where the strength of IP lies rather than trying to do everything. This evaluation revealed that the project achieved more in the area of the HBC component and caring for OVCs. Efforts should be directed to this area as it seems this is the component that most funders found very challenging. The component of livelihood and IGA should not be overlooked in future projects, as this is an essential component that could keep the project going.

There is the need to review and restructure the numbers of volunteers on the project and provide remuneration to enable them do their jobs well. It is not about the number of volunteers that matters, but how well they are able to perform. In addition, an adequate monitoring system should be in place to ensure quality delivery of programs to the beneficiaries.

Despite the issues and challenges discussed above, there is no doubt that the PL Project is well-designed and very relevant to addressing the limited access to services experienced by the poor and vulnerable groups at the community level. The project has touched the lives of Nigerians who are very vulnerable, but the issues and challenges discussed above limited the extent of the project's impact.

VIII. RECOMMENDATIONS

Below are recommendations that should be considered in implementing and managing future projects to enhance effectiveness and efficiency.

A. PROJECT DESIGN

Consultation with stakeholders is vital while designing this kind of a project. The design would have spelled out and guided the issue of coverage, distance, etc., and guided the planning of staffing and other facilities required to enhance effectiveness and efficient project delivery. The consultation, and its anticipated challenges, will provide a clear focus on the components of the community work, and implications of the costs involved. It will also consider the strength of CEDPA, or the implementing partner, and their capability to deliver various components. In addition, the consultation will guide the stakeholder's involvement in the project and the extent of their participation. Finally, it will guide the appropriate selection of IAs and MOs and be very clear on their roles and responsibilities from inception.

B. CAPACITY AND NEEDS ASSESSMENT OF IMPLEMENTING PARTNERS AND AGENCIES

USAID should conduct a capacity assessment of the IPs, identify gaps, and come up with clear plans on how and what an IP should address before the award of contracts or the signing of cooperative agreements. This assessment will be prophylactic, managing any eventualities that could thwart effective and efficient management of the project. Likewise, the IP should conduct a capacity assessment and, if possible, a mapping of IAs, should identify gaps, and plan to address the gaps. The IP's capacity assessment should cover what will be required to do an effective job, especially at the inception phase of the project, and should also expand to cover the necessary equipment or provisions that would enhance delivery of projects activities in order to attain the expected project outcomes.

C. INTRODUCTION ON INCEPTION PHASE IN PROJECT MANAGEMENT AND IMPLEMENTATION

An inception phase should be introduced for the implementation and management of this kind of project in the future. The phase will develop the essential preparatory activities required for the project's takeoff. For example, it is not ideal for vehicles or office spaces, etc., to be procured midway or toward the end of the project. These should be done at the preparatory phase for each level of project implementation and management. This is also true of other activities such as trainings etc. An IA in Enugu, compared the PL Project with PSRHH project delivered in the past. She was quoted:

> *"If PL Project is delivered in 12 full months, we will deliver results. The PSRHH project was configured as follows: three months of entry/preparation for take-off of activities, six months of intensive phase for implementation of activities, three months for phasing out where CBOs are expected to be constituted and empowered to enhance sustainability of the project."*

Such configuration could be applied to the implementation of the PL Project with reference to the configuration of the COP years.

Introducing an inception phase will also allow the USAID, the IPs, and IAs to assess and agree on what is doable in order to achieve the targets or address issues noted at this phase. The inception phase will also be helpful in conducting advocacy with key stakeholders at all required level.

D. EARLY ACQUISITION AND PROPER ALLOCATION OF EQUIPMENT TO FACILITATE QUALITATIVE DELIVERY OF PROJECT ACTIVITIES

The date of acquisition of certain equipment such as vehicles was analyzed in the above section on the Introduction on Inception Phase in Project Management and Implementation. Essential equipment that will facilitate implementation and enhance project delivery should be acquired at the inception phase and allocated appropriately to the various levels of project implementation and management. Late acquisition of this equipment prevented monitoring of project activities as envisaged. Also, most IAs do not have any vehicles to conduct monitoring of volunteers' activities and their visits to households to ascertain the quality of services delivered and provide further on the job-training.

E. RECRUITMENT AND REMUNERATION OF ADEQUATE KEY PERSONNEL WITH REQUISITE SKILLS AND EXPERIENCE

This is vital to achieving project objectives and expected outcomes. Remuneration that is competitive with other IPs and the creation of an enabling and friendly working environment are vital in ensuring staff retention and motivation. A staff member noted:

> *"CEDPA should avoid the attitude of if you are not happy, you can go. Conditions of service make one insecure. In the past, I longed to work for CEDPA because things were well arranged and in order."*

Limited concern about staff welfare will only encourage staff attrition. This issue must be addressed as much as possible.

F. REVIEW OF ANNUAL PORTFOLIO REVIEW

The annual portfolio review conducted by USAID should expand beyond a desk review and verbal consultations with the IPs. An independent annual Output to Purpose Review (OPR) should be considered and extend to the level of beneficiaries to assess the quality of services provided, project performance, etc., and to put in place recommendations to address any issues that arise. USAID should guide the IP to draw implementations plans for the recommendations and this should serve as criteria for subsequent disbursement of grants for each COP year.

G. CAPACITY DEVELOPMENT OF STAFF (MANAGERIAL & TECHNICAL)

For effectiveness and efficiency, staff capacity must be continuously improved to ensure delivery and enhance performance of any project or organization. This may be through trainings, mentoring, etc. And where staff do not have the capacity to do the job when hired, there must be proper orientation and plans for on-the-job training and mentoring to enable them to deliver. Running a project through trial and error is not ideal, considering the rights-based approach to humanity projects.

H. SYSTEM FOR PERIODIC PROGRAM MONITORING & EVALUATION

A system for monitoring project performance and the quality of that performance is critical for successful implementation of the project. Such a system would allow managers and decision-makers to monitor progress toward achieving planned project results, make course corrections, and inform planning. It will also serve to give project staff objective feedback on their performance.

I. EFFECTIVE ADVOCACY, COORDINATION, AND COLLABORATION WITH KEY STAKEHOLDERS AT NATIONAL AND STATE LEVELS

This is vital in the spirit of The 3 Ones. This project keyed in to one national strategy, one M&E system, but not the coordination aspect. This should be improved on as no project can be solely managed without appropriate linkages with other bodies required to enhance the project's success. Collaboration with NACA, SACAs, and the appropriate cadre of officers in the line ministries must be explored as much as possible. Awareness should be created about the benefits of the projects as well as their challenges, so that stakeholders who are sensitized could collaborate as required where necessary.

Before the final closure of the project, efforts should be made to properly hand over notes for each state and at national level. This would help with the utilization of human resources whose capacity has been built at the community level, as well with providing continuity of care for the beneficiaries.

J. DECENTRALIZATION OF MANAGEMENT STRUCTURE

Management structure should be decentralized, there should be clear roles and responsibilities, power and authority, clear and adequate reporting lines that allow staff to function and perform maximally at country and in the field offices. This will go a long way in achieving the objectives, vision, and, mission of the organization as originally designed. CEDPA Nigeria has a board of trustees set up to manage the affairs of the organization in the country. This should be allowed to work, as it would go a long way in redeeming the image of the organization. *"In the past, funding flows to country level for operations, unlike now, money and power sit in CEDPA Washington office; this must be reversed for any country program to work. The management of CEDPA needs to reverse back to the vision and mission of the founders in order not to lose focus and the purpose in which the organization was established"* noted past staff of CEDPA, Nigeria.

K. INVOLVEMENT OF STATE OFFICES IN THE SELECTION AND MANAGEMENT OF IAS

Even though most IAs were inherited from GHAIN at the commencement of the project, there is need for clear communication with field offices following staff recruitment, as well as their engagement in the selection of IAs later in the project. The idea of IAs being managed from the country office or headquarters should be looked into. If the field staff are not be allowed to manage the IAs, then there is no point creating field offices. The value of creating of creating field offices is to ensure decentralization and effective management of the project. This should be allowed to work as much as possible in future projects.

L. CONSTITUTION AND STRENGTHENING OF PAC AT ALL LEVELS, ESPECIALLY AT THE COMMUNITY LEVELS

The constitution and strengthening of PAC at all levels should be given adequate consideration in future projects, as stated in the project document. The PAC could support the project in providing direction to the structure and content of the project, advise on integration of networking opportunities, assist in the promotion of partnerships with government and other stakeholders, and act as a link with relevant role players in their respective states and communities. The PAC could also participate in developing and implementing public engagement strategies, including profiling the project amongst stakeholders and organizations. It could also help build momentum for policy change and development, and for dissemination of project results.

M. INDIVIDUALIZATION OF HBC KITS

Ingenuity needs to be applied for HBC kits provided to volunteers so that content can be packed for individual clients, used once, and then disposed. This will encourage cleanliness, and prevent cross infection or possible transmission of HIV to non-infected volunteers. It will also help guide clear budgeting since the cost of kits is calculated on per-capita basis.

N. REVIEW OF BUDGET FOR FUTURE COMMUNITY PROJECTS

The idea of per-capita based budget for the various components of this project is a challenge as expatiated in section three of this report. The idea of per capita may be a good one, but the amount allotted per head may need to be reviewed to ensure that it makes provisions for the following:

- Cost of travel by the volunteers to the facilities to recruit clients,
- Cost of travel for initial home visits and telephone call cards,
- Cost of individualized disposable care kits,
- Cost for follow up visits and care kits which should be determined based on the condition of individual clients,
- Cost for monitoring of the volunteers, and
- Salary for project staff at the level.

APPENDIX A. SCOPE OF WORK

Final Evaluation of the Centre for Development and Population Activities' Positive Living Project in Nigeria (Final 05-24-10)

I. PURPOSE

The purpose of this final evaluation is to assess the process and achievements of the Positive Living (PL) Project implemented by the Centre for Development and Population Activities (CEDPA) in Nigeria under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program. The evaluation will review and analyze both the technical strategies used to improve the quality of life of people living with HIV/AIDS (PLWHA) and their families, as well as the overall management of the project.

Key findings and recommendations are expected to provide USAID/Nigeria's Investing in People (IIP) Office with sufficient information to make programmatic and budgetary decisions regarding future directions. The evaluation will outline opportunities, challenges, and critical areas to address and make recommendations on the most effective and efficient path forward.

Through this evaluation USAID/Nigeria hopes to contribute to advancing the state-of-the-art thinking on technical programming for the care and support of PLWHA in Nigeria specifically and in Africa more generally. The final evaluation report will be disseminated internally, within the Agency, as well as externally, to other U.S. government agencies, PEPFAR partners, the Government of Nigeria, and other stakeholders.

II. BACKGROUND

Project Name:	Positive Living Project
Cooperative Agency:	Centre for Development and Population Activities (CEDPA)
Agreement/Contract Number:	620-A-00-06-00106-00
Agreement Value:	$24,949,850.00
Period of Agreement:	June 2006 to June 2010

Positive Living (PL) is a four-year, USAID-funded project that aims at improving the quality of life of PLWHA and their families, through comprehensive, gender-sensitive, collaborative and consolidated community programs that enhance access to HIV prevention, care, and support services.

The project was implemented in 14 states in Nigeria (including FCT). The Positive Living Project is implemented in close collaboration with two key faith-based multiplier organizations, the Anglican Communion AIDS Control Program (ACAP) and the AIDS program for Muslim Ummah of the National Supreme Council of Islamic Affairs (APMU/NSCIA). The project also collaborates with six triage centers(a mix of public and community-based or faith-based run primary health facilities); and 51 community-based, faith, and non-governmental organizations including networks of PLWHA support groups to deliver adult basic care and support services, care for Orphan & Vulnerable Children (OVC), community TB/HIV treatment support services and sexual prevention services.

Project Strategy

The Positive Living project strategy focuses on three key areas that are essential to building comprehensive community-based HIV services for PLWHAS and their families:

1. Capacity Building: Strengthening community capacity and health systems, focusing on (a) strengthening local organizations, managerial, and primary health care technical capacities; (b) training several cadres of skilled community health workers, PLWHA, and volunteers to deliver quality, comprehensive community-based prevention, care and support services, and; (c) strengthening of the referral systems and health and social networks in the communities.

2. Institutionalization and expansion of community-based HIV services. These include: (a) expanding community-based prevention interventions and services; (b) establishing community-based palliative/home-based care services through systematic organization of the outreach Home-Based Care (HBC) volunteer program and the complementary medical services at both Positive Living and other USG clinical points of care; (c) expanded care for orphans including ensuring education, health and income generation opportunities; and (d) effective management of opportunistic infections.

3. Partnerships with key stakeholders in the communities for joint non-duplicative community action and sustainability.

Expected Outcomes of the Project

To make progress toward reaching its intended goal of improving the quality of life of PLWHA and their families, the Positive Living Project seeks to achieve the following objectives:

- Expanded and comprehensive gender-sensitive community-based/home-based adult care and support services to PLWHA and their families;
- Increased access to HIV sexual prevention services and interventions;
- Facilitate prompt and efficient TB diagnosis, treatment support services, and TB management among PLWHA and their families;
- Expanded care and support to orphans and vulnerable children;
- Provide livelihood programs including sustainable income generating activities (IGA) for PLWHA and affected vulnerable families and children; and
- Strengthened institutional capacity of multiplier organizations (MOs), community-based organizations (CBOs), and/or implementing agencies (IA).

III. STATEMENT OF WORK

In considering the technical aspects of the Positive Living Project, the final evaluation will assess not only the accomplishments made on expected outcomes and challenges, but also the effect on the quality of life of PLWHA and their families and behavior change within target communities. Concerning project administration, the evaluation will assess management issues, and cost-effectiveness and constraints in the process of implementing of the project.

Overarching Questions

The evaluation team will be tasked with addressing the following five overarching questions:

1. What are the greatest achievements made by the project both toward expected outcomes and toward the overall goal of improving the quality of life of PLWHA in communities targeted by the project?
2. To what extent has the project improved the quality of life of PLWHA and their families and catalyzed change of behavior within target communities?
3. How successful were the project's management systems and procedures in facilitating the achievement of expected outcomes and overall project goals?
4. What are the project's major challenges and lessons learned?
5. What strategies should USAID/Nigeria pursue in future programming of interventions addressing the needs of PLWHA, their families, and communities?

Additional Questions

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

1. Greatest achievements toward both expected outcomes and the overall goals
   - What has been the project's level of performance on set targets?
   - What key accomplishments has the project made toward achieving each its six expected outcomes?
   - What key accomplishments has the project made toward achieving its goal of improving the life of PLWHA and their families?
   - To what extent has the project been innovative and creative in its approach to addressing the needs of PLWHA, their families and communities? Was this creativity in ways to reach quantified targets or to improve the quality of services offered?
   - How sustainable is progress made on the project's six expected outcomes?
2. Impact on the quality of life and behavior change
   - To what extent has HIV-related knowledge, attitude, and practice changed in various target groups (e.g., in-school youths, out-of-school youths, teachers, most-at-risk-groups, etc.)?
   - To what extent has the project improved the quality of life of various groups (e.g. PLWHA men and women, OVCs, families of PLWHA, etc.)?
   - What impact has the project had on the quality of care and care-seeking behavior of participating PLWHA?
3. Project management
   - How effective and efficient was the project's organizational and management structure in achieving results?
   - To what extent was the project management team responsive and accountable to its client (i.e., USAID/Nigeria) and key partners (i.e., GHAIN, Government of Nigeria

(NACA, SACA, and Federal Ministry of Women Affairs), faith-based multiplier organizations, health care facilities, and community-based faith and non-governmental organizations (including networks of PLWHA support groups)? What could have been done to make the partnership more effective?

- Were the systems developed by the project for monitoring, evaluation, and knowledge application effective? How have these elements of the program supported the achievement of the overall project objective?
- If specific targets set on performance indicators were not met, why was this the case?
- How effective was USAID in managing the project?

4. Major lessons learned and challenges
   - What specific technical approaches or outputs have demonstrated the greatest impact?
   - What are the factors that contributed to or hindered progress toward outcomes, including those linked to program design, management, and partnerships?
   - Did the project use a cost-effective implementation strategy? What is the estimated cost per unit of outputs produced? How do Positive Living's costs compare with PEPFAR norms and with other projects? What accounts for differences?
   - What issues and gaps have had a significant effect on sustainability?
5. Recommended strategies for future programming
   - What strategies are needed to further strengthen the efficiency, effectiveness, management, and sustainability of the project?
   - What are some more cost-efficient and effective approaches for achieving the results (evaluate from both a short and long-term perspective)?
   - What are the priority areas for future USAID projects addressing the needs of PLWHA, their families, and communities?
   - What components of the Positive Living project strategy should be maintained in their current form? What components should be retained, but modified? Are there components or approaches that are no longer needed?
   - What are some promising new developments in the area of care and support of PLWHA that should be explored in possibly future activities?

IV. METHODOLOGY

The evaluation will be conducted by a team to be identified by USAID/Nigeria in consultation with CEDPA, and data will be collected using primary and secondary sources. Methods and procedures could include:

1. Review of relevant documentation,
2. Self assessment,
3. Team planning meeting,
4. Survey of partner organizations and health facilities,
5. In-depth interviews with key informants,

6. Site visits,

7. Data analysis, and

8. Cost-effectiveness analysis.[12]

A brief description of each data source is provided below. The assessment team will discuss with USAID/Nigeria its specific approach to data gathering, analysis, and presentation prior to field visits.

1. Review of documents and their utilization

USAID/Nigeria and the Positive Living project will provide the evaluation team with historical project documents before the team planning meeting. These documents will include the request for application, technical proposal, initial agreement, amendments, yearly workplans, CEDPA self-assessment reports, financial documents, progress reports, reports from assessments and self-assessments, the mid-term evaluation, official USAID correspondence and feedback (e.g., from portfolio reviews), and any other relevant materials documenting the management, implementation process and results. The evaluation team will be responsible for collecting and reviewing any other relevant documents throughout the evaluation. These include project tools, technical reports and trip reports. The team will review all available materials prior to conducting key informant interviews and as necessary throughout the course of the assessment to be able to determine the extent and nature of their use.

2. Self-assessment

The evaluation team will prepare a self-assessment tool to appraise CEDPA's organizational capacity. This tool will be based on the modified organizational capacity assessment tool used by the mid-term evaluation team to assess CEDPA in 2008. The Mission will share the tool with the evaluation team for review and input during the TPM. The evaluation team will then share the tool with key CEDPA staff in Nigeria and Washington for completion within a two-week timeframe.

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

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

- Share background, experience, and expectations of each of the team members for the assignment;
- Formulate a common understanding of the assignment, clarifying team members' roles and responsibilities;
- Agree on the objectives and desired outcomes of the assignment;
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
- Revisit and finalize the evaluation timeline and strategy for achieving deliverables;

[12] Cost-effectiveness analysis guidelines are available at: http://www.fhi.org/NR/rdonlyres/ez7svgsmatlnljiupck35ipxkbfwqr43tmidspsesufm2ptudeudeiithei2ufzwfbcsebjiilt4ca/31776textR1enhv.pdf

- Develop and finalize data-collection methods, instruments, tools, and guidelines and obtain Mission approval before implementation; and
- Develop preliminary outline of the team's report and assign drafting responsibilities for the final report.

As part of this meeting, the team will meet with the USAID/Nigeria and PL Project staff to review the purpose and scope of the evaluation and finalize the evaluation questions, methods, deliverables, and timeline. The outcome of the team planning meeting will be a detailed workplan report for the evaluation.

4. Survey of partner organizations and health facilities

Since only a small sample of partner organizations can be visited for face-to-face interviews, the evaluation team will develop and administer a survey to gather information from the large number of organizations and health service delivery facilities involved in the project. Organizations to be included in this survey will include: two key faith-based multiplier organizations, primary health care facilities and community-based faith and non-governmental organizations, including networks of PLWHA support groups to deliver adult basic care and support services, care for Orphan & Vulnerable Children (OVC), community TB/HIV treatment support services and sexual prevention services.

Considering the fact that these organizations, not CEDPA, carry out most project activities, the survey will enable the evaluation team to assess critical information such as what motivates partners, what kind of work they are doing, and how they view the systems that CEDPA has put in place. Sufficient time will be allowed to ensure the survey instrument is well designed and pre-tested and that participants are warned that it is coming and of its importance.

5. In-depth interviews with key informants

The evaluation team will conduct in-depth interviews with key stakeholders and partners of the Positive Living project. The evaluation team will develop a structured interview guide that will be used to conduct the interviews. The interviews should be loosely structured, but following the list of questions in the guide. The interviewer will probe for additional information related to each question and document the responses. Interviews will be conducted through face-to-face contact or by telephone as is necessary, subject to the availability of the respondent for a face-to-face interview, which could be determined by time or space.

Respondents to the interviews will be identified by USAID/Nigeria and the project. A list of potential respondents will be developed prior to the start of the evaluation process. Potential respondents will include but not limited to:

- USAID/Nigeria staff;
- Staff of Positive Living partner organizations, including the staff from collaborating USAID projects (e.g., GHAIN);
- Participants in Positive Living project activities e.g., beneficiaries, peer educators, health workers; and
- Positive Living project and support staff.

6. Site visits

The evaluation team will make a limited number of visits to project sites and offices of key partners. Decisions on the sites to be visited will be made jointly by USAID/Nigeria and the

project prior to the start of the evaluation process. The sample of sites to be visited will constitute a representative mix of both successful sites and sites with limited project successes. Additional literature related to Positive Living that might not have been available in Abuja will be collected during these visits.

To be able to truly assess on-the-ground realities, a considerable amount of the evaluation team's time will be spent not only visiting CEDPA's regional offices and the offices of participating NGOs, but also observing the actual delivery of services to beneficiaries. This will entail visiting homes of PLWHA, community centers, schools, hospitals, and other sites where services are delivered. In collaboration with USAID and the Positive Living project, the evaluation team will determine an adequate sample of districts where services are delivered to be visited.

7. Data analysis

The evaluation team leader will be responsible for coordinating the data analysis at the end of the data collection process. The analysis will focus on answering the overarching and specific questions outlined above, as well as any other questions that might come up during the data collection process. Each evaluation team member will participate in the analysis and contribute to the interpretation and triangulation of the data, as their area of specialty allows. Special attention will be given to comparing results from the organizational capacity self-assessment conducted in 2008 at mid-term and the final self-assessment.

The evaluation team will also identify and gather information from other credible sources, such as Demographic Health Surveys (i.e., comparing old and new data), on key data for expected outcomes, target zones and sub-populations targeted under the Positive Living project. The evaluation team will then analyze the data relevant to the project to make plausible association. The evaluation team will present this data in a way that shows the project's potential impact and informs strategic and operational planning for future programs.

8. Cost-effectiveness analysis

The Mission would like the evaluation team to assess the cost-effectiveness of CEDPA's implementation strategy. The SoW provides a link to suggested guidelines for conducting cost-effectiveness analyses on page 4. The Team Leader will discuss this with the Mission at the beginning of the in-country work to clarify expectations.

V. TEAM COMPOSITION

In the proposal, a six-member evaluation team is proposed. This will include two international consultants (a team leader and a deputy team leader) and two local external consultants. In addition to these four consultants, USAID/Nigeria and CEDPA/Nigeria will provide one staff member each for data collection. The team should have the following skills mix:

1. Understanding and hands-on knowledge of USAID and PEPFAR programs;
2. Public health expertise in two or more of the following areas:
   - HIV care and support,
   - Behavior change communication,
   - OVC care and support, and
   - Income generating activities;
3. Financial/grants management;

4. Organizational development and institutional capacity-building; and
5. Knowledge and experience in design, implementation, monitoring and evaluation of international health programs in Africa.

Each team member should have at minimum:

- An advanced degree in health sciences or social sciences, and
- Five to eight years' experience working on public health issues.

In addition, the team leader must have excellent English language skills (both written and verbal) as s/he will have the overall responsibility for the final report. Hausa skills will also be an asset as interviews will have to be conducted with Hausa speaking informants. The proposed team leader is expected to provide a sample of other reports s/he has written for consideration by USAID/Nigeria.

Research/Logistics Assistants (2): The team will be supported by one or two local Research/ Logistics Assistants who will provide logistical and admin support during the team work in country. The logistics assistant will work directly with and report to the team leader.

Responsibilities will include: Arrange for copying/compiling reading materials, field visits, local travel reservations, hotel reservations, appointments with stakeholders, arranging for vehicles for appointments and on-site visits, and other tasks as requested by the team.

- Serve as note takers and organizers during interviews and FGD,
- Participate in daily field debriefing, and
- Write, revise, and submit hard and electronic copies of interviews field notes to the TL.

VI. DURATION, TIMING AND SCHEDULE

The evaluation will begin o/a May 24 and will require about five to six weeks of in-country work. One/two week(s) for preparation, document review and drafting interview and FGD guidelines/questions, two week(s) of data collection and two week(s) of analysis and writing.

An illustrative timeline and LOE schedule is presented below:

Activity	Team Leader LOE	Deputy Team Leader LOE	Local Consultant A LOE	Local Consultant B LOE
PL Project conducts self-assessment	--	--	--	--
PL and USAID submit draft list of key informants to evaluation team	--	--	--	--
Conduct initial team-building meeting and begin document review	1	1	1	1
Review background documents and begin developing and pre-testing data collection tools (for survey and interviews)	4	4	4	4
Travel to Nigeria	2	1	0	0

Activity	Team Leader LOE	Deputy Team Leader LOE	Local Consultant A LOE	Local Consultant B LOE
Team Planning Meeting & Meeting with USAID/Nigeria and PL Project team	2	2	2	2
Finalize data-collection tool and list of key informants based on USAID and PL input	2	2	2	2
Submit data-collection tools for review by USAID/Nigeria	--	--	--	--
USAID and PL review data-collection tools and provide feedback to evaluation team for revision and completion	1	1	1	1
Information and data collection, including interviews with key informants in Abuja	4	4	4	4
Information and data collection, including interviews with key informants in the field	10	10	10	10
Data analysis and draft evaluation report	7	7	7	7
Debrief meeting with USAID and PL Project staff (will be a separate meeting)	1	1	1	1
Submit draft report to USAID/Nigeria and PL Project before team's departure from Nigeria	--	--	--	--
Depart Nigeria /Travel to US/Europe/Africa	2	1	--	--
USAID/Nigeria and PL Project provide comments on draft report (10 days)	--	--	--	--
Team revises draft report and submits in final to USAID (out of country)	8	3	2	2
Mission provides sign-off on the report (5 days)	--	--	--	--
GH Tech edits/formats report (one month)	--	--	--	--
Total Number of days	44	37	35	35

Note: A six-day work week is approved when team is working in country.

VII. DELIVERABLES

The following deliverables will be submitted to USAID/Nigeria Acting Team Leader HIV/AIDS & TB. The timeline for submission of deliverables will be finalized and agreed upon during the team planning meeting.

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

evaluation. The work-plan will include, but not be limited to, a timeline for key activities, due dates for deliverables, and schedules for key informant interviews, country visits, and debriefing meetings.

2. A debriefing will be organized by USAID/Nigeria for the team leader and the team to present key highlights of the evaluation findings to USAID staff using a PowerPoint presentation format. The team leader is expected to be available to lead the debriefing on the date and time agreed to by USAID/Nigeria and the Positive Living project. The team will consider USAID comments and revise the draft report accordingly, as appropriate.

3. A draft report (in both hard and electronic formats) will be submitted by the team leader to USAID/Nigeria and the Positive Living project for review and feedback prior to departure from country and will incorporate comments and feedback from the debriefing.

   The report will provide a comprehensive assessment of the strengths and weaknesses of the Positive Living project; identify successes and achievements, including what worked and what did not work. The report should also include recommendations that will provide guidance for USAID/Nigeria to make decisions on future programming directions. The draft report will be submitted prior to the team leader's departure from Nigeria. Each member of the evaluation team should receive a hard copy of the report for review. USAID/Nigeria and the Positive Living project will provide comments on the draft report to GH Tech within 10 working days of receiving the document.

4. Final report in both hard (**6 copies**) and electronic format. The team leader should submit a final report within 10 working days after receiving written feedback from both USAID/Nigeria and the Positive Living project.

   GH Tech will be responsible for editing and formatting the final report, which takes approximately **30 days** after the final unedited content is approved by USAID/Nigeria. GH Tech makes its evaluation reports publicly available on its website and through the Development Experience Clearinghouse unless there is a compelling reason to keep the report internal (such as procurement-sensitive information).

VIII. LOGISTIC SUPPORT

GH Tech will be responsible for providing logistics support for this assignment. Research Assistants/Logistics Coordinator(s) will be hired to assist the team. USAID/Nigeria guidance on hotels and methods of in-country travel is essential and appreciated.

IX. ROLES AND RESPONSIBILITIES

GH Tech will conduct and manage the assessment and will undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the consultant team.
- Make all logistical arrangements, including travel and transportation, country travel clearance, lodging, and communications.
- Respond to all points included in the SOW and submit a final report, which provides clear and concise findings, conclusions, and recommendations.
- Edit and format the final report and provide the final product to USAID/Nigeria in a timely manner.

GH Tech will also manage and direct the efforts of the local Evaluation Logistics Consultant.

USAID/Nigeria will provide overall technical leadership and direction for the team throughout the assignment and will undertake the following specific roles and responsibilities:

Prior to in-country work:

- Assist GH Tech with identification of potential local consultants and provide relevant information about the implementing partner being evaluated that could create a potential conflict of interest, or the appearance of such, with proposed consultants.
- Identify and prioritize background materials for consultants and provide them to GH Tech as early as possible prior to team work.
- Provide information as early as possible on allowable lodging and per diem rates for stakeholders that will travel/participate in activities with the evaluation team.
- Provide a list of site visit locations, key contacts, and suggested lengths of visit for use in planning in-country travel and accurate estimation of country travel line-items costs (i.e.. number of in-country travel days required to reach each destination, and number of days allocated to interviews at each site).
- Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and identify a person to assist with logistics.

During in-country work:

USAID/Nigeria will undertake the following while the team is in-country:

- Ensure constant availability of the Mission Point of Contact person(s) and continue to provide technical leadership and direction for the team's work.
- Support the Evaluation Logistics Consultant in arranging partner meetings, site visits, and debriefings, particularly with national and local government officials. These meetings should be set up well in advance to ensure their availability.
- Provide guidance on the team's selection of meeting venues for interviews and/or focus group discussions. Introduce team to project partners, local government officials, and other stakeholders, and where applicable and appropriate, prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

Following in-country work:

USAID/Nigeria will undertake the following once the in-country work is completed:

- Provide timely review of draft/final reports and approval of the deliverables.

X. MISSION CONTACT PERSON

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APPENDIX B. PERSONS CONTACTED

Name	Organization	Position
Rose Khasiala Amolo	CEDPA, Abuja	Deputy Chief of Party/HQ Backstop
Lanre Alabi	CEDPA, Abuja	Director, M&E
Sylvester Utulu	CEDPA, Abuja	Asst. Director
Daryl Gutierrez	CEDPA, Abuja	Finance Consultant
Abimbola Oladejo	CEDPA, Abuja	Training Coordinator
Jumoke Oluwayinka	CEDPA, Abuja	FCT, M&E Officer
Uche Eze	CEDPA	Palliative Care Advisor, Imo
Timothy Paul Daret	CEDPA	Palliative Care Advisor
Aruku Christopher	CEDPA	M&E Officer, Calabar
Amina Gadzama	CEDPA	Prevention Advisor
Ajeh Anthony	CEDPA	Palliative Care Advisor
Nwanya Patience	CEDPA	Palliative Care Advisor
Chiakodili Irene	CEDPA	Consultant, M&E
Charles Umar	CEDPA	FCT, Palliative Care Advisor
Olajumoke Williams	CEDPA	M&E Officer, Benue/Kogi
Olufunlola Adedeji	CEDPA	Palliative Care Advisor
Suleiman Tijani	CEDPA	Prevention Advisor, Bauchi Muhammed
Ibrahim Iliyasu	CEDPA	Prevention Advisor
Alfred Kobo	CEDPA	Prevention Advisor
Toochi E. Ohaji	CEDPA	M&E Officer, Imo
Usiemuata Osazuwa	CEDPA	Assoc. Director, Prevention Services
Janet Ibinola	CEDPA	Palliative Care Advisor, Bauchi
Habsat Adano	CEDPA	Administrative Assistant
Leila Madueke	CEDPA	Former Country Director & Chief of Party
Ejiro Otive Igbuzor	CEDPA	Former Country Director
Uche Eze	CEDPA, Enugu	Team Leader & Palliative Care Advisor
Ohaji Toochi	CEDPA, Enugu	Zonal M&E officer
Lungi Okoko	USAID	Strategic Information Advisor
Trevor Rittmiller	USAID	Actg. Deputy Team Leader
Adeola Seweje-Chimunda	USAID	AOTR, CEDPA
Joyce Elele	USAID	M&E Specialist

Name	Organization	Position
Olubunmi Dili-Ejinaka	USAID	Admin
Isa Iyortim	USAID	Program Manager
Akin Atobatele	USAID	M&E Manager
Duke Lawrence Ogbokor	USAID	HMIS Manager
Doreen Magaji	USAID	
Samuel Nwanokwu	USAID	
Dr. Kalada Green	USAID	Head Prevention Team USAID
Tessy	USAID	Programme Assistant, HIV Prevention
Dolapo Ogundehin	USAID	Programme Manager, PMTCT
Temitope Odusote	USAID	Head TB Programme
Hamzat Mohammed	USAID	Programme Manager, TB
Otse Ogorry	USAID	Member, TB Team
Rev. Samuel Akale	ACAP	Coordinator
Ven. N. Ik Okpunor	ACAP	Project Director
Yetunde Ipinoye	ACAP	Project Manager
Tom Ellah	ACAP	Support Group Coordinator
Justina Ebhoerameye	ACAP	M&E Officer
Danjuma Abdullahi	APMU	Project Officer
Alh. Sadiq Rabu	USI	Project Manager
Musa M. Jene	USI	Prevention
Hauwa Usman	APMU	Prevention
Mamunat Ishaq	APMU	Accountant
Ahmed Isah	USI	Project Manager
Maimuna Mohammed	NACA, Abuja	Director, Partnership, Support and Coordination.
Idoteyin Ezirim	NACA, Abuja	CSO Forum Coordinator
Dr. Umo Midred Ene-obong	NASCP	Deputy Director & Head National HIV/AIDS Programme, FMoH.
Dr Orji Nneka	NASCP	Focal Person, Partnership & Collaboration
Yusuf Oliver	BDACA, Bauchi	PE Coordinator
Polmi Timothy	BDACA, Bauchi	Peer Educator
Adamu Abdullahi	BDACA, Bauchi	Peer Educator
Gambo Marti	BDACA, Bauchi	Peer Educator
Danjuma Gidado	BDACA, Bauchi	Peer Educator
Thomas Maji	BDACA, Bauchi	Peer Educator

Name	Organization	Position
Dantani Musa	BDACA, Bauchi	Peer Educator
Amabi John	CEFMI, Kogi	CEO/Managing Director
Ugbede Egwu	CEFMI, Kogi	HBC, Coordinator
Oche David	CEFMI, Kogi	Programme Officer
Idris Yunusa	CEFMI, Kogi	Prevention Officer
Oyibo Abudu Oyibo	CEFMI, Kogi	Project Accountant
Samuel Ochala	CEFMI, Kogi	Palliative Coordinator
Ogijo Gideon	CEFMI, Kogi	Prevention Officer
Ojoma Queen	CEFMI, Kogi	Prevention Officer
Deborah Alhassan	CEFMI, Kogi	M&E Officer
Patience Wada	CEFMI, Kogi	
Attah Omakwu	Owowolo Community, Kogi	Igago-Chief
Yahaya Akwu	Owowolo Community, Kogi	Igago-Chief
Hon. James Akoji	Owowolo Community, Kogi	Councillor , Ochamadu Ward
Aliu Musa	Owowolo Community, Kogi	Community Leader
Mohammed Ocholi	Owowolo Community, Kogi	School Principal & Imam
Memuna Onoja	Owowolo Community, Kogi	Women Leader
Dr. Irene Aniyom	Cross River State Agency for the Control of AIDS	Director General
Martins Atokpa	Cross River State Agency for the Control of AIDS	Admin/Gender Officer
Beatrice A. Takon	Cross River State Min. Women Affairs	Permanent Secretary
Patience O. Uke	GHAIN, Calabar	Referral Coordinator
Hubert Ogar	GHAIN, Calabar	Zonal Manager
Sylvia Enegbeoford	GHAIN, Calabar	HCT Coordinator
Kenneth Oboh	SFH, Calabar	Territorial Manager
Kalu Uka	SFH, Calabar	Regional Manager
Andrew Okpe	SFH, Calabar	Assistant Manager
IniAbasi Nglass	SFH, Calabar	Assistant Manager
Christopher Aruku	SFH, Calabar	M&E Officer
Vivian Imogbo	PDF, Calabar	Palliative Care
Cecilia Ofum	PDF, Calabar	HBC Team Head
Mesembe Idem	PDF, Calabar	M&E Officer
David Sunday	PDF, Calabar	OVC Care Coordinator
Rose Omini	PDF, Calabar	Finance Officer
Bassey S. Ante	PDF, Calabar	OVC Care Coordinator

Name	Organization	Position
Pastor Daniel C. Madebueze	PDF, Calabar	Prevention Coordinator
Love E. Bassey	PDF, Calabar	Prevention Team Head
Hope Meadows	PDF, Calabar	Project Coordinator
Uwem Effiong	PDF, Calabar	Beneficiary
Pastor Sunday Joshua	CAIV, Calabar	
Gertrude E. Nsah	CAIV, Calabar	
Happiness Ezekwe	CAIV, Calabar	
Juliana Ukan	CAIV, Calabar	
Sarah Okon Daniel	CAIV, Calabar	
Abigail Edet Peter	CAIV, Calabar	
Henry Henshaw	CAIV, Calabar	
Glory Micheal Ikunya	CAIV, Calabar	
Ettah Evans	CAIV, Calabar	
Mary Mbrukem	CAIV, Calabar	
Effiong Harim	CAIV, Calabar	
Edet Sunday	CAIV, Calabar	
John Ita	CAIV, Calabar	
Patience Owahi	CAIV, Calabar	
Aniedi Albert	CAIV, Calabar	
James Etim	CAIV, Calabar	
Maryjane Osang	CAIV, Calabar	
Blessing Benjamin	CAIV, Calabar	
Wakoni Eno	CAIV, Calabar	
Stella Okon	CAIV, Calabar	
Obi B. Appolonia	SWAAN, Enugu	Project Director
Ezekunie Appolonia	SWAAN, Enugu	HBC Coordinator
Stephen Ihemeobi	SWAAN, Enugu	Admin/Finance Officer
Anekwe Frances N.	SWAAN, Enugu	Project Coordinator
Ogbodo Sandra N.	SWAAN, Enugu	M&E Officer
Ugwu Juliet C.	SWAAN, Enugu	Prevention Coordinator
Aneke Chinasa	SWAAN, Enugu	
Nwobodo Ihemeremma	SWAAN, Enugu	
Edeh Modecai	SWAAN, Enugu	
Omaba Ozoemena	SWAAN, Enugu	
P.O. Samuel	SWAAN, Lagos	Executive Secretary

Name	Organization	Position
Owolabi O.K.	SWAAN, Lagos	Project Officer
Oguntoye Olawale	SWAAN, Lagos	HBC Coordinator
Oseni Bukola	SWAAN, Lagos	M&E Officer
Fagbolagun Olusegun	SWAAN, Lagos	Peer Educator
Euna Enyia	WCH, Lagos	M & E Officer
Emeka Nwakwo	WCH, Lagos	Project Coordinator
Moses Odey	WCH, Lagos	Accountant
Chika Nnoruka	WCH, Lagos	HBC Coordinator
Eneachu Petrus	GHARF, Enugu	Prevention Coordinator
Ogoamaka Aginam	GHARF, Enugu	Project Coordinator
Egbune Augustina	GHARF, Enugu	M&E Officer
Juliet Agu	GHARF, Enugu	Finance Officer
Ogechi Ogu	GHARF, Enugu	HBC Coordinator
Barr. Maria Ohsho	GHARF, Enugu	Administrative Officer
Abdusalam Adetokunbo	MAGA, Lagos	Project Manager
Abdulyakeen Aisha	MAGA, Lagos	HBC Coordinator
Fadile Abimbola	MAGA, Lagos	Finance/Admin Officer
Mohammed Ibrahim	GHAIN	Director medical Services
Jael Kwakfut	GHAIN	Coordinator Referral Services
Obinna Ogbanufe	GHAIN	Senior Advisor Care & Support
Eze Bishop	GHAIN, Awka	Project Manager
Abubakar Ahmad	GHAIN, Kano	Zonal Referral Coordinator
Mr Tocka	Agbani District Hospital Enugu	GHAIN Project Coordinator
Fransisca Nwokolo	Enugu SACA	Community Mobilization Officer
Amal Shehu	SFH, Kano	Regional Manager
Hadiza Alhamdul	SFH, Kano	Assistant Manager
Dr, Ashiru Rajab	SMoH/SACA, Kano	SAPC/Secretary
Ibrahim Ilyasu	CEDPA, Kano	Program Manager
Rabi Ibrahim	CEDPA, Kano	Former State Team Leader
Farouk R. Mudi	CEDPA, Kano	Current State Team Leader
Hajiya Hauwa A. Mohammed	SMoWA & SD, Kano	Deputy Director, Social Welfare
Ahmed Alli	CEDPA, Kano	Admin/Receptionist
Abdullahi Sani Ibrahim	Tamaiko Support Group, Kano	Project Staff
Danladi Ibrahim	Tamaiko Support Group, Kano	Prevention Coordinator
Atine Abubakar	Tamaiko Support Group, Kano	OVC Coordinator

Name	Organization	Position
Abdulhadi Abdullahi	Tamaiko Support Group, Kano	Director
Nafisat Mukhtar	Tamaiko Support Group, Kano	HBC Coordinator
Nura Uba	Tamaiko Support Group, Kano	OVC Coordinator
Suraya S. Khalid	Tamaiko Support Group, Kano	HBC Coordinator
Pius Bature	Tamaiko Support Group, Kano	HBC Coordinator
Farouk Umar Garba	Tamaiko Support Group, Kano	Accountant
Abdullahi Mohammed	Tamaiko Support Group, Kano	Project Coordinator
Safiya Sanusi	Tamaiko Support Group, Kano	HBC Coordinator
Mohammed Dabo Karanga	Tamaiko Support Group, Kano	Prevention Coordinator
Danladi Mohammed	Tamaiko Support Group, Kano	Prevention Coordinator
Fatima Harunna	Tamaiko Support Group, Kano	M&E Officer
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Hafsat Umaru	TSG/NURTW	Peer Educator
Nahima Abdullahi	TSG/NURTW	Peer Educator
Ali Sabo	TSG/NURTW	Peer Educator
Umaru Ahmed	TSG/NURTW	Peer Educator
Buraimah Jibor	TSG/NURTW	HVOP Beneficiary
Abdul I. Abdul	TSG/NURTW	HVOP Beneficiary
Ibrahim Khalid Aliyu	TSG/NURTW	HVOP Beneficiary
Ummi G. Shu'aibu	TSG/NURTW	HVOP Beneficiary
Nafisah Mukhtar	TSG Member	OVC Caregiver/PLWHA
Aisha Salisu	TSG Member	OVC Care giver/PLWHA
Jamila Zakari	TSG Member	OVC Caregiver/PLWHA
Maryam Balarabe	TSG Member	OVC Caregiver/PLWHA
Zulai Idris	TSG Member	OVC Caregiver/PLWHA
Hauwa Mohammed	TSG Member	OVC Caregivers/PLWHA
Rukayat Mohammed	TSG Member	OVC Caregiver/PLWHA
Rayila Sahad	TSG Member	OVC Caregiver/PLWHA
Rahama Isah	TSG Member	OVC Caregiver/PLWHA
A Group of 12 IDUs	TSG	HVOP Beneficiaries
Umaru A. Tara	BDACA, Bauchi	HBC Beneficiary
Abdullahi Nuhu	BDACA, Bauchi	HBC Beneficiary
Ishaya Daniel	BDACA, Bauchi	HBC Beneficiary
Ladia Solomon	BDACA, Bauchi	HBC Beneficiary
Hanatu Dashi	BDACA, Bauchi	HBC Beneficiary/OVC Caregiver
Moses Obida	BDACA, Bauchi	HBC Beneficiary

Name	Organization	Position
Jude Solomon	BDACA, Bauchi	HBC Beneficiary
Mary Dashi	BDACA, Bauchi	OVC
Matthew Dashi	BDACA, Bauchi	OVC
Bamayi Bitrus	BDACA, Bauchi	HBC Beneficiary/OVC Caregiver
Rev. O.W Basharu	BDACA, Bauchi	M&E Officer
Paul Dayit Ian	BDACA, Bauchi	Project Coordinator
Gbenga Falodun	BDACA, Bauchi	Project Accountant
Yusuf Oliver	BDACA, Bauchi	Prevention Coordinator
Tangana Mohd Gidado	FOMWAN, Bauchi	Health Team Leader
Suleiman Tijjani Muhammad	RAHAMA Women Development Programme, Bauchi	Prevention Coordinator
Hadiza Musa	RAHAMA Women Development Programme, Bauchi	Project Coordinator
Elizabeth Gajere	RAHAMA Women Development Programme, Bauchi	Basic Care & Support Coordinator
Habiba A. Alli	RAHAMA Women Development Programme, Bauchi	Project Director
Miriam Y. Illya	RAHAMA Women Development Programme, Bauchi	Program Officer
Usman Hamma Lamara	RAHAMA Women Development Programme, Bauchi	Peer Health Facilitator
Sanusi Ladan	RAHAMA Women Development Programme, Bauchi	Peer Health Facilitator
Lukman Muhammad	RAHAMA Women Development Programme, Bauchi	Peer Health Facilitator
Wilson Dunga	RAHAMA Women Development Programme, Bauchi	Peer Health Facilitator
Peter Philip	RAHAMA Women Development Programme, Bauchi	Peer Health Facilitator
Josiah Markus	RAHAMA Women Development Programme, Bauchi	HVAB Beneficiary
Samu Ayuba	RAHAMA Women Development Programme, Bauchi	HVAB Beneficiary
Aliyu D. Muhammad	RAHAMA Women Development Programme, Bauchi	HVAB Beneficiary
Rabi Isa	RAHAMA Women Development Programme, Bauchi	HBC Beneficiary/OVC Caregiver
Habiba Yakubu	RAHAMA Women Development Programme, Bauchi	HBC Beneficiary/OVC Caregiver
Hussaina Saidu	RAHAMA Women Development Programme, Bauchi	HBC Beneficiary

Name	Organization	Position
Aishatu Abubakar	RAHAMA Women Development Programme, Bauchi	HBC Beneficiary
Fatima Suleiman	RAHAMA Women Development Programme, Bauchi	HBC Beneficiary
Patience N. Caleb	RAHAMA Women Development Programme, Bauchi	HBC Beneficiary
Dorcas Yohanna	RAHAMA Women Development Programme, Bauchi	HBC Beneficiary
Rukaiyatu Umar	RAHAMA Women Development Programme, Bauchi	HBC Beneficiary
Christiana Dangana	RAHAMA Women Development Programme, Bauchi	HBC Beneficiary
Muhammad Kabir Ahmed	RAHAMA Women Development Programme, Bauchi	HIV Prevention Beneficiary
Ismail Musa Bello	RAHAMA Women Development Programme, Bauchi	HIV Prevention Beneficiary
Usman Bello	RAHAMA Women Development Programme, Bauchi	HIV Prevention Beneficiary
Zuwaira Aminu	RAHAMA Women Development Programme, Bauchi	HIV Prevention Beneficiary
Aishatu Musa	RAHAMA Women Development Programme, Bauchi	HIV Prevention Beneficiary
Buhari Ladan	RAHAMA Women Development Programme, Bauchi	HIV Prevention Beneficiary
Aishatu Idris	RAHAMA Women Development Programme, Bauchi	HIV Prevention Beneficiary
Grace John	RAHAMA Women Development Programme, Bauchi	OVC Beneficiary
Fatima Suleiman	RAHAMA Women Development Programme, Bauchi	OVC Beneficiary
Nyaraumu John	RAHAMA Women Development Programme, Bauchi	OVC Beneficiary
Fatima Salisu	RAHAMA Women Development Programme, Bauchi	OVC Beneficiary
Zabba'u Hudu	RAHAMA Women Development Programme, Bauchi	HIV Prevention Beneficiary
Kabiru Mohammed	RAHAMA Women Development Programme, Bauchi	HIV Prevention Beneficiary
Firdausi B. Jibrin	RAHAMA Women Development Programme, Bauchi	HIV Prevention Beneficiary
Ikilima Gidado	RAHAMA Women Development Programme, Bauchi	HIV Prevention Beneficiary
Amina Gidado	RAHAMA Women Development Programme, Bauchi	HIV Prevention Beneficiary

Name	Organization	Position
Abdu Danladi Mohammed	Bauchi State Ministry of Health	State AIDS Programme Coord.
Abdullahi A. Saleh	Bauchi State Ministry of Health	M&E Officer, SASCP
Hussaini Lawal Bello	Bauchi State Health Mgt. Board	CHEW, State TB Program
Rakiya Idris	SWATCH, Kano	HBC Volunteer
Salamatu Ilyasu	SWTACH, Kano	HBC Beneficiary
Habiba Adamu	SWTACH, Kano	HBC Beneficiary
Rebecca Sunday	SWTACH, Kano	HBC Beneficiary
Hudiatu Baba	SWTACH, Kano	HBC Beneficiary
Zuwaira Mustapha	SWTACH, Kano	HBC Volunteer
Fati Mustapha	SWTACH, Kano	HBC Volunteer
Rabi Abdullahi	SWTACH, Kano	HBC Volunteer
Abdullahi M. Yala	SWTACH, Kano	Program Officer
Ramatu Shehu Garba	SWTACH, Kano	Project Director
Bilkisu Garba	SWTACH, Kano	M&E Officer
Muhammad Nasir	SWTACH, Kano	Account Officer
Zubaida Hassan	SWTACH, Kano	HBC Beneficiary/Volunteer
Fatima Mamuola	SWTACH, Kano	HBC Beneficiary/Volunteer
Rafiya Muhammed	SWTACH, Kano	HBC Beneficiary/Volunteer
Zainab Mamuola	SWTACH, Kano	HBC Beneficiary
Fatima Falalu	SWTACH, Kano	HBC Beneficiary
Umma Ashiru	SWTACH, Kano	HBC Beneficiary
Hauwa Isah	SWTACH, Kano	HBC Beneficiary
Hadiza Umar	SWTACH, Kano	HBC Beneficiary
Abubakar Muhammed	SWTACH, Kano	HBC Beneficiary
Sabo Idris	SWTACH, Kano	PLWHA Support Group member
Umar Ibrahim	SWTACH, Kano	HBC Beneficiary
Baba Balarabe	SWTACH, Kano	HBC Volunteer
Garba Suleiman	SWTACH, Kano	HBC Volunteer
Farouk Abdullahi	SWTACH, Kano	HBC Volunteer
Haruna Muhammed Gano	SWTACH, Kano	HBC Beneficiary
Auwal Suleiman	SWTACH, Kano	HBC Beneficiary
Usman Musa	SWTACH, Kano	HBC Volunteer
Mustapha Suleiman	SWTACH, Kano	Chairman, PLWHA Support Group
Yahawasu Mahmud	SWTACH, Kano	Peer Health Facilitator – AB
Ameenafu Ubah	SWTACH, Kano	Peer Health Facilitator – AB
Rukayyat Abdullahi	SWTACH, Kano	Peer Health Facilitator – AB

Name	Organization	Position
Maimunata Yahaya	SWTACH, Kano	Peer Health Facilitator – AB
Garba Haladu	SWTACH, Kano	Peer Health Facilitator - AB
Usman Saleh Auwal	SWTACH, Kano	Peer Health Facilitator – AB
Nura Ibrahim	SWTACH, Kano	HIV Prevention Beneficiary – AB
Salisu Muhammed	SWTACH, Kano	HIV Prevention Beneficiary – AB
Shigaba Jackson J.	YAHWEP, Lokoja, Kogi	Peer Educator – AB
Adeleye Taiye	YAHWEP, Lokoja, Kogi	Peer Educator – AB
Aguda M. Ruth	YAHWEP, Lokoja, Kogi	Peer Educator – AB
Adeleye Kehinde	YAHWEP, Lokoja, Kogi	Peer Educator – AB
Adebayo Tope	YAHWEP, Lokoja, Kogi	HIV Prevention Beneficiary – AB
Adagiri Ruth	YAHWEP, Lokoja, Kogi	Peer Educator – AB
Ogundare Taiye	YAHWEP, Lokoja, Kogi	HIV Prevention Beneficiary
Ajewole Samuel	YAHWEP, Lokoja, Kogi	HIV Prevention Beneficiary
Oni Blessing	YAHWEP, Lokoja, Kogi	HIV Prevention Beneficiary
Ameh O. Victor	YAHWEP, Lokoja, Kogi	HIV Prevention Beneficiary
John Joan	YAHWEP, Lokoja, Kogi	HIV Prevention Beneficiary
Gloria Ameh	YAHWEP, Lokoja, Kogi	HBC Coordinator
Matthias A. Okpnanchi	YAHWEP, Lokoja, Kogi	Project Coordinator

APPENDIX C. REFERENCES

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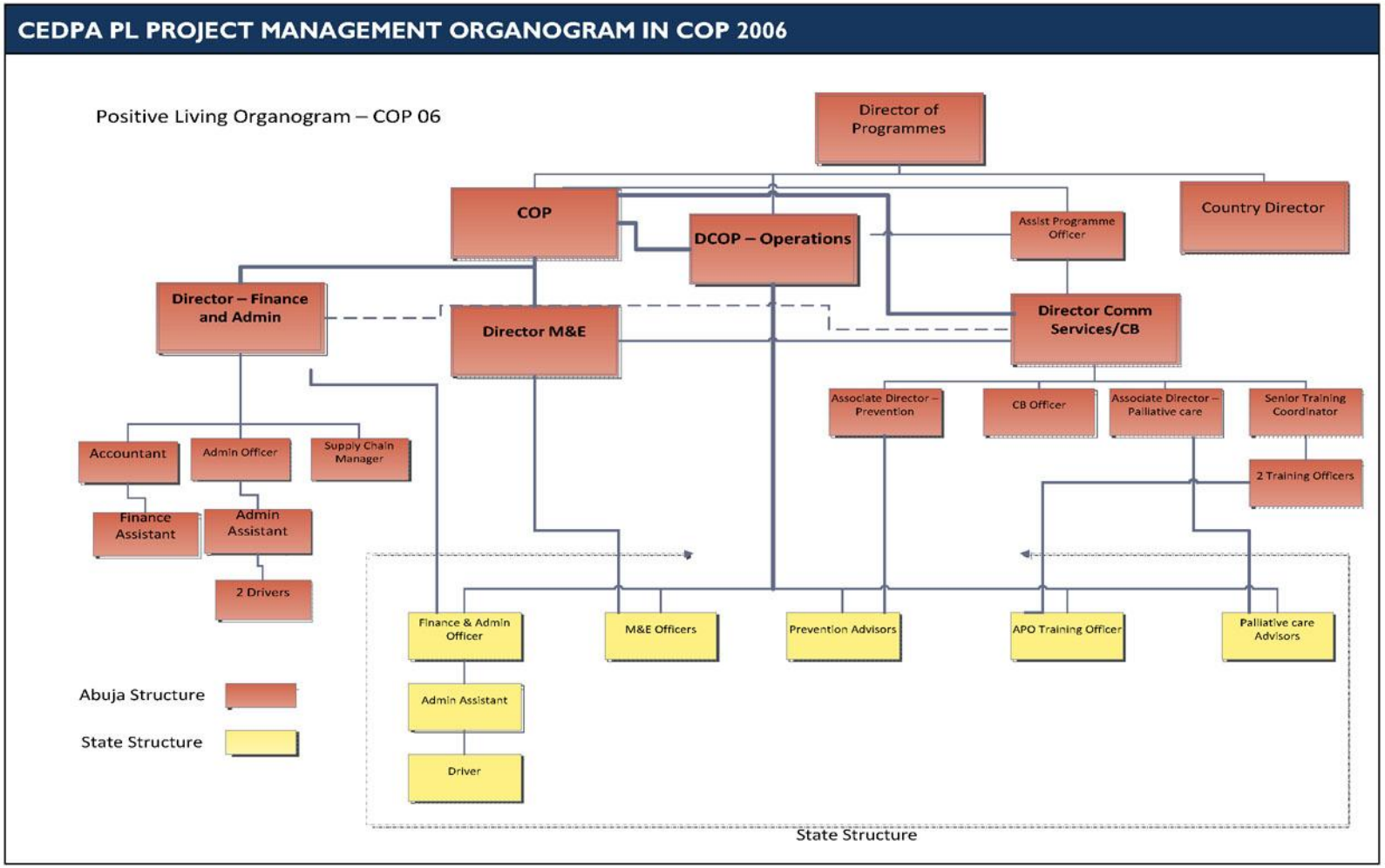
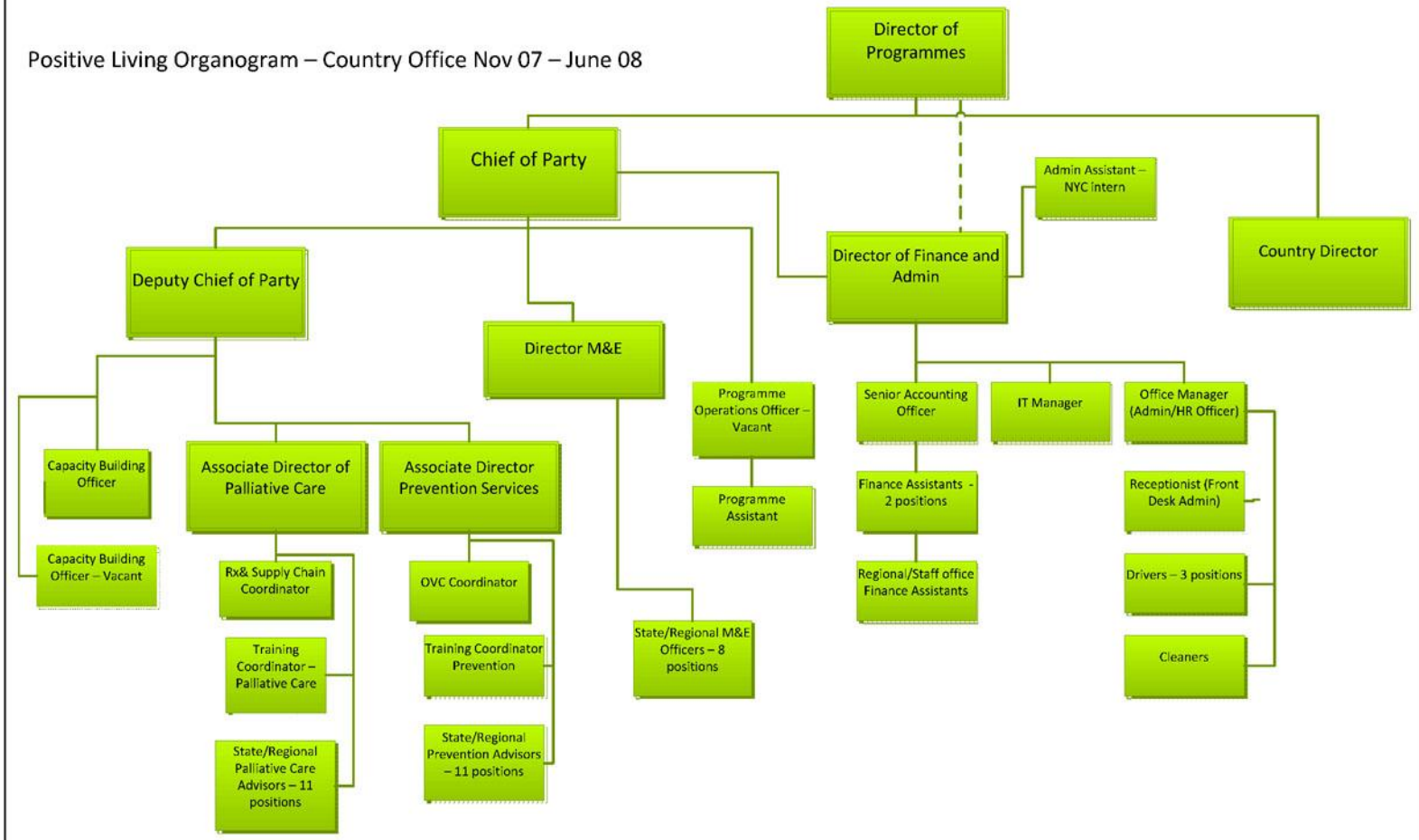
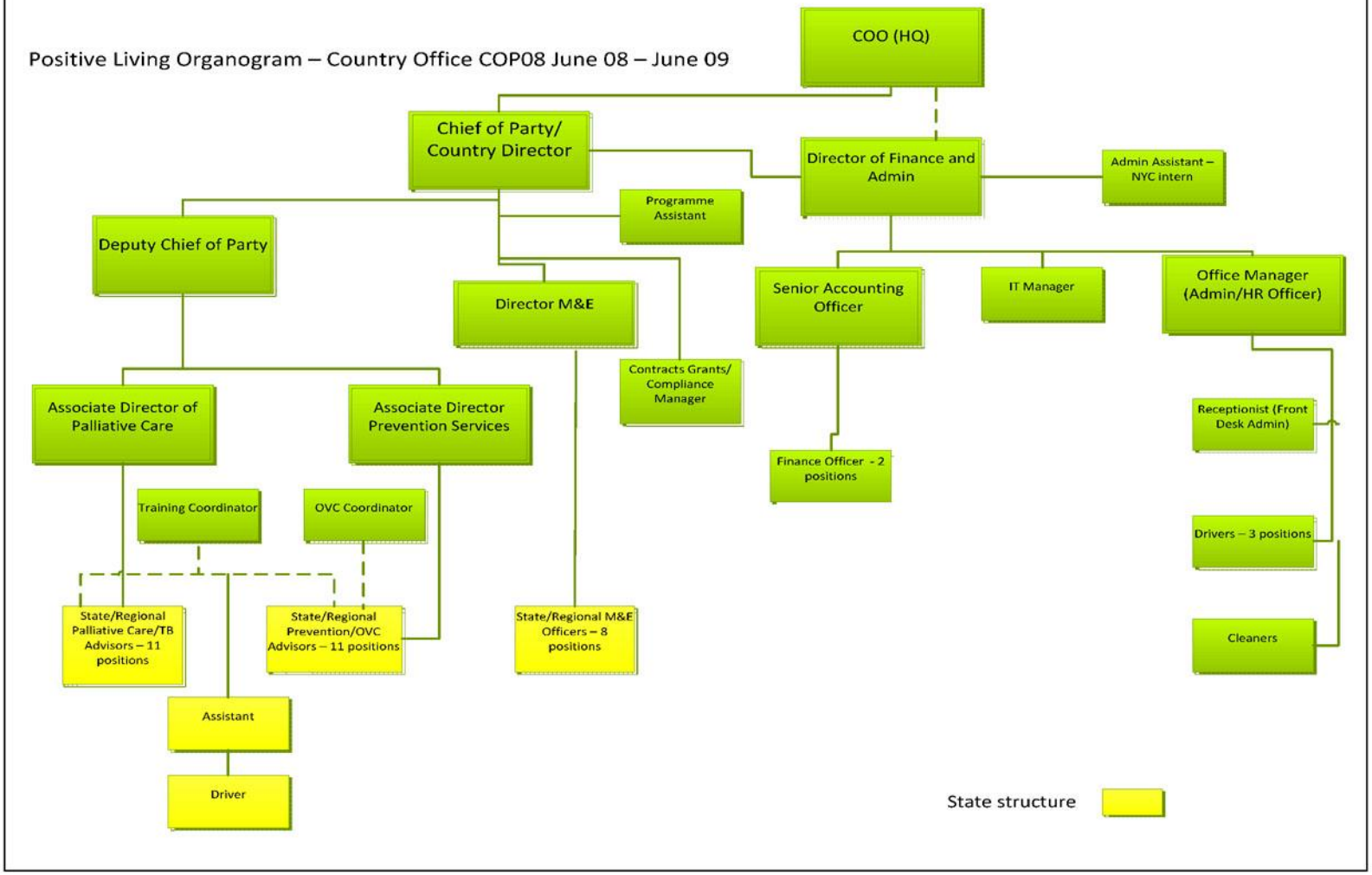
APPENDIX D. CEDPA PL PROJECT MANAGEMENT ORGANOGRAM FOR COP YEARS 2006–2009



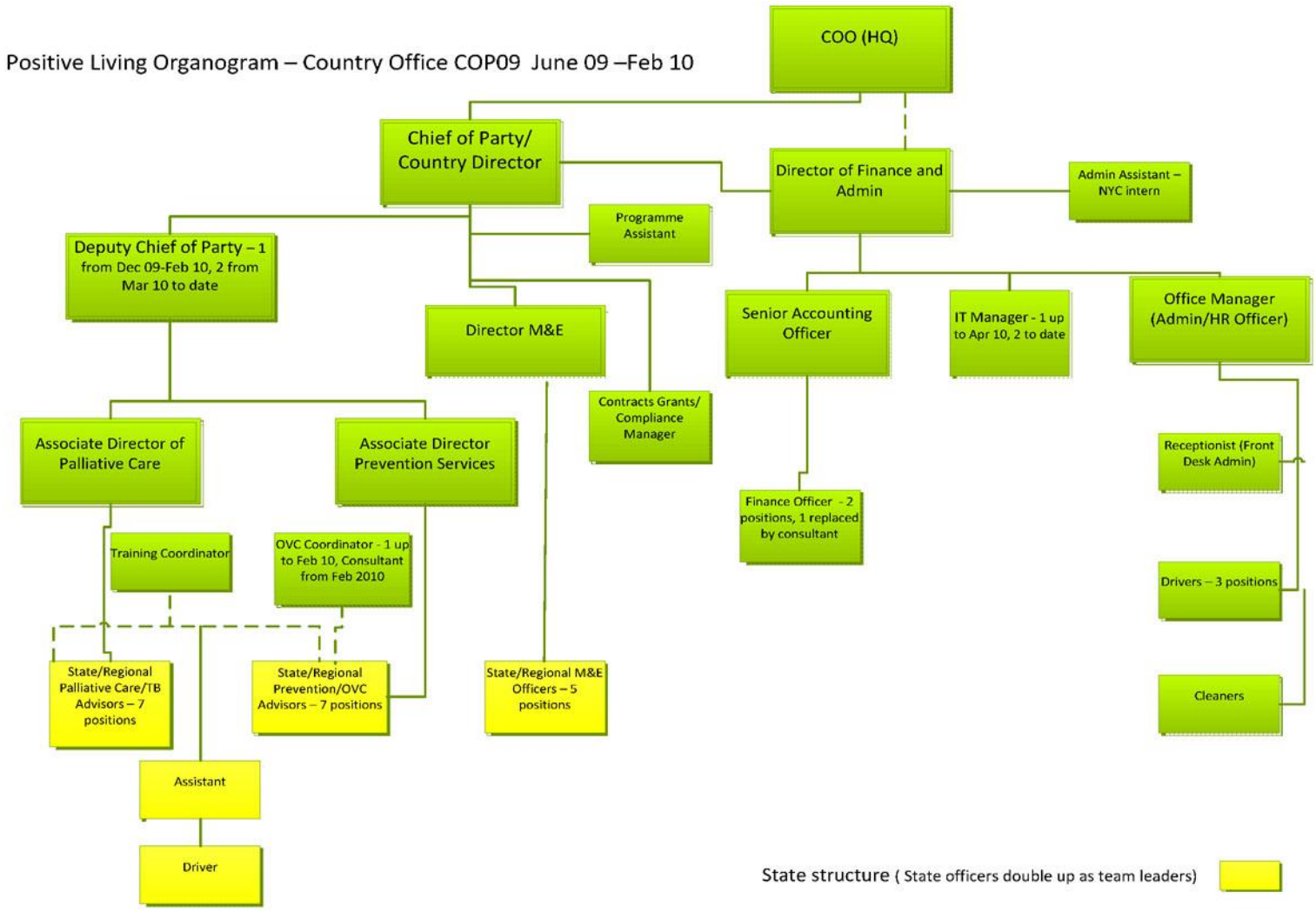
CEDPA PL PROJECT MANAGEMENT ORGANOGRAM IN COP 2007



CEDPA PL PROJECT MANAGEMENT ORGANOGRAM IN COP 2008



CEDPA PL PROJECT MANAGEMENT ORGANOGRAM IN COP 2009



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